



**Unmasking Strength:
The Impact of the Strong Black Woman Archetype on Health, Coping, and
Wellness in Black Women in U.S. Southern Communities**

Noelle E. Smith

North Carolina Central University

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FEMtor: Tiffani Reeves

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Abstract

The Strong Black Woman Archetype (SBWA) describes a culturally embedded expectation that Black women exhibit unwavering strength, emotional restraint, and self-reliance despite the chronic stress and structural adversities they face. While this archetype has often been framed as resilience, emerging research suggests that internalizing such expectations may contribute to adverse physical and mental health outcomes. This literature review examines how the SBWA intersects with health disparities, medical mistrust, and stress-related illness among Black women, with a particular focus on Southern U.S. communities and the state of North Carolina.

Drawing on local, regional, national, and global data, this review demonstrates that heightened stress exposure, elevated allostatic load, and delayed engagement with healthcare systems are consistent patterns across geographic contexts. These disparities are not isolated to North Carolina but reflect a broader, global expectation of strength placed on Black women. Nationally, the review synthesizes data related to cardiovascular disease, mortality rates, and chronic stress among Black women, while regional analyses highlight how these inequities are intensified across the Southern United States. At the local level, the review examines disparities documented in Durham County, Wake County, and the city of Raleigh, illustrating how aggregate improvements can obscure persistent racial inequities. Collectively, these findings reveal gaps in existing research and policy, particularly the lack of culturally responsive, community-driven approaches that center Black women's lived experiences. Policy recommendations emphasized the adaptation of existing global and national models including respectful maternity care frameworks, Medicaid-supported perinatal services, and community-based chronic disease prevention programming. Together, these findings highlight the urgent need for equity-driven policies that address both structural health disparities and the cultural expectations that disproportionately burden Black women's physical and psychological well-being.

Introduction: The Archetype of Strength and Its Hidden Costs

Black women in the United States continue to experience profound health disparities shaped by intersecting systems of race, gender, and structural inequality (Chinn et al., 2021). Despite overall advancements in women's health, Black women remain disproportionately affected by stress-related and reproductive health outcomes. Nationally, Black women are approximately three to four times more likely to die from pregnancy-related causes than their White counterparts, demonstrating persistent inequities in care and chronic stress exposure (Chinn et al., 2021). Beyond physical outcomes, racialized and gendered social conditions, such as the Strong Black Woman Archetype (SBWA), influence psychological well-being, coping behaviors, and patterns of help-seeking amongst Black women. Comparable patterns emerge globally, as women of African descent across diverse contexts encounter similar intersections of structural disadvantage and cultural expectations (Edge & Rogers, 2005). The importance of examining these disparities lies in understanding how culturally embedded norms, especially those emphasizing emotional restraint and resilience, shape psychological responses to stress. This research seeks to bridge that gap by examining how the Strong Black Woman Archetype influences health and coping among Black women in Southern communities. It explores how cultural expectations of resilience shape responses to stress and help-seeking behavior, and how organizations centered on Black women's empowerment work to counter these challenges. The central research question of this study is: How does internalizing the Strong Black Woman Archetype impact the health and coping strategies of Black women in Southern U.S. communities, and how can culturally relevant interventions promote well-being?

Strong Black Woman Archetype

The image of the Strong Black Woman Archetype (SWBA) has long been celebrated as a symbol of unyielding endurance, independence, and resilience. This archetype reflects a societal expectation, and in many ways, a stereotype, which demands Black women constantly exhibit strength, self-reliance, and emotional restraint (Subhan & Johnson, 2022). Society praises these traits as virtues, yet they come at a silent cost, placing an enduring weight upon the shoulders of Black women. Over a century ago, W.E.B. Du Bois (2020) reflected on this resilience, writing, "*But what of Black women? I most sincerely doubt if any other race of women could have brought its fineness up through so devilish a fire.*" His reflection captures how the archetype was born as a form of survival—a response to the centuries of racial and gendered oppression. Yet, what was once a necessity for endurance has evolved into an expectation for absolute perfection. For many Black women, embodying strength feels like "putting on armor" each day in preparation for the burdens of discrimination and societal expectation (Manke, 2019). While this

archetype can serve as a source of pride and empowerment, it has its hidden costs. Legendary author and scholar Gloria Jean Watkins, better known as “bell hooks,” reminds us in *Ain't I a Woman: Black Women and Feminism* of the following:

when people talk about the ‘strength’ of Black women, they are referring to how they perceive Black women coping with oppression. They ignore the reality that to be strong in the face of oppression is not the same as overcoming oppression, that endurance is not to be confused with transformation (hooks, 1981).

Her words highlight the central paradox of the Strong Black Woman Archetype: that the ability to endure pain and adversity has been mistaken for genuine societal healing and liberation. Her insight underscores the notion that strength, while essential to survival, should not be romanticized when it conceals the psychological and physiological costs that Black women carry. True transformation, as hooks emphasizes, requires moving beyond mere endurance to create space for vulnerability, rest, and holistic care.

However, the Strong Black Woman archetype cannot be fully understood without tracing its roots. SBWA emerges, in part, from the Superwoman Schema, a framework developed by Cheryl Woods-Giscombé (2016). The Superwoman Schema arose as a response to the racism and sexism that Black women endured, serving as both a survival mechanism and a culturally empowering reaction to centuries of oppression. It specifically pushed back against long-standing stereotypes such as “The Mammy,” “The Jezebel,” and “The Sapphire. These harmful and inaccurate caricatures reduced Black womanhood to distorted roles that ignored the complexity and humanity of real Black women. The Superwoman Schema sought to counteract these narratives by emphasizing strength, resilience, and independence (Woods-Giscombé et al., 2016).

While the schema began as a positive and empowering response, over time it evolved into a form of suppression. What once represented empowerment became a psychological expectation. Many Black women began to feel compelled to project strength at all times—even within the comfort of their own homes. Author Marita Golden discusses how she never once saw her mother cry, and how, in turn, she worried her own son would never see her cry either (Golden, 2021, p. 25). Crying, often seen as a symbol of weakness, became yet another act discouraged by societal norms, particularly when performed by Black women.

Cultural Reinforcement of the Strong Black Woman

Society also reinforces these expectations constantly through modern media. For instance, in many of Shonda Rhimes’s television series, the SBWA is vividly portrayed. In *How To Get Away with Murder*, Viola Davis’s character exemplifies the SBWA through her fierce independence and emotional

restraint (D'Elia et al., 2014). Similarly, in *Scandal*, Kerry Washington's portrayal of Olivia Pope embodies the archetype: resilient, commanding, and composed, yet internally conflicted and emotionally isolated. The company's motto, "Olivia Pope and Associates does not cry," perfectly captures this suppression of emotion and the pressure to remain unshakably strong; this pressure is rooted in and continually reinforced by intraracial expectations emphasized through parental influence, underscoring the pervasive nature of the Strong Black Woman archetype (McGuigan, 2012; Kerry Washington: At the Center, 2025).

Outside of the media, this phenomenon is observable throughout history. Harriet Tubman, a formerly enslaved abolitionist, led others to freedom through the Underground Railroad in the United States during the nineteenth-century (Dawson, 2024). Sojourner Truth, also formerly enslaved, emerged as a prominent advocate for both racial equality and women's rights, delivering powerful speeches such as "Ain't I a Woman?" shaping early discourse on Black womanhood (Women & The American History, n.d.). Katherine Johnson was a NASA mathematician whose calculations were critical to the success of early U.S. space missions; her story was depicted in the movie *Hidden Figures* later on in 2016 (Shetterly, 2016; Melfi, 2016). Michelle Obama served as the First Lady of the United States and later emerged as a global advocate for education, health, and social equity; while also publicly reflecting on the racialized and gendered scrutiny she faced as a Black woman in the role (The White House Historical Association, 2019). Similarly, Kamala Harris made history as the first Black woman to serve as Vice President of the United States ("Kamala Harris Becomes First Female, First Black and First Asian-American VP," 2021). Each of these women represents a public embodiment of perseverance and resilience while also reflecting the expectations of the Strong Black Woman Archetype, which demands endurance in the face of sustained societal, cultural, and structural pressures. Although these women are widely regarded as remarkable, it is critical to consider the cumulative stress and burden such expectations may have imposed during these periods.

Further, while this study does not focus on childhood development of the SBWA, it is critical to acknowledge that this archetype can emerge at a very young age, reinforcing the idea that the intergenerational cycle of strength and emotional suppression is heavily prevalent amongst Black women (Fleming, n.d.). Ruby Bridges, a civil rights figure who integrated into an all-white elementary school at the age of six during the desegregation era, is often remembered for her composure and resilience in the face of intense hostility and public scrutiny (Dawson, 2025). Her experience reveals how Black girls are frequently expected to display emotional restraint and maturity well beyond their developmental years, normalizing strength as a requirement rather than a choice. This early imposition of resilience highlights how expectations associated with the SBWA are transmitted intergenerationally, shaping emotional expression and coping patterns developed long before adulthood (Fleming, n.d.).

Medical Mistrust and Barriers

The significance of examining the Strong Black Woman archetype extends far beyond cultural analysis—it represents an act of advocacy, inclusivity, and a call for greater equity within the health and well-being of Black women. This topic holds immutable importance because it seeks to expose how deeply ingrained societal expectations have come to shape the emotional and physical lives of Black women, often without recognition or support. Historically, the Black community has maintained a justified mistrust toward the research and clinical realms due to centuries of medical racism and exploitation (Cox, 2024). Among Black women in particular, research suggests that there is a weak relationship with the medical and research community, driven by generations of exclusion, bias, and mistreatment in the health settings (Le et al., 2022). As Le et al. (2022) found, “reasons pertaining to participants’ relationship with physicians and researchers were most salient,” reflecting a lack of trust that continues to shape how Black women specifically engage with modern healthcare and psychological services. Wallace (2018) emphasizes that Black women who embody the Strong Black Woman archetype, often as a result of the Superwoman Schema, “are not your typical mental health client.” These women are not seeking therapy to navigate simple life decisions; they are attempting to reconcile their identities within a system that demands strength yet provides little space for vulnerability (Abrams et al., 2018). For many, counseling is not merely a form of guidance but a means of developing lifelong coping mechanisms to manage the emotional, social, and physical toll of the archetype while maintaining their sense of integrity and well-being (Abrams et al., 2018).

The endurance celebrated within the Strong Black Woman Archetype comes at a significant cost to health and wellness. Studies show that chronic emotional suppression and self-sacrifice associated with this identity contribute to heightened stress responses and increased allostatic load (Tan et al., 2017; Erving et al., 2024). Allostatic load is the cumulative physiological strain that elevates the risk of hypertension, heart disease, obesity, and other chronic illnesses among Black women (Guidi et al., 2020). These health consequences are not merely biological but sociocultural, rooted in the expectation that strength must replace vulnerability (Tan et al., 2017). As a result, Tan et al. (2017) acknowledges that many Black women become discouraged from seeking professional care, resorting instead to coping mechanisms shaped by cultural history and community norms. Within healthcare systems, these patterns are too often misunderstood or ignored, leaving a gap in culturally informed care.

Historical Roots

The Strong Black Woman Archetype (SBWA) is not a recent social construct, but rather a culmination of centuries of imposed expectations, survival mechanisms, and distorted narratives about

Black womanhood. Historically, Black women have been placed in tightly constrained categories that define their worth through service, sacrifice, and silence. These categorizations originated during slavery, particularly in the Antebellum South. As Knight (2024) explains, enslaved Black women were expected to rise at dawn and work until dusk, performing both field and domestic labor under relentless physical and emotional duress. Enslaved Black women served as the backbone of the Southern economy, performing dual forms of labor. This would include working alongside men in the fields while sustaining the oppressor's household through exhaustive domestic, reproductive, and emotional labor (Knight,2024). Within the plantation hierarchy, they were treated as commodities rather than human beings, with their value measured solely by productivity and endurance (Marshall, 2022).

Enslaved women's labor was diverse and exhaustive—ranging from cooking, washing, weaving, and childcare to agricultural work and reproductive exploitation. Knight (2024) notes that they were forced to provide “round-the-clock services” as nurses, seamstresses, and caretakers, often within the homes of their enslavers, while still being expected to maintain their own families and communities in the slave quarters. Finley (2020) expands this ideology by highlighting how enslaved women's reproductive labor demanded “emotional labor,” requiring Black women to mask exhaustion and frustration behind practiced composure. This survival mechanism required suppressing visible dismay to avoid punishment or devaluation. This conditioning to conceal pain and persist through adversity became one of the earliest cultural imprints of the Strong Black Woman ideal.

Moreover, enslaved women's exploitation extended into scientific and reproductive domains. Knight (2024) details how medical doctors purchased and leased enslaved women, subjecting them to experimental procedures that led to the development of early gynecology. Their bodies were commodified through forced reproduction, particularly after the 1808 ban on the transatlantic slave trade, as planters sought to increase the enslaved population domestically. Enslaved women were often denied autonomy over their bodies, marriages, and motherhood (Feimster, 2023). Although sexual assault is recognized as a crime today, this was not the case for Black women during slavery or even in the years that followed (Feimster, 2023). Their abuse often went undocumented and unpunished because white supremacy controlled both the legal system and record-keeping. This historical reality reflects how social constructs and institutional systems have long perpetuated the oppression of Black women. Moreover, the structures that exist today are still deeply rooted in those same foundations; systems originally designed to exclude and dehumanize Black people for over three hundred years.

Yet even within these dehumanizing conditions, enslaved women created quiet forms of resistance. Knight (2024) describes how the slave quarters became a place of comfort where Black women could express emotions such as “joy, peace, happiness, pain, sadness, and sorrow.” These spaces sustained through care and emotional reciprocity were crucial sites of resilience and community healing.

In these acts of hidden defiance, Black women redefined strength and community. Within these communal spaces, Black women found the freedom to express themselves authentically and to release the pain they carried. Over time, these spaces evolved into the modern communities that Black women continue to seek for empowerment and healing, including faith-based church support networks that provide emotional and social support, female-focused Historically Black Colleges and Universities (i.e., Spelman College and Bennett College) that intentionally center Black women's educational and developmental experiences, and Black-women led organizations that advocate for community equity and collective well-being (Nguyen et al., 2019; Deggs, n.d.; Leigh, 2024). However, it remains imperative for society to recognize the harm in placing unrealistic expectations on Black women and to understand the profound effects such pressures can have on their mental and physical health.

Black Women Boxed In

As slavery transitioned into Reconstruction, Jim Crow, and segregation, the mechanisms used to control Black women shifted from overt physical domination to cultural regulation through stereotypical imagery. These controlling images, specifically the Mammy (caregiver), the Jezebel (seductress), and the Sapphire (angry/hot headed), functioned as social scripts that defined the boundaries of acceptable Black womanhood. These 'images' were socially circulated archetypes that often characterized Black women not as individuals with complex interior lives, but as simplistic, generic types whose social value was predetermined by race and gender. West (2008) emphasized that ideologies surrounding these stereotypes became normalized through American material culture, literature, advertising, and visual media, shaping social expectations of Black womanhood long after slavery legally ended.

The Mammy caricature depicts Black women as loyal, maternal, self-sacrificing caregivers who derive fulfillment from serving others (Pilgrim, 2000). This image was the most enduring racial caricature of African American women, appearing on everyday objects such as ashtrays, postcards, and souvenirs, and reinforcing the notion that Black women were content in subservient roles. Its origins lie in the antebellum South, where enslaved women were forced into domestic labor and caregiving for white families; this coercion was later reframed by society as a positive, nostalgic, and seemingly affectionate image (West, 2008). This stereotype aimed to justify the exploitation of Black women by suggesting that they naturally belonged in caregiving work and that their emotional needs were secondary or nonexistent. Today, remnants of the Mammy image continue to shape societal expectations embedded within the Strong Black Woman Archetype, positioning Black women as inherently responsible for caregiving and emotional labor, even in the face of persistent adversity (Abrams et al., 2018).

In contrast, the Jezebel stereotype constructs Black women as hypersexual, seductive, and morally unrestrained (Pilgrim, 2012). According to Pilgrim (2012), this depiction began during slavery,

when objects in everyday life (e.g., postcards, entertainment paraphernalia, magazines) portrayed Black women as inherently promiscuous, lacking modesty and self-control. As West (2008) emphasizes, the Jezebel image was used historically to rationalize sexual violence amongst Black women, framing sexual exploitation as a natural consequence of Black women's alleged innate identity. This stereotype continues to shape contemporary assumptions about Black women's bodies, contributing to the continued sexual objectification and public perception that prioritizes assumption over autonomy.

The Sapphire caricature portrays Black women as angry, emasculating, and emotionally unrestrained (Pilgrim, 2008). This image recasts Black women's emotional expression, especially responses to oppression or injustice, as irrational hostility rather than legitimate feeling. The Sapphire stereotype emerged most prominently in the early twentieth century and was popularized through media that equated Black women's assertiveness with aggressiveness (West, 2008). Over time, the Sapphire stereotype has been reproduced and rearticulated within contemporary cultural narratives, emerging in modern form as the "Angry Black Woman" trope. This reframing has intensified the stereotype's reach by embedding it within contemporary media forms, including social media platforms, television programming, news media, and film. In these spaces, Black women, both as a fictional character and as real individuals, are frequently portrayed as hostile, confrontational, or emotionally excessive, particularly when expressing dissatisfaction or asserting boundaries. These portrayals reinforce the presumption that anger is an inherent characteristic of Black womanhood rather than a contextual response to structural integrity or interpersonal harm.

The psychological consequences of this evolution are particularly burdensome. When Black women are consistently filtered through a lens of presumed anger, emotional expression becomes socially precarious (Ashley, 2014). As a result, many Black women engage in heightened emotional regulation, suppressing vulnerability and moderating affect to avoid being perceived as confirming the stereotype. Over time, this dynamic promotes the internalization of emotions as both a protective strategy and a social necessity for survivability. In this context, the Strong Black Woman Archetype can be understood to have emerged as an adaptive response, emphasizing composure, resilience, and emotional restraint as mechanisms for navigating racialized and gendered surveillance.

However, this adaptation comes at a profound psychological cost. The endorsement of the Strong Black Woman archetype reinforces the very constraints imposed by the Angry Black Woman stereotype, limiting the range of emotions deemed socially acceptable for Black women to express. Strength becomes synonymous with emotional silence, while vulnerability is reframed as weakness or liability (Ashley, 2014). As Golden (2021) argues, the SBWA has become increasingly maladaptive, offering little room for emotional expression or ordinary human vulnerability and instead normalizing emotional suppression as a marker of competence and worth. Within this framework, Black women are positioned

to prioritize endurance over emotional well-being, internalizing expectations that discourage help-seeking and validate self-neglect (p.52). Consequently, Black women are boxed into a narrow behavioral and emotional framework in which resilience is expected, distress is minimized, and emotional needs are routinely deprioritized (Abrams et al., 2014). These historically rooted stereotypes coalesce into a restrictive social archetype that is widely accepted and reinforced, compelling Black women to internalize and embody constrained forms of strength that deny the emotional complexity naturally intertwined with their humanity.

Methods: Literature Review of the Strong Black Woman Archetype

Original Study Design

This project was originally conceptualized as a qualitative, exploratory study examining how community-based organizations understand and respond to the Strong Black Woman Archetype (SBWA) and its effects on the health, coping, and wellness of Black women in the Southern United States. The study sought to explore how the SBWA can influence health outcomes, emotional well-being, and access to care and how organizational leadership supports or challenges these dynamics within its own programming.

Although Institutional Review Board (IRB) approval was obtained, recruitment efforts with four North Carolina-based community organizations did not yield sufficient participation within the project timeline. As a result, the planned semi-structured interviews could not be implemented.

Adaptation of Study Design

In accordance with ethical reporting requirements, the study design was therefore adapted to center a structured review guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework. This methodological shift allowed the project to maintain its original purpose by grounding the analysis in existing empirical and theoretical literature on the SBWA and its implications for health and wellness of Black women. Although the interview component could not be conducted, the material originally developed for the qualitative phase, including the interview protocol and organizational focus, was retained and incorporated into the discussion of future research directions. This ensured that the study's initial aims continue to inform the broader trajectory of inquiry into how community-based organizations support, understand, and respond to the SBWA.

PRISMA-Guided Literature Search Strategy

To guide the structured literature review, a PRISMA-based search strategy was implemented across four major academic databases: ProQuest, Google Scholar, PubMed, and PsycNet. Seven distinct search queries were developed to capture the multidimensional impact of the Strong Black Woman archetype on health, stress, coping, and wellness among Black women. These queries incorporated combinations of terms such as “Black women,” “Strong Black Woman,” “health,” “stress,” “coping,” “support,” “diabetes,” “mortality rates,” and “gendered racism,” with geographic filters including “United States,” “South,” and “North Carolina” where applicable.

Figure 1 illustrates the number of results retrieved for each query across the four databases. Search 1 focused on Black women, health, and stress across the broad spectrum of the United States and North Carolina returned 513 results in ProQuest, 776 in Google Scholar, 489 in PubMed, and 16 in APA PsycNet. Search 2, which explicitly included the SBWA, yielded 7,027 results in ProQuest but far fewer in Google Scholar (153), PubMed (747), and APA PsycNet (58). Although ProQuest produced the largest volume of search results, many of these records were dissertations. While these documents were not used as primary sources, their reference lists were screened to identify additional peer-reviewed studies relevant to the review. This variability highlights both the richness and fragmentation of the existing literature. All search results were documented in a PRISMA-aligned flowchart to ensure transparency in the identification, screening, and selection process.

Study Selection

All records identified through the database searches were screened using predefined inclusion and exclusion criteria. Studies were included if they centered Black women in the United States, examined psychological, emotional, and health-related outcomes, addressed stereotype internalization, identity-based stress, or culturally specific coping mechanisms, and were published in peer-reviewed journals or other reputable scholarly sources. Exclusion criteria removed articles that lacked empirical grounding, were published more than twenty years ago, or did not meaningfully align with the conceptual focus of the SBWA or the broader aims of the project. Titles and abstracts were reviewed first, followed by full-text analysis to determine final eligibility.

After completing the full PRISMA screening process, seventeen sources met the inclusion criteria for meaningful data collection. These sources ranged from peer-reviewed journal articles to qualitative studies and clinical research reports. Collectively, they provided a robust evidence base for conveying the importance of this research topic and illuminated persistent gaps in organizational responses, region-specific data, and community-engaged interventions.

Filters
• APA PsycNet:
PsycArticles

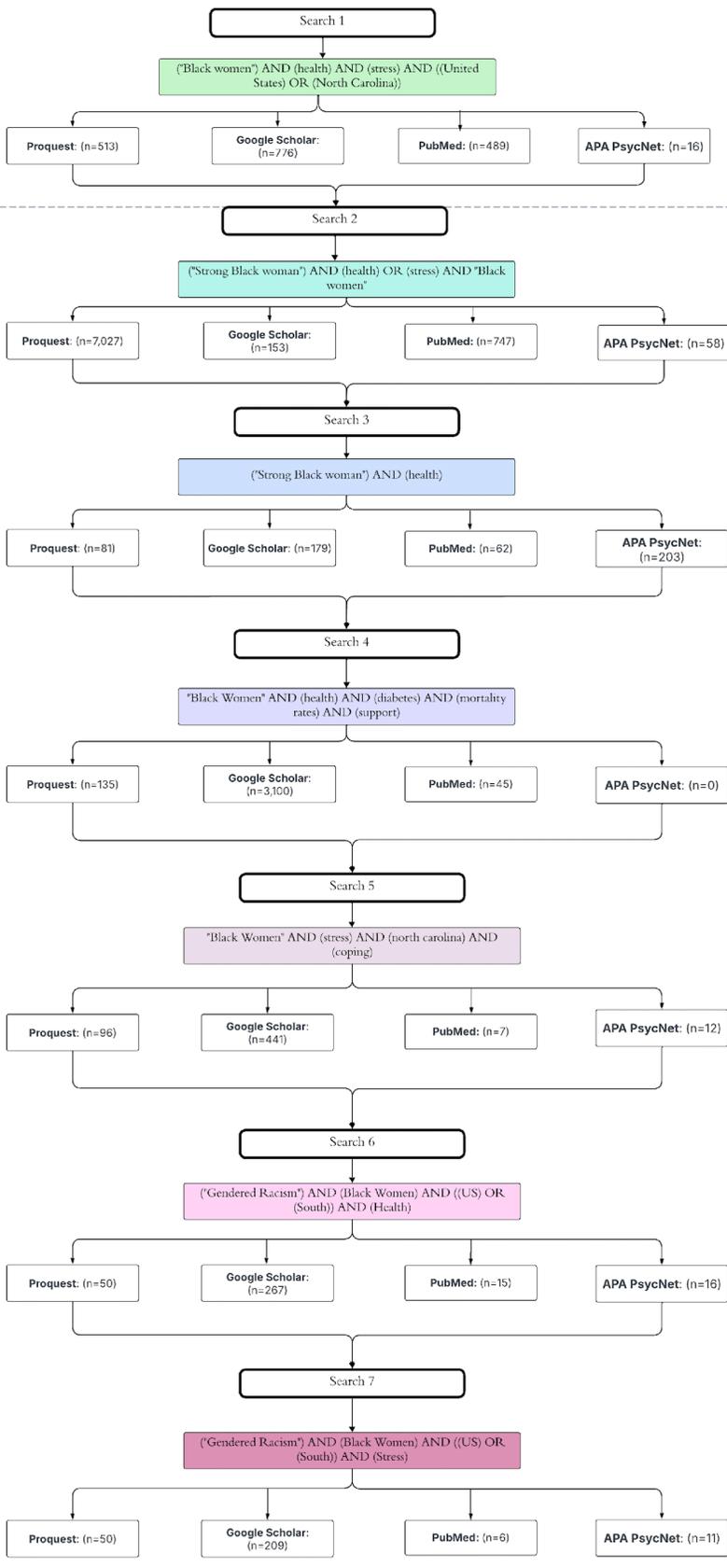


Figure 1**Findings: Thematic Analysis of Findings*****Overview of Included Studies***

Across the included studies, Black women, 18 and older, were the central population of focus, and the research addressed a wide range of physical, psychological, and structural health concerns. The final sample consisted of seventeen studies that met all inclusion criteria following the PRISMA screening process. These studies varied in methodological approach, including qualitative, quantitative, mixed-methods, and clinical research designs. Collectively, these sources offered a multifaceted view of the health landscape affecting Black women.

Thematic Finding Analysis

In this review, thematic findings refer to the recurring patterns, concepts, and relationships that emerged across the included studies. Rather than focusing on isolated results from individual sources, a thematic approach allows for complex synthesis of multidimensional evidence that reflects the broader experiences and health realities of Black women. The results that follow are organized according to this thematic structure revealed during source analyses.

Themes**Black Women Not Centered In Healthcare**

The enduring expectation of resilience embedded within the Strong Black Woman Archetype has significant implications for the physical and mental health of Black women. As Tan et al. (2017) notes, Black women in the United States experience disproportionately high rates of chronic illness, mortality, and negative health-care interactions; outcomes shaped by the combined influence of cultural expectations, structural inequities, and psychological stressors. Despite possessing comparable or higher socioeconomic status in some cases, Black women continue to face markedly poorer health outcomes (Golden, 2021, p.52).

Maternal Mortality and Reproductive Health Disparities

National surveillance data and large-scale demographic analyses consistently demonstrate that Black women experience the highest rates of maternal and infant mortality in the United States. Chinn, Martin, and Redmond (2021), synthesized federal datasets from the National Center for Health Statistics and the Centers for Disease Control and Prevention to document persistent disparities in maternal, pregnancy-related, and infant mortality across racial groups. These findings align with broader research

showing that Black women's reproductive outcomes are shaped by structural racism, chronic stress exposure, and perennial inequities in access to high-quality maternal care (Tan et al., 2017). State-level data further reveal that these disparities are embedded within broader social determinants of health, including insurance coverage, poverty, food insecurity, and housing instability, which disproportionately affect Black women across the country (National Women's Law Center, 2023).

Maternal Mortality Rate

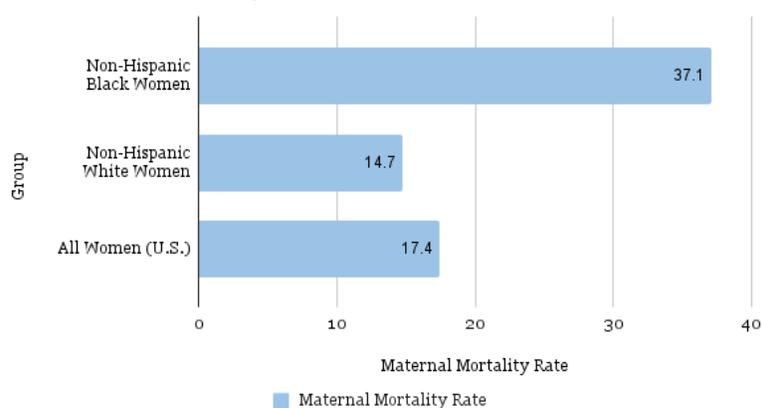


Figure 2

Maternal mortality rates per 100,000 live births show that non-Hispanic Black women experience substantially higher mortality (37.1) than both non-Hispanic White women (14.7) and the national average for all women (17.4). The rate for Black women is more than double that of White women and significantly greater than the overall U.S. rate (Chinn et al., 2021).

Pregnancy-Related Mortality Rate

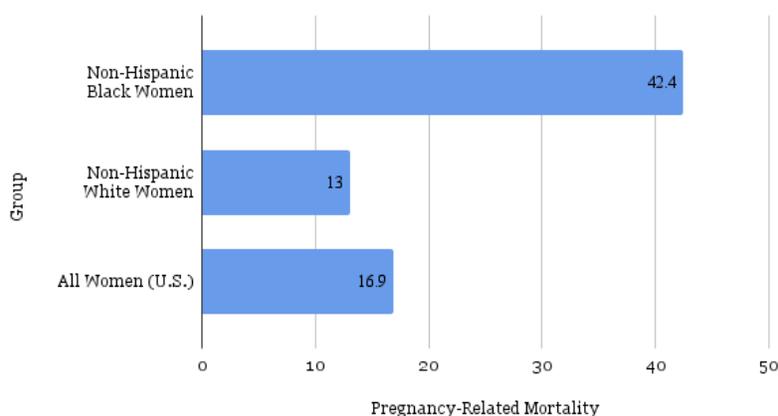


Figure 3

Pregnancy-related mortality rates per 100,000 live births indicate that non-Hispanic Black women have a higher mortality rate (42.4) compared with non-Hispanic White women (13.0) and all women in the United States (16.9). The rate for Black women is over three times higher than that of White women and with a markedly significant difference compared to the national average (Chinn et al., 2021).

Infant Mortality Rate

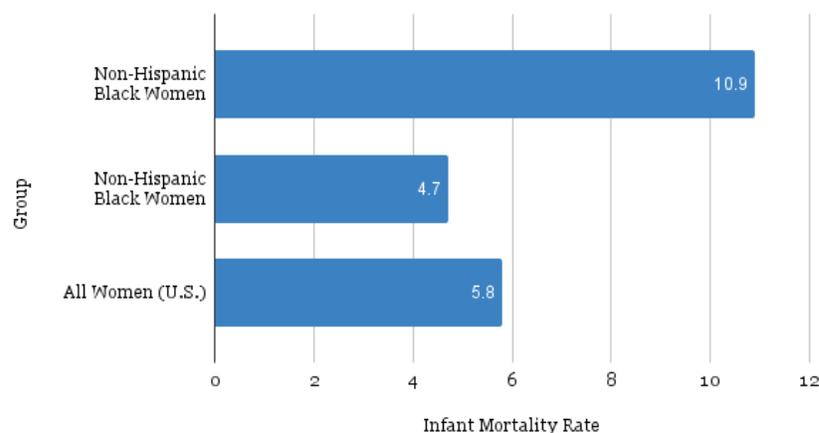


Figure 4

Infant mortality rates per 1,000 live births revealed that infants born to non-Hispanic Black women die at a rate of 10.9 compared to a rate of 4.7 for non-Hispanic White women. The national average is 5.8 for all women. The rate of Black women's infant mortality rate is more than twice as high as the rates of White and all women within the United States (Chinn et al., 2021).

National CDC data further highlights the severity of these disparities. In 2023, the maternal mortality rate for non-Hispanic Black women was 50.3 deaths per 100,000 live births, compared with 14.5 for non-Hispanic White women and 18.6 for all women in the United States (Rossen et al., 2025). This disparity indicates that Black women experience maternal mortality at rates exceeding three times those of White women and nearly triple the national average. Age-stratified data show similar patterns: Black women ages 25-39 had a maternal mortality rate of 53.6, compared with 13.8 amongst White women. For women aged 40 and older, the maternal mortality rate for Black women (132.9) was more than twice the rate for White women (56.6).

State-level social determinants of health metrics underscore how structural conditions intensify these reproductive health disparities. According to the National Women's Law Center (2023), Black women experience disproportionately high rates of uninsurance, with southern states such as Florida (18.5%), Georgia (17.0%), and Alabama (14.0%) reporting some of the highest rates in the country. High uninsurance rates limit access to prenatal care, postpartum follow-up, and emergency obstetric services. Similarly, poverty rates among Black women exceed 20% in many states, reaching 26.8% in Arkansas

and 28.1% in the District of Columbia. Poverty often intersects with food insufficiency, creating conditions that increase stress, reduce access to healthy environments, and undermine maternal health.

Globally, maternal mortality remains a significant public health concern, with an estimated 197 deaths per 100,000 live births in 2023 (UNICEF, 2025). Although this reflects a 40% decline since 2000, progress has slowed, and the global rate remains far above the Sustainable Development Goal target of 70 deaths per 100,000 by 2030.

Cardiovascular Disease and Hypertension Disparities Among Black Women

Cardiovascular disease (CVD) and hypertension remain leading causes of morbidity and mortality in the United States, with non-Hispanic Black women experiencing a significant burden compared to non-Hispanic White women and national averages. Despite decades of public health efforts, stark disparities persist in prevalence, control, and outcomes reflecting the interplay of biological, behavioral, social, and structural determinants. The data and figures in this section synthesize the most recent and reliable statistical data from authoritative sources, including the Centers for Disease Control and Prevention (CDC), American Heart Association (AHA), peer-reviewed journals, and national health surveys. Together, these provide an in-depth analysis of CVD and hypertension prevalence among non-Hispanic Black women.

CVD Prevalence by Race/Ethnicity (2017-2020)

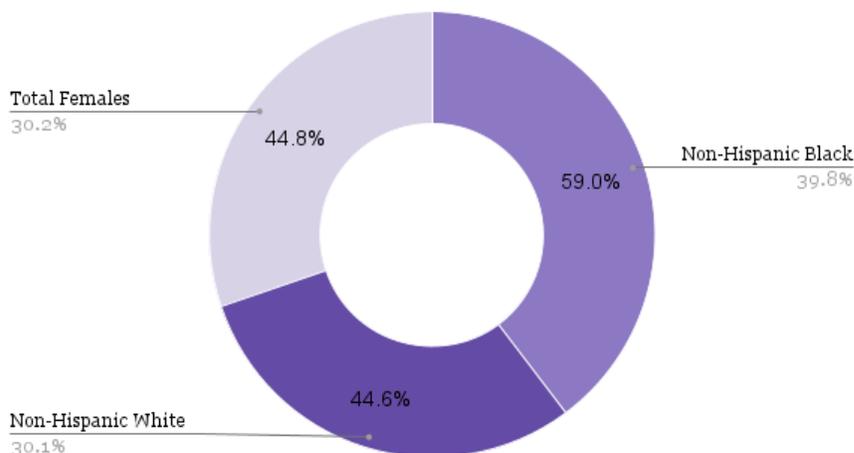


Figure 5

This figure illustrates cardiovascular prevalence among women aged 18 and older from 2017 to 2020. Non-Hispanic Black women show a higher prevalence (59.0%) than both non-Hispanic White

women (44.6%) and the total female population (44.8%) (Centers for Disease Control and Prevention, 2024).

Hypertension Prevalence by Race/Ethnicity (2017-2020)

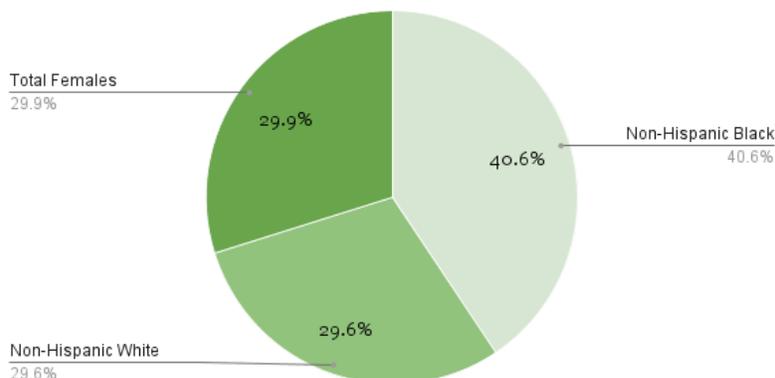


Figure 6

This figure presents hypertension prevalence data from 2017 to 2018, specifically, females aged 18 and older. Non-Hispanic Black women have the highest prevalence at 40.6%, compared to 29.6% for non-Hispanic White women and 29.9% for all females (American Heart Association, 2025).

Age-Adjusted CVD Mortality Rates

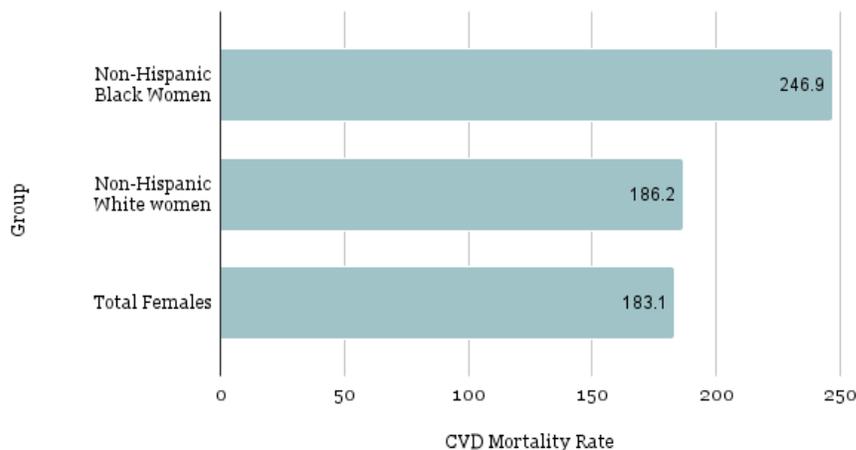


Figure 7

Cardiovascular disease mortality rates per 100,000 among adult women aged 18 and older. Non-Hispanic Black women (246.9) indicated higher mortality than non-Hispanic White women (186.2) and the national average for all females (183.1). Data is age-adjusted using CDC standard population categories of 18-39, 40-59, and 60+ (Centers for Disease Control and Prevention, 2024).

Age-Adjusted Hypertension Mortality Rates

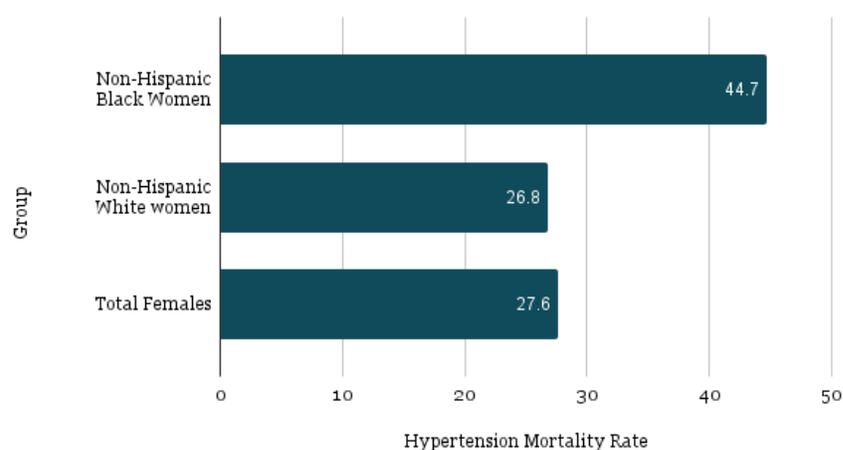


Figure 8

Hypertension-related mortality rates per 100,000 among adult women aged 18 and older. Non-Hispanic Black women had a higher rate of 44.7 compared to non-Hispanic White women with a rate of 26.8. The national average for all females was 27.6. Data is age-adjusted using CDC standard population categories of 18-39, 40-59, and 60+ (American Heart Association, 2025).

Comorbidity of Hypertension and Cardiovascular Disease

Comorbidity patterns between hypertension and cardiovascular disease reveal additional disparities among non-Hispanic Black women, with national datasets noting elevated prevalence, higher rates of uncontrolled blood pressure, and disproportionate cardiovascular mortality. CDC surveillance data indicates that 40.6% of non-Hispanic Black women report hypertension, and among those, nearly 60% also present with at least one cardiovascular condition (e.g., coronary heart disease, stroke, or heart failure) (Centers for Disease Control and Prevention, 2024). Kalinowski et al. (2021) similarly found that Black women with hypertension exhibit higher rates of uncontrolled blood pressure, with over 45% remaining above recommended thresholds despite treatment, compared with 28% of non-Hispanic White women. These findings illustrate a pattern of higher comorbidity prevalence, greater severity, and increased mortality among non-Hispanic Black women relative to other demographic groups.

Mental Health, Stress, and the Strong Black Woman

Black women's mental health experiences reflect a range of stressors shaped by their social, cultural, and structural environments. Across the reviewed literature, researchers described how factors such as chronic stress, internalized expectations of strength, and limited access to supportive resources

influence how Black women navigate emotional well-being. These studies also highlight patterns related to coping, psychological distress, and the pressures associated with the Strong Black Woman ideal. Together, these findings provide insight into the mental health challenges Black women encounter and the broader contexts in which these challenges occur.

Psychological Distress in Black Women

In Hall et al.'s (2021) qualitative study, 62 Black women participated, describing persistent emotional strain and the need to maintain psychological stability. Many reported knowingly engaging in behaviors that compromised their emotional well-being, citing the expectation to remain composed and resilient. One participant, a single mother, described “falling apart and becoming more depressed” while continuing to fulfill the dual roles of a mother and father (Hall et al., 2021).

National survey data from Schumacher et al. (2024) illustrates the psychological burden experienced by Black women in healthcare settings. In a 2024 report, 61% of Black women reported engaging in “vigilant behaviors,” such as preparing for possible insults or modifying their appearance to ensure fair treatment by providers. These behaviors were more common among younger women (ages 18-49) and those with darker skin tones, who also reported higher rates of unfair treatment. Specifically, 21% of Black women overall, and 27% of those with darker skin, stated they had been mistreated by a healthcare provider due to their race, compared to just 3% of White women.

Watson and Hunter (2015) provided quantitative evidence that endorsement of the SBWA intensified the association between stress and depressive symptoms in a sample of 95 Black women aged 18 to 65. Building on these findings, the present results indicated that greater endorsement of the SBWA was associated with an increased likelihood of depressive symptoms, including fatigue and self-silencing. This pattern aligns with Woods-Giscombé and Lobel (2008), who suggest that African American women often experience difficulties with emotion regulation, particularly self-silencing, which contributes to elevated stress and rumination.

Abrams et al. (2018) further provided additional quantitative evidence of psychological distress among Black women. The study measured psychological distress using the Center for Epidemiological Studies Depression Scale (CES-D), which aims to measure the frequency and severity of depressive symptoms experienced in the past week, including feelings of sadness, hopelessness, loss of appetite, and sleep disturbance. In the study, the CES-D was administered to a sample of 194 Black women, including both college students and community members aged 18 to 82. The mean CES-D score was 14.31 (SD=10.66), indicating elevated depressive symptomatology across the representative sample. Higher scores on the CES-D were significantly correlated with endorsement of the Strong Black Woman schema ($r = .34, p < .001$), suggesting a relationship between internalized expectations of strength and increased

psychological distress. These findings align with the qualitative reports from Hall et al. (2021), in which participants described suppressing emotional needs and maintaining a persona of strength despite experiencing symptoms of depression and anxiety.

Maladaptive Coping Patterns: Internalization of the Archetype

Beyond psychological distress and reduced engagement with mental health services, internalization of the Strong Black Woman schema was consistently associated with elevated psychological strain. Across the reviewed studies, the SBWA was widely endorsed and described as both a culturally transmitted expectation and a salient personal identity among Black women. Studies defined the SBWA as a persona operationalized through dimensions of emotional restraint, self-reliance, and caregiving.

Within Hall et al.'s (2021) study, all participants (N=62; 100%) endorsed the Strong Black Woman Archetype (SBWA), frequently describing it as a learned behavior transmitted intergenerationally. Participants reported perceived constraints on emotional disclosure, particularly with respect to symptoms of depression and anxiety, which they attributed to concerns about being perceived as weak. This belief was endorsed by 81% (n=50) of the participants. Strength was further characterized as a collective and historically embedded expectation within the Black community, with participants emphasizing its perceived necessity for survival. Additionally, several participants described psychological help-seeking among Black women as being stigmatized and framed as incongruent with cultural and racial norms.

Similarly, in Abrams et al.'s (2018) study, 80% of the same (N=194) endorsed the Strong Black Woman archetype. The study examined the psychological processes associated with endorsement of the SBWA using a cross-sectional survey design. The authors operationalized SBW endorsement through measures assessing perceived obligation to appear strong, emotional suppression, and externalized self-perceptions. Mediation analyses identified self-silencing and externalized self-perceptions as intersecting variables in the relationship between perceived strength obligations and mental health outcomes for Black women. Specifically, higher perceived obligation to exhibit strength was positively associated with self-silencing and externalized self-perceptions.

Thomas et al. (2004) examined the internalization of stereotypic roles by developing the Stereotypic Roles for Black Women Scale (SRBWS). In a sample of 186 African American women, a confirmatory factor analysis supported a four-factor structure comprising the Mammy, Sapphire, Jezebel, and Superwoman roles. Mean endorsement scores were highest for the Superwoman (M=3.19, SD= .67) and Mammy (M=3.01, SD= .70) roles, indicating strong identification with expectations of caregiving and resilience. Regression analyses revealed that Mammy and Sapphire scores were significantly

negatively correlated with self-esteem, suggesting that internalizing these roles was associated with poorer psychological outcomes.

Beauboeuf-Lafontant (2007) offered qualitative insights into suppression as a culturally reinforced coping strategy. In qualitative interviews with a nonclinical sample size of 44 Black women, participants described masking distress as a moral obligation tied to cultural pride, explaining that acknowledging vulnerability was incompatible with the endorsement of the SBW identity. The interviews revealed that participants often had delayed recognition of depressive symptoms due to suppression. Within these interviews, several participants described coping strategies (e.g., excessive eating, shopping, and drinking) that emerged as secondary consequences of internalizing the archetype. Women in this study reported presenting an outward attitude of “I can do it,” while privately questioning their emotional capacity and mental endurance to manage the responsibilities they had assumed. Beauboeuf-Lafontant (2007) notes that the internalization of stress associated with the Strong Black Woman Archetype can lead to displaced emotional responses and adverse health outcomes, including hypertension, cardiovascular strain, difficulty breathing, and depression.

Lewis et al. (2017) applied an intersectional framework to examine how gendered racism influences the health outcomes of 231 Black women. Using the Gendered Racial Microaggressions Scale, the study found that greater frequency of gendered racial microaggressions significantly predicted poorer self-reported mental and physical health. Mediation analyses revealed that disengagement coping (e.g., denial, self-blame, distraction) explained part of this relationship, linking microaggressions to adverse health outcomes. Moderated mediation analyses further showed that women with lower levels of gendered racial identity centrality were more likely to rely on disengagement coping when exposed to frequent microaggressions, which in turn predicted worse health. Higher identity centrality was associated with greater use of spirituality, social support, and engagement coping, which were linked to more positive health outcomes.

Adaptive Coping Patterns

While many coping responses among Black women reflected maladaptive strategies, several studies identified adaptive mechanisms that mitigated the impact of stress and discrimination. These strategies included spirituality, social support, and engagement coping, which were often culturally reinforced and associated with more positive health outcomes.

Sapiro et al. (2016) examined coping strategies among six Black mothers following Hurricane Katrina and documented how the Strong Black Woman Archetype served as both a resilience mechanism and a coping framework during disaster recovery. Interviews were conducted with the daughters of these six mothers to capture how the archetype manifested when it intersected with the stress of recovery from

a natural disaster. Participants reported that their mothers relied heavily on ideals of strength, caregiving, and perseverance to navigate displacement and resource scarcity. Mothers were observed providing care for others, engaging in prayer, turning to advocacy, and demonstrating cognitive shifts in mindset as primary coping strategies. Participants also noted emotional exhaustion associated with sustained reliance on these strategies.

Castelin and White (2022) provided recent quantitative evidence on coping among college-aged Black women. The study found that SBW endorsement was associated with greater self-reliance and the use of emotional regulation strategies, which participants described as “necessary” for navigating academic and social stressors. While high endorsement was linked to lower overall resilience scores, women reported that self-reliance and perseverance enabled them to maintain high functionality in demanding environments.

Discussion: Interpreting the Data Through a Strong Black Woman Archetype Lens

The seventeen studies synthesized in this review revealed a set of interrelated themes that consistently intersected across psychological, physical, and structural domains of health. Notably, this pattern of intersection mirrors the nature of the Strong Black Woman Archetype itself. The SBWA is inherently an intersectional construct, shaped by the convergence of historical, social, and cultural factors that have been internalized over time and embodied within Black women’s identities. While the archetype is often framed as a source of strength, promoting confidence, resilience, independence, and self-reliance, it is not inherently protective in all contexts. When continuously enacted without adequate structural support or opportunities for vulnerability, the SBWA may place substantial psychological and physiological strain on Black women. The findings across the reviewed datasets illustrate that, although the archetype can function as a coping framework, it is more frequently associated with adverse outcomes than protective ones, particularly in relation to physical health and psychological well-being.

According to the reviewed literature, internalization of the SBWA was consistently associated not only with elevated psychological distress but also with indicators of physiological burden linked to chronic stress exposure. Extensive research, Mariotti (2015), demonstrates that prolonged stress exerts strain on the body; however, the findings synthesized here suggest that Black women experience this burden in compounded ways due to the intersection of racialized and gendered stressors. Beyond managing the demands of daily life, Black women often contend with chronic stress rooted in societal expectations, caregiving responsibilities, and persistent inequities, which in turn contribute to intergenerational health consequences historically documented within Black communities (Golden, 2021, p. 52). As noted in the introduction, resilience has long been transmitted intergenerationally as a

necessary survival strategy. Yet the SBWA (derived from the historical legacy of slavery in the United States) has reinforced expectations of endurance without rest or relief. The health outcomes identified across the reviewed studies reflect this cumulative burden, including significantly higher rates of cardiovascular disease, hypertension, maternal and pregnancy-related mortality, infant mortality, and breast cancer among Black women (see Figure 2-8).

Critically, the Strong Black Woman archetype (SBWA) does not develop or operate in isolation. Rather, it is learned, reinforced, and at times adopted as a psychological defense mechanism in response to persistent social, historical, and structural adversity. Within the theme of Black women not being centered in healthcare, patterns of underutilization of medical and mental health services should not be interpreted as simple avoidance or disinterest. Instead, these patterns reflect the convergence of structural barriers, social determinants of health, and deeply rooted mistrust of the U.S. medical system. As Golden (2021) notes, the Black community has long carried the belief that “health care is a privilege, not a right” (p.45), a notion shaped by centuries of exclusion and mistreatment within medical institutions. The persistence of this belief illustrates how historically designed systems continue to reproduce fear, skepticism, and disengagement among Black communities today.

This mistrust can also be understood through the lens of post-traumatic slave syndrome, which describes the enduring psychological, social, and behavioral consequences of centuries of slavery and systemic racism experienced by African Americans (DeGruy, 2014). The theory emphasizes that historical trauma does not remain confined to the past; rather, it is sustained across generations and reactivated when contemporary systems fail to evolve in ways that are protective and responsive (Golden, 2021, p.112). For Black women, repeated experiences of marginalization within healthcare settings reinforce this legacy, shaping expectations of harm and contributing to defensive coping strategies, including emotional suppression and avoidance of care.

Consistent with this interpretation, the findings demonstrate that many Black women refrain from seeking medical and mental health services due to prior harmful and dehumanizing encounters with healthcare providers. As reported by Schumacher et al. (2024), a substantial proportion of Black women have experienced mistreatment by healthcare professionals, with a significant amount reporting they feel compelled to alter their appearance when seeking care, particularly women with darker skin tones. These behaviors raise critical questions regarding the racialized and colorist ideologies embedded within U.S. healthcare systems. More importantly, disengagement from care is not rooted in apathy, but it reflects an acute awareness of anticipated interactions and the emotional labor required to navigate spaces perceived as unsafe. As Golden (2021) articulates, the psyches of Black women have been “twisted and turned inside out by the stories we tell ourselves...and the stories that are told about us” (p.22). This quote

captures the psychological toll of internalized narratives shaped by both lived experience and systemic messaging.

While healthcare institutions play a significant role in reinforcing SBWA-related stress and disengagement, internalization of emotional suppression does not originate solely within medical systems. It also emerges and is sustained within the Black community itself, where intergenerational norms surrounding strength, resilience, and self-reliance remain deeply ingrained. Historically, spirituality and religious faith have served as primary coping resources, often preferred over professional counseling (Golden, 2021; Beaubouef-Lafontant, 2007). Mental illness and psychological distress were frequently stigmatized, framed as demonic, contagious, or morally suspect, inducing silence around emotional suffering (Golden, 2021, p.45). Although contemporary discourse surrounding mental health has become more accepting, these multigenerational beliefs continue to ripple through the community, contributing to the perception that vulnerability is incompatible with strength and that women who fail to embody the SBW are weak or unstable.

Qualitative evidence further illustrates how these norms manifest in daily life. Participants in Beaubouef-Lafontant's (2007) study described a persistent obligation to take on additional responsibilities while privately struggling with exhaustion, self-doubt, and diminished emotional capacity. Despite experiencing internal distress, women reported presenting an outward image of composure, consistent with the expectations set by the SBWA. These patterns were observed across age groups, underscoring that the internalization of strength is not confined to a particular life stage, but instead a shared feature of Black womanhood.

Comparative Reflection

A comparative analysis across local, regional, national, and global datasets demonstrates that the health disparities experienced by Black women in North Carolina, particularly in Wake and Durham County, are not isolated incidents but rather localized manifestations revealing broader social inequities. Nationally, Black women continue to face disproportionately high rates of maternal mortality, pregnancy-related death, cardiovascular disease, and hypertension compared to White women and national averages. These disparities persist even after considering socioeconomic indicators, illuminating the enduring influence of structural racism, chronic stress exposure, and inequitable healthcare systems in shaping the health trajectories of Black women.

These patterns extend beyond the United States and are reflected globally among women of African descent, particularly within Afro-Caribbean and African contexts. Research examining Black Caribbean women's experiences during pregnancy, childbirth, and early motherhood demonstrates similarly elevated psychological distress linked to chronic stress exposure (Edge & Rogers, 2005).

Similarly, studies of Afro-Caribbean women in the United States demonstrate that cumulative stress exposure significantly increases depressive symptoms and the likelihood of major depressive episodes, reinforcing the transnational continuity of these health vulnerabilities endured by women (Erving, 2021). Comparable trends have been observed across parts of Africa, where women's mental health has been adversely affected by compounded domestic labor, economic strain, and limited institutional support, particularly during periods of crisis (Mueller et al., 2023).

Across these global contexts, research consistently highlighted expectations of strength, self-sacrifice, and emotional suppression as an adaptive yet burdensome coping mechanism for Black women navigating the embodiment of the SBWA. While the SBWA is often named within U.S.-based scholarship, its core characteristics (i.e., endurance, emotional restraint, and responsibility for others) are reflected in parallel cultural expectations placed upon Black women globally. These shared patterns suggest that the embodiment of strength functions as a universal social expectation rather than a region-specific concept, contributing to the sustained stress activation and adverse health outcomes across diverse settings. Among immigrant and refugee women, social support networks frequently emerge as critical coping resources in the absence of accessible, culturally responsive healthcare systems, further reflecting how resilience is often mobilized to compensate for systemic gaps in care (Kassam, 2019). Collectively, these global similarities indicate that the disparities observed among Black women in North Carolina and the United States is a part of a broader global pattern shaped by intersecting forces of race, gender, and chronic stress exposure. This universality highlights the importance of examining culturally specific perceptions of strength while also advancing global, equity-centered strategies at alleviating the disproportionate stress burden placed on Black women worldwide.

Within the Southern United States, these inequities are further exacerbated by policy environments characterized by elevated rates of uninsurance, persistent poverty, and limited access to comprehensive healthcare services. Southern states consistently report some of the highest uninsurance rates among Black women, constraining access to preventative care, chronic disease management, and mental health support. For example, Florida reported an uninsurance rate of 18.5%, followed by Georgia at 17.0% and Alabama at 14.0%. North Carolina had a lower rate of 13.3% for Black women. Poverty rates among Black women in the region frequently exceeded 20%, intersecting significantly with food insecurity, housing instability, and environmental stressors that heighten physiological vulnerability. North Carolina reflects these broader regional patterns, with racial disparities as a central theme in maternal health, cardiovascular disease, and mental health outcomes that align with similar trends across the South (National Women's Law Center, 2023).

The Durham County State of the County Health Report revealed that the overall infant mortality rate in Durham County for the period of 2018-2022 was 6.0 deaths per 1,000 live births, slightly lower

than the North Carolina statewide rate of 6.8 per 1,000. However, pronounced racial disparities persisted. Among Black or African American infants in Durham County, the infant mortality rate was 11.4 deaths per 100,000 live births, compared to 2.8 per 1,000 among White infants. This indicates that Black infants in Durham County died at a rate four times higher than White infants, reflecting continuous inequities linked to structural racism and differential access to care (Durham County Government, 2024).

Based on Wake County public health surveillance data, the overall infant mortality rate in Wake County for recent reporting period has remained below the North Carolina state average, ranging between 5.0 and 5.5 deaths per 1,000 live births. Despite this comparatively lower overall rate, racial disparities remain evident within the county. Black infants in Wake County consistently experience infant mortality rates that are approximately two to three times higher than those of White infants. This revelation portrays the notion that even aggregate county-level improvements can mask the inequities that affect Black families. Further, these results highlight that even in a county that has comparatively greater healthcare infrastructure and economic resources, there are still discrepancies between the Black infant mortality and the White infant mortality rates (Centers for Disease Control and Prevention et al., 2024).

Gaps in the Literature

Despite a growing body of scholarship examining health disparities, stress, and coping among Black women, significant gaps remain in how these experiences are documented and understood. Much of the existing research on Black health and well-being has historically been conducted *about* Black communities rather than *by* Black scholars or through frameworks grounded in Black lived experience. As a result, many narratives within medical and psychological literature reflect external interpretations shaped by dominant, often Eurocentric, research paradigms, rather than culturally situated perspectives that center Black women's voices (Sharp et al., 2022). This dynamic has contributed to inconsistent data, limiting the development of a continuous, community-informed timeline of Black women's health experiences.

Furthermore, the longstanding mistrust between Black communities and medical/ research institutions has further constrained the participation and reporting of Black experiences over time (Scharff et al., 2010). This mistrust has influenced not only research participation and help-seeking behaviors but also the scope and depth of available data, particularly regarding culturally specific coping strategies and internalized expectations such as the Strong Black Woman Archetype (SBWA). Consequently, although the SBWA is referenced with increasing frequency in contemporary scholarship, there remains a lack of longitudinal, community-driven research that fully captures the archetype's developmental origins, health implications, and intergenerational influence. Addressing these gaps

requires research approaches that prioritize culturally responsive methodologies, elevate Black women's perspectives, and actively involve Black scholars and communities in the production of knowledge.

Implications/ Future Directions/ Policy Recommendations

Implications

The findings of this review provide a comprehensive synthesis of how the Strong Black Woman archetype (SBWA) operates across psychological, physical, and structural domains of health; however, several methodological considerations shape the interpretation of these results. The reviewed literature is characterized by substantial methodological discrepancies, including qualitative interviews, cross-sectional survey designs, mixed-methods studies, and large-scale surveillance data. While this diversity strengthens the breadth of evidence and allows for a deep multidimensional analysis, it limits the ability to draw definitive conclusions and compare effect sizes across studies.

Further, much of the empirical work examining the SBWA relies on cross-sectional and self-reported data, which restricts developmental processes and validity. Given that self-silencing, emotional suppression, and healthcare disengagement are themselves outcomes of internalized strength norms, self-report measures may have underestimated the distress among women to account for participants' social desirability.

Although this project was initially designed as a qualitative study centered on Black-women focused organizations in North Carolina, recruitment constraints necessitated a methodological pivot to a PRISMA-guided literature review. While this adaptation allowed the research aims to be preserved and strengthened through the synthesis of existing evidence, it limited the ability to examine active organizational practices, attitudes, and interventions empirically.

Future Directions

Future research should extend this work by addressing several critical gaps identified across the reviewed studies. First, scholars should expand sampling frameworks to include a broader and more diverse range of organizations, particularly those operating outside the Southern United States. Comparative regional in-depth analyses would authorize researchers to examine how cultural norms surrounding strength, vulnerability, and help-seeking vary by geographic and policy context, and how these differences may shape the health outcomes of Black women.

Future research should also utilize a longitudinal, life-course research approach that allows the observation of how the SBWA internalization and effects emerge and evolve over the developmental lifespan of Black girls, from early childhood through adolescence. This design would be valuable in

examining how expectations of strength, resilience, caregiving, and constraint progress throughout girlhood to adulthood and how early socialization processes influence later coping and mental health trajectories. Longitudinal approaches would also enable identification of key, sensitive developmental periods in which culturally informed therapeutic interventions or educational programming could meaningfully alter life outcomes.

Finally, future studies should prioritize intervention-focused research that explicitly tests mechanisms identified in this review. Evaluating culturally grounded interventions within community-based organizations, healthcare settings, and educational institutions would advance the field and scholarship beyond documentation of disparities and help implement empirically supported practices that center on the betterment of Black women's well-being.

Policy Recommendations

The findings of this review reveal the need for policy responses that move beyond individual-level interventions and instead address the cultural, structural, and systemic determinants shaping Black women's health and well-being. While health disparities affecting Black women have been widely documented, emerging policies at the global, federal, state, and local levels demonstrate increasing recognition of the importance of equity-driven, culturally cognizant care. The following policy recommendations build upon existing and effective policies currently implemented in other regions of the world and across various U.S. states. Adapting these approaches would allow stakeholders and community members to fully consider the lived experiences of Black women in Southern communities and within the state of North Carolina. By drawing from established models rather than proposing entirely new frameworks, these recommendations emphasize scalable, evidence-informed strategies capable of addressing the persistent health inequity Black women experience.

1. Global Policy Implementation

- a. Globally, the World Health Organization's Respectful Maternity Care (RMC) framework emphasizes dignity, autonomy, informed consent, and freedom from discrimination during a woman's pregnancy and childbirth. Countries that have implemented RMC principles integrate bias-aware training, patient advocacy, and accountability mechanisms into the maternal care systems. Adapting RMC standards within the United States and its birthing centers would directly address findings in this review that revealed a link between maternal mortality, healthcare mistrust, and anticipatory vigilance amongst Black women. This framework would be beneficial to reduce the need for Black women's automatic defensive strength that is heavily prevalent when navigating the healthcare system and ensures that the system becomes a more protective and responsive

environment that considers the histories, lived experiences, and complexities of being a Black woman (Cantor et al., 2024).

2. Regional (Southern U.S.) Policy Implementation

- a. A promising regional policy model that could be adopted across the Southern United States is Medicaid coverage for doula services, which provide non-clinical, continuous emotional, informational, and advocacy-based support during pregnancy, childbirth, and the postpartum period (United Healthcare, 2024). States such as California and Colorado have implemented Medicaid-funded doula benefits, formally recognizing doulas as essential members of the perinatal care team (Williams, 2024). Evidence from these states indicates that doula-supported births are associated with lower rates of cesarean delivery, reduced preterm birth, and improved patient satisfaction outcomes that had previously been at high rates for Black women (Williams, 2024)
- b. In relation to the findings of this review, the equity-driven intervention ideology of this policy is as valuable as the medical advancement it offers. Medicaid-funded doula care represents a structural, equity-oriented initiative that directly addresses mechanisms that can help alleviate the stress load of expecting Black mothers. Adoption of this policy within the Southern region of the United States offers the potential to reduce reliance on the strength of the SBWA as a survival mechanism during the perinatal period and promote more culturally responsive and affirmative maternal care for Black women.

3. Local Policy Implementation (Durham County and Wake County)

- a. At the local level, public health departments could implement community-based cardiovascular health screening and prevention programs specifically designed for Black women, taking into consideration the empirical research. Given the significantly higher rates of hypertension, cardiovascular disease, and related mortality documented in this review, local governments are well-positioned to expand access to blood pressure screenings, cholesterol checks, and cardiovascular risk assessments in trusted, non-clinical settings such as community centers, college campuses, faith-based institutions, workplaces, or at Black women-focused organizational facilities.
- b. In addition to clinical screening, these programs should integrate stress-reduction and mental health interactive educational interventions that help educate individuals on how to reduce allostatic load and stress in order to prevent the development of serious health problems. Specific programming should educate individuals on effective ways to do at-home checkups, meditation, or coping strategies to implement within everyday life routine, and engaging programming that allows for Black women to connect and be

vulnerable within healthcare settings. These implemented programs can directly address the negative outcomes exhibited within this review (e.g., sustained stress exposure, self-silencing, and delayed care-seeking) that contribute to the cardiovascular risk Black women face.

Stakeholders and Power Dynamics

These policy recommendations outline actionable strategies across multiple levels; however, their effectiveness depends on the engagement and sustained commitment of key stakeholders responsible for implementation. Actors shaping Black women's health outcomes include federal and state policymakers, healthcare institutions, insurance systems, public health departments, and community-based organizations. Yet, as documented in the literature, power within these systems has historically been concentrated in institutions that have marginalized Black women's voices, often resulting in policy solutions that prioritize biomedical outcomes over the lived experience (Brailey & Slatton, 2024). In contrast, community-led organizations, faith-based networks, and Black women-centered advocacy groups serve as critical counterbalances to these power dynamics by offering culturally grounded interventions that address both structural barriers and the psychological stressors associated with the Strong Black Woman archetype (Leigh, 2024). Sustained funding and advocacy for these organizations are essential, as they expand capacity to deliver tailored educational programming, wellness initiatives, and supportive spaces that center Black women's lived experiences and promote long-term health equity.

Conclusion: Reframing Strength, Centering Care

This review demonstrates that the Strong Black Woman Archetype is not a singular or isolated identity, but a deeply embedded framework that Black women navigate through psychological, physical, and structural realities. Rooted in the historical context of slavery and reinforced through generations of survival, the SBWA has functioned as a necessary adaptive response to persistent racial and gendered oppression. However, the findings synthesized in this review highlights that the physiological pressure disproportionately borne by Black women is inextricably linked to the psychological and emotional labor demanded by this archetype. Chronic stress, self-silence, weathering, and delayed help-seeking reflect the cumulative cost of embodying strength within systems that have historically failed to offer protection, care, and equity.

The SBWA does not exist in isolation from other intersecting stereotypes that shape Black women's lived experiences. Expectations of unwavering resilience are intertwined with complex narratives of emotional restraint and self-sacrifice in the face of adversity. Together, these identities reflect a broader cultural mandate that Black women must endure without complain, remain productive without rest, and persevere without support. While these norms may instill resilience and confidence,

they have also repressed vulnerability and reinforced coping strategies that become maladaptive. The evidence reviewed here underscores that strength, when continuously demanded without structural support, becomes embodied as physiological risk and psychological burden.

The SBWA cannot be fully understood without understanding its historical origins and contemporary reinforcement; this is essential before meaningful progress can be made towards alleviating its harms. Efforts to dismantle the archetype without acknowledgement of its survival function risk pathologizing Black women rather than addressing the systems that made it necessary in the first place. Instead, this research calls for a reframing of strength; one that preserves resilience while expanding space for rest, care, emotional expression, and help-seeking. Such reframing must occur across all relevant dimensions.

This review aims to inform both policy and practice by illuminating the need for structural interventions and culturally responsive programming that supports Black women holistically. By grounding educational initiatives, organizational practices, and health policies in an accurate understanding of the SBWA, stakeholders can help Black women engage with strength in ways that are sustainable rather than self-sacrificial. Recognizing that the Strong Black Woman Archetype can function as both a source of empowerment and a site of harm is not a contradiction but a necessary step towards promoting health equity. Meaningful change will require shifting responsibility away from individualized endurance and towards systems that can support Black women in not just surviving, but in their overall wellbeing.

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