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Racial Stressors, Resiliency, and African American Women Counselors

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Walden University
2024

Abstract

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MS, Prescott College, 2015

BS, Lesley University, 2011

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

African American women therapists are the second largest group of counseling providers, with many displaying behavioral health symptoms differently than other cultures. This quantitative correlational cross-sectional study explored the resiliency of African American women counselors related to racial-specific stressors inclusive of self-identity, COVID-19 anxiety, and daily discrimination. Initially, three research questions were selected to investigate the relationship between demographic factors (age, education level, active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination), and resiliency in 112 African American women counselors. Emails and an online survey were sent to collect data to answer the research hypotheses. Multiple linear regression analyses were used to process the data, which showed no statistically significant relationships between racial stressors, demographics, and resiliency. However, post-data analysis prompted two additional research questions as many African American women counselors' level of anxiety due to COVID-19 and their resiliency, and daily discrimination and society's viewpoint about a person being Black showed negative relationships. African American counselors indicated some form of public discrimination. The implication for positive social change includes the expanded cultural understanding of racial-specific stressors and resiliency, which enhances professional and peer discussions, self-care initiatives, and training program design.

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Dedication

I dedicate this dissertation to God the Father and my Lord Jesus Christ, who placed the thought of completing a Ph.D. into my mind in the first place. I would have stopped my formal education with a master's degree and would have been happy with it. However, God put wonderfully caring people and situations in my life that encouraged and pushed me beyond complicity. One of those people was my mom, who endured her 2nd stroke, the return of breast cancer, and finally passed away from ovarian cancer in the middle of this dissertation process. My second supporter is my daughter Aziah, a fighter in her own right; despite what gets in her way, she becomes more creative, assertive, courageous, and open to new ideas and opportunities. Another inspiration was my great-aunt Emma, who, throughout her 88 years of life, overcame cultural, racial, and gender disparities on her terms. Unfortunately, she unexpectedly passed away in spring 2023, so she never saw the finished product, but she voiced many times how proud she was of me. Finally, I am eternally grateful to my village, including family members: Ms. Lisa Wright, Mrs. Eveline Quinerly, Mrs. Gloricia Foderingham, Mr. and Mrs. Desi and Jennifer Alexander, and Ms. Wennifer Williams. My mentors on this journey are Dr. Christiane Seifring, Ms. Johnnie Hadley, Ms. BriGette McCoy, Ms. Sharon Harris, and Dr. Marlena Glover (Walden alum). So many other family members, mentors, prayer warriors, friends, and peers poured their love, time, and energy into me, and my gratitude for your presence in my life is endless. As an African American woman born into poverty in a single-parent household and became a single parent myself, I was not expected to succeed. However, God had other plans and still does.

Acknowledgments

I want to thank my Chair, Dr. Nathan Moran, for his support during this challenging process. Dr. Tammy Totten, I appreciated your attention to detail that provided the structure necessary for this work to make sense to everyone. Finally, I would like to thank Dr. Shari Jorissen for the opportunity to write a research paper that was meaningful and rich in cultural and gender knowledge that supported my social and personal commitment to the culture and racial group I represent.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

African American women play a significant role in the physical and mental care of others. The United States Bureau of Labor Statistics (2021) showed that a third of the 2.8 million health and behavior providers identified as African American women. Mental health providers are ethically responsible for self-assessing their physical, emotional, spiritual, social, and mental wellness, but resiliency-specific management is nonexistent (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2021; Clayton et al. 2021; Warren et al., 2010). The absence of resiliency-specific management strategies for African American counselors was evident during the coronavirus pandemic (Cook et al., 2021; Newell, 2020). Unlike area-specific natural disasters, the coronavirus pandemic redefined mental health availability because of the mask mandates and social distancing practices and highlighted the need for racial-specific resiliency programs (Kumar & Nayar, 2021; Lambert & Lawson, 2013; Szilagyi, 2021).

Seeking mental health care is not easy for many African Americans. African American adults with severe behavior diagnoses chose not to go to counseling because of monetary concerns, self-imposed ideals, fear of being ostracized by family or friends, or adverse social and historical perceptions (Campbell & Mowbray, 2016; Center for Behavioral Health Statistics & Quality, 2021; Hall et al. 2021). On the other hand, 33% to 57% of African American women sought counseling services for mild to severe diagnoses, and 37% benefitted from treatment (Center for Behavioral Health Statistics &

Quality, 2021). African American women experience a complex mixture of lifetime cultural stressors that sometimes required an appearance positive and overly confident behavior despite their negative feelings (Abrams et al., 2014; Knowles & Bryant, 2011; Geyton et al., 2022; Watson & Hunter, 2015).

Although resilience factors are critical when dealing with crises, mental health professionals without healthy coping skills or robust supportive environments risk psychological decline (Hamilton-Mason et al., 2009; Howard & Navega, 2018). Resilient or adaptable behavior is familiar to the African American culture; however, that presentation of strength may be false (Anderson, 2019; Odafe et al., 2017). Self-care practices are essential for helping professionals; however, social influences may weaken that resiliency (Baker & Gabriel, 2021; Miller & Owens, 2019; Sandil et al., 2015). Former studies on psychological distress and natural wellness suggested that a person's drive depends on multiple internal and external factors that will be attended to or ignored (Fox et al., 2021; Morin et al., 2017; Sumner et al., 2016). Nevertheless, resilient, or adaptable behavior may be a challenge that elicits a false representation among some African American counselors (Jones & Sam, 2018; Mercer et al., 2011).

Through this quantitative correlational cross-sectional study, I increased knowledge about African American women counselors' emotional health affected by racially specific stressors and offered insight into potential culturally specific treatments and educational training for mental health professionals. Because the professional counseling career does not have a retirement timeline, all participants must meet the educational requirement to participate in my study (American Counseling Association,

2014; American Psychological Association, 2017; National Association of Social Workers, 2021). Therefore, 98 participants are needed for a vigorous study (Faul et al., 2009; Gladding, 2019). This first chapter contains background information, problem statement, the purpose of the study, research questions and hypotheses, theoretical framework, the nature of the study, definitions, assumptions, scope, delimitations, limitations, and significance of the research study.

Background

As a human being, it is natural that any social, biological, and job concerns cross over into the other areas of a counselor's life, unfortunately creating distress and less self-compassion (Friedman, 2017; Koffer et al., 2016; Posluns & Gall, 2020). The collective presence of racial-specific stressors and transitional stages in age, relationship, physical health, identity, and personal resources can impact African American women's resiliency (Schulz et al., 2000; Thomas et al., 2018). In addition, sometimes indirect sources of racism, such as news reporting about an African American being harmed, prompts some form of emotional reaction (Alsan et al., 2020; Chae et al., 2021). For resiliency to be optimal, culturally specific resiliency training may help.

Unfortunately, the presentation of distress is different for many African American women. When an African American woman counselor experiences symptoms of depression, anxiety, or loneliness, it may not be as apparent because the persona of strength, such as the stereotype of a Strong Black Woman, may obscure their understanding of a positive or negative reaction (Donavon &West, 2015; Liao et al., 2020). By definition, a Strong Black Woman is a community-imposed reflection of an

African American woman's strength or added burden, or a sense of dishonor and discrimination for some, which can prohibit her from taking part in mental health care (Hall et al., 2021; Watson & Hunter, 2015). African American women may view their cultural identity as a defense against harmful social perceptions and motivation to succeed academically (Butler-Barnes et al., 2018; Geyton et al., 2022). Being a Strong Black Woman in the presence of emotional and social ties and stereotypical cultural behavior may provide positive reinforcement or negative implications about her character (Davis & Afifi, 2019; Stewart et al., 2014; Watson-Singleton, 2017).

Overlooking racial identity is not entirely possible for the African American woman because the historical context of strength made it seem like African American women were invincible (Avent-Harris, 2019; Geyton et al., 2022; Hall et al., 2021; Hamilton-Mason et al., 2009; Watson & Hunter, 2015). However, the African American woman counselor is as vulnerable as other counselors, but she learned resilient behavior that helped her to hide it to protect herself, her community, and her professional self (Abrams et al., 2014; Hall et al., 2021; Geyton et al., 2022). A resilient African American woman counselor is paramount as the helping relationship can be a two-way conduit of emotional stability between therapist and client, as well as a professional expectation based on her appearance and gender (Howard & Navega, 2018; Geyton et al., 2022; Lakioti et al., 2020). Racial identity is not just a belief but a foundation that can strengthen or diminish her resolve as she encounters other forms of stress, such as the physical and mental distress of the coronavirus (Abrams et al., 2014; Hall et al., 2021).

The coronavirus, or COVID-19, highlighted the sensitivity of the African American community to infectious diseases (Centers for Disease Control and Prevention, 2021). At the height of the pandemic people from different countries and cultures experienced fear and anxiety about COVID-19 symptoms that could lead to death; but African Americans shared some of the highest infection rates (Chae et al., 2021; Rosen et al., 2020). Adverse mental strain for people within the African American community resulted from previous worldwide calamities (Chae et al., 2021; Ferreira et al., 2020; Novacek et al., 2020; Stark et al., 2020). The increased vulnerability might be in part due to medical care expenses, lack of trust in the medical system, or limited cultural understanding of medical or mental health practitioners (Alsan et al., 2020; Cha & Cohen, 2020; Chae et al., 2021; Lynch, 2021; Novacek et al., 2020; Vernon, 2020). Wellness considerations were not the only resiliency issues during the pandemic; safety measures created another obstacle (Chaban et al., 2021).

Safety protocols for COVID-19 changed the counseling delivery protocols and challenged mental health professionals' resiliency (Rosen et al., 2020). Face-to-face sessions decreased, and telehealth increased, which added pressures like maneuvering an online platform and maintaining confidentiality for clients while working from home or seclusion from everyone at the behavior health worksite (Agba et al., 2020; Bray, 2020; Chong et al., 2020; Rosen et al., 2020). Although these isolative conditions helped connect the clients to a therapist, resiliency practices changed as working from home increased the mental health providers' responsibilities, including being a daycare provider, schoolteacher, and child's playmate (Agba et al., 2020; Lippin, 2020; Prime et

al., 2020; Shepherd-Banigan et al., 2016). Social interactions outside the home were few without masks, a physical precaution that could not protect the African American counselors from nationally broadcasted race-directed crimes that hurt many in their community (Prime et al., 2020).

In 2020, discriminatory practices toward African Americans were more evident in the United States (Chae et al., 2020). The senseless deaths of African American men and women publicized on national television highlighted reasons for distrust in society and increased racial-specific campaigns to address such issues (Chae et al., 2020; Husband, 2016). Understanding the dilemma by safely talking about it or, on the other hand, hiding their feelings about these events to protect their loved ones and their clients was vital for improving African American women's resiliency (Baker & Gabriel, 2021; Campbell & Mowbray, 2016). The overlapping of multiple social experiences was quite different for the African American woman counselor (Husband, 2016; West, 2015). However, it is reasonable to believe that culturally tailored training and resiliency programs may aid her resilient life (Carter & Rossi, 2019; Husband, 2016; West, 2015).

Current counseling programs focus on ethical and social considerations from their clients' viewpoint, helping the therapist to acknowledge their cultural attitudes toward their clients so that they can make better treatment decisions (Gerstein et al., 2011; Kivlighan et al., 2019; Oramas 2017; Ridley et al., 2021). This accountability structure may accelerate the appearance of countertransference and vicarious trauma within the counseling professional especially considering the pandemic and increased social unrest (Stefanatou et al., 2022; Veach et al., 2020). This study fills in the gap by distinguishing

between the resiliency of African American women counselors related to self-identity, COVID-19 pandemic anxiety, daily discrimination, and other mental health providers.

This study is needed because resiliency management and psychological training tailored to African American women-specific needs may be an effective intervention for strengthening the resiliency of counseling professionals (Forbes & Fikretoglu, 2018; Jones et al., 2019). African American women's mental wellness is related to the complexity of their thoughts about themselves and their profession, all of which contribute to their adaptation to the combined societal trauma that influences health, community, home life, and professional performance (Goodkind et al., 2020; Holloway & Varner, 2021). Moreover, supportive resiliency applications that use diverse interconnecting social systems might minimize the impact of social factors that placed African American counselors at risk for poor resiliency (Abrams et al., 2018; Fox et al., 2021; Newell, 2020). Counseling professionals need self-care models that they can use to navigate the wellness threats to increase longevity and personal balance (Brown, 2020; Watson & Hunter, 2015).

Problem Statement

The resiliency of helping professionals is challenging to manage as the increased psychological exposure attributed to the profession and the need to constantly engage in restorative practices (Blount & Lambie, 2018; Posluns & Gali, 2020). Twenty-two percent of counselors are African American women (United States Bureau of Labor Statistics, 2019). In 2020, one-fourth of African American adults were diagnosed with the severity of behavior distress, including self-harming behavior (Center for Behavioral

Health Statistics & Quality, 2022; United States Bureau of Labor Statistics, 2021). Four to 6% had thoughts of self-harm, and more than 63% did not receive any behavioral health treatment because of cost, cultural perceptions of mental health, and other social factors (Center for Behavioral Health Statistics & Quality, 2022). The need for racial-specific resiliency programs is critical, with elevated behavioral health services in the African American community. Therefore, the problem that I addressed in this study is the resiliency of African American women counselors related to racial-specific stressors of self-identity, COVID-19 pandemic anxiety, and daily discrimination that created acute emotional strain and taxing mental tensions.

Purpose of the Study

The purpose of this quantitative correlational cross-sectional study was to investigate the relationships between racial stressors (i.e., self-identity, COVID-19 pandemic anxiety, and everyday discrimination), demographic factors (i.e., age, education level, active counseling years), and resiliency in African American women counselors. Correlational studies determine a relationship among multiple variables (Seeram, 2019). The correlation process showed the influence of the relationship between variables, whether positive or negative, but it could not thoroughly assess the cause of the connection (Cunningham et al., 2013; Hendricks, 2018). A cross-sectional evaluation can be used for a one-time-only assessment of the different ages of participants, as a longitudinal study can be expensive (Putnick, 2018; Sullivan, 2009). Based on the overwhelming need for strong mental health providers, this study pinpointed some areas of concern for a particular racial or ethnic group (Abrams et al., 2018; DeForge, 2022).

Research Questions and Hypotheses

Research Question 1 (RQ1): What is the relationship between demographic factors (age, education level, and active years as a counselor) and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0$1): There is no statistically significant relationship between demographic factors (age, education level, and active years as a counselor) and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis (H_a1): There is a statistically significant relationship between demographic factors. (age, education level, and active years as a counselor) and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Research Question 2 (RQ2): What is the relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale, and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0$2): There is no statistically significant relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency

as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis (H_a2): There is a statistically significant relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Research Question 3 (RQ3): What is the relationship between demographic factors (age, education level, and active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Inventory of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale, and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0$3): There is no statistically significant relationship between demographic factors (age, education level, and active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis (H_a3): There is a statistically significant relationship between demographic factors (age, education level, and active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Theoretical Framework for the Study

The theoretical framework that I used in this study is Rutter's (2012) and Luthar's (2016) adaptation and protective concepts. Resilience is a person's strength against external risk (Rutter, 2012). This idea aligned with the premise that life challenges promote a person's resiliency. When life difficulties are absent, it hinders a person's ability to learn new coping methods (Forbes & Fikretoglu, 2018). Resiliency is an individual adaptation to changes in culture, family, and other socially connected systems, which takes time to develop (Masten et al., 2021, Rutter, 2012). It takes different forms based on the individual's spiritual, psychological, social, and professional needs (Newell, 2019). Sometimes the ability to bounce back develops quickly because of the need to forge new ways of thinking (Folke, 2016). So, long-term social conditioning that created personal resiliency requires more understanding to be managed appropriately (Anderson, 2019).

Resiliency comes from experiences, both professional and socially constructed (Conway-Phillips et al., 2020; Lakioti et al., 2020). Therapist resilience consists of

managing the pressures of the job, personal life, and mental capacity (Lakioti et al., 2020). Also, understanding why one person is more resilient than another provides a greater awareness to support those who are less resilient (Infurna & Luthar, 2016). For African American woman counselors, the constant pressure of traditions and discriminatory practices creates racial battle fatigue, potentially lowering a woman's stress threshold (Conway-Phillips et al., Husband, 2016). The African American population may benefit from resolved lingering social issues and generational trauma that now included the COVID-19 pandemic and mental health initiatives (Anderson, 2019; Chaban et al., 2021; Cinar, 2020; Petzold et al., 2020; Prime et al., 2020; Stark et al., 2020). Chapter 2 contains more detailed information about the theoretical framework for this study.

Nature of the Study

This research study is a quantitative correlational cross-sectional study. Researchers use quantitative analysis to calculate the odds from the population data (Little, 2013). Quantitative research is used for measuring different variables with a statistical instrument (Creswell & Creswell, 2018). Correctional research designs are used to explore the associations between other variables without manipulating any of the variables or determining the cause of the associations (Salkind, 2005a). This research design predicts the relationship between two or more variables and further explains whether there is a positive or negative interaction between variables (Hendricks, 2018; Seeram, 2019). At the same time, a cross-sectional research design is a cheaper way to collect data within a short timeframe (Bowling, 2014; Salkind, 2005b). A quantitative

correlational cross-sectional study is the best choice to analyze any connections between variables because I gathered survey data from a sole source in time and had more than one independent and dependent variable.

The independent variables in this study were demographic factors and racial-specific stressors. The demographic variable included age, education level, and active years as a counselor, which provided participants' identification information that was specific to them, could not be modified, and represented the targeted population required for the validity of the research (Lavrakas, 2008; Long, 2022; Salkind, 2010). The second independent variable was racial-specific stressors, which included self-identity, COVID-19 pandemic anxiety, and daily discrimination, as separate categories (Creswell & Creswell, 2018). The dependent variable was resiliency and how it pertained to African American women counselors.

I used a multiple regression analysis to establish the relationship between multiple independent variables and predicted any changes to the dependent variable (see Creswell & Creswell, 2018, Rudestam & Newton, 2015). Because of the flexibility of multiple regression, I was able to test continuous or categorical variables. I collected data from an electronic survey and posted it on numerous social media platforms. I posted a recruitment flyer on multiple social media platforms such as Facebook, LinkedIn, Workspace, Walden University participant pool, and the American Counseling Association Connection site. The recruitment flyer included demographic information, participation criteria, and the Qualtrics survey link and survey QRC code. Data derived from survey sources were input and analyzed by the latest version of the SPSS program.

Definitions

Terms used throughout the research study were:

African American/Black Identity: Someone who identifies as Black or African American based on their social and cultural understanding or individual acceptance (Sellers et al., 1998; Burrell-Craft & Eugene, 2021). The perception of oneself determines how one thinks and interacts in different environments (Burrell-Craft & Eugene, 2021).

Counselor: An interchangeable term for helping professionals that include mental health professionals/therapists/providers, professional counselors, clinical social workers, psychologists, and psychiatrists who provide behavioral health support for clients (Nystul, 2016). They are graduate level trained to help professionals who assist clients with improving self-awareness, coping, and critical thinking skills that may be helpful as they navigate life issues (American Counseling Association, 2022; American Psychological Association, 2022)

COVID-19: A novel coronavirus infection leading to contagious exposure and death (Centers for Disease Control and Prevention, 2020). A life-threatening pandemic also triggered global fear and anxiety (Lee, 2020; Novacek et al., 2020).

Racial stressors: The condition of more than one negative source of racial tension directed at a particular person or ethnic group (Chae et al., 2021). The experience of racism or discrimination creates mental and physical distress for African American or African American people (Odafe et al., 2017).

Resilience: The ability of an individual or group to adapt positively to difficult situations while continuing to achieve their goals (Brown & Sottile, 2017; Saban et al.,

2019). Also, the psychobiological or cultural ability to effectively manage stress during or following a negative experience (Dale & Saban, 2018).

Resiliency: A psychological characteristic that separates how one person adapts to a tragic situation from another (Salkind 2005c). A method of positively realigning a person's pattern of functioning in the presence of a challenge (Sultan, 2019).

Assumptions

The two assumptions in this research were participation and instrument appropriateness. My first assumption was that African American participants would not answer the survey question accurately. African Americans have become suspicious of people outside the community because of past events where they were poorly treated or wrongly depicted (Alsan et al., 2020; Chae et al., 2021; Royal, 2019). Also, memory recall can be complicated unless a person writes down their feelings, a significant event occurs, or a repetitive career process becomes an unconscious behavior (American Psychological Association, 2021; Ozawa, 2021). Several options to increase participation are to write an apparent reason for the research study, use everyday language or descriptions, and underline the potential benefits to the community (Royal, 2019). Using the suggested approach improved the data collection process.

My second assumption was that the instruments are appropriate for use with the African American population. Several researchers used the resiliency, identity, and discrimination Scales with African American population (Brown, 2008; Fuller et al., 2018; Kershaw et al.,2016; McClain et al., 2016). Although the pandemic anxiety scale was national, it was valid in a cross-sectional design to describe the relationship between

mental health and COVID-19 stress (Milman et al., 2020). The COVID-19 Pandemic Anxiety Scale (CPAS-10), based on Lee's (2020) Coronavirus Anxiety Scale (CPAS), is a short mental health assessment used with the male and female adult population to gauge physical and somatic indications of depression and anxiety in the given population. Typically, African American women show anxiety and depression symptoms differently; the CPAS-10 provided a meaningful interpretation of symptom identification (Donavon &West, 2015; Liao et al., 2020).

Scope and Delimitations

My goal for this study was to investigate the resiliency of the 20% of African American women helping professionals in the field (United States Bureau of Labor Statistics, 2021). African American women counselors are the 2nd most prominent group of therapists behind White women counselors, the 3rd being Hispanic or Latino women and the 4th being Asian women (United States Bureau of Labor Statistics, 2021). Resiliency theory, described as psychological adjustments to compensate for life distress, may clarify the increase in anxiety and depression for some African American women counselors (Center for Behavioral Health Statistics & Quality, 2022; Donavon &West, 2015; Hope et al., 2021; Infurna & Luthar, 2016; Rutter, 1993). The research problem was that many African American women counselors may need to openly and without judgment to express their influences of racial stressors and resiliency (Center for Behavioral Health Statistics & Quality, 2022; Donavon &West, 2015; Hope et al., 2021). This research has generalizability for other populations because racial specifics stress

may be different but not limited to one cultural group, gender, or profession (Boden et al., 2018; Clayton et al., 2021; Frey, 2018; Johnson et al., 2005; Sandil et al., 2015).

Other delimitations to consider are the type of questions and length of the research survey. The instruments used to collect the data of the independent and dependent variables are Likert-style questions, which were beneficial for evaluating the occurrence of the participants' answers (Dworkin, 2018). Also, shortening the length of each survey minimized survey mistakes by encouraging participants to answer each question, and closed-end questions provided consistent feedback (Dworkin, 2018; Leung, 2020).

Limitations

This study has several limitations, including research design, data collection, and instrument bias. Some challenges/difficulties with correlational cross-sectional studies are the confounding dilemmas of knowing if one variable changes another variable's direction and that the evaluation is only completed once (Hendricks, 2018; Salkind, 2022). Cross-sectional studies are a cost-effective way to capture data at a specific moment. In comparison, longitudinal studies reassess the same population at various stages, which can be expensive (Putnick, 2018). Survey data collection yields much information quickly but can become very costly if parameters are not set up to prevent it. (Dworkin, 2018; Craig-Hare, 2022). However, participants from the African American community may decline participation or fail to complete the surveys because of previous negative historical interactions with researchers (Lu & Franklin, 2018; United States Census Bureau, 2021; Warner, 2013).

Additional research concerns are sampling procedures and measurements (Thorkildsen, 2022). Convenience and snowball sampling are both non-probability forms of sampling (Huck et al., 2022). Non-probability sampling can be limiting because the population sample is defined after the data collection process (Huck et al., 2022; Hussey, 2022). A power analysis program determines the sample information and minimizes that limitation (Faul et al., Hussey, 2022). Unfortunately, instrument bias occurs when a measure designed for one population is modified for use with different people; I used each instrument in its original form (Thorkildsen, 2022). The Connor-Davidson Resiliency Scale, the Multidimensional Model of Black Identity Scale, and the Everyday Discrimination Scale previously proved valuable with the African American population. (Brown, 2008; Fuller, et al., 2018; Kershaw et al., 2016; McClain et al., 2016). However, the COVID-19 Pandemic Anxiety Scale was a nationally developed instrument used to collect general population pandemic information, not particular to a specific race or ethnic group (Kumar et al., 2020b).

Significance

This study is significant because African American women fill various behavioral health positions in local and national agencies (United States. Bureau of Labor Statistics, 2021). Center for Behavioral Health Statistics and Quality (2021) showed that almost one-half of Black or African American women respondents needed individual counseling services for mild to severe behavioral health problems. Resiliency results from a person's internal or external ability to adapt, be flexible when uncomfortable situations arise, and able to function despite the additional emotional or psychological stress that caused the

discomfort (Brown & Sottile, 2017; Forbes & Fikretogl, 2018; Masten et al., 2021; Saban et al., 2019). Various mental health associations have procedures to improve the cultural and social awareness of their helping professionals and client-therapist interactions (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2021). Training and self-care programs must be as unique and culturally specific as the individual therapist, or the clients may suffer the consequences (Hamilton-Mason et al., 2009; Howard & Navega, 2018; United States Bureau of Labor Statistics, 2021).

Summary

African American women are the second largest group of mental health care providers (US Bureau of Labor Statistics, 2021). For many social and cultural reasons, African American women display psychological and biological symptoms differently than women who did not designate themselves as African American (Donavon & West, 2015; Liao et al., 2020; Schulz et al., 2000; Thomas et al., 2018). Choosing mental health care is not always a consideration for some African Americans because of cost, traditions, stigma, and mistrust in healthcare systems (Campbell & Mowbray, 2016; Center for Behavioral Health Statistics & Quality, 2021; Hall et al., 2021). Healthy coping is an essential element of resiliency as different biological, psychological, and career choices increase difficulty (Conway-Phillips et al., 2020; Lakioti et al., 2020).

In the African American community, self-identity, COVID-19, and discriminatory experiences sometimes challenge resilient behavior (Centers for Disease Control and Prevention, 2021; Chae et al., 2020; Davis & Afifi, 2019; Stewart et al., 2014; Watson-

Singleton, 2017). Racial stressors must be considered in resiliency training and self-care initiatives to promote career longevity (Forbes & Fikretoglu, 2018; Jones et al., 2019). In this quantitative correlational cross-sectional study, I explore the relationship between the resiliency of African American women counselors related to racial-specific stressors of self-identity, COVID-19 pandemic anxiety, and daily discrimination. Hopefully, this current study fills the gap between resiliency and racial-specific stressors. Chapter 2 provided the literature review that supported this research study.

Chapter 2: Literature Review

Introduction

Racial stressors and mental stability concern most African American women (Center for Behavioral Health Statistics & Quality, 2021; Hamilton-Mason et al., 2009). Between 2019 and 2021, African American women provided one-third of mental wellness care (United States Bureau of Labor Statistics, 2019; United States Bureau of Labor Statistics, 2021). Of the people who required counseling services for severe mental problems, 66% were African American adults (Substance Abuse and Mental Health Services Administration, 2020). Psychological health depends on cultural and traditional methods (Galea & Abdalla, 2020; 2020; Langwerden et al., 2021; Rosen et al., 2020; Sneed et al., 2020). Physical and behavioral stress subsides with stress management training (McLean & Syed, 2014; Srivastava, 2011). With behavioral health services being so elevated in the African American community and African American women conducting a large share of counseling services, racial-specific resiliency programs are critical.

Racial stress adversely impacts a person's resiliency. One racial stressor for African American women was the health risk of getting sick or dying from a pandemic illness (Centers for Disease Control, 2020). The initial findings of a higher positive COVID-19 infection rate in African Americans compared to other ethnic groups due to employment, neighborhoods, and health issues contributed to the anxiety in many Black communities (Centers for Disease Control, 2020; Coughlin et al., 2020; Sneed et al., 2020). Also, the publicized racially caused deaths of several African American men and

women, which caused an influx of social advocacy, was a problem that negatively affected African American women's ability to recover equilibrium (Gale & Abdalla, 2020; Locke, 2016; Watson-Singleton et al., 2020). Regrettably, even after social and health issues subside, previous evidence suggested there may be lingering psychological distress, especially when a person comes from an affected group and repeatedly experiences the health decline of someone whom they identify with (Galea & Abdalla, 2020; Rosen et al., 2020; Sneed et al., 2020).

Historically, African American people rarely used therapy services outside of the Black church because of the previous maltreatment, systemic obstacles, the perception of mental challenges in the community, and minimal services from people familiar with their African American concerns (Dempsey et al., 2016; Sneed et al., 2020). In contrast to traditional ideas, half of the African American women diagnosed with mental health challenges benefitted from counseling services (Center for Behavioral Health Statistics & Quality, 2021). The pandemic created a safe opportunity for therapy services by using an online platform, which may not have eliminated the African American therapist's anxiety about infection vulnerability or social unrest, but it provided a safe environment for her to be resilient (Bray, 2020; Sneed et al., 2020).

How people see themselves and how others identify them is vital to a person's resiliency (Gérain & Zech, 2019; Webber, 2020). For example, an African American woman identifying as a Strong Black Woman, a historical gender ideal reflecting a cultural shift of strength, abilities, and resiliency despite obstacles, may believe she has unlimited power (Davis & Afifi, 2019; Kirby, 2020). Many social aspects shape the

resiliency of an African American woman counselor. Therefore, knowing the resiliency factors of African American women counselors related to racial-specific stressors of self-identity, COVID-19 pandemic anxiety, and daily discrimination may minimize the distress and mental strain within the populations (Alinia, 2015; Blount & Lambie, 2018, Brown, 2020; Cook et al., 2021; Howard & Navega, 2018; Newell, 2020). This chapter includes the literature search strategy, theoretical foundation, and the literature review of the critical variables.

Literature Search Strategy

To obtain literature for this review, I used the Walden University Library databases, Google Scholar, and the journal reference list. The resources were obtained from Thoreau multi-database search, Center for Disease Control and Prevention (CDC), EPSCO, ERIC, Pubmed, ProQuest Central, ScienceDirect, Elsevier, National Alliance on Mental Illness (NAMI), SAGE Journals, Substance Abuse and Mental Health Services Administration (SAMHSA), ScienceDirect, Wiley Online Library, and SAGE knowledge databases. The keywords that I used during the search were: *multi-cultural counseling, stress, resiliency, stress and profession, stress and resilience, hardiness, resiliency and aging, resiliency and gender, co-occurring stressors, co-existing anxiety, simultaneous stress and mental health, minority stress and resiliency, Black or African American counselors, people of color, cultural identity, self-identity, COVID-19, Coronavirus, gender and multiple roles, identity theory, racial identity, social identity, race-related stressors, African American identity theory, personality and resiliency of Black or African American women, women counselors, working and caregiving, Black or African*

American and civil unrest, Black or African American women and resiliency, Black or African American women and stress, Black lives matter, Strong Black Woman, stress and mental health, psychological distress and Black or African American women, multi-stressors and mental health, multiple trauma, multiple health events, multiple stressors and women, and life stressors and Black or African American population.

The literature search ranged from 2005 to the present; however, for the theoretical foundation and research instruments, I used sources from as early as 1993. I used the APA Psyctest, Health, and Psychosocial Instrument and the Mental Measurement Yearbook databases to narrow down the appropriate survey scales for measurement tools.

Theoretical Foundation

The theoretical base for this study was Rutter's (1993) and Luthar's (2006) resiliency theories, which focuses on the idea that how people handle life situations is evidence of their significant adversity and positive adaptation. Their foundation principle is based on a person's ability to thrive is not situational but a projection of how to endure despite the situation (Fleming & Ledogar, 2008). Resiliency has many spectrums, including being hopeful, having stable thoughts and feelings, working well with others, personal belief, finding meaning, utilizing brainstorming skills, good health practices, and accessing spirituality (Schwabrow, 2019). An individual's coping skills, confidence level, and understanding of personal strengths also protect them during stressful times (Ewert & Tessneer, 2019). Adaptations are necessary for African American counselors, as the cognitive outcome from a personal attack, an individual's profession, or cultural or social

hazards may cause mental and physical discomfort (Dale & Safren, 2018; Davis & Afifi, 2019; Lakioti et al., 2020).

Development of Resiliency Theory

Resiliency theory was first conceptualized in the 1970s but has since evolved into four phases of development because of its relevance within different academic settings (Masten et al., 2021). The first phase centered on observational details of human development and protective measures (Kuldas & Foody, 2022; Masten et al., 2021; Van der Hallen et al., 2020). Many researchers wanted to understand the favorable resiliency capacity of some people when faced with adverse conditions as they interacted with others and used their resources or defense mechanisms (Reich et al., 2010; Van der Hallen et al., 2020).

The second phase of resiliency development was about what people did, their thoughts, feelings, or emotional push to maintain their resiliency, which could be positive or negative based on the level of stress and individual flexibility (Lavretsky, 2014; Masten et al., 2021). Some people considered the process effective coping instead of resiliency because it developed before the adverse event (Forbes & Fikretoglu, 2018). Also, learning about contributing factors for a successful bounce back of the individual may help replicate that process in others (Kuldas & Foody, 2022). Identifying the actions of resilient people was very important, but looking into what shaped those actions, which included an individual's system such as family, friends, culture, social interactions, and workplaces, further clarified resiliency development (Masten, 2021; Park et al., 2021; Shashikala et al., 2020).

The third phase of resiliency was discovering the right interventions that built or sustained a person's resiliency (Kuldas & Foody, 2022; Masten et al., 2021; Reich et al., 2010). Personal recovery increased when implementing coping strategies into high-intensity work processes and resiliency training programs, which were helpful in unexpected situations (Niederhauser et al., 2022; Schwabrow, 2019). Self-regulation is a monitoring and self-correcting restorative measure that makes resiliency possible (Cinar, 2020; McLarnon et al., 2021). Some interventions, whether self-discovered or taught, can be used by people to grow through personal disruptions, increasing their ability to heal (Forbes & Fikretoglu, 2018; Newe11, 2019; Richardson, 2002, Thompson & Drew, 2020).

The last or current development of resiliency theory consists of advancing research as well as identifying the multiple facets of resiliency such as a person's DNA or neurological process, work-life balance, level of training, professional development, personal sense of well-being, justice or fairness, work environment, communication skills, technology, and system development, (Kuldas & Foody, 2022; Masten et al., 2021; Reich et al., 2010; Robinson et al., 2015; Todt et al., 2021). Resiliency theory changes as the understanding advances regarding the adaptive capacity of individuals and their interconnections, which create a never-ending opportunity for growth and development (Anderson, 2019; Padesky & Mooney, 2012).

Resilience vs. Resiliency

Resilience has many definitions and is sometimes interchangeable with the term resiliency. Resilience describes a reactive psychological state of the individual's

thoughts, feelings, an inherited process, or a trait of resilience, not a condition or state of resiliency (Kuldas & Foody, 2022; Luthans & Youssef-Morgan, 2017). Resiliency is a stress-free life process, with resilience energizing it (Richardson, 2002). Resilience is a regulatory measure against behavioral health concerns (Jamebozorgi et al., 2022). Resilience is both the positive doing and the result of adapting to life transitions despite internal and outside forces based on a person's viewpoint, access to resources, and consistent use of coping skills (American Psychological Association, 2022). Resilience is also a positive by-product of personal risk or adversity (Mayordomo et al., 2016).

This inconsistent viewpoint of trait and state reflects the confusion between resilience and resiliency as the terms are unique and conditional to the occasion, gender, age of the person, values, spiritual concepts, self-concept, and cultural perspectives (Folke, 2016; Immink, 2018; Kuldas & Foody, 2022; Lavretsky, 2014; Schwabrow, 2019; Southwick & Charney, 2012; Todt et al., 2021). Both resilience and resiliency are ongoing processes not limited to people but organizations and communities to recover from a crisis quickly (Anleu-Hernandez et al., 2021). Multiple interpretations do not limit the theory's development but highlight the need to understand further these rejuvenating experiences (Forbes & Fikretoglu, 2018).

Components of Resiliency Theory

Two components of resiliency theory are protective factors and adversity. Protective factors are the individual, family, and community, as well as thinking patterns, genetic disposition, resources, and spirituality, which contribute to how well a person manages demanding situations (Tay & Lim, 2020; Van der Hallen et al., 2020). Social

support or human capital formation through relationships, professional affiliations, demographic comparison, cultural traditions, education, and values strengthens a person's resolve when trying things occur (Graber et al., 2016; Killian, 2017; Reich et al., 2010). When people can solve issues, communicate successfully, view themselves in a positive versus negative light, and find hope within adversity, this shielding sustains their resiliency (Killian, 2017; Reich et al., 2010; Tay & Lim, 2020). However, resiliency is a delicate balance between protective factors and adversity, as the experiences of stress and accessibility to resources improve or reduce the person's ability to overcome the obstacle well (Hayman et al., 2017).

Adversity or risk factors originate from isolative, negative behaviors, natural disasters, national security concerns, pandemics, or simultaneous natural events such as social unrest and national illness (Karairmak & Figley, 2017; Gilgun & Abrams, 2005). Age, environment, consistency, and monetary benefits boost a person's capacity or increase sensitivity to troubles (Gupta et al., 2022; Masten et al., 2021). Also, stigma attitudes, social stressors, racial discrimination, and pandemics may decline people's resiliency power (Anderson, 2019; Campbell & Mowbray, 2016; Geyton et al., 2022; Harper & Neubauer, 2021; Seaton & Iida, 2019). Emotional regulation, gender differences, professional hazards, and medical necessity elevate a person's vulnerability and impact their quality of life (Brown, 2019; Dale & Safren, 2018). Many things put people at risk; however, resiliency makes thriving attainable (Harper & Neubauer, 2021; Windle et al., 2011).

Resiliency Theory and Demographics

Resiliency theory, as it relates to demographic information such as a person's biological, physical, and sociological identification and professional designation, is vital to distinguishing differences, if any, between groups (Long, 2022, Salkind, 2010). Resilience determines the wellness skills of individuals during periods of high stress and threats (Kimhi et al., 2020). Demographics features and resiliency responses are similar for most groups; however, Kimhi et al. confirmed that people experiencing a worldwide pandemic amplified the appearance of distress, but older adults, men, and smaller communities were resilient despite the risks. Although different from other populations in age and size of the community, populations with steady demographic growth can provide information to other groups on how to produce a resilient outcome (Capdevila et al., 2020; Gilgun & Abrams, 2005).

Gathering personal information supports wellness as people encounter hardship conditions (West et al. 2020). Linking demographic information improved research duplication and met internal and external validity requirements needed for a robust research investigation (Long, 2022). The distinctive character properties between populations separated by professional longevity, academic completion, marital status, and age showed positive resiliency (Afshari et al., 2021; Ang et al., 2018). Finally, age and the gender of a person seemed to decrease mental health capacity, especially when managing multiple roles (Tseliou & Ashfield-Watt, 2022).

Age & Resiliency Theory

Resiliency built over a lifetime of experiences was based on everyone's health and mental well-being (Hicks & Conner, 2014; Lavretsky, 2014; Reich, 2010). Stress is formulated because of a personal flow of adaptivity, which grows through years of experience and sometimes presents itself as negative brain and physical responses (Sousa et al., 2018). Resiliency requires navigating adult life experiences through the person's narrative of themselves and how they see others in themselves (Fullen & Gorby, 2016; Mayordomo et al., 2016). As the definition of social interactions differed based on a person's age, it seems older adults ages 65 and above had more emotional control and problem-solving skills; however, younger adults between the age of 18-25 had stronger social connections (Gooding, 2012; Li et al., 2021).

Age was a defense against adverse behavior because it developed preparation, wisdom, strength, caution, patience, and options (Hayman et al., 2017; Hicks & Conner, 2014; Lavretsky, 2014). As a person ages, identifying an individual's protective measures and sensitivities improves their ability to adapt (Majeski & Stover, 2019). Also, age and resiliency may adjust when health, finances, and self-sufficiency are lost (Lavretsky, 2014; Reich et al., 2010). Age-appropriate functioning determines positive or negative resiliency (Reich et al., 2010). Aging diminishes a person's physical and cognitive quality of life; perseverance, uplifting social connections, laughter, high self-esteem, and willingness to adjust promote a rebounding lifestyle (Fullen & Gorby, 2016). Erikson's 8 Stages of Psychosocial Development sometimes connected age and the resilient life process that resulted from the successful adaptation from another stage of life, but in some incidents was not always the case (Orenstein, 2022).

Gender & Resiliency Theory

Gender was a resiliency factor determined by traditional society assignments (Christman & McClellan, 2012; Gilgun & Abrams, 2005; Hirani et al., 2016). Traditionally, gender roles had certain societal expectations and contrast in physical and psychological wellness (Hirani et al., 2016). Male roles centered around deciding the course of the family, working outside the home, aligning themselves with the idea of being strong or resilient, and sometimes limiting their stressful conversations to job or money matters (Hirani et., 2016; Kim & Jung, 2021). Usually, some men were incapable of asking for help except when seeking medical aid, which, from some cultural perspectives, was contrary to traditional men's behavior (James et al., 2016). Also, men who pursued higher education and were employed showed a lower stress level, increasing positive resiliency (Kim & Jung, 2021).

Resiliency has been linked to increasing age among the traditional female gender, with women being more at risk of poor mental health (Hu et al., 2015). Women serving many roles, as caregivers, wives, professionals, and moms, discussed stressful issues but scored lower on previous resiliency studies that focused on family stressors (Gupta et al., 2021; Hirani et al., 2016). Using the Cost of Caring perspective, women showed an increased risk of mental health illnesses due to experiencing chronic stress from adverse life events, which sometimes presented itself as depression, anxiety, or inability to complete a task (Brown, 2019; Kessler et al., 1985; Watson & Hunter, 2015). Even in a workplace setting, women experienced adverse behaviors due to their age, gender, self-confidence, individuality, and mental and physical state of health; however, with

increased awareness, they found a way to be happy (Blunt & Lambie, 2018; Stripling & Maccarrone, 2021).

Race and Resiliency Theory

Sometimes, the term race was typically based on a person's biological description but not the social factors that created racial unfairness in minority communities (Wu, 2021). In minority families' children were prepared early to experience adverse racial behavior (Masten et al., 2021). Physical and mental health was contingent on racially induced stress, which could sometimes exceed a person's resiliency capacity (Allan et al., 2021; Meyer, 2013). Social injustice was not limited to one ethnic group, as the magnitude of uncivil relationships for African American people created a mental crisis and a legal breakdown for humanity (Lavin et al., 2017). Social injustice victims were compared to natural disaster victims inferring that a person's thoughts about the world they lived in equaled their well-being (Riaz et al., 2015). Psychological distress like racial battle fatigue, defines the continuous social, bodily, and mental management of direct or indirect comments or actions that negatively cause harm to minority groups and impact their ability to thrive (Husband, 2016).

In the African American family, resilient living was modeled and passed down through family lines and spiritual practices (Brown & Coker, 2019; Figley, 2012; Reich et al., 2010). African Americans had a history of working through generational community trauma caused by the lack of housing, jobs, healthcare services, and social victimization (Figley, 2012; Lavin et al., 2017). For example, the recent deaths of Michael Brown in 2014 and George Floyd in 2020, both African American men, incited

national and global in-person and social media platform protests that centered around addressing the absence of race and social civility and racial bias/treatment (MacDonald & Symmonds, 2018). Social issues and health disparities in the United States challenged or potentially broke the individual strength and dignity of the African American community, thereby diminishing their fulfillment of life, self-confidence, and physical well-being (Lavin et al., 2017; Odafe et al., 2017).

Literature Review Related to Key Variables and Concepts

Black Identity

In the 1970s, Black identity became the focus of racial understanding (Burrell-Craft & Eugene, 2021). Two critical pioneers of Black identity development were Cross and Phinney (Cross, 1994; Jaynes, 2005; Phinney, 2010). Cross used the term nigrescence, which meant a person identifying as Black or African American based on race and multiple identities, not physical presentation (Burrell-Craft & Eugene, 2021; Cross, 1994; William & Lewis, 2021). The four critical stages of identification are *pre-encounter, encounter, immersion-emersion, and internalization (*Burrell-Craft & Eugene, 2021; Cross, 1994; Hines, 2021). These steps ranged from not thinking about race, comparing themselves to other ethnic groups, being about everything African American, and then self-discovery by balancing their stress management (Burrell-Craft & Eugene, 2021; Cross, 1994; Hines, 2021).

Phinney's (2010) four stages of Black development were self-identification, involvement, belonging, and achievement of all ethnic groups. The cultural and social experiences as an African American woman were transformative as identity took on a

new meaning from one stage to another (Neville & Cross, 2017; Worrell et al., 2001). Order of exposure was the basis for Cross and Phinney's identity development theories (Cross, 2001; Phinney, 2010). However, the difference between both theorists centered on the universal application of the identification process with other ethnic groups (Cross, 2001; Phinney, 2010). Changes in a person's identity often resulted from the many opportunities available, the choice to sustain that choice, and the identity-specific interactions a person engages in (Del Toro & Wang, 2020; Phinney, 2010).

Development of Black/Racial Identity

Previous researchers gauged their knowledge about African Americans from their cultural or personal standards and mainly from a negative perspective (Burrell-Craft & Eugene, 2021). Identity was based on how people believed other ethnic groups perceived their individual group designation and the connection to authority, fairness in opportunities, justice, and the living conditions of that population (Hawkman, 2019; Thomas & Columbus, 2009). Black or racial identity was a positive interchangeable term used for people finding meaning as Black or African American through various life experiences, as well as signifying the many roles they filled in society (McClain et al., 2016; McLean & Syed, 2014; Stryker & Burke, 2000; Umaña-Taylor et al., 2014). Black identity was a psychological process in African Americans' transitions from the negative association as a minority group member to embracing positive feelings about their identity (Cokley, 2005). Racial identity as a protective factor helped to lower suicide rates in the African American community and was limited by experiences because gender

plays an integral part in the acceptance of one's uniqueness (Street et al., 2012; Williams & Lewis, 2021).

Women and African American Identity

African American women's development into womanhood included many social stressors and resources of resilience (Hamilton-Mason et al., 2009). A protective identity for African American women during highly stressful times is the Strong Black Woman (SBW) beliefs; however, opposing a cultural stereotype can be beneficial (Butler-Barnes et al., 2018; Liao et al., 2020; McLean & Syed, 2014). The confidence of a Strong Black Woman originated from years of severe cultural difficulties, traumatic experiences, and managing multiple cultural and societal roles as an African American woman (Abrams et al., 2019). The term Strong Black Woman embodies a multi-layer context of not just previous enslavement but a modern-day symbol of overcoming, self-awareness, personal development, and community, thereby providing a very detailed behavior plan for some African American women to follow (Nelson et al., 2016; Watson & Hunter, 2015).

In the African American custom, this mythical woman does not permit emotions to get in the way of accomplishing her goals because of her assertiveness, strong-mindedness, stress manager, and caregiver of family and community (West et al., 2016). The African American woman's identity consists of being vulnerable and challenging societal ideas as these obstacles align with the perceived social pressures, which were not as crucial to maintaining a level of resiliency as the internal pressures (Watson & Hunter, 2016; Williams & Lewis, 2019). Sometimes, the Strong Black woman's lack of social support, whether due to limited resources or cultural gender roles, resulted in self-reliant

behavior (Watson-Singleton, 2017). This unsupported position came from generational social-cultural disparities and social era-based music, which echoed the image of an African American woman in voice and statue (Kirby, 2020). Social media, gender-specific magazines, and visual platforms encouraged African American women to show strength over weakness and independence over support (Abrams et al., 2014).

A Strong Black Woman was a spiritual experience of protection and sometimes avoidance of physical and mental discomfort (Avent-Harris**,** 2019). Unfortunately, an African American woman's identity can be confusing due to the fluidity between gender and racial stereotypes (Jones et al., 2018). This identity as a strong African American woman is a crucial motivator for learning and adapting to self-beliefs (Stryker & Burke, 2000; Thomas & Columbus, 2009). It is also vital to self-concept as personal experiences, gender roles, and cultural understanding shape personal meaning and strength (Stryker & Burke, 2000; Thomas & Columbus, 2009).

Some identification milestones for African American women resorted from adverse associations with some of the stereotypical labels of Strong Black Woman (SBW), mammy, brass, and jezebel, which remain a concern almost ten years later (Carter & Rossi, 2019). Music across the era contained negative ideas about African American women (Kirby, 2020). The lyrics shaped the public's acceptance and internal perspective of being a Black woman and how she should act, which also created a potentially hazardous developmental situation (Carter & Rossi, 2019; Kirby, 2020).

There have been many different approaches to understanding the protective factor of African American women (Jones et al., 2018; McClain et al., 2016; Watson & Hunter,

2016). For example, McClain et al. (2016) chose a fact-finding method to study the Strong Black Woman in a collegiate setting using informational scales and multiple regression analysis to show the two sides of the stress response to mental health. Watson and Hunter (2016) took a personal approach as they looked at the lived experiences of a Strong Black Woman. West et al. (2018) thematic evaluation also yielded similar results as Watson and Hunter's (2016), but their focus included coping skills and mental wellness. Jones et al. (2018) content analysis of gender, gender roles, and African American gender roles revealed that African American sampling was problematic in prior research studies.

Nelson et al. (2016) qualitative process found that African American women redefined the Strong Black Woman persona based on individual experiences, which was very helpful when implementing mental health interventions. Watson (2017) investigation included the Strong Black Woman identity, the Superwoman and Mammy subscales of the Stereotypical Roles of Black Woman Scale, the Multidimensional Scale of Perceived Social Support Scale, and the Hopkins Symptoms Emotional Support Checklist Scale. These measurements provided the connection between the SBW and psychological resilience, which depended on personality, personal feelings about self, the community's perception of Black women and seeking mental health (Abrams et al., 2018; Liao et al., 2020; Watson & Hunter, 2015).

Professional Identity Development

Professional identity development was a process that started with the decision to choose a profession (Dweck, 2007; Ewe & Ng, 2022; Puglia, 2008). An individual's

choice of occupation was due to their interest, exposure, taking required classes, interacting with faculty members from different careers, on-the-job training, and continuous learning throughout the person's occupation (Council for Accreditation of Counseling and Related Educational Programs, 2022; Dweck, 2007; Ewe & Ng, 2022; Puglia, 2008). Social acceptance based on training and certification in a particular area of study instills professional identity (Carvalho et al., 2021; Gondim et al., 2016; Tajfel, 1983). Professional identity requires an educational and employment commitment and a willingness to create opportunities to advance the profession (McLean & Syed, 2014). An individual's professional development mostly happens after college graduation, where practicing skills generate obstacles that may differ from previously learned protocols (DiBenigno, 2022; Matthews et al., 2019). Various internal and external systems affected professional identity and required constant self-monitoring (Raemy, 2021).

Professional identity was a calling as the efficiency of individual skills was integrated with finding meaning (Bloom et al., 2021). Personal and professional identity were sometimes interchangeable as the history, cultural, and social experiences formulated a connection of belonging and acceptance (Arjona-Castilla et al., 2022; Bloom, 2022). The lack of critical skills might deflate individual confidence level and professional value without a clear understanding of a person's professional self, and if not addressed, more significant issues such as role crossing may affect the work climate (Brown, 2000; De Lasson et al., 2016; Trede et al., 2011; Matthews et al. 2019; Sundberg et al., 2017; Turner & Knight, 2015). A healthy professional identity is an inward

understanding developed from social behavior, occupational expectations, and personal values (Bloom, 2022).

Counselor Identity

Counseling theories, training, and licensure centered on the identity of a counselor (Ewe & Ng, 2022). A counselor had, at a minimum, a master's degree in mental wellness and completed post-graduation requirement to formally apply for state professional licensure (Council for Accreditation of Counseling and Related Educational Programs, 2022; Klein & Beeson, 2022). In England, collegiate social workers found some of their education contrary to their beliefs and hard to comprehend, requiring new boundaries to be set to maintain their wellness (Beddoe et al., 2011; Bride & Figley, 2007; O'Leary, 2012; Rajan-Rankin, 2014). A helping professional provides understanding through the life cycle, embraces the benefits of diverse relationships, and constructs safe places for clients to express emotions and tend to their psychological well-being (American Counseling Association, 2014). Unfortunately, when counselors care for others, it might compete with a counselor caring for themselves, which is why flexibility, a counselor's senses, intellect, and other self-care alternatives are critical to a counselor's well-being (Lakioti et al., 2020; Skovholt, 2012).

Black Women Counselor Identity

African American women counselors represent many national helping professionals (United States Bureau of Labor Statistics, 2019; United States Bureau of Labor Statistics, 2021). African American women were very selective about career choices, originating from purpose and family encouragement (Marks et al., 2018).

African American women counselors must learn to separate work life from home life and cultural stance from a professional perspective, which could be difficult but necessary for career longevity (Bryant et al., 2005). Also, diverse types of relationships, lifestyle choices, and stereotypical roles were the basis of emotional regulation (Abrams et al., 2019; Liao et al., 2020; Watson & Hunter, 2016; West, 2015). These obstacles, aligned with negative social beliefs are not as harmful to the practice of resiliency as the internal pressure placed by negative self-acceptance (Williams & Lewis, 2019).

Mental Health Identity Development and Resiliency

Mental health and resiliency refer to the adaptation process, which occurs when a person feels threatened and accepts the change while staying true to the person they have become (Breakwell, 2021). Personal confrontations, the actions of others, financial conditions, or adverse life encounters contribute to the lifetime achievement of mental health identity (McLean & Syed, 2014). The strong connection between mental health and resilience should be a concern at every level of development, as stress appears differently from one person to another based on previous experiences and personal beliefs (Hammond et al., 2021; Steffens et al., 2017; Verhoeven et al., 2019). Stress management skills depend on resolving issues without a physical or mental breakdown (McLean & Syed, 2014; Srivastava, 2011).

A person's psychological well-being is sometimes racially or socially constructed in African American and other racial or ethnic groups (Galea & Abdalla, 2020; Langwerden et al., 2021; Rosen et al., 2020). Some investigators believed that women's psychological wellness was quite different because the causes of stress may affect their

ability to thrive (Forsdike et al., 2022). Social and cultural connections influence a person's identity and mental stability; however, good mental health balances work and life issues (Breakwell, 2021; Srivastava, 2011). For some, resiliency is a trainable survival trait that does not always come naturally (Srivastava, 2011).

African American Identity Development and Mental Health

The mental health of an African American woman originated from her identity, which has been misunderstood for years (McClain et al., 2016). Culturally, African American women who had self-harmful thoughts sought crisis assistance more often than men within and outside their racial group (Flowers et al., 2014). Fortunately, African American women with an increased sense of self effectively navigated gender-racial micro-aggressions and showed improved depression symptoms (Williams & Lewis, 2019). However, Carter and Rossi (2019) surmised that their resiliency contained highs and lows that range from selflessness to maintaining emotional boundaries. The stigma of being a Strong Black Woman provides a level of comfort with a potential mental health diagnosis if the caring therapist understood the concept of *blackness*, which in history hindered many African American people from seeking psychological treatment outside of cultural recommendations (Watson & Hunter, 2015).

African American women had little or no concerns about their mental health because, from a feminist lens, empowerment from the Strong Black Women label built strength and increased self-awareness and psychological and physical health (Carter & Rossi, 2019). The identity of being an African American woman showed a robust mental ability that would sometimes prevent therapy participation from her cultural perspective,

even if professional training supported treatment (Watson & Hunter, 2015). Nevertheless, whether gendered or culturally shaped, the Strong Black Woman's resilient state was further hindered if the woman was a high achiever because making mistakes sometimes impacted her mental health (Liao et al., 2020).

The illusion of always being firm no matter the circumstance was challenging for many African American women to try to obtain because the realism of not being strong enough weakens her mental well-being, which created a domino effect within her community (Abrams et al., 2019). Also, racial aggravation and secondary exposure to opposing opinions devalued or stigmatized many racial or ethnic women (Chae et al., 2021). With such social and cultural points of view, self-acceptance as a Strong Black Woman created the necessity of implementing healing interventions because the image symbolized strength and endurance, not weakness or needing assistance, which was a deterrent to a productive mental health plan (Watson & Hunter, 2015).

African American Women's Resiliency & Mental Health

Abrams et al. (2019) noted a hesitation for many African American women to acknowledge any wrongness in their psychological state because of their assumed social and cultural obligations, personal values, and self-silencing behavior. African American women struggled with determining whether mental health interventions were needed, which verified why emotional disengagement's consequences may accelerate mental stability symptoms (Watson & Hunter, 2015). As a result, African American women vulnerable to mental distress hardly participated in formal treatment but sought spiritual guidance, which was a cultural or gender norm (Avent-Harris, 2019; Carter & Rossi,

2019). Although generational, some form of spirituality was a powerful tool for maintaining a strength-building role and a healthy life (Avent-Harris, 2019; Carter & Rossi, 2019; Gupta et al., 2021; Morin et al., 2017). Most African American women had their mental wellness under control (Sandil et al., 2015). However, the reality might be quite different than the African American woman let on because various stress levels associated with racial and economic disparities contribute to the decline in heart health and psychological distress (Brewer et al., 2018; Sandil et al., 2015).

Women of different life stages, especially in the midlife stage, struggle to navigate co-existing tensions due to bias, transitions, and age-related medical challenges (Thomas et al., 2018). Of course, micro-system and macro-system issues create an abundant amount of tension experienced by one individual, which may be equal to the availability of personal and professional resources at their disposal (Koffer, 2016). Resilience was not just about adapting to circumstances but a simple adjustment in how a person maneuvered through that situation (Anderson, 2019). So, for some, cultural strength was a valuable resource as African American women's continued marginalization was an emotional long-term physical hazard that transformed into the current perception of racial and gender stressors (Anderson, 2019; Brewer et al., 2018; Donovan & West, 2015).

In addition, the heavy responsibilities of family and community can weaken the health of African American women (Adkins-Jackson et al., 2019). Collective distress caused by social pressures and physical health for African Americans was not a new concept (Schulz et al., 2000; Sousa et al., 2018; Szymanski et al., 2014). However,

adding other stressors to an already stretched resource might deplete it beyond repair, as personal or environmental conflict may diminish the outcome (Schulz et al., 2000; Sousa et al., 2018; Szymanski et al., 2014). It seems that people from the majority population and those from the minority population do not have the same internal or external experiences related to social denials and positive self-identification, which contributes to the lack of progress (Szymanski et al., 2014). Nevertheless, ethnic groups unaware of racial stressors' adverse effects on African Americans cannot imagine how these groups continue to try to overcome multiple psychological distresses (Anderson, 2019).

Counselor Mental Health & Resilience

A therapist's state of resilience does not develop from instincts (Friedman, 2017; Hou & Skovholt, 2020; Winkel et al., 2019). Many researchers felt resilience was a learned condition of continuous self-examination of acknowledgment, letting go of negative experiences, and incorporating a therapeutic practice, sometimes almost in unison as the woman counselor monitors their client's responses (Friedman, 2017; Hou & Skovholt, 2020; Winkel et al., 2019). Therefore, non-resilient counselors could potentially exhaust themselves and experience trauma threatening a person's well-being by introducing negative associations that deflated a person's energy as professional identity contributed to a productive and healthy existence (Skovholt, 2012). Helping professionals were prone to experience major stressors due to their caregiving nature and addressing counseling issues outside of work hours (West, 2015). A counselor's vulnerability originated from hereditary relationships, environmental influences, and

lifestyle choices, which were the basis of emotional dysregulation regulation (Cinar, 2020; West, 2015).

Different African American woman counselors defined self-care, and the care they provided to others was based on how they processed information, which might conflict with problem-solving initiatives (Estrada-Martínez et al., 2012). A counselor could stay resilient by focusing on something positive, like their job, which was to care for others rather than focusing on adverse situations, but their self-care might be lacking (Lakioti et al., 2020). Also, regularly refreshing a person's positive power was essential, as long-term stress conditions affected the brain's ability to adapt (Sousa et al., 2018). However, cultural and professional stigma could prevent the African American woman counselor from receiving the full benefit of mental health recovery (Bray, 2020; Novacek et al., 2020).

Connection Between Identity Development, Resiliency, & Mental Health

Identity development, resiliency, and mental health are intertwined and conditional to an individual's reactions to adverse situations (Breakwell et al., 2021). Psychological bounce back and identity were culturally, socially, and biologically developed (Breakwell et al., 2021; Vignoles et al., 2006). Contributing factors to personal self-concept, resiliency, and mental wellness were categorized as positive thinking, self-reliance, intellect, coping strategies, and regular self-care measures (Breakwell, 2021; Ong et al., 2006; Sapienza & Masten, 2011; Smeekes & Verkuyten, 2015). Proactive mental living was a process that individually measured a person's ability to adapt to different life situations, which promoted a quick recovery to a normal state of being

(Afek et al., 2021). Some coping mechanisms that encouraged resilience, self-concept, and behavioral health were persistence, religion, social and professional support, and personal assessment (Ranjan-Raknin, 2014).

COVID-19 Pandemic

In 2019, the COVID-19 pandemic created a global and national health emergency because of its severe symptoms and high transmission rate (Centers for Disease Control and Prevention, 2021; Kimhi et al., 2020; Li et al., 2021). The COVID-19 pandemic changed how people interacted with others in daily and social activities, and financial security changed in response to mandatory safety precautions (Li et al., 2021; Powell et al., 2202). During this time, people's fear, anxiety, anger, and depression increased, and the mandating of mask-wearing and isolation practices did not de-escalate people's concern about taking care of basic needs of food, daycare, and housing accommodations for those infected (Prime et al., 2020; Powell et al., 2022). Helping and medical professionals worked extended hours as their biological and psychological needs increased unprecedentedly (Afshari et al., 2021; Li et al., 2021; Jamebozorgi et al., 2022; Prime et al., 2020; Wang et al., 2019).

As of December 2022, over 100 million people were impacted by this virus as it constantly changed its composition but remained transmittable (Centers for Disease Control and Prevention, 2022). Pandemics, in general, are incredibly stressful conditions that can cause physical and mental strain (Li et al., 2021). Routine resiliency practice may aid in successfully managing the additional pressure (Afshari et al., 2021; Li et al., 2021). However, COVID-19 threatened people's safety and physical and mental way of

life (Kimhi, 2021). Although scientists better understood the disease, monitoring post-COVID-19 behavior was essential because the pandemic extended beyond the individual to different racial and ethnic international communities (Prime et al., 2020; Tanhan et al., 2020).

COVID-19 in the United States

In the United States, the year 2020 became a fight for life as COVID-19 spread flu and pneumonia-like symptoms nationwide for months (Balogun, 2020; Malik, 2020; Yan et al., 2020). This worldwide crisis had affected every area of a person's mental, physical, and social existence (Kazlauskas & Quero, 2020). Researchers showed that discrepancies in universal health and social disparities among the non-white minority population made racial and ethnic groups more vulnerable to infection (Centers for Disease Control and Prevention, 2021). Earlier mutations of Coronavirus caused life-and-death consequences within many African American communities (Sneed et al., 2020; Vaishna et al., 2020). The national concern about contracting the virus increased mental strain as pandemic grief, end-of-life cultural traditions, and public attendance at milestone events such as graduations and weddings tested safety protocols (Sneed et al., 2020).

The United States and international researchers used various research tools to explore the mental health conditions due to this COVID-19 phenomenon. One researcher used a cross-sectional design to investigate a person's resiliency factor amid COVID-19 and found a strong connection between age, education, and resilience and that a support system was necessary to manage the increased feelings of distress (Ferreira et al., 2020).

Another researcher conducted a literature review of the human development systems to consider the negative consequences of the family dynamics pre-COVID and how adaptation to pandemic conditions may differ from other disaster responses (Prime et al., 2020). An examination of resilience literature from several researchers supported that COVID-19 stress reactions are different and that existing protective factors in flexibility, mental health initiatives, and updated policies could potentially meet long-term effects (Chen & Bonanno, 2020; Stark et al., 2020).

Milman et al.'s (2020) cross-sectional design showed how people think about themselves and how they see the world mediates their reaction to pandemic stress. Li et al.'s (2021) literature review and one-way analysis of variance (ANOVA) evaluated resilience, support, mental health, and COVID-19 infection impact on Chinese respondents. The investigators concluded that social support and resiliency measures were essential to mental health (Li et al., 2021). Khaustova et al. (2021) also researched resiliency, fear, anxiety, and personal health in Ukraine. They showed a positive and negative relationship between mental wellness and COVID-19, which could imply physical fitness should be considered a factor in a person's overall resiliency level (Khaustova et al., 2021).

COVID-19 Restrictions and Mental Health

The possibility of being infected was on the mind of most people as steps taken to provide the best-known protection for staying healthy also increased anxiety, depression, and other mental and medical issues inherent to disaster-associated events (Ferreira et al., 2020; Kazlauskas & Quero, 2020). Many thoughts and feelings associated with COVID-

19 were so unlike those in other natural environmental crises because the pandemic affected a person's social conscience, physical health, spiritual beliefs, and monetary status, which led to social disparities in some communities (Chae et al., 2021; Novacek et al., 2020; Prime et al., 2020; Tanhan et al., 2020). Some noted emotional and mental functional changes caused by the pandemic included relationship problems, self-harming thoughts, loss of daily functioning, the anticipation of death, and feelings of grief and loss (Milman et al., 2020; Prime et al., 2020).

Safety measures, which include social distancing, isolation, washing your hands, telehealth, and teleworking, were not required in previous natural environmental crises to sustain good health (Tahan et al., 2020). COVID-19 precautionary measures differed from the prior environment or realistic situations because family and community support were vital to stabilizing a person's mental health (Li et al., 2021). A few researchers believed people's elevated stress and anxiety levels during the COVID-19 crisis were more biological than psychological, decreasing their coping ability (Chen & Bonanno, 2020; Li et al., 2021). One researcher felt that the pandemic brought out the good in others as people took necessary safety precautions to stay physically and mentally healthy, which increased the survivability of the people in their surroundings (Shashikala & Basha, 2020).

Resiliency involving the community's health and personal well-being required a daily review of needs, including looking out for each other and taking safeguards to stay physically and mentally healthy, which could improve everyone's survival (Henning & Armstrong, 2020). The World Health Organization (2021) suggested that people

engaging in physical and behavioral care, reduced the amount of COVID-19 information received, monitored the use of alcohol, video games, and social media; and supported each other when necessary. Historically, the connection between resilience and disasters, whether natural or man-made, impacted people who were racially and socially oppressed differently than those outside of that group designation (Ferreira et al., 2020; Milman et al., 2020; Novacek et al., 2020). Other considerations were age, gender, language, stress perception, and making meaning based on a person's beliefs about themselves, their future, and the world around them challenging to maintain (Ferreira et al., 2020; Milman et al., 2020; Novacek et al., 2020).

COVID-19 Pandemic & Counselor Service Delivery Changes

As a result of the coronavirus pandemic, a national safety measure to minimize exposure led to some helping professionals working remotely and delivering mental health assessments and treatment via telephone or video platforms (Chong et al., 2020; Rosen et al., 2020; Tanhan et al., 2020). Previous disaster exposure tended to change individual and community perspectives while continuing productivity and instilling a sense of calm; however, some mental health providers had no training experience in maintaining confidential protocols in the video or audio environment (Donnelly & Proctor, 2015; Rosen et al., 2020). Telework allows workers to schedule flexibility and increase family time; however, working from home sometimes gets in the way of completing assigned workloads, mainly when family obligations intrude on the in-home work environment (Dhiman et al., 2020; Jostell & Hamlin, 2018).

Counselors working from home experienced some difficulty as everyday tasks occurred within the same space (Fisher et al., 2020; Ornell et al., 2020; Vaishnav et al., 2020). Safety practices helped minimize exposure; socially distant activities kept the family physically engaged, flexible work schedules addressed the need for income, and being careful around older adults kept loved ones safe (Fisher et al., 2020; Ornell et al., 2020; Vaishnav et al., 2020). Stay-at-home emergency orders before COVID-19 were helpful in flexible work schedules as remote work provided women with small children with a work-life balance that decreased stress and improved their mental health (Chong et al., 2020; Shepherd-Banigan et al., 2016). However, the pandemic's swift telework implementation created new generational experiences in psychological sensitivity and resiliency measures (Chong et al., 2020; Shepherd-Banigan et al., 2016; Stark et al., 2020). COVID-19 safety measures contributed to the mental and physical health condition of children, spouses, or partner relationships as the physical separation from normal social events such as spending time at school, work, or with extended family and friends became unsafe and promoted a more secluded and sedentary lifestyle (Koohsari et al., 2021; Prime et al., 2020).

Therapists became more creative with their choice of interventions by using what was available in the client's home, as face-to-face options were impossible (Bray, 2020). In a traditional therapy session, natural pauses, verbal conversations, and body language tell the client's story, which could become harder to understand in the virtual setting (Lippin, 2020). Behavior health telehealth initiatives were regular treatment options before COVID-19; however for the therapist and client who were not utilizing this

method, the immediacy of implementation could have caused mixed emotions (Bray, 2020; Lippin, 2020, Rosen et al., 2020). The unique stressors from COVID-related mental health disturbances were conditional and not typical for counselors in previous natural crisis mental health care but very vital in the implementation of future applications (Rosen et al., 2020).

Service Delivery Changes and Social Service Provider Mental Health During the COVID-19 Pandemic

The potential for coronavirus diagnoses changed client evaluations and interventions for people with COVID-19-related physical and mental symptoms of depression, anxiety, substance use, and self-harm thoughts (Kumar et al., 2020; Lee, 2020; Milman et al., 2020). The characteristics of pandemic mental health can become chronic anxiety and depression symptoms if misdiagnosed and left untreated (Bernando et al., 2020; Omary, 2020). As a result of mandatory physical separation, some individuals showed signs of elevated feelings of loneliness, which weakened their internal resistance system and presented itself as adverse social and domestic problems (Prime et al., 2020; Tanhan et al., 2020). In many countries, mental health services increased as spiritual buildings, indoor physical activities, and workplaces closed from public use (Tanhan et al., 2020). As self-care services changed, the availability of technological advances such as the Internet, video, and telephone proved helpful by providing mental health information which kept clients and mental and medical health providers safe (Wang et al., 2020).

If a helping or healthcare professional's job carried a critical care status, the option to quarantine at home was not available, so altering in-person sessions minimized disease transmission (Bray, 2020). Regrettably, in China and Bangladesh, medical workers who continued to show up to work physically received negative feedback from landlords, neighbors, and family members because of their work environment and potential contact with COVID-19 patients (Dye et al., 2020; Golhar et al., 2021; Razu et al., 2021; Son et al., 2022). Although the need for helping professionals increased, continuously working in a high-stress environment, and repeated exposure to the disease decreases their ability to rebound (Chaban et al., 2021; Schlotz et al., 2011). Also, the worldwide scarcity of personal protection gear made it difficult for social service and healthcare workers to keep the required safety precautions, which increased anxiety (Omary, 2020; Razu et al., 2021). For some professionals, the natural desire for routine, even during a pandemic, was beneficial in maintaining their mental health as they worked with COVID-positive patients; however, their inability to implement self-care practices may have concerned them more (Khaustova et al., 2021; Wang, 2020).

Summary and Conclusion

These past pandemic years were challenging for most people, as predicting how one stressful situation impacts a person's wellness was impossible (Omary, 2020; Yep, 2020). The physical health concerns of the pandemic were only one part of the cycle of positive health, and the second was the aftermath of personal mental health, especially for minorities (Novacek et al., 2020). Resiliency was contingent on distinct aspects such as age, gender, and race (Hayman et al., 2017; Hirani et al., 2016; Wu, 2021). Resiliency

was an evolution of resolve, openness, identifying who's at risk, enlisting support, and self and community awareness (Henning & Armstrong, 2020; Masten et al., 2021). On the other hand, a person's identity is cultural, gender, and professionally driven (Arjona-Castilla et al., 2022; Bloom, 2022).

The year 2020 intertwined medical and social unrest that increased tensions on all spectrums of health care across the United States (Masten et al., 2021; Spong, 2020). The four prior epidemics in the past 100 years provided different lessons that improved health policies (Pergolizzi, 2021). During the COVID-19 crisis, many African Americans relied on cultural strengths to survive, elevating their fears, and requiring more race-related behavior interventions (Novacek et al., 2020; Omary, 2020; Sneed et al., 2020). Previous racial bias and mental health issues in African Americans created additional distress, as COVID-19 affected more people of color than others (Cobb et al., 2021). The alignment of identity, illness, and social injustice pressures created an opportunity for discovering and implementing new practices that included racially or ethnically related spiritual practices (Leamy, 2011; Singh et al., 2020).

African American counselors' collision of racial stressors stretched their resiliency because of publicized social injustice actions; managing COVID-19 safety precautions and identity contributed to their resiliency (Bray, 2020; Chae et al., 2021). Multi-cultural training on the effects of such cultural incidents helped with these stressing racial issues (McAdams & Keener, 2008; Ridley et al., 2021). A person's capacity to adapt to many environmental factors builds their level of resiliency (Gale & Abdalla, 2020; Locke, 2016; Masten et al., 2021). Counselors have personality traits developed

from their ideas, cultures, and values that mesh into their professional identities (Boden et al., 2018; Klein & Beeson, 2022). African American women counselors are skilled in helping professional tools to mend or sustain their client's thoughts, feelings, and emotions due to life situations (Ewe & Ng, 2022; Marks et al., 2018).

The training to become a professional counselor culminated in learning and applying different resilience self-care principles (Council for Accreditation of Counseling and Related Educational Programs, 2022). At the same time, the identity of African American women counselors expressed a reserve of ability that originated from upbringing or group expectations that protect her throughout many adverse situations (Brewer et al., 2018; Sandil et al., 2015). Personal development programs that focus on combining the two resources of resiliency might be the intervention that makes her thrive and not crumble underneath the mental weight of everything, as a person's stress level equals the amount and type of exposure (Boden et al., 2018; Koffer et al., 2016; Phinney, 2010). Because of their career choice, most counselors experience internal and external stress because therapists can neglect to address their own personal feelings, thoughts, and emotions (Friedman, 2017; Lakioti et al., 2020). This quantitative study fills at least one gap in the research by detailing factors specific to African American women counselors and the influences of racial stressors on their ability to remain resilient. Chapter 3 covered the research methods, research design, purpose for this investigation, population, and different sampling methods used to gather the research data.

Chapter 3: Research Method

Introduction

The lack of resiliency of African American women counselors related to racial-specific stressors of self-identity, COVID-19 pandemic anxiety, and daily discrimination creates acute emotional strain and taxing mental tensions (Alinia, 2015; Blount & Lambie, 2018; Brown, 2020; Cook et al., 2021; Howard & Navega, 2018; Newell, 2020). The purpose of this quantitative correlational cross-sectional study was to investigate the relationships between racial stressors (i.e., self-identity, COVID-19 pandemic anxiety, and everyday discrimination), demographic factors (i.e., age, education level, and active counseling years) and resiliency measured by the Connor-Davidson Resiliency Scale-10 in African American women counselors. This chapter includes discussion of the research design and rationale, methodology, threats to validity, targeted population, sampling and recruitment procedures, measurement constructs, data analysis, ethical considerations, and the introduction to Chapter 4.

Research Design and Rationale

Quantitative research is valuable when a researcher wants to understand the relationship between variables (Creswell & Creswell, 2018). Researchers recommended that analyses that clarify the influences between variables and not manipulate variables should use a nonexperimental design (Bhattache, 2012; Warner, 2013). The first research question had three independent variables (age, education level, and active years as a counselor). The second research question had three independent variables (self-identity, COVID-19 pandemic anxiety, and everyday discrimination). The third research question

had six independent variables (age, education level, active years as a counselor, self-identity, COVID-19 pandemic anxiety, and everyday discrimination). All three research questions had the same dependent variable of resiliency, measured by the Connor-Davidson Resiliency Scale-10 in African American women counselors.

Prior researchers used qualitative research design to explore racial stressors, gender roles, mental wellness, and resiliency in African Americans (Jones et al., 2018; Novacek et al., 2020; Watson & Hunter, 2016). Qualitative research is a personal approach based on a particular interest, language, patterns, and a person's experience. Quantitative research evaluates totals, percentages, and variables of interest (Dawes & Levitt, 2017; Steel, 2011). Qualitative studies could be helpful when working with a smaller number of participants and gathering detailed information about an event instead of predicting the occurrence of an event (Dawes & Levitt, 2017; Steel, 2011).

Both research designs are valuable in collecting information about racial stressors, identity issues, and coping skills to promote positive wellness for African American women counselors (Archibald et al., 2012; Seaton & Iida, 2019; Shashikala & Basha, 2020). However, because the variables were predetermined and not thematic or subjective, the qualitative design was not an option for this study, and I chose quantitative correctional cross-sectional design.

Correlational research studies are used to determine the direction of the relationship between one variable and another, but the reason for the connection cannot be clearly understood (Cunningham et al.,2013; Hendricks, 2018; Seeram, 2019). While cross-sectional studies provide a glimpse into a researcher's hypotheses by randomly

selecting participants to answer survey questions, which decreases no-show rates, increases participation, and reduces participants bias which can affect internal validity (Bhattache, 2012; Salkind, 2006). Cross-sectional studies also allow the researcher the ability to record the participants age within a set time frame, which becomes harder to monitor in a life stage longitudinal study (Putnick, 2018; Salkind, 2006; Sullivan, 2009). By combining the correlational and cross-sectional research designs, researchers can investigate the relationships between variables at a selected time (Bhattache, 2012; Cunningham et al.,2013; Hendricks, 2018; Salkind, 2006; Seeram, 2019).

I used a correlational cross-sectional design to investigate the relationship between potential resiliency variables of African American women counselors. My goal was to conduct a cross-sectional study to advance research knowledge about specific racial stressors, demographic factors, and resiliency.

Methodology

Population

According to the 2020 Labor Force Statistics, there were over 300,000 counseling professionals, 60% - 80% of whom were women (United States Bureau of Labor Statistics, 2020). In my study the targeted population was the second largest group of active, licensed women counselors who identified as Black or African American as identified in the national survey report (United States Bureau of Labor Statistics, 2021). Research participants were licensed woman counselors who are master's level or doctoral level graduates: psychologists, counselors, marriage and family therapists, or clinical social worker students who provide behavioral health services to clients in their

practicum, internship, or counseling field. An active counselor sometimes works beyond the national retirement age, which is why the age range of the participants was 25 years or older. For a robust research study, a minimum of 98 participants was required.

Sampling and Sampling Procedures

Inclusion Criteria

To participate in this study, an individual must meet all inclusion criteria:

- 18 years of age or older
- African American/Black woman
- Licensed counselor (Master's or Doctoral level)
- Have been a counselor for at least six months before the COVID-19 pandemic lockdowns started (6 months before March 2020)
- Engaged as a counselor during the COVID-19 pandemic
- Read and understand English

Anyone that did not meet all these inclusion criteria was excluded from participating in this study.

Sampling Strategy

The two types of non-probabilistic sampling methods I used to maximize participation were convenience and snowballing (see Huck et al., 2022). Many researchers believe that participants should have every opportunity to be selected to participate in the study, but when a researcher does not have a predetermined population target ahead of time, it may affect the strength of the research (Daniel, 2012; Huck et al., 2022; Hussey, 2022). Probability sampling increased the chances of everyone being able

to participate in the research study; however, if availability and flexibility were a concern, a nonprobability sample was the best choice (see Creswell & Creswell, 2018). One strength of convenience sampling is the participants' readiness to complete online questionnaires (Creswell & Creswell, 2018; Frey, 2018). These methods of selection increased sampling errors, which is why it is necessary to add demographic questions (Frey, 2018). On the other hand, snowballing sampling can be useful for finding hard-to-reach populations, such as the African American community, through peer and professional associations (see Alanoglu & Karabatak, 2021; Hunk et al., 2022).

Traditionally, random sampling is preferred for many researchers looking for diverse respondents (Warner, 2013). However, many social collegiate programs chose less preferred sampling methods to minimize research costs and for populations that historically avoid research practices (Lu & Franklin, 2018; Warner, 2013). One disadvantage to convenience or snowballing sampling is that the participant is not mandated to complete the survey (Friker, 2017; Lu & Franklin, 2018). The participant's decision, although it is their right, could be problematic when gathering research data from the African American population, but having the questionnaire posted on several different websites increased the influx of completed questionnaires (see Friker, 2017; Lu & Franklin, 2018; United States Census Bureau, 2021; Warner, 2013). The survey distribution was primarily online, a quick, efficient, and cost-effective way to gather data (see Fricker, 2017). Participants were able to access questionnaires from social media groups like Facebook, LinkedIn, Walden University participant pool, and the American Counseling Association Connection site.

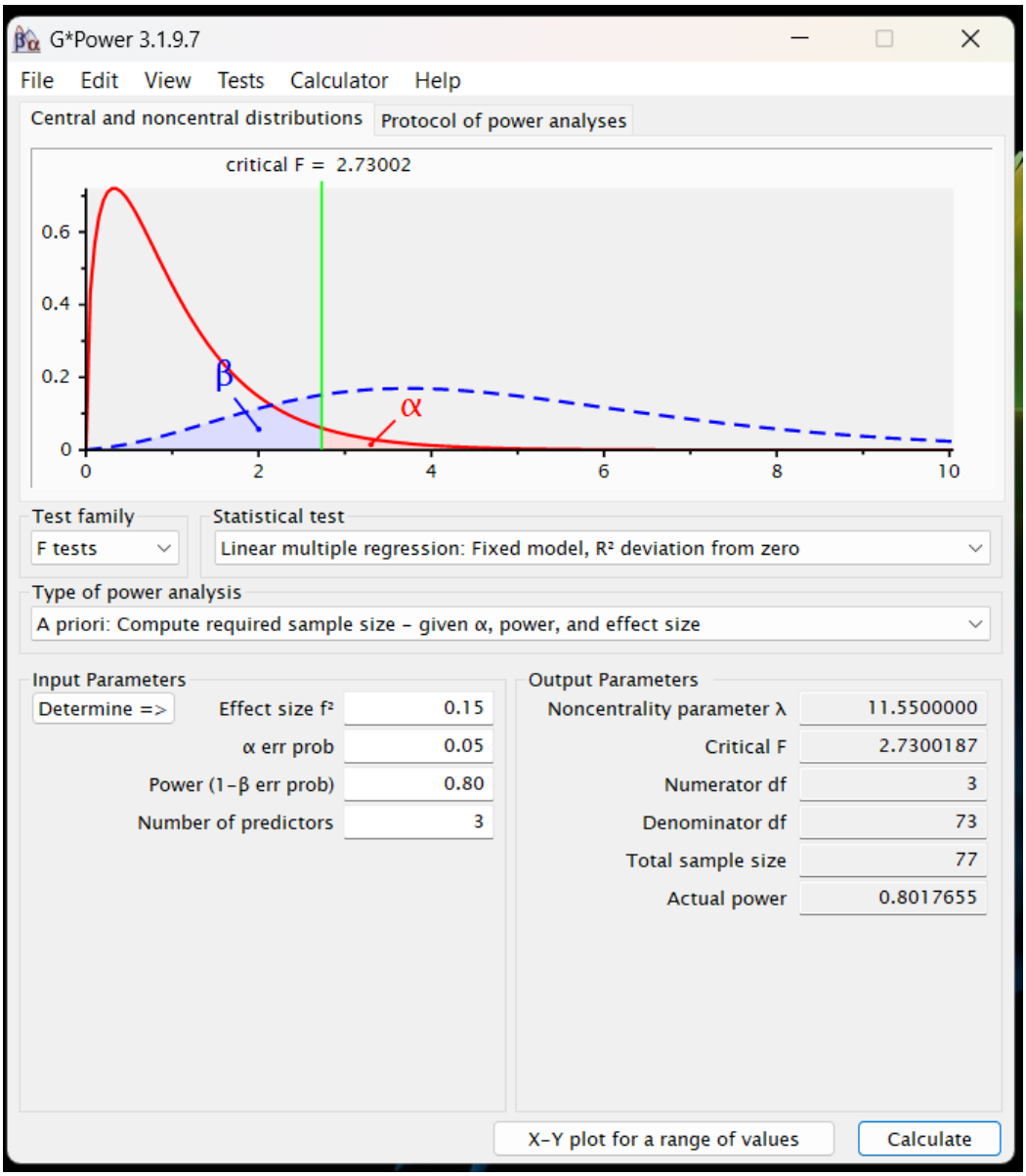
Sample Size

Cohen (2016) suggested a power analysis of .80 because a lesser power increases the risk of a Type II error, and a power analysis over .80 would increase the required number of participants, increasing the research cost. I chose a medium effect size of .15 because access to technology within the African American community could increase the possibility of larger samples and the chances of incomplete questionaries (Kelley, 2022; United States Census Bureau, 2021). At the same time, a small sample size might misrepresent the characteristics of the African American population (Connolly et al., 2017). Alpha level .05, or Type I error, is the standard risk most researchers take to increase the probability of rejecting the null hypothesis (Creswell & Creswell, 2018). The alpha .05, with a power or confidence interval of .80 and a medium effect size of .15, was my choice for this study because it decreased research time, reduced costs, minimized the risk, and increased the researcher's ability to receive more completed surveys that appropriately represents the African American woman counselor.

The G-Power analysis calculator was a statistical population sample determent program used to determine the sample size for multiple linear regression analysis (Faul et al. 2009). I used the F-test Linear multiple regression model to select the sample size based on the number of predicting variables (Faul et al. 2009). There were three independent variables for RQ1 and RQ2 and the calculated needed sample size using an alpha of .05, medium effect size of .15, and desired statistical power of .80 for each question was 77 (see Figure 1).

Figure 1

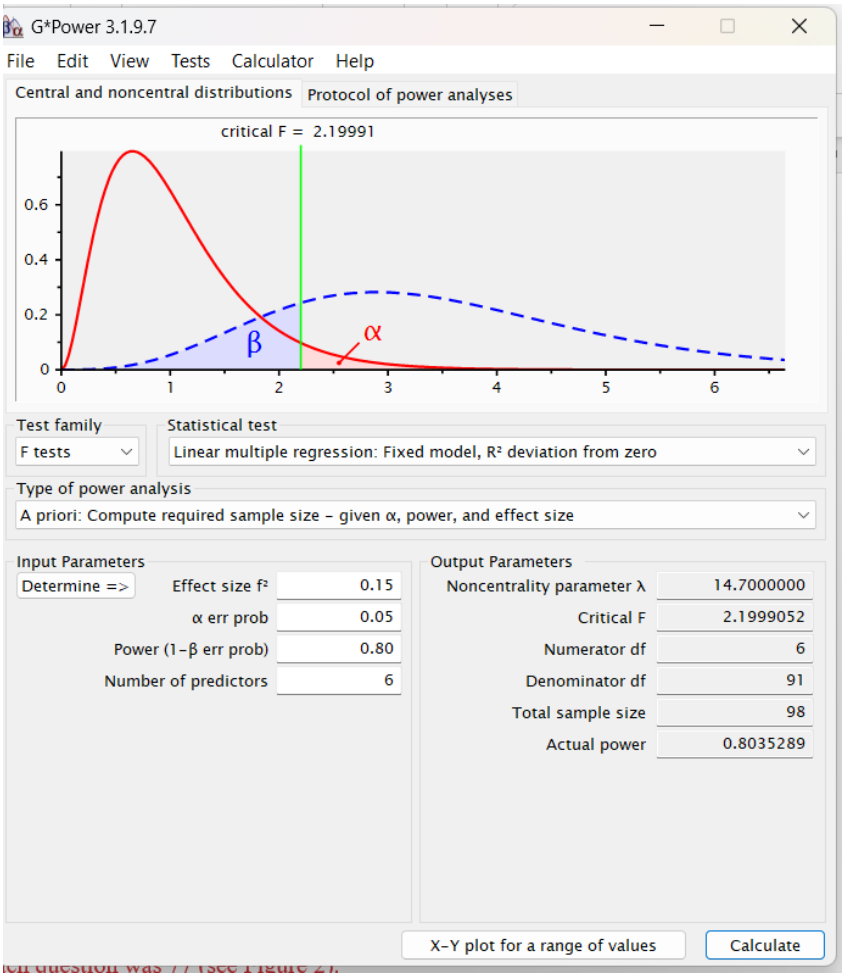
GPower Sample Size Calculation for RQ 1 & RQ 2



For RQ3, there were six independent variables, and the calculated needed sample size using an alpha of .05, medium effect size of .15, and desired statistical power of .80 was 98 (see Figure 2). I collected a larger sample of 98.

Figure 2

GPower Sample Size Calculation for RQ 3



Procedures for Recruitment, Participation, and Data Collection

Recruitment

Walden University Institutional Review Board formally approved the research study before the start of the recruitment process. After approval, I posted post electronic recruitment flyers on social media sites such as Facebook, LinkedIn, Workspace, Walden University participant pool, and the American Counseling Association connect page. Since a monetary incentive was not given for participation in this study, I did not have to

worry about the misconception of financial exploitation; however, a thorough explanation of the study and peer promotions increased participation and maintained the integrity of the research study (Creswell & Creswell, 2018; Far, 2018). At least 98 African American women counselors completed the online survey (Faul et al., 2009).

Participation

Participants launched the survey link within the email or flyer or contact the researcher's email for access (see Appendix A and Appendix B). Once the connection was open, a list of inclusion factors comprised of "yes" or "no" answers determined if they met the research criteria. All responses must be "yes", for "no" answers in the demographic section excluded the person from the study, and the participant was thanked for their interest and exited from the survey. Participants who meet all the research criteria continued to the informed consent. At the end of the informed consent, the participants were asked if they consent to participate. If they answered no, the participants were thanked for their interest in the study and exited from the survey. If they answered yes, they moved onto the demographic items.

Data Collection

The demographic question followed the informed consent, including age, education level, and active years as a counselor). The next step was to answer questions from the four instruments. The survey did not take more than 26 minutes to complete. As a safety precautionary, the researcher added the 988 Suicide and Crisis Lifeline in case they experienced mental health challenges in response to the research questions.

After the Chief Academic Officer (CAO) signed the study, I posted a one-page summary of the completed research on the recruitment sites.

I built the survey in Qualtrics, an online program that was easy to use which allowed me to receive more than 100 participants responses and quickly transfer data into the SPSS program (Qualtrics, 2023). Once the required number of filled-out responses were received, I downloaded the data in SPSS format with the appropriate labeling and preassigned coding. To increase data accuracy, I eliminated cases where not all answers were provided on the instruments used (Warner, 2013). However, if any demographics were answered with "prefer not to answer" or were missing, and the instrument values were complete, I kept those cases in the data.

Demographic Information

The demographic information followed the electronic consent and consisted of age, education level, and active years as a counselor, which reflected individual and professional traits as a counseling professional and national demographic identifiable factors (Lakioti et al., 2020, United States Census Bureau, 2023).

Instrumentation and Operationalization of Constructs

Instruments

Multidimensional Model of Black Identity (MMBI). The Multidimensional Model of Black Identity (MMBI/MIBI) evolved from the Multidimensional Model of Racial Identity (MMRI) model. This scale is accessible for public use, however, the MMBI 2018 version which was the scale I used required authorization from the originator as no accessibility statement was included. Sellars et al. (1997) constructed the

initial Multidimensional Model of Racial Identity that Identity to minimize previous researchers' opinions about Black people. The MMRI was a testable means to explore an individual's racially provoked beliefs and behaviors that forge their self-concept from a psychosocial lens (McClain et al., 2016). This original tool consisted of four emotional levels of influence: salience, centrality, regard, and ideology. Meanwhile, the updated measurement, the Multidimensional Model of Black Identity, left out the salience condition because of its minimal influence on the other three areas of evaluation (Vandiver et al. 2009).

Many African Americans embraced the concept of identity when responding to news events about civil unrest and COVID-19 (Dale & Safren, 2018; Liao et al., 2020; Melaku, 2021; Schulz et al., 2000). The difference between salience and centrality was short-term versus long-term effects. Salience measured the relevancy of race-related self-ideology during an exact timeframe, and centrality assessed the race-related impact on a person's belief about themselves over time and through various circumstances (Willis & Neblett, 2020). On the other hand, the sub-category regard addresses a person's perceptions of how others should act based on their unique racial and cultural backgrounds and ideology compared to individual behavior and reactions to the majority behavior which can be rewarding and challenging (Willis & Neblett, 2020).

As social influences focused on cultural or historical factors of an African American identity could be influenced by temporary social ideals, the Multidimensional Model of Black Identity streamlined the Multidimensional Model of Racial Identity assessment to the three most specific areas of racial concerns: centrality, regard, and

ideology (Sellars et al.,1998). Also, removing public regard questions was necessary to increase the internal reliability (Sellars et al.,1998). Professional researchers noted in a confirmatory factor and exploratory analysis which compared the Multidimensional Model of Black Identity and the Cross-Racial Identity Scale that many similarities existed between the two measurement tools and that one of the subscale measurements had an average score of .05 to .57 (Valdiver et al., 2002). Sellers et al. surmised that the MIBI optimized the three more important points of the MMRI and provided valid alpha coefficients of .70 to .79 in the centrality and ideology scales and internal consistency.78 for both areas of the regard subscales. However, the MMBI evaluation is newer; participants' racial notions aligned with previous rankings.

Seven years after Valdiver et al. (2002) original study utilizing the Multidimensional Model of Black Identity, the completion of their second study expanded research knowledge by using the scale with different populations, genders, and levels of educated participants (Valdiver et al., 2009). Consequently, these researchers also recommended that further development of the MIBI was necessary for actual racial specifics (Valdiver et al., 2009) Fortunately, another researcher used a qualitative investigation utilizing the full-scaleScale MIBI which indicated that it was possible to gauge an African American perspective on racial influences and identity (Jones, 2014). But only a few researchers used the to measure racial identity factors and showed good connections between identity and personal and social concerns about discrimination (McClain et al.,2016; Powell et al., 2016; Willis & Neblett, 2020).

McClain et al. (2016) used the subset of racial centrality of the MIBI to connect the racial identity of Black college students with mental stability. The researchers concluded that the subgroup was reliable with a Cronbach alpha of .78, slightly improved compared to the normal range of .67 to .74 from prior studies. Powell et al. (2016) used the centrality part of the Multidimensional Model of Black Identity to emphasize the importance of an African American man's racial identity and wellness. A strong connection between self-identification, daily racial discrimination, and resilient health also reflected a higher Cronbach's α of .88 (Powell et al., 2016). Other researchers gauged cumulative distress level and racial identity by using the centrality, regard, and ideology sub-levels of the MIBI, finding African American adults were not as psychologically distressed about what others thought about them as a person or were people who cared about how others perceived themselves (Willis & Neblett, 2020). One interesting point from this study was that African American women stressed over situations longer than African American men, which intertwined with their understanding of self and gender (Abrams et al., 2018; Watson-Singleton, 2017; Willis & Neblett, 2020).

Holloway and Varner (2021) mentioned that racial beliefs shape a person's perspective, which consists of internalized and verbalized responses to race issues that produce stress. These researchers noted that racial identification was vital to how each African American parent reacted to stress, which contributed to how they protected their children from racially charged situations (Abrams et al., 2018; Holloway & Varner, 2021; Watson-Singleton, 2017). In Holloway and Varner's (2021) study, racial centrality and private regard were positively co-related. However, racial centrality and the public eye

were negatively co-related, which meant that parents were concerned more about what they thought about racial-related problems than what others felt about them (Holloway & Varner, 2021). Racial identity seemed more personal for an African American individual than the need for approval or acceptance from other ethnic groups (Holloway& Varner, 2021; Willis & Neblett, 2020).

African American women's experiences are unique, so some researchers adapted the MIBI regard subscale to measure the intersection of gendered identity (Williams & Lewis, 2019). These researchers found that Cronbach's α was .64 for private regard and .87 for public concern, consistent with the MMRI and the MIBI in previous studies (Williams & Lewis, 2019). The Multidimensional Model of Black Identity was a versatile instrument and reflected scale consistency in the investigation of self-esteem in European-Americans, Latinos, and Native American students (Johnson et al., 2005). Yet there seemed to be some disagreement in the results as the gender factor between Latinos and European Americans racial self-concept was not a consideration among Native-American students (Johnson et al., 2005).

Age was as important as gender in evaluating racial identification and resiliency, as shown in the study about racial identity safeguards and adverse racial attitudes for an African American teenage girl student (Butler-Barnes et al., 2018). The modification of the MIBI-teen assessment included areas of interest towards the teen population such as racial centrality with a .58, private regard .79, nationalist ideology with a .72, and minority ideology with a .55 Cronbach α (Butler-Barnes et al., 2018). The findings showed lower individual scores than the previous adult MMRI and the original MIBI

scales with adults in centrality and regard (Sellers et al., 1998; McClain et al., 2016). MIBI scale in whole or parts has a solid validity for exploring the viewpoint of the African American racial experience (Jones, 2014; McClain et al., 2016; Powell et al., 2016). The centrality sub-level and regard sub-levels was used in their research to measure the variable self-identity in African American women counselors.

The MIBI instrument had twenty questions with three individually scored sections. The Likert score ranged from (1-7) with choices "strongly disagree, neutral, to strongly agree" (Sellars, 2013). The centrality sub-scale consisted of eight questions, with questions one, four, and eight scored in reverse order. The private regard section had six questions, with question four scored in reverse. The public regard section also had six questions, with questions three and four reversed scored. The researcher "subtracted eight points from each reverse question" before averaging each subscale (Sellers, 2013).

Everyday Discrimination Scale. The original Everyday Discrimination Scale (EDS) had nine measured areas that evaluated daily experiences about politeness, admiration, level of service, intelligence, fear, honesty, and bullying in the lives of African Americans (Williams et al., 1997). The Everyday Discrimination Scale could be used for educational purposes without permission. The scale also had thirteen follow-up demographic questions if needed. The six possible responses range from "daily" to "never experience." The tenth question that involved harassment while shopping came 10 years later (Williams et al., 2008). The scores were added together and then averaged, the more significant the average, the more discrimination. The short version of the EDS only had five questions but included thirteen follow-up questions (Sternthal, 2011). The

Cronbach alpha for the short version is .77 (Sternthal, 2011). The Everyday Discrimination Scale, combined with other racism scales, created the Daily Life Experience Scale, which provides the overall frequency of discriminative practices felt by African American men and women and had a Cronbach alpha of .86 (Lee et al., 2021).

In the study investigating obstacles to health with African American men, the researchers used a lengthy questionnaire with a Cronbach alpha of .95 (Powell et al., 2016). When Michaels et al. (2019) investigated high blood pressure and the mental health of middle-aged African American women, they modified the participants' answers by adding specific coding parameters, which yielded a stronger association between high blood pressure and depression. Greenfield et al. (2021) used a 9-question version of the EDS with factors of race/ethnicity and skin coloration to evaluate microaggression and discrimination in American Indian and Alaska Native college students. The scale proved valid with a Cronbach alpha of .79 (Greenfield et al., 2021). The Everyday Discrimination Scale with follow-up questions and health assessment was given to the Hispanic population to assess discrimination and COVID-19, showing a strong connection between discrimination and depression in the first months of the pandemic (Lee et al., 2022). These researchers rated the population using a 4-point Likert scale instead of the 6-point scale, which showed that a shorter version was effective.

Kershaw et al. (2016) also developed a modified version of the Everyday Discrimination measure, including the standard nine questions and a 6-point Likert scale. The possible answer is “never to almost every day” (Kershaw et al., 2016). Still, unlike Lee et al. (2022), Kershaw et al. did not ask any follow-up questions or use any

additional health assessment. The score range of this scale is 9-54 based on the total measure score (Kershaw et al., 2016). The demographic questions were very similar to the follow-up questions in the long and short versions of the Everyday Discrimination scale; I used the 9-question modified version to measure the variable daily discrimination in African American women counselors.

COVID-19 Pandemic Anxiety Scale. Kumar et al. (2020a) created the COVID-19 Pandemic Anxiety (CPAS-10) scale to better understand people's anxiety levels about the Coronavirus. This assessment tool was available without formal consent (Kumar et al., 2020b. However, the originator specified that research participants use the scale or those in formal education requiring information about COVID-19 anxiety and not for researchers who want to support a specific mental health diagnosis (Kumar et al., 2020b). Kumar et al. (2020a) confirmed the convergent validity of the original scale by comparing it to the Lee (2020) Coronavirus Anxiety Scale, which measured fear and bodily reactions and had a Cronbach alpha of .83. The pilot research for the CPAS-10 contained an exploratory factor analysis (EFA) and a confirmatory factor analysis (CFA). The EFA showed a "high internal consistency of .86 for the fear sub-scales and .83 for the somatic sub-scales" (Kumar et al., 2020a, p. 1021). At the same time, the CFA indicated that the CPAS was a very reliable and valid scale to measure fear and somatic responses due to COVID-19.

Two categories that made up this questionnaire were fear and bodily concerns. Fear was calculated from questions one through six, and somatic matters were calculated from questions seven through ten. Each question had four answers: "did not apply at all,

applied some of the time, applied good part of the time, and applied most of the time" (Kumar et al., 2020b). A high combined score indicates an extreme level of anxiety. The possible score is between “0 to 30” (Kumar et al., 2020b). I used the CPAS-10 to measure COVID-19 anxiety among African American women counselors because of its previously use with the general population.

Connor Davidson Resilience Scale (CD-RISC). There are three different versions of the Connor Davidson Resiliency Scale: the CD-RISC-2, CD-RISC-10, and the CD-RISC-25, which looked at the character traits of people as they personal bounce back following challenging conditions that produced physical and mental reactions (Conner-Davidson, 2011; Falavarjani & Yeh, 2019; Korneev & Bochaver, 2021). The number extension represented the number of questions (Conner-Davidson, 2011). The original Connor-Davidson Resiliency Scale consisted of a 25-question instrument that measured a person's bounce-back potential and intervention response (Connor & Davidson, 2003). This scale has been used in different populations as a self-measure, with each question comprised of five possible answers (Connor & Davidson, 2003; Li et al., 2021; West et al., 2020). The scores were then added together to reflect an individual level of resilience, with the higher the score, the higher the resiliency (Connor & Davidson, 2003; Hirani et al., 2016).

Some researchers used a cross-sectional analysis to measure nurses' burnout, resiliency, and social demographic factors a year after the start of the COVID-19 pandemic and showed that women nurses showed higher rates of distress and exhaustion (Jameebozorgi et al., 2022). The Connor-Davidson Resilience Scale -25 showed the

Cronbach alpha ranged between .89 and .76 depending on the sub-category measured (Jameebozorgi et al., 2022). In a study about African American/Black women stereotypes, sadness, and resilient behavior mediated by social inclusion, gender, and racial understanding, the investigators found that African American woman suppressed their emotions if they identify with Black women stereotypes (Nelson et al., 2022). When other researchers evaluated African American women's resilience and heart disease, they also used the CD-RISC-25, which reflected a strong connection between the two factors (Saban et al., 2019). The first study about African American women yielded an alpha of .90; the second was .89 (Nelson et al., 2022; Saban et al., 2019). As women tend to identify with their gender, roles, and racial group, their resiliency could be positively or negatively impacted (Jameebozorgi et al., 2022; Nelson et al., 2022; Saban et al., 2019).

In a confirmatory factor analysis evaluating resiliency, African Americans and gender showed different responses in gender when using the Connor-Davidson Resiliency Scale-10 (Silverstein et al. 2022). African American women were more stressed about situations than African American men, which caused differences in gender responses (Abrams et al., 2018; Watson-Singleton, 2017; Willis & Neblett, 2020). African American women had a mean score of 30.39 and a Cronbach alpha of .89; African American men had a mean score of 32.68 and a Cronbach alpha of .88 when assessed with the CD-RISC-10 (Silverstein et al., 2022). When validating the CD-RISC-10 with South African school teachers and COVID-19, it proved to be a reliable and valid measure for researchers and an excellent tool to use in healthcare settings (Pretorius &

Padmanabhanunni, 2022). Russian researchers also used the CD-RISC-10 with Russian youth, which revealed a Cronbach alpha of .84 with positive correlations in resiliency and mental health and a negative correlation to resiliency and physical health (Nartova-Bochaver et al., 2021).

The CD-RISC-2 was used to measure the relationships between social support and resilience in the mental wellness of different age groups during the initial months of the COVID-19 infection and utilized before the pandemic to assess the strength in doctors and workers in other careers (Li et al., 2021; West et al., 2020). Before the pandemic, these researchers showed doctors exhibited stronger resiliency than other career professionals but were still vulnerable to burnout. After the pandemic, increased social support was vital to improve mental health and resiliency levels (Li et al., 2021; West et al., 2020). The Cronbach alpha was .79 in one study, and the other showed the p-value was <.001 when participants answered the two questions about their ability to adapt when facing challenges (Li et al., 2021; West et al., 2020). Based on the consistent reliability of all three scales and the need for more African American participation, as suggested by previous researchers, I used the CD-RISC-10 in my research study (Silverstein et al., 2022).

This scale was not a free or public-use scale. I emailed the originator according to the CD-RISC website to request the instruction to submit a formal request. Once I received the email, I completed the request form and emailed it to the originator's representative. Once the originator's staff reviewed the email request, their representative sent another email to me requesting my agreement to protect the scale and payment. After

I signed the contract for use and paid the fee, I received a copy of the CD-RISC 10 scale, scoring sheet, and updated instructions..

The CD-RISC-10 has ten questions, which are scored from 0 to 4. Participants can choose from "not true at all, rarely true, sometimes true, often true, and true nearly all the time" (Davidson, 2022). The sum should range between 0-40 (Davidson, 2022). The CD-RISC scores differ in the national and international regions, so the originator suggested that the median score for the United States population is 36. (Davidson, 2022).

Operationalization of Constructs

Table 1 contains the independent variables and dependent for this study and the assigned scoring/coding.

Table 1

Variables and Code Assignments

Research Question	Data Analyses	Variable Type	Variable Name	Variable Category	Coding
1, 3	Multiple Linear Regression	Independent	Age 18 +	No Yes Prefer not to answer (excluded from the study)	0 1 99
			Education level	Master's Degree Doctoral Degree Prefer not to answer (excluded from the study)	0 1 99
			Currently Counseling	No Yes Prefer not to answer (excluded from the study)	0 1 99
			Years' Experience	Less than 1 Prefer not to answer	0 99
2, 3	Multiple Linear Regression	Independent	Racial Stressors	MMBI sub-category centrality	CS-MMBI
				MIMBI sub-category Private regard	RS-MMBI
				MIMBI sub-category Public regard	PR-MMBI
				COVID-19	CPA
				Everyday discrimination	EDS
1, 2, 3	Multiple Linear Regression	Dependent	Resiliency	Resiliency	CDR

Data Analysis Plan

The participants' demographics information and answers to the Multidimensional Model of Black Identity Scale, the COVID-19 Pandemic Anxiety Scale, Everyday Discrimination Scale, and the Connor-Davidson Resilience Scale-10 will be exported from Qualtrics database into the IBM's Statistical Package for Social Science (SPSS)

version 28 for analysis because online survey programs make data transfers less difficult using popular analyzing systems (Cox, 2016).

Data Cleaning

Once I completed the data transfer, I performed a line-by-line comparison between the original data source and my downloaded copy which highlighted missing information (Warner, 2013). Although there were no discrepancies in the data, I downloaded a separate back-up copy and renamed both copies. I included outliers or significant differences in mean cases as determined by its value on the research outcome into the data analysis (Warner, 2013). Also, inadequate sample size and any outliers could cause regression analysis problems (Belhekar, 2016).

I also completed any reverse coding vital to data accuracy during data cleaning. The MMBI had several questions requiring reverse re-coding, so eight points were deducted from each question in each subscale before the data analysis (Osborne, 2017; Sellers, 2013). Reverse coding before data analysis decreased errors (Sellars, 2013; Creswell & Creswell, 2018; Warner, 2013). Also, to improve the number of participants' responses in the sample, any participant with missing information in the instrument area of the survey was excluded from the study (Belhekar, 2016; Creswell & Creswell, 2018; Warner, 2013).

Sample Description

Frequencies. After I had all the data loaded into SPSS, I ran a descriptive statistical analysis to ensure the frequencies of the demographic factors, age, education level, and active years as a counselor, were represented in the sample population. The

frequency chart summarized the scores, missing data, and the means to observe any inconsistencies or heterogeneity statistics (Wagner & Gillespie, 2019). The frequency chart allowed me to see if representation within each variable was fair or required another action (Warner, 2013). One researcher suggested that variables such as education level and age are divided into ranges universally varying by national data surveys such as the United States Census Bureau, which made the review easier (Wagner, 2017).

Instrument Reliability Analysis. I performed a Cronbach alpha reliability analysis in SPSS 28 for each of the four instruments in the survey. The Multidimensional Model of Black Model (MIBI) had three subscales (centrality, public regard, and private regard) (Sellars, 2013). Since I scored the subscales separately each required separate Cronbach alpha assessments (Laerd, 2023). Also, the MIBI had six questions that needed to be scored in reverse order; this meant I had to adjust the scores before the reliability analysis, as negative totals could decrease accuracy (Osborne, 2017; Sellars, 2013). However, the COVID-19 Pandemic Anxiety Scale, Everyday Discrimination Scale, and the Connor-Davidson Resiliency Scale-10 had overall totals, so I only had to run one reliability test per instrument.

Multiple Linear Regression. Multiple linear regression assessed one variable's importance based on the importance of other variables (Laerd Statistics, 2023; Segrin, 2022). Because of its flexible nature, multiple regression could be useful in assessing any connection between independent and dependent variables and between several independent variables and a single dependent variable (Segrin, 2022). Also, multiple regression allowed me to determine the overall fit of the testing model (Laerd Statistics,

2023). Multiple linear regression was only good if specific assumptions were maintained (Segrin, 2022).

Assumption Testing. There were several assumptions for multiple linear regression analysis.

- Assumption 1: The dependent variable was measured on a continuous scale (Laerd Statistics, 2023). The Connor-Davidson Resiliency Scale-10 consisted of five progressive answers such as "not true at all, rarely true, sometimes true, often true, and true nearly all the time" (Conner & Davidson, 2018, n.p.).
- Assumption 2: There must be two or more independent variables (Laerd Statistics, 2023). The two independent variables in this study were demographics and racial stressors.
- Assumption 3: There must be an "independence of observations," determined with the Durbin-Watson statistic test in SPSS (Laerd Statistics, 2023). Specifically, this test indicated whether a positive or negative autocorrelation exists, invalidating multiple regression analysis. (Lewis-Beck et al., 2004).
- Assumption 4: A linear relationship between the dependent and independent variables must be linear. I created scatterplots to verify the connection (Laerd Statistics, 2023; Warner, 2013)
- Assumption 5: The distribution was normal between variables, and the homoscedasticity or variance of errors was reliable as invalid assumptions allowed for computation biases that could impact the outcomes' significance (Belhekar, 2016; Seguin, 2022; Weiner et al., 2012). In regression evaluations,

the dependent value changed based on the independent variable, which showed homoscedasticity (Fay, 2022). Homoscedasticity was noticeable using graphs such as scatterplots or Spearman's Rank correlation (Belhekar, 2016; Fay, 2022)

- Assumption 6: Multicollinearity did not appear to influence the individually collected data by other participants or a relationship between predictor (independent or dependent) variables (Belhekar, 2016; Seguin, 2022; Weiner et al., 2012). Multicollinearities exist when there are "insignificant t-values despite high R2", strong relationships between predictor variables, low tolerance levels correlations among the predictors, and the matrix determinant showed values closer to zero (Belhekar, 2016). I inserted variables into a correlation matrix, looking for a coefficient of .80 or above, which showed the existence of multicollinearities (Statisticssolutions, 2023)
- Assumption 7: There were no significantly elevated outliers' points because they could adversely impact results (Laerd Statistics, 2023; Warner, 2013). I detected the outliers in SPSS by using "casewise diagnostics, studentized deleted residuals" or "Cooks Distance" (Laerd Statistics, 2023).
- Assumption 8: The residual errors were normally distributed (Laerd Statistics, 2023). The scores of all variables formed an identified bell-shaped distribution curve (Warner, 2013). A histogram and a Normal P-P Plot; or a histogram and Normal Q-Q Plot of the studentized residuals identified the distribution curve required for quantitative variables (Laerd Statistics, 2023; Warner, 2013).

Assumptions 1 and 2 was tested first to maximize results (Laerd Statistics, 2023). Because the test proved valid, the remaining assumptions were tested in order (Laerd Statistics, 2023). Since each research question had different combinations of variables, I ran the assumption test for all three research questions (Warner, 2013).

Variable Entry Method. Multiple linear regression was the most conventional and less complicated assessment because all the variables were entered simultaneously with equal consideration (Belhekar, 2016; Warner, 2013). Multiple regression analysis summarized interactions between variables at a particular time and was a valuable tool for testing continuous and categorical variables (Seguin, 2022; Weiner et al., 2012). However, hierarchical or statistical multiple regression analysis might provide an understanding of how each variable contributes to a person's resiliency, the process of entering which variable at what step must be theoretically or research question-based (Belhekar, 2016; Segrin, 2022; Warner, 2013). Since this was the preferred method of analysis not based on a particular theory of priority, all variables in this study were entered simultaneously (Warner, 2013).

Research Question 1

RQ1: What is the relationship between demographic factors (age, education level, active years as a counselor) and resiliency measured by the Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0$1): H01: There is no statistically significant relationship between demographic factors (age, education level, active years as a counselor) and

resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis (H_a1): There is a statistically significant relationship between demographic factors (age, education level, active years as a counselor) and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Statistical Analysis Used. Multiple Linear Regression

Research Question 2

RQ2: What is the relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale, and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0 2$): There is no statistically significant relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis ($H_a 2$): There is a statistically significant relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model Black Identity

Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Statistical Analysis Used. Multiple Linear Regression

Research Question 3

RQ3: What is the relationship between demographic factors (age, education level, active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale, and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis (H_{03}): H03: There is no statistically significant relationship between demographic factors (age, education level, active years as a counselor, racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis (H_a3): HA3: There is a statistically significant relationship between demographic factors (age, education level, active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale,

COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Statistical Analysis Used. Multiple Linear Regression

Threats to Validity

External Validity

External validity describes how the variables in one population sample could be generalized with another population (Mitchell, 2018). A threat to external validity happens when researchers conclude from the target sample that it was untrue based on the environment, other people, or past research studies (Creswell & Creswell, 2018). Random sampling increases the general ability of the process; however, it takes time and adds additional costs (Huck et al., 2022; Mitchel, 2018). When other sampling styles were utilized, specific factors of each area within the research design must be maintained, such as the timeline, reason for the study, and theory, to maximize the general use of the research (Hubbard, 2016; Mitchel, 2018). Testing reactivity and interaction effects of selection and experimental variables were the external validity concerns in this research process.

Testing Reactivity

When researchers have limited time to conduct the research or the survey length affected the participation, the results might vary when used in future studies (Creswell & Creswell, 2018; Kalanian & Kasim, 2008). A unique situation like the pandemic could hinder the impact of resiliency, making generalization impossible (Leighton, 2010).

However, as pandemic infections were still a national health concern, variables selection may be applicable and repeated in later studies (Creswell & Creswell, 2018).

Interaction Effects of Selection and Experimental Variable

I investigated the racial stressors and resiliency of African American women counselors, which differentiated the choices of variables for other ethnic groups of counselors (Creswell & Creswell, 2018). Also, the demographic factors (age, education level, active years as a counselor) and racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) closely related the original study with a different population study (Kalanian & Kasim, 2008). People who chose to participate could be randomly selected, increasing the possibility of the same amount of participant representation in each evaluated factor, which improved research replication with other women counselors (Creswell & Creswell, 2018).

Internal Validity

Internal validity occurs when associations of factors are assumed as external factors decrease (Warner, 2013). Internal validity is threatened when the research process or participant observations affect my ability to form a valid conclusion (Creswell & Creswell, 2018).

History. History was described as the distance from the actual event or exposure, such as the Coronavirus, and the occurrence of racial stressors was challenging if the perimeter were not set (Creswell & Creswell, 2018; Meltzoff & Cooper, 2018). Participants taking the online survey within a specific time frame might decrease this threat.

Maturation. The participants' ages might also affect the research results (Creswell & Creswell, 2018). Also, participants' development could influence changes to the dependent variable (Cramer & Bork, 2017). The potential maturation problem was addressed by having an age range for participants to choose from (Creswell & Creswell, 2018).

Statistical Regression. Participants with a significantly higher or lower mean score were chosen over the other participants to minimize this internal threat; I selected participants based on certain factors such as education level and counselor longevity, which decreased any statistical regression (Creswell & Creswell, 2018).

Experimental Mortality. The mortality or attribution rate of the study's participants depended on many things (Creswell & Cress, 2018). My goal was to increase participation, which required a motivating factor such as a detailed explanation of the research value or a monetary reward (Kalanian & Kasim, 2008). As dropout rates or survey incompletion were possible, recruiting a larger sample than needed offset the number of participants who chose to leave the research study (Creswell & Creswell, 2018).

Selection-Maturation Interaction. Sometimes, the participants were chosen based on specific character traits and exposure so I could have randomly selected participants to improve the normal distribution of the sample population (Creswell & Creswell, 2018).

Construct or Statistical Conclusion Validity

The construct validity may be examined if my choice of measurements was valid to assess the targeted population (Cramer & Bork, 2017). Also, If the wrong statistical power or assumptions were violated, I would not have an accurate population estimate (Creswell & Creswell, 2018). The strength in the relationship between the research questions and measurements used was appropriate for determining the demographics, racial-specific stressors, and resiliency of African American counselors, as the details of the research questions measured the expected outcome (Ruel, 2019). The Multidimensional Model of Black Identity Scale, the Everyday Discrimination Scale, and the Connor-Davidson Resiliency Scale-10 were measurements used with African American women (Michaels et al., 2019; Powell et al., 2016; Silverstein et al., 2022). On the other hand, the COVID-19 Pandemic Anxiety Scale was a new scale used with the general population and was not gender or profession-specific (Kumar et al., 2020).

Ethical Procedures

I completed the Walden University Institutional Review Board (IRB) application for proposal approval before collecting research data (Walden University Office of Research and Doctoral Services, 2021). The IRB reviewed the research study plans to comply with federal law, which guarded against human rights violations (Creswell & Creswell, 2018; Rudestam & Newton, 2015). The informed consent was also a part of the IRB application. The IRB approved the application, and I included the approval number 07-07-23-0758571 in the final copy of the dissertation.

Participants were recruited on a volunteer basis; however, a participant must meet the research criteria listed in the demographics section. Participants did not feel pressured

to participate and were not excluded based on perceived traditions, stereotypes, spiritual preference, or gender, which promotes possible bias (Creswell & Creswell, 2018; Rudestam & Newton, 2015). The informed consent included a statement of withdrawal from the study to reassure the participants of their rights (Creswell & Creswell, 2018; Rudestam & Newton, 2015).

Participants withdrawing from the study for any reason or having mental health concerns because of the survey received a copy of the SAMHSA safety plan that included the 988 Suicide and Crisis Lifeline information as well as allowing the participant to identify triggers, warning signs, coping skill and people that can call for help if warranted (Creswell & Creswell, 2018; SAMHSA, 2022). Participants could dial 988, text message, or participate in the chat line 988lifeline.org (SAMHSA, 2022). Safety concerns were included in the informed consent and at the end of completing the research questions as part of the debriefing process (Rudestam & Newton, 2015).

All collected data adhered to the right to privacy for everyone who contributed. to the research. Participants were anonymous to avoid inadvertent disclosure (Creswell & Creswell, 2018). I controlled raw research data that included research procedures and SPSS analysis data; however, it was accessible to the committee members and the IRB when requested (Creswell & Creswell, 2018; Walden University Office of Research and Doctoral Services, 2021). The American Psychological Association (2020) recommended that final data interpretation materials and any auxiliary research material be stored between 5 to 10 years and disposed of appropriately. Nevertheless, as a Walden doctoral student, everything that pertained to the research, including surveys and electronic

materials, must be stored in two different locations for up to 5 years from finalizing the dissertation (Walden University Office of Research and Doctoral Services, 2021). Once the CAO approved the completed dissertation, I posted a one-page study summary on all recruitment websites. Also, a summary copy of the final research was available to each volunteer when requested.

Summary and Conclusion

The purpose of this quantitative correlational cross-sectional study was to explore the relationships between racial stressors (i.e., self-identity, COVID-19 pandemic anxiety, and everyday discrimination), demographic factors (i.e., age, education level, and active counseling years), and resiliency in African American women counselors. Convenience and snowballing sampling provided the needed participants and increased the validity of the research (Daniel, 2012; Huck et al., 2022; Hussey, 2022). Participant selection was based on their informed consent and demographic information (Israel, 2015; Lakioti et al., 2020; United States Census Bureau, 2023). I conducted several multiple linear regression analyses to explore the research hypotheses. The Multidimensional Model of Black Identity (MIBI), COVID-19 Pandemic Anxiety Scale, Everyday Discrimination Scale, and Connor-Davidson Resiliency Scale-10 instruments provided the data. Possible internal, external, and construct validity threats were identified, and solutions were addressed. I also discussed ethical concerns that included IRB approval, recruitment, the safety of participants, data collection, and storage.

Hopefully, this research increased professional and social awareness of the effects of multiple events on African American women counselors. Training and self-care

initiatives could adapt based on different social influences. Chapter 4 contained a brief introduction, data collection, results, and research summary.

Chapter 4: Results

Introduction

In this quantitative correlational cross-sectional study, my goal was to investigate the relationships between racial stressors (i.e., self-identity, COVID-19 pandemic anxiety, and everyday discrimination), demographic factors (i.e., age, education level, active counseling years), and resiliency in African American women counselors. The following research questions and hypotheses were evaluated:

RQ1: What is the relationship between demographic factors (age, education level, and active years as a counselor) and resiliency measured by the Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0 1$): There is no statistically significant relationship between demographic factors (age, education level, and active years as a counselor) and resiliency as measured by the Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis ($H_a 1$): There is a statistically significant relationship between demographic factors (age, education level, and active years as a counselor) and resiliency as measured by the Connor-Davidson Resiliency Scale-10 in African American women counselors.

RQ2: What is the relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale,

and Everyday Discrimination Scale, and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0$2): There is no statistically significant relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis (H_a2): There is a statistically significant relationship between racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity - Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

RQ3: What is the relationship between demographic factors (age, education level, and active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Inventory of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale, and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Null Hypothesis ($H_0$3): There is no statistically significant relationship between demographic factors (age, education level, and active years as a counselor), racial-

specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors.

Alternative Hypothesis (H_a3): There is a statistically significant relationship between demographic factors (age, education level, and active years as a counselor), racial-specific stressors (self-identity, COVID-19 pandemic anxiety, and everyday discrimination) as measured by the Multidimensional Model of Black Identity Scale, COVID-19 Pandemic Anxiety Scale, and Everyday Discrimination Scale and resiliency as measured by Connor-Davidson Resiliency Scale-10 in African American women counselors?

Chapter 4 includes data collection, results, and study summary.

Data Collection

I collected data from July 14, 2023, until January 7, 2024. I sent the original recruitment email and posted the flyer on July 14, 2023. The recruitment material included a Qualtrics survey link and a QRC code for participation. However, because of participants' questions about who could participate and a slow response, I submitted a request approved by the IRB to revise the recruitment flyer to include a more precise counselor definition. The new recruitment material was emailed and reposted on several social media sites on September 14, 2023. I also took out weekly paid Facebook ads to increase participation. It took nearly 7 months to reach the minimum threshold of 98

participants, with only eight participants choosing the QRC option, and the remainder chose the survey link to participate. I then downloaded the Qualtrics survey results into SPSS-28 for data cleaning and analysis.

I collected the population sample using convenience and snowball sampling. Two hundred sixty-eight participants opened the survey, but only 135 answered the demographic questions and consented to participate. I removed the participants who exited the survey before completion, leaving 112 participants. The participants in this sample identified as English-speaking African American or Black women counselors between the ages of 28 and 69. They were also master's or doctoral level licensed counselors who had been a counselor for at least 6 months before the COVID-19 pandemic lockdowns started (6 months before March 2020) and engaged as a counselor during the COVID-19 pandemic. I ran a frequency of the demographic factors: age, education level, and active years as a counselor which were represented in the sample population. The sample number of participants remaining was 112, with one missing value for years of counseling experience (See Figure 3). I kept the missing value by filling it in with the sum of the mean score.

Figure 3

Demographic Frequencies

Statistics

		What is your age (in years)?	What is your highest level of education?	SMEAN (YrsExperience)
N	Valid	112	112	112
	Missing	0	0	0
Mean		43.47	.21	12.10
Median		42.00	.00	10.00
Mode		42	0	10

Results

I performed a preliminary analysis before the data were ready to be analyzed. My first task was to conduct a Cronbach alpha reliability test for each scale. Since the Multidimensional Model of Black Identity (MMBI) has three subscales, each scale was scored separately. For the centrality subset (CS-MMBI) items, the Cronbach α was .212 with eight items. For the private regard subset (RS-MMBI) items, the Cronbach α was .349 with six items. The public regard subset (PR-MMBI) items Cronbach α was .217 with six items. The centrality, private regard, and public regard subset reliability scores of the MMBI were between the average range of .05 to .57, like the MMRI and Cross-Racial Identity Scale (Vandiver et al., 2002). See Appendix A for all subset instruments' reliability scores.

The Cronbach α for the COVID-19 Pandemic Anxiety Scale (CPA) was .832 (see Appendix B) with 10 items aligned with the scale originator's values, and the mean score of 7.49 showed that African American women counselors had less anxiety caused by the COVID-19 pandemic (Kumar et al., 2020a). The Everyday Discrimination Scale (EDS)

Cronbach alpha was .931 (see Appendix B), with nine items having a mean score of 25.9, which showed a strong indication of daily discrimination in the lives of African American women counselors. The EDS reliability score was less than the Cronbach alpha .95 of the longer scale version used with African American men but higher than Cronbach alpha scores of the shorter version used in the study assessing microaggressions and discrimination with the American Indian and Alaska Native college students and discrimination and COVID-19 in the Hispanic population four months after the pandemic (Lee et al., 2022; Powell et a., 2016).

The Connor-Davidson Resiliency Scale-10 Cronbach α was .864 (see Appendix B) with a mean score of 29.94, which was close to the evaluation of gender stress of African American men and women, which reflected a Cronbach alpha of .89 and a mean score of 30.39 (Silverstein et al., 2022). The scale originator suggested that the median score for the population in the United States is 36, which was not based on a particular gender or profession; however, the median score for African American women counselors was 30 (see Figure 4), which could indicate that African American women counselors are more resilient (Davidson, 2022).

Figure 4

Resiliency Frequency

Statistics

CDR

N	Valid	112
	Missing	0
Mean		29.9464
Median		30.0000

Before scoring could be done, I had to reverse-code six questions in the MIBI subsections, including CS-MMBI 1, 4, and 8; RS-MMBI 4; and PR-MMBI 3 and 4. Once reversed, the CS-MIBI, RS-MMBI, and PR-MMBI variables were scored individually and averaged together. Also, the EDS and CPA scales were totaled individually before I combined all five scales to create the new independent variable labeled RacialStressors. The second independent variable, Demographics, was created by combining age, education level, and active years as a counselor, and the dependent variable, resiliency, was scored and labeled CDR.

I conducted eight assumption tests before running the multiple linear regression analysis. The first and second assumptions were valid as the dependent variable CDR was a continuous scale ranging from zero to five, and there was more than one independent variable: RacialStressors, which included five variables, and Demographics, which included three variables. The Durbin-Watson statistic test showed 2.072, confirming no autocorrelation between variables and validating the third assumption (see Appendix C). I created two scatterplots which showed partial positive and negative linear relationships between racial stressors and resiliency and demographics and resiliency (see Appendix C). The histogram displayed a normal distribution curve between the dependent and independent variables, validating the fourth assumption (see Appendix L).

The Spearman's Rank correlation showed a weak statistical significance of -.235 between resiliency and racial stressors and -.227 between demographics and racial stressors (see Appendix D). Homoscedasticity was reliable, which validated assumption five. No multicollinearity appeared between the dependent and independent variables, as

shown by the VIF value 1.042, validating assumption six (see Appendix M). I ran the Cooks Distance test to validate assumption seven and created a scatterplot showing one outlier. I ran a case wise diagnostic which reflected an elevated outliner, case number 48 had a residual of -3.007, slightly over the ±3. Hence, I kept the case within the data set. The last assumption tested was that the residual errors were distributed normally, as shown in the histogram and the Normal P-P Plot graph line (See Appendix C). I performed the multiple regression analysis with all the preliminary assumptions met.

I used the simultaneous method to conduct three separate multiple linear regressions. The first multiple linear regression analysis I conducted was to examine the relationship between demographic factors: age, education level, active years as a counselor, and resiliency in African American women counselors. I input all demographic and resiliency factors together to answer RQ1. The results of the multiple linear regression were not significant at a confidence interval of 80 percent, $F(1,108) = .002$, $p < .05$ at 1, $R^2 = .000$, and the adjusted $R^2 = -.028$ have a weak effect size. Predictors, age with a slope $\beta = .005$, $t = .073$, $p < .942$, education level slope $\beta = .013$, $t = .010$, $p < .992$, and active years as a counselor slope $\beta = -.002$, $t = -.017$, $p < .986$. The R^2 value of zero indicates that zero percent of resiliency is not attributed to age, education level, and active years of counseling. The null hypothesis was accepted, and the alternate hypothesis was rejected. The combined variables within the model could not predict resiliency. Appendix F depicts the regression summary.

I conducted the second multiple linear regression analysis to examine the relationship between racial-specific stressors: self-identity, COVID-19 pandemic anxiety,

and everyday discrimination and resiliency in African American women counselors. I input all racial-specific stressors and resiliency factors together to answer RQ2. The results of the multiple linear regression were not significant at a confidence interval of 80 percent, $F(5,106) = 2.678$, $p > .05$ at .025, $R^2 = .112$, and the adjusted $R^2 = -.070$. Self-identity predictors centrality slope $\beta = .241$, $t = .441$, $p < .660$, private regard slope $\beta = .736$, $t = .665$, $p < .507$ and public regard slope $\beta = -.222$, $t = -.360$, $p < .720$; COVID-19 pandemic anxiety slope $\beta = -.301$, $t = -2.649$, $p < .009$, and everyday discrimination slope $\beta = -.062$, $t = -.956$, $p < .341$ has a weak effect size. The R^2 value of .112 indicates that 11% of resiliency is not attributed to racial-specific stressors: self-identity, COVID-19 pandemic anxiety, and everyday discrimination. The null hypothesis was accepted, and the alternate hypothesis was rejected. The combined variables within the model could not predict resiliency. Appendix G depicts the regression summary.

I conducted the last multiple regression analysis to examine the relationship between demographic factors: age, education level, active years as a counselor, racial-specific stressors: self-identity, COVID-19 pandemic anxiety, and everyday discrimination and resiliency in African American women counselors. I input all demographic factors, racial-specific factors, and resiliency at once to answer RQ3. The results of the multiple linear regression were not significant at a confidence interval of 80 percent, $F(8,103) = 1.725$, $p < 05$ at .101, $R^2 = .118$, and the adjusted $R^2 = .50$ with a weak effect size. Predictors, age with a slope $\beta = -.051$, $t = -.083$, $p < .497$, education level slope $\beta = -.416$, $t = -.321$, $p < .749$, and active years as a counselor slope $\beta = .011$, $t = .013$, $p < .914$, self-identity predictors centrality slope $\beta = .131$, $t = .223$, $p < .824$, private regard

slope $\beta = .858$, $t = .749$, $p < .456$ and public regard slope $\beta = -183$, $t = -.288$, $p < .774$; COVID-19 pandemic anxiety slope $\beta = -.371$, $t = -2.703$, $p < .008$, and everyday discrimination slope $\beta = -.063$, $t = -.967$, $p < .336$. The R^2 value of .118 indicates that 12% of resiliency is not attributed to age, education level, active years of counseling, racial-specific stressors: self-identity, COVID-19 pandemic anxiety, and everyday discrimination. The null hypothesis was accepted, and the alternate hypothesis was rejected. The combined variables within the model could not predict resiliency. Appendix H depicts the regression summary.

Bivariate Regression

While analyzing the data to evaluate the primary research questions, I noticed a statistically significant relationship between some individual independent and dependent variables at the .05 and .01 levels (see Appendix K). I completed a preliminary bivariate analysis to evaluate the relationship between the independent and dependent variables: age and resiliency, education level and resiliency, active years as a counselor and resiliency, self-identity factors separately, and resiliency, COVID-19 pandemic anxiety and resiliency, and everyday discrimination and resiliency in African American women counselors. However, only COVID-19 pandemic anxiety and resiliency and private regard the subset of MMBI and resiliency showed a connection.

The bivariate regression helps to predict "raw scores of X and Y variables" (Warner, 2013, p. 344). The G-power post hoc analysis predicted a minimum sample of 100 for linear bivariate regression (Faul et al., 2009). See Appendix K for the results. At the same time, one researcher suggested a sample size of over 105 with one predictor

variable was needed to conduct a bivariate regression (Warner, 2013). The sample size in this study was 112, which is more than the requirement. The assumptions were very similar to the multiple regression analysis: appropriate sample size, the dependent and independent variables were on a continuous scale, independence of observation, no significant outliers, the existence of a linear relationship, normality, homoscedasticity, and normal distribution of errors/residuals and were all validated for both research questions see Appendix K and L (Laerd Statistics, 2024). The independent variable for RQ4 was COVID-19 pandemic anxiety, and the dependent variable was resiliency. The independent variable for RQ5 was how one feels about one's identity, and the dependent variable was resiliency.

Research Question #4 and Results

RQ4: What is the relationship between COVID-19 pandemic anxiety and resiliency in African American women counselors?

Null Hypothesis ($H_0$4): There is no statistically significant relationship between COVID-19 pandemic anxiety and resiliency in African American women counselors.

Alternative Hypothesis (H_a4): There is a statistically significant relationship between COVID-19 pandemic anxiety and resiliency in African American women counselors.

I used the bivariate regression analysis to determine if COVID-19 pandemic anxiety was a statistically significant predictor of resiliency in African American women counselors. The results of the bivariate regression analysis were significant at a confidence interval of 80 percent, $F(1,110) = 11.198$, $p < .001$ at 1, $R^2 = .092$, and the

adjusted R^2= .084, which has a positive but weak effect size. The R^2 value of .092 indicates that 9 percent of resiliency is attributed to COVID-19 pandemic anxiety. The null hypothesis was rejected, and the alternate hypothesis was accepted; see Appendix T for regression results.

Research Question #5 and Results

RQ5: What is the relationship between how one feels about one's identity (private regard) and resiliency in African American women counselors?

Null Hypothesis ($H_0$4): There is no statistically significant relationship between how one feels about one's identity (private regard) and resiliency in African American women counselors.

Alternative Hypothesis (H_a2): There is a statistically significant relationship between how one feels about one's identity (private regard) and resiliency in African American women counselors.

I used the bivariate regression analysis to determine if how one feels about their own identity was a statistically significant predictor of resiliency in African American women counselors. The results of the bivariate regression analysis were significant at a confidence interval of 80 percent, $F(1,110) = 3.962$, $p < .05$ 1, R^2 =.035, and the adjusted R^2= .026, which has a positive but weak effect size. The R^2 value of .035 indicates that 4 percent of resiliency is attributed to how one feels about one's own identity. The null hypothesis was rejected, and the alternate hypothesis was accepted; see Appendix V for regression results.

Summary

The sample size of participants was met, but the three multiple regression analyses were too weak to determine if the resiliency was related to the demographic factors of age, education level, active years as a counselor, and racial-specific stressors due to self-identity, COVID-19 pandemic anxiety, and everyday discrimination. Although none of the combined independent variables predicted resiliency in African American women counselors, the independent variables, COVID-19 pandemic anxiety and how one feels about one's identity (private regard), proved to be weak but small contributing factors in their resilient posture. Scale reliability was also crucial as the COVID-19 Pandemic Anxiety Scale, Everyday Discrimination Scale, and Connor-Davidson Resiliency Scale-10 indicated that it was highly reliable in this population. Even though the Multidimensional Model of the Black Identity Scale, consisting of three subscales, centrality, private regard, and public regard, showed low reliability individually, the scores were in the range with prior identity model subscale (Vandiver et al., 2002). The multiple regression was an excellent choice to evaluate the relationship between variables as it investigated several factors that may impact the resiliency of African American women counselors. Chapter Five interprets the findings, limitations, recommendations, implications, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this quantitative correlational cross-sectional study, I explored the relationships between racial stressors (i.e., self-identity, COVID-19 pandemic anxiety, and everyday discrimination), demographic factors (i.e., age, education level, active counseling years), and resiliency in African American women counselors. African American women therapists are the second largest group of counseling providers, displaying behavioral health symptoms differently than other cultures (Donavon &West, 2015; Liao et al., 2020; United States Bureau of Labor Statistics, 2021). Therapy seeking in the African American community is traditionally difficult because of past social stressors that left the community very suspicious of the research process and outcomes (Dempsey et al., 2016; Sneed et al., 2020). My goal in this study was to evaluate resiliency-specific areas of concern related to African American woman counselors; however, the study results were too weak to provide inclusive factors. This fifth chapter includes the study's interpretation of the findings, limitations, recommendations, implications, and conclusion.

Interpretation of the Findings

Jones et al. (2018) believed that sampling the African American population was problematic in research focusing on gender and roles in their community. However, I got sufficient support through convenience sampling, snowball sampling, and posting and running advertisements on social media, school, and association platforms. The downside of those two sampling processes was that participants could opt out of the survey at any time, which caused me to eliminate participants for survey incompletion. Technology has

made investigating this population possible, which may increase the chances of further studies.

Prior psychological researchers contended that adults over the age of 65 exhibited more self-control and the ability to solve most life problems, whereas adults under 25 had stronger social connections, which aided in their resiliency (Fullen & Gorby, 2016; Gooding, 2012; Li et al., 2021; Mayordomo et al., 2016). The average African American woman counselor taking this survey was 43 years old, which meant they may have improved social connections and the increased ability to problem solve as the profession demands that they are resourceful in the areas of life cycles and diverse relationships to meet their client's needs (American Counseling Association, 2014). African American women counselors have multiple roles as members of a racially exposed community, expectations of being a Black woman, and a licensed professional counselor, so the premise that age and gender negatively affect a person's mental health was unfounded in this study as they appeared educated and resilient.

Eighty percent of participants were master level educated, and 20 % obtained their doctoral degrees. African American women counselors had at least 12 years of counseling experience, 2 years of which were during the pandemic. This dedication shows a commitment to the profession and attention to self-care during a worldwide crisis (Coughlin et al., 2020; DiBenigno, 2022; Lakioti et al., 2020; Matthews et al., 2019). It also confirms that being a high achiever helps with being a resilient, Strong Black woman rather than a hindrance, as previous researchers suspected (see Liao et al., 2020; Watson-Singleton et al., 2020). In this case, the context of being a Strong Black

woman was a symbol of triumphant, personal understanding and growth, and becoming more than the community and society demanded (Abrams et al., 2019; Nelson et al., 2016; Watson & Hunter, 2015).

Despite the decades of racially caused deaths of African American men and women, although a harmful psychological stressor within the community, my data did not show that it helped or diminished the bounce-back potential of the African American woman counselor. Racial stress in connection with self-identity, COVID-19 pandemic anxiety, and everyday discrimination had mixed results. Based on the individual average scores of centrality, private regard, public regard, and the social factors of being Black were important but not as important as how a person felt about their self-image. As my study revealed, African American women counselors' private regard, centrality, and resiliency had a positive relationship. Meanwhile, a person's level of anxiety due to COVID-19 and their resiliency, and daily discrimination and society's viewpoint about a person being Black showed negative relationships, as African American female counselors reported forms of public discrimination. Nevertheless, the combined stress of racial factors had a weak but negative relationship with resiliency.

Resilience theory is based on the active adjustment to life changes by utilizing coping mechanisms even in the event of personal life-threatening situations common to African American women's lives (American Psychological Association, 2022; Mayordomo et al., 2016). Gathering the data 2 years after the start of the COVID-19 pandemic, the African American women counselors seemed less fearful and had lower somatic symptoms of anxiety. Their response may have been different at the height of the

initial outbreak as the vulnerable population to exposure and death were the African American social groups (see Centers for Disease Control and Prevention, 2021; Sneed et al., 2020; Vaishna et al., 2020). Also, as a precautionary measure to decrease COVID-19 exposure, an abrupt change in the delivery service for therapy applications that included more telehealth options and less in-person care continues today, meeting everyone's psychological needs and decreasing personal anxiety (Wang et al., 2020).

Limitations

The limitations found in research design, data collection, and instrument bias were minimal. In this quantitative correlational cross-sectional study, I evaluated the relationship between predetermined variables at a specific time. Collecting data through an online survey speeded up the collection process, which minimized cost and decreased the number of participants; I removed over 100 cases from the study because of incomplete responses in the variable portions of the survey. Deciding the sample size for a multiple linear regression analysis before the collection process also reduced costs, minimized the Type 1 error, and increased participation (see Cohen, 2016; Connolly et al., 2017; Faul et al., 2009).

The African American women counselors' access to technology seemed to increase the number of participants, which could have adversely affected the collection process as in prior research studies (see Kelley, 2022; Lu & Franklin, 2018; United States Census Bureau, 2021; Warner, 2013). Instrument bias was minimized as no modifications were needed because the Connor-Davidson Resiliency Scale, the Multidimensional Model of African American Identity, and the Everyday Discrimination Scale were

previously used with the African American population (see Brown, 2008; Fuller et al., 2018; Kershaw et al., 2016; McClain et al., 2016; Thorkildsen, 2022). Although the COVID-19 Pandemic Anxiety Scale was used worldwide, it proved to be a valid instrument to use with African American women counselors (see Kumar et al., 2020b).

Racial stress is not exclusive to African American women counselors, which makes generalizability possible (see Boden et al., 2018; Clayton et al., 2021; Frey, 2018; Johnson et al., 2005; Sandil et al., 2015). The combination of demographic factors, cultural and professional identity, discrimination, and health concerns can affect the resiliency of different populations (see Chae et al., 2021; Kalanian & Kasim, 2008; Long, 2022). Convenience and snowball sampling used within a specific timeline and theory supported extends the general usage of this research (see Hubbard, 2016; Mitchel, 2018). Although COVID-19 pandemic anxiety decreased as time passed, other worldwide and national health crises that affect a person's resiliency are possible (Centers for Disease Control and Prevention, 2022; Li et al., 2021).

Recommendations

Further research should identify the type of socially or individually initiated self-care practices therapists use to maintain their bounce-back, such as spirituality, therapy services, or professional connections (Graber et al., 2016; Killian, 2017). Participants should also define resiliency or resilience as it could differ between genders and races (Karairmak & Figley, 2017; Tay & Lim, 2020). Additionally, clarifying specific protective factors and risks could solidify which theory component is more accurate (Tay & Lim, 2020; Van der Hallen et al., 2020). Also, future researchers should expand the

term counselor to include professional terms that might improve research participation (Nystul, 2016). I found that the generic term counselor created a recruitment obstacle because helping professionals align themselves by their professional designations rather than the general term (see American Counseling Association, 2022; American Psychological Association, 2022; National Association of Social Workers, 2021).

Researchers might also consider using fewer racial factors and measurement scales to shorten the survey process, potentially reducing incomplete responses (Dworkin, 2018; Leung, 2020). Finally, including the QRC code on recruitment material uses modern technology; the survey link provided immediate access to social media platforms, as participants had to use a camera to activate the QRC code, which would have been appropriate for physically posted materials.

Implications

I showed that it was possible to research African American women professionals. Resiliency practices are encouraged by counseling associations to meet the helping professional and client needs (see American Counseling Association, 2014; American Psychological Association, 2022; National Association of Social Workers, 2021). My research showed that some of the second-largest providers took their association's suggestions seriously by supporting research and highlighting issues that could keep them from being their best selves. African American women counselor's ability to maintain a sense of resiliency might come from their professional and social perception of mental health and self-care. These perceptions might originate from mandatory certification training and the client-therapist relationship, which sometimes reflects the lack of self-

care or their cultural upbringing about their Blackness (Brewer et al., 2018; Boden et al., 2018; Koffer et al., 2016; Phinney, 2010; Sandil et al., 2015).

Resilient behavior based on age, gender, race, self and community awareness, and professional drive provides the need for personalized resiliency interventions (see Arjona-Castilla et al., 2022; Bloom, 2022; Hayman et al., 2017; Henning & Armstrong, 2020; Hirani et al., 2016; Masten et al., 2021; Wu, 2021). Although medical and social unrest can create additional stress, new interventions that offer racially or ethnically related processes might improve adaptation and bounce-back potential (Leamy, 2011; Singh et al., 2020). Even when the initial exposure to a traumatic event seemed never-ending, time, situational understanding, and routine help the resiliency process (Chaban et al., 2021; Khaustova et al., 2021).

Conclusion

My quantitative correlational cross-sectional study did not show a connection between the combined racial stressors (i.e., self-identity, COVID-19 pandemic anxiety, and everyday discrimination), demographic factors (i.e., age, education level, and active counseling years), and resiliency in African American women counselors. However, it did reveal that racial stressors still exist in society and are experienced by some of the most highly educated mental health professionals. However, the internalization and adverse effects of those stressors on African American women counselors depend on how each person feels about it and not so much on what outside influences think they should respond. The implications of such information may show the African American community that their voices in research are essential in providing culturally specific care

concerning their mental health needs and that the counseling profession includes well-trained African American woman who not only understands their stressors but has first-hand knowledge about what it takes to thrive in a society that still questions their worth.

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Appendix A: Instrument Correlation

Table A1. Five Scales Correlation

Correlations

		CDRSUM	PRMMBImean	RSMMBImean	CSMMBImean	EDSSUM	CPASUM
CDRSUM	Pearson Correlation	1	.048	.186*	.028	-.180	-.304**
	Sig. (2-tailed)		.614	.049	.767	.058	.001
	Sum of Squares and Cross-products	3549.679	26.976	65.193	18.964	-1000.375	-962.054
	Covariance	31.979	.243	.587	.171	-9.012	-8.667
	N	112	112	112	112	112	112
PRMMBImean	Pearson Correlation	.048	1	.174	-.096	-.298**	-.172
	Sig. (2-tailed)	.614		.066	.316	.001	.070
	Sum of Squares and Cross-products	26.976	88.214	9.599	-10.116	-261.167	-85.810
	Covariance	.243	.795	.086	-.091	-2.353	-.773
	N	112	112	112	112	112	112
RSMMBImean	Pearson Correlation	.186*	.174	1	.350**	-.276**	-.288**
	Sig. (2-tailed)	.049	.066		<.001	.003	.002
	Sum of Squares and Cross-products	65.193	9.599	34.442	23.149	-151.219	-89.829
	Covariance	.587	.086	.310	.209	-1.362	-.809
	N	112	112	112	112	112	112
CSMMBImean	Pearson Correlation	.028	-.096	.350**	1	.051	.153
	Sig. (2-tailed)	.767	.316	<.001		.591	.108
	Sum of Squares and Cross-products	18.964	-10.116	23.149	126.826	54.000	91.411
	Covariance	.171	-.091	.209	1.143	.486	.824
	N	112	112	112	112	112	112
EDSSUM	Pearson Correlation	-.180	-.298**	-.276**	.051	1	.283**
	Sig. (2-tailed)	.058	.001	.003	.591		.003
	Sum of Squares and Cross-products	-1000.375	-261.167	-151.219	54.000	8728.563	1402.438
	Covariance	-9.012	-2.353	-1.362	.486	78.636	12.635
	N	112	112	112	112	112	112
CPASUM	Pearson Correlation	-.304**	-.172	-.288**	.153	.283**	1
	Sig. (2-tailed)	.001	.070	.002	.108	.003	
	Sum of Squares and Cross-products	-962.054	-85.810	-89.829	91.411	1402.438	2821.991
	Covariance	-8.667	-.773	-.809	.824	12.635	25.423
	N	112	112	112	112	112	112

*. Correlation is significant at the 0.05 level (2-tailed).

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

Appendix B: Instruments Reliability

Table B1. Centrality Subscale: CS-MMBI

Reliability Statistics

Cronbach's Alpha	N of Items
.219	8

Table B2. Private Regard Subscale: RS-MMBI

Reliability Statistics

Cronbach's Alpha	N of Items
.349	6

Table B3. Public Regard Subscale: PR-MMBI

Reliability Statistics

Cronbach's Alpha	N of Items
.208	6

Table B4. Everyday Discrimination Scale: EDS

Reliability Statistics

Cronbach's Alpha	N of Items
.931	9

Table B5. COVID-19 Pandemic Anxiety Scale: CPA

Reliability Statistics

Cronbach's Alpha	N of Items
.832	10

Table B6. Connor-Davidson Resiliency Scale-10: CDR

Reliability Statistics

Cronbach's Alpha	N of Items
.864	10

Appendix C: Assumption Graphs

Figure C1. Racial Stressors & Resiliency Linearity

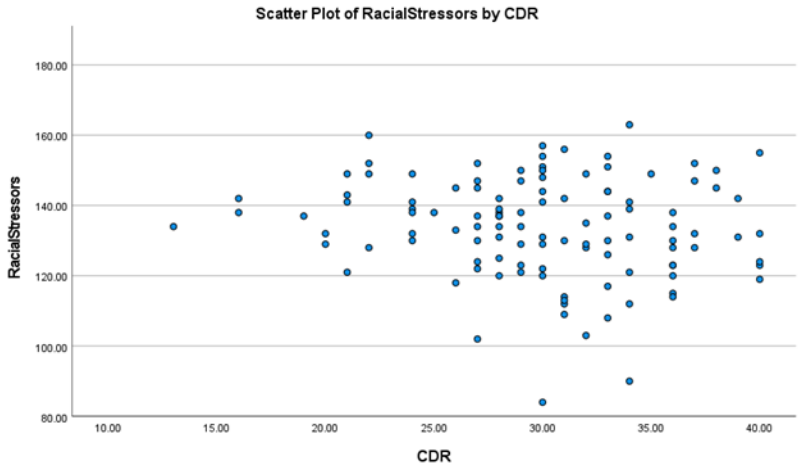


Figure C2. Demographics & Resiliency Linearity

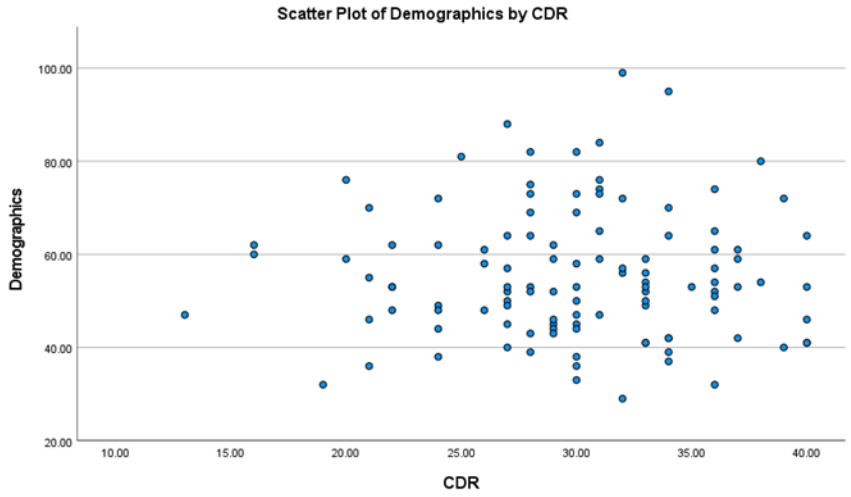


Figure C3. Normal Distribution

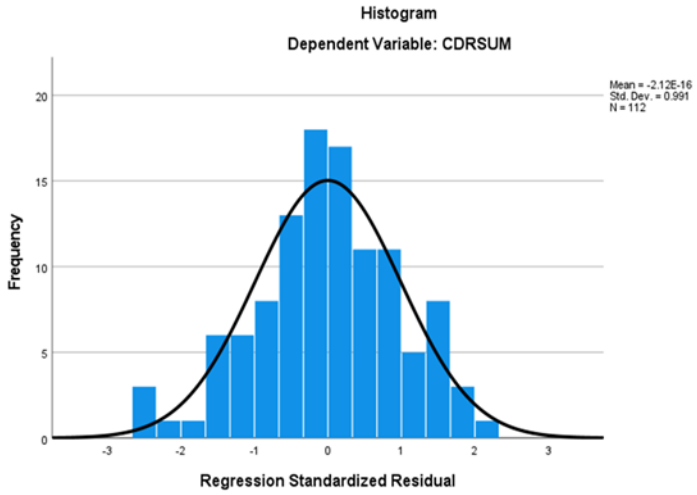
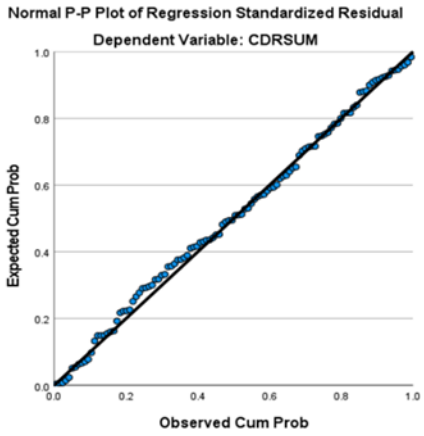


Figure C4. Linear P-Plot



Appendix D: Assumptions Tables

Table D1. Spearman Rank Between Demographic & Racial Stressors

Correlations

			Demographics	RacialStressors
Spearman's rho	Demographics	Correlation Coefficient	--	
		Sig. (2-tailed)	.	
		N	112	
	RacialStressors	Correlation Coefficient	-.227*	--
		Sig. (2-tailed)	.016	.
		N	112	112

*. Correlation is significant at the 0.05 level (2-tailed).

Table D2. Spearman Rank Between Resiliency & Racial Stressors

Correlations

			CDR	RacialStressors
Spearman's rho	CDR	Correlation Coefficient	--	
		Sig. (2-tailed)	.	
		N	112	
	RacialStressors	Correlation Coefficient	-.235*	--
		Sig. (2-tailed)	.013	.
		N	112	112

*. Correlation is significant at the 0.05 level (2-tailed).

Table D3. Spearman Rank Between Resiliency & Demographics

Correlations

			CDR	Demographics
Spearman's rho	CDR	Correlation Coefficient	--	
		Sig. (2-tailed)	.	
		N	112	
	Demographics	Correlation Coefficient	-.003	--
		Sig. (2-tailed)	.971	.
		N	112	112

Table D4. Residuals

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	26.2406	33.0479	29.9464	1.52221	112
Std. Predicted Value	-2.434	2.037	.000	1.000	112
Standard Error of Predicted Value	.524	1.784	.858	.273	112
Adjusted Predicted Value	25.2973	33.2207	29.9378	1.53644	112
Residual	-14.54151	11.60062	.00000	5.44628	112
Std. Residual	-2.646	2.111	.000	.991	112
Stud. Residual	-2.661	2.209	.001	1.004	112
Deleted Residual	-14.70446	12.70267	.00866	5.59622	112
Stud. Deleted Residual	-2.739	2.249	-.001	1.014	112
Mahal. Distance	.019	10.698	1.982	2.062	112
Cook's Distance	.000	.154	.009	.020	112
Centered Leverage Value	.000	.096	.018	.019	112

a. Dependent Variable: CDR

Table D5. Outlier

Casewise Diagnostics[a]

Case Number	Std. Residual	CDR	Predicted Value	Residual
49	-3.007	13.00	29.9938	-16.99376

a. Dependent Variable: CDR

Table D6. No Autocorrelation

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.269[a]	.072	.055	5.49602	2.072

a. Predictors: (Constant), Demographics, RacialStressors

b. Dependent Variable: CDR

Table D7. No Multicollinearity

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	37.835	3.493		10.831	<.001		
	RacialStressors	-.140	.048	-.275	-2.917	.004	.959	1.042
	Demographics	-.020	.038	-.049	-.522	.603	.959	1.042

a. Dependent Variable: CDR

Appendix E: Results of RQ1 Multiple Regression Analysis

Table E1. RQ1 Model Summary Demographics & Resiliency

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.008[a]	.000	-.028	5.73284

a. Predictors: (Constant), SMEAN(YrsExperience), What is your highest level of education?, What is your age (in years)?

Table E2. RQ1 ANOVA Demographics & Resiliency

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.207	3	.069	.002	1.000[b]
	Residual	3549.471	108	32.865		
	Total	3549.679	111			

a. Dependent Variable: CDR

b. Predictors: (Constant), SMEAN(YrsExperience), What is your highest level of education?, What is your age (in years)?

Table E3. RQ1 Coefficients Demographics & Resiliency

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			80.0% Confidence Interval for B		Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	29.738	2.679		11.101	<.001	26.284	33.193					
	What is your age (in years)?	.005	.071	.008	.073	.942	-.086	.097	.007	.007	.007	.692	1.444
	What is your highest level of education?	.013	1.324	.001	.010	.992	-1.693	1.720	.001	.001	.001	.995	1.005
	SMEAN(YrsExperience)	-.002	.101	-.002	-.017	.986	-.132	.128	.003	-.002	-.002	.690	1.450

a. Dependent Variable: CDR

Appendix F: Results of RQ2 Multiple Regression Analysis

Table F1. RQ2 Model Summary Racial Stressors & Resiliency

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.335[a]	.112	.070	5.45264

a. Predictors: (Constant), PRMMBImean, CSMMBImean, CPASUM, EDSSUM, RSMMBImean

Table F2. RQ2 ANOVA Racial Stressors & Resiliency

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	398.163	5	79.633	2.678	.025[b]
	Residual	3151.515	106	29.731		
	Total	3549.679	111			

a. Dependent Variable: CDR

b. Predictors: (Constant), PRMMBImean, CSMMBImean, CPASUM, EDSSUM, RSMMBImean

Table F3. RQ2 Coefficients Racial Stressors & Resiliency

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			80.0% Confidence Interval for B		Correlations		
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part
1	(Constant)	28.288	7.479		3.782	<.001	18.643	37.933			
	CPASUM	-.301	.114	-.269	-2.649	.009	-.448	-.155	-.304	-.249	-.242
	EDSSUM	-.062	.064	-.097	-.956	.341	-.145	.021	-.180	-.092	-.088
	CSMMBImean	.241	.546	.046	.441	.660	-.463	.945	.028	.043	.040
	RSMMBImean	.736	1.107	.073	.665	.507	-.691	2.164	.186	.064	.061
	PRMMBImean	-.222	.617	-.035	-.360	.720	-1.018	.574	.048	-.035	-.033

a. Dependent Variable: CDR

Appendix G: Results of RQ3 Multiple Regression Analysis

Table G1. RQ3 Model Summary Demographics, Racial Stressors & Resiliency

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.344[a]	.118	.050	5.51286

a. Predictors: (Constant), What is your age (in years)?, What is your highest level of education?, RSMMBImean, PRMMBImean, EDSSUM, CPASUM, CSMMBImean, SMEAN (YrsExperience)

Table G2. RQ3 ANOVA Demographics, Racial Stressors & Resiliency

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	419.342	8	52.418	1.725	.101[b]
	Residual	3130.337	103	30.392		
	Total	3549.679	111			

a. Dependent Variable: CDR

b. Predictors: (Constant), What is your age (in years)?, What is your highest level of education?, RSMMBImean, PRMMBImean, EDSSUM, CPASUM, CSMMBImean, SMEAN(YrsExperience)

Table G2. RQ3 Coefficients Demographics, Racial Stressors & Resiliency

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			80.0% Confidence Interval for B		Correlations		
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part
1	(Constant)	30.302	8.048		3.765	<.001	19.922	40.683			
	CPASUM	-.317	.117	-.282	-2.703	.008	-.468	-.166	-.304	-.257	-.250
	EDSSUM	-.063	.065	-.099	-.967	.336	-.148	.021	-.180	-.095	-.089
	CSMMBImean	.131	.587	.025	.223	.824	-.626	.888	.028	.022	.021
	RSMMBImean	.858	1.146	.085	.749	.456	-.620	2.337	.186	.074	.069
	PRMMBImean	-.183	.634	-.029	-.288	.774	-1.000	.634	.048	-.028	-.027
	SMEAN(YrsExperience)	.011	.101	.013	.108	.914	-.119	.141	.003	.011	.010
	What is your highest level of education?	-.416	1.295	-.030	-.321	.749	-2.087	1.255	.001	-.032	-.030
	What is your age (in years)?	-.051	.075	-.083	-.682	.497	-.147	.045	.007	-.067	-.063

a. Dependent Variable: CDR

Appendix H: Results of RQ3 Multiple Regression Analysis

Table H1. RQ3 Model Summary Demographics, Racial Stressors & Resiliency

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.344[a]	.118	.050	5.51286

a. Predictors: (Constant), What is your age (in years)?, What is your highest level of education?, RSMMBImean, PRMMBImean, EDSSUM, CPASUM, CSMMBImean, SMEAN (YrsExperience)

Table H2. RQ3 ANOVA Demographics, Racial Stressors & Resiliency

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	419.342	8	52.418	1.725	.101[b]
	Residual	3130.337	103	30.392		
	Total	3549.679	111			

a. Dependent Variable: CDR

b. Predictors: (Constant), What is your age (in years)?, What is your highest level of education?, RSMMBImean, PRMMBImean, EDSSUM, CPASUM, CSMMBImean, SMEAN(YrsExperience)

Table H2. RQ3 Coefficients Demographics, Racial Stressors & Resiliency

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			80.0% Confidence Interval for B		Correlations		
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part
1	(Constant)	30.302	8.048		3.765	<.001	19.922	40.683			
	CPASUM	-.317	.117	-.282	-2.703	.008	-.468	-.166	-.304	-.257	-.250
	EDSSUM	-.063	.065	-.099	-.967	.336	-.148	.021	-.180	-.095	-.089
	CSMMBImean	.131	.587	.025	.223	.824	-.626	.888	.028	.022	.021
	RSMMBImean	.858	1.146	.085	.749	.456	-.620	2.337	.186	.074	.069
	PRMMBImean	-.183	.634	-.029	-.288	.774	-1.000	.634	.048	-.028	-.027
	SMEAN(YrsExperience)	.011	.101	.013	.108	.914	-.119	.141	.003	.011	.010
	What is your highest level of education?	-.416	1.295	-.030	-.321	.749	-2.087	1.255	.001	-.032	-.030
	What is your age (in years)?	-.051	.075	-.083	-.682	.497	-.147	.045	.007	-.067	-.063

a. Dependent Variable: CDR

Appendix I: Bivariate Regression Sample Size

Figure I1. GPower Sample Visual Slope

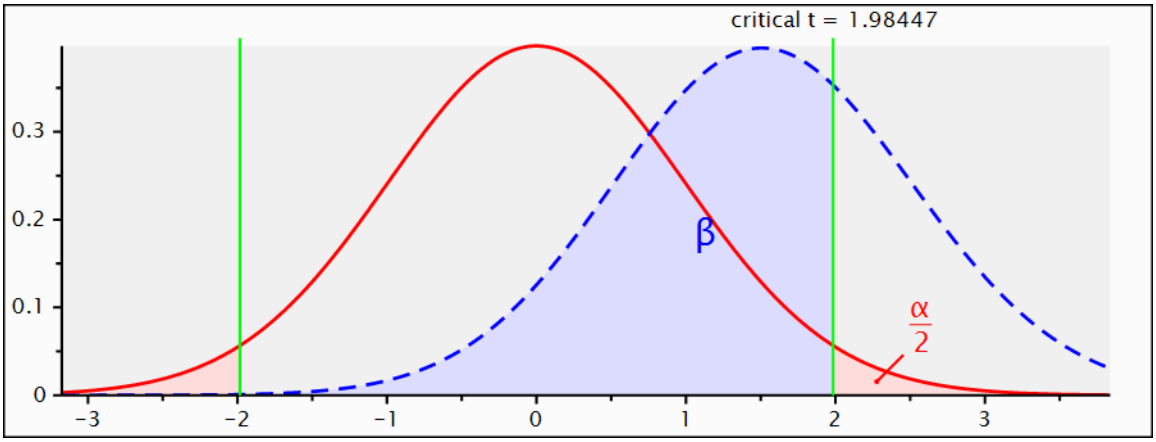


Figure I2. GPower Sample Size

t tests – Linear bivariate regression: One group, size of slope

Analysis:	Post hoc: Compute achieved power		
Input:	Tail(s)	=	One
	Slope H1	=	0.15
	α err prob	=	0.05
	Total sample size	=	100
	Slope H0	=	0
	Std dev σ_x	=	1
	Std dev σ_y	=	1
Output:	Noncentrality parameter δ	=	1.5171652
	Critical t	=	1.6605512
	Df	=	98
	Power (1−β err prob)	=	0.4450530

Appendix J: RQ4 Assumptions

Figure J1. RQ4 Linearity

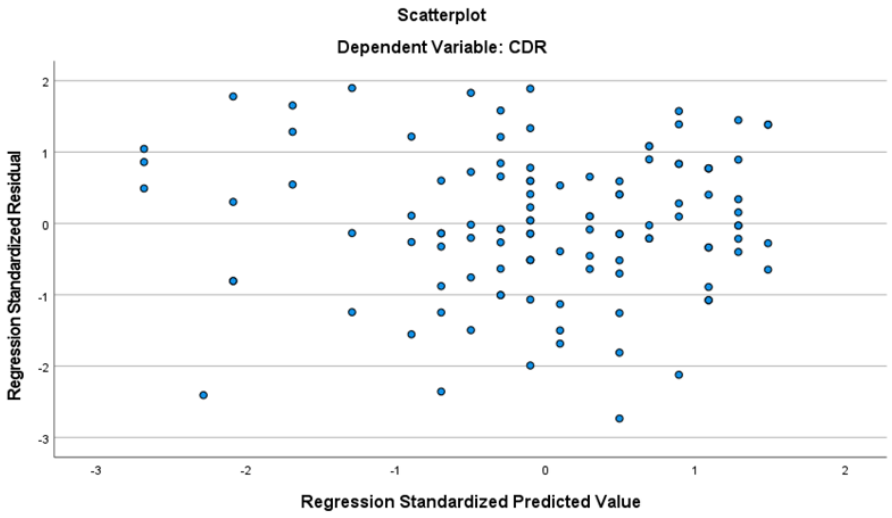


Figure J1. RQ 4 Normal Distribution

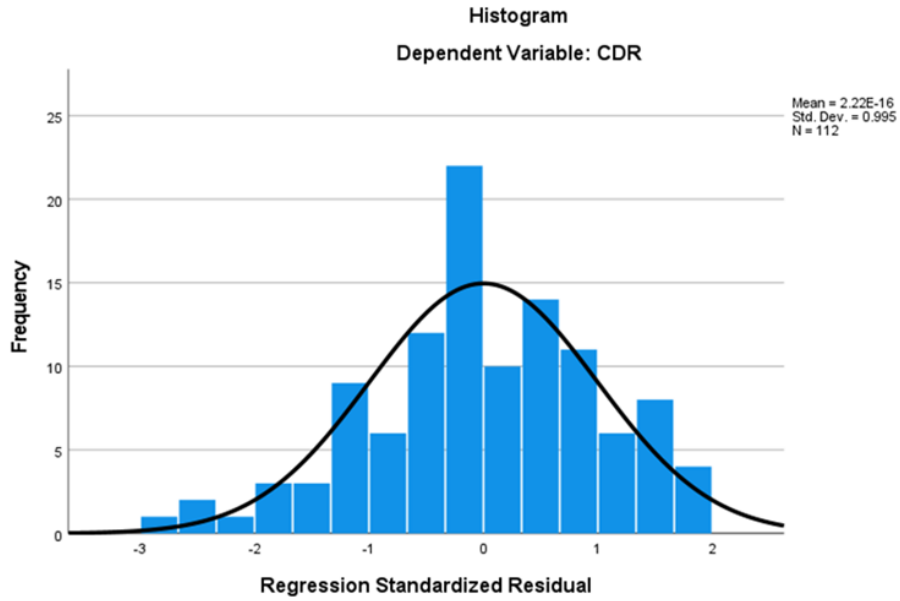
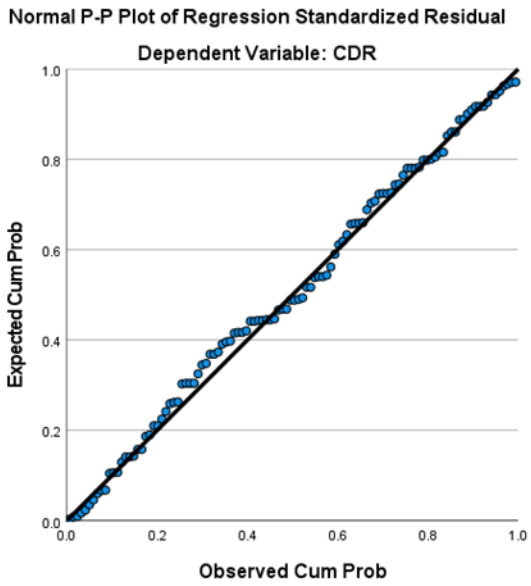


Figure J1. RQ 4 Linear P-Plot



Appendix K: Results of RQ4 Bivariate Regression

Table K1. RQ4 Model Summary COVID-19 Anxiety & Resiliency

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.304[a]	.092	.084	5.41186	2.111

a. Predictors: (Constant), CPASUM

b. Dependent Variable: CDR

Table K2. RQ4 Model Summary COVID-19 Anxiety & Resiliency

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	327.977	1	327.977	11.198	.001[b]
	Residual	3221.702	110	29.288		
	Total	3549.679	111			

a. Dependent Variable: CDR

b. Predictors: (Constant), CPASUM

Table K3. RQ4 Coefficients COVID-19 Anxiety & Resiliency

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			80.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	32.500	.919		35.378	<.001	31.316	33.685		
	CPASUM	-.341	.102	-.304	-3.346	.001	-.472	-.210	1.000	1.000

a. Dependent Variable: CDR

Appendix L: Results of RQ5 Assumptions

Figure L1. RQ 5 Linearity

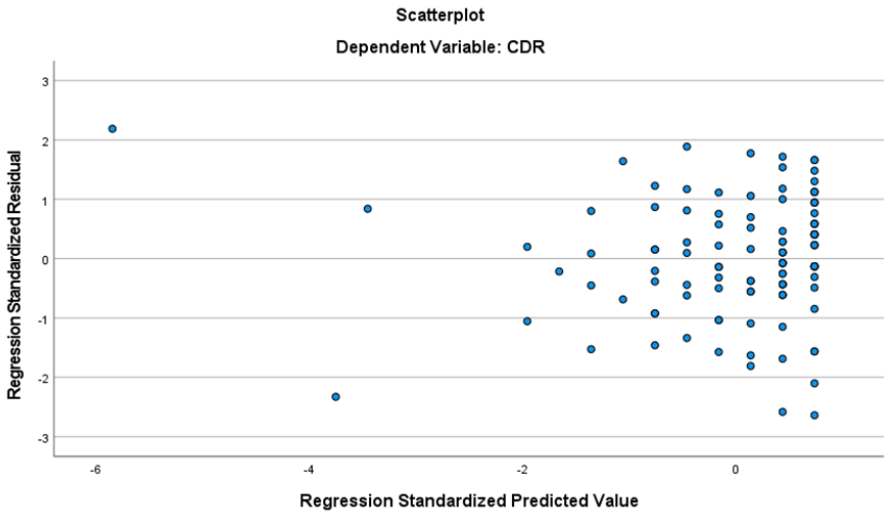


Figure L2. RQ 5 Normal Distribution

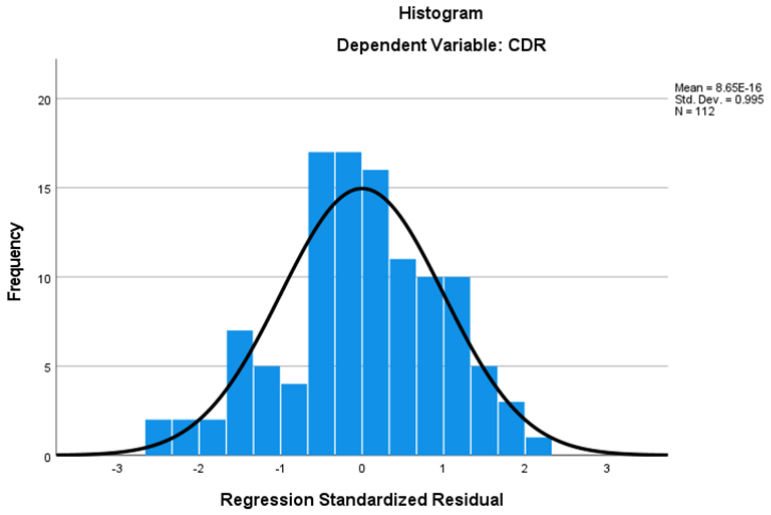
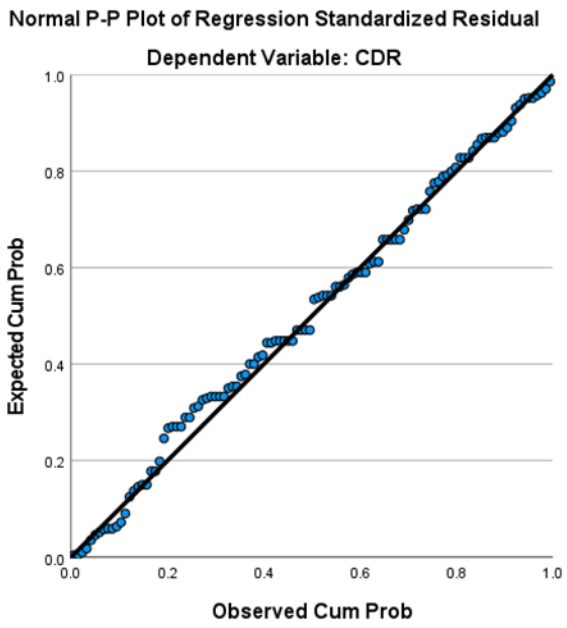


Figure L3. RQ5 Linear P-Plot



Appendix M: Results of RQ5 Bivariate Regression

Table M1. RQ5 Model Summary Private Regard & Resiliency

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.186[a]	.035	.026	5.58104	2.042

a. Predictors: (Constant), RSMMBImean

b. Dependent Variable: CDR

Table M2. RQ5 ANOVA Private Regard & Resiliency

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	123.401	1	123.401	3.962	.049[b]
	Residual	3426.278	110	31.148		
	Total	3549.679	111			

a. Dependent Variable: CDR

b. Predictors: (Constant), RSMMBImean

Table M3. RQ5 Coefficients Private Regard & Resiliency

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	80.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	17.477	6.287		2.780	.006	9.371	25.583
	RSMMBImean	1.893	.951	.186	1.990	.049	.667	3.119

a. Dependent Variable: CDR