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Perceptions of Superwoman Schema and Stress Among African American Women with Pre-Diabetes

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Abstract

Three focus groups were conducted with African American women with elevated cardiometabolic risk to better understand how Superwoman Schema/the strong Black woman role influences their stress and how this cognitive-emotional aspect of health may need to be targeted in future research on cardiometabolic health disparities, such as prediabetes and diabetes. Results from this study revealed that participants' descriptions of stress and the superwoman role were consistent with the Superwoman Schema Conceptual Framework, including specific emphasis on 1) an obligation to manifest strength, 2) an obligation to suppress emotions and 3) an obligation to help others. Implications for targeting Superwoman Schema and stress as social determinants of health are described.

Introduction

African American women have disproportionately higher rates of stress-related health conditions such as diabetes, cardiovascular disease, and adverse birth outcomes (Centers for Disease Control and Prevention, 2016; Giscombe & Lobel, 2005; Mozaffarian et al., 2015; Woods-Giscombe & Lobel, 2008). Evidence suggests that African American women are more susceptible to stress (American Psychological Association - Stress and Health Disparities Working Group, 2017). The concepts of "allostatic load" and "weathering" are two perspectives grounded in the social determinants of health that have been explored to provide an explanation of increased susceptibility to stress among African American women as compared to European American women (Geronimus, 2000; McEwen, 1998). Allostatic load refers to the imbalance in systems that promote adaptation within the human body (McEwen, 1998). One potential cause of this imbalance may be related to the repeated stressors that cause the system to wear out or become exhausted, leading either failure of the system to shut-off or respond (McEwen, 1998). Allostatic load takes into consideration the cumulative effect of stress on physiological systems. It is postulated that African American women's repeated lifelong exposure to racism and discrimination increases their susceptibility to stress; these social determinants of health perpetuate inequities (Belgrave and Abrams, 2016). Additionally, the weathering framework

(Geronimus, 2000) suggests that African American women experience health deterioration as a consequence of the "cumulative impact of repeat experience with social, economic, or political exclusion"(Geronimus, 2000, p. 133).

Building upon the foundational frameworks of allostatic load and weathering, recent literature suggests that "African American women are exposed to higher levels of stress as a result of their race/ethnicity, gender and social position"(Woods-Giscombé, Lobel, Zimmer, Wiley Cené, & Corbie-Smith, 2015). In particular, the Superwoman Schema (SWS) Conceptual framework developed by Woods-Giscombe (2010) posits that there are unique gender and race related stressors that African American women have experienced in their lifetime that cause them to maintain a stalwart exterior in the face of experiences of vulnerability resulting in emotional suppression and limited prioritization of self-care. The Superwoman Schema Conceptual framework outlines five characterizations of the superwoman role, namely; 1) obligation to manifest strength, 2) obligation to suppress emotions, 3) resistance to being vulnerable or dependent, 4) determination to succeed despite limited resources and 5) obligation to help others. Research findings by Black and Peacock (2011) and Woods-Giscombe (2010) also suggest that stress related outcomes in African American women may be influenced by the unique characteristics of SWS. SWS characteristics are associated with perceived stress, depressive symptoms, emotional eating, sleep disturbance, and sedentary behavior in African American women (Woods-Giscombe, Allen, Black, Steed, Li, & Lackey 2019). Taking care of family, friends and loved ones and the stress that it can create contributes to distress in this population. The obligation to help others significantly drives the caregiver role that African American women take on. This aspect of SWS will be further explicated in this paper.

In 2015, Woods-Giscombé et al. (2015) explored the role of network stress among African American women. Network stress is defined as "stress related to events that occur to family, friends, or loved ones" (Woods-Giscombé et al., 2015, p. 710). African American women were exposed to a greater number of network-stress related events as compared to self-stress events, and they perceived both types of events as similarly stressful. Network stress was identified as an important construct to explore in studies conducted to examine the mechanisms through which stress influences health behaviors and health outcomes. In addition, network stress may be a potentially important target in future culturally-relevant research designed to enhance stress management strategies among African American women.

The purpose of the current study was to examine perceptions of Superwoman Schema among African American women with elevated cardiometabolic risk to better understand the ways in which Superwoman Schema influences their stress and how this emotional aspect of health may need to be targeted in future research on cardiometabolic health disparities, such as prediabetes and diabetes. Three research questions were explored:

1. What are the participant's perceptions about the concept of strong black woman/ superwoman role in African American women?
2. What are the participant's perceptions of the experience of stress in African American women?

3. Does SWS, in particular, obligation to manifest strength, obligation to suppress emotions and obligation to help others, influence how African American women talk about stress?

Methods

Data Source

To explore African American women's perceptions of Superwoman Schema and how it may influence the way in which they talk about stress, a qualitative focus group study was conducted with Robert Wood Johnson Foundation (RWJF) funding awarded to the second author. This study was entitled, *Stress, Superwoman Schema, and Obesity Risk in African American Women: Developing a Culturally-Relevant Intervention to Reduce Health Disparities*. Focus group participants in this study included women (aged 25–65) who were previous participants in the "We Can Prevent Diabetes" research study (Woods-Giscombe et al., 2019b), a randomized controlled, feasibility stress management and diabetes prevention study with African American adults diagnosed with prediabetes. All women from the "We Can Prevent Diabetes" study who completed pre-intervention surveys and biomarker assessments were invited to participate in one of three focus groups: one focus group included study participants who were randomized to a diabetes risk reduction education treatment group that included mindfulness meditation to target stress reduction, a second focus group included participants who were randomized to the diabetes risk reduction education only attention control group, and the third focus group included women who were eligible for randomization, but chose not to participate in the intervention component of the study. While the RWJF grant had three specific aims, the data for the current study was derived from the third aim, which was to identify specific factors that will enhance the overall cultural relevance and feasibility of an intervention designed specifically to target the links among stress, SWS, stress-related eating, and obesity risk in African American women. Twenty African American women agreed to participate in the RWJF-funded focus group study. Presented here are the participants' perspectives, from all three focus groups, regarding their perceptions of Superwoman schema and their experiences of stress as it relates to their health.

Focus Group Data

The focus group design was guided by the work of Kitzinger and Barbour (1999). All potential participants were mailed an invitation letter followed by an email and a telephone call to assess interest in participating in a focus group, which was then followed by an invitation to participate in a 2-hour focus group at a private community location. Interview guides for all three focus groups included the following topics: (1) perceptions about the cause of health disparities in African American women; (2) perceptions regarding the connection among psychological stress, SWS, use of food to cope, obesity, and diabetes risk in African American women; (3) ideas about how best to recruit women to an intervention to reduce stress-related risk factors for diabetes.

Prior to recruitment of participants, the study was approved by the Institutional Review Board at The University of North Carolina at Chapel Hill. The PI of the study and focus

group moderator (an African American woman in her late 30s at the time of the study and second author) and a research assistant (an African American woman in her mid 30s at the time of the study) conducted the focus groups. Example focus group questions included, 'Have you heard of the concept strong black woman/superwoman schema?', 'What do you think of when you hear that phrase?', 'What are some of the causes of health disparities in African American women?' and "How do you think stress contributes to these health disparities?". Participants signed consent forms after the study methodology was described to them. Each participant was given a personal copy of the consent form to take home. All focus group interviews were audiotaped and professionally transcribed, verbatim, by a transcription company.

After a brief icebreaker activity, the focus group moderator used a topical outline of broad key questions to guide the discussion and to generate interaction among the participants (Farquhar & Das, 1999; Kitzinger & Barbour, 1999). The research assistant was present to distribute consent forms and questionnaires and to take careful notes during the focus group discussion. We documented and maintained field log notes and memos to facilitate auditability of the study (Sandelowski, 1986). At the end of the focus group, study participants were asked debriefing questions, which included a review of major topics discussed during the session. To enhance accuracy, the moderator asked questions such as: "Is there anything I didn't ask that I should have?" and "What was it like being in the group?"

Data Analysis

Several strategies were utilized to enhance the scientific rigor and trustworthiness of this qualitative focus group study. To address potential bias, study team members practiced reflexivity to maintain consistent awareness of assumptions, as well as the meanings we associated with the focus group discussions during the data collection and analysis processes (Dowling, 2006). The transcripts were read and reread by an independent researcher (the first author, and an African American woman in her 40s) who was not present during the focus group sessions. This facilitated the development of a familiarity with the "essential features" of the interviews without an initial obligation to engage in analysis too quickly or try to make comparisons across interviews. The initial readings served as an opportunity to get a sense of the whole (Sandelowski, 1995). Interesting phrases were underlined but efforts were made to avoid rushing to assign initial codes. Next, transcripts were read with the PI who was also the moderator of the focus groups. The purpose of this working session was to add context to the transcripts with field notes collected by the PI and research assistant during the focus group sessions. ID numbers for the focus group participants were also assigned based on these field notes, which assisted in linking comments made by the same participant during the interviews. Transcripts were then proofed in accordance with corresponding audiotapes (Sandelowski, 1995), which facilitated clarification of sections initially identified by the professional transcriptionist as "inaudible". This allowed for deeper understanding of context and content while getting a sense for the whole once again. Initial codes were then assigned and entered into Atlas.ti® analysis software. The codes were then refined and combined as themes were identified. Data were reduced through extracting codes pertaining specifically to the SWS conceptual framework (deductive

approach). Importantly, this initial use of a framework did not preclude an emergence of illuminating themes that stayed true to the participants as well. Themes were also identified inductively, which shaped the answers to research questions 2 and 3. Throughout the process, analytic memos were written to capture emergence of new ideas and reflect upon deeper and complex meanings that arose (Saldaña, 2009).

Results

Superwoman Schema

The Superwoman Schema (SWS) conceptual framework posits that personal contextual, sociohistorical and cultural factors accompanied with expectations to maintain a stoic exterior in times of stress and vulnerable experiences may result in African American women suppressing emotions and decreasing the prioritization of self-care (Woods-Giscombe, 2010). This superwoman role is a multifaceted phenomenon, which encompasses five hallmark characteristics; obligation to manifest strength, obligation to suppress emotions, resistance to being vulnerable or dependent, determination to succeed despite limited resources, and obligation to help others (Woods-Giscombe, 2010). Participants in this study were asked about their perceptions of the Superwoman role and its role in stress and health disparities in African American women.

The most salient sentiments regarding the perception of the Superwoman role that emerged across all three focus groups are encompassed by three of the five characteristics of the Superwoman Conceptual Framework, namely; 1) obligation to manifest strength, 2) obligation to suppress emotions and 3) obligation to help others. Participants repeatedly shared experiences and thoughts that exemplified these three themes.

Obligation to manifest strength.—When asked to describe what the phrase *strong black woman* or *superwoman* meant to them, participants used words like, “I can do it all” and “anything a man can do, a woman can do”. One woman stated, I think that sometimes we think that we’re supposed to be strong. Some women indicated that family members viewed them as “strong” and often assumed they could handle multiple demands placed upon them. One woman indicated that her adult children referred to her as, “…mommy’s a superwoman. Mommy can do it all”.

While these shared perceptions of the superwoman role at times appeared to be embraced with a sense of pride, the women also communicated experiences of stress during which the superwoman role shifted from being about the strength of a black woman to a role overloaded with obligations. These obligations and commitments to family members (children, parents etc.) and friends prohibited the woman’s willingness to display weakness. They felt the need to appear strong, despite feeling the contrary, because others depended on them to do so. When talking about stressful experiences in her life, one participant said,

> So, all of those things are stressful events, but then someone said “Put your big girl panties on and deal with the hill.” That’s the Superwoman thing. Your big girl panties have the S on it...

The participants suggested that their obligation to maintain an appearance of strength was also associated with the obligation to suppress emotions. Some women used phrases like "do what you've got to do and then you keep on going..." suggesting that there is no time to show emotion when faced with life stressors because there are multiple demands and responsibilities that have to be managed. Women also shared that the obligation to manifest strength occurred in settings outside of their immediate social circles. These obligations manifested in the workplace and often resulted in additional demands on their time and energy because of the perception of strength. One woman attributed this obligation to appear strong and suppress emotions as part of the burden of being an African American stating she didn't feel comfortable talking about her problems at work because she was "the only minority in the whole building".

Obligation to suppress emotions.—Participants shared the perceived obligation to suppress emotions. Many expressed that allowing others to see them as vulnerable or crying in front of others could be viewed as a "sign of weakness". One participant expressed this sentiment in the following way:

> Well, I think sometimes when I think about a black woman, you've just got to know that you've got to go through whatever. It's not always going to be easy. Your parents teach you that it's not going to be easy, so you don't cry and -- at least you don't cry out where everybody see. You just don't – ….and [you]do what you've got to do and then you keep on going.

When talking about their stressful experiences, emotional suppression and obligation to manifest strength also emerged in the form of minimization. Some women said, "maybe I'm just making it more than it is" and "it's just my perception, it may not even be that bad". They attempted to devalue the stress they felt when relaying the stressful event, thereby emotionally suppressing. Interestingly, only one participant (who happened to be in focus group 3) talked about the potential connection between suppressing emotions, mental illness and the stigma associated with mental illness in the African American community. She stated,

> We don't deal with a lot of mental illness aspects of our community because we've always pushed it aside and rise to the occasion, put it in your big girl underwear, whatever the case may be, whatever, big boys don't cry, but we do and we do get hurt…

Several women talked about enjoying the opportunity to be in the current study, stating that the focus group discussion was one of the first opportunities they had to talk openly and honestly about these types of issues. It allowed them to open up and share their emotions, which was not something they usually did.

> A lot of things you don't ever say out loud. I've probably said a lot out loud in here... I done said more out loud than nobody ever hear. Nobody knows me like this…

Obligation to help others.—The participants discussed feeling obligated to help others. This theme was one of the most prevalent themes. Women shared sentiments that, "It's

involuntary giving. If I don't give, then nothing goes right" and "It's just that you do it or you feel obligated to do what you do because you want to out of love". Many stated that the obligation to help others had been influenced by what they learned from previous generations.

Their collective perspectives indicated that the caregiver role had been passed down from their ancestors, foremothers and grandmothers. When this generational connection of the learned caregiver role was mentioned, women always referred to female elders that had modeled (knowingly or unknowingly) or taught them how to be caregivers. Participants shared thoughts like "I just think it's passed down. I didn't even realize I was doing it" and "my grandmother raised six of us, and me being the oldest, I was a giver at 12 and 13, 14. It's what I do". One woman mentioned the learned caregiver role as soon as the interview began stating,

> And I think some of that has passed down through generations. I watched my mom do that and so a part of me says I'm supposed to do that… I've taken on that role that I saw they did.

Women also shared experiences or acknowledged that the caregiver role led to the postponement of self-care. They indicated that they focused more on taking care of others rather than prioritizing their own health. Some admitted to cancelling or delaying appointments with healthcare providers or preventative health measures due to their caregiving role.

The women also discussed feelings of guilt surrounding the delay of their own self-care but nonetheless, felt that their family and friends needs superseded their own.

> [We] tend to not make time for ourselves, and maybe just to make an appointment to go to the doctor. That's something that I realize as I get older, and now that my parents get older, I've taken on that role that I saw they did. So I think that's a big deal in our community.

The women recognized how prioritizing caregiving over self-care may impact their health behaviors and risk for adverse health outcomes.

> The part about the stress of trying to take care of everybody else and not taking care of yourself and then that Superwoman part. To me, that all kind of went together. Even though you know something wrong with you, it's like you put it on the back burner and say "Aw, I can do it later." And then you get obesity when -- you don't really do it, but you start eating the good stuff because everybody has stressed you out and this is how you cope with it.

How African American Women Talked About Stress

When exploring how African American women talked about their experiences of stress within the context of SWS, two themes emerged from the data; *internal struggle* and *taking on the burdens of loved ones*. The internal struggle was shaped by the participant's use of *expressions of exhaustion* and their views surrounding *saying "no"*. Additionally, taking on

the burdens of loved ones had both overt and covert qualities, which became evident as the participants talked about their caregiver role.

The undertone of the internal struggle the women experienced was evident as they tried to reconcile in their minds their feelings of obligation (obligation to manifest strength, obligation to suppress emotion and obligation to help others) with their own fundamental self-care needs. This manifested as *using expressions of exhaustion* and conflicting ideas surrounding *saying "no"*.

Internal Struggle.

Using expressions of exhaustion.: When talking about what it means to be a strong black woman and taking on the many responsibilities that comes with that title, many participants used expressions and phrases that underscored the mental and physical exhaustion they experienced. One participant shared her experience of feeling like she had do it all,

> I know in my head, my head is telling me, "You can't keep doing this, you can't keep doing this," but over here, this side is saying, "Keep going, keep going, keep going." So, I keep going **until I'm flat out**.

The above quote is illustrative of the conversations that women had about stress. These conversations were interwoven with phrases like "I'm about to run myself down" and "I need the break, I need time, I need to just rest". The women were not overtly admitting to exhaustion (most likely related to their obligation to manifest strength and suppress emotions) rather the comments they made carried the tone (which are embedded within their stories) of their exhaustion, both mentally and physically.

A thought-provoking conversation occurred in the second focus group, during which the women shared their concerns and opinions regarding one participant. They believed this participant gave too much (in the form of the caregiver role) to her grandchildren and children. After receiving this feedback and support from the group, the critiqued participant said with resignation, "I probably need some therapy". Movingly, different members of the group started saying, "we all do".

> I probably need some therapy.
>
> [Laughter]
>
> We all do. We all do.
>
> We all broke.
>
> We broke.

The sentiment that "we are all broke" or broken is a particularly poignant and unified one that speaks to the burden of doing these things for others while overextending themselves to the detriment of their own mental and physical health. The women are essentially acknowledging that although, they felt this participant was doing too much for her family, they had all done similar things. The women shared in the collective internal struggle between what they know they *should* do to take care of themselves and what they *actually*

do. The commitment they have to their family and friends seems to undermine prioritization of self-care.

Saying "no"- The difficulty, The guilt, The empowerment.: Women shared experiences of having to say "no" to loved ones when they were unable to do something for them (such as provide financial or transportation support or childcare). Invariably, each story surrounding the experience of saying "no" was accompanied by the internal struggle the women experienced in reaching that conclusion. Some women talked about the difficulty of saying no, some shared their experience of guilt when they said no and yet others talked about the empowerment of saying no. Each are illustrated below,

The Difficulty

> I don't know how to say no…. I feel I have an issue with saying no. I will spread myself like peanut butter out.

Women discussed that helping others was an outward expression of showing their care and love therefore, saying no was often difficult. The preceding quote illustrates the difficulty in saying no but also contains the familiar expression of exhaustion. This particular expression of exhaustion holds the connotation that despite multiple demands and possibly limited resources she "spreads herself out" to accomplish what needs to be done for her loved ones. Although not explicitly stated many women across the focus groups subtly expressed that they overextended themselves even to their own detriment.

The Guilt—Some participants expressed feelings of guilt when they said no to taking care of a loved ones needs. One woman shared her experience and, while it appears that she wanted to get across the empowerment that can happen when saying no, what came forward was the internal struggle and guilt that accompanies saying no. She shared with the group the process she goes through in her mind to overcome the guilt she feels when she says no to family members,

> And I have to play it out in my head that I wasn't being mean, that I didn't say it rude, or either I have to address them and say, "I wasn't being rude. I just said no, I can't do it and I'm not going to do it. No."

This internal conflict and consequence of what happens when women say no to a loved ones needs was particularly evident when another woman said,

> I want to give, but I have to give, do you know what I mean? And I might necessarily don't want to give, I might just want to shut you out and close the door, but I have to because this is what keeps the family going.

The common thread of giving because the family depends on them is interwoven throughout many of the focus group discussions. Women share this idea of wanting to give but not wanting to give at the same time. They want to give because they want to show their love but they don't want to give because they are mentally and physically exhausted.

Spirituality was brought up in conversation on occasion, one woman shared that she prayed regarding her caregiving demands, "But see, I also pray a lot. So, I'm just saying, when I

can't do anymore, then it's like, okay, well, there's a reason.". However, in most cases, the women indicated that they give because it is what sustains their family and community.

The Empowerment—A counter narrative from the difficulty and guilt of saying "no" was a sense of empowerment when saying "no". One woman observed,

> *… but sometimes saying no is powerful. It doesn't mean you can't help that person. It doesn't mean no to whatever the situation that they're in, so just learning how to feel empowered to do that.*

When the empowerment of saying no was discussed the conversation leading up to and surrounding it still involved the internal struggle that was felt. One participant who had shared the guilt she felt when saying "no" also mentioned the spiritual aspect when she said, "You know what? There's an anointing in the word no," [laughter] and I said no. " Here she is implying that there is an anointing from God that gives her the strength to say no. When she ended her comment with an emphatic "no" it carried with it a sense of empowerment.

Taking on the burdens of loved ones.—As African American women talked about their experiences of stress within the context of SWS, there was a theme of "taking on the burdens of others‖- both a physical "taking on" as well as a mental or psychological "taking in". When participants described how they took care of family members and friends, they described how they "overtly" took care of them but also there was an undertone and interwoven story of an internal or "covert" taking in of others burdens. This covert taking in of loved one's concerns is reflective of network stress.

The physical or overt, external —taking on‖ is illustrated in the following quote,

> I take care of my sister. She's mentally challenged. I am her caregiver... I make sure she get all this stuff checked for herself. She went and got her test last, was it, November? I made sure I signed her up for it. I said, "You change your mind?" She said, "No, I didn't change my mind. If you signed me up, I guess I need to go." And anything I tell her she needs to go take, she goes and takes it. And I put myself off. I did put myself off, and it's a sad thing…

Here it is apparent that the participant physically took care of her sister by transporting her to her appointments and making sure she received the proper medical care for her condition. However, many women talked about "taking in" the burdens of others in a way that was psychological or internal. They expressed views of when a loved one is struggling they felt "hurt" or they were "going through" what their loved one was going through. Often this empathy extended to wanting to try and "fix it" or "figure it out" for their loved ones.

> "*Whatever she's going through, I'm going through that with her, and my girlfriends, and her man - I'm going through that with her, whatever it is".*

and

> *"I'm the type of person that if you feel bad in my family, I feel bad, too, I feel your pain*."

Women's shared experiences of the internal "taking in" of the cares and burdens of loved ones is an example of network stress that was pervasive among the narratives in all of the focus groups.

Discussion

Summary of Findings

Presented in this article are twenty African American women's perceptions of the Superwoman role and stress in their lives. Deductive analysis of the data, indicate that of the five hallmark characteristics of SWS, the three most salient themes across all three focus groups were obligation to manifest strength, obligation to suppress emotions and obligation to help others. All three obligations shaped how African American women experienced stress and how they talked about stress.

Findings from this study corroborate findings from the original study conducted to develop the Superwoman Conceptual Framework (Woods-Giscombe, 2010). The majority of the themes discussed by participants in the current study parallel the sentiments expressed by the participants in Woods-Giscombe's initial study of African American women and their perceptions of stress. Interestingly, both an obligation to suppress emotion and an obligation to manifest strength seemed to co-occur in the stories the women shared and shaped the way in which African American women experienced stress. All three obligations were a pervasive undercurrent in all of their experiences and resonated across focus groups. Not only did SWS shape and influence the experiences of stress, it shaped how they talked about stress. The internal struggle they expressed when sharing their stories became evident in their use of expressions of exhaustion and views regarding saying "no". Additionally, SWS played a role in the "taking on" and "taking in" of another's burdens.

There were no distinctive factors that were unique to any particular focus group pertaining to SWS or how women talked about stress. The distinction in focus groups was more related to how they interacted with one another based on their familiarity with each other from the pilot study. The control group seemed to be the most connected and bonded and they shaped the narrative of the interview around their suspicion of the medical profession, which paralleled previous research findings (Woods-Giscombe et al., 2016). Although, not addressed in this article, the focus group differences were more evident/prevalent when the women talked about food choices and use of food to cope as it related to stress.

Limitations

Limitations of this study include the characteristics of the primary dataset including, incomplete audio and transcripts with multiple inaudible sections Participants were invited to participate in a focus group to explore perceptions of stress, health disparities and superwoman schema. This may have resulted in sampling women with higher levels of stress than the general African American population. African American women who did not participate in the study may have had lower levels of stress.

Future Implications

Key findings from this study should be considered for clinical practice and future research aimed at addressing social determinants of health (Wilkinson and Marmot, 2003) and health disparities among African American women. For African American women, social determinants of health include the social, cultural and institutional factors that influence stress, including stressors influenced by historical oppression, discrimination, and trauma (Belgrave and Abrams, 2016). Findings from this study can help to guide culturally-relevant assessment and treatment practices. In considering the original aim for this study, which was to identify specific factors that will enhance the overall cultural relevance and feasibility of an intervention that will be designed specifically to target the links among stress, SWS, stress-related eating, and obesity risk in African American women, the importance of network stress and social support should not be understated.

As suggested by Woods-Giscombé et al. (2015), network stress is a significant aspect of African American women's experiences of stress. Their obligation to take care of others and prioritization of loved ones significantly impacts their life. As evidenced in their "taking on" and "taking in" of loved one's burdens in this study, African American women demonstrated a fierce loyalty to their family, friends and community. When developing a culturally relevant stress management intervention, this aspect of stress should be considered. The unique need for social support as it pertains to self- care for African American women should be considered. When explicitly asked about what they deemed important in the development of a stress management intervention, many voiced the need for an "accountability partner"; someone who would hold them accountable to taking care of themselves. Being accountable to someone else also fulfills their need to care for someone, which is an important motivator for this population. Women shared that this accountability could increase the chances that they will be more diligent in committing to what they need to do for themselves; the support through the "accountability partner" could increase the likelihood of self-care. Interestingly, within the focus group dynamic of this study, when talking about stressful experiences, the women clearly articulated what they needed. They became a support for one another and they demonstrated what can happen when African American women are put together in an environment where they are encouraged to freely talk about their stresses, worries and demands- perhaps true change in the prioritization of self can occur if these types of support systems are facilitated in group-based or individual therapeutic settings.

The findings from this study are relevant for behavioral health providers, including psychiatric mental health nurses, psychologists, and counselors as they work to promote mental health among African American women. In addition, researchers can incorporate these insights to help make culturally-relevant contributions to interventions for reducing stress and stress-related health disparities in African American women. By understanding the Superwoman Schema, network stress, and the challenges related to emotional suppression and inadequate self-care, culturally-relevant strategies to address social determinants of emotional health and stress might be more successfully implemented and utilized.

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Highlights

- African Americans have disproportionately high rates of stress-related chronic health conditions, including diabetes and cardiovascular disease.
- Frameworks such as allostatic load, the weathering hypothesis, and Superwoman Schema suggest that social factors influence disparities in stress-related morbidity.
- Characteristics of Superwoman Schema, including obligations to manifest strength, suppress emotions, and help others are salient for African American women with elevated cardiovascular risk.
- Future clinical and research interventions should consider the potential strategies that can successfully address the superwoman role, stress, and the overall emotional health of African American women to optimally reduce stress-related health disparities.