AN EXPLORATION OF THE STRONG BLACK WOMAN SCHEMA AND SEXUAL FUNCTIONING AMONG BLACK WOMEN IN THE UNITED STATES: "STRONG AIN'T ALWAYS SEXY"

by

JESSICA ROSS

A dissertation submitted in partial fulfillment of the
requirements for the degree of

DOCTOR OF PHILOSOPHY IN EDUCATION: COUNSELING

2025

Oakland University
Rochester, Michigan

Doctoral Advisory Committee:

James T. Hansen, Ph.D., Chair
Julia Smith, Ed.D.
Rebecca Vannest, Ph.D.
Brian Taber, Ph.D.

To my children—
Thank you for your endless patience, love, and understanding throughout this journey. This work is for you—may you always know the power of your voice, the strength of your story, and the freedom to live fully, joyfully, and unapologetically.
With all my love,
Mom

ACKNOWLEDGMENTS

First and foremost, I thank God for the strength, grace, and guidance that carried me through this journey. This work would not have been possible without divine alignment and the reassurance that I was never walking alone.

I would like to extend my deepest gratitude to my dissertation committee: Dr. James Hansen, my chair, for his unwavering support and thoughtful guidance; Dr. Julia Smith, Dr. Rebecca Vannest, and Dr. Brian Taber, for their valuable feedback, encouragement, and steadfast commitment to seeing me through this process. Your insight and dedication have helped shape this work and enriched my academic growth.

To my parents, who are no longer here with me in body but whose presence I feel every day, thank you for being my first source of inspiration, strength, and unconditional love. Your legacy lives on in everything I do, and this accomplishment is a reflection of the values you instilled in me.

Jessica Ross

ABSTRACT

AN EXPLORATION OF THE STRONG BLACK WOMAN SCHEMA AND SEXUAL FUNCTIONING AMONG BLACK WOMEN IN THE UNITED STATES: "STRONG AIN'T ALWAYS SEXY"

by

JESSICA ROSS

Adviser: James T. Hansen, Ph.D.

Black women are remarkable. Yet, despite their significant contributions to society, they are tasked with navigating a world that marginalizes their identity. To cope with racialized sexism and historical trauma, Black women have internalized the Strong Black Woman (SBW) schema, which emphasizes strength, independence, and caregiving. Although the SBW schema has served as a survival mechanism, it has also had unintended consequences on the physical and mental health of Black women. Existing at the intersection of mental and physical health, it is reasonable to hypothesize that sexual health, specifically sexual functioning, is also subject to the negative effects of internalizing the SBW schema. However, the relationship between sexual functioning and the SBW schema internalization has not been explored. This dissertation investigates the relationship between SBW schema internalization and sexual functioning among Black women in the United States. To explore this relationship data from the BeWell Project was used. SBW schema was measured using the Giscombe Superwoman Schema Questionnaire (G-SWS-Q) and sexual functioning was measured using the Changes in Sexual Functioning Questionnaire (CSFQ-14).

TABLE OF CONTENTS

LIST OF TABLES

LIST OF TABLES—CONTINUED

LIST OF FIGURES

CHAPTER ONE
INTRODUCTION

Black women in America have a complex history that is intertwined with race, gender, and power. Having been subject to racism, sexism, discrimination, physical and sexual violence, and exploitation, Black women have faced numerous adverse experiences (Prather et al., 2018; West & Johnson, 2013; Wilson, 2021). These experiences have not only influenced their lives but also the way Black women navigate society, interact in relationships, and develop their sense of identity (Jones et al.,2021; Collin, 2000). Dating back to chattel enslavement, Black women were seen as property and their bodies were commodified for labor and reproduction (Prather et al., 2018). Objectification by White culture during enslavement led to the hypersexualization of Black women, who were often sexualized and seen as inherently promiscuous, thereby contributing to a long history of sexual violence and exploitation (West, 1995). As a mechanism of survival, Black women have internalized the Strong Black Woman (SBW) schema, which emphasizes strength, resilience, and self-sacrifice (Beauboeuf-Lafontant, 2009; Davis & Jones, 2021).

While empowering in many ways, the SBW schema also has negative effects on the health of Black women (Abrams et al., 2014; Anyiwo et al., 2022; Woods-Giscombe, 2010). Black women who internalize the SBW schema experience issues related to their psychological and physical health (Abrams et al., 2019; Woods-Giscombe, 2010). Given that sexual health encompasses physiological functioning and psychological aspects of one's overall well-being (Kinghorn G, 2001), it is likely that the SBW schema also impacts sexual health.

Sexual health is multifaceted and is inclusive of identity, desires, and behaviors (WHO, 2006). Influenced by biopsychosocial and cultural factors, sexuality is a dynamic part of who we are. Deeply tied to our mental and physical health, sexual health is inclusive of sexual functioning, which is an important aspect of overall well-being (Owolabi et al., 2024). Sexual functioning is the ability to engage in sexual experiences that are pleasurable and free from infirmity (WHO, 2006). When sexual functioning is compromised, it can negatively impact mental health and relationship satisfaction (Thorpe et al., 2024). Women experience a range of physical, emotional, and psychological elements that contribute to their sexual experiences. Additionally, Black women also navigate their sexuality within the context of the complex intersectionality of race and gender (Pascoe & Smart Richman, 2009; Williams & Mohammed, 2013).

The intersection of race and gender is central to understanding the experiences of Black women, whose realities cannot be fully understood through either racism or sexism alone (Collins, 2019; Crenshaw, 1989). Rather, Black women navigate overlapping systems of oppression that shape their experiences of discrimination and marginalization (Collins, 2000). These interlocking systems expose Black women to racialized gender discrimination and chronic stressors that impact their well-being (Crenshaw, 1991; Woods-Giscombe, 2010). In response to these conditions, as a means of coping with the stress of discrimination and marginalization, Black women have developed the Strong Black Woman (SBW) schema as a culturally-specific strategy of coping. (Beauboeuf-Lafontant, 2007; Woods-Giscombe, 2010). The SBW schema reflects societal expectations that Black women must be strong, endure hardship without expressing vulnerability, prioritize the needs of others over their own, suppress emotions, and be

resilient (Beauboeuf-Lafontant, 2007). While this schema can serve as a source of empowerment and survival, it is also associated with emotional suppression, psychological distress, and health-compromising behaviors (Woods-Giscombe, 2010). Understanding the SBW schema is critical when exploring how Black women navigate their overall well-being, which includes sexuality.

Research has shown that Black women who internalize the SBW schema experience negative effects on their overall well-being (Woods-Giscombe, 2010). Well-being includes both physical and mental health; sexual health exists at the intersection of these two domains (Kinghorn, 2001). Sexual health encompasses sexual functioning, which can be affected by both psychological and physical factors. Sexual functioning is compromised when a person experiences issues related to the sexual response cycle that cause distress. While sexual dysfunction impacts all genders, women tend to experience higher rates of issues related to sexual functioning.

Additionally, studies have found that Black women experience sexual dysfunction at higher rates than their White counterparts (Chapa et al., 2020; Laumann et al., 1999). Emerging research has begun to explore the complexities of Black women's sexuality, examining the ways in which sociocultural factors may shape their sexual experiences and expressions. For example, emotional silencing, resilience, and the prioritization of other's needs can often lead to sexual passivity where Black women are reluctant to express their needs, initiate sexual activity, or openly communicate about sexual concerns (Dogan et al., 2022). Moreover, the pressure to appear strong can make it difficult to seek help for sexual health problems. Additionally, many Black women hesitate to talk about issues like pain during sex, sexual dysfunction, or emotional distress related to intimacy

for fear that their vulnerability will be seen as weakness (Dogan et al., 2022). While there is some beginning evidence of the connection between Black women's sexuality and sociocultural factors, research has yet to definitively answer the question: "What are the factors that cause Black women to have higher rates of sexual dysfunction?" Given that Black women have unique experiences related to the intersection of their gender and race, which has resulted in the internalization of the SBW schema, it is important to consider whether the internalization of that schema has influenced sexual functioning in the same way it is known to have negatively impacted physical and mental health. To answer this question, this study aims to explore the relationship between sexual dysfunction in Black women and the internalization of the SBW schema.

Conceptual Framework

The intersectionality framework guides this dissertation as a critical lens for understanding the complexity of Black women's experiences. Black women cannot be understood from a single lens, such as race or gender (Collins, 2019). Using the lens of intersectionality, Black women encounter overlapping systems of oppression that impact their lived experiences (Crenshaw, 1991). Intersectionality emphasizes that Black women's experiences are not additive but rather unique in that they occur at the intersection of multiple marginalized identities. Therefore, applying an intersectional lens in this study allows for a nuanced examination of how culturally-specific responses to systemic oppression, discrimination, and other culturally-based stressors influence the sexual health and functioning of Black women. My dissertation study used a quantitative approach to explore the relationship between the racialized gendered expectations of Black women and sexual dysfunction.

Positionality

I am a Black woman. As a Black woman doing research that involves Black women, my positionality plays a crucial role in the process and conceptualization of this study. I openly acknowledge that my identity, which is influenced by the intersection of race, gender, and culture, impacts how I approach this research, interpret the findings, and engage with the community I wish to learn more about (Milner, 2007). My positionality requires me to be aware of potential biases that may arise based on my beliefs, values, personal experiences, and identity. As a result, I had to reflect on how my experiences as a Black woman, shaped by transgenerational messaging, historical trauma, and societal pressures such as the SBW schema, inform the way that I understand both the resilience and the vulnerabilities of others. I honor and recognize that my lived experiences provide invaluable context and insight, which also necessitates the ongoing need for self-reflection to ensure that my research remains objective and sensitive to the diverse experiences of Black women.

In the role of researcher, I am committed to reflexivity and regularly questioning how my identity, background, and perspective influence my interactions with the data. Quantitative research involves measuring variables and testing hypotheses, which is objective and less reliant on the researcher's interpretation. However, my subjectivity can affect the research design, data analysis, and interpretation of the data (Milner, 2007). As such, I set aside any assumptions that I may have had about the relationship between the internalization of the SBW schema and sexual functioning and approached the data openly, testing the hypotheses without bias.

Definition of Key Terms

This dissertation used key terms that are important to understanding Black women's experiences related to sexual functioning. The key terms are "Black," "woman," "Black woman," "schema," "internalization," "sexual dysfunction," and "SBW schema."

Black- For this dissertation, the term Black is used as it pertains to the African diaspora. This definition includes individuals of African descent, regardless of their geographic location or specific cultural background.

Cisgender Woman- Cisgender woman is defined as a person who was assigned female at birth and whose gender identity aligns with that assigned sex.

Black woman- A Black woman is defined as an individual of African descent, regardless of geographic location or specific cultural background.

Schema- Made up of cognitions and sensory information, a schema is a mental framework that people use to interact with the world based on lived experiences (Howarth et al., 2014). "Thus a schema constitutes the basis for screening out, differentiating, and coding the stimuli that confront the individual" (Beck et al., 1979, p. 13) to help them understand themselves in relation to others and the world and determine if threats exist (Howarth et al., 2014).

Internalization- unconscious assimilation of ideas, attitudes, and/or feelings of others, to the extent that they become embedded in a person's value system and identity (APA, n.d.).

Sexual dysfunction- persistent sexual problems during any phase of the sexual response cycle that cause distress

Strong Black Woman schema- A psychological framework internalized by Black women that dictates that they be strong, independent, self-sacrificing, and capable of enduring hardship without showing vulnerability or seeking help (Woods-Giscombe, 2010).

Research Questions and Hypotheses

The following research questions and hypotheses will be used to analyze the relationship between the SBW schema and sexual dysfunction in Black women.

1. To what extent is the internalization of the SBW schema associated with sexual dysfunction in Black women?
    a. H_0: There is no significant association between the internalization of the SBW schema and sexual dysfunction in Black women.
    b. H_1: There is a significant association between the internalization of the SBW schema and sexual dysfunction in Black women.
2. Is a higher level of SBW schema internalization related to an increased likelihood of specific sexual dysfunction in Black women?
    a. H_0: There is no significant relationship between the level of internalization of the SBW schema and the likelihood of specific sexual dysfunctions in Black women.
    b. H_1: A higher level of internalization of the SBW schema is significantly related to an increased likelihood of specific sexual dysfunction in Black women.

CHAPTER TWO
LITERATURE REVIEW

Problems with sexual functioning impact over 35% of the population (Pereira et al.,2013; Shaeer & Shaeer, 2012). Sexual dysfunction refers to a range of persistent difficulties that individuals experience in one or more phases of the sexual response cycle, which include desire, arousal, plateau, orgasm, and resolution (Ross, 2024). Overall, sexual dysfunction encompasses various forms of sexual problems and psychological distress related to sexual functioning. Common sexual dysfunctions include pain with penetration, low sexual desire, and problems with erection and orgasm. These difficulties can manifest in various forms and impact both men and women. This dissertation uses the terms "men" and "women" to align with the research data referenced, though it is recognized that gender exists beyond a binary framework.

Notably, sexual dysfunction impacts men and women differently (Laumann et al., 1999; Ross, 2024). Women report high rates of hyposexual desire (Chapa et al., 2020; Laumann et al., 1999, Shifren et al., 2008), while men report high rates of sexual issues concerning penis functioning (Gray et al., 2018). Overall, sexual dysfunction impacts both genders but is more prevalent for women (Laumann et al., 1999). In general, female sexual dysfunction (FSD) is a common problem for women, with studies demonstrating that most women experience at least one issue related to FSD in their lifetime (Bortolami et al, 2015; Cerentini et al., 2023; Zheng et al., 2020). Chapa et al. (2020) studied the prevalence of sexual dysfunction in women 18 to 29 years of age in a university setting. The study supported the high prevalence of sexual dysfunction in young women. Furthermore, the study found that Black women, specifically, were noted to have a higher

risk of experiencing FSD than other women (Chapa et al., 2020). This finding is consistent with the data from the National Health and Social Life Survey (NHSLS) study that noted Black women tend to have higher rates of low sexual desire and experience less sexual pleasure than their white counterparts (Laumann et al., 1992; Laumann et al., 1999).

It is interesting to consider why Black women tend to have higher rates of sexual dysfunction than other racial groups. In an emerging area of research on sexuality, Crooks et al. (2023) found that Black women may be socialized to internalize sexuality differently from other women. Specifically, Crooks et al. (2023) found that Black women internalize the Strong Black Woman (SBW) schema early in life, and this schema informs their sexual development.

The SBW schema developed during the chattel enslavement of African Americans. It served as a mechanism of survival and control within the context of the systemic oppression and exploitation of Black women. The schema compels Black women to be resilient, independent, self-sacrificing, and capable of enduring significant hardships without showing vulnerability or seeking support (Beauboeuf-Lafontant, 2009; Harris-Perry, 2011; Walker-Barnes, 2014; Woods-Giscombe, 2010). The *Strong Black woman* believes she should manage multiple roles and responsibilities, including those related to family, work, and community, all while remaining stoic and unyielding in the face of adversity. From a young age Black women are socialized to internalize the SBW schema, which shapes their identity development (Beauboeuf-Lafontant, 2009; Woods-Giscombe, 2010).

While the SBW schema may initially appear positive, it can have detrimental effects on the mental, physical, and emotional well-being of Black women (Leath et al., 2020; Woods-Giscombe, 2010). The SBW schema can lead Black women to disregard their own needs and prioritize the needs of others (Crooks et al., 2023). It can also lead to pressure to constantly prove oneself, reluctance to seek help (Beauboef-Lafontant, 2009; Romero, 2000; West et al., 2016), and the internalization of stress without appropriate coping mechanisms (Crooks et al., 2023).

Regarding sexuality, Crooks et al. (2023) found that Black women who internalize the SBW schema expect themselves to have strength, resilience, and emotional fortitude, which may lead them to suppress and disregard their own sexual needs (Dogan et al., 2022). For example, Dogan et al. (2022) found that Black women often do not disclose their experience of FSD to their partners because they prioritize their partner's pleasure over their own. Moreover, the SBW schema may lead to stress and burnout, which can adversely affect sexual functioning (Crooks et al., 2023). Internalizing the SBW schema may be one reason Black women are more susceptible to sexual dysfunction.

Indeed, it makes conceptual sense that the internalization of the SBW schema would impact sexual functioning. Black women who internalize the SBW schema experience negative impacts on their health, namely their emotional, mental, and physical health (Bellinger et al., 2015; Woods-Giscombe, 2010; Thomas et al., 2022). Physical health consists of both the physical state of the body and its ability to function (WHO, 2006). Considering that physical health is negatively impacted by the internalization of the SBW schema (Bellinger et al., 2015; Woods-Giscombe, 2010; Thomas et al., 2022),

and sexual health is connected to physical health, it is reasonable to suppose that the SBW schema may be associated with the sexual health of Black women. In fact, it may impact sexual health in multiple ways. Upholding the image of strength and resilience may deter Black women from seeking help or support for sexual health concerns (Dogan et al., 2022; Malone et al., 2022). The pressure to fulfill caregiving roles may strain relationships (Crooks et al., 2023), affecting sexual dynamics and satisfaction. Additionally, the normalization of stress and trauma inherent in the schema may manifest in sexual difficulties, such as lack of pleasure and reduced libido (Chapa et al., 2020; Crooks et al., 2023; Laumann et al., 1999). In this regard, Crooks et al. (2023) found that the endorsement of always being strong and resisting vulnerability restricts Black women from engaging in the "emotional connectedness…" and "the vulnerability associated with having sex" (p. 1396).

While there is some beginning evidence that there may be a relationship between the internalization of the SBW schema and FSD in Black women (Thorpe et al., 2024), the precise relationship is unknown. Therefore, to add to these beginning findings, my study will conduct a comprehensive quantitative analysis of the relationship between the SBW schema and sexual dysfunction in Black women. Theoretically, this study will help to gain an understanding of the conceptual relationship between specific aspects of the SBW schema and sexual dysfunction in Black women. On a practical level, investigating the relationship between the SBW schema and sexual dysfunction has the potential to inform treatment. Specifically, understanding the relationships between the SBW schema and FSD may inform the development of targeted interventions and support systems to address the unique sexual health needs of Black women.

Sexual Dysfunction

Sexual problems within the DSM-5-TR (APA, 2022) are classified into three categories: sexual dysfunction, paraphilias, and gender identity disorders. When individuals experience problems in one of the three areas, they have a sexual health problem. For the purpose of this section, the focus is sexual dysfunction. Sexual dysfunction impacts a large portion of the population (Laumann et al., 1999; Shrifen et al., 2008). Over 35% of people experience sexual dysfunction (Laumann et al., 1999; Shrifen et al., 2008). In the last ten years, that number has increased, with 45% of women and 38% of men reporting having experienced sexual dysfunction (Pereira et al., 2013; Shaeer & Shaeer, 2012). According to Halvorsen and Metz (1992), 75% of cisgender women and at least 50% of cisgender men report difficulties with sexual functioning in their lifetime. Moreover, the rates of sexual dysfunction are reported to be similar for transgender, non-binary, and genderqueer individuals (Bhurga & Colombini, 2013). With such high rates of sexual dysfunction, sexual well-being is often impacted.

Sexual well-being is multidimensional and essential to the human experience (Kahn & Gunasekaran, 2019; Kinghorn, 2001; Lewis et al., 2024). While distinct from sexual health, it is inclusive of a person's ability to independently manage their sexual health, achieve sexual satisfaction, and experience sexual pleasure (Lewis et al., 2024). Sexual well-being is not merely the absence of sexual dysfunction (World Health Organization, 2024) but the ability to actively participate in the sexual response cycle. Sexual well-being is associated with overall well-being (Sathyanarayana Rao et al., 2024). Therefore, sexual functioning is a critical part of sexual well-being.

Sexual function is defined as problematic when a person encounters one or more of the following: difficulties initiating sex, consummating a sexual relationship, or experiencing sexual pleasure (Kahn & Gunasekaran, 2019). This impairment is characterized by an inability to engage effectively with the sexual response cycle, leading to various types of sexual dysfunctions (Kahn & Gunasekaran, 2019; Ross, 2024). Furthermore, to be considered a sexual dysfunction, the Diagnostic and Statistical Manual of Mental Disorders (5th ed revised.; DSM–5-TR; American Psychiatric Association, 2022) requires that a person have difficulty responding to adequate sexual stimuli for at least six months. Sexual dysfunctions can be acute or lifelong. That is, sexual dysfunctions may be present since a person first became sexually active or they may be short-term reactions to particular situations or life circumstances. Additionally, certain sexual dysfunctions may be generalizable across situations, while others may be situational, specific to a person, situation, or particular type of stimulation (APA, 2022).

Research has identified over 200 reasons why individuals engage in sex, including bonding and connection, expressing love and care, experiencing pleasure, reproduction, stress reduction, and improved health (Gianotten et al., 2021; Meston & Buss, 2007). Therefore, when sexual functioning is compromised, it can lead to personal distress, relationship issues, and a negative impact on well-being (Kahn & Gunasekaran, 2019; Rosen & Merwin 2019). For example, individuals experiencing low sexual desire may experience personal distress, such as anxiety, thoughts of worthlessness, and depression (Kalmbach et al., 2012, Kennedy, 1998). Relationship issues may also result from a lack of understanding or awareness of a sexual health issue. For example, a person may

personalize a lack of sexual interest from a partner because they may misinterpret the lack of interest to mean that their partner is not attracted to them, when actually the partner might be suffering from low sexual desire. Mental, sexual, emotional, and physical health are interconnected with general well-being. As such, distress in one or more areas may have a negative impact on overall well-being.

Sexual Dysfunction Disorders

The DSM-5-TR (APA, 2022) classifies sexual dysfunctions into four main categories: desire/interest disorders, arousal disorders, pain disorders, and orgasm disorders (Gunasekaran & Kahn, 2019). Desire/Interest disorders manifest as a lack of interest or desire in sexual activity, even when adequate stimuli are present. Arousal disorders involve a physiological inability to become sexually aroused despite the presence of appropriate stimuli. Pain disorders entail experiencing pain during sexual activity or its anticipation. Lastly, orgasm disorders are characterized by either the absence of orgasm, anorgasmia, or an inconsistent ability to achieve orgasm. These categories provide a framework for understanding the diverse ways in which sexual dysfunctions can manifest and their impact on individuals' sexual well-being.

Additionally, sexual dysfunction can be divided into disorders that impact female-bodied individuals, male-bodied individuals, and those that affect anyone. For example, erectile dysfunction is specific to male-bodied individuals, female orgasmic disorder is specific to female-bodied individuals, and desire disorders impact everyone without regard to gender. Overall, sexual dysfunction refers to issues that interfere with a person’s ability to achieve sexual satisfaction or sexual pleasure.

Desire Disorders

Sexual desire, also known as libido, is a fundamental aspect of human sexuality, characterized by the motivation or interest in sexual activity (Lakshmi & Kahn, 2019). Sexual desire is a part of the sexual response cycle. Since the sexual response cycle is non-linear (Basson, 2002), desire can arise at any point in the cycle, including before sexual stimuli are presented or after arousal. Desire disorders involve a lack of interest or desire in sexual activity despite appropriate stimuli (APA, 2022), which can result from a combination of biological, cultural, or psychological factors (Meston & Stanton, 2017). Individuals with these disorders often experience low libido and are unresponsive to sexual stimuli, both alone and with a partner. Many also report a scarcity of sexual fantasies, urges, or thoughts. The DSM-5-TR (APA, 2022) recognizes two desire disorders: male hypoactive sexual desire disorder (HSDD) and female sexual interest/arousal disorder (FSIAD).

HSDD is described as a lack of interest in sexual activity. Laumann et al. (1992) found that 15% of men had experienced HSDD in their lifetime. The rate of HSDD increases as males age, with Arajuo et al. (2002) reporting that each decade after 40 years of age, males will see a significant decrease in sexual desire. Furthermore, Wang et al. (2023) reported that males who experience HSDD report decreased sexual well-being. This decreased sexual well-being is consequential because sexual well-being is a factor that impacts overall well-being (Mitchell et al., 2021). While the exact cause of HSDD is unknown (Segraves & Balon, 2014), as it may differ by person, research suggests that several factors may contribute to HSDD.

Evidence suggests that the etiology of HSDD consists of multiple biological and psychosocial factors (Meston & Stanton, 2017). Weeks and Gambescia (2002) proposed a systemic etiological model to help further understand the cause of male HSDD. The model suggests that three components contribute to HSDD: individual, interactional, and intergenerational (Weeks & Gambescia, 2002). Individual factors include both biological and psychological factors. Biological factors that impact sexual desire can be both organic or an iatrogenic result of treatment. For example, males who have received chemotherapy may experience lower levels of testosterone and have a decreased libido (NCI, 2022). Organic factors include age, genetics, hormonal, vascular, and neurological issues (Delameter & Sill, 2005). Moreover, McCarthy and Cohn (2017) found that 90% of HSDD was secondary to other sexual dysfunctions. Interactional factors consist of interpersonal dynamics (i.e., relational factors). Intergenerational factors are messages each person inherits from their family, culture, or society that tell them how to think about and act concerning sexuality (Meston & Stanton, 2017). These factors are interwoven and impact sexual functioning, often causing performance anxiety, such as erectile dysfunction, or responsive anxiety, such as HSDD (Weeks & Gambacia, 2002).

Low sexual desire, clinically referred to as Female Sexual Interest/Arousal Disorder (FSIAD), represents a significant challenge for many women. FSIAD encompasses both desire and arousal issues, but for this section, the focus will be solely on sexual desire, as Basson (2002) noted that sexual interest and arousal are relatively indistinct.

Research indicates that low sexual desire is the most prevalent sexual dysfunction among women (Shrifen et al., 2008), with over 27% of women reporting low sexual desire at some point in their lives (Laumann et al., 1999). One of the most well-known reasons for low sexual desire is age (Lakshmi & Kahn, 2019). As women age, their levels of hormones such as estrogen and testosterone decrease, negatively impacting their desire to be sexually active (Lakshmi & Kahn, 2019). Another significant factor is the menstrual cycle (Lakshmi & Kahn, 2019). Sexual desire fluctuates throughout the menstrual cycle, with women experiencing the most interest at the time of ovulation (Maruccia & Maurizi, 2017). Other factors influencing sexual desire are sociocultural, biological, and psychological (DeLamater & Sill, 2005).

Biological factors include responses to medications or chronic illnesses, such as endometriosis or pregnancy. Psychological factors typically include stress, relationship distress, or a history of abuse. Sociocultural factors are comprised of intergenerational messages, societal pressures, and intersectionality. As in males, biological, psychological, and sociocultural factors are often interwoven, and one or multiple factors can cause sexual dysfunction in females (Lakshmi & Kahn, 2019). Low libido in women may have an impact on their sexual health and overall well-being. Moreover, low sexual desire can lead to various adverse outcomes, including relationship dissatisfaction, emotional distress, and diminished quality of life, as there is a direct link between mental well-being and sexual quality of life (Ovesis, 2022). Low sexual desire is also known to be comorbid with sexual arousal difficulties.

Arousal Disorders

Chivers (2005) defines sexual arousal as a psychological and physiological sexual response to sexual stimuli, with the relationship between the two being bidirectional. Physiological arousal is inclusive of genital reactions, such as erection or lubrication. Psychological arousal is described as subjective, emotional, and experiential (Basson, 2002; Handy et al., 2018; Meston & Stanton, 2017). Overall, psychological arousal occurs when a person physically, emotionally, and mentally responds to internal or external sexual stimuli (Vandervoort, 2024). Moreover, sexual arousal is not solely a physical response; it is also influenced by psychological factors, such as stress, anxiety, mood, and interpersonal relationships. Psychological arousal, which includes cognitive and emotional aspects, can significantly impact physical arousal and overall sexual functioning. For instance, chronic stress or negative body image can inhibit sexual arousal, leading to sexual dysfunctions.

Sexual arousal is unique in that it can be triggered by pleasant and unpleasant sexual and non-sexual stimuli (Vandervoort, 2024). Pleasant stimuli do not cause subjective harm or distress and include positive sexual cues. Unpleasant stimuli are stimuli that are ordinarily perceived as unpleasant or potentially harmful. Although these unpleasant stimuli are ordinarily perceived as harmful, some people may be sexually aroused by unpleasant stimuli. For example, research has found that certain females have arousal responses to unpleasant stimuli, such as video scenes related to sexual assault (Suschinsky & Lalumiere, 2011; Vandervoort, 2024).

Arousal is activated by several areas in the brain, namely the hypothalamus, anterior cingulate cortex, and the amygdala, which are all a part of the limbic system (Maruccia & Maurizi, 2017). These brain regions are crucial in processing emotions, stress responses, and reward pathways, thereby influencing sexual arousal and desire. The hypothalamus plays a vital role in regulating hormonal responses and is pivotal for maintaining homeostasis in the body. It regulates the release of sex hormones, which are essential for sexual functioning and arousal. The anterior cingulate cortex is involved in emotional regulation and decision-making processes, while the amygdala is critical for emotional processing and the formation of emotional memories. These regions collectively contribute to the complex experience of sexual arousal (Maruccia & Maurizi, 2017).

Arousal is a significant part of the sexual response cycle and can impact sexual functioning. The sexual response cycle is comprised of four main phases: excitement, plateau, orgasm, and resolution. Arousal primarily occurs during the excitement and plateau phases, where increased blood flow to the genital area, elevated heart rate, and heightened sensitivity to sexual stimuli are observed. Many factors can impact arousal.

Sexual arousal can be impacted by both mental and physical health. The Sexual Tipping Point model (STP model) indicates that mental and physical (MAP) health can impact sexual excitation or inhibition (Perelman, 2016). The STP model highlights that a person’s sexual response is a function of a person's biological ability and other factors, such as cultural influences, health, and psychological well-being. Furthermore, the model suggests that stimuli activating and inhibiting sexual arousal exist simultaneously, and a

person's response depends on which stimuli elicit a stronger reaction (Pahwa & Foley, 2017). The stimuli can be positive, which will encourage sexual response, or negative, which decreases the likelihood of sexual response. A person's sexual tipping point is then determined by considering both negative and positive stimuli. Overall, sexual arousal is dependent on many factors working together to produce an appropriate and desired outcome to sexual stimuli.

Because the biological make-up of men and women are different, they experience sexual arousal differently as it relates to genital reactions. For men, the primary focus of sexual dysfunction related to sexual arousal is erectile functioning. For women, arousal issues may include a lack of erect tissue in the vulva or issues with the vaginal canal becoming lubricated. Arousal is a significant part of the sexual response cycle and can impact the ability to have satisfactory sexual intercourse (Maruccia & Maurizi, 2017). There are two recognized sexual arousal disorders: erectile dysfunction (ED) and female sexual interest/arousal disorder (FSIAD) (APA, 2022).

Erectile dysfunction (ED) is one of the most prevalent sexual dysfunctions among men (Feldman et al., 1994; Laumann et al., 1992; Rosen, 2000). ED is characterized by an inability to get or maintain a penile erection that is sufficient for sexual penetration (Gunasekaran & Kahn, 2019; APA, 2022). Although often unreported, ED probably impacts at least 150 million men and is predicted to affect at least 150 million more by the year 2025 (Gunasekaran & Kahn, 2019). Nearly half of all men will have experienced ED by 50 years of age, with that number continuing to increase with age (Inman et al.,2009).

ED has many precipitating factors that are similar to hypoactive sexual desire disorder [HSDD]. While causal factors have been previously discussed, ED is also known to be caused by diseases like diabetes and cardiovascular disease (Gunasekaran & Kahn, 2019). This means that those diagnosed with high blood pressure, heart disease, or diabetes are more likely to report experiences of ED. While there are physiological mediating factors, many studies have suggested that ED can also be caused by psychological factors that are independent of the physiological factors (Gunasekaran & Kahn, 2019).

As noted above, FSIAD encompasses issues related to sexual interest and sexual arousal in females. For this section, the focus will be sexual arousal. Sexual arousal is a physiological response to sexual stimuli, which can be internal or external. Sexual arousal can be in response to thoughts and fantasies or visual or auditory stimuli. Less common than low libido for women, sexual arousal has been found in 19%-27% of women reporting a lack of erection, blood flow to the vulvovaginal region that causes the labia and clitoris to be erect, or filled with blood, and trouble lubricating (Lauman et al., 1999; Shifren et al., 2008). As with sexual interest, sexual arousal is known to decline with age for females (APA, 2022). Additionally, when sexual arousal is negatively impacted, difficulty orgasming may also be present.

Orgasmic Disorders

Orgasmic disorders are characterized by a lack of control over orgasms. Examples include an inability to achieve orgasm, decreased intensity of orgasms, or having an orgasm before the desired time. The DSM-5-TR (APA, 2022) outlines five factors that

contribute to orgasm disorders. These factors include a partner's level of sexual functioning, relationship issues, the presence of other sexual dysfunctions or psychological issues, and medical problems (APA, 2022). The DSM-5-TR orgasmic disorders are premature ejaculation (PE), delayed ejaculation (DE), and female orgasm disorder (FOD) (APA, 2022).

Premature Ejaculation (PE) is a common problem in men (Laumann et al., 1992). It is defined as an inability to intentionally delay ejaculation (APA, 2022). Additionally, to qualify for the disorder, the lack of control over ejaculation must cause significant clinical distress. Rosen (2000) found that 36% of men experienced difficulty and distress related to PE. PE tends to increase as men age (McCarthy & Cohn, 2017).

PE is most commonly thought to be caused by psychological factors such as stress, low self-esteem, and anxiety (Pahwa & Foley, 2017). However, research has found that PE can be caused by a lack of opportunities to have intercourse, certain religious beliefs, and societal messaging, as well as gender role expectations and pressure to perform (Pahwa & Foley, 2017). Multiple factors may cause PE. For example, a person might experience PE because of low self-esteem as a singular factor or due to a combination of stress and negative societal messaging about sex.

Delayed Ejaculation (DE) is an ejaculation disorder that can impact sexual functioning and fertility (Natarajan & Khan, 2019). Of all male sexual dysfunctions, DE is the least prevalent and most difficult to diagnose. Between 1% and 4% of males report being impacted by DE (Natarajan & Khan, 2019). DE is known as an inability to orgasm, or a significant delay in orgasm, with the presence of arousing sexual stimuli (APA,

2022). Waldinger et al. (2005) defined delayed ejaculation as taking longer than the average 5-10 minutes to ejaculate, specifically when it takes 20-30 minutes or more beyond the desired time. While delayed ejaculation occasionally happens to many men, the diagnosis of DE is reserved for men who experience a persistent problem with delayed ejaculation and related distress.

While an exact cause has yet to be identified, researchers suggest that DE may stem from psychological and physical factors (Fiala et al., 2022; Natarajan & Khan, 2019). Psychological factors, such as response anxiety, relationship issues, or past traumatic experiences, can contribute to DE. In contrast, physical factors may include the use of selective serotonin reuptake inhibitors (SSRIs), diabetes, or spinal cord injury (Natarajan & Khan, 2019).

Moreover, there is evidence linking DE with antidepressant use, as men taking an antidepressant may struggle with DE at a higher rate than the general population. In a study involving 50 male participants diagnosed with depression, all of whom received treatment with an antidepressant for at least 24 weeks, DE was observed in all participants and reported to have a significant impact on their quality of life (Fiala et al., 2022). The mentioned study highlights the intricate interplay between mental health and sexual functioning, particularly how the use of antidepressants can impact DE. Moreover, the study emphasizes the significant effect DE has on the quality of life for men undergoing treatment for depression and underscores the importance of addressing both mental health and sexual health in the management of DE.

Female Orgasmic Disorder (FOD) is the second most prevalent sexual disorder for females (Brody, 2017). Defined as a delay in orgasm, an inability to achieve, or significantly decreased intensity/sensation of orgasms (APA, 2022; Halvorsen & Metz, 1992), FOD has an impact on at least 20% of premenopausal women with the numbers increasing for postmenopausal women (Brody, 2017). Furthermore, women who experience nonvoluntary childlessness are at high risk for experiencing FOD (Lara, 2017). It is important to consider the orgasmic trigger when discussing FOD. Approximately 70% of women orgasm through clitoral stimulation, whereas approximately 30% orgasm from coitus (Nagoski, 2015). Considering the orgasmic trigger for a particular woman is important to best understand how the woman is being impacted and what treatment model might be most effective (Brody, 2017).

FOD is impacted by physiological factors, psychological factors, and relationship distress (Halvorsen & Metz, 1992; Maruccia & Maurizi, 2017). Physiological factors can consist of chronic illness, pregnancy, reactions to medications such as anxiolytics or antipsychotics, or hormonal issues (Brody, 2017; Halvorsen & Metz, 1992). Studies have also found a myriad of other factors that are associated with FOD. For example, women who had healthy contact with their fathers had a greater chance of being orgasmically triggered by penis-in-vagina (PIV) intercourse, as opposed to direct clitoral stimulation, than women who did not have healthy contact with their fathers (Brody, 2017). In contrast, women who reported having been sexually abused were less likely to be orgasmic regardless of the trigger (Brody, 2017).

Sexual Pain

The DSM-5-TR (APA, 2022) has one diagnosis specific to sexual pain: Genito-Pelvic Pain/Penetration Disorder (GPPPD). GPPPD is specific to females and is characterized by difficulties with vaginal penetration, marked vulvovaginal or pelvic pain during intercourse or penetration attempts, fear or anxiety about pain in anticipation of, during, or as a result of vaginal penetration, and tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (APA, 2022). Sexual pain is often comorbid with FSIAD or FOD, as sexual pain can distract from pleasurable sexual interactions. GPPPD highlights the interplay between physical and psychological factors in sexual functioning, as the pain experienced can further exacerbate anxiety and avoidance behaviors, creating a cycle of distress that impacts overall sexual health and well-being (Chisari, 2021).

While less talked about in the literature than other sexual disorders, GPPPD affects approximately 15% of women presenting for gynecological care (Graziottin & Gambini, 2017). Many physicians attribute GPPPD to psychological factors when, in fact, there is evidence to suggest that biological factors may contribute (Graziottin & Gambini, 2017). Additionally, GPPPD is often comorbid with other sexual dysfunctions, such as FSIAD. Often under-treated and under-diagnosed, GPPPD is complex due to its multifaceted nature, involving physical, psychological, and relational factors that contribute to the pain and difficulty experienced during vaginal penetration. Its prevalence varies significantly based on cultural factors, highlighting the importance of considering sociocultural influences in understanding and addressing this condition

(Lakshmi & Khan, 2019). GPPPD can have profound effects on women's emotional and sexual well-being, often leading to distress, anxiety, and diminished quality of life. Moreover, the impact extends beyond the individual, affecting intimate relationships and interpersonal dynamics. Partners of individuals with GPPPD may also experience challenges in understanding and coping with their loved one's condition, potentially straining the relationship further or contributing to sexual dysfunction, such as low sexual desire in the partner of the person suffering from GPPPD (Pawha & Foley, 2019).

In conclusion, sexual dysfunction is influenced by multiple factors, including religion, geographic location, race/ethnicity, sociocultural factors, and the intersecting identities a person holds (Reddy, 2019). However, there are notable differences in the prevalence and types of sexual dysfunctions reported among genders (Laumann et al., 1999). While both genders commonly experience sexual dysfunctions that cause distress and significantly negatively impact their quality of life, the specific manifestations may vary. For men, the primary focus of sexual dysfunction is related to sexual arousal. Men often report higher rates of arousal disorders compared to women (Laumann et al.,1999; Shrifen et al.,2008). Typically, this involves difficulty achieving or maintaining an erection, which can lead to performance anxiety, feelings of inadequacy, and other psychological issues. Whereas women report higher rates of desire, orgasm, and pain disorders, all of which directly impact sexual functioning and sexual pleasure. Overall, sexual dysfunction impacts women at a greater rate than men (Laumann et al., 1999) and can be influenced by multiple factors.

Black Women and Sexual Health

FSD is common and affects more than 50% of women during their lifespan (Sood et al., 2024; Zheng et al., 2020). FSD is characterized by consistent, persistent, and distressing sexual dysfunction symptoms (Cerentini et al., 2023; Sood et al., 2024) that impact the sexual response cycle over at least six months (APA, 2022). These symptoms can encompass a wide range of issues, including low sexual desire, arousal difficulties, inability to achieve orgasm, and pain during intercourse.

Various factors contribute to FSD in women. These factors are often interconnected and can vary significantly from one individual to another. Vignozzi (2017) discussed five factors that impact FSD: psychological factors, sociocultural factors, relational factors, sexual history, and biological factors. Psychological factors are a woman's views of self, body image, and mental health (Halvorsen & Metz, 1992; Maruccia & Maurizi, 2017). Additionally, societal and cultural expectations regarding gender roles and sexuality can shape women's sexual experiences and contribute to dysfunction (Crooks et al., 2023). The internalization of these roles and norms can create pressure and stress, leading to sexual difficulties (Thorpe et al., 2023). Relationship satisfaction also plays a crucial role in sexual function (Brotto, 2018). Issues such as communication problems, lack of emotional intimacy, and unresolved conflicts can lead to or exacerbate FSD. Furthermore, biological factors such as hormonal changes, medical conditions, and the side effects of medications can all contribute to FSD. Lastly, previous sexual experiences, sexual education, and sexual trauma can influence current sexual functioning.

While 50% of women will have had at least one experience with FSD during their lifetime (Zheng et al., 2020), FSD rates vary based on race (Laumann, et al.,1999). For example, a lack of interest in sex was found to impact 44% of Black women compared to 29% of white women and 30% of Hispanic women (Laumann, et al.,1999). Additionally, anxiety to perform, anorgasmia, and lack of pleasure during sex were reported at higher rates among Black women than among women of other racial groups (Laumann et al., 1999). The disparities listed above suggest that cultural, social, and possibly economic factors may play a role in sexual functioning for Black women. The higher prevalence of sexual dysfunction in Black women may be linked to the historical trauma experienced by Black women that is connected to the intersection of gender and race. Black women have endured racialized gender discrimination, which has likely led to stress as well as decreased access to healthcare and sexual education.

Historical Development of Black Women's Sexuality

To better understand racial differences, it is helpful to understand the historical development of Black women's sexuality in the context of systemic oppression and cultural stereotypes. Historically, Black women had no control over their bodies due to the legacy of the enslavement of Black people, which has shaped how Black women perceive and experience their sexuality. As a result of gendered racism during chattel enslavement, Black women's sexuality has been both hypersexualized and devalued. These historical factors, while shaping societal views of Black women's sexuality, have impacted Black women's experience of sexual health, sexual autonomy, and sexual freedom.

1619-1865

From 1619 until 1865, the enslavement of Africans and African Americans was a legal institution that impacted the community and economy of the United States of America. Black women were indeed considered property and a commodity in America. The intersection of race, gender, and social status placed Black women in a unique and oppressive position, where their bodies, labor, and reproduction were controlled and exploited by the dominant culture. The institution of chattel enslavement not only denied Black women their humanity and rights but also subjected them to dehumanizing treatment and relentless labor, both in the plantation fields and within the domestic sphere. As a result, the legacy of enslavement has significantly shaped the experiences and perceptions of Black women's sexuality in the United States.

During chattel enslavement, Black women were enslaved and separated from their husbands and children as a form of control (Prather et al., 2018). Separating Black women from their families weakened the ability of a family to bond, disrupting the ability to form healthy intimate relationships. This ensured dependence on enslavers and prevented the formation of solid or cohesive family units, as there was an assumption that the ability to be strong, supportive, and connected as a community might cause those enslaved to resist and rebel against enslavement and oppression (Prather et al., 2018). This was also disempowering as it kept Black women from being able to choose a partner and maintain relationships. Furthermore, the threat of separation was used as a psychological tool by enslavers to control Black women. This manipulative tactic naturally resulted in Black women forming fewer secure attachments for fear that a

romantic or sexual partner could be taken away at any time (Prather et al., 2018). This fear has been generationally passed down, which has arguably led to Black women having difficulties related to sexual communication, sexual passivity, trust, and the ability to have an emotional connection with an intimate partner (Avery et al., 2022; Thorpe et al., 2023). Additionally, the intentional fragmentation of the Black family and the emotional manipulation of enslavers led Black women to be submissive to oppressors to protect their families, often putting the needs of others before their own. Arguably, putting the needs of others ahead of one's own needs is a trait that has been generationally passed down among Black women. Understandably, this trait likely impacts the sexuality of Black women as they may put the sexual needs of their partner above their own needs. For instance, Black women may not disclose sexual pain to a partner and engage in sex to satisfy the needs of the partner, thereby sacrificing their own need for sexual pleasure (Dogan et al., 2022).

Since Black women were seen as property, that meant they could be traded, sold, and bought at the discretion of their enslaver, again taking away their ability to control what happened to them and their bodies (Prather et al.,2018). Black women were publicly paraded nude at auction, physically examined in the open to explore reproductive ability, and raped by enslavers (West & Johnson, 2013; Wilson, 2021). Black women were raped for pleasure and economic gain beginning in adolescence and often used as breeders to increase the enslaved population (Wilson, 2021). Moreover, they were forcibly impregnated by White enslavers (West & Johnson, 2013). At the discretion of enslavers, Black women were also given abortions by force, medically experimented on, and

provided surgeries without anesthesia (Small et al., 2023; Washington, 2012). Today, Black women experience disproportionately high maternal mortality rates, with research indicating that they are three to four times more likely to die from pregnancy-related complications than White women (Hill et al., 2022). Additionally, studies have shown that Black women's pain is frequently dismissed by healthcare providers, contributing to inadequate medical care and poorer health outcomes (Hoffman et al., 2016; Prather et al., 2018).

The trauma experienced by Black women during periods of sexual exploitation and dehumanization was both profound and immediate, significantly impacting their sense of safety, personal and sexual agency, and self-identity. This trauma has left a lasting legacy, passed down through generations of Black women (Crooks et al., 2020; Dennis & Wood, 2012).

Today, the historical objectification of Black women's bodies persists, evident in both media representations and sociopolitical contexts (Gammage, 2016). This is characterized by race-based sexual stereotypes (RBSS), which shape Black women's sociosexual behavior and influence their sexual scripts (Bond et al., 2021). These stereotypes, often depicting Black women as hypersexual, pressure them to conform to a societal script that limits their ability to assert sexual autonomy.

As a result, Black women may struggle with expressing their own needs and setting sexual boundaries, feeling conflicted or pressured to be submissive in sexual relationships (Bond et al., 2021; Dogan et al., 2022). The internalization of RBSS can make it difficult for them to navigate their own desires and agency, reinforcing patterns

of submission and reducing their capacity to maintain healthy, autonomous sexual relationships.

1865-1975

During the late 19th and 20th centuries, the rape of Black women remained widespread (West & Johnson, 2013). Even after the abolition of slavery, systemic oppression and sexual violence persisted, with rape continuing as a means of control. The lack of legal protection meant that these acts of violence often went unpunished, perpetuating a cycle of trauma, loss of sexual agency, and disempowerment (Feimster, 2009). Black women were frequently blamed for their assaults and labeled as sexually promiscuous rather than seen as survivors (Dennis & Wood, 2012). This reinforced the harmful Jezebel stereotype (Black women as hypersexual), which served as a justification for sexual violence. The absence of legal recourse further underscored the societal belief that Black women's bodies did not belong to them. This messaging likely became internalized, leading to negative impacts on Black women's beliefs and attitudes about sexual autonomy. Consequently, this lack of perceived sexual autonomy likely has an adverse impact on the overall sexual well-being of Black women (McGuire, 2011; Roberts, 1997).

The objectification of Black women also manifested in the eugenics movement. In 1897, the movement gained traction when Michigan introduced the first sterilization bill, promoting the idea that certain populations, including people of color, the impoverished, and those with disabilities, were unfit to reproduce (Lambardo, 2011). Black women were targeted at disproportionately high rates and often subjected to sterilization because

they were seen as sexually promiscuous and incapable of managing their reproduction (Roberts, 1997).

The trauma from historical sexual violence, systemic oppression, and reproductive control continues to impact Black women today, affecting their sexual functioning, health, and autonomy. Stereotypes like the Jezebel, which once erroneously served to justify exploitation, also shape Black women's interactions with the legal and healthcare systems. For example, Black women are more likely to experience sexual violence and less likely to be believed when reporting sexual assaults due to perceptions of them as sexually available and promiscuous (Schachtman & Kaiser, 2024). Moreover, stereotypes about hypersexuality also result in Black women being more frequently pressured into using long-acting contraceptives or undergoing sterilization (Roberts, 1997).

Furthermore, discriminatory practices in the healthcare system make it difficult for Black women to express vulnerability. When Black women attempt to show vulnerability, such as expressing pain or distress, they are often dismissed and not taken seriously (Dogan et al., 2023). Therefore, if a Black woman faces a sexual issue, she may hesitate to seek help for fear of being stereotyped or discriminated against. This reluctance to express vulnerability can extend into intimate relationships, where openness is essential for connection and trust. Decreased emotional vulnerability, hindered sexual communication, and a reduced likelihood of seeking support for sexual functioning are experienced by Black women as a result (Dogan et al., 2023; Harris-Perry, 2011; West,

1995). The combination of these factors increases the risk of sexual dysfunction and dissatisfaction.

Today, Black women continue to experience dismissiveness regarding their pain, histories of sexual trauma, and concerns when interacting with the healthcare system (Higginbotham, 1992). The legacy of forced sterilization and lack of reproductive autonomy has created ongoing disparities in the reporting of sexual health concerns and access to appropriate care for Black women (Prather et al., 2018; Roberts, 1997).

1975-Present

The enslavement of Africans and African Americans in the United States established a deeply oppressive social system that profoundly impacted Black women. Regarded as property, Black women endured dehumanizing treatment, including sexual exploitation, forced labor, and the complete loss of reproductive autonomy. The commodification of Black women's bodies created intergenerational trauma, perpetuating a legacy of pain and psychological distress that continues to resonate today. The consistent societal messaging conveyed to Black women has reinforced the notion that their bodies are not their own, undermining their sexual autonomy and reproductive freedom. The historical sexual trauma faced by Black women continues to shape the lived experiences of Black women, influencing their relationships, self-perception, and sexual functioning.

During the late 20th century, Black women continued to experience racial discrimination and gender inequality. While the feminist and Civil Rights movements

were prominent at the time, those movements did not directly address the unique needs of Black women. This gap gave rise to groups like the Combahee River Collective, a Black feminist group that first alluded to the concept of intersectionality in 1977 (The Combahee Collective reprise, 2019), a term later coined by Kimberlé Crenshaw to describe the interconnectedness of race and gender for Black women (Crenshaw, 1989). In 1978, the U.S. Supreme Court upheld affirmative action, which enabled Black women to have increased access to higher education. With more Black women than Black men enrolled in post-secondary institutions, Black women asserted more independence and rejected traditional roles. However, this newfound independence led to conflict with societal expectations of womanhood, which likely impacted the self-esteem and self-perception of Black women. Furthermore, research has found that Black women in higher education often prioritize their studies over their relationships and often fail to receive support, which is one of the reasons Black women in higher education may have a hard time maintaining intimate relationships (Smith, 2021).

As Black feminism rose, the crack epidemic in the Black community brought a surge in incarceration rates of Black men. Harsh sentencing laws targeted Black Americans, leading to a significant rise in imprisonment (Anderson, 2019). According to the Bureau of Justice (2021), Black men are 28.5% more likely to serve a prison sentence compared to just 4.4% of white men, with Black men being incarcerated at 5.5 times the rate of their white counterparts (Pettit & Gutierrez, 2018). This ongoing pattern of mass incarceration left many Black children growing up in single-parent households. The U.S. Census Bureau (2020) reports that more than 60% of Black households are led by a

single Black woman, a statistic that underscores the enduring legacy of racial inequity and the social consequences of mass incarceration on the Black family structure.

As the 90s approached, the conversation about race and gender was highlighted by Supreme Court Justice Clarence Thomas, who was accused of sexual harassment by Anita Hill. Her testimony in front of Congress in 1991 sparked a national discussion about the politics of race, gender, and power dynamics. Within this same decade, Kimberlé Crenshaw further developed the theory of intersectionality and emphasized how the legal aspects of criminalizing Black women often used a single-axis framework, which assumes that a person can only be discriminated against based on one identity without respect for the intersection of identities like gender and race (Crenshaw, 1991).

Beginning in 2000, the next decade brought with it both monumental successes and defeats for Black women. Michelle Obama supported her husband's political ascent and demonstrated a new ideal of Black womanhood (Harris-Perry, 2011). In many ways, Michelle Obama represented the requirement to conform to respectability politics for Black women, emphasizing the need to conform to mainstream standards of behavior, dress, and demeanor (Spiller, 2009). Conforming to the concept of respectability politics theoretically aids in avoiding discriminatory behavior and increases social acceptance by the dominant culture (Latimer et al., 2024). Adhering to mainstream social norms in this way is often done to avoid being stereotyped as ghetto, overtly sexual, or as the angry Black woman (Higginbotham, 1993). Despite adhering to these standards, former First Lady Michelle Obama was often stereotyped as angry and unpatriotic (Meyers & Goman, 2017), highlighting the failure of respectability politics to fully shield Black women from

discrimination. With Michelle Obama emerging as a prominent figure post her husband's election to the presidency in 2008, the decade saw Black women's participation in higher education increase. In 2009, Black women had the highest college enrollment rates compared to any other gender or race (National Center for Education Statistics, 2020).

Several significant events occurred in the decade following 2010 that continued to raise societal consciousness about Black issues in general and Black women in particular. In 2013, the Black Lives Matter Movement was founded by three Black women activists (Black Lives Matter, 2017). In the years that followed, intersectionality was brought to the mainstream through a highly viewed TED talk (Crenshaw, 2016), there was a push for more critical race theory in education, Black women continued to lead in higher education, and Kamala Harris was historically elected as the first Black woman in the White House. These events challenged the stereotypes attributed to Black women and highlighted a sense of resilience and community advocacy.

The previously mentioned historical events continue the themes of previous eras, which have undoubtedly had an impact on the sexuality of Black women. This emphasis on the dangers of sexual activity can be traced back to the historical context of slavery and the post-slavery era, as well as to incidents like the Anita Hill hearing, where Black women were hypersexualized and subjected to control over their bodies, leading to a generational transmission of fear and caution around sexual topics (Roberts, 1997; West & Johnson, 2006). As a result of the dangers associated with sexuality, Black women were naturally reluctant to talk openly about sexual issues for fear that they would be perceived as hypersexual and objectified as sexual objects. The objectification of Black

women has historically resulted in their victimization. Consequently, this has likely led Black women to be less vocal about their sexuality, less assertive of their sexual autonomy, and less likely to address sexual health concerns.

Furthermore, the mass incarceration of Black men left many Black mothers to raise their children in the absence of Black fathers. Due to the absence of Black fathers in the home, Black mothers were often solely responsible for providing sexual education to their daughters (Dennis & Wood, 2012). Historically, Black women have been viewed as sexual objects and hypersexual, which led to Black mothers being protective of their daughters' sexuality. Black mothers responded to the societal pressure of being hypersexualized by being reactive to sexual vulnerabilities that arose with their daughters rather than having preventative and proactive conversations about sex (Dennis & Wood, 2012; Nwoga, 2000). Therefore, generations of Black daughters learned that sexual conversations are only permissible when they warn about the dangers of sexuality. This led Black women to be reluctant to discuss sex openly, which likely prevented them from being open about and seeking help for sexual problems.

The compounded social pressure highlighted by each era has forced Black women to appear invulnerable while maintaining expectations of strength and resilience. The historical context creates an interweaving of stress, trauma, and self-silencing that likely leads to a lack of sexual agency, decreased likelihood of seeking pleasure for self, increased likelihood of putting a partner’s needs ahead of their own, and higher rates of sexual dysfunction in Black women as a result of systemic and personal socio-context.

In fact, the stressors that Black women have faced throughout their history have led Black women to adopt certain personality characteristics, which have been called the Strong Black Woman (SBW) schema. Just as the various societal pressures on Black Women have resulted in them having sexual difficulties, the SBW schema has also contributed to sexual problems in Black women. Therefore, to understand the sexual difficulties experienced by Black women, it is necessary to understand the SBW schema.

The Strong Black Woman Schema

Black women experience intersecting forms of oppression stemming from both their racial and gender identities (Crenshaw, 1989, 1991; Geyton et al., 2022). While facing oppression and adversity, Black women are expected by society to be strong, resilient, and have emotional control even in the face of hardship (Beauboeuf-Lafontant, 2009). This set of expectations is a general stereotype about Black women that is often internalized by Black women as the Strong Black Woman (SBW) schema (Davis & Jones, 2021).

The SBW schema represents a set of culturally racialized gender expectations rooted in the history of slavery. The schema is unique in that it can be considered both an essential aspect of Black women's identity and a stereotype (Jones et al., 2021). Black women's internalization of the SBW schema helps them to cope with societal oppression and discrimination and manage life stressors (Jones et al., 2021; Woods-Giscombe, 2010). Additionally, Black women who internalize the SBW schema often exhibit traits such as emotional suppression, self-sacrifice, independence, resilience, and the prioritization of others' needs over their own (Beauboeuf-Lafontant, 2007; Black &

Peacock, 2011; Thomas et al., 2022; Woods-Giscombe, 2010). The SBW schema shapes not only societal perceptions of Black women but also their self-presentation and identity. The enduring societal marginalization and discrimination faced by Black women have reinforced and perpetuated this schema over time.

The conceptual forerunner to the SBW schema was the *Superwoman Syndrome,* a term coined by Dr. Marjorie Hansen Shaevitz in 1984 (Shaevitz, 1984) to describe the societal expectation that women should be strong and capable despite significant adversity. Initially, this concept was applied broadly to women of diverse cultural and ethnic backgrounds. However, by the 1990s, the discourse shifted specifically to Black women with the introduction of the terms Superwoman schema (Woods-Giscombe, 2010) and Strong Black Woman, which have been described as a myth, stereotype, ideal, or schema (Golden, 2021; Thomas et al., 2022). When used in a psychological context, the Strong Black Woman construct is referred to as a "schema" because Black women use it as an internalized, psychological template to navigate the world. Although the Strong Black Woman is also a stereotype, the focus of my research is on the psychological internalization of this stereotype by Black women and how it impacts their sexual functioning. Therefore, I focus my research on the Strong Black Woman schema.

The SBW schema consists of three fundamental characteristics: strength, independence, and caregiving (Leath et al., 2023; Liao et al.,2020; Jones et al., 2021). Strength is often demonstrated through exaggerated independence, prioritizing success, resilience, and the suppression of emotional needs (Parks & Hayman, 2024; Thomas et al., 2022). Black women adhering to this schema may feel compelled to present a facade

of invulnerability, even in the face of significant stress or adversity. In a study completed by Jones et al. (2021), which focused on Black women in the U.S. in a college setting, the characteristic of strength was endorsed as being important to their identity. This emphasis on strength can result in an internalized belief that expressing vulnerability is a sign of weakness. Historically, Black mothers emphasized strength as a part of development to equip Black daughters to respond to various types of oppression and to teach them to keep their families together (Jones et al., 2021).

Independence, particularly as manifested in perfectionism, a focus on career advancement, and a refusal to seek help (Geyton et al., 2022; Liao et al.,2020), is a key element of the SBW schema. For Black women, independence stems from a need to maintain control because circumstances in the lives of Black women have often been unstable and oppressive. Independence has historically been reinforced by societal expectations that frame Black women as the backbone of their families. The word resilient is often used in the literature to describe Black women who demonstrate independence, highlighting their ability to survive difficult circumstances and persevere despite both adversity and consequences (Geyton et al., 2022; Watson-Singleton et al., 2024). To achieve their career aspirations and maintain their independence, Black women often partition their identities through codeswitching (i.e., modifying their speech and appearance to assimilate and appear non-threatening in predominantly white environments), a practice that can be taxing on their mental and emotional health (Davis, 2018; Geyton et al., 2022). Codeswitching can also be seen as a sign of caretaking as it involves putting the comfort and perceptions of others ahead of self.

As a component of the SBW schema, caregiving manifests as self-sacrifice, self-silencing, and prioritizing the needs of others over one's own. This includes taking on responsibilities not just within the family but also within the broader community, often at the expense of personal well-being. Black women are frequently expected to serve as emotional anchors for those around them, embodying the role of nurturer and caretaker, regardless of the personal toll (Abrams et al., 2019; Anyiwo et al., 2022; Liao et al., 2020). As children, Black women are taught to care for others and sacrifice their own needs for the needs of others.

The characteristics of the SBW schema, strength, independence, and caretaking, are embedded in Black women from childhood (Crooks et al., 2023; Anyiwo et al., 2022). The gendered racialized socialization (i.e., socializing Black women to cope with the unique type of racism that emanates from the intersection of being Black and being a woman) of Black women occurs at an early age. Black girls are often raised to be strong because of the inevitable adversity they will face as a consequence of them being both a woman and Black (Abrams et al., 2019; Holman, 2012; Leath et al., 2023). The SBW schema traits are primarily inculcated in Black girls from Black mothers, grandmothers, and other significant Black women in the lives of Black girls (Leath et al., 2023; Oshin & Milan, 2019). Oshin & Milan (2019) described the socialization of Black girls as including emotional suppression, an emphasis on self-reliance, and a prioritization of caregiving with a focus on the ability to survive and adapt. These lessons, which are often rooted in love and the desire to protect, prepare Black girls to navigate a world where they are likely to encounter racism, sexism, and other forms of marginalization. However,

while this form of socialization fosters resilience, it can also inadvertently perpetuate emotional silencing and the expectation that Black women prioritize the needs of others over their own well-being, laying the foundation for long-term psychological and emotional strain (Abrams et al., 2019; Woods-Giscombe, 2010).

The SBW schema, passed down transgenerationally, has functioned as a psychological shield against the cumulative effects of discrimination, societal devaluation, and systemic inequities (Thomas et al., 2022; Thorpe et al., 2023). Its roots trace back to the era of chattel enslavement, when Black women endured systemic marginalization, including the forced separation of families and pervasive sexual exploitation. Members of the dominant culture imposed the SBW schema during slavery, portraying Black women as inherently strong and invulnerable to justify inhumane working conditions, sexual violence, and the denial of their basic humanity (Thomas et al., 2022; White, 1999). This stereotype not only rationalized their subjugation but also stripped Black women of the right to express vulnerability or receive care.

Over time, the societal pressures to conform to this ideal persisted, reinforced by the intersecting oppressions of racism and sexism. Many Black women internalized the SBW schema, adopting it as a survival mechanism and a framework for navigating a world fraught with systemic challenges (Thomas et al., 2022). While this framework has been crucial for survival (Avery et al., 2022), the ability to respond to societal stressors, and has increased Black women's cultural pride and resilience (Anyiwo et al., 2022), it has also contributed to significant mental and physical health challenges for Black women (Thomas et al., 2022; Woods-Giscombe, 2010).

The SBW schema presents significant challenges for Black women, particularly in relation to their psychological well-being. Research indicates that Black women who internalize this schema often experience elevated rates of negative psychological outcomes, including depression, anxiety, and chronic stress (Abrams et al., 2019; Woods-Giscombe, 2010). Abrams et al. (2019) conducted a study with 194 Black women living in the United States, ranging in age from 18 to 82, to examine the relationship between depressive symptoms and endorsement of the SBW schema. This study revealed that caregiving, a central aspect of the SBW schema, plays a critical role in these negative outcomes. Specifically, self-silencing, a behavior characterized by suppressing one's emotions, needs, or desires to preserve relationships, was found to significantly increase the likelihood of experiencing symptoms consistent with depression. The act of prioritizing the well-being of others while neglecting one's own emotional health highlights the paradoxical nature of the SBW schema: while it may provide resilience in the face of adversity, it often exacerbates emotional and psychological distress.

In addition to psychological well-being, numerous studies have explored the impact of the SBW schema on the physical health of Black women. Black women are disproportionately affected by chronic health conditions such as obesity, heart disease, breast cancer, and autoimmune disorders (Black & Woods-Giscombe, 2012; Thomas et al., 2022; Warren-Findlow, 2006; Woods-Giscombe, 2010). Research suggests that the higher prevalence of these illnesses is partly linked to the coping mechanisms associated with the SBW schema (Woods-Giscombe, 2010). The constant stress of societal marginalization, the demands of caregiving, and the expectation to always appear strong

and resilient place a considerable strain on the physical health of Black women. For instance, one notable consequence of internalizing the SBW schema for Black women is disrupted sleep patterns, with Black women experiencing greater difficulty achieving restorative sleep due to these compounded stressors (McLaurin-Jones et al., 2021). Over time, this lack of adequate rest exacerbates the risk for chronic illnesses, illustrating the intricate connection between the SBW schema, stress, and physical health.

The SBW schema emerged from intersecting oppressions of race and gender faced by Black women, perpetuating expectations of strength, resilience, and caregiving while suppressing vulnerability. Rooted in the history of slavery, this schema has been internalized by Black women as a survival mechanism against systemic discrimination. It is transmitted through gendered racialized socialization, often from Black mothers to daughters, emphasizing independence, emotional suppression, and self-sacrifice. While the schema fosters resilience, it also contributes to negative psychological outcomes such as depression, anxiety, and chronic stress, and is linked to physical health disparities like heart disease and disrupted sleep. The stress and psychological burden of the SBW schema may also be linked to other health disparities such as sexual dysfunction.

SBW Schema and Sexual Dysfunction

Sexual dysfunction impacts a large portion of the population (Pereira et al.,2013; Shaeer & Shaeer, 2012). Overall, women have the highest rates of sexual dysfunction (Laumann et al., 1999). Two studies found that Black women specifically have higher rates of FSD than other women (Chapa et al., 2020; Laumann et al., 1999). While neither

study explained why Black women were found to have higher rates of FSD, it is worth considering the various factors that may influence their sexual functioning.

One factor that may contribute to Black women's sexual functioning is the SBW schema, which emphasizes strength, independence, emotional restraint, and caretaking. Black women are socialized from an early age to embody the characteristics of the SBW schema, leading to its early internalization, which informs their sexual development (Crooks et al., 2023). The SBW schema is how Black women navigate racialized sexism and stressors. Historically, stereotypes of Black women's hypersexuality and moral deviance were imposed during slavery and persist in modern media portrayals, contributing to both external judgments and internalized narratives about their sexual worth and agency (Gordon, 2008). These conflicting expectations of being both sexually available and morally strong create unique challenges for Black women in expressing and experiencing their sexuality. As a result, many Black women may struggle to reconcile societal demands for strength and control with the vulnerability and openness often required for sexual functioning.

Logically, the SBW schema is likely connected to sexual functioning in Black women, as it has already been linked to both physical and mental health challenges (Woods-Giscombe, 2010). For instance, Black women who internalize the SBW schema experience higher rates of mental health concerns, such as depression and are more likely to suffer from health issues like high blood pressure compared to women in other demographic categories (Thomas et al., 2022; Woods-Giscombe, 2010). Given that sexual health exists at the intersection of mental and physical health, it follows that the

internalization of the SBW schema would have a significant impact on sexual health. However, there are a limited number of studies that have examined this relationship between sexuality and the SBW schema.

Avery et al. (2022) conducted a quantitative study to better understand how the SBW schema impacts sexual self-assertiveness in Black women. The study, conducted with 597 Black undergraduate and graduate women, explored whether self-silencing and SBW schema endorsement were linked to lower levels of sexual assertiveness. Endorsement of the SBW schema was measured using the 9-item embodiment subscale of the Strong Black Woman Scale (Thomas, 2006). As the scale is an unpublished measure, the investigators completed a factor analysis, which used a principal axis factor extraction to further explore the structure of the subscale. Avery et al., (2022) found that self-silencing behaviors (a component of the SBW schema) among Black women can contribute to sexual passivity and a lack of sexual assertiveness. This dynamic often results in Black women being less likely to prioritize their own sexual pleasure, more likely to place their partner's needs above their own, and less likely to disclose experiences of sexual dysfunction (Avery et al., 2022). These patterns reflect the broader impact of the SBW schema. That is, the pressure to suppress personal needs and maintain strength can extend into intimate and sexual relationships and potentially compromise sexual functioning and satisfaction. While this study provides an initial exploration of the connection between the internalization of the SBW schema and sexuality in Black women, particularly in relation to their likelihood of asserting their sexual needs, endurance coping, and deprioritizing their own pleasure, it does not directly examine how

specific components of the SBW schema endorsed by Black women impact sexual functioning.

To further consider the link between SBW schema internalization and sexual functioning for Black women, Townes et al. (2019) examined sexual pain using data from the 2018 National Survey of Sexual Health Behavior (NSSHB) focusing on a sample of 1,654 participants, 1079 White women and 575 Black women. While women overall reported experiencing sexual pain at relatively equal rates, Black women were more likely to experience persistent pain and were less likely to disclose their pain to a partner or seek medical treatment. Black women were less likely to disclose for fear of being seen as vulnerable and weak (Dogan et al., 2022). Self-silencing and appearing invulnerable, key characteristics of the SBW schema, contributed to the reluctance to acknowledge or address sexual health concerns. This study describes how Black women's experiences with sexual dysfunction are shaped not just by physiological factors but also by societal and cultural influences. Townes et al. (2019) linked one aspect of sexual functioning to the SBW schema, specifically examining the impact of the SBW schema on how sexual pain is experienced. While this beginning information is useful, it only provides data about one sexual dysfunction.

The BeWell Project by Thorpe et al. (2024) aimed to better understand how specific factors impact the sexual functioning of Black women. The study focused on sexual distress, a sign of sexual dysfunction, among Black women that identified as heterosexual or queer. Using a cross-sectional survey with 448 Black women aged 19–67, the study examined how factors such as the SBW schema, sexual objectification, PTSD,

financial worry, and perceived stress contribute to sexual distress. The study found that both psychological functioning and minority stressors, such as the internalization characteristics of the SBW schema, were positively correlated with sexual distress among Black women, with Black queer women reporting higher endorsements of the SBW schema. Thorpe et al. (2024) identified a link between sexual distress, a component of sexual dysfunction, and the SBW schema. However, this study only focused on one component of sexual dysfunction (i.e., sexual distress).

The above studies suggest a connection between sexual functioning and the SBW schema. Additionally, Avery et al. (2022) found that Black women who internalize the SBW schema are less likely to be sexually assertive and more likely to engage in endurance coping, often forgoing their own sexual pleasure. Furthermore, Townes et al. (2019) found that due to internalizing the SBW schema, Black women experience more persistent sexual pain, which they are unlikely to disclose. Thorpe et al. (2024) made a more direct link between sexual functioning and Black women by examining the experience of sexual distress in relation to several factors, including the SBW schema, and found high levels of sexual distress in Black women. However, none of these studies comprehensively investigated the SBW schema and its relationship to sexual dysfunctions in Black women. The studies only looked at certain aspects of the SBW schema and particular sexual dysfunctions. Therefore, the overall relationship between the SBW schema and sexual dysfunction in Black women remains unclear. This dissertation aims to explore the constructs of the SBW schema and sexual dysfunction to better understand the relationship between them. The results of this study will provide

theoretical clarity about the relationship between various components of the SBW schema and different types of sexual dysfunction. Furthermore, on a practical level, the results will shed light on how to help Black women who suffer from sexual dysfunctions.

Therefore, this study will be guided by the following hypotheses:

1. There is a significant association between the internalization of the SBW schema and sexual dysfunction in Black women.
2. A higher level of internalization of the SBW schema is significantly related to an increased likelihood of specific sexual dysfunction in Black women.

CHAPTER THREE

METHODS

The research reviewed in the previous chapter forms the foundation for the working premise that sexual dysfunction among Black women may be linked to the internalization of the SBW schema. While previous research has explored the relationship between sexuality and the internalization of the SBW schema (Avery et al., 2022; Crooks et al., 2023; Thorpe et al., 2024; Townes et al., 2019), no studies have specifically examined the connection between sexual dysfunction and the internalization of the SBW schema in Black women. Due to this gap in the literature, the purpose of this quantitative research study will be to determine if there is a relationship and to what extent that relationship exists between the internalization of the SBW schema and the experience of sexual dysfunction by Black women. For this reason, this dissertation will examine the following research questions:

1. To what extent is the internalization of the SBW schema associated with sexual dysfunction in Black women?
2. Is a higher level of SBW schema internalization related to an increased likelihood of specific sexual dysfunction in Black women?

Research Design

This study was completed using secondary data analysis. I used existing data from the IRB-approved BeWell Project (Thorpe et al., 2024). The BeWell Project's purpose was to quantitatively explore, in a quasi-experimental design, the impact of specific variables on the sexual functioning of heterosexual and queer Black women. Those

variables included relationship satisfaction, mental well-being, sexual functioning, and minority stressors.

Participants

Population

The following criteria had to be met by participants to participate in the BeWell Project:

- Identify as Black or African American
- Identify as cisgender
- Age 18 or older
- Live in the United States of America
- Had to have had sexual intercourse within the 6 months preceding the study

Participants were recruited using digital recruitment, specifically social media postings on Instagram and Facebook, and snowball sampling, as the posts were shared from the principal investigators' original post. Purposive sampling was also used as the researchers selected participants for the study based on predefined criteria. Participants completed a screener to confirm eligibility.

Participant Characteristics

The sample included 448 participants. Participants lived in various regions of the United States. 44.2% lived in the South, 24.3% in the Northeast, 20.8% in the Midwest, and 10.7% in the West. The age range of participants was between 19 and 67 (M=33.6, SD = 8.71). Although all participants identified as Black, they were asked to self-select their race and ethnicity. 82.8% of participants identified as African American, 6.5% as

Caribbean, 4.9% as Bi-racial, 4.0% as African, 1.1% as Hispanic/Latina, and .7% as Multiethnic. All participants in the study self-identified as African American cisgender women. Additionally, each participant met the inclusion criteria for the study, as they identified as women of African American heritage and aligned with the definition of African descent provided within the context of the African diaspora. Of the 448 participants, 32% had a degree from a four-year university, and 43% had graduate degrees. Sexual identity varied among the participants. 62.2% of the participants identified as heterosexual, 13.9% as bisexual, 11.6% as queer, 5.4% as lesbian, 5.1% as pansexual, 0.7% as asexual, 0.4% as questioning, 0.4% as preferring to self-describe but did not give further explanation, and 0.3% as having no label. For the purposes of this study, only participants who had completed data on the G-SWS-Q and the CSFQ-14 measures were included, giving a final sample size of 387.

Data Collection

Prior to data collection in the BeWell Project, approval was obtained from the Institutional Review Board (IRB) at the University of Kentucky to ensure the research study's compliance with ethical research standards. Once eligibility was confirmed by completion of a screener, participants were contacted via email to complete an informed consent form detailing the purpose, procedures, potential risks, and confidentiality measures. Once consent was received, the participants completed the 20-25-minute Qualtrics survey. Once the survey was completed, each participant was entered into a raffle for the opportunity to win one of 40 Amazon E-gift cards. Response rates were checked daily to remove bots and spammers from the survey data and the raffle. Qualtrics protections were also used. All collected data were de-identified and securely stored in a

password-protected database. Only the principal investigator and authorized research assistants had access to the data. Data for the study were collected from January to February 2023.

Instrument and Measures

The BeWell Project used a web-based survey tool, Qualtrics, to construct and administer the instruments used for the study. The instrument was constructed to measure three factors: psychological well-being, minority stressors, and sexual well-being. Psychological well-being was measured by looking at the following factors: (1) psychological distress, (2) post-traumatic stress disorder, (3) perceived stress, and (4) financial worry. Minority Stressors were measured by looking at two factors: (1) SBW schema and (2) sexual objectification. Sexual well-being was measured by measuring (1) sexual distress, (2) sexual functioning, and (3) sexual mindfulness. Additionally, demographic variables such as age, ethnicity, sexual orientation, region of the U.S. lived in, number of children, relationship status, length, and racial make-up, and highest level of education were measured.

To answer the research question within this study, I focused on two scales from the dataset, the Giscombé Superwoman Schema Questionnaire (G-SWS-Q) (Woods-Giscombé et al., 2019) and the Changes in Sexual Functioning Questionnaire (CSFQ-14) (Clayton et al., 1997; Keller et al., 2006). It is important to note that Strong Black Woman schema (SBW) and Superwoman Schema (SWS) are used interchangeably in the literature to describe the expectations of Black women to be invulnerable, demonstrate strength through adversity, independence, resiliency, and to be self-sacrificing (Mclaurin et al.,2021; Romero, 2000; Woods-Giscombé, 2019). In fact, the Superwoman Schema

Conceptual Framework describes the characteristics of the Strong Black Woman/ Superwoman identity (Woods-Giscombé et al., 2019). Therefore, the Giscombé Superwoman Schema Questionnaire (G-SWS-Q) was used as the instrument to measure the Strong Black Woman (SBW) schema. The G-SWS-Q has been widely used to measure the SBW/Superwoman schema (Woods-Giscombé et al., 2019).

Superwoman Schema Questionnaire

The G-SWS-Q is a 35-item self-report questionnaire with five subscales. The five subscales include an obligation to present an image of strength, an obligation to suppress emotions, resistance to being vulnerable, an intense motivation to succeed despite limited resources, and an obligation to help others (Woods-Giscombé et al., 2019). Level of endorsement is reported for each item as follows: this is not true for me or this is true for me (*rarely, sometimes, or all the time*), and level of distress was measured by answering this bothers me *(not at all, somewhat, or very much)*. The instrument has both continuous variables (item scores, subscale scores, and total item score) and categorical variables (*low, moderate*, or *high* for the subscale scores and the total score). Construct validity was assessed based on correlations with instruments that are valid and measure related psychological constructs (Woods-Giscombé et al., 2019). To assess structural validity, a confirmatory factor analysis (CFA) was conducted using data from 561 African American women aged 18-65 living in the United States (Woods-Giscombé et al., 2019). Table 3.1 describes the reliability of the subscale and total score of the G-SWS-Q. It is interesting to note that, for this sample, the reliability of the scales and subscales was

higher than that reported in the psychometric study, except for "Obligation to suppress emotions."

Table 3.1
Reliability Coefficients for the G-SWS-Q Subscales and Composite

Subscale	Published Psychometrics (α)	BeWell Study (α)
Obligation to present an image of strength	.73	.81
Obligation to suppress emotions	.85	.83
Resistance to being vulnerable	.86	.87
An intense motivation to succeed despite limited resources	.70	.80
Obligation to help others	.87	.88
Total G-SWS-Q	.93	.94

Changes in Sexual Functioning Questionnaire

The CSFQ-14 is a self-report measure designed to evaluate sexual functioning (Keller et al.,2006). The CSFQ-14 includes 14 items, each rated on a 5-point Likert scale ranging from 1 (never) to 5 (every day), where higher scores indicate better sexual functioning. The female version was administered as all participants in the study identified as cisgender women. The CSFQ-14 assesses sexual functioning in the following domains: sexual desire/frequency, sexual desire/interest, arousal/excitement, and orgasm/completion and includes three phase-specific scales: pleasure, arousal, orgasm/completion (Clayton et al., 1997; Clayton et al., 1997; Keller et al., 2006). The

CSFQ-14 has good internal consistency and construct validity (Keller et al., 2006). Table 3.2 describes the reliability of the subscale and total score for the CSFQ-14

Sample questions from these subscales include:

- **Desire/Frequency**: "How frequently do you engage in sexual activity now?"
- **Desire/Interest**: "How often do you desire to engage in sexual activity?"
- **Arousal/Excitement**: "Are you easily aroused?"
- **Orgasm**: "Are you able to have an orgasm when you want to?"
- **Pleasure**: "How much pleasure or enjoyment do you get from orgasms?"

For the first subscale, "Sexual desire/frequency," there were only two items, so their correlation is reported in a third column. Unlike the G-SWS-Q measures, the reliability estimates of these measures for this sample were lower than those reported on the psychometric report, except for "Orgasm/completion."

Table 3.2
CSFQ-14 Psychometrics for the Total and Each Scale

Scale	Published Psychometrics(α)	BeWell study (α)	Pearson r
Sexual desire/frequency	.74		*.315**
Sexual desire/interest	.75	*.72*	
Arousal/excitement	.74	*.67*	
Orgasm/completion	.68	*.78*	
Three Phase-Specific Scales			
Pleasure	.81	*.70*	
Arousal	.74	*.67*	
Orgasm completion	.86	*.78*	
Total CSF-Q-14	.90	*.75*	

**p-value <.001*

Data Analysis

Measures Used in the Study

Sexual functioning is the dependent variable in this study. The CSFQ-14 was used to assess sexual functioning. This instrument provides both a total sexual functioning score and eight scale scores that focus on the five domains and the corresponding three phases of the sexual response cycle shown in Table 3.2. Higher scores are reflective of higher sexual functioning. The CSFQ-14 was used to determine the overall score of sexual functioning for each participant. Table 3.3 describes the minimum and maximum score for participants and includes the mean and standard deviation for each variable.

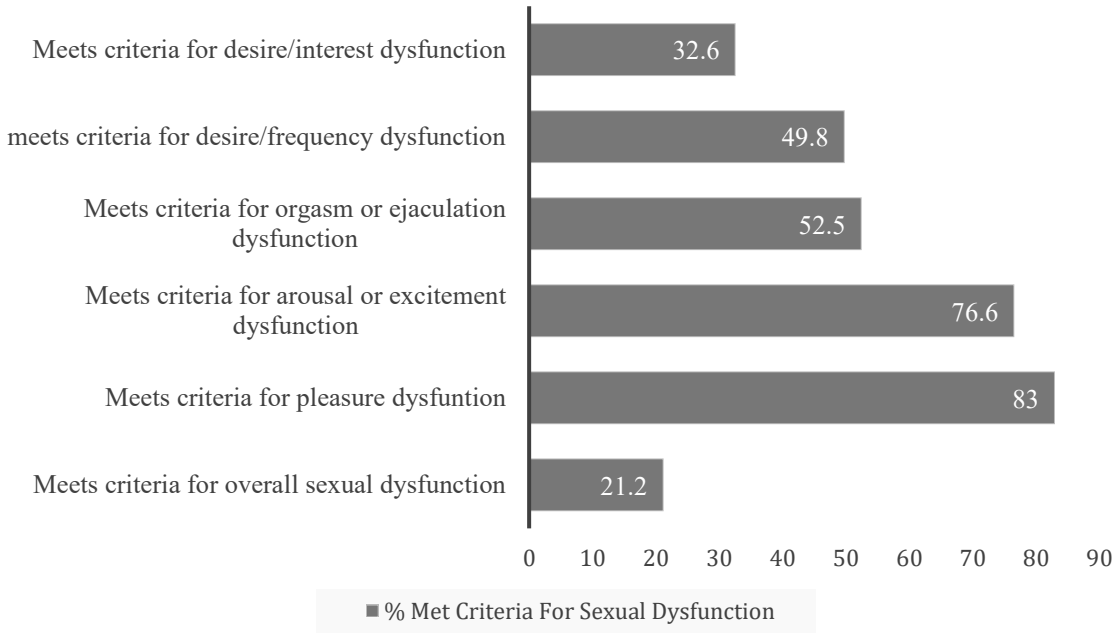
Table 3.3
CSFQ-14 Descriptive Statistics

Scale	Minimum	Maximum	Mean ($\bar{x}$)	Std. Deviation (σ)
Total Score	28	31	46.71	6.29
Pleasure	0	1	.56	.49
Arousal	6	15	10.75	2.07
Orgasm	3	15	11.13	2.50
Desire/frequency	2	10	6.56	1.27
Desire/Interest	3	15	10.36	2.33

Additionally, sexual dysfunction was measured across each subscale and was categorized into two levels using the instrument's dichotomous cutoffs to show individuals who met the cutoff for sexual dysfunction. The levels were determined by the established cut-off points on the Likert scale, with 0 indicating no dysfunction and 1 indicating a dysfunction. Figure 3.1 reflects the percentage of women that met the criteria for each subscale of sexual dysfunction.

Figure 3.1

Percentages Of Women Meet the Criteria for Specific Sexual Dysfunction



Internalization of the SBW schema was measured using the G-SWS-Q. The G-SWS-Q consists of 35 items that assess five subscales, including an obligation to present an image of strength, an obligation to suppress emotions, resistance to vulnerability, a strong drive to succeed despite limited resources, and the obligation to help others. The level of internalization of the SBW schema was determined by participants' level of agreement with these items. The total score from the G-SWS-Q was used to assess the degree to which participants internalized the SBW schema. Table 3.4 describes the mean and standard deviation for each scale.

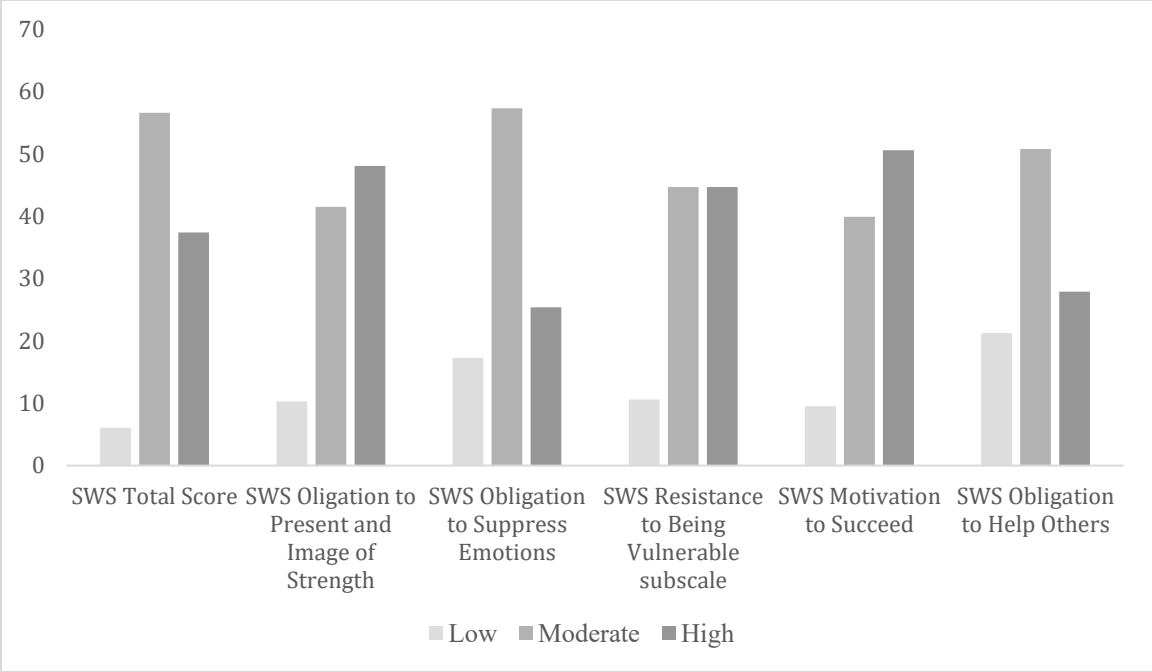
Table 3.4

G-SWS-Q Means and Standard Deviation

Scale	Mean ($\bar{x}$)	Std. Deviation (σ)
SWS Obligation to Present and Image of Strength categorical	2.4	.66
SWS Obligation to Suppress Emotions categorical	2.1	.65
SWS Resistance to Being Vulnerable subscale categorical	2.3	.66
SWS Motivation to Succeed categorical	2.4	.65
SWS Obligation to Help Others categorical	2.1	.69
SWS Total Score Categorical	2.3	.58

Moreover, internalization was then classified as low, moderate, or high. Scores range from low (0–35), moderate (36–70), and high (71–105). A higher score indicates a higher level of endorsement of the SBW schema. Table 3.5 shows the percentage in each category. This allowed me to examine whether there were significant differences in outcomes based on levels of internalization.

Figure 3.2
SWS Categorical Scores



Once I was able to determine if there was a relationship between the SBW schema and sexual dysfunction, the study explored possible covariates that may potentially influence sexual dysfunction. These covariates include age and relationship satisfaction. Participant age was collected as a part of the demographic questions, and relationship satisfaction was measured using the Relationship Satisfaction Scale.

Data Analysis Approach

This study hypothesized that the internalization of the SBW schema is associated with sexual functioning in Black women, potentially serving as a predictor of increased rates of sexual dysfunction. Descriptive statistics were completed to provide an overview of the data. To examine whether SBW schema internalization is associated with sexual dysfunction and the extent of the relationship, I conducted several statistical analyses.

To assess the direction and strength of the relationship between the internalization of the SBW schema and sexual functioning, I completed a Pearson correlation. A correlation provides an estimate of the relationship between two variables, testing whether, on average, a unit change in one variable is consistently related to a change in the other variable. This determination is made by comparing the covariance shared between the two variables in the analysis, as measured by the cross-product of the sum of the distance of each data point to its mean, to the combined sample variances of each variable in the analysis. As such, the correlation can range theoretically from negative one (a perfect inverse relationship) to positive one (a perfect relationship). The test of significance tests the likelihood of observing the given correlation when the actual relationship is zero. The goal of completing the Pearson correlation was to determine whether higher levels of SBW schema internalization are associated with greater sexual dysfunction. A significant positive correlation would indicate that higher internalization of the SBW schema is linked to more sexual dysfunction, while a negative correlation would suggest the opposite.

In addition to the correlation analysis, I conducted a multiple linear regression analysis to determine whether the SBW schema internalization significantly predicts sexual dysfunction. Multiple linear regression is a statistical technique used to examine the relationship between one continuous dependent variable and two or more independent variables. The p-values associated with each predictor's coefficient will be examined to determine whether the effect of that variable is statistically significant. If $p < 0.05$, the variable has a statistically significant relationship with the dependent variable. Multiple linear regression allowed me to investigate how SBW schema internalization influenced

sexual dysfunction, while accounting for the influence of other variables. Control variables such as age and relationship status were included to account for potential confounding factors. The goal of using multiple linear regression is to provide insight into the predictive relationship between SBW schema internalization and sexual dysfunction, helping to clarify how the internalization of the SBW schema might influence sexual health outcomes.

Finally, a cross-tabulation (or chi-square analysis) was used to examine the association between categorical variables, levels of SBW schema internalization (categorized as low, medium, and high), and the presence or absence of specific sexual dysfunctions (e.g., desire, arousal, satisfaction). Cross-tabulation is used to analyze relationships between categorical variables by comparing the observed frequency in each category to the expected frequency under the assumption of no association. The chi-square test statistic will determine whether a significant relationship exists between the predictor (SBW internalization) and the outcome (sexual dysfunction). Standardized adjusted residuals will be used to assess whether individual cells in the cross-tabulation contain significantly more or fewer cases than expected. A residual greater than 1.98 indicates a higher-than-expected frequency, while a residual lower than -1.98 suggests a lower-than-expected frequency. For both the chi-square test and the standardized adjusted residuals, statistical significance will be set at $p < .05$.

CHAPTER FOUR
RESULTS

Various methods of statistical analysis were used to structure the results section of this dissertation. Initially, I reviewed the univariate results to include descriptive data analysis using SPSS on both measures in this study, the Giscombé Superwoman Schema Questionnaire (G-SWS-Q) and the Changes in Sexual Functioning Questionnaire (CSFQ-14) which can be found in Chapter Three. The G-SWS-Q was used to measure the internalization of the Strong Black Woman (SBW) Schema. The CSFQ-14 was used to measure sexual dysfunction. Participant responses of the CSFQ-14 were analyzed first, followed by participant responses of the G-SWS-Q. The results of the descriptive analysis conducted with the data from the CSFQ-14 are in Table 3.3. The descriptive analysis results from the G-SWS-Q appear in Table 3.4.

Regression Analysis of SWS Subscales as Predictors of Sexual Functioning

Following the review of the univariate data presented in Chapter Three, I compared the size of the relationship of the level of SWS internalization to changes in sexual functioning. I completed a linear regression analysis with only one predictor and one outcome. To do so I used the scale score of the CSFQ-14, which was based on the actual indicator of the sums of the scale. Standardized coefficients are reported in the following tables, indicating the amount of standard deviation change in the outcome for every standard deviation increase in the predictor.

Impact of the Overall SWS Score on Sexual Functioning

The first set of regression analyses examined the impact of the overall score for SWS on each of the six indicators of change in sexual functioning. Table 4.1 presents the results of these analyses. In this table, each row shows the results of a different regression, with the outcome indicated in the first column, the standardized coefficient in the second column, and the statistical test information in the last two columns. For this table, the relationships that were significant are highlighted in bold.

Table 4.1

Relationship between SWS Overall Score and the Six Indicators of Change in Sexual Dysfunction

Outcome Measure	Std Coefficient	*T*-Value	*P*-Value
Overall Changes in sexual functioning	**.11**	**2.22**	**.027**
Changes in sexual functioning-desire frequency subscale	.08	1.55	.122
Changes in sexual functioning-desire interest subscale	**.17**	**3.43**	**.001**
Changes in sexual functioning-arousal/ excitement subscale	**.10**	**2.07**	**.039**
Changes in sexual functioning-orgasm subscale	.02	.40	.693
Change in pleasure functioning	-.06	-1.12	.262

Bold entries mark relationships that are significant at $p < .05$

The pattern was generally positive, with the exception of changes in pleasure functioning. The relationships between the SWS sum scale score and desire/frequency, orgasm functioning, and pleasure functioning were not significant. There was a positive relationship found between the SWS sum scale score and the overall changes in sexual

functioning. The higher the overall sum score for the internalization of the SWS the more changes were seen in the sexual functioning sum score. As the overall sum score for the internalization of the SWS score increased, desire/frequency dysfunction showed a marginal increase. Moreover, the higher the overall sum score for the internalization of the SWS the higher the desire/interest dysfunction score and the arousal excitement dysfunction score

Impact of the SWS Obligation to Present an Image of Strength on Sexual Functioning

The second set of regression analyses examined the impact of the SWS Obligation to Present an Image of Strength scale on each of the six indicators of change in sexual functioning. Table 4.2 presents the results of these analyses. In this table, each row shows the results of a different regression, with the outcome indicated in the first column, the standardized coefficient in the second column, and the statistical test information in the last two columns. For this table, the relationships that were significant are highlighted in bold.

Table 4.2

Relationship between SWS Obligation to Present an Image of Strength and the Six Indicators of Change in Sexual Dysfunction

Outcome Measure	Std Coefficient	*T*-Value	*P*-Value
Overall Changes in sexual functioning	**.07**	**1.47**	**.142**
Changes in sexual functioning-desire frequency subscale	.05	1.06	.287
Changes in sexual functioning-desire interest subscale	**.09**	**1.82**	**.069**
Changes in sexual functioning-arousal subscale	**.10**	**2.15**	**.032**
Changes in sexual functioning-orgasm subscale	.30	.61	.544
Change in pleasure functioning	.00	.03	.974

Bold entries mark relationships that are significant at $p < .15$

The relationships between the SWS Obligation to Present and Image of Strength subscale and desire/frequency functioning, orgasm functioning, and pleasure functioning scales were not significant. Overall changes in sexual functioning and changes in desire/interest demonstrated a marginal positive relationship to the internalization of the subscale. A positive correlation was found between the internalization of the SWS obligation to present an image of strength subscale and changes to sexual arousal/excitement.

Impact of the SWS Obligation to Suppress Emotions on Sexual Functioning

The third set of regression analyses examined the impact of the SWS Obligation to Suppress Emotions scale on each of the six indicators of change in sexual functioning. Table 4.3 presents the results of these analyses. In this table, each row shows the results

of a different regression, with the outcome indicated in the first column, the standardized coefficient in the second column, and the statistical test information in the last two columns. For this table, the relationships that were significant are highlighted in bold.

Table 4.3

Relationship between SWS Obligation to Suppress Emotions and the Six Indicators of Change in Sexual Dysfunction

Outcome Measure	Std Coefficient	*T*-Value	*P*-Value
Overall Changes in sexual functioning	.06	1.29	.198
Changes in sexual functioning-desire frequency subscale	.03	.63	.529
Changes in sexual functioning-desire interest subscale	**.09**	**1.85**	**.065**
Changes in sexual functioning-arousal subscale	**.11**	**2.19**	**.029**
Changes in sexual functioning-orgasm subscale	.00	-.007	.994
Change in pleasure functioning	-.06	-1.33	.185

Bold entries mark relationships that are significant at $p < .10$

SWS Obligation to Suppress Emotions was marginally positively correlated to changes in functioning for the desire/interest subscale. A significant positive correlation was found between changes in sexual functioning arousal/excitement scale and the SWS obligation to present an image of strength subscale, indicating that higher levels of internalization were related to higher levels of arousal/excitement dysfunction.

Impact of the SWS Resistance to Being Vulnerable on Sexual Functioning

The fourth set of regression analyses examined the impact of the SWS Resistance to Being Vulnerable scale on each of the six indicators of change in sexual functioning.

Table 4.4 presents the results of these analyses. In this table, each row shows the results of a different regression, with the outcome indicated in the first column, the standardized coefficient in the second column, and the statistical test information in the last two columns. For this table, the relationships that were significant are highlighted in bold.

Table 4.4

Relationship between SWS Resistance to Being Vulnerable and the Six Indicators of Change in Sexual Dysfunction

Outcome Measure	Std Coefficient	*T*-Value	*P*-Value
Overall Changes in sexual functioning	**.11**	**2.23**	**.026**
Changes in sexual functioning-desire frequency subscale	-.004	-.091	.928
Changes in sexual functioning-desire interest subscale	**.19**	**3.88**	**.000**
Changes in sexual functioning-arousal subscale	**.09**	**1.90**	**.058**
Changes in sexual functioning-orgasm subscale	.06	1.37	.172
Change in pleasure functioning	-.06	-1.32	.187

Bold entries mark relationships that are significant at $p < .10$

No significant relationship was found for desire/frequency functioning, orgasm functioning, or pleasure functioning. As internalization of SWS resistance to being vulnerable increased the changes in overall sexual functioning, desire/interest dysfunction, and arousal/excitement dysfunction increased, resulting in a positive correlation as demonstrated in Table 4.4.

Impact of the SWS An Intense Motivation to Succeed Despite Limited Resources on Sexual Functioning

The fifth set of regression analyses examined the impact of SWS An Intense Motivation to Succeed Despite Limited Resources scale on each of the six indicators of change in sexual functioning. Table 4.5 presents the results of these analyses. In this table, each row shows the results of a different regression, with the outcome indicated in the first column, the standardized coefficient in the second column, and the statistical test information in the last two columns. For this table, the relationships that were significant are highlighted in bold.

Table 4.5

Relationship between SWS An Intense Motivation to Succeed Despite Limited Resources and the Six Indicators of Change in Sexual Dysfunction

Outcome Measure	Std Coefficient	*T*-Value	*P*-Value
Overall Changes in sexual functioning	.11	**2.39**	**0.17**
Changes in sexual functioning-desire frequency subscale	**.09**	**1.96**	**.05**
Changes in sexual functioning-desire interest subscale	**.15**	**3.09**	**.002**
Changes in sexual functioning-arousal subscale	**.10**	**2.14**	**.033**
Changes in sexual functioning-orgasm subscale	.04	.90	.369
Change in pleasure functioning	-.002	-.04	.966

Bold entries mark relationships that are significant at $p < .05$

Table 4.5 shows a significant positive relationship between An Intense Motivation to Succeed Despite Limited Resources and overall changes in sexual functioning and changes in desire/frequency functioning, desire/interest functioning, and arousal/excitement functioning. This result indicates that as the level of internalization of the SWS subscale an intense motivation to succeed increased, so did the likelihood of

experiencing dysfunction in those dimensions of sexual functioning. A significant relationship was not found between the scale and orgasm functioning or pleasure functioning.

Impact of the SWS Obligation to Help Others on Sexual Functioning

The sixth set of regression analyses examined the impact of SWS An Intense Motivation to Succeed Despite Limited Resources scale on each of the six indicators of change in sexual functioning. Table 4.6 presents the results of these analyses. In this table, each row shows the results of a different regression, with the outcome indicated in the first column, the standardized coefficient in the second column, and the statistical test information in the last two columns. For this table, the relationships that were significant are highlighted in bold.

Table 4.6

Relationship between SWS Obligation to Help Others and the Six Indicators of Change in Sexual Dysfunction

Outcome Measure	Std Coefficient	*T*-Value	*P*-Value
Overall Changes in sexual functioning	**.09**	**1.95**	**.052**
Changes in sexual functioning-desire frequency subscale	.06	1.39	.162
Changes in sexual functioning-desire interest subscale	**.16**	**3.38**	**.001**
Changes in sexual functioning-arousal subscale	.04	.93	.351
Changes in sexual functioning-orgasm subscale	-.007	-.138	.890
Change in pleasure functioning	-.05	-1.02	.306

Bold entries mark relationships that are significant at $p < .10$

Table 4.6 shows a positive correlation between SWS obligation to help others and changes in overall sexual functioning and changes in sexual functioning as it relates to desire/interest. As internalization of the SWS subscale obligation to help others increases the likelihood of experiencing changes in overall sexual functioning and desire/interest dysfunction increases. Desire/frequency functioning, arousal/excitement functioning, orgasm functioning, and pleasure functioning did not have a significant relationship with the scale.

In general, these analyses revealed that internalization of the SWS and its subscales demonstrated some statistical significance as it related to predicting sexual dysfunction for specific domains.

SWS Internalization and Sexual Functioning

Continuing my focus on the bivariate data analysis, I reviewed the results for the cross-tabulation. Cross-tabulation was tested for significance using a chi-square statistic. The chi-square was reviewed to see if there was an overall difference in each category of sexual dysfunction based on low, moderate, or high internalization of the superwoman schema. If a significant difference was found, the adjusted standardized residual was reviewed to observe the differences between categories. This will help explain the difference between low, moderate, and high SBW schema internalization as it relates to those who meet the criteria for overall sexual dysfunction and each category of sexual dysfunction.

Level of Internalization for Overall Sum Score and Sexual Dysfunction Categories

The first set of cross-tabulation analyses examined the association between levels of SWS internalization (low, medium, high) and the presence/absence of specific sexual dysfunction. Table 4.7 presents the results of these analyses. In this table, each row shows the results, with the outcome indicated in each column by levels, the Chi-square test statistic in the fourth column. For this table, asterisks were used to indicate the relationships that were significant.

Table 4.7

Cross-Tabulation of SWS Internalization Overall Sum Score and Sexual Dysfunction Categories with Chi-Square Test and Adjusted Residuals

	Low SWS % Internalization (adj. Std. residual)	Moderate SWS % Internalization (adj. Std. residual)	High SWS % Internalization (adj. Std. residual)	Chi-square (p level)
Overall sexual dysfunction*	20.8% (0.10)	24.7% (2.7*)	12.5% (-2.8*)	8.07 (.018)
Desire/Interest*	37.5% (.6)	38.1% (2.9*)	21.9% (-3.3*)	10.98 (.004)
Desire/Frequency	50% (-.1)	54.5% (1.7)	45.3% (-1.7)	3.02 (.22)
Orgasm	33.3% (-1.7)	53.6% (1.5)	47.9% (-.7)	4.056 (.132)
Arousal/Excitement*	75% (-.2)	81.1% (2.4*)	70.1% (-2.4*)	6.02 (.049)
Pleasure	87.5% (.7)	83% (.7)	79.1% (-1.1)	1.50 (.47)

*indicates that the adjusted standardized residual is significantly different from what would be expected by chance

Table 4.7 displays the three levels of the total score of the G-SWS-Q run against each sexual dysfunction category. No significant difference from chance was found for women with low SWS internalization in any category of sexual dysfunction. In addition, no difference between groups was found in orgasm dysfunction, desire/frequency dysfunction, or pleasure dysfunction, meaning that all levels of internalization as it relates to each category are within the probability of chance.

For those who met the criteria of overall sexual dysfunction, there was a significant difference based on the moderate and high levels of SWS internalization. Women who had moderate SWS internalization were significantly different in meeting the criteria for overall sexual dysfunction; there were more women in this group than expected by chance. Additionally, women who had high SWS internalization were significantly different in meeting the criteria for overall sexual dysfunction, with less than

expected by chance. A significant difference was also found for arousal/excitement, specifically in moderate and high SWS internalization. More than expected were noted in the moderate SWS internalization with less than expected by chance in the high SWS internalization. Moreover, a significant difference was also found for desire/interest dysfunction. specifically in moderate and high SWS internalization. More than expected were noted in the moderate SWS internalization with less than expected by chance in the high SWS internalization.

Level of Internalization for the Obligation to Present an Image of Strength Scale and Sexual Dysfunction Categories

Next, I reviewed the Obligation to Present an Image of Strength scale, which was assessed against each sexual dysfunction category. Table 4.8 presents the results of these analyses. In this table, each row shows the results, with the outcome indicated in each column by levels, the Chi-square test statistic in the fourth column. For this table, asterisks were used for the relationships that were significant.

Table 4.8

Cross-Tabulation of SWS Internalization Scale Obligation to Present an Image of Strength and Sexual Dysfunction Categories with Chi-Square Test and Adjusted Residuals

	Low SWS % Internalization (adj. Std. residual)	Moderate SWS % Internalization (adj. Std. residual)	High SWS % Internalization (adj. Std. residual)	Chi-square (p level)
Overall sexual dysfunction	20.5% (-.2)	26% (2.0*)	17.5% (-1.8)	4.03 (.134)
Desire/Interest	22.7% (-1.5)	37.5% (1.8)	30.5% (-.9)	4.26 (.119)
Desire/Frequency	50% (-.1)	54.5% (1.7)	45.3% (-1.7)	3.02 (.773)
Orgasm	43.2% (-1.3)	59.4% (2.4*)	48.8% (-1.5)	6.03 (.049)
Arousal/Excitement	77.3% (-.3)	79% (1.3)	72.4% (-1.5)	2.28 (.321)
Pleasure	84.1% (.3)	85.3% (1.2)	80% (-1.4)	1.94 (.379)

*indicates that the adjusted standardized residual is significantly different from what would be expected by chance

There was no significant difference noted for internalization of the SWS as it related to desire/interest dysfunction, desire/frequency, arousal/excitement dysfunction, and pleasure dysfunction. The results noted in Table 4.8 reflect a significant difference for moderate SWS internalization as it relates to overall dysfunction and orgasm dysfunction. These two results both indicated there was a higher endorsement of overall dysfunction and orgasm dysfunction than expected by chance.

Level of Internalization for the Obligation to Suppress Emotions Scale and Sexual Dysfunction Categories

The Obligation to Suppress Emotions scale, which was assessed against each sexual dysfunction category using a cross-tabulation analysis with a Chi-square test statistic, is noted in Table 4.9. The table presents the results of these analyses. In this table, each row shows the results, with the outcome indicated in each column by levels,

the Chi-square test statistic in the fourth column. For this table, asterisks were used for the relationships that were significant.

Table 4.9

Cross-Tabulation of SWS Internalization Scale Obligation to Suppress Emotions and Sexual Dysfunction Categories with Chi-Square Test and Adjusted Residuals

	Low SWS % Internalization (adj. Std. residual)	Moderate SWS % Internalization (adj. Std. residual)	High SWS % Internalization (adj. Std. residual)	Chi-square (p level)
Overall sexual dysfunction	20.3% (-.2)	24.8% (2.2*)	13% (-2.4*)	6.33 (.042)
Desire/Interest	34.7% (.4)	34.8% (1.2)	25.9% (-1.7)	2.89 (.236)
Desire/Frequency	48.7% (-.5)	50% (.4)	49.1% (.0)	.257 (.880)
Orgasm	40.5% (-2.1*)	55.5% (1.8)	50.9% (-.2)	5.14 (.076)
Arousal/Excitement	86.7% (2.4*)	74.8% (-.6)	70.6% (-1.5)	6.55 (.038)
Pleasure	85.3% (.6)	85.1% (1.4)	76.4% (-2.1*)	4.46 (.107)

*indicates that the adjusted standardized residual is significantly different from what would be expected by chance

Table 4.9 notes the results of the cross tabulation completed using the Obligation to Suppress Emotions scale and the low, moderate, and high categories of the G-SWS-Q. Several scales were found to be significant. Overall sexual dysfunction was significant as it related to moderate and high internalization of the SWS. There was no significant difference found for desire/interest dysfunction or desire/frequency dysfunction. Orgasm dysfunction was found to be marginally significant at low internalization of the SWS. Arousal/excitement dysfunction was found to be significant at low internalization of the SWS. Pleasure dysfunction was marginally significant with high SWS internalization.

Level of Internalization for the Resistance to Being Vulnerable Scale and Sexual Dysfunction Categories

Table 4.10 presents the results of the cross-tabulation analysis completed using the levels of internalization for the Resistance to Being Vulnerable Scale and the categories of sexual dysfunction. In this table, each row shows the results, with the outcome indicated in each column by levels, the Chi-square test statistic in the fourth column. For this table, asterisks were used for the relationships that were significant.

Table 4.10

Cross-Tabulation of SWS Internalization Resistance to Being Vulnerable Scale and Sexual Dysfunction Categories with Chi-Square Test and Adjusted Residuals

	Low SWS % Internalization (adj. Std. residual)	Moderate SWS % Internalization (adj. Std. residual)	High SWS % Internalization (adj. Std. residual)	Chi-square (p level)
Overall sexual dysfunction*	30.4% (1.6)	24.9% (1.7)	15.3% (-2.7*)	7.88 (.019)
Desire/Interest	43.5% (1.6)	38.3% (2.2*)	24.5% (-3.3*)	11.11 (.004)
Desire/Frequency	54.3% (.7)	46.9% (-1.1)	51.5% (.7)	1.27 (.531)
Orgasm	50% (-.3)	57.3% (1.9)	47.9% (-1.6)	3.49 (.174)
Arousal/Excitement	82.6% (1.1)	77.6% (.7)	73.1% (-1.3)	2.29 (.318)
Pleasure	91.3% (1.6)	83% (.0)	80.9% (-1.0)	2.83 (.243)

*indicates that the adjusted standardized residual is significantly different from what would be expected by chance

For participants who had high internalization of the SWS subscale overall sexual dysfunction was found to be significant, with less than expected by chance, as noted in Table 4.10. Desire/Interest dysfunction was noted as significant, with higher levels than expected as it relates to moderate internalization and lower levels than expected with high internalization. Additionally, no significant difference was found with desire/frequency dysfunction, orgasm dysfunction, arousal/excitement dysfunction, or pleasure dysfunction.

Level of Internalization of An Intense Motivation to Succeed Despite Limited Resources Scale and Sexual Dysfunction Categories

Table 4.11 shows the relationship between level of SWS internalization for the scale, An Intense Motivation to Succeed Despite Limited Resources, and each category of sexual dysfunction. In this table, each row shows the results, with the outcome indicated in each column by levels, the Chi-square test statistic in the fourth column. For this table, asterisks were used for the relationships that were significant.

Table 4.11

Cross-Tabulation of SWS Internalization An Intense Motivation to Succeed Despite Limited Resources Scale and Sexual Dysfunction Categories with Chi-Square Test and Adjusted Residuals

	Low SWS % Internalization (adj. Std. residual)	Moderate SWS % Internalization (adj. Std. residual)	High SWS % Internalization (adj. Std. residual)	Chi-square (p level)
Overall sexual dysfunction	30% (1.5)	25.6% (1.9)	15.4% (-2.8*)	8.04 (.018)
Desire/Interest	32.5% (.0)	39.5% (2.8*)	26.5% (-2.5*)	7.18 (.028)
Desire/Frequency	52.5% (.2)	57.1% (2.0*)	46.5% (-2.0*)	4.31 (.116)
Orgasm	47.5% (-.5)	54.2% (1.0)	49.8% (-.6)	.996 (.608)
Arousal/Excitement	77.5% (.0)	82% (1.7)	74.4% (-1.7)	3.14 (.208)
Pleasure	87.5% (.8)	84.5% (.8)	80.3% (-1.3)	1.90 (.386)

*indicates that the adjusted standardized residual is significantly different from what would be expected by chance

For overall sexual dysfunction and desire/interest dysfunction, there was a significant difference, and for desire/frequency dysfunction there was marginal significance. Following the pattern of Table 4.7, there were lower levels than expected with high SWS internalization and higher levels than expected with moderate SWS

internalization. No significance was noted for orgasm dysfunction, arousal/excitement dysfunction, or pleasure dysfunction.

Level of Internalization for the Obligation to Help Others Scale and Sexual Dysfunction Categories

Last, I reviewed the Obligation to Help Others scale, which was assessed against each sexual dysfunction category. Table 4.12 presents the results of these analyses. In this table, each row shows the results, with the outcome indicated in each column by levels, the Chi-square test statistic in the fourth column. For this table, asterisks were used for the relationships that were significant.

Table 4.12

Cross-Tabulation of SWS Internalization Obligation to Help Others Scale and Sexual Dysfunction Categories with Chi-Square Test and Adjusted Residuals

	Low SWS % Internalization (adj. Std. residual)	Moderate SWS % Internalization (adj. Std. residual)	High SWS % Internalization (adj. Std. residual)	Chi-square (p level)
Overall sexual dysfunction	22% (-.3)	22.9% (1.0)	16.2% (-1.4)	2.09 (.351)
Desire/Interest	35.2% (.8)	34.9% (1.4)	23.7% (-2.2*)	4.96 (.084)
Desire/Frequency	50.5% (.2)	52.5% (1.2)	43.7% (-1.5)	2.44 (.295)
Orgasm	45.1% (-1.5)	55.1% (1.3)	51.7% (-.1)	2.61 (.271)
Arousal/Excitement	79.1% (.8)	76.3% (.2)	72.9% (-.9)	1.12 (.571)
Pleasure	79.1% (-1.2)	84.8% (.9)	83.2% (.0)	1.47 (.479)

*indicates that the adjusted standardized residual is significantly different from what would be expected by chance

In Table 4.12, the only cell that showed a significant difference from what would be expected by chance was for high levels of SWS internalization and dysfunctional

desire/interest. For this cell, participants who indicated high SWS internalization as it relates to the obligation to help others scale had lower levels of desire/interest dysfunction than expected by chance. No other category of sexual dysfunction was found to be significant.

In general, higher internalization of the SWS for the Obligation to Suppress Emotions scale, An Intense Motivation to Succeed Despite Limited Resources scale, and the Resistance to Being Vulnerable scale are significantly associated with lower rates of some types of sexual dysfunction. This indicates that high levels of SWS internalization may be protective, possibly due to high resilience and preconditioned psychological defense mechanisms. Low SWS internalization varied inconsistently as it related to sexual dysfunction, with moderate levels of SWS internalization tending to correlate with a higher risk of certain types of sexual dysfunctions.

Covariate Analysis

The study explored covariates that may potentially influence sexual dysfunction. These covariates included age and relationship satisfaction. Participant age was collected as part of the demographic questions, and relationship satisfaction was measured using the Relationship Satisfaction Scale.

Is Age related to SBW schema or Sexual Functioning?

To evaluate if age is a covariate for a connection between SBW schema and sexual functioning, I completed a series of linear regressions with SWS scale as the outcome and age as the predictor. Age was only related to Obligation to Present Strength

scale (*beta* = .143, *t* = 2.98, *p* = .003), indicating that the older the subjects, the more the subjects internalized the need to present an image of strength. It was not related to any other SWS measure.

Next, I assessed whether age was related to changes in sexual functioning. Age and changes in orgasm functioning were marginally related (*beta* = .092, *t* =1.95, *p* = .052), meaning the older the subjects, the more changes in orgasm functioning the subjects experienced. Age was not significantly related to any other changes in sexual functioning subscales.

A two-step linear regression was completed next. Age was found to be non-significant as it related to the impacts of SBW schema internalization on changes in sexual functioning (*beta* = .038, *t* = 0.772, *p* = .44 uncovaried, *beta* = .026, *t* = 0.53, *p* = .595 covaried). This result indicated that, while there were relationships with each of the other variables, age did not mediate the relationship between presenting an image of strength and orgasm functioning.

Is Relationship Satisfaction related to SBW schema or Sexual Functioning?

To evaluate if relationship satisfaction is a covariate for a connection between SBW schema and sexual functioning, I took the following steps. A series of linear regressions were completed with SWS scale as the outcome and relationship satisfaction as the predictor. SWS Motivation to Succeed Despite Limited Resources was noted as having a significant relationship with relationship satisfaction. No other significant relationship between relationship satisfaction and SBW schema was found. Therefore, the

only SWS subscale that was tested for mediation was Motivation to Succeed Despite Limited Resources.

Next, I ran another series of linear regressions to examine the relationship between relationship satisfaction and changes in sexual functioning. Relationship satisfaction was the predictor and changes in sexual functioning the outcome. Table 4.13 shows the results of these analyses.

Table 4.13

Regression Results Examining Relationship Satisfaction and Different Sexual Functioning Measures

	Beta	**T-Value**	**P-Value**
Overall Changes in Sexual Functioning	.172	3.103	.002
Desire/Frequency	.093	1.682	.093
Desire/Interest	.071	1.271	.205
Arousal/Excitement	.139	2.508	.013
Orgasm	.242	4.460	<.001
Pleasure	.341	6.508	<.001

Relationship satisfaction was significantly related to the overall sexual dysfunction scale, arousal/excitement scale, orgasm scale, and pleasure scale. Therefore, I tested whether the relationship between SWS Motivation to Succeed Despite Limited Resources and Overall sexual dysfunction score, arousal/excitement, orgasm, and pleasure reduces after taking relationship satisfaction into account.

A two-stage linear regression for each sexual functioning outcome that was significantly related to relationship satisfaction was completed. First, just SWS Motivation to Succeed Despite Limited Resources was tested to see what its non-covariate relationship is to sexual functioning. Without controlling for relationship

satisfaction, SWS Motivation to Succeed Despite Limited Resources was significantly positively related to changes in sexual functioning overall score (t=2.08, p=.039).

Next, relationship satisfaction was added. This was to answer the questions whether there is a significant relationship and if so, then by how much does the relationship between SWS Motivation to Succeed Despite Limited Resources and sexual functioning change prior to and post controlling for relationship satisfaction. After controlling for relationship satisfaction, SWS Motivation to Succeed Despite Limited Resources was no longer significantly related to changes in sexual functioning overall score (t=1.69, p=.103). In fact, there was an 18.8% reduction in the relationship. Relationship Satisfaction did mediate the relationship between Motivation to Succeed Despite Limited Resources and Arousal/Excitement to non-significant. Table 4.14 presents the results of the mediation analysis, which tested whether relationship satisfaction mediated the impact of the SWS Motivation to Succeed Despite Limited Resources on sexual functioning categories. Outcomes are presented before and after including relationship satisfaction as the covariate.

Table 4.14

Results of Tests for Relationship Satisfaction Mediating the Impact of SWS Motivation to Succeed Despite Limited Resources on Sexual Functioning Indicators

Impact of SWS Motivation to Succeed Despite Limited Resources on Sexual Functioning Indicator	**Changes in Sexual Functioning**			
	Overall Score	**Arousal Sub-score**	**Orgasm Sub-score**	**Pleasure Sub-score**
Non-covaried relationship				
Beta	.117	.098	.054	-.001
P value	.039	.085	.340	.996
Covaried relationship				
Beta	.095	.080	.021	-.046
P value	.103	.160	.706	.369
Percentage change in *Beta*	-18.8%	-18.4%	N/A	N/A

CHAPTER FIVE

DISCUSSION

The aim of this dissertation was to investigate the relationship between the internalization of the Strong Black Woman (SBW) schema and sexual dysfunction. Research has shown that there is a relationship between the SBW schema and sexuality (Crooks et al., 2023). Specifically, Crooks et al. (2023) found that because Black women are socialized at an early age to internalize the characteristics of the SBW schema, their sexual development is impacted. Moreover, research has shown that self-silencing behavior, a tenet of the SBW Schema, is associated with sexual passivity and a lack of sexual assertiveness for Black women (Avery et al., 2022). Research has also shown that Black women who internalize the need to present an image of strength and resist the need to be vulnerable, two components of the SBW schema, are less likely to disclose to a partner or seek treatment for sexual pain (Dogan et al., 2022; Townes et al., 2019). Furthermore, the BeWell Project investigated the relationship between minority stressors such as the SBW schema and sexual distress, reporting a positive correlation between the internalization of the SBW schema and sexual distress (Thorpe et al., 2024). While the literature has linked the internalization of the SBW schema to sexuality, the relationship between sexual dysfunction and the internalization of the SBW schema has not been explored.

My study explored the relationship between the internalization of the SBW schema and sexual dysfunction for Black women. I focused on two questions:

1. To what extent is the internalization of the SBW schema associated with sexual dysfunction in Black women?

2. Is a higher level of SBW schema internalization related to an increased likelihood of specific sexual dysfunction in Black women?

To answer these questions, I used secondary data analysis with data from the BeWell Project (Thorpe et al., 2024). 448 Black women were surveyed using Qualtrics between January and February 2023. I conducted descriptive statistics to get an overview of the data. Following the descriptive analysis, I completed a Pearson correlation to measure the strength and direction between sexual dysfunction and the internalization of the SBW schema amongst Black women. I also conducted a multiple linear regression to determine if the SBW schema predicted sexual dysfunction. Lastly, I conducted a cross-tabulation analysis with a chi-square test statistic to examine the association between categorical variables. Chapter Four describes the results of these analyses. In this chapter, I discuss my research findings, theoretical and practical implications, study limitations, future research suggestions, and my conclusions.

Summary of Findings

Regression analyses and cross-tabulation with a chi-square predictor were used to examine the overall relationship between the internalization of the SBW schema and sexual dysfunction, as well as each subscale of the SBW schema in relation to each domain of sexual dysfunction. The main finding of this study is that there is a significant relationship between the internalization of the SBW schema and sexual dysfunction. In general, as internalization of the SBW schema increased, problems with sexual dysfunction decreased.

Research Question One: To what extent is the internalization of the SBW schema associated with sexual dysfunction in Black women?

The hypothesis that I examined in this section is whether there was a significant relationship between the level of internalization of the SBW schema and sexual dysfunction in Black women. I tested this hypothesis by conducting a series of regression analyses. The analysis revealed a significant negative association between levels of internalization of elements of the SBW schema and specific sexual dysfunctions. Specifically, this finding was observed for sexual desire/interest dysfunction and sexual arousal/excitement dysfunction. The higher the level of SBW schema internalization, the fewer challenges Black women had related to sexual dysfunction as it related to desire/interest and arousal/excitement, which was an unexpected finding.

The analyses examined the relationship between each SWS subscale (the instrument used to measure SBW schema) and the six subscales of sexual dysfunction, which yielded several unexpected findings as follows. The first SWS subscale examined was Obligation to Present an Image of Strength, which yielded a significant positive relationship with arousal/excitement functioning. This unexpected finding indicated that the greater the obligation to present as strong, the better sexual arousal/excitement functioning. The next SWS subscale examined was Obligation to Suppress Emotion. The findings indicated a significant positive relationship between emotional suppression and arousal/excitement dysfunction. An Intense Motivation to Succeed Despite Limited Resources subscale was also positively associated with overall sexual functioning, desire/frequency functioning, desire/interest functioning, and arousal/excitement functioning. This result indicates that the greater the motivation to succeed, the less

sexual dysfunction in those areas. Furthermore, the final scale reviewed was Obligation to Help Others, which had a significant negative relationship as it relates to desire/interest dysfunction. This finding indicates that the higher the internalization of the Obligation to Help Others scale, the better the desire/interest functioning subscale score. Table 5.1 describes results in a synthesized table. In general, desire/interest functioning and arousal/excitement functioning appeared to be the most frequently impacted by the internalization of the SBW schema subscales.

Table 5.1
Summary of SWS Subscales and Sexual Function Outcomes

	Overall Sexual Functioning	**Desire/ Frequency**	**Desire/ Interest**	**Arousal/ Excitement**	**Orgasm**	**Pleasure**
Overall SWS Score	Positive Significant	—	Positive Significant	Positive Significant	—	—
Obligation to Present Image of Strength	—	—	—	Positive Significant	—	—
Obligation to Suppress Emotions	—	—	—	Positive Significant	—	—
Resistance to Vulnerability	Positive Significant	—	Positive Significant	—	—	—
Motivation to Succeed Despite Limited Resources	Positive Significant	Positive Significant	Positive Significant	Positive Significant	—	—
Obligation to Help Others	—	—	Positive Significant	—	—	—

Research Question Two: Is a higher level of SBW schema internalization related to an increased likelihood of specific sexual dysfunction in Black women?

The second hypothesis I examined was that a higher level of SBW schema internalization would be associated with an increased likelihood of experiencing a specific sexual dysfunction, using the scale cut-offs to determine dysfunction. To answer this question, I completed a series of cross-tabulation analyses with a chi-square predictor. This analysis examined each level of the SWS across subscales and each sexual dysfunction category. Table 5.2 is a summary of the results of the analysis to include a highlight of the observed pattern of the analysis.

Table 5.2

Summary of Significant Associations between SWS Internalization (Overall Internalization and Subscales) and the Categories of Sexual Dysfunction

	Significant Domains	**Observed Pattern of Internalization**
Overall SWS Internalization	Overall sexual dysfunction, Desire/Interest dysfunction, Arousal/Excitement dysfunction	Moderate = ↑dysfunction High = ↓ dysfunction
Obligation to Present an Image of Strength	Orgasm dysfunction	Moderate = ↑dysfunction
Obligation to Suppress Emotions	Overall sexual dysfunction, Arousal/Excitement dysfunction	Moderate = ↑dysfunction High = ↓ dysfunction
Resistance to Being Vulnerable	Overall sexual dysfunction, Desire/Interest dysfunction	Low = ↑dysfunction High = ↓ dysfunction
An Intense Motivation to Succeed Despite Limited Resources	Overall sexual dysfunction, Desire/Interest dysfunction	Moderate = ↑dysfunction High = ↓ dysfunction
Obligation to Help Others	Desire/Interest dysfunction	High = ↓ dysfunction

Age was examined to determine if it mediated the experience of sexual dysfunction. Age was positively significantly related to Obligation to Present an Image of

Strength. While there was a relationship to the above variable, age did not mediate the relationship between the internalization of the Obligation to Present an Image of Strength subscale and sexual dysfunction. Relationship satisfaction was also explored to determine if it mediated the experience of sexual dysfunction. Relationship satisfaction was significantly related to SWS Motivation to Succeed Despite Limited Resources. It was also positively significantly associated with the overall sexual dysfunction scale, arousal/excitement scale, orgasm scale, and pleasure scale. Relationship satisfaction did not mediate the relationship between SWS Motivation to Succeed Despite Limited Resources and overall sexual dysfunction, orgasm dysfunction, or pleasure dysfunction. However, it did mediate the relationship for the Motivation to Succeed Despite Limited Resources subscale and arousal/excitement dysfunction, making it non-significant.

The overall pattern demonstrated that moderate internalization of the SBW schema was linked to higher rates of sexual dysfunction, and higher SBW schema internalization was associated with lower rates of sexual dysfunction. This finding was unexpected, as the hypothesis projected a linear relationship.

Implications

The body of literature on the SBW schema and sexuality revealed a need to explore how the SBW schema is related to sexual dysfunction. Furthermore, there is a lack of quantitative research in this area. This dissertation responded to the need for quantitative research in the area of SBW schema and sexual functioning. Theoretical and practical implications have resulted from this study.

Theoretical Implications

My dissertation study was developed and designed using the conceptual framework of Intersectionality (Crenshaw,1989). Kimberlé Crenshaw developed the theory of Intersectionality in the 1980s in response to DeGraffenreid v. General Motors, a legal case in which five Black women alleged that they were being discriminated against based on their gender and race (Crenshaw, 1989). The case was dismissed by the courts, asserting that they could only argue that they were being discriminated against because of race or gender, but not both. Recognizing the gap in both legal and social frameworks, Crenshaw developed Intersectionality theory, coining the term in 1989, to describe the unique marginalization of Black women, having multiple identities that overlap and create a unique oppressive experience that cannot be understood by a single-axis lens (Crenshaw, 1989). Intersectionality highlights how overlapping identities contribute to experiences of oppression or privilege.

My study highlighted Black women and their internalization of the SBW schema as it relates to their experience with sexual dysfunction. This study has theoretical implications for Intersectionality theory, as my focus was on the fact that Black women cannot be viewed through a single lens. Black women experience a unique relationship with sexual dysfunction based on their coping mechanism, the SBW schema, which is employed to cope with experiences of racialized gender oppression that are specific to Black women. While this study did not focus on discrimination, it did focus on Black women's experiences based on their response to societal and systemic stressors.

This study was the first comprehensive quantitative study to examine the relationship between the SBW schema and sexual dysfunction. It also contributes to the

literature on the intersection of racialized gender schemas and Black women's sexual health. This study empirically examined the association of the SBW schema and sexual dysfunction, as well as specific levels of SBW schema internalization and each category of sexual dysfunction. What was surprising about the results was that although there was a significant relationship between SBW schema internalization and overall sexual functioning, desire/interest, and arousal/excitement, the relationship was generally in the opposite direction from what I predicted. That is, generally speaking, the higher the level of SBW schema internalization, the better the sexual functioning.

It is interesting to speculate why higher internalization of the SBW schema was generally associated with lower levels of sexual dysfunction. The obligation to present as strong and to succeed despite limitations may serve as a protective factor, pushing Black women to work harder to experience greater sexual satisfaction and less sexual dysfunction. Another possible interpretation could be that high internalization serves as a protective mechanism, allowing for compartmentalization. Compartmentalizing may allow Black women to maintain sexual functioning despite stressors and sexual functioning issues. This means that Black women with high SBW schema internalization may be able to engage in sexual activity despite distress because of their ability to separate and isolate specific thoughts and emotions, preventing them from negatively impacting sexuality.

Additionally, when a Black woman internalizes the need to be strong, suppress emotions, be invulnerable, succeed despite limitations, and put others before self, sex may be engaged in intentionally with special attention to performance and "showing up" for a sexual partner. This might facilitate physical responsiveness even when there is a

lack of emotion or vulnerability. This means that Black women may be more intentional about their sexual experiences and engaging in sexual activity for the sake of their partnership. In this way, sex becomes a purposeful act. Furthermore, Black women may be deliberate about dismissing experiences of sexual dysfunction to avoid appearing weak to their partner. This may mean they are suppressing their emotions and experiences of dysfunction. In general, engaging in sex, despite dysfunction, becomes an act of resistance, a refusal to accept the issues present, and possibly a willingness to work hard to defy something Black women may perceive as a weakness.

There is also the possibility that Black women with higher SBW schema internalization have increased self-assurance, assertiveness, and a better presence of mind. This may lead them to be more purposeful about their sexual experiences as a result. That is, Black women who have a relatively high internalization of the SBW schema may actively work on areas of sexual functioning that may be problematic or intentionally avoid situations that would highlight sexual dysfunction.

Pleasure was also not significantly related to the SBW schema. This finding may indicate that some Black women can compartmentalize sexual performance and pleasure. Moreover, it is possible that pleasure was conflated with the experience of having an orgasm, which is possible even when intimacy, emotional availability, and desire are not present.

This study also found that relationship satisfaction and the SWS subscale "Motivation to Succeed Despite Limited Resources" were negatively correlated. This result suggests that as relationship satisfaction decreased, the motivation to succeed increased, indicating that there is a drive to achieve even when under-supported by a

partner. Black women who reported lower relationship satisfaction may feel more compelled to be successful in other areas of their lives, allowing "Motivation to Succeed Despite Limited Resources" to serve as a coping mechanism in place of relational support or intimacy. This means that when Black women with relatively high "Motivation to Succeed Despite Limited Resources" struggle in their relationship, they may work harder in other areas of life, such as career, to compensate for the lack of success in their relationship. This finding could also explain how the emotional labor within romantic relationships contributes to the SBW schema's activation and the internalization of the roles of strength and emotional suppression. Relationship satisfaction was also significantly related to the overall sexual dysfunction, arousal/excitement, orgasm, and pleasure. As relationship satisfaction changed, so did each of those categories of sexual functioning, which is consistent with the literature on relationship satisfaction and sexual functioning (Brotto & Nagoski, 2018).

My study generally mirrored past research related to the SBW schema. Specifically, the SBW schema has often been helpful to Black women, particularly in the face of intersectional oppression. However, the need of Black women to appear strong and invulnerable has also been harmful in various areas, including physical health and psychological well-being (Woods-Giscombe, 2010). In my study, the SBW schema has also proved to be both helpful and harmful as it relates to sexual dysfunction. Specifically, high SBW schema internalization was related to better sexual functioning, and moderate internalization was associated with more sexual dysfunction. This could indicate that Black women who have higher internalization have increased self-

confidence, which leads them to care for their sexual selves better and pursue sexual relationships that do not cause sexual distress.

SBW schema internalization and sexual functioning have a complex relationship. On the one hand, high SBW internalization may serve as a protective factor that supports resilience, which supports better sexual functioning. On the other hand, moderate internalization of the SBW schema is associated with sexual dysfunction. This juxtaposition between high and moderate internalization may indicate that Black women's sexual functioning could be empowered through resilience and agency and simultaneously constrained by strength and self-sacrifice. This emphasizes that Black women's sexuality must be understood at the intersection of multiple lenses that consider racialized gendered perspectives.

Practical Implications

This dissertation has practical implications for healthcare providers, mental and relational health providers, sexual health educators, and public health practitioners. The results support the idea that the SBW schema can serve as both a protective factor and a maladaptive coping mechanism. SBW schema internalization assessment can be therapeutically woven into services for Black women, investigating internalized strength-based narratives and their contribution to sexual health disparities. For example, the use of screening tools that assess the internalization of the SBW schema would be useful in identifying the level of internalization and exploring related developmental and schema-based narratives that may impact a client's sexual functioning.

While the SBW schema may help Black women protect themselves from social and systemic oppression, as well as help them achieve their goals, the SBW schema may

also have a negative impact on the well-being and functioning of Black women. To support Black women's sexual functioning, practitioners must move to a decolonized, non-Eurocentric, and non-medicalized understanding of sexual dysfunction. This means that assessment tools and interventions need to be culture-centered and specific to Black women, free from the social effects of colonization, and approached using a person-centered lens. This study reinforces that sexual functioning is not just a matter of biological or psychological function but rather must also be viewed through a cultural lens. Interventions that do not account for the coping mechanisms Black women use to manage intersectional oppression may fail to adequately support Black women's sexual wellness.

Furthermore, these findings can be used to design and promote culturally congruent education and sexual wellness programming that acknowledges the impact of racialized gendered identity. For example, one practical implication is to create a program that focuses on deconstructing sexual myths based on racialized gender stereotypes. Additionally, another implication is to use somatic interventions that focus on the mind-body connection to increase sexual functioning. Therapeutic interventions might focus on better understanding the root cause of sexual dysfunction, which is a combination of multiple components. These components include cultural factors, such as the internalization of the SBW schema, societal messaging, familial messaging, and biological and psychological underpinnings, amongst other things, such as religious beliefs and socioeconomic status.

Limitations

As with any study, this study had limitations. One limitation was the cross-sectional design of the study. A cross-sectional design does not allow one to infer causation between the internalization of the SBW schema and sexual dysfunction. This means that it is unknown whether the internalization of the SBW schema influences sexual dysfunction or if sexual dysfunction reinforces SBW schema internalization (or whether other factors mediate both variables). Additionally, this study relied on self-report measures. All data were collected via a self-report questionnaire that consisted of multiple measures. Self-report questionnaires are subject to response bias, which includes responding in a socially desirable way, error in memory recall, and possibly discomfort with disclosing information related to their sexual experiences (Lavrakas, 2008). Response fatigue was also a limitation. This happens when motivation begins to decline toward the latter part of a survey (Lavrakas, 2008). The survey had over 100 questions and took 20-25 minutes to complete. While the overall sample was 448 participants, only 387 completed both the G-SWS-Q and the CSFQ-14. I speculate this occurred due to participants becoming tired of answering the survey items.

Future Research

While the findings of this study fill in a gap in the literature concerning the roles of the internalization of the SBW schema and sexual dysfunction, additional research needs to be done. Future research should provide an understanding of the internalization of the SBW schema and its relationship to sexual functioning and pleasure, particularly exploring the apparent non-linear relationship observed, in which moderate internalization was associated with higher dysfunction, but high internalization was

associated with lower dysfunction. Additionally, future research should involve additional qualitative studies and examine protective factors.

Qualitative research might help to understand the reason for the unexpected finding that Black women with high SBW schema internalization generally reported better sexual functioning. Quantitative studies can only provide limited information about this question. However, qualitative research, by attending to the lived experiences of Black women, may help to clarify and deepen our understanding of the relationship between internalization of the SBW schema and sexual functioning. Furthermore, qualitative research could also be useful to help answer the questions about why SBW schema internalization at the moderate level impacts sexual desire/interest and arousal. A qualitative study would also help prioritize the narratives of Black women in relation to their experiences.

Another recommendation is for future research to examine protective factors. Examples of protective factors include self-compassion, sex education, culturally competent therapy, and wellness practices. Additionally, it would be valuable to explore how protective factors may mediate the relationship between the internalization of the SBW schema and sexual dysfunction. The development of culturally competent intervention tools that target the reduction of the maladaptive mechanisms of the internalization of the SBW schema without stripping away its helpful properties may be helpful to explore.

Conclusion

The general purpose of my research was to determine if there is a relationship between the level of internalization of the SBW schema and sexual dysfunction. A more

specific aim of my research was to understand the relationship of specific sexual dysfunction categories with various aspects of the SBW schema. The results revealed that moderate SBW schema internalization was associated with sexual dysfunction, whereas high SBW schema internalization was associated with better sexual functioning. Pleasure was not associated with SBW schema internalization. These results were generally unexpected and further demonstrate that the SBW schema is both a protective factor and is correlated with distress for Black women. The higher the level of internalization of the SBW schema, the more protective it may be as it relates to sexual functioning. It is also possible that the better the sexual functioning, the higher the self-confidence for Black women, the more they internalize the SBW schema tenets. Moreover, it may also be an unknown factor that mediates the relationship between SBW schema internalization and sexual dysfunction. The results of my dissertation have both theoretical and practical implications for understanding Black women's sexual functioning and considering best practices related to assessment and intervention. The SBW schema proved to be a valuable lens for understanding sexual functioning for Black women.

REFERENCES

Abrams, J. A., Hill, A., & Maxwell, M. (2019). Underneath the mask of the strong Black woman schema: Disentangling influences of strength and self-silencing on depressive symptoms among U.S. Black women. *Sex Roles, 80*(9–10), 517–526. https://doi.org/10.1007/s11199-018-0956-y

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Publishing.

American Psychological Association. (n.d.). Internalization. In *APA Dictionary of Psychology*. Retrieved March 29, 2025, from https://dictionary.apa.org/internalization

Anderson, C. L. (2019). Opioids are the new black. *DePaul Law Review, 69*(1), 55–93. https://via.library.depaul.edu/law-review/vol69/iss1/3/

Anyiwo, N., Stanton, A. G., Avery, L. R., Bernard, D. L., Abrams, J. A., & Golden, A. (2022). Becoming strong: Sociocultural experiences, mental health, and Black girls' strong Black woman schema endorsement. *Journal of Research on Adolescence, 32*(1), 89–98. https://doi.org/10.1111/jora.12707

Avery, L. R., Stanton, A. G., Ward, L. M., Trinh, S. L., Cole, E. R., & Jerald, M. C. (2022). The strong, silent (gender) type: The strong Black woman ideal, self-silencing, and sexual assertiveness in Black college women. *Archives of Sexual Behavior, 51*(3), 1509–1520. https://doi.org/10.1007/s10508-021-02179-2

Ayee, G. Y. A., Johnson Carew, J. D., Means, T. N., Reyes-Barriéntez, A. M., & Sediqe, N. A. (2019). White House, Black mother: Michelle Obama and the politics of motherhood as First Lady. *Politics & Gender, 15*(3), 460–483.

https://doi.org/10.1017/S1743923X1900031X

Basson, R. (2002). A model of women's sexual arousal. *Journal of Sex & Marital Therapy, 28*(1), 1–10. https://doi.org/10.1080/0092623023172510704

Beauboeuf-Lafontant, T. (2009). *Behind the mask of the strong Black woman: Voice and the embodiment of a costly performance*. Temple University Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. Guilford Press.

Bellinger, J. D., Millegan, W., & Abdalla, A. E. (2015). I'm not ashamed to talk on it!: African-American women's decisions about cervical cancer prevention and control in South Carolina. *Women's Health Issues, 25*(2), 120–127. https://doi.org/10.1016/j.whi.2014.10.006

Black, A. R., & Woods-Giscombé, C. (2012). Applying the stress and "strength" hypothesis to Black women's breast cancer screening delays. *Stress and Health, 28*(5), 389–396. https://doi.org/10.1002/smi.2464

Black Lives Matter. (2017, July 7). *Editorial herstory*. https://blacklivesmatter.com/herstory/

Bond, K. T., Leblanc, N. M., Williams, P., Gabriel, C. A., & Amutah-Onukagha, N. N. (2021). Race-based sexual stereotypes, gendered racism, and sexual decision making among young Black cisgender women. *Health Education & Behavior, 48*(3), 295–305. https://doi.org/10.1177/10901981211010086

Bortolami, A., Vanti, C., Banchelli, F., Guccione, A. A., & Pillastrini, P. (2015).

Relationship between female pelvic floor dysfunction and sexual dysfunction: An observational study. *The Journal of Sexual Medicine, 12*(5), 1233–1241. https://doi.org/10.1111/jsm.12882

Chapa, H. O., Fish, J. T., Hagar, C., & Wilson, T. (2020). Prevalence of female sexual dysfunction among women attending college presenting for gynecological care at a university student health center. *Journal of American College Health, 68*(1), 52–60. https://doi.org/10.1080/07448481.2018.1515751

Chisari, C., Monajemi, M. B., Scott, W., Moss-Morris, R., & McCracken, L. M. (2021). Psychosocial factors associated with pain and sexual function in women with vulvodynia: A systematic review. *European Journal of Pain, 25*(1), 39–50. https://doi.org/10.1002/ejp.1668

Clayton, A. H., McGarvey, E. L., & Clavet, G. J. (1997). The Changes in Sexual Functioning Questionnaire (CSFQ): Development, reliability, and validity. *Psychopharmacology Bulletin, 33*(4), 731–745. https://www.proquest.com/scholarly-journals/changes-sexual-functioning-questionnaire-csfq/docview/212441913/se-2

Clayton, A. H., McGarvey, E. L., Clavet, G. J., & Piazza, L. (1997). Comparison of sexual functioning in clinical and nonclinical populations using the Changes in Sexual Functioning Questionnaire (CSFQ). *Psychopharmacology Bulletin, 33*(4), 747–753.

Collins, P. H. (2000). Gender, Black feminism, and Black political economy. *The ANNALS of the American Academy of Political and Social Science, 568*(1), 41–53. https://doi.org/10.1177/000271620056800105

Collins, P. H. (2019). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (4th ed.). Routledge.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum, 1989*(1), 139–167.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Crenshaw, K. (2016, October). *The urgency of intersectionality* [Video]. TED Conferences. https://www.ted.com/talks/kimberle_crenshaw_the_urgency_of_intersectionality?subtitle=en

Crooks, N., Barrie, R., Singer, R., & Donenberg, G. (2023). The role of the strong Black woman in Black female sexual development. *Archives of Sexual Behavior, 52*(4), 1389–1402. https://doi.org/10.1007/s10508-023-02529-2

Davis, S. M. (2018). Taking back the power: An analysis of Black women's communicative resistance. *Review of Communication, 18*(4), 301–318. https://doi.org/10.1080/15358593.2018.1461234

Davis, S. M., & Jones, M. K. (2021). Black women at war: A comprehensive framework for research on the strong Black woman. *Women's Studies in Communication, 44*(3), 301–322. https://doi.org/10.1080/07491409.2020.1838020

DeLamater, J. G., & Sill, M. (2005). Sexual desire in later life. *Journal of Sex Research, 42*(2), 138–149.

Dogan, J. N., Thorpe, S. Y., Malone, N., Jester, J., Stevens-Watkins, D., & Hargons, C. (2022). 'My partner will think I'm weak or overthinking my pain': How being superwoman inhibits Black women's sexual pain disclosure to their partners. *Culture, Health & Sexuality*. https://doi.org/10.1080/13691058.2022.2072956

Feimster, C. N. (2009). *Southern horrors: Women and the politics of rape and lynching*. Harvard University Press.

Gammage, M. M. (2016). *Representations of Black women in the media: The damnation of Black womanhood*. Routledge.

García, J. D. (2024). Black feminism. *Salem Press Encyclopedia*.

Geyton, T., Johnson, N., & Ross, K. (2022). "I'm good": Examining the internalization of the strong Black woman archetype. *Journal of Human Behavior in the Social Environment, 32*(1), 1–16. https://doi.org/10.1080/10911359.2020.1844838

Gunasekaran, K., & Khan, S. D. (2019). Erectile dysfunction. In *Erectile dysfunction* (pp. 33–43). Springer Singapore. https://doi.org/10.1007/978-981-13-1226-7_3

Halvorsen, J. G., & Metz, M. E. (1992). Sexual dysfunction, Part I: Classification, etiology, and pathogenesis. *The Journal of the American Board of Family Practice, 5*(1), 51–61.

Hansen, M., Andersen, T. E., Armour, C., Elklit, A., Palic, S., & Mackrill, T. (2010). PTSD-8: A short PTSD inventory. *Clinical Practice and Epidemiology in Mental Health, 6*(1), 101–108. https://doi.org/10.2174/1745017901006010101

Harris-Perry, M. V. (2011). *Sister citizen: Shame, stereotypes, and Black women in America*. Yale University Press.

Higginbotham, E. B. (1992). African-American women's history and the metalanguage of

race. *Signs: Journal of Women in Culture and Society, 17*(2), 251–274.

Higginbotham, E. B. (1993). *Righteous discontent: The women's movement in the Black Baptist Church, 1880–1920*. Harvard University Press.

Hill, L., Artiga, S., & Ranji, U. (2022, November 1). Racial disparities in maternal and infant health: Current status and efforts to address them. *Kaiser Family Foundation*. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113

Holman, A. R. (2012). *Gendered racial socialization in Black families: Mothers' beliefs, approaches, and advocacy* (Doctoral dissertation, University of California, Berkeley). *eScholarship*. https://escholarship.org/uc/item/7xd4r8w8

Howarth, A., Freeston, M., Reichelt, K., & James, I. A. (2014). Clinicians' views on the clinical utility of a revised definition of schema and its implications for the treatment of depression. *The Cognitive Behaviour Therapist, 7*, E24. https://doi.org/10.1017/S1754470X14000026

Jones, M. K., Harris, K. J., & Reynolds, A. A. (2021). In their own words: The meaning of the strong Black woman schema among Black U.S. college women. *Sex Roles, 84*(5–6), 347–359. https://doi.org/10.1007/s11199-020-01170-w

Kalmbach, D. A., Ciesla, J. A., Janata, J. W., & Kingsberg, S. A. (2012). Specificity of anhedonic depression and anxious arousal with sexual problems among sexually healthy young adults. *The Journal of Sexual Medicine, 9*(2), 505–513. https://doi.org/10.1111/j.1743-6109.2011.02533.x

Keller, A., McGarvey, E., & Clayton, A. (2006). Reliability and construct validity of the Changes in Sexual Functioning Questionnaire Short-Form (CSFQ-14). *Journal of Sex & Marital Therapy, 32*(1), 43–52. https://doi.org/10.1080/00926230500232909

Kennedy, R. (1998). *Race, crime, and the law*. Random House.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., Walters, E. E., & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959–976. https://doi.org/10.1017/S0033291702006074

Khan, S. D., & Gunasekaran, K. (2019). The human sexual response. In *Erectile dysfunction* (pp. 1–13). Springer Singapore. https://doi.org/10.1007/978-981-13-1226-7_1

Kinghorn, G. (2001). A sexual health and HIV strategy for England. *BMJ (Clinical Research Ed.), 323*(7307), 243–244. https://doi.org/10.1136/bmj.323.7307.243

Lakshmi, M., & Khan, S. D. (2019). Sexual pain disorders in women. In *Erectile dysfunction* (pp. 99–107). Springer Singapore. https://doi.org/10.1007/978-981-13-1226-7_7

Lakshmi, M., & Khan, S. D. (2019). Female sexual dysfunction. In *Erectile dysfunction*

(pp. 85–98). Springer Singapore. https://doi.org/10.1007/978-981-13-1226-7_6

Latimer, A., Onuoha, A. C., Key, D., & Leath, S. (2024). Piecing together respectability: Black women's reflections on familial socialization messages. *Sex Roles, 90*(7), 811–831. https://doi.org/10.1007/s11199-024-01486-x

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1992). *National Health and Social Life Survey: [United States]*. Inter-university Consortium for Political and Social Research. https://doi.org/10.3886/ICPSR06647.v2

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *JAMA, 281*(6), 537–544. https://doi.org/10.1001/jama.281.6.537

Leath, S., Billingsley, J., Jones, M., Johnson, K., Taliaferro, J., & Gaskin-Cole, G. (2023). Raising resilient Black women: A study of superwoman mothering and strength as a form of gendered racial socialization in Black mother-daughter relationships. *Sex Roles, 89*(11–12), 625–642. https://doi.org/10.1007/s11199-023-01417-2

Leath, S., Pittman, J. C., Grower, P., & Ward, L. M. (2020). Steeped in shame: An exploration of family sexual socialization among Black college women. *Psychology of Women Quarterly, 44*(4), 450–467. https://doi.org/10.1177/0361684320948539

Lewis, R., Bosó Pérez, R., Maxwell, K. J., Reid, D., Macdowall, W., Bonell, C., & Mitchell, K. R. (2024). Conceptualizing sexual wellbeing: A qualitative investigation to inform development of a measure (Natsal-SW). *The Journal of Sex Research*. https://doi.org/10.1080/00224499.2024.2326933

Liao, K. Y. H., Wei, M., & Yin, M. (2020). The misunderstood schema of the strong Black woman: Exploring its mental health consequences and coping responses among African American women. *Psychology of Women Quarterly, 44*(1), 84–104. https://doi.org/10.1177/0361684319883198

Malone, N., Thorpe, S., Jester, J. K., Dogan, J. N., Stevens-Watkins, D., & Hargons, C. N. (2022). Pursuing pleasure despite pain: A mixed-methods investigation of Black women's responses to sexual pain and coping. *Journal of Sex & Marital Therapy, 48*(6), 552–566. https://doi.org/10.1080/0092623X.2021.2012309

Cerentini, T. M., La Rosa, V. L., Goulart, C. L., Latorre, G. F. S., Caruso, S., & Sudbrack, A. C. (2023). Female sexual dysfunctions: Prevalence and related factors in a sample of young university women – A cross-sectional study. *Sexual & Relationship Therapy, 38*(1), 106–117. https://doi.org/10.1080/14681994.2020.1748592

Maruccia, S., & Maurizi, A. (2017). Anatomical and physiological description of women's sexuality. In *Female sexual function and dysfunction*. Springer.

McCarthy, B., & Cohn, D. M. (2017). Treatment of male hypoactive sexual desire disorder. In *Clinical handbook of sexual disorders* (pp. 135–149). Springer. https://doi.org/10.1007/978-3-319-52539-6_9

McLaurin-Jones, T. L., Anderson, A. S., Marshall, V. J., Lashley, M. B., & Carter-Nolan, P. L. (2021). Superwomen and sleep: An assessment of Black college women across the African Diaspora. *International Journal of Behavioral Medicine, 28*(1), 130–139. https://doi.org/10.1007/s12529-020-09930-4

McGuire, D. L. (2011). *At the dark end of the street: Black women, rape, and resistance: A new history of the civil rights movement from Rosa Parks to the rise of Black*

power. Vintage.

Meston, C. M., & Buss, D. M. (2007). Why humans have sex. *Archives of Sexual Behavior, 36*(4), 477–507. https://doi.org/10.1007/s10508-007-9175-2

Meston, C. M., & Stanton, A. M. (2017). Evaluation of female sexual interest/arousal disorder. In W. IsHak (Ed.), *The textbook of clinical sexual medicine* (pp. 99–110). Springer.

Meyers, M., & Goman, C. (2017). Michelle Obama: Exploring the narrative. *Howard Journal of Communications, 28*(1), 20–35. https://doi.org/10.1080/10646175.2016.1235520

Milner, H. R. (2007). Race, culture, and researcher positionality: Working through dangers seen, unseen, and unforeseen. *Educational Researcher, 36*(7), 388–400. https://doi.org/10.3102/0013189X07309471

Mitchell, K. R., Lewis, R., O'Sullivan, L. F., & Fortenberry, J. D. (2021). What is sexual well-being and why does it matter for public health? *The Lancet Public Health, 6*(8), e608–e613. https://doi.org/10.1016/S2468-2667(21)00099-2

National Cancer Institute. (2022). *Sexual health issues in men with cancer*. https://www.cancer.gov/about-cancer/treatment/side-effects/sexuality-men

National Center for Education Statistics. (2020). College enrollment rates. In *The condition of education 2020* (NCES 2020-144). U.S. Department of Education, Institute of Education Sciences. https://nces.ed.gov/programs/coe/pdf/coe_cpb.pdf

Oshin, L. A., & Milan, S. (2019). My strong, Black daughter: Racial/ethnic differences in the attributes mothers value for their daughters. *Cultural Diversity and Ethnic Minority Psychology, 25*(2), 179–187. https://doi.org/10.1037/cdp0000206

Owolabi, O. O., Hopkins, J., Bankole, A., & Bearak, J. (2024). Progress towards

sustainable development goals related to sexual health. *Bulletin of the World Health Organization, 102*(12), 895–903. https://doi.org/10.2471/BLT.23.291163

Parks, A. K., & Hayman, L. L. (2024). Unveiling the Strong Black Woman schema—Evolution and impact: A systematic review. *Clinical Nursing Research, 33*(5), 395–404. https://doi.org/10.1177/10547738241234425

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135*(4), 531–554. https://doi.org/10.1037/a0016059

Pettit, B., & Gutierrez, C. (2018). Mass incarceration and racial inequality. *American Journal of Economics and Sociology, 77*(3–4), 1153–1182. https://doi.org/10.1111/ajes.12241

Pereira, V. M., Arias-Carrión, O., Machado, S., Nardi, A. E., & Silva, A. C. (2013). Sex therapy for female sexual dysfunction. *International Archives of Medicine, 6*(1), 37. https://doi.org/10.1186/1755-7682-6-37

Prather, C., Fuller, T. R., Jeffries, W. L., IV, Marshall, K. J., Howell, A. V., Belyue-Umole, A., & King, W. (2018). Racism, African American women, and their sexual and reproductive health: A review of historical and contemporary evidence and implications for health equity. *Health Equity, 2*(1), 249–259. https://doi.org/10.1089/heq.2017.0045

Rao, T. S. S., Tripathi, A., Manohar, S., & Tandon, A. (2024). Promoting sexual well-being. *Indian Journal of Psychiatry, 66*(Suppl 2), S262–S271. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_612_23

Roberts, D. E. (1997). *Killing the Black body: Race, reproduction, and the meaning of liberty*. Pantheon Books.

Romero, R. E. (2000). The icon of the strong Black woman: The paradox of strength. In L. C. Jackson & B. Greene (Eds.), *Psychotherapy with African American women: Innovations in psychodynamic perspectives and practice* (pp. 225–238). Guilford Press.

Rosen, R. C. (2000). Prevalence and risk factors of sexual dysfunction in men and women. *Current Psychiatry Reports, 2*(3), 189–195. https://doi.org/10.1007/s11920-996-0006-2

Ross, J. (2024). Identifying and assessing sexual dysfunction: Strategies for counselors. *Journal of Mental Health Counseling, 46*(1), 2–18.

Schachtman, R., & Kaiser, C. R. (2024). Bystanders' thresholds for intervention in Black vs. White women's sexual harassment. *PLOS ONE, 19*(2), e0296755. https://doi.org/10.1371/journal.pone.0296755

Segraves, R. T., & Balon, R. (2014). Antidepressant-induced sexual dysfunction in men. *Pharmacology Biochemistry and Behavior, 121*, 132–137. https://doi.org/10.1016/j.pbb.2013.11.003

Sood, R., Mara, K. C., Vencill, J. A., Kling, J. M., & Faubion, S. S. (2024). Association of resilience with female sexual dysfunction. *Maturitas, 183*, 107939. https://doi.org/10.1016/j.maturitas.2024.107939

Spillers, H. J. (2009). Views of the East Wing: On Michelle Obama. *Communication and Critical/Cultural Studies, 6*(3), 307–310.

Shaeer, O., & Shaeer, K. (2012). The Global Online Sexuality Survey (GOSS):

Ejaculatory function, penile anatomy, and contraceptive usage among Arabic-speaking internet users in the Middle East. *Journal of Sexual Medicine, 9*(2), 425–433. https://doi.org/10.1111/j.1743-6109.2011.02338.x

Shaevitz, M. H. (1984). *The superwoman syndrome*. Warner Books.

Shifren, J. L., Monz, B. U., Russo, P. A., Segreti, A., & Johannes, C. B. (2008). Sexual problems and distress in United States women: Prevalence and correlates. *Obstetrics and Gynecology, 112*(5), 970–978. https://doi.org/10.1097/AOG.0b013e3181898cdb

Smith, C. J. (2021). *Understanding the experiences of Black women in obtaining marital partners while pursuing advanced degrees* (Doctoral dissertation, Oakland University). *ProQuest Dissertations & Theses Global*.

Suschinsky, K. D., & Lalumière, M. L. (2011). Prepared for anything? An investigation of female genital arousal in response to rape cues. *Psychological Science, 22*(2), 159–165. https://doi.org/10.1177/0956797610394660

The Combahee River Collective. (2019). A Black feminist statement. *Monthly Review, 70*(8), 29–36. https://doi.org/10.14452/MR-070-08-2019-01_3

Thomas, K. (2006). *Gender role development in African Americans: The impact of the "strong Black woman" stereotype* (Unpublished master's thesis). University of Michigan.

Thomas, Z., Banks, J., Eaton, A. A., & Ward, L. M. (2022). 25 years of psychology research on the "Strong Black Woman." *Social and Personality Psychology Compass, 16*(9), e12705. https://doi.org/10.1111/spc3.12705

Thorpe, S., Dogan-Dixon, J., Malone, N., & Palomino, K. A. (2024). 'Just be strong and

keep going': The influence of Superwoman Schema on Black women's perceived expectations of coping with sexual pain. *Culture, Health & Sexuality, 26*(3), 346–361. https://doi.org/10.1080/13691058.2023.2210199

Townes, A., Fu, T.-C. (J.), Herbenick, D., & Carter, A. (2019). Painful sex among White and Black women in the United States: Results from a nationally representative study. *The Journal of Sexual Medicine, 16*(Suppl. 1), S26. https://doi.org/10.1016/j.jsxm.2019.03.512

Townes, A., Thorpe, S., Parmer, T., Wright, B., & Herbenick, D. (2021). Partnered sexual behaviors, pleasure, and orgasms at last sexual encounter: Findings from a U.S. probability sample of Black women ages 18 to 92 years. *Journal of Sex & Marital Therapy, 47*(4), 353–367. https://doi.org/10.1080/0092623X.2021.1878315

Walker-Barnes, C. (2014). *Too heavy a yoke: Black women and the burden of strength*. Cascade Books.

Wang, R., Carson, K. A., Sao, S. S., & Coleman, J. S. (2023). Association of neighborhood economic status and race with developing pelvic inflammatory disease after sexually transmitted infections. *Obstetrics & Gynecology, 142*(4), 948–955. https://doi.org/10.1097/AOG.0000000000005341

Warren-Findlow, J. (2006). Weathering: Stress and heart disease in African American women living in Chicago. *Qualitative Health Research, 16*(2), 221–237. https://doi.org/10.1177/1049732305278651

Washington, D. A. (2012). Examining the "stick" of accreditation for medical schools through a reproductive justice lens: A transformative remedy for teaching the

Tuskegee Syphilis Study. *Journal of Civil Rights and Economic Development, 26*(1), 153–195.

Watson-Singleton, N. N., Spivey, B. N., Harrison, E. G., Nelson, T., & Lewis, J. A. (2024). Double-edged sword or outright harmful? Associations between Strong Black Woman schema and resilience, self-efficacy, and flourishing. *Sex Roles, 90*(9), 1123–1135. https://doi.org/10.1007/s11199-024-01503-z

Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist, 57*(8), 1152–1173. https://doi.org/10.1177/0002764213487340

Weeks, G. R., & Gambescia, N. (2002). *Hypoactive sexual desire: Integrating sex and couple therapy*. W. W. Norton.

West, C., & Johnson, K. (2013). Sexual violence in the lives of African American women. https://doi.org/10.13140/2.1.3850.9444

West, C. M. (1995). Mammy, Sapphire, and Jezebel: Historical images of Black women and their implications for psychotherapy. *Psychotherapy, 32*(3), 456–466. https://doi.org/10.1037/0033-3204.32.3.456

West, L. M., Donovan, R. A., & Daniel, A. R. (2016). The price of strength: Black college women's perspectives on the strong Black woman stereotype. *Women & Therapy, 39*, 390–412. https://doi.org/10.1080/02703149.2016.1116871

White, D. G. (1999). *Ar'n't I a woman?: Female slaves in the plantation South*. W. W. Norton & Company.

World Health Organization. (2006). *Current working definition of sexual health*. https://www.who.int/health-topics/sexual-health#tab=tab_2

Woods-Giscombé, C. L. (2010). Superwoman schema: African American women's views on stress, strength, and health. *Qualitative Health Research, 20*(5), 668–683. https://doi.org/10.1177/1049732310361892

Woods-Giscombé, C. L., Allen, A. M., Black, A. R., Steed, T. C., Li, Y., & Lackey, C. (2019). The Giscombe Superwoman Schema Questionnaire: Psychometric properties and associations with mental health and health behaviors in African American women. *Issues in Mental Health Nursing, 40*(8), 672–681. https://doi.org/10.1080/01612840.2019.1584654

Zheng, J., Skiba, M. A., Bell, R. J., Islam, R. M., & Davis, S. R. (2020). The prevalence of sexual dysfunctions and sexually related distress in young women: A cross-sectional survey. *Fertility and Sterility, 113*(2), 426–434. https://doi.org/10.1016/j.fertnstert.2019.09.027