Developing a Manual to Address Mental Health Stigma and Barriers for African American Women

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Abstract

This project developed and evaluated *This House: A Manual for Culturally Responsive Mental Health Care*, designed to address the stigma and cultural barriers African American women face when seeking mental health services. Grounded in cultural competence theory and intersectionality, the manual was created to support mental health professionals better understand and respond to the cultural narratives that shape help-seeking. A qualitative methodology was used, incorporating structured rubric reviews and a focus group discussion with African American women with lived experiences, faith-based leaders, and mental health professionals. Data from rubric evaluations and the group discussion were analyzed thematically to assess the manual's clarity, cultural relevance, and practical usefulness. Results indicated that the manual effectively addressed key cultural barriers and was viewed as a valuable tool for improving engagement among African American women. Participant feedback informed revisions to enhance clarity, cultural depth, and applicability across clinical and community settings. Overall, the project underscores the need for culturally responsive resources that reduce stigma, increase accessibility, and support more equitable mental health care for marginalized populations, with recommendations for continued research on the manual's impact in real-world mental health practice.

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Section 1: Foundation

The problem addressed by this project was the persistent underutilization of mental health services by African American women because of cultural stigma and systemic barriers. Although African American women face heightened risks for anxiety, depression, and psychological distress due to the compounded effects of racism, sexism, and discrimination (Deblaere et al., 2014); in addition, fewer than ten percent of those living experiencing symptoms of mental illness seek treatment (Ward et al., 2009). African American (AA) women encounter substantial barriers to accessing mental health care, with stigma remaining one of the most pervasive obstacles. Campbell and Mowbray (2016) asserted stigma severely hinders African American women from seeking mental health care, which perpetuates the disparities in access to treatment. This disparity is further exacerbated by the cultural stigmatization of mental illness, as African American women are frequently socialized to adhere to the "strong Black woman" (SBW) ideal, an identity that discourages help-seeking and increases vulnerability to contributes to a heightened risk for untreated mental health conditions such as depression and anxiety (Woods-Giscombe et al., 2016). These systemic issues have yet to be adequately addressed, as current interventions fail to consider the unique cultural and social experiences of African American women, resulting in ongoing gaps in treatment accessibility and quality.

Efforts to increase access to mental health services for this population have been insufficient, particularly as many interventions fail to account for the culturally ingrained stigma and distrust that African American women have toward the healthcare system (Campbell & Mowbray, 2016). To address these barriers, this project involved mental health professionals, faith-based leaders, and African American women with lived experience in reviewing *This*

House: A Manual for Culturally Responsive Mental Health Care to assess its helpfulness and identify areas for improvement.

Statement of the Problem

The problem to be addressed by this project was to explore how the SBW schema (Jones et al., 2020) and cultural stigma influenced African American women's decisions to seek mental health services. The project's primary aim was to develop a manual that provides culturally competent tools for mental health professionals. The manual will assist in overcoming stigma, building trust, and engaging African American women in therapy. It will contain practical strategies that encourage self-efficacy, provide culturally relevant interventions, and educate both clients and clinicians about the cultural dynamics at play in mental health care.

The manual was reviewed by a diverse panel of stakeholders, including licensed mental health professionals, African American therapists, faith-based leaders, peer support advocates, academic scholars, and African American women with lived experiences in mental health challenges. Their feedback was useful in ensuring the manual is both impactful and relevant.

The insights gained through this review process will inform the final version of *This House: A Manual for Culturally Responsive Mental Health Care*. This manual will provide mental health professionals with practical strategies to reduce stigma, foster trust, and deliver culturally competent care that speaks to the unique experiences and needs of African American women. By addressing both individual and systemic barriers, this project sought to contribute to more equitable mental health outcomes for this underserved population.

Purpose of the Project

The purpose of this qualitative phenomenological project was to explore how the SBW schema (Jones et al., 2020) and cultural stigma influenced African American women's decisions

to seek mental health services. The project's primary aim was to create a manual that provides culturally competent tools for mental health professionals. The manual was designed to assist in overcoming stigma, building trust, and engaging African American women in therapy. It includes practical strategies that encourage self-efficacy, provide culturally relevant interventions, and educate both clients and clinicians about the cultural dynamics at play in mental health care.

The manual was reviewed by a diverse panel of stakeholders, including licensed mental health professionals, African American therapists, faith-based leaders, and African American women with lived experiences in mental health challenges. Their feedback was used to refine the content to ensure the manual is both impactful and relevant.

The insights gained through this review process informed the final version of *This House: A Manual for Culturally Responsive Mental Health Care*. This manual now provides mental health professionals with practical strategies to reduce stigma, foster trust, and deliver culturally competent care that speaks to the unique experiences and needs of African American women. By addressing both individual and systemic barriers, this project has contributed to more equitable mental health outcomes for this underserved population.

Nature of the Project

This project addressed the underutilization of mental health services by African American women, with a focus on overcoming barriers such as cultural stigma, fear, and historical mistrust of mental health care. The central component of this project was the creation of *This House: A Manual for Culturally Responsive Mental Health Care*. This manual was designed to guide mental health professionals in effectively engaging African American women in therapy by providing culturally relevant strategies, tools, and interventions. These approaches

were developed to help reduce stigma, foster trust, and encourage African American women to seek the mental health care they need.

The manual includes a 10-week therapeutic group program, specifically tailored to address the unique challenges faced by Black women. This program incorporates activities and interventions aimed at building coping skills, identifying and overcoming barriers to treatment, and challenging the myths surrounding mental health in the Black community.

A qualitative phenomenological approach was employed to capture expert insights and feedback on *This House: A Manual for Culturally Responsive Mental Health Care*, a manual designed to break down barriers and boost engagement in mental health care for African American women. This method explored the nuanced, real-world factors—such as cultural stigma and the pressure to embody strength—that often keep these women from seeking therapy, ensuring the intervention is both grounded in their lived experiences and truly effective. Through semi-structured interviews, a focus group, and participant reflections, the research captured rich, narrative data on how stigma, cultural beliefs, and previous experiences influence treatment-seeking behaviors. The data were analyzed thematically to identify key themes and patterns across participants' experiences, which informed revisions to the manual. The manual underwent a comprehensive review process to ensure it is culturally competent, relevant, and practical for both African American women and mental health professionals. The review process involved a diverse group of stakeholders who provided feedback and suggestions for improvement, including:

1. **Licensed Mental Health Professionals:** Evaluated the clinical applicability of the manual and assessed how well the strategies aligned with evidence-based practices.

2. **African American Therapists and Counselors:** Ensured the manual spoke to the unique experiences, cultural values, and needs of Black women, making the content both relatable and respectful.
3. **Faith-Based Leaders:** Provided feedback on whether the manual appropriately integrated spirituality and aligned with religious values while maintaining its therapeutic focus.
4. **African American Women with Lived Experience:** Shared input to ensure that the manual reflected real-world concerns and barriers to care while offering practical solutions.

Following the collection of feedback, a focus group was conducted to allow participants to clarify and expand on their perspectives, providing deeper insight. Based on these discussions, the manual was revised to reflect participant insights and recommendations. The iterative process of feedback and revision ensured that the manual is now culturally responsive, practical, and impactful, aligning with the overarching goals of the project.

Need for Project

African American women often navigate a complex web of barriers to mental health care, rooted in the overlapping realities of racial identity, gender, and deeply ingrained cultural pressures to remain strong. Despite experiencing disproportionately higher rates of mental illnesses such as depression, anxiety, and posttraumatic stress disorder (PTSD), African American women continue to be among most underrepresented groups in mental health service utilization (Nelson et al., 2020; Nelson et al., 2022). This disparity is fueled by structural, cultural, and psychological barriers, including stigma, distrust of the healthcare system, and the internalization of the SBW schema (SBWS; Castelin & White, 2022; Green, 2019; Nelson et al.,

2020). Addressing these barriers is crucial to improving mental health outcomes for African American women and ensuring equitable access to care. African American women bear a disproportionate burden of mental health challenges, often linked to experiences of gendered racism, systemic discrimination, and social isolation. Despite the high prevalence of mental health challenges, African American women access mental health services far less often than other populations (Nelson et al., 2022). Key barriers include the stigma surrounding mental illness, cultural mistrust of medical providers, and systemic inequities in access to care. The SBWS, which emphasizes emotional suppression, extraordinary caregiving, and self-reliance, discourages African American women from seeking help for mental health challenges. Compounding this is the pervasive stigma around mental health within African American communities, which hinders women from acknowledging their struggles or engaging with professional services. Even when African American women recognize the need for mental health care, fears of judgment and mistrust of providers further impede access (Castelin & White, 2022; Gaston et al., 2016; McKnight-Eily et al., 2009). Traditional mental health systems frequently fail to address the cultural and historical contexts of African American women's experiences, and culturally tailored interventions remain scarce (Cuevas et al., 2016). Programs that integrate stigma reduction strategies, resilience-building, and mindfulness have shown promise but are not widely implemented (Rivera et al., 2021).

This project will address these gaps by reviewing and informing content revisions of *This House: A Manual for Culturally Responsive Mental Health Care*, a psychoeducational resource designed to help mental health professionals better understand the cultural and systemic barriers African American women face and provide practical, culturally sensitive strategies for fostering engagement. The manual will offer guidance on addressing stigma, building trust, and tailoring

interventions to meet the unique needs of this population. By providing mental health professionals with tools to create safe and supportive therapeutic spaces, this project aims to empower African American women to seek and sustain mental health care.

The need for this manual is especially critical because current interventions often fail to acknowledge the cumulative impact of systemic inequities, historical trauma, and cultural expectations on African American women's mental health (Nelson et al., 2020). By identifying factors contributing to low mental health service utilization and offering culturally responsive solutions, this project will bridge existing gaps in the field, inform policy and practice, and promote equitable mental health outcomes for African American women. Ultimately, this work will contribute to changing the narrative around mental health within African American communities and fostering greater trust between mental health providers and their clients.

Project Questions

This project seeks to explore the perspectives of African American women regarding the cultural expectations and stigmas that shape their experiences with mental health care. The project aims to gain deeper insight into how cultural factors, such as the SBW archetype and the stigma surrounding mental health, influence the perceptions of treatment and the likelihood of seeking help. By addressing the following questions, the project aims to refine the manual and provide actionable recommendations to enhance culturally responsive care and reduce barriers to treatment for this underserved population.

PQ1

What insights, perceptions and reactions do participants have to the cultural expectations highlighted in the manual such as, the SBW archetype and specific stigmas that can affect African American women's perceptions of mental health and their likelihood to seek treatment?

PQ2

How do participants suggest improving the manual to better equip providers in reducing stigma and increasing accessibility for African American women in need of mental health care?

Theoretical Framework

This doctoral project employed an integrated theoretical framework combining the health belief model (HBM) and critical race theory (CRT) to address the complex barriers African American women face in accessing mental health care. These frameworks can be integrated to explore both individual attitudes and systemic barriers, providing a comprehensive understanding of the stigma and inequities that hinder treatment-seeking behaviors in this population.

HBM is a psychological framework that explains and predicts health-related behaviors by focusing on individuals' attitudes and beliefs (Rosenstock, 1974). This model will help explore how African American women perceive their mental health needs, evaluate the benefits of seeking treatment, and identify barriers to accessing care. Key components of HBM include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and self-efficacy. For example, African American women may recognize their vulnerability to mental health challenges (perceived susceptibility), yet underestimate the negative consequences of untreated conditions (perceived severity) due to societal stigma or cultural norms (Nelson et al., 2020). The model also highlights the perceived barriers, such as stigma, financial constraints, and mistrust of providers, that discourage engagement with mental health services (Alang, 2016; Nelson et al., 2020). Addressing these barriers through psychoeducation will enhance self-efficacy, empowering African American women to navigate the mental health care system with confidence (Ward et al., 2009).

While HBM focuses on individual-level attitudes, CRT provides a structural lens to examine systemic barriers to mental health care. CRT asserts racism is not an anomaly but a pervasive feature of societal systems, including healthcare (Sohn, 2017). Historical events such as the Tuskegee Syphilis Study have created lasting mistrust in medical institutions, which continues to influence African American women's perceptions of mental health care (Paul & Brookes, 2015; Wilkins et al., 2013). Racial and ethnic minorities generally experience poorer overall health compared to White Americans (Bahls, 2011). According to the Centers for Disease Control and Prevention (CDC, 2017, as cited in Pappas, 2021), Black women also face health disparities that translate to a life expectancy at birth that is 3 years shorter than non-Hispanic White women (77.9 years versus 81 years). Black women are more likely to experience racism and other forms of discrimination which are linked to increases in high blood pressure, heart disease, depression, and stress (Robinson-Wood, 2014). In addition, two-thirds of African Americans who need mental health care go without it (Dalencour et al., 2017). CRT also incorporates intersectionality, a concept introduced by Crenshaw (1989) to analyze how overlapping identities of race, gender, and class exacerbate barriers to care. For example, the SBWS, which encourages emotional suppression and self-reliance, perpetuates stigma and discourages help-seeking behaviors (Nelson et al., 2020; Woods-Giscombe et al., 2016).

CRT also emphasizes counter storytelling, which challenges dominant narratives and amplifies the voices of marginalized groups. This project will use counter storytelling to highlight the lived experiences of African American women, providing insights into their unique barriers to mental health care and disrupting harmful stereotypes (Awosan et al., 2011; Nelson et al., 2020). Furthermore, CRT's focus on structural barriers, such as the underrepresentation of African American clinicians and the lack of culturally competent providers, underscores the need

for systemic change to improve mental health outcomes for African American women (Nelson et al., 2020).

By integrating HBM and CRT, this project addresses both individual and systemic factors contributing to mental health disparities among African American women. HBM's emphasis on individual attitudes and behaviors complements CRT's analysis of structural inequities and historical context. Together, these frameworks will guide the development of a psychoeducational manual that reduces stigma, promotes self-efficacy, and equips mental health professionals with culturally competent strategies to support African American women. This dual approach ensures that the manual not only addresses personal barriers but also advocates systemic change, fostering a more inclusive and equitable mental health care system.

Significance of the Project

This project is significant as it targets a long-standing gap in mental health services for African American women. By creating a manual that not only speaks to the experiences of Black women but also offers actionable tools for mental health professionals, this project will have a dual impact. It will enhance the therapeutic process for Black women by providing resources tailored to their needs, while also educating clinicians on how to approach these women with cultural sensitivity and respect.

The manual will serve as a bridge between African American women and mental health professionals, facilitating more open conversations about mental health and fostering an environment in which African American women feel comfortable seeking the help they need. As the findings from Woods-Giscombe et al. (2016) suggest, many African American women view depression and other mental health challenges as a normal response to life stressors, rather than

conditions requiring professional intervention. This manual will offer an alternative perspective, emphasizing the importance of professional support for emotional health.

Nelson et al. (2020) emphasized that "cultural mistrust of healthcare providers, rooted in historical and contemporary racism, continues to be a significant barrier to care for African American women" (p. 13). Through this manual, mental health professionals will learn to apply culturally sensitive interventions that encourage Black women to engage in therapy. By reducing the stigma around seeking mental health care, the manual will help create an environment where African American women can prioritize their mental well-being without fear of judgment or cultural invalidation.

Definitions of Key Terms

Culturally Sensitive Interventions

Culturally sensitive interventions are therapeutic approaches designed to account for and respect the cultural beliefs, practices, and experiences of a specific population (Oh & Lee, 2016).

Help-Seeking Behavior

Help-seeking behavior refers to the process of recognizing the need for and actively pursuing professional support for mental health concerns (Nelson et al., 2020).

Historical Trauma

Historical trauma is the cumulative psychological and emotional harm experienced by a group of people over generations because of systemic oppression, violence, and discrimination (Wilkins et al., 2013).

Mental Health Service Utilization

Mental health service utilization refers to the extent to which individuals access professional mental health services such as therapy, counseling, and psychiatric care. African

American women's utilization rates are significantly lower than other groups because of stigma, distrust, and systemic barriers (Campbell & Mowbray, 2016).

Mistrust of Healthcare System

Mistrust of the healthcare system is the skepticism and lack of confidence in medical institutions, often based on historical exploitation and ongoing systemic discrimination (Wilkins et al., 2013)

Racism and Sexism

Racism and sexism refer to systemic biases and discrimination based on race and gender, respectively (Nelson et al., 2021).

Systemic Barriers

Systemic barriers refer to institutional and structural obstacles that disproportionately affect certain groups, making it harder for them to access essential services, including healthcare (Wilkins et al., 2013)

Literature Review

Only as Sick as the Secrets We Keep

"What goes on in this house, stays in this house" is a common mandate in African American households. According to Nelson et al. (2020), barriers to mental health service use among African American women have been explored; however, little is understood about how stigma impacts help-seeking attitudes and behaviors in Black women. Research shows depression tends to be more persistent, intense, and debilitating for Black women in the United States compared to White women, although estimates of its prevalence among Black women vary (Castelin & White, 2022). While African Americans have similar or lower rates of common mental disorders than Caucasians, the literature suggests oppressive experiences including

racism, discrimination, classism, and sexism put African American women more at risk for low-income jobs, multiple role strain, and health problems (Aruguete & Edman, 2019). This makes African American women more likely than White women to experience persistent feelings of sadness, hopelessness, worthlessness, constant exhaustion or "that everything is an effort all of the time" (Woods-Giscombe et al., 2016, p. 1126). The combination of these factors exacerbates the risk for mental illness in Black women.

The Struggle Is Real!

Most research related to depression and other mental health disorders disproportionately focuses on Caucasian populations. These studies predominantly concentrate on the impact of depression on White women; the scarcity of studies relating to African Americans, women in particular, should cause significant alarm. While statistics suggest 13.8% of Black women report current depressive symptoms (Green, 2019), only one in three with a diagnosis pursue treatment (Nelson et al., 2020). African American women's limited use of psychological services often means unaddressed psychological symptoms, leading to detrimental consequences for them, their families, and communities (Watson-Singleton et al., 2017). Considering exposure to racism, sexism, classism, colorism, besides the increased risk of childhood abuse, sexual abuse, domestic violence, and poverty, Black womanhood has become synonymous with struggle. Racism and other forms of discrimination, childhood abuse, sexual abuse, domestic violence, and poverty have a traumatizing impact. While there is plenty of research on trauma, mental illness, and barriers to treatment for the majority culture, the mental health needs of Black women have been underserved and understudied (Nelson et al., 2022). Robinson-Wood (2014) noted trauma exposure increases risk of hypertension, heart disease, clinical depression, and a host of other somatic illnesses. Furthermore, McKnight-Eily et al. (2009) asserted racial disparities, poverty,

cultural socialization patterns, social health problems, obesity, diabetes, and exposure to interpersonal and community violence describe social, psychological, and physiological issues that predispose Black women to depression. Not unlike research related to depression, the research regarding Black women and trauma remains insufficient. The scarcity of research on depressive symptoms and how they present, or impact Black women, may contribute to underdiagnosis, misdiagnosis, and inappropriate or culturally insensitive treatment, which may also affect the rate in which Black women seek treatment (Alang, 2016, 2019; Cuevas et al., 2016; Nelson et al., 2022).

What's Really Going On?

To gain an understanding of the disproportionate use of psychological services in African American women, a necessary starting point is an exploration of barriers to treatment. Understanding Black women's attitudes/beliefs towards the perceived barriers to using mental health services can lead to greater comprehension of how these beliefs affect their participation in services. Several studies have identified numerous barriers that Black women face when seeking treatment and inversely, barriers the healthcare system encounters when trying to reach and serve Black women. Distrust of the medical community, adherence to the SBW stereotype, stigma associated with receiving mental health care, and reliance strictly on faith as a coping mechanism interfere with seeking mental health treatment (Alang, 2016, 2019; Castelin & White, 2022; Cuevas et al., 2016; Green, 2019; Nelson et al., 2020; Nelson et al., 2022)

Other factors that hinder treatment for Black women include disparities in health care access and quality and the disproportionately small number of African American/Black mental health clinicians (Green, 2019; Nelson et al., 2020). According to the Office of Disease Prevention and Health Promotion (2020), access to health care refers to the proximity of

services, the ability to afford services, and being able to find a suitable provider. Alang (2019) found that individuals living in non-metropolitan areas were more likely to report challenges with access to care. Given that more than half of the Black population in the United States resides in the rural South (United States Census Bureau, 2020), this suggests access to care may be a significant issue in these regions. Compounding the problem of access, about 14 percent of African Americans lack health insurance (Sohn, 2017). However, even those with insurance have financial concerns, "Yes I have insurance and a $25 co-pay with each visit. But it is still $25.... What if I have to go to therapy every week?" (Alang, 2019, p. 350). Although insurance coverage is one of the most important determinants for deciding to seek treatment among African Americans and White Americans, insurance alone, at least when provided by private sector plans, fails to eliminate disparities in access between African Americans and White Americans (United States Department of Health and Human Services [USDHHS], 2001).

If able to overcome proximity and affordability, African Americans are then faced with being able to find a suitable clinician to provide quality care. While the MFT field boasts 14.7% of degrees awarded to African Americans (Data USA, 2017), overall, African Americans remain underrepresented in the field of mental health, leading to a prevalence of misdiagnosis of Black people as it relates to racial bias among clinicians providing treatment to African Americans (Bulhan, 1985; Jegarl et al., 2023). In 2001, the United States Surgeon General addressed mental health for the first time. His report noted African Americans are more likely to be incorrectly diagnosed than Caucasians. Holden et al. (2013) agreed, indicating African Americans were more likely to be diagnosed with a severe mental illness (e.g., schizophrenia) than to be diagnosed with an affective disorder (e.g., major depression). No explanation was given.

The mental health system in America has long been criticized for its deeply embedded structural racism, evident in the historical development of treatment theories, diagnostic practices, and access to care. The American Psychological Association (APA) acknowledged its role in perpetuating systemic racism, as outlined in its formal 2021 apology, recognizing that psychology as a discipline has often pathologized marginalized communities while upholding Eurocentric standards of "normalcy" and health. This systemic bias has disproportionately harmed African American communities by contributing to misdiagnoses, stigmatization, and exclusion from mental health services (Alang, 2019; Bulhan, 1985; Cuevas et al., 2016; National Alliance on Mental Illness [NAMI], 2020). The Institute of Medicine (IOM) defined disparity as an incongruence in health care quality that is not related to differences in health care needs or preferences of the patient (Smedley et al., 2003). Black people when treated were more likely to receive substandard mental health care. African Americans are less likely to receive mental health treatment than White Americans and when they receive treatment, it is more likely to be provided by a primary care physician, an emergency room, or an inpatient psychiatric hospital (USDHHS, 2001). These settings and patterns of treatment undermine delivery of high-quality mental health care. Snowden (2012) defined quality of care as receiving medication management with appropriate medication for at least two months, including four follow-up visits to any physician monitoring or participating in a minimum of eight sessions of therapy. Black people (women in particular) seek treatment less often, are less likely to follow up after the first visit, stayed in treatment for shorter courses, are less likely to be prescribed antidepressants and are more likely to end psychotherapy prematurely (Woods-Giscombe et al., 2016).

Shackled, Subjugated, and Studied

Over 400 years ago, the first Africans were kidnapped from their homes and brought unwillingly to the United States in shackles on slave ships to provide a lifetime of forced servitude to White European colonials. These Black servants were designated as a sub-human class and deprived of legal protections. Any physical punishment could be inflicted upon the enslaved, who were regarded as inferior, treated as property, and deprived of basic human rights (Wilkins et al., 2013). Regularly stripped away from people they loved, they taught their children to be tough, show no weakness, rely on yourself, do not ask for help, and most importantly, do not expect help. The idea that you can expect no help from outside sources contributes to the SBW barrier to be explored later. As the emancipation of slaves provided freedom in 1863, it came after 300 years of enslavement that deprived the community of education, land, and resources to survive independently. Although the 14th Amendment decreed the citizenship of the newly freed slaves, this did not end the oppression of African Americans. Former slaves continued to face a denial of access to education, hospitals, orphanages, and poorhouses. As contended by Wilkins et al. (2013), "Instead of treating the trauma of slavery with healing centers, newly freed African Americans were raped, castrated, and lynched" (p.18). This sustained lived reality only deepened the mistrust between African Americans and the White majority culture.

As if slavery was not enough, many African Americans acknowledge the Tuskegee syphilis experiment (Tobin, 2022) as a contributing reason for distrust in the medical community. In 1932, in Macon County, Alabama, the United States Department of Public Health began an experiment that was supposed to last for 6 to 8 months to study the effects of syphilis on Black men; however, the study continued for 40 years (Paul & Brookes, 2015). The

participants were told that they were being treated for bad blood, but they were not being treated for anything. They were left to get sicker with no treatment until most of them succumbed to the illness. This unethical study has had a lasting impact on the Black community, creating distrust of the medical community, which also extends to the mental health community. Early mental health diagnoses, such as drapetomania, used flawed methods to pathologize African Americans, studies manipulated data to support racist conclusions, and psychiatry lacked standardized diagnostic criteria, leading to skewed generalizations about Black mental health (Helm, 2023). In a Baltimore-based study, Passamanick (1963) reported Black Americans experienced psychiatric hospitalization at a rate 75% higher than White Americans. Fischer (1969), Pokorny and Overall (1970), and Pettigrew (1964, 1974) confirmed Black individuals are overrepresented in public psychiatric hospitals. From the 1950s to the 1970s, Black people were subjected to involuntary institutionalizations at rates that look like present day incarceration rates. In the 1950s, there was a Black man in Mississippi who was committed to an asylum for having the audacity to apply to a state college; the judge argued he had to be insane (Wall, 2020). During the civil rights movement, Black activists were falsely labeled as psychotic to justify institutionalization (Misra et al., 2022). Bell et al. (2015) concluded Black people are more likely to be diagnosed with a severe mental illness. According to Schwartz et al. (2019), African Americans are disproportionately diagnosed with schizophrenia-spectrum disorders at a rate 2.4 times higher than White individuals, who tend to receive mood disorder diagnoses more frequently. Another study found tBlack patients with schizophrenia were nearly twice as likely to be involuntarily admitted to psychiatric hospitals compared to White patients (Barnett et al., 2019). This disparity is attributed, in part, to clinician bias and cultural insensitivity in diagnostic practices. Studies have also shown Black individuals with psychotic disorders are more likely to experience police

involvement during mental health crises and have higher rates of involuntary psychiatric hospitalizations compared to White individuals. For instance, in Boston, 41% of involuntary hospitalization applications were for Black or African American individuals, despite this group comprising only 23% of the city's population (Simon et al., 2025).

With a 400-year history of being perceived as inferior, abused and marginalized, and the APA (2021) apologizing for its part in perpetuating racism in the field, it is no wonder that many African Americans are leery about participating in therapy. This also may provide insight into the lack of research regarding African Americans and mental health.

Holding It Down for Everyone

The SBW is who African American women long to be and hate having to be at the same time (Castelin & White, 2022). "The dominant society has never viewed Black women as sympathetic or normatively feminine figures" (Beauboeuf-Lafontant, 2007, p. 30). Jones and Shorter-Gooden (2003, as cited in Beauboeuf-Lafontant, 2007) contended "If you're trying to identify depression in Black women, one of the first things to look for is a woman who is working very hard and seems disconnected from her own needs" (p. 32). Woods-Giscombe et al. (2016) agreed, remarking "African American women did not seek mental healthcare for depression because they believed it was a normal reaction to difficult life situations rather than an illness that needed immediate attention" (p. 1127). A case study presented by Martin et al. (2013) explored this dynamic:

> Karen is college educated, articulate, attractive, friendly, impeccably dressed, and her hair and makeup are always neat. She is highly functional at home, work, and church—the first to cheerfully offer her services to care for, relieve, and support colleagues,

> family, and church members. She does not appear to be sad, mad, nervous, or angry although she feels each of these emotions intensely. (p. 8)

Karen insisted on bearing the burden of it all because her mother taught her that Black women take care of their families. Seeking help from outside sources is not viewed as maximizing resources but as having a lack of strength. "Assistance was associated with weakness and therefore was an invalidation of one's claim to an authentic Black femininity" (Beauboeuf-Lafontant, 2007, p. 40); therefore, a woman's self-reliance equals strength. The SBW does not have time for depression. In the Black community, depression is viewed as a white thing. Beauboeuf-Lafontant (2007) agreed, asserting:

> Unlike White men, whose depression is often "characterized . . . as a sign of genius"; White women, "who are depicted as idle, spoiled, or just plain hysterical"; and Black men, who are "demonized and pathologized", when a Black woman suffers from a mental disorder, "the overwhelming opinion is that she is weak. And weakness in Black women is intolerable. (p. 33)

What Goes on in This House...

Passed down generation to generation, there is a stigma associated with seeking mental health care services. Nadeem et al. (2007) defined stigma as "being embarrassed to talk about personal matters with others," "being afraid of what others might think," and "family members might not approve" (p. 1548). Never seeing mothers, grandmothers, or other female role models cry or openly express pain or discomfort with the stressors of life may add to Black women's resistance to show vulnerability.

By example, Black women learn to be totally self-sufficient lest they display the weakness that is intolerable. If the community distrusts the mental health care system and frowns

upon a woman showing weakness, imagine the hurdle of showing weakness and seeking help from that very system. Woods-Giscombe et al. (2016) concluded that in Black Americans, all age groups, socioeconomic status, and education levels held the same beliefs regarded to being seen as weak for seeking help. It is socially acceptable for Black women to congregate in small groups to talk about their lives. It is also permissible to go to church and ask for the prayers of others; however, sharing personal matters with strangers likely will result in disapproval or judgment from others. After all, what goes on in this house stays in this house. Telling family secrets can cause the Department of Human Resources to be called (citation), which nobody wants. Telling family secrets might get the police called on someone in the family. This type of interference can cause a victim to be further victimized, isolated, or even ostracized for going against family and community norms and talking to "the White folks." Racial inequality pervades the foster care system, as 1 in 10 Black children—twice the rate for white children—experience foster care with more placements, less treatment, and fewer relative placements, undermining their stability (Laub & Haskins, 2018). Edwards and Selas (2025) argued adverse experiences with public agencies—such as those in child welfare, social services, or the judicial system—can distort perceptions of available support, erode trust, and foster negative views of therapeutic help.

Try Jesus

Black people traditionally are a very religious or spiritual community with Black women being even viewed as the backbone of the church (Avent Harris, 2021) Spiritual practices, like prayer, reading the Bible, and going to church are embedded in the culture and often used as coping mechanisms for other adverse health conditions (Millett et al., 2018; Skipper et al., 2018; Woods-Giscombe et al., 2016). Church provides a safe place for emotional expression. It is

perfectly acceptable to cry, shout, moan, or otherwise verbally express your emotions. "Pray about it," they say. "Give it all to the Lord," they suggest. While faith is a perfectly acceptable coping skill, "Black women may believe, due to cultural and religious reasons, that they must resolve problems solely on their own" (Robinson-Wood, 2014, p. 65). African American women feel obligated to appear strong, repress negative feelings, and avoid reliance on mental health professionals. While it is acceptable to go to the pastor or minister, going to see a professional mental health counselor is often viewed as a lack of faith or belief in God's abilities to heal (Ward et al., 2009). Even though in Woods-Giscombe et al.'s work (2016), participants agreed that pastors were frequently ill-equipped to handle their concerns, the flawed idea that trusting Jesus is all that is needed to heal emotional and mental concerns prevents Black women from seeking professional help for these problems (Abrums, 2000).

Y'all Don't Hear Me

African Americans comprise 13 percent of the population of the United States; however, they only make up 5 percent of mental health providers. Bulhan (1985) underscored a striking imbalance in the mental health profession, pointing out Black individuals made up only 2% of American psychiatrists, 4% of psychologists, and 7.6% of social workers, while being disproportionately represented as patients. Nearly 40 years later, the gap remains largely unchanged. According to the United States Government Accountability Office (GAO) (2022), Black professionals currently account for 2% of psychiatrists, 4% of psychologists, 7% of marriage and family counselors, and 11% of professional counselors. CACREP accredited masters' programs require only one multicultural class. To maintain licensure as a licensed professional counselor (LPC) in the state of Alabama, six continuing education units in ethics are required every two years; however, multicultural studies, diversity, sensitivity training, or

anything that helps clinicians work with populations different from themselves is not required (Alabama Board of Examiners in Counseling [ABEC], 2024). In fact, very few states nationwide require multicultural continuing education for clinicians. A few states—California, Texas, New York, and Georgia—mandate such training for LPCs or LMFTs, leaving most states, including Alabama, with no specific requirements for diversity or multicultural competency in continuing education (American Counseling Association [ACA], 2025). Many Black people fear White clinicians cannot understand and therefore cannot help. There is a fear of being judged, mistreated, and even misdiagnosed by people who just do not get it. The assumptions that Black women feel White clinicians make about them widen the chasm. Alang (2019) found "sometimes, clinicians unconsciously suggested that Black patients should assimilate to a dominant culture that characterizes counseling, or that Black patients should only see Black providers" (p. 352). According to Woods-Giscombe et al. (2016), Black women identified cultural insensitivity by providers as a barrier. African American patients often interpret their experiences through a racial lens shaped by both historical and present-day encounters with racial discrimination, particularly in interactions with social institutions. As Cuevas et al. (2016) asserted, these experiences influence how individuals engage with healthcare, education, and other systems, often contributing to mistrust and reluctance to seek services. Understanding this context is crucial in addressing barriers to mental health treatment and fostering a more culturally responsive approach. African American women are aware of their experiences with race and discrimination while non-Black clinicians are often unaware of their biases. Participants in Woods-Giscombe et al.'s (2016) study felt non-Black therapists did not have "a keen understanding of the life experiences of African American women, that they lacked the compassion, patience, and competence needed to work optimally with African American

women" (p. 1133). "Lack of cultural understanding" is a salient factor that deters African American clients from seeking therapy (Awosan et al., 2011, p. #). Clients will not confront a therapist for being inappropriate; they will stop going to therapy and write off the profession. Leaving a Black woman to surmise that family, friends, educators, pastors, ministers, and the neighborhood can be more supportive and provide better solutions than the current mental health system.

What's Being Done About It?

The field of marriage and family therapy has an ethical responsibility to address the gaps in research and issues previously mentioned. There have been a few studies that focused on culturally sensitive therapy interventions for African American; however, as Wilkins et al. (2013) noted that "MFTs have not yet incorporated interventions geared towards African American clients into mainstream practice, training and research" (p. 14). For African Americans, treatment must be acceptable, accessible, and understandable. Not all therapy models are appropriate for this population (Becker & Liddle, 2001).

Robinson and Ward (1991) created the resistance theory in the early 1990s to help Black women and girls identify and resist oppression in their lives. The concepts of resistance theory reflect the Kwanzaa principles. In 1966 as a celebration of life, the African American community began celebrating Kwanzaa, an annual cultural holiday observed from December 26 through January 1. The seven principles of Kwanzaa include:

1. Umoja—Unity with others across age, class, gender, and race.
2. Kujichagalia—Incorporation of a healthy identity.
3. Ujima—Healthy reliance on self and others.
4. Ujaama—Sharing fiscal and human resources.

5. Nia—Having a sense of agency and purpose.
6. Kuumba—Actively creating new and empowering ways of being in the world.
7. Imani—Trusting that life gets better and that the universe is benevolent and responsive. (Martin et al., 2013)

Martin et al. (2013) contended by using these principles resistance theory focuses on identifying suboptimal resistance: needing to fix others and sacrificing self, inability to ask for help, and the inability to say NO, feelings of worthlessness and isolation while increasing optimal resistance: willingness to ask for help, utilizing healthy resources and support from others, belief that it will get better, healthy interdependence, developing a healthy identity, and having a sense of purpose. Resistance theory was created with two goals in mind: helping Black women and girls push back against oppression (e.g., racism & sexism) and avoiding suboptimal "resistance" (coping skills) like comfort eating, isolation from support system, unprotected sex, and alcohol/ drug use (Robinson-Wood, 2014). In 2002, Robinson returned to the table to verify the validity of the Resistance Model Inventory, ensuring that the questions measured resistance and were adequate for research; the inventory was updated, and 15 questions were removed (Robinson-Wood, 2014). Resistance theorists do not claim Black women who optimally resist will avoid depression; however, resistance supports health and healing. The major problem with resistance theory is lack of use/exposure; it has not been incorporated into mainstream practice.

Becker and Liddle's (2001) work focused on the impact of specific therapy interventions on unmarried Black women and their adolescent's, noting that African American families are increasingly headed by single mothers. Being a parent is stressful enough without the added pressure of doing it alone; another burden that is disproportionately affecting Black women. When working with the single mother, the onus is on the therapist to not overburden the client by

assuming she has the desire or the strength to make changes, while also not giving her resources that are not desired making her feel like a "charity case." Multidimensional family therapy (MDFT) is a family-focused, strength-based therapeutic approach that is often effective for addressing adolescent behavior issues, while also recognizing the distinct needs of the parent, particularly single mothers. MDFT emphasizes restoring or strengthening the attachment bond between the adolescent and parent, which can be especially important in families facing challenges such as substance use, behavioral issues, or mental health concerns (Becker & Liddle, 2001). However, it is important to recognize that while MDFT is valuable for addressing relational dynamics, it also requires a broader, holistic view of the family system and individual needs. This is a significant benefit for Black women, as it does not engage in pathologizing or stigmatizing them, a common issue in therapy where cultural and racial factors might be overlooked.

Nevertheless, the family-centered nature of MDFT presents a potential limitation when it comes to working with African American women who may seek therapy for individual, rather than family-related, concerns. If the woman is coming to therapy alone to address personal challenges, rather than family dynamics, the family systems framework might not be the most appropriate. For instance, addressing family attachment issues or focusing on family therapy interventions might not align with the client's immediate needs or therapeutic goals. This is an important consideration, as therapy should be structured to meet the specific circumstances and preferences of the client, ensuring that the treatment approach is relevant to the specific context in which the woman is seeking help.

To increase the engagement in psychiatric treatment for African American youth and their families, Breland-Noble et al. (2006) developed a motivational interviewing (MI)

intervention. Motivational interviewing considers a client's readiness for change or lack thereof, avoids direct confrontation, rolls with resistance, encourages self- efficacy, and expresses empathy.

By attending to the aspects of culture deemed important by African Americans—namely, striving over obstacles, identifying and attending to individual and family perspectives on their own needs, and using a brief approach—the intervention sought to directly address some of the individual and systemic barriers that African Americans face regarding psychiatric treatment engagement (Breland-Noble et al., 2006). Breland-Noble et al. (2006) also concluded that "success in increasing health-promoting behaviors is greatest when interventions are tailored to an individual's stage of change" (p. 160). The whole point is to identify the client's goals and barriers to treatment and help them overcome barriers and meet their self-identified goals. With a focus on willingness to change or lack thereof, MI does not address distrust for the therapist, the culturally insensitive therapist, or the stigma of seeking help.

Something Has to Be Done

One strategy that new clinicians are taught in master's programs is to do an asset or strength search for their clients. Black women are not without resources. Black women have been using what they have, to deal with mental health concerns, since the beginning of time. Despite a significant distrust for the medical community, Black women have even begun seeking professional treatment. Black women use church, small group Bible study, book clubs, Girls' Night Out, and prayer as coping for life stressors, to name a few. The MFT field should begin incorporating these resources into mental health treatment. Dismantling the effects of over 400 years of slavery and its brutal aftermath is not likely to occur with one study and will not undo the residual effects of slavery. However, careful evaluation that seeks to understand the SBWS

and the stigma of the refusal to ask for help or seek mental health treatment, when necessary, may provide significant insight that could result in the development of resources that could improve the numbers of Black women seeking mental health treatment.

Ethical Assurances

This research project adhered to rigorous ethical standards, particularly due to the sensitive nature of the data being collected from an historically marginalized population, African American women. Given that this project collected qualitative data on experiences related to stigma and barriers to mental health care, it was critical to protect participants' confidentiality, ensure informed consent, and maintain cultural sensitivity throughout the research process (Castelin & White, 2022).

IRB approval (Appendix A) was obtained to ensure that the project design and data collection methods adhered to ethical principles, including the safeguarding of participants' rights and privacy. This approval guaranteed that participants were fully informed about the purpose of the project, the voluntary nature of their participation, and their right to withdraw at any time without penalty. Additionally, the project's methodology was reviewed and implemented to ensure that the language, tools, and approaches used were culturally competent and sensitive to the unique needs and experiences of African American women. This included addressing the potential emotional impacts of discussing stigmatized topics such as mental health, while offering support and resources where necessary. The ethical considerations outlined above ensured the project was conducted in a respectful, responsible, and ethical manner, with the goal of providing valuable insights that will benefit both the participants and the broader mental health community.

Summary

African American women face significant barriers to mental health care, including cultural stigma, systemic inequities, and the pervasive SBW archetype, which discourages vulnerability and help-seeking. Historical distrust of the healthcare system, fueled by events like the Tuskegee syphilis study, further compounds these challenges, alongside limited access to culturally competent providers and reliance on religious coping mechanisms. Despite higher rates of untreated mental health conditions like depression, anxiety, and PTSD, African American women underutilize professional mental health services, leaving critical needs unmet. Literature underscores a lack of research addressing their unique experiences and help-seeking behaviors, particularly regarding the intersection of race, gender, and cultural expectations.

This project addressed these gaps by exploring how mental health professionals can decrease stigma and the societal norms that are barriers to African American women's mental health care decisions. Guided by the health belief model and critical race theory, it identified culturally sensitive interventions to reduce stigma and enhance access to care. The findings informed the development of strategies that empower African American women to overcome barriers and advocate for systemic change, ensuring equitable and effective mental health support. The accompanying manual now serves as a practical resource, translating these findings into actionable steps for mental health professionals, community advocates, and organizations dedicated to improving mental health outcomes. By offering guidance on culturally responsive practices, outreach methods, and community education, the manual equips stakeholders with the tools necessary to foster trust and engagement among African American women, ultimately contributing to a more inclusive and supportive mental health system.

Section 2: Methodology and Design

The problem to be addressed by this project was to explore how the SBW schema (Jones et al., 2020) and cultural stigma influenced African American women's decisions to seek mental health services. The purpose of this qualitative phenomenological project was to explore how the SBW schema (Jones et al., 2020) and cultural stigma influenced African American women's decisions to seek mental health services. Stigma continues to be a major barrier to mental health treatment for African American women, often leading to unaddressed trauma and other psychological concerns (Alang, 2019). The goal of this project was to introduce and refine a manual to be used by therapists and faith-based leaders that reduces the impact of stigma, ultimately increasing mental health treatment rates within this demographic. The manual, titled *This House: A Manual for Culturally Responsive Mental Health Care*, was developed based on an extensive review of literature, culturally grounded frameworks, and existing research on stigma, mental health disparities, and engagement strategies among African American women. This section outlines the methodological framework of the project, focusing on the selected design and methods. It also explains the appropriateness of the chosen approach in addressing the identified problem and purpose, and it reviews alternative designs and methods that were considered along with the rationale for their exclusion.

Design and Method

This qualitative phenomenological project was designed to inform the development of *This House: A Manual for Culturally Responsive Mental Health Care*. The phenomenological approach was chosen because it prioritized the exploration of personal experiences, providing rich, detailed narratives that reflect the unique cultural and systemic barriers faced by African American women. According to van Manen (1990), phenomenology focuses on "lived

experience" (p. #) as the central element of understanding human existence. The approach was particularly suited for examining complex issues such as stigma and cultural perceptions in mental health treatment. It allowed the exploration of how these issues are experienced and understood by African American women, making their voices central to the process of reviewing the effectiveness of the manual. As van Manen (1990) explained, the aim was not to impose predefined concepts onto participants' experiences but to allow the meaning of the experiences to emerge naturally through the research process. This aligned with the goals of the project, which sought to ensure the manual addressed real, lived challenges in mental health care.

The project used a manual review rubric alongside semi-structured interviews conducted in a focus group format to gather and analyze feedback on *This House: A Manual for Culturally Responsive Mental Health Care*. All participants were provided the same evaluation rubric, which included domains such as cultural relevance, clarity and readability, practical usefulness, sensitivity to emotional needs, engagement strategies, addressing stigma, and clinical and therapeutic alignment. Because the “Clinical and Therapeutic Relevance” domain presupposes professional training, this item was omitted for African American women with lived experience. This ensured that participants were only asked to evaluate areas that aligned with their expertise while maintaining comparability across the other domains.

In addition, semi-structured interviews were conducted during the focus group, allowing participants to share verbal feedback in their own words. A HIPAA-compliant transcription service was used to record and transcribe the discussion, ensuring accuracy while safeguarding participant confidentiality. This approach enabled participants to expand on their rubric responses, clarify their perspectives, and provide deeper insights into the manual’s strengths and areas for improvement.

Thematic analysis was employed to examine the qualitative data from both the rubric responses and the transcribed interviews. Following Braun and Clarke's (2006) structured approach, the analysis identified and interpreted key patterns, highlighting how cultural stigma, systemic barriers, and lived experiences influence African American women's engagement in mental health treatment. These findings directly informed revisions to the manual, strengthening its cultural responsiveness and practical utility.

By using semi-structured interviews, participants are empowered to tell their stories authentically, while thematic analysis reveals meaningful patterns that shape the direction and substance of the manual. The manual includes integrated findings from both individual interviews and focus group discussions to provide actionable strategies for reducing stigma, fostering trust, and improving cultural competence among mental health professionals. By focusing on lived experiences, the manual contains practical tools and interventions designed to address specific barriers identified during the project.

Alternative designs, such as quantitative surveys or experimental methods, were considered but deemed less appropriate. Quantitative approaches lacked the depth required to explore complex cultural phenomena, and experimental designs focus on causality rather than understanding nuanced experiences. The qualitative phenomenological method was selected because it aligns with the project's goal of producing a practice-oriented, culturally informed resource. This approach ensured that the voices of African American women and the clinicians who work with them remain central to the manual's refinement, providing insights that can guide mental health professionals in delivering more equitable and effective care. Thematic analysis was employed not only to highlight key challenges but also to identify strategies that resonated

with the lived experiences of participants, ensuring the manual's practical application in diverse clinical settings.

Population and Sample

The population for this project included mental health professionals who work with African American women and have experience addressing the stigma and systemic barriers that impact their access to mental health care. This group consisted of licensed professional counselors (LPCs), clinical social workers (LCSWs), psychologists (PsyDs/PhDs), and marriage and family therapists (MFTs), as well as faith-based leaders. In addition, African American women with lived experience in mental health treatment were also included in the project. These individuals provided valuable insight into the cultural, systemic, and psychological barriers that often keep African American women from seeking therapy. Because this was a qualitative phenomenological project, the sample size was intentionally small to allow for deep, meaningful exploration of themes. While Dworkin (2012) suggested qualitative research typically includes 5 to 50 participants, phenomenological studies often involve 6 to 15 participants to allow for in-depth exploration while maintaining manageability of the data (Creswell & Poth, 2018). For this project, a total of 18 participants were recruited, including mental health professionals, faith-based leaders, and African American women with lived experience in mental health treatment.

The final breakdown of participants was as follows:

- 7— Licensed Mental Health Professionals
- 5— Faith-Based Leaders
- 7— African American Women with Lived Experience

This distribution allowed the perspectives of service providers, faith-based leaders, and those with lived experience to be incorporated while maintaining balance in the representation of each

group. The inclusion of these three perspectives ensured that the manual was developed in a manner that is both clinically practical and culturally relevant. Service providers contributed their professional expertise and understanding of therapeutic application, while faith-based leaders offered insight into the spiritual and communal dimensions that shape many African American women's mental health experiences. Women with lived experience grounded the manual in authenticity by sharing first-hand accounts of barriers, stigma, and pathways to healing. Together, these voices strengthened the credibility of the manual, enhanced its cultural sensitivity, and ensured that it remained both evidence-informed and responsive to the real-world contexts in which it will be used.

Additionally, since a focus group was conducted as part of the data collection process, guidelines for qualitative research recommended 6 to 10 participants to allow for a rich discussion while ensuring each participant had the opportunity to share their insights (Powell & Single, 1996). The focus group discussion was beneficial for generating deeper insights into social issues such as stigma in mental health treatment by allowing participants to express their experiences and perceptions in a dynamic group setting (Akyildiz & Ahmed, 2021). Recruitment procedures, including specific strategies for engaging participants and obtaining informed consent, are discussed in detail later in this section.

While African American women represent roughly 13% of the overall female population in the United States (United States Census Bureau, 2020), they continue to be among the most underserved in accessing mental health care (Nelson et al., 2022). This reality highlights the urgent need for a resource that equips mental health providers with the tools to break down stigma and build trust with African American women seeking support. By selecting a diverse yet focused participant pool and maintaining a structured sample size, this project ensured that

feedback on *This House A Manual for Culturally Responsive Mental Health Care* was both representative and actionable.

This population was the best fit for this project because the manual was designed to help mental health professionals engage African American women in therapy more effectively. Mental health providers were able to give critical feedback on whether the manual offers practical, actionable strategies that can be used in real-world clinical settings. At the same time, insights from African American women with lived experience ensured that the manual spoke directly to the concerns and needs of the population it seeks to serve. Including faith-based leaders added another layer of depth, recognizing the role that spirituality and community networks play in mental health support for many African American women.

Materials

This project utilized a structured rubric and a focus group discussion guide to gather qualitative feedback from mental health professionals and other key stakeholders on *This House: A Manual for Culturally Responsive Mental Health Care*. These tools were designed to assess the clarity, cultural relevance, and practical application of the manual in clinical and community-based mental health settings.

Manual Review Rubric

The manual review rubrics served as structured qualitative evaluation tools, allowing participants to express their thoughts, insights, and critiques in an open-ended format. This approach ensured that responses captured deep, nuanced perspectives rather than being limited to numerical ratings. The rubrics focused on the following key areas:

- Clarity of Content – Are the concepts and recommendations easy to understand? Do they align with professional best practices and real-world mental health experiences?

- Cultural Relevance – Does the manual effectively address cultural barriers specific to African American women? Does it reflect lived experiences, challenges, and strengths of the population it seeks to support?
- Practical Application – Can mental health professionals implement the suggested strategies in real-world therapeutic and community-based settings? Are the recommendations feasible, realistic, and applicable?
- Gaps and Areas for Improvement – Are there critical elements missing that should be included? What additional information, resources, or perspectives would strengthen the manual?

Participants provided descriptive written responses for each section, allowing them to express their insights in their own words. This allowed for rich, meaningful feedback, aligning with the qualitative nature of this project.

Focus Group Procedures

In addition to completing the manual review rubric, participants had the opportunity to take part in a virtual focus group 14 days after feedback deadline. This focus group was intended to gather deeper insight and collaborative discussion and further refine *This House: A Manual for Culturally Responsive Mental Health Care.* Participation in the focus group was completely voluntary and was offered twice— at the time of initial recruitment to gauge initial interest, and again after the rubric had been submitted to confirm participation.

A single focus group was conducted and consisted of five participants, with the intentional inclusion of individuals from each participant category—one mental health professional, one faith-based leader, and three African American women with lived experience. This composition allowed for a balanced exchange of perspectives, ensuring that the manual was

evaluated not only from a clinical standpoint but also through the lens of cultural and spiritual relevance as well as lived experience. Although the overall group size was modest, the structured representation across categories strengthened the richness of the discussion by creating opportunities for dialogue between professionals, faith-based leaders, and women directly impacted by mental health stigma. This intentional balance enhanced the credibility and applicability of the findings by ensuring that multiple vantage points were considered in refining the manual. This approach ensured that a well-rounded set of voices and experiences was represented in the discussion (Creswell & Poth, 2018; Patton, 2015).

The following step-by-step process was utilized to conduct the focus group:

1. Invitation to Participate

   After submitting their rubric feedback, participants received a follow-up email thanking them for their input and inviting them to participate in a virtual focus group. The email included an overview of the focus group's purpose, the expected duration (approximately 60-75 minutes), and the type of questions that would be asked. They were also asked to confirm their interest and availability.

2. Scheduling

   Once a pool of interested participants was identified, the scholar coordinated a mutually agreeable date and time using a Google survey. The focus group was conducted via a secure RingCentral session to accommodate participants from different regions.

3. Confirmation and Consent

   Selected participants received a confirmation email including:

   - The RingCentral link and calendar invitation
   - A digital copy of the focus group discussion guide

- A copy of the informed consent form to review and sign electronically

  The informed consent covered expectations for confidentiality, voluntary participation, and recording for transcription purposes. Participants were reminded that they could opt out at any time. At the start of the session, participants were asked to verbally reconfirm their consent and agreement to be recorded (Lincoln & Guba, 1985).

4. Conducting the Focus Group

   The focus group was moderated by the scholar using a semi-structured discussion guide. The discussion covered shared experiences, reactions to the manual, and suggestions for enhancing its cultural relevance, clarity, and usability. The tone of the session remained conversational and respectful, with care taken to ensure that all voices are heard, and no one was pressured to speak. During the focus group, participants were addressed by first names only to protect confidentiality, and pseudonyms were used when reporting findings to maintain confidentiality (Krueger & Casey, 2014). The session was transcribed using RingCentral's secure platform.

5. Post-Group Follow-Up

   Following the session, participants received a thank-you message and a summary of the themes discussed. They were invited to provide any clarifications or additions to ensure their contributions were captured accurately—a process known as participant validation or member checking (Creswell & Poth, 2018). Only two participants offered additional feedback; all responses offered were incorporated into the data analysis.

6. Data Management

   Focus group recording was transcribed by a secure, HIPAA-compliant transcription

service, RingCentral. Transcripts have been de-identified to remove personal or identifying information. The data has been coded and analyzed using thematic analysis to identify shared patterns and insights that can further inform revisions to the manual (Braun & Clarke, 2006).

By following these detailed steps, the focus group process ensured transparency, ethical engagement, and meaningful collaboration to shape a culturally responsive manual grounded in real-world experience and professional expertise.

Justification for Materials Used

By using open-ended qualitative methods, this project ensured participant voices drove the refinement of the manual in a way that is authentic, relevant, and applicable to real-world settings. This approach also aligned with the phenomenological framework, which emphasizes lived experiences and meaning making. Ensuring trustworthiness in this qualitative project was essential to maintaining credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). To strengthen this project, multiple strategies were employed throughout the process. To establish credibility, participant review was utilized, allowing participants to review and confirm the accuracy of their responses as well as the themes identified during the analysis (Creswell & Poth, 2018). This process helped reduce misinterpretation and ensured that the findings remain grounded in participants' lived experiences.

To ensure dependability, an audit trail was created to document all coding processes, theme development, and analytical reflections (Nowell et al., 2017). This detailed documentation provided transparency into how data was gathered, managed, analyzed, and interpreted, ensuring that another scholar could replicate the project's methodology and arrive at similar conclusions. To develop consistency, thematic analysis followed a structured coding

framework (Braun & Clarke, 2006). A codebook was developed to define key themes, ensuring uniformity in data interpretation. The data underwent repeated coding at different intervals to ensure consistency and reliability in the coding process. These processes helped maintain reliability and prevented shifts in data interpretation over time.

To decrease the potential for bias, bracketing was implemented. Bracketing minimized the impact of bias by allowing the scholar to set aside personal assumptions, preconceptions, and prior knowledge of the topic being studied (Husserl, 1931). This process involved maintaining a reflexive journal, documenting potential biases and consistently reflecting on how personal perspectives can influence data interpretation (Tufford & Newman, 2012). This reflective process enhanced credibility and ensured that participants' voices remained central to the project's findings.

To improve transferability, the project included rich descriptions of participant experiences, cultural context, and thematic findings (Lincoln & Guba, 1985). This detailed approach will allow other researchers, scholars, mental health professionals, and community leaders to determine how these findings can apply to similar populations and settings. By capturing the complexities of stigma, cultural mistrust, and mental health engagement, the project provided insights that can be adapted and implemented in various therapeutic and faith-based environments.

Additionally, the project clearly outlined participant demographics and cultural factors that influenced the findings. This approach will help future scholars, researchers, and practitioners assess whether the manual's strategies and recommendations are relevant in other settings, ultimately expanding the impact of culturally responsive mental health interventions. By using these strategies, this project ensured that its findings were trustworthy, reflective of

participant experiences, and safeguarded against bias. The ultimate goal was to develop a culturally responsive manual that meaningfully equips mental health professionals to address stigma, improve engagement, and enhance the therapeutic experience for African American women seeking mental health care.

Project Goals and Objectives

Goal

The primary goal of this project was to develop and refine a culturally responsive manual, *This House: A Manual for Culturally Responsive Mental Health Care*, which equips mental health professionals with tools to reduce stigma, increase engagement, and improve mental health outcomes for African American women.

Objectives

To achieve this goal, the project focused on the following specific, measurable objectives:

1. Conduct a thorough qualitative evaluation of the manual by gathering structured feedback from mental health professionals, faith-based leaders, and African American women using an open-ended review rubric.
2. Analyze thematic feedback to identify key strengths, areas for improvement, and gaps in cultural relevance, clarity, and practical application.
3. Refine the manual based on the collected feedback, ensuring that it accurately reflects the lived experiences of African American women and offers actionable strategies for mental health professionals.
4. Assess the manual's effectiveness in addressing stigma, cultural barriers, and mental health engagement through a follow-up review by selected experts.

These objectives directly aligned with the problem statement, which identifies stigma, cultural mistrust, and systemic barriers as factors limiting mental health engagement among African American women. They also supported the purpose statement, ensuring that the manual was developed using a qualitative, phenomenological approach that captures the experiences and insights of those directly impacted by mental health disparities.

Project Procedures

This project followed a structured set of procedures to ensure methodological rigor and compliance with ethical standards.

Step One: Institutional Review Board (IRB) Approval

The project began with securing approval from the National University IRB. No recruitment or data collection activities occurred until IRB approval was obtained. This step included the submission of all recruitment materials, consent forms, and data collection instruments for review and approval.

Step Two: Identifying Potential Participants (Appendix B)

Participants were recruited from three categories: African American women with lived experience, faith-based leaders, and mental health professionals. African American women were recruited through community networks, social media platforms, and referrals from mental health providers to ensure authentic and diverse perspectives. Faith-based leaders were recruited through African American churches, community-based organizations, and social media platforms actively engaged in conversations around mental health and wellness. Mental health professionals were contacted through targeted outreach using email, Facebook, and LinkedIn to ensure broad professional representation.

Step Three: Developing Recruitment Materials

Tailored recruitment emails were created for each participant group—mental health professionals (Appendix C), faith-based leaders (Appendix D), and African American women with lived experience (Appendix E). Each email explained the project purpose, eligibility criteria, confidentiality, and expectations for participation. A recruitment flyer (Appendix F) was designed for both digital and community distribution.

Step Four: Distributing Recruitment Materials

Recruitment materials were distributed through multiple channels, including professional networks, community organizations, churches, and social media platforms (LinkedIn, Facebook, Instagram). Flyers were both digitally posted and physically distributed. Phone outreach was also conducted, particularly for provider referrals, to clarify project purpose and expectations.

Step Five: Screening and Eligibility Confirmation

Interested participants completed an online interest form to provide demographic details and confirm eligibility. The scholar reviewed each submission and followed up via email or phone to verify qualifications. Participants meeting eligibility criteria were sent a formal informed consent form (Appendix G) for review and signature.

Step Six: Confirming Participation

Once consent forms were signed and returned, participants received a welcome email that included:

- A digital draft of *This House: A Manual for Culturally Responsive Mental Health Care.* (A complete copy of *This House: A Manual for Culturally Responsive Mental Health Care* is provided in the final appendix)
- The structured feedback rubric (Appendix H/I)
- A deadline for feedback submission.

Step Seven: Scheduling and Conducting the Focus Group

After rubric feedback was collected, participants were emailed a Google survey offering four different date and time options for the focus group. The date that received the most votes was selected as the official session. Once scheduled, participants were sent a RingCentral link and instructions for participation. Prior to beginning the session, participants reviewed the informed consent form and confidentiality. Participants were asked to consent verbally to the transcript recording. The focus group was recorded for transcription and analysis, and a discussion guide (Appendix J) was used to facilitate a structured conversation. Participants were encouraged to expand on rubric feedback, engage in dialogue, and reflect on their experiences. The session concluded with a debrief, during which participants were invited to ask questions, thanked for their contributions, and informed of the next steps.

Step Eight: Data Analysis

The focus group session was recorded using RingCentral, which generated a verbatim transcript. This eliminated the need for manual transcription while allowing for accurate capture of dialogue. The transcript was stored securely on an encrypted device, with pseudonyms assigned to protect confidentiality.

The analysis drew on two data sources: the structured rubric feedback submitted by participants prior to the focus group, and the focus group transcript. Both sets of data were analyzed together using Braun and Clarke's (2006) thematic analysis framework. The rubric responses provided structured insights into cultural relevance, clarity, and practical application, while the focus group discussion offered deeper, contextualized perspectives and opportunities for participants to elaborate on their rubric responses.

The coding process began with repeated readings of rubric responses and the transcript to ensure immersion in the data. Initial codes were generated to capture significant concepts, which were then clustered into categories and broader themes. Themes were compared across data sources to identify where participant perspectives aligned, differed, or added new insights.

To strengthen trustworthiness, member checking was conducted by sharing selected quotes and preliminary themes with participants to confirm accuracy and resonance. An audit trail (Appendix K) documented coding decisions, theme development, and reflexive notes throughout the process, ensuring transparency and credibility.

Step Nine: Refinement of the Manual

Themes and feedback from both rubric responses and the focus group were systematically reviewed and applied to refine *This House: A Manual for Culturally Responsive Mental Health Care*. Revisions included clarifying instructions, enhancing cultural and spiritual relevance, and adding practical tools recommended by participants. The goal was to ensure the manual reflected lived experiences, professional expertise, and faith-based perspectives while remaining clinically practical.

Step Ten: Secure Storage and Compliance

All project-related data—including transcripts, coding files, rubrics, and draft revisions—were stored confidentially on an encrypted USB drive in the scholar's locked office. This practice aligned with the informed consent agreement and maintained compliance with IRB requirements.

Data Collection and Analysis

To ensure structured and actionable feedback, participants followed the outlined steps below:

1. Participants Reviewed the Manual
    - Participants were given two weeks to carefully read through *This House* manual.
    - The scholar provided clear instructions and guidance on how to review the manual, ensuring that participants understood the objectives and expectations.
    - Participants were encouraged to highlight sections that resonated with their experiences, note areas of confusion, and suggest improvements.
    - The scholar was available via email or scheduled calls to address any questions or concerns throughout the review period.
    - Participants were also asked during this stage whether they were willing to participate in a follow-up focus group. Participation in the focus group was voluntary and did not affect their role in the project.
2. Completing the Feedback Rubric
    - Participants were given 14 days to review the manual and complete the rubric and feedback form; extensions were granted upon request to accommodate scheduling needs.
    - Participants provided detailed written responses using the descriptive feedback rubric addressing:
        - Clarity and readability.
        - Cultural relevance and representation.
        - Practical application for mental health professionals.
        - Addressing stigma and encouraging help-seeking behaviors.
    - Monitored the completion process to ensure that participants felt supported and encouraged to provide thorough and honest feedback.

- Optional follow-up prompts allowed open-ended reflections on how the manual could be improved.

3. Submitting Feedback
    - Participants submitted their completed rubrics through:
        - A secure online survey platform (Google Forms).
        - Emailing their responses directly to the scholar using an encrypted method.
        - Phone interviews were offered for those who preferred to provide verbal feedback.
    - The scholar confirmed receipt of each submission and tracked responses to ensure all participants' voices are included in the analysis.
    - After receiving and reviewing the completed rubrics, the scholar contacted all participants who expressed interest in participating in the focus group to confirm their participation.
4. Focus Group Participation (Optional)
    - A single focus group was conducted, composed of participants from each participant category (1 mental health professional, 1 faith-based leader, and 3 African American women with lived experience).
    - The focus group allowed participants to expand on their written feedback, explore shared insights, and offer additional perspectives that may further refinement of the manual.
    - The discussion followed a semi-structured guide (Appendix J.) and was recorded and transcribed for thematic analysis.

- Participation was completely optional, and informed consent was re-confirmed before the session.

5. Follow-Up for Clarifications
    - Although the scholar remained available to participants for clarification or elaboration, no additional follow-up was required.
6. Finalizing Data Collection
    - The scholar sent each participant an email confirming receipt of all rubrics and feedback.
    - Participants were thanked for their time and informed about the next steps in the project.

Ensuring Rigor and Consistency

- Recruitment and data collection steps were carefully documented to ensure the process is replicable.
- A recruitment tracking log was maintained to monitor outreach, participant responses, and consent documentation; this record supported transparency and ensured adherence to inclusion criteria.

By following this detailed, structured approach, this project ensured that *This House* was thoroughly reviewed, refined, and optimized for its intended audience—mental health professionals supporting African American women in overcoming barriers to care.

Metrics and Performance Measurements

To track progress and ensure success, the project used a combination of process metrics and performance measurements:

Process Metrics (Tracking Progress)

1. Participant Recruitment Rate – Number of mental health professionals, faith-based leaders, and African American women who agreed to participate in the manual review process.
2. Rubric Completion Rate – Percentage of participants who submitted a fully completed qualitative review rubric with detailed feedback.
3. Focus Group Participation Rate – Number of participants who engaged in follow-up discussions to expand on their feedback.

These process metrics ensured that the project remained on track, with sufficient data collected to support a meaningful evaluation of the manual.

Performance Measurements (Evaluating Success)

1. Depth and Quality of Feedback – The extent to which participants provided detailed, meaningful responses in their reviews, measured by the richness of themes emerging from thematic analysis.
2. Identified Areas for Improvement – The number and type of revisions made based on feedback, ensuring that key cultural and practical concerns were effectively addressed.
3. Post-Revision Expert Validation – The extent to which experts in the field endorsed the revised manual as culturally relevant, practical, and applicable to their work.
4. Potential for Implementation – Participant responses indicating how likely they are to use the manual in professional or community settings and how useful they perceived it to be.

These performance measurements align with the problem and purpose statements by ensuring that the manual is not only developed but also refined in a way that makes it actionable, relevant, and impactful for mental health professionals working with African American women.

By combining process metrics with qualitative performance measures, this project effectively evaluated the manual's development, revision, and potential impact, ensured that it meets the critical need for culturally competent mental health interventions.

Assumptions

This project operated under several key assumptions that shaped its design and approach. First, it was assumed that participants would provide honest and thoughtful feedback when reviewing *This House: A Manual for Culturally Responsive Mental Health Care*. Given the deeply personal and often stigmatized nature of mental health within African American communities, participants were expected to share genuine insights based on their experiences. However, it was acknowledged that factors such as social desirability bias or discomfort in discussing sensitive topics might have influenced responses (Nelson et al., 2020). To mitigate this, the project incorporated confidential, open-ended feedback collection methods, ensuring participants felt safe sharing their perspectives without fear of judgment or repercussions (Gaston et al., 2016).

Additionally, the project assumed that the themes and barriers identified in existing literature accurately reflected the lived experiences of African American women navigating mental health care. The manual was designed to bridge the gap between professional practice and real-world concerns by addressing cultural stigma, systemic barriers, and mistrust of the mental health system (Castelin & White, 2022; Woods-Giscombe et al., 2016). The manual was informed by empirical research on stigma, cultural mistrust, and disparities in mental health care, ensuring its relevance to the population it sought to serve (Nelson et al., 2022; Rivera et al., 2021).

Lastly, it is assumed that mental health professionals and faith-based leaders engaged with the manual from a professional perspective, evaluating its practicality, effectiveness, and cultural relevance based on their expertise. These professionals were expected to assess how well the manual equipped them to better serve African American women in mental health spaces rather than allowing personal biases to shape their feedback. Participants were intentionally selected based on their experience working with African American women, ensuring that their feedback was grounded in practical, real-world application rather than theoretical assumptions (Nelson et al., 2022). These assumptions were essential to ensuring that the manual was developed, refined, and implemented in a way that truly resonated with both mental health professionals and the African American women they served.

Limitations

This project had several limitations that should be acknowledged when interpreting the findings. The sample size was relatively small (n= 17 rubric respondents and 5 focus group participants), which limited the generalizability of the results. Although qualitative research prioritizes depth over breadth, a larger or more diverse sample might have provided broader perspectives and enhanced the transferability of findings. The goal was to gather rich, narrative-driven feedback that can inform a culturally relevant manual, rather than producing statistical generalizations (Dworkin, 2012).

Because this project employed purposive sampling and focused specifically on African American women's experiences with mental health stigma, the findings may not have been directly applicable to all African American women or mental health professionals. This represents a limitation of transferability; however, thick description was provided to enable readers to determine the applicability of findings to their own contexts.

Participant bias was another potential challenge. Individuals reviewing the manual may have held preexisting attitudes about mental health care or stigma that shaped their feedback. Some participants were highly engaged in mental health advocacy, while others held more traditional views that reinforced stigma, leading to differing perspectives on the manual's content. Faith-based leaders and clinicians may have assessed the manual through their own professional or theological lenses, which could have influenced their evaluations. To account for this, a diverse range of participants was included to ensure multiple perspectives were represented, reducing the risk of one dominant viewpoint shaping the results (Castelin & White, 2022).

Although reflexivity and a structured coding process were used to enhance credibility, the subjective nature of qualitative analysis means that interpretations may have varied. To mitigate this, coding strategies were consistently applied, and participant feedback was analyzed systematically to ensure that themes were accurately represented (Nelson et al., 2020). Additionally, participants reviewed the finalized themes for accuracy, contributing to validation of the findings.

The scholar's dual role as both practitioner and manual developer introduced potential bias. Given the deep investment in the topic, there was a risk of unintentionally favoring affirming feedback or responding defensively to critique. To mitigate this, the scholar engaged in bracketing to consciously set aside personal experiences, expectations, and reactions during data analysis (Creswell & Poth, 2018). All participant feedback, whether positive or critical, was evaluated objectively for thematic significance, recurrence, and clarity to ensure that the final manual reflected the diverse voices and lived realities of those it was designed to support, rather than the researcher's personal preferences or assumptions.

Finally, time constraints limited the extent to which the manual could be refined and evaluated. While this project collected meaningful feedback from professionals and stakeholders, it did not include long-term studies of the manual's real-world effectiveness. Future research will be necessary to evaluate how the manual influences clinical practice and whether it leads to measurable improvements in engagement among African American women seeking mental health services (Woods-Giscombe et al., 2016).

Despite these limitations, the project represented an essential step toward addressing stigma and increasing culturally responsive mental health care for African American women.

Delimitations

This project has specific delimitations that defined its scope and focus. One key delimitation was the exclusive focus on African American women's experiences with mental health stigma and engagement. While stigma exists across many racial and ethnic groups, this project was intentionally designed to address the unique cultural, historical, and systemic factors that specifically shape how Black women perceive and interact with mental health care. African American women are disproportionately affected by stigma, the SBWS, and cultural distrust of the healthcare system, all of which significantly impact their likelihood of seeking and remaining engaged in treatment (Castelin & White, 2022; Nelson et al., 2022). This population was chosen because Black women face a distinct intersection of race and gender-based barriers in mental health care that have been underexplored in research. While African Americans as a whole experience disparities in access to mental health services, Black women often navigate additional challenges, including societal expectations of resilience and self-reliance, which discourage vulnerability and help-seeking behaviors (Woods-Giscombe et al., 2016). By centering this population, the project ensured that the manual was tailored to the specific barriers and needs of

African American women, rather than attempting to generalize solutions that may not adequately reflect their lived experiences. Addressing stigma among this group has the potential to improve engagement in mental health services and promote culturally responsive interventions that better serve their needs.

Another delimitation was the selection of participants. This project included African American women (AA), faith-based leaders (FBL), and mental health professionals (MHP); all of whom are key stakeholders who provide services or influence mental health discussions within the African American community. While including African American women with lived experiences of stigma provided valuable insights, this project prioritized the perspectives of those who will be implementing the manual. This decision ensured that the manual was evaluated by individuals with the training and expertise to assess its clinical and practical applications (Woods-Giscombe et al., 2016).

The methodology also established certain boundaries. This project used a qualitative approach, specifically phenomenology, to capture in-depth narratives rather than quantitative data. While a mixed methods approach could have provided additional statistical insights, the qualitative method allowed for a richer understanding of the barriers and facilitators to mental health engagement among African American women. Thematic analysis was used to extract patterns and themes from participant feedback, ensuring that the manual reflects real-world concerns and actionable strategies (Dworkin, 2012; Nelson et al., 2020).

Additionally, the project was geographically limited to participants from urban and rural areas in the Southern United States. While mental health stigma and access issues are national concerns, this project focused on a region where African American populations are heavily concentrated and where mental health disparities are particularly pronounced. This regional

focus allowed for a more in-depth exploration of the cultural, social, and systemic factors influencing mental health engagement in Southern Black communities (Rivera et al., 2021).

Finally, this project was designed as an initial phase in developing *This House: A Manual for Culturally Responsive Mental Health Care*. While the project gathered meaningful feedback from professionals, it did not extend to long-term evaluation or implementation in clinical settings. Future research will be needed to assess the manual's effectiveness in increasing mental health engagement among African American women and to refine it based on real-world application (Castelin & White, 2022; Woods-Giscombe et al., 2016). These delimitations ensured that the project remained focused, culturally relevant, and actionable while laying the groundwork for future research and application.

Summary

This section provided a comprehensive overview of the design and methodological approach used for this project, ensuring alignment with the problem, purpose, and project questions. Since the goal of this project was to develop *This House: A Manual for Culturally Responsive Mental Health Care*, a qualitative phenomenological approach was chosen to capture the real, lived experiences of African American women navigating stigma in mental health care, along with the insights of mental health professionals and faith-based leaders who support them. Phenomenology focuses on lived experiences and meaning making, making it the best fit for exploring the deep-rooted cultural and systemic barriers that impact mental health treatment for this population (van Manen, 1990).

The design and method section explained why semi-structured interviews and thematic analysis were used to collect and analyze participant feedback. Semi-structured interviews allowed participants to share their insights in their own words, while thematic analysis ensured

that patterns and key themes emerged organically, keeping participant voices at the center (Braun & Clarke, 2006). Alternative methods, like surveys or experimental designs, were considered but were found to be too rigid and impersonal for capturing the complex cultural nuances of stigma and help-seeking behaviors in African American communities (Nelson et al., 2020).

The population and sample selection subsection detailed who was involved—mental health professionals, faith-based leaders, and African American women with lived experience—and why their perspectives were essential. These individuals play key roles in either experiencing, addressing, or mitigating mental health stigma within the Black community. Their feedback helped refine the manual into a practical, culturally informed resource for mental health professionals. This project followed qualitative research standards for sample size and saturation, ensuring that feedback is meaningful and comprehensive (Dworkin, 2012).

The materials and instrumentation section described the tools used to gather participant feedback. The manual review rubric was a structured tool that prompted open-ended responses to assess clarity, cultural relevance, and practical application. A focus group discussion explored and expanded on key themes, ensuring a well-rounded evaluation (Castelin & White, 2022).

The project goals and objectives outlined the primary aim: to develop and refine a culturally responsive manual that equips mental health professionals to engage African American women more effectively. Objectives included gathering and analyzing structured feedback, refining the manual, and assessing its real-world applicability through expert validation. This aligns directly with the problem and purpose statements, ensuring the manual is designed in a way that addresses the barriers African American women face in accessing therapy (Nelson et al., 2022).

The recruitment and data collection section provided a step-by-step breakdown of how participants were identified, contacted, and engaged. Recruitment occurred through professional networks, faith-based communities, social media, and direct referrals from mental health providers. This multi-channel approach ensured a diverse range of perspectives, making the findings more comprehensive and applicable. Data collection involved structured manual reviews and a focus group, allowing participants to evaluate and discuss the manual's relevance, clarity, and practicality in both clinical and community-based settings (Gaston et al., 2016). The metrics and performance measurements subsection explained how progress and effectiveness were tracked and assessed. The project used process metrics, such as the number of participants recruited and response rates, alongside performance measurements that assessed the depth and quality of participant feedback, key areas of revision, and overall usefulness of the manual (Rivera et al., 2021).

The section closed with discussions on assumptions, limitations, and delimitations, acknowledging that qualitative research carries inherent subjectivity and that findings may not be generalizable to all African American women. However, by using a diverse participant pool, maintaining rigorous thematic analysis, and centering participant voices, the project ensured that the insights gained were meaningful, applicable, and culturally relevant (Woods-Giscombe et al., 2016). With this strong methodological foundation in place, Section 3 focuses on analyzing the findings and translating participant insights into practical recommendations, ensuring that *This House: A Manual for Culturally Responsive Mental Health Care* becomes a valuable tool in reducing mental health stigma and increasing engagement among African American women.

Section 3: Findings, Implications, and Recommendations

The purpose of this project was to evaluate *This House: A Manual for Culturally Responsive Mental Health Care* to determine its cultural relevance, effectiveness in addressing stigma, and usefulness for providers and community stakeholders. Feedback was collected from three participant groups: African American women with lived experience (AA), faith-based leaders (FBL), and mental health professionals (MHP). Participants first completed a rubric evaluating the manual across domains such as cultural relevance, clarity, and usefulness and provided written feedback. Then, a select group of participants participated in a focus group to deepen their perspectives and recommendations.

This section presents the findings organized around two guiding project questions. The first question (PQ1) explored how African American women and stakeholders perceive the cultural expectations and stigma that influence help-seeking. The second question (PQ2) examined participant recommendations for improving the manual's effectiveness and usefulness in practice. Following these analyses, a discussion of trustworthiness (credibility, transferability, dependability, and confirmability) is provided to demonstrate the rigor of the project.

Findings by Project Question(s)

This section begins with an overview of participant demographics to provide context for the feedback. Table 1 presents the number of participants invited, those who responded to the rubric, and those who attended the focus group.

Table 1

Participant Demographics

Participant Type	Invited	Responded	Focus Group Participants
African American Women with Lived Experience (AA)	8	6	3
Faith-Based Leaders (FBL)	6	4	1
Mental Health Professionals (MHP)	7	7	1
Total	21	17	5

In total, there were 21 individuals who were invited to participate in this project. Of these, 17 provided feedback through rubric responses, representing an 81% response rate. Participants included six African American women with lived experience, four faith-based leaders, and seven mental health professionals. Six participants agreed to participate in the final, optional focus group; however, due to a family emergency, one participant was unable to attend. As a result, five participants were present: one mental health professional, one faith-based leader, and three African American women with lived experience. Both the clinician and the faith-based leader also identified as African American women with lived experience, which added intersectional perspectives to the data. All faith-based leaders had completed seminary or comparable ministry training, ensuring they could provide informed perspectives on the intersection of faith and mental health.

Each participant completed a rubric evaluating the manual. The rubric included numerical ratings across multiple domains (cultural relevance, clarity and readability, practical usefulness, sensitivity to emotional needs, engagement strategies, addressing stigma and clinical or

therapeutic alignment). Participants rated each domain on a 4-point Likert-type scale, where 1 indicated “does not meet expectations,” 2 indicated “partially meets expectations,” 3 indicated “meets expectations,” and 4 indicated “exceeds expectations.” These ratings provided a structured overview of how participants assessed the manual, which was later expanded through open-ended feedback and the focus group discussion. All participant names presented in this section are pseudonyms used to maintain confidentiality.

Table 2

Rubric Domains and Rating Scale

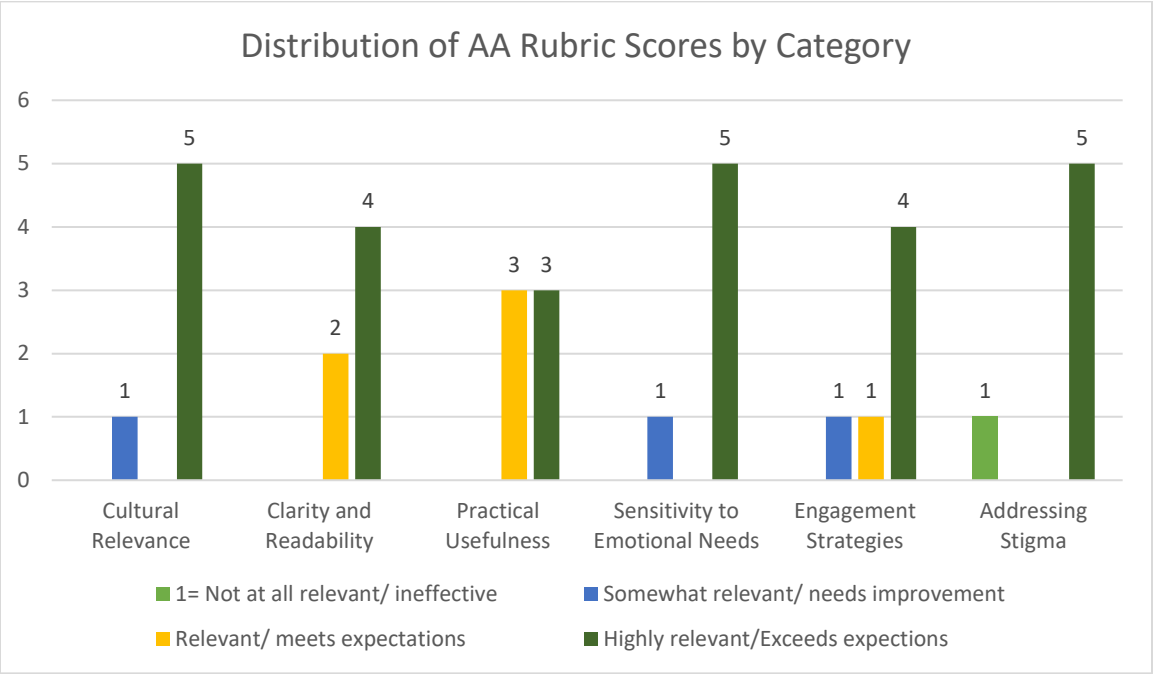
Domain	Description	Rating Scale
Cultural Relevance	Evaluates how well the manual reflects African American women’s lived experiences, values, and cultural context.	1 = Does not meet expectations 2 = Partially meets expectations 3 = Meets expectations 4 = Exceeds expectations
Clarity and Readability	Assesses the clarity of language, organization, and ease of understanding for diverse readers.	Same as above
Practical Usefulness	Measures the manual’s applicability in real-world settings (clinical, faith-based, community).	Same as above

Sensitivity to Emotional Needs	Evaluates whether the content promotes psychological safety, empathy, and trauma-informed awareness.	Same as above
Engagement Strategies	Rates the ability of activities and prompts to foster reflection, participation, and connection.	Same as above
Addressing Stigma	Measures how effectively the manual challenges stigma and promotes open dialogue around mental health.	Same as above
Clinical or Therapeutic Alignment	(For clinicians only) Evaluates consistency with ethical and evidence-based therapeutic principles.	Same as above

Figures 1-3 display the distribution of rubric scores across the three participant groups.

Figure 1

Distribution of Rubric Scores for African American Women with Lived Experience.



Note: This group did not complete the "Clinical and Therapeutic Relevance" domain.

Figure 2

Distribution of Rubric Scores for Faith-Based Leaders

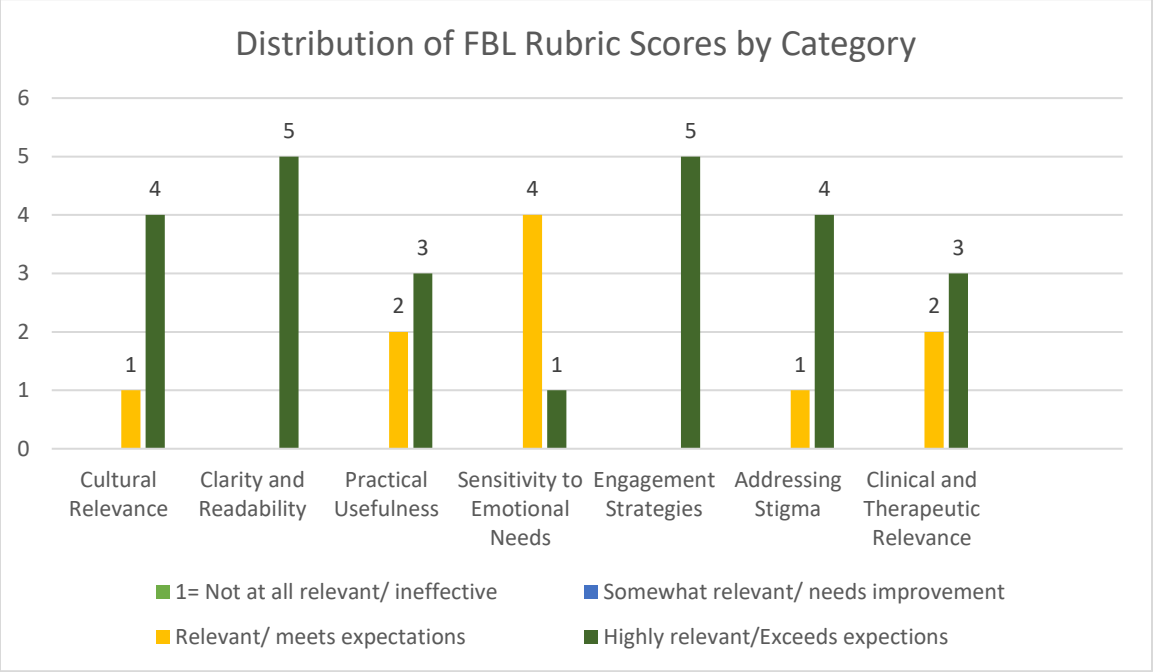
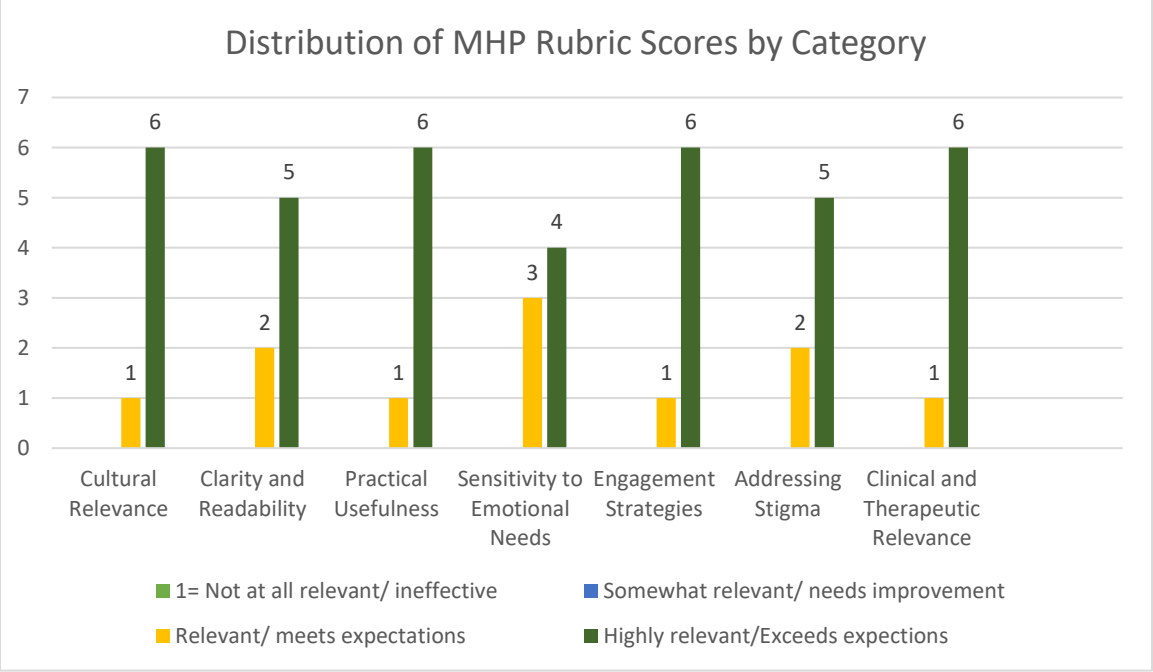


Figure 3

Distribution of Rubric Scores for Mental Health Professionals



Figures 1—3 illustrate consistent patterns across groups. Mental health professionals provided the most consistent ratings, with nearly all scores of "4," reflecting strong alignment with clinical expectations. Faith-based leaders also rated the manual positively, though their ratings for sensitivity to emotional and spiritual needs were somewhat lower, suggesting a desire for stronger integration of faith. African American women's scores showed the most variability, with one participant assigning low scores ("2" and "1") for cultural relevance and stigma, suggesting gaps in cultural depth may not have been uniformly experienced among participants. This participant did not provide written clarifications for her ratings and did not participate in the focus group, limiting the ability to interpret the reasons for her lower evaluation. These differences set the stage for the thematic findings addressed in Project Question 1.

Project Question 1:

The first project question explored how African American women and community stakeholders perceive the cultural expectations and stigma that influence help-seeking. Data from rubric responses and the focus group highlighted three central themes: cultural silence and secrecy, the Strong Black Woman (SBW) schema, and community messages about mental health. For each theme, rubric feedback is presented first, followed by elaboration from the focus group.

Cultural Silence and Secrecy. Feedback on the rubric consistently identified the theme of silence in African American families, noting how this expectation has reinforced stigma. Respondents affirmed that the manual captured this cultural message effectively. In her rubric response, Michelle (AA) described the section addressing "what happens in this house, stays in this house" as particularly resonant, calling it, "a universal Black household rule that must be named if we are going to break cycles of secrecy and trauma."

Clinicians reinforced this in their rubric responses. Dana (MHP) praised the manual for directly tackling generational silence and "keep it in the house" messaging. She noted that it created a "structured space to rename shame and practice language," which she identified as a clear strength of the manual.

The focus group elaborated further on this theme. Andrea (AA) explained:

> Every Black household had the same rule of, what happens in this house, stays in this house. To have a manual and therapy sessions that specifically speak to that rule and how it created unhealed trauma and unhealthy trauma responses is relevant to not just Black women, but the Black community as a whole.

Glenda (FBL) also connected secrecy to church traditions, pointing out that "silence is often spiritualized—we were taught to pray about it, not talk about it." Irene (MHP) affirmed that silence is an ongoing barrier, adding that "secrecy is still what keeps families from seeking services until crisis hits." Participants appreciated that the manual explicitly named this expectation, providing language and a structured space to challenge secrecy and begin reframing help-seeking as strength rather than something shameful.

The Strong Black Woman Schema. Rubric feedback emphasized the pervasiveness of the SBW identity as both a source of pride and a barrier to vulnerability. Respondents agreed the

manual accurately highlighted the costs of this expectation. Jenny (MHP) reported many African American women are "depleted and trying to live on fumes," underscoring the physical and emotional toll of strength expectations." Dana (MHP) praised the manual for centering Black women's lived experiences, specifically addressing "what happens in this house" and SBW expectations, and described this as a clear strength. Jasmine (AA) affirmed the manual validated her experience, saying, "It makes me feel seen — it reflects my lived experience."

Focus group participants expanded on these points by sharing how the SBW expectations shape their daily lives and influence help-seeking. Irene (MHP) observed, "Being strong has been expected, but it also keeps us from admitting we need help." Andrea (AA) shared, "I feel I was groomed to be an SBW." Glenda (FBL) asserted churches often reinforced SBW expectations, explaining, "We celebrated women who carried everything—family, work and church—without breaking, but we never asked what it cost them."

Community Messages about Mental Health. Rubric feedback demonstrated that the manual reflected the cultural narratives that shape African American women's mental health experiences. Jenny (MHP) praised the manual for naming "spiritual bypassing" while allowing flexibility for faith integrations. Sharon remarked it "directly talked [about] silence, 'keep it in the house,' strength messages, and myths vs. facts inside psychoeducation." Together, their comments indicated that the manual already addresses community messages that reinforce stigma and silence.

The focus group built on these observations by describing the influence of community and cultural narratives on perceptions of mental health. Michelle (AA) recalled being told, "You just need to pray… let God fix it. You don't need to tell anybody about it." Glenda (FBL) echoed this message from her faith context, explaining, "As a believer you don't have no business being

depressed, just get in your Bible." She emphasized that such messages compound shame and confusion for women who were experiencing both psychological and spiritual struggles.

Mary (AA) contrasted the way physical and mental health are discussed, asserting, "When you say health, people see that in a positive light. But if you put the word mental in front of it, then all of a sudden, we're only taking about somebody being crazy. She further contended group therapy is often associated with alcoholism or extreme dysfunction rather than being recognized as a healthy coping mechanism. Irene (MHP) added symptomatology is often dismissed or rationalized, rather than taken seriously, and mistrust of the medical system further complicates help-seeking in Black communities.

Participants also reflected on how these messages shaped their self-perception. Andrea (AA) explained hearing faith-based stigma initially made her believe something was wrong with [her] spiritually" if she felt depressed, leading her to delay seeking help. Over time, she learned to reject those stigmas and embrace therapy, groups, and even medication as valid supports: "God made professionals to help you…I'm all for the happy pills now if that helps me focus and heal."

Taken together, these accounts demonstrate how community messages from family, churches, and broader cultural contexts often reinforce silence, spiritualize suffering, and frame therapy, medication, or help seeking in general as weakness. At the same time, participants affirmed that the manual highlights and challenges these narratives, making them visible for reflection and change.

Project Question 2:

The second project question examined participant recommendations for improving the manual's effectiveness and usefulness in practice. Feedback was collected from rubric responses

and elaborated upon in the focus group discussion. Four themes emerged: practical tools and accessibility, facilitator support, clinical rigor, and cultural expansion.

Practical Tools and Accessibility. Participants appreciated the manual's emphasis on concrete, usable strategies while recommending ways to make them more flexible. Women with lived experience pointed to body scans, journaling prompts, self-care lists, and the feelings wheel as helpful for "managing emotions in the moment" (Michelle, AA). At the same time, they asked for brief, concrete strategies for times when women may be "too overwhelmed to sit down and read or reflect" (Andrea, AA). Several participants further suggested expanding activities that could help women reframe strength to include vulnerability, self-care, and permission to seek support. Mary (FBL) suggested adding role-plays and visuals to make sessions more engaging and accessible, as well as including statistics about African American women's mental health to emphasize the significance of treatment.

The focus group elaborated on these ideas. Glenda (FBL) explained "if we added practices like prayer and affirmations, it would show that faith and therapy can work together to break stigma. Andrea (AA) echoed this integrative perspective, explaining both faith and professional support were necessary for her well-being: "I believe in faith-based and mental health help. It all ties in together for me." Faith based leaders also suggested that embodied activities such as burning bowl rituals, sound bowls, and reflective journaling to broaden the range of coping tools. Participants agreed that explicitly blending faith practices with therapeutic strategies would enhance the manual's cultural relevance and usability in both church and community settings.

Facilitator Support. Faith based leaders emphasized the need for resources that would support both clinical and non-clinical facilitators. Denise (FBL) suggested the addition of embodied and faith-based practices (i.e., breath prayers, affirmations, and reflective journaling) as ways to integrate spirituality more fully into sessions. She explained, “These strategies could meet women where they are, both spiritually and emotionally.” She also recommended facilitators be provided with explicit frameworks for addressing stigma tied to the SBW identity. Mary (AA) recommended providing clearer directions for clinicians noting, “This [manual] seems more geared towards more experienced clinicians. Less experienced clinicians may need more directions and scripts.” She also emphasized the importance of continuity, suggesting that each woman should leave the group with an aftercare plan or referral to a provider to ensure ongoing support beyond the manual. Faith-based leaders further suggested that visuals, scripts, and facilitator tips be included in each session to guide discussion to ensure consistency.

Clinical Rigor. Clinicians praised the manual for its strong alignment with best practices but recommended expanding its clinical structure. Sharon (MHP) described the psychoeducation sections as a strength but suggested stigma-reduction strategies be “woven throughout the sessions rather than appearing in isolated places.” Dana (MHP) called for clearer group guidelines, including “inclusion and exclusion criteria so facilitators know how to handle more complex issues like substance use or personality disorders.”

The focus group expanded on these recommendations. Dana (MHP) explained scripted transitions and prompts would increase consistency across facilitators and would reduce confusion for participants. She further articulated the importance of considering delivery format: “Is there a virtual option to increase access to women who may not be able to attend in person?” Irene (MHP) recommended incorporating validated measures, such as Strong Black Woman

Cultural Construct Scale (SBWCCS) or Gendered Racial Socialization of the Strong Black Woman Questionnaire (G-SWS-Q), to help facilitators assess how women identify with the SBW construct and guide discussion. These comments indicated that participants found the manual practical and clinically grounded, but wanted additional scaffolding to ensure safe, consistent, and accessible use.

Cultural Expansion. Participants encouraged the manual to deepen its cultural grounding and specificity. Denise (FBL) reflected the manual "could take a deeper dive into race-based trauma" and more clearly demonstrate how it is tailored for African American women rather than broadly applicable across groups. Mary (AA) described the manual as validating but encouraged expansion of activities that reflect Black women's daily realities. Participants proposed role-play scenarios and incorporating films such as *For Colored Girls Who Have Considered Suicide/When the Rainbow Is Enuf* or Tyler Perry's *Straw* to spark dialogue. Faith-based leaders added that stigma is often compounded in church settings and recommended integrating frameworks that directly address spiritualized silence and stigma. Glenda (FBL) explained that naming these dynamics explicitly would bridge the gap between faith and therapy. While most participants affirmed the manual's cultural specificity, one rubric response scored relevance as a 1 (low). The participant did not provide additional explanation, nor participate in the focus group, which limited interpretation of the outlier.

Taken together, participant recommendations emphasized the need for a manual that is culturally specific and practically adaptable. Women with lived experience asked for tools that could be used in moments of overwhelm as well as in a structured group setting. One woman specifically suggested each woman leave the group with an after-care plan to include a referral to a provider to ensure continuity of care. Faith-based leaders emphasized the importance of

facilitator support, including clear scripts and visuals to strengthen usability. Clinicians highlighted the value of enhancing clinical rigor through validated measures, inclusion and exclusion criteria, and scripted prompts to ensure safe and consistent delivery. Across groups, participants agreed that the manual should continue to deepen its cultural grounding, explicitly naming race-based trauma and integrating practices drawn from faith, ritual, and lived experience. Collectively, these recommendations point to ways the manual can evolve into an even more relevant, actionable, and accessible resource for African American women and the communities that support them.

Trustworthiness of the Data

Establishing trustworthiness is essential to ensure that the findings of this project are credible, rigorous, and meaningful. Following Lincoln and Guba (1985), trustworthiness was addressed through credibility, transferability, dependability, confirmability, and authenticity (Elo et al., 2014; Kelp & Simion, 2023). These dimensions provide a structured approach for evaluating qualitative research and aligning with current best practices in content analysis (Elo et al., 2014; Kelp & Simion, 2023).

Credibility was supported through methodological triangulation and the inclusion of diverse participant perspectives. Three groups (African American women with lived experience, faith-based leaders, and mental health professionals) were invited to complete rubric evaluations and written feedback before engaging in a focus group discussion. This layering of data sources allowed convergence and elaboration of findings, strengthening their validity. Additionally, participants were given the opportunity to review and confirm the identified themes for accuracy, ensuring that the interpretations authentically represented their perspectives. The use of direct

participant quotations in the results section further enhanced credibility by grounding interpretations in participants' own words. (Elo et al., 2014).

Transferability was addressed by providing detailed descriptions of the participant groups, the context of the project, and the cultural frameworks under study. Although this project was designed for African American women and stakeholders within specific community settings, thick description of cultural expectations, stigma, and intervention strategies allows readers to judge the applicability of findings to their own contexts. By situating the manual within broader cultural discourses, the study offers insights that may inform mental health initiatives across diverse African American communities and similar populations facing stigma-related barriers.

Dependability was ensured by maintaining a consistent and transparent process of data collection and analysis. All participants received the same rubric, with one exception: African American women with lived experience were not asked to complete the "Clinical and Therapeutic Relevance" domain, as this criterion assumes professional training. This adjustment safeguarded the validity of their responses while preserving comparability across all other domains. The focus group followed a semi-structured guide, ensuring comparability while allowing participants to elaborate on their experiences. An audit trail was maintained, documenting analytic decisions and coding processes, which increases the stability and reliability of the finding over time (Elo et al., 2014).

Confirmability was strengthened through systematic documentation and reflexive practices. The rubric responses were aggregated and presented in figures to transparently display scoring patterns, while the focus group transcript was coded to capture emergent themes. Reflexive journaling was used throughout the analytic process to document personal insights, reactions, and decision-making; selected excerpts are provided in Appendix K. A master

codebook was also developed to track theme development, inclusion criteria, and exemplar quotes; the codebook is available in Appendix L. Researcher bias was mitigated by presenting both convergent and divergent perspectives, including outlier scores from African American women participants, and by explicitly linking findings to raw data. This approach demonstrates that the findings are grounded in participants' perspectives rather than researcher preconceptions (Kelp & Simion, 2023).

Lastly, authenticity was supported by including participants whose roles and lived experiences, reflected multiple vantage points within the African American community. Feedback from African American women, faith-based leaders, and mental health professionals offered a balanced view of both challenges (i.e., stigma and cultural expectations) and community strengths (i.e. spirituality and resilience). This range of perspectives prevented any single viewpoint from dominating the analysis and captured the cultural complexity surrounding mental health. Together, these strategies demonstrate that the project aligns with established standards of qualitative rigor. Addressing credibility, transferability, dependability, confirmability, and authenticity strengthened the overall integrity of the findings. This project provides findings that are both trustworthy and actionable for practice, policy, and future research.

Evaluation of the Outcomes

The outcomes of this project indicated that *This House: A Manual for Culturally Responsive Mental Health Care* effectively addressed the project problem and purpose by providing a culturally grounded, stigma-reducing framework for African American women. Rubric scores across groups (Figures 1-3) indicated generally high evaluations of cultural relevance, clarity, and practical usefulness, consistent with the manual's intended purpose. At the

same time, qualitative feedback revealed important refinements to increase its clinical rigor, accessibility for faith-based leaders, and resonance with women with lived experience.

The findings align with prior literature describing the burden of the SBWS (Abrams et al., 2014) and cultural silence around mental health in African American communities. Participants affirmed that the manual named and challenged these dynamics, creating what Yalom and Leszcz (2020) described as a structured therapeutic setting where secrecy and stigma can be openly addressed. The inclusion of psychoeducation, group dialogue, and reflective activities parallels Yalom and Leszcz's (2020) therapeutic factors of universality, instillation of hope, and corrective emotional experience, which are essential to group-based interventions.

At the same time, feedback from participants highlighted the continued influence of faith-based stigma and spiritual bypassing, where depression was reframed as a lack of faith. This echoes research showing how spiritual discourses can either buffer or intensify stigma, depending on the context (Abrams et al., 2014). The manual was praised for flexibility in integrating faith-based practices, but participants requested stronger linkages (i.e., prayer, affirmations, and embodied activities) to ensure accessibility for facilitators without clinical training.

Clinician's recommendations, such as incorporating culturally normed measures and clarifying facilitator guidelines, strengthen the manual's alignment with evidence-based group practice. These suggestions echo Elo et al.'s (2014) emphasis on methodological rigor in content analysis and highlight the importance of transparent, replicable procedures in group facilitation. The outcomes demonstrate both convergence with existing theory and literature and potential for iterative refinement to maximize cultural and clinical usefulness.

Factors Influencing the Outcomes

Several factors may have influenced these results. Because the project intentionally recruited three distinct stakeholder groups, their varied professional and personal identities, naturally shaped the insights they shared. For example, faith-based leaders with seminary training emphasized spiritual integration, while clinicians prioritized structured rigor. The relatively small sample size, particularly for the focus group, may limit the generalizability of findings; however, this limitation is expected in qualitative research, which prioritizes depth of understanding over broad generalization. Outlier ratings, such as the low scores from the one woman with lived experience, highlight the heterogeneity of perspectives even within a culturally defined group. Rather than weakening the findings, these differences highlight the need for interventions that are flexible and adaptable to multiple realities.

Contribution to the Project Purpose and Literature

Overall, the outcomes affirm that *This House* manual is a promising tool for addressing stigma and cultural barriers in African American women's mental health care. The findings extend existing literature by demonstrating how cultural narratives can be integrated into group manuals in ways that resonate with women, faith leaders, and clinicians. The recommendations also offer a roadmap for strengthening the manual to ensure cultural specificity, clinical rigor, and accessibility. In this way, the outcomes contribute both to practice, by informing implementation of the manual, and to scholarship on culturally responsive interventions, by documenting the process of stakeholder-informed refinement and culturally responsive adaptation.

Action Plan

The next steps for this project are based directly on the feedback gathered from participants and the outcomes of the analysis. As part of the project, the first version of *This House: A Manual for Culturally Responsive Mental Health Care* was developed, distributed to stakeholders, and systematically evaluated through rubric ratings, written feedback, and a focus group discussion. These steps ensured that diverse voices (African American women with lived experience, faith-based leaders, and mental health professionals) were included in shaping the manual.

Based on participant recommendations, immediate revisions included the addition of facilitator scripts, transitions prompts, and clearer activity explanations to improve usability; the integration of faith-based practices such as prayer, affirmations, and reflective journaling to enhance cultural and spiritual relevance; and the incorporation of culturally normed assessments, such as the Strong Black Woman Cultural Construct Scale (SBWCCS) (Woods-Giscombe & Lobel, 2008), to strengthen clinical rigor. In addition, participants highlighted the need for role-play activities, visuals, and after-care planning (e.g., referrals to local providers or resources at the conclusion of the group), which will be embedded in the next version of the manual.

Future actions will focus on pilot implementation of the revised manual in both community and clinical settings. Partnerships with churches, counseling practices, and community organizations will be explored to test the manual's feasibility across contexts. Training opportunities for clinicians and faith-based leaders will be developed to ensure consistent and culturally grounded facilitation. Finally, data from pilot groups will be collected to assess outcomes such as reduction in stigma, improvement in help-seeking attitudes and participant satisfaction, providing evidence for broader dissemination.

Implications and Recommendations for Practice

The findings of this project carry several implications for mental health practice in clinical, community, and faith-based contexts.

Addressing Cultural Narratives

The results confirm the importance of intentionally confronting cultural narratives such as "what happens in this house, stays in this house" and the SBWS. Practitioners in diverse settings can incorporate discussion of these expectations into assessment, psychoeducation, and intervention. By naming and challenging these narratives, providers create space for African American women to critically examine how secrecy and strength expectations shape their experiences, thereby reducing stigma and opening pathways to help-seeking (Abrams et al., 2014; Woods-Giscombé, 2010).

Using Culturally Relevant Tools

This project demonstrates the usefulness of *This House* as a contextually grounded framework for group work with African American women. Practitioners can adopt the manual as a core intervention tool while supplementing it with validated measures, such as the Giscombe Strong Black Woman Cultural Scale (SBWCCS) (Woods-Giscombé & Walker-Barnes, 2019), the Cultural Mistrust Inventory (Terrell & Terrell, 1981), and the Spiritual Well-Being Scale (Paloutzian & Ellison, 1991). In faith-based or community settings, leaders can integrate spiritual practices (i.e. prayer, affirmations, journaling) to increase accessibility and affirm that mental health care and faith can complement one another (Avent Harris, 2021). Together, *This House* and these complementary culturally relevant tools ensure both clinical rigor and cultural resonance. Table 2 summarizes culturally relevant assessment tools that may complement the use of *This House* in both clinical and community contexts.

Table 3

Culturally Relevant Assessment Tools to Supplement the Manual

Tool	Purpose	Citation
Giscombe Superwoman Schema Questionnaire (G-SWS-Q)	Assesses endorsement of the SBW, including obligations to present strength, suppress emotions, resist vulnerability, achieve despite barriers, and help others.	Woods-Giscombé, 2010
Cultural Mistrust Inventory (CMI)	Assesses levels of mistrust toward dominant institutions, including health care providers, which may influence engagement with therapy.	Terrell & Terrell, 1981
Spiritual Well-Being Scale (SWBS)	Evaluates the role of spiritual health as a protective or risk factor in coping with distress.	Paloutzian & Ellison, 1991

Supporting Facilitators

The findings highlight the broader need for facilitator preparation across all types of group interventions. For clinicians, this may involve ensuring that manuals include consistent scripts, clear activity explanations, and structured transitions. For faith-based leaders or

paraprofessional facilitators, it may involve seeking out or adapting materials that provide guidance without requiring advanced clinical training. This implication underscores a wider principle in group-based practice: fidelity and adaptability must be balanced so that groups are delivered consistently, but with flexibility for cultural adaptation (Yalom & Leszcz, 2020).

Ensuring Continuity of Care

The project emphasizes the importance of planning for participant support beyond the life of the group. Practitioners in all settings should consider how women will continue their healing journey once a group ends, whether through referrals, aftercare plans, or resource sharing. This practice reflects ethical guidelines for continuity of care (American Association for Marriage and Family Therapy [AAMFT], 2022) and ensures that the benefits of group work are not limited to the structured sessions themselves.

Overall Implications

Together, these insights reinforce that culturally responsive care requires more than content changes within a single manual. Across the field, practitioners should actively confront cultural narratives, adopt contextually relevant tools, ensure facilitator preparedness, and plan for continuity of care. By doing so, clinicians, community leaders, and faith-based facilitators can expand the impact of culturally grounded interventions and better support African American women navigating stigma and cultural barriers in mental health.

Recommendations for Future Projects/Research

Future research should continue to refine and evaluate *This House: A Manual for Culturally Responsive Mental Health Care* through broader testing with diverse African American women across geographic, socioeconomic, and denominational contexts. Given that one participant provided notably low rubric scores, future studies should intentionally explore

divergent perspectives to ensure the manual resonates across varied lived experiences. Quantitative validation studies, including the use of culturally specific assessments such as the SBWCCS (Hamin, 2008) or the G-SWS-Q (Woods-Giscombé & Lobel, 2008), would provide stronger empirical grounding for the manual's effectiveness. Longitudinal research is also needed to assess sustained outcomes, including whether reductions in stigma and secrecy lead to improved mental health service utilization over time. Additionally, future projects should evaluate the manual's adaptability in different settings, such as schools, community organizations, and faith-based institutions, and test delivery across multiple modalities (in-person, virtual, and hybrid). By systematically addressing these areas, future research can strengthen both the cultural specificity and generalizability of this intervention.

Conclusions

This project evaluated *This House: A Manual for Culturally Responsive Mental Health Care* to determine its cultural relevance, effectiveness in addressing stigma, and usefulness for African American women and the communities and professionals who serve them. The findings confirmed that the manual effectively confronted cultural narratives such as secrecy ("what happens in this house, stays in this house") and the SBWS while offering practical tools to support help-seeking and healing. Rubric ratings and focus group feedback demonstrated that the manual was both culturally resonant and clinically useful, while also identifying areas for refinement, including facilitator support, integration of faith-based practices, and aftercare planning.

The outcomes of the project highlight that culturally responsive interventions are not only possible but essential for reducing stigma and improving access to care for African American women. By grounding therapeutic tools in lived experiences, cultural narratives, and evidence-

based frameworks, this project contributes to the broader literature on culturally adapted interventions and offers practical guidance for implementation.

Moving forward, clinicians, scholars, and community leaders are called to collaborate in adapting, testing, and disseminating tools like *This House,* ensuring that African American women not only gain access to care but also experience mental health treatment that honors their cultural realities and affirms their strength.

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Appendices

Appendix A: **IRB Approval**

Outlook

IRB-FY25-26-19 - Initial: Exempt from Further Review

From do-not-reply@cayuse.com <do-not-reply@cayuse.com>
Date Sun 8/3/2025 3:40 PM
To Cherie Edwards <C.Edwards1708@o365.ncu.edu>; khall@ncu.edu

<khall@ncu.edu> You don't often get email from do-not-reply@cayuse.com.

Learn why this is important

National UNIVERSITY

9388 Lightwave Ave. San Diego, CA 92123
irb@nu.edu

Notice of Exemption

August 3, 2025

To: Cherie Edwards

Project Title: This House: Developing A Manual for Culturally Responsive Mental Health Care

NU IRB Number: IRB-FY25-26-19

Determination: Exempt from further review 45 CFR 46.101 Category 2.(ii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

Status: Active - Research activities may begin as

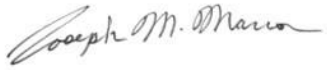
of August 3, 2025 Dear Cherie Edwards:

The study referenced above has been reviewed by the National University IRB. The IRB has determined

your research is exempt from further review under 45 CFR 46.104, which means you will not need to renew your study and may begin your study effective immediately. However, if you find the need to change your study in any way, you will need to submit a modification to the IRB prior to implementing the changes. This will allow the IRB to determine whether or not the study still meets exemption criteria.

Please review your Post Approval Responsibilities here: Approved Documents Guidelines For any questions regarding your protocol, please reach out to the IRB at irb@nu.edu.

Sincerely,



Dr. Joseph Marron, IRB Chair

Dr. Brianne Mongeon, Director, HRPP & IRB

Jenessa Eberhardt, Associate Director, HRPP & IRB

Appendix B: **Eligibility Criteria**

- **Licensed Mental Health Professionals**
    - Licensure & Credentials**:** Must be a licensed mental health professional (e.g., LPC, LCSW, LMFT, PsyD, PhD in Clinical or Counseling Psychology, Psychiatrist).
    - Clinical Experience**:** Must have at least two years of direct experience providing mental health services.
    - Experience with African American Clients: Must have experience working with African American women in clinical settings.
    - Cultural Competency & Specialization**:** Preference will be given to professionals with training or demonstrated experience in culturally competent therapy, trauma-informed care, or addressing racial disparities in mental health.
    - Practice Setting: Can work in private practice, community mental health centers, hospitals, academic settings, or faith-based counseling programs.
- **African American Adult Women**
    - Race/Ethnicity: Must identify as African American or Black.
    - Gender Identity**:** Must identify as a woman (inclusive of both cisgender and transgender women).
    - Age: Must be 18 years or older to ensure legal consent for participation.
    - Must have attended at least three sessions with a licensed mental health professional (LPC, LCSW, LMFT, PsyD, or Psychiatrist).
    - Therapy must have been for personal mental health concerns, not just family or couples' therapy.

  - Therapy must not have been court-ordered or employer-mandated to ensure voluntary participation.
  - Geographic Location: Must reside in urban or rural areas within the Southern United States (pseudonym: “Southern Health Region”).
  - Awareness of Stigma and Barriers: Must be able to articulate personal or cultural experiences related to the stigma surrounding mental health treatment in African American communities.
  - Willingness to Participate in the Project: Must be willing to engage in discussions about mental health experiences, stigma, and cultural barriers. Must consent to being recorded during discussions for transcription and analysis purposes.
- **Faith-Based or Community Leaders who play an informal but significant role in mental health support for African American women.**
  - Leadership Role: Must be a pastor, minister, chaplain, faith-based counselor, or spiritual leader serving African American communities for a minimum of two years.
  - Demonstrated Experience Supporting Mental Health Needs within their congregation or community (e.g., offering pastoral counseling, leading grief or emotional wellness groups, or engaging in community outreach on mental health topics).
  - Community Engagement: Should be actively engaged in congregational leadership, community outreach, or support programs that intersect with mental health.

- Faith Tradition: Can represent any Christian denomination, Islam, or other religious traditions commonly practiced by African American communities.

National University IRB
9338 Lightwave Ave., San Diego, CA 92123
irb@nu.edu

Appendix C: Mental Health Professionals Recruitment Email

My name is Cherie Edwards, and I am a doctoral student at National University. I am conducting a research project to explore ways to reduce stigma and improve engagement in mental health care for African American women. As a part of this effort, I am developing a culturally responsive manual—*This House: A Manual for Culturally Responsive Mental Health Care*—designed to support providers in serving this population more effectively.

I am inviting licensed mental health professionals who meet the following criteria to participate in this project:

- Must have at least two years of experience providing mental health services.
- Must have worked with African American women in a clinical or community mental health setting.

If you decide to participate in this project, you will be asked to:

1. Review a draft of the manual (provided via email or print)
2. Complete a structured qualitative review rubric, providing open-ended feedback on the clarity, cultural relevance, and practical application of the manual. (Estimated time: 30-45 minutes)
3. Optionally participate in a virtual focus group discussion to further explore key themes and potential improvements. (Estimated time: 60 minutes, conducted via Zoom)

During these activities, you will be asked for your insights on:

- How well the manual addresses cultural barriers to care
- Barriers and challenges you have observed regarding African American women seeking mental health services.
- Recommendations for refining the manual to better support African American women and the clinicians who serve them.

If you are interested in participating in this project, or if you have any questions, please contact me at c.edwards1708@o365.ncu.edu or 205-994-4563 ext. 200.

Thank you for considering this opportunity to contribute to work that seeks to enhance mental health accessibility, cultural sensitivity, and provider competency in serving African American women. Your expertise and insights are invaluable.

Regards,

Cherie Edwards, MA, LPC-S

Doctoral Candidate| National University

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Appendix D: Faith Based Leaders Recruitment Email

My name is Cherie Edwards, and I am a doctoral student at National University. I am conducting a research project designed to help break the stigma around mental health and increase treatment for African American women. As a part of this effort, I am developing a culturally responsive manual—*This House: A Manual for Culturally Responsive Mental Health Care*— designed to equip providers and leaders with culturally relevant tools and strategies.

I am inviting faith-based leaders to participate who meet the following criteria:

- Serve in a leadership role within a faith-based or spiritual community.
- Have experience providing counsel, mentorship, or emotional/ spiritual guidance to African American women.

If you choose to participate, you will be asked to:

1. Review a draft of the manual, (provided via email or print.)
2. Complete a structured qualitative review rubric, providing open-ended feedback on the clarity, cultural relevance, and practical application of the manual. (Estimated time: 30-45 minutes)
3. Optionally participate in a virtual focus group discussion to further explore key themes and potential improvements. (Estimated time: 60 minutes, conducted via Zoom)

You will be invited to share:

- Your impressions of the manual's cultural relevance and usefulness.
- Your observations about barriers African American women face when seeking support.
- Suggestions for improving the manual so it resonates with both community leaders and the people they serve.

If you would like to be involved or learn more, please do not hesitate to reach out to me at c.edwards1708@o365.ncu.edu or 205-994-4563 ext. 200.

Your voice matters. Thank you for considering this opportunity to shift the conversation around mental health in our communities.

In partnership,

Cherie Edwards, MA, LPC-S

Doctoral Candidate| National University

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9338 Lightwave Ave., San Diego, CA 92123
irb@nu.edu

Appendix E: African American Women with Lived Experience Recruitment Email

My name is Cherie Edwards, and I am a doctoral student at National University. I am conducting a research project to explore ways to reduce stigma and improve access to mental health care for African American women. As part of this project, I am developing a culturally responsive manual designed to help mental health professionals better support Black women in therapy.

I am looking for African American women who meet the following criteria:

- Are at least 18 years old.
- Have sought mental health services at some point (minimum of three sessions with a LPC, LCSW, LMFT, PsyD, PhD in Clinical or Counseling Psychology, Psychiatrist)
- Are willing to provide feedback on how mental health care can be improved for African American women.

What Participation Involves:

1. Reviewing a draft of the manual, *This House: A Manual for Culturally Responsive Mental Health Care*, which is designed to help mental health professionals better serve African American women.

2. Completing a structured feedback form, where you can share your thoughts about what works, what is missing, and how the manual can be improved (Estimated time: 30-45 minutes).
3. Optional: Participating in a virtual focus group with other Black women to discuss mental health, stigma, and experiences with therapy (Estimated time: 60 minutes, conducted via Zoom).

Why Your Voice Matters:

Your personal experiences and insights can help shape a manual that ensures Black women receive culturally competent, respectful, and effective mental health care. Your feedback will help break the stigma, improve accessibility, and create real change in how mental health professionals work with our community.

Interested?

If you are interested in participating in this project, or if you have any questions, please contact me at c.edwards1708@o365.ncu.edu or 205-994-4563 ext. 200. Thank you for considering this opportunity to contribute to work that seeks to empower African American women in mental health spaces. Your voice is powerful, and I would love to hear your perspective!

Best regards,

Cherie Edwards, MA, LPC-S

Doctoral Candidate| National University

Appendix F: Recruitment Flyer

RESEARCH PARTICIPANTS NEEDED

Help Improve Mental Health Support for African American Women

What You'll Do:

- Read a short manual (~60–90 minutes)
- Complete an open-ended feedback form (~30–45 minutes)
- Optional: Join a virtual focus group to discuss your thoughts (via Zoom)

Who We're Looking For:

- Mental Health Professionals
  - At least 2 years of experience
  - Experience working with African American women
- Faith-Based Leaders
  - Currently serve in a leadership or counseling role
  - Experience guiding African American women in mental/emotional well-being
- African American Women (Lived Experience)
  - Have participated in counseling/ mental health treatment.
- Located in the Southern United States (urban or rural areas)
- 📅 Flexible Scheduling
- 🔒 All responses are confidential

💌 Interested?
Contact Cherie Edwards at:
✉️ c.edwards1708@o365.ncu.edu
📞 205-994-4563 ext. 200

📢 Let's break barriers and build better mental health care—together.

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irb@nu.edu

Appendix G: Informed Consent

My name is Cherie Edwards, and I am a doctoral student at National University (NU). I also hold a role as a Licensed Professional Counselor-Supervisor (LPC-S) and Owner of Work in Progress Counseling, LLC.

I am asking you to take part in a research project about how we can reduce stigma and improve engagement in mental health care for African American women by using culturally responsive strategies. The name of this project is "What Goes on in This House Stays in This House: Developing a Research Informed Manual to Address the Impact of Stigma and Cultural Barriers on Mental Health Service Provision for African American Women."

I hope to include 15-20 people in this research.

Please read this form carefully and ask any questions you may have before agreeing to take part in the project.

Participation Criteria

You are eligible to participate in this project if you meet one of the following:

- A licensed mental health professional with at least two years of experience and a history of working with African American women.

- A faith-based leader who provides support or guidance to African American women.
- An African American woman who has had lived experience with mental health care or has faced barriers to accessing it.

What Participation Involves

If you choose to participate, you will be asked to:

1. Review a draft of the manual *(Estimated time: 60–90 minutes)*
2. Complete a qualitative feedback rubric with open-ended questions related to clarity, cultural relevance, and applicability *(Estimated time: 30–45 minutes)*
3. Optional: Participate in a virtual focus group via Zoom *(Estimated time: 60 minutes)*

During these activities, you will be asked questions about:

- Your professional or community-based experience supporting African American women in mental or emotional wellness.
- Your feedback on *This House: A Manual for Culturally Responsive Mental Health Care*, including its clarity, cultural relevance, and practical application.
- The barriers and stigma you have observed or experienced related to African American women seeking mental health care.
- Strategies that have helped engage African American women in therapeutic or supportive services.
- Recommendations for improving the manual to make it more impactful and culturally responsive.

Demographic questions will include:

- Your age, race/ethnicity, gender identity, professional title or leadership role, years of experience, and geographic region

Sensitive topics that may arise:

- Discussions of stigma, racism, cultural mistrust, or trauma-related experiences, especially as they relate to mental health access and treatment among African American women.

Your responses will be collected through a secure Google Form or by email. You may also request a phone interview to provide your feedback verbally.

Potential Risks and Benefits

There are minimal risks associated with this study. Some questions may lead to reflection on personal or sensitive topics, such as mental health stigma. If at any point you feel uncomfortable, you may stop participating.

Benefits of this project include contributing to the development of a culturally sensitive resource that may help reduce barriers for African American women accessing mental health care.

Mandated Reporting:

As a licensed professional counselor, I am required by law to report any suspicion of child abuse or neglect, elder abuse or neglect, and/ or harm to self or others to the appropriate authorities.

Confidentiality and Data Protection

Your participation is voluntary and confidential. Any identifiable information will be removed from transcripts or reports. Responses will be stored in a secure, password-protected database and will be accessed only by the investigator. You may use a pseudonym if you wish. The focus group will be recorded for transcription purposes, but recordings will not be shared publicly and will be deleted after transcription and data analysis.

Voluntary Participation and Right to Withdraw

Participation is completely voluntary. You may withdraw from the study at any point, with no penalty or loss of benefits. You may also skip any question that you do not feel comfortable answering.

Questions or Concerns

If you have questions about the study, you may contact me at: c.edwards1708@o365.ncu.edu or call 205-994-4563 ext. 200.

If you have questions about your rights as a participant or would like to speak with someone independent of the research, you may contact the National University Institutional Review Board (IRB) at irb@nu.edu.

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irb@nu.edu

Consent Statement

By signing below, you indicate that you have read and understood this information, you are at least 18 years old, and you voluntarily agree to participate in this project.

Printed Name: _____

Signature: _____

Date: _____

Please indicate your role in this project (check one):

☐ Licensed Mental Health Professional

☐ Faith-Based Leader

☐ African American Woman with Lived Experience of Mental Health Care

☐ I agree to be contacted for an optional focus group.

☐ I would prefer to complete my feedback via phone interview instead of written form.

Appendix H: Manual Rubric for Mental Health Professionals and Faith-Based Leaders

Instructions for MHPs and FBLs:

Thank you for reviewing the *This House: A Manual for Culturally Responsive Mental Health Care*. Please evaluate the manual based on the criteria below, considering your unique perspective as either a Mental Health Professional or a Faith-Based Leader. Your feedback will help ensure the manual is culturally competent, clinically relevant, and effective in engaging African American women in therapy.

For each of the following criteria, assign a rating based on your judgment:

- Excellent (4): The manual exceeds expectations in this area.
- Good (3): The manual meets expectations, but some improvements could be made.
- Fair (2): The manual partially meets expectations but requires significant revision in this area.
- Needs Improvement (1): The manual does not meet expectations and needs substantial revision.

Criteria for Evaluation:

Criteria	Excellent (4)	Good (3)	Fair (2)	Needs Improvement (1)
Cultural Relevance	The manual is highly relevant and sensitive to the unique cultural experiences and values of African American women.	The manual is mostly relevant, but there are a few areas that could be more culturally specific.	The manual has some cultural relevance but lacks depth in addressing the experiences of African American women.	The manual is not culturally relevant or does not address African American women's unique experiences.
Clarity and Readability	The manual is clear, well-organized, and easy to read, with language accessible to both clinicians and clients.	The manual is mostly clear, but some sections could be more concise or clarified.	Some parts of the manual are unclear, and certain sections are difficult to follow.	The manual is hard to understand and poorly organized.
Practical Usefulness	The manual provides actionable, practical tools and steps that are easy to implement in real-life therapy or support settings.	The manual offers practical advice but could benefit from more concrete examples or detail.	The manual provides limited practical advice, and some of it is difficult to apply in real-life scenarios.	The manual lacks practical, actionable advice and is difficult to implement in real-life settings.
Sensitivity to Emotional and Spiritual Needs	The manual excellently integrates sensitivity to emotional and spiritual needs of African American women, respecting faith-based perspectives.	The manual addresses emotional and spiritual needs well but could incorporate more faith-based strategies or culturally appropriate emotional support.	The manual touches on emotional and spiritual needs but does not integrate these elements deeply.	The manual overlooks or inadequately addresses emotional and spiritual needs.

Criteria	Excellent (4)	Good (3)	Fair (2)	Needs Improvement (1)
Engagement Strategies	The manual provides highly effective strategies that resonate with African American women and encourage therapy engagement.	The manual provides good strategies for engagement but could benefit from more specific examples or detail.	The manual includes some strategies but lacks effective ways to engage African American women in therapy.	The manual fails to provide adequate or practical strategies to engage African American women in therapy.
Addressing Stigma	The manual excels at addressing stigma surrounding mental health care and encourages African American women to seek help without shame.	The manual addresses stigma effectively but could benefit from additional strategies to overcome cultural or community-based stigma.	The manual addresses stigma but does not offer enough tools for overcoming it or does so ineffectively.	The manual does not adequately address stigma or how to overcome it.
Clinical and Therapeutic Relevance	The manual is highly applicable to clinical settings and aligns with evidence-based practices, ensuring that mental health professionals can use it effectively.	The manual is mostly applicable but could be more aligned with clinical practices or evidence-based methods.	The manual has some clinical relevance but lacks consistency with evidence-based practices.	The manual does not align with clinical practices or lacks relevance for therapists and mental health professionals.
Suggestions for Improvement	Provides clear, actionable suggestions that would significantly improve the manual's cultural sensitivity, practicality, and effectiveness.	Provides helpful suggestions but could be more detailed or specific in terms of how to improve cultural sensitivity or engagement strategies.	Offers some suggestions for improvement but lacks clarity or specificity.	No suggestions for improvement or feedback is unclear.

Final Instructions:

- Evaluate Each Criterion: Please provide a rating for each criterion based on your assessment of the manual.
- Provide Feedback: For each rating, offer constructive feedback. What did you like? What could be improved? Your suggestions are critical for making the manual more effective and culturally responsive.
- Honesty: There are no right or wrong answers. We are interested in your honest opinions to ensure the manual is useful and relevant for African American women seeking therapy.

Appendix I: Manual Rubric for African American Women with Lived Experience

Instructions for African American Women with Lived Experience:

Thank you for reviewing the *This House: A Manual for Culturally Responsive Mental Health Care*. Your feedback is incredibly valuable in ensuring that the manual is relevant, practical, and sensitive to the needs of African American women seeking therapy.

Please evaluate the manual based on the following criteria, considering your personal experience with mental health care and the barriers you face as an African American woman. For each criterion, assign a rating based on your judgment:

- Excellent (4): The manual exceeds expectations in this area.
- Good (3): The manual meets expectations, but some improvements could be made.
- Fair (2): The manual partially meets expectations but requires significant revision in this area.
- Needs Improvement (1): The manual does not meet expectations and needs substantial revision.

Criteria for Evaluation:

Criteria	Excellent (4)	Good (3)	Fair (2)	Needs Improvement (1)
Cultural Relevance	The manual feels highly relevant and resonates deeply with my experiences as an African American woman.	The manual is mostly relevant, but there are a few aspects that could be more relatable to my experience.	The manual is somewhat relevant, but there are parts that don't connect with my experience.	The manual feels disconnected and irrelevant to my life and experiences.
Clarity and Readability	The manual is easy to read, well-organized, and written in clear, accessible language.	The manual is mostly clear, but some sections could be more concise or clarified.	Some parts of the manual are unclear, and certain sections are difficult to follow.	The manual is confusing and hard to follow.
Engagement Strategies	The manual offers highly effective strategies that make me feel supported and motivated to seek therapy.	The manual provides some useful strategies but could be more motivating or specific.	The manual includes some strategies but lacks clear motivation or practical guidance.	The manual fails to provide effective strategies to help me engage with therapy.

Criteria	Excellent (4)	Good (3)	Fair (2)	Needs Improvement (1)
Addressing Stigma	The manual excellently addresses stigma and encourages African American women to seek therapy without feeling ashamed.	The manual addresses stigma well but could use more strategies to overcome it or be more specific to my experience.	The manual touches on stigma but doesn't do enough to help me overcome it.	The manual does not adequately address stigma or how to overcome it.
Practical Usefulness	The manual provides practical tools and steps that I can use in real life to seek therapy and overcome barriers.	The manual is mostly practical, but more real-world examples and tools would be helpful.	The manual offers limited practical advice, and some of it is difficult to apply in real-life situations.	The manual does not provide practical advice or tools that can be used in real life.
Sensitivity to Emotional Needs	The manual is very sensitive to my emotional needs and experiences as a Black woman seeking therapy.	The manual is mostly sensitive to my emotional needs, but some parts could show more empathy or understanding.	The manual shows some sensitivity to emotional needs but lacks empathy in some areas.	The manual does not consider or adequately address my emotional needs as an African American woman.
Suggestions for Improvement	Provides detailed and specific suggestions on how to make the manual more relatable, helpful, and supportive.	Provides helpful suggestions but could be more specific or actionable.	Suggestions for improvement are limited and not very actionable.	No suggestions for improvement, or suggestions are unclear.

Final Instructions:

- Evaluate Each Criterion: Please provide a rating for each criterion based on your assessment of the manual.
- Provide Feedback: For each rating, offer constructive feedback. What did you like? What could be improved? Your suggestions are critical for making the manual more effective and culturally responsive.
- Honesty: There are no right or wrong answers. We are interested in your honest opinions to ensure the manual is useful and relevant for African American women seeking therapy.

Appendix J: Combined Focus Group Questions

1. What sections of the manual resonated with you most, and why?
   (Follow-up: Were there any that didn't feel as relevant or impactful?)
2. How well do you think the manual reflects the real-world experiences of African American women navigating mental health care?
3. What messages have you encountered—personally or professionally—about mental health in African American communities? (Follow-up: How have these messages shaped your understanding or approach to mental health?)
4. How has the "strong Black woman" notion shown up in your experience, and how do you think it affects decisions to seek mental health care?
5. Are the tools and strategies in the manual clear and actionable for use in your role or life? (Follow-up: What would make them more usable or relatable?)
6. In what ways does the manual effectively address stigma and cultural mistrust? Where do you think it could go deeper?
7. What's missing? What would you want to add to make the manual stronger, more culturally relevant, or more practical?
8. If you were sharing this manual with a colleague or peer, how would you describe its value or purpose in one sentence?

Appendix K: Journal Excerpts

Sept. 4, 2025

Feedback from an African American woman with lived experience

Today I received feedback from an African American woman with lived experience. I found myself feeling annoyed and frustrated. Her response came eight days past the due date, and she had asked for an extension twice. Rather than engaging with both tools as others had, she only completed the rubric and did not offer any narrative comments. Her scores were notably low—she has been the only participant, thus far, to select a 2 or a 1 in any category. In particular, she rated relevance to her life experience as a 1. What bothers me the most is not the low score itself, but the lack of explanation or suggestions that could help me understand her perspective. She also has declined to participate in the focus group. Without context, I am left with so many unanswered questions: What specifically did not resonate? What could have been changed to increase relevance? I recognize that critical feedback is valuable, but in this case, I feel limited because there is no direction for improvement. This is frustrating because I put effort into ensuring the manual connected to lived experience, and I had hoped for constructive suggestions that would help me strengthen that aspect. Instead, this feedback feels incomplete. I'm reminding myself that not every participant will engage in the same way, and some may be less invested or able to articulate their responses fully. Still, this experience highlights the importance of not relying too heavily on any single participant's scores, especially when they are provided without explanation. I also am resisting the urge to reach out to her for further clarification as that is not a part of my project procedures. *I note this*

reaction to acknowledge my frustration and to bracket it, ensuring my interpretation of the data remains grounded in the participants' responses rather than my emotional reaction to them.

Sept. 8, 2025

Feedback from MHP participant

Today I received verbal feedback from one of the mental health participants. While I arrived at the session feeling nervous, I left the conversation feeling both proud and deeply motivated. Her praise gave me a sense of encouragement—it reminded me that my hard work and dedication are being seen and valued. That affirmation was meaningful, especially during a process that has felt so overwhelming at times. At the same time, her suggestions sparked something in me she mentioned some scales that I've heard of before, but I hadn't considered applying them in my work. The fact that this was raised makes me realize that there are even more valuable tools available to strengthen my project. I plan to take time to research these scales and think critically about how they might fit into my framework. Overall, the balance of affirmation and constructive guidance left me energized. Rather than feeling discouraged, I feel motivated to stretch further This feedback has helped me to see opportunities that I have overlooked and I'm grateful for the push to expand my thinking and my approach. *I record this reflection to acknowledge both my pride and motivation while setting these feelings aside, so they do not unduly shape my interpretation of the participant's feedback.*

Appendix L: Master Codebook

Master Codebook

Code	Definition	Illustrative Quotes
Cultural Relevance	The extent to which the manual reflects the lived experiences, language, and cultural realities of African American women.	"The Color Purple assignment was culturally relevant and impactful…" (Lived Experience) "Every Black household had the rule 'what happens in this house, stays in this house.'" (Lived Experience) "The manual could be used for any race—consider what makes it unique to African American women." (Faith-Based Leader) "Centers Black women's lived experiences… strong Black woman expectations, church dynamics, generational silence." (MHP) "Include culturally normed assessments (Strong Black Woman, Jezebel, Miami scales)." (MHP)
Clarity & Readability	How easy the manual is to read, understand, and follow for both clients and facilitators.	"The manual is easy to read and not too therapy driven." (Lived Experience) "The manual is well organized and clear." (Faith-Based Leader) "Clear and accessible, not filled with jargon." (MHP) "Some formatting issues were distracting; add time boxes for sessions." (MHP)
Engagement Strategies	Techniques and activities that motivate participation, foster group cohesion, and sustain interest.	"Circle of sociometry helps participants feel less isolated." (Lived Experience) "Meditations and group activities created a safe, comfortable space." (Lived Experience) "Group sessions are engaging; consider role-play as an activity." (Faith-Based Leader) "Games like Coping Bingo and Feelings Jenga offer multiple entry points." (MHP) "Provide more scripting so facilitators know how to introduce activities." (MHP)
Practical Usefulness	The degree to which the manual offers actionable tools and strategies that can be applied in daily life or therapy practice.	"Body scan, self-care lists, and feelings wheel were especially helpful." (Lived Experience) "SMART goals were practical and empowering." (Faith-Based Leader) "Clear, actionable instructions clients can use daily." (MHP) "Manual could benefit from a participant workbook with weekly handouts." (MHP)
Addressing Stigma	How effectively the manual confronts cultural stigma around mental health care and encourages help-seeking without shame.	"Directly addresses stigma and the silence of 'what happens in this house…'." (Lived Experience) "Providing tips or frameworks would help facilitators guide stigma discussions." (Faith-Based Leader) "Touches on key phrases like 'don't air your dirty laundry,' giving women the green light to seek help." (MHP) "Stigma is addressed well in one section but could be infused throughout." (MHP)

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Sensitivity to Emotional & Spiritual Needs	Recognition of participants' emotional struggles and the role of faith/spirituality in healing.	"The manual felt sensitive, validating, and made me feel seen as a Black woman." (Lived Experience) "Could dive deeper into faith-based strategies (Lectio Divina, breath prayers)." (Faith-Based Leader) "Add creative embodied rituals (sound bowls, burning bowl, affirmations)." (Faith-Based Leader) "Names spiritual bypassing, affirms that faith + therapy can coexist." (MHP) "Explore differences between spiritual counseling vs. traditional therapy." (MHP)
Clinical & Therapeutic Relevance	Alignment with evidence-based practices, clinical applicability, and ability for other professionals to implement.	"Could be implemented by another clinician without your guidance." (MHP) "Evidence-based practices clinicians can easily apply." (MHP) "Add participant criteria (e.g., personality disorders, substance use)." (MHP) "Ensure referenced screeners/worksheets are included (e.g., Self-Care Assessment)." (MHP)
Suggestions for Improvement	Concrete recommendations to strengthen cultural sensitivity, engagement, or facilitator support.	"Add quick self-care list for when women feel overwhelmed." (Lived Experience) "Incorporate visuals and statistics to increase engagement." (Faith-Based Leader) "Develop a workbook with art/drawing activities alongside journaling." (Faith-Based Leader) "Include more culturally specific films (e.g., For Colored Girls)." (MHP) "Add virtual delivery options for accessibility." (MHP)

Appendix M: Manual

THIS HOUSE

Breaking Generational Silence, Reclaiming Our Healing

A Group Therapy Program for Black Women Navigating Mental Health, Shame, and Stigma

Program Developed By:

Cherie Edwards, MA, LPC-S

Licensed Professional Counselor – Supervisor

EMDR Certified | Sandtray Certified | Boundaries Specialist

To request permission to view this manual please contact me directly at: cherie@workinprogressllc.com