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# Resilience in Black Mental Health Counselors

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**Abstract**

Though resilience is a commonly studied variable in different disciplines, there is relatively little research on occupational settings. Researchers take various perspectives in defining resilience as a trait, process, and an outcome. Regardless of how it is defined, it is a vital protective factor for Black mental health counselors who may be significantly impacted by similar experiences, such as racism and racial discrimination, as the Black clients they serve. This dissertation study consisted of two studies utilizing the same data set. In the first study, psychometric properties of a new quantitative instrument, the Race-Based Resilience Scale (RBRS), was constructed to measure Race-Based Resilience (RBR) within a group of Black mental health counselors. The second study investigated group differences in Vicarious Traumatization (VT) and Race-Based Resilience (RBR) for Black mental health counselors with moderate and high levels of Racial Centrality (RC) using an independent samples t-test. Findings of the first study yielded a 14-item instrument with a three-factor solution (Self-Efficacy, Coping Mechanisms, and Multicultural and Social Justice Advocacy) that reflected high factor loading accounting for nearly 60% of the variance. For the second study, there was no significant difference in Vicarious Traumatization (VT) or Race-Based Resilience (RBR) scores for Black mental health counselors with moderate to high levels of Racial Centrality (RC).

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**Section 1 - Introduction**

**Resilience Defined**

Despite the varying positions of how resilience is defined, resilience is a necessary component for navigating adversity. The study of resilience within occupational settings is relatively new (Smith et al., 2020).  Resilience is a commonly used variable in research, that has been conceptualized in a myriad of ways. Researchers denote the construct is complex to understand (Bowman, 2013; Brown et al., 2019; Grant & Kinman, 2013; Smith et al., 2020). The researcher, the discipline where it is being studied, and the theoretical framework all determine whether resilience is deemed an outcome, character trait, or process (Bonanno, 2005; Panter-Brick & Leckman, 2013; Waginald & Young, 1993). Broadly defined, resilience is "the psychological capacity to adapt and cope with adversity" (Parker et al., 2015, p. 583). Within counseling and other mental health professions, resilience indicates positive adaptability to hardship (Goodkind et al., 2020). Mental and behavioral components of adaptability within a socio-ecological framework imply bouncing back from hardships through negotiation of cultural, social, and psychological resources (Dale & Safren, 2018). The systems perspective references resilience as reactivity to a threat that attempts to infiltrate and disrupt the function of the system (Masten, 2016b). Yet another definition depicts resilience as the ability of the system to absorb the disturbance (Folke et al., 2010). Ryff et al. (1998) described resilience in the context of the recovery of well-being as an important component of subjective well-being (Bajaj & Pande, 2015).

Scholars argue resilience as a personality quality or trait reflects one's ability to cope with difficulty (Masten, 2018), protects individuals against adversity and traumatic

events, and allows them to flourish when navigating turmoil (Connor & Davidson, 2003). As a result of resilience, adjustments during adversity allow people to cope (Bajaj & Pande, 2015). Opposing scholars argue the maintenance of resilience is a perpetual process that evolves (Anderson 2015; Holtorf, 2018), which may imply changes at various points in time. In simple terms, one's resilience in the past may look different five years in the future. This is a common position for researchers with a Black participant base (Cunningham et al., 2018; Defreitas, 2020; Goodkind et al., 2020; DiClemente et al., 2016).

A controversial topic of debate in social sciences lies in resilience outcome research. From this perspective, resilience is a process the reflects positive adaptation (Luthar et al., 2015) and a fundamental part of human existence (Mancini & Bonanno (2009). Furthermore, resilience outcomes are defined by dominant nonminority groups' interpretations of success. Researchers have argued that the entrenchment in the Westernized value system fails to capture the significance of resilience relative to culture and that incorporation of culture into resilience is essential as it provides perspective on how one views and engages in the world (Triandis, 1972; Unger, 2017). Cultural values affect one's interpretation and response to a traumatic event (Kalmanowitz & Ho, 2017). Therefore, Black people may experience resilience differently at different points in time.

In this research study series, resilience will be defined as both a trait and a process i.e., resilience as a trait is natural, in-born part of each person and resilience as a process is perpetual and changes over time. Masten (2018) argued the rationale for this justification is based on "interactions of many processes across and between systems". Resilience is viewed as an innate, trait-based response, and normative part of all

individuals (Cicchetti, 2010; Masten, 2001) and not an extraordinary characteristic people have (Masten, 2001). The capacity for resilience is influenced by internal (i.e., strengths, self-perception) and external (i.e., environment, social support) factors that develop over time (Masten, 2001). Consequently, Race-Based Resilience (RBR) is a new construct that is defined in this study as the ongoing process of a positive inborn trait based on a response to a racial event or encounter that may cause traumatic injury. Responses may differ at various points in time. An investigation of how Black mental health counselors use their racial identity in resilience will provide insight into how they navigate work with their Black clients.

**Importance of Resilience in Counseling**

The study of resilience in occupational settings commonly concentrates on career-sustaining behaviors such as self-compassion, well-being, and social support (McCann et al., 2013). The American Counseling Association (ACA) and Counsel for Counseling and Related Educational Programs (CACREP) underline the importance of well-being in mental health professionals.  Resilience is an essential protective factor to mental well-being, especially for Black mental health counselors who are often impacted personally and professionally by similar systemic barriers as their clients, which can prevent them from delivering effective care (Dupree et al., 2015; Lambert & Lawson, 2013). Resilience can assist Black mental health counselors in developing means of defense against overwhelming situations in and out of the counseling room.

This series of dissertation studies are meaningful as they contribute to literature on counselor resilience as a part of counselor wellness.  Using a strength-based approach, this research aims to expand the scholarship to address the limited research on protective

factors that assist Black mental health counselors with their well-being (Blocker et. al, 2019; Browning et al, 2019). In study one, a new Race-Based Resilience Scale (RBRS) was created to assess Race-Based Resilience (RBR) in Black mental health counselors. The scale development was guided by the Connor-Davidson Resilience Scale (CD-RISC) and resilience literature. Study two investigated relationships between Vicarious Traumatization (VT), Race-Based Resilience (RBR), and Racial Centrality (RC) in two groups of Black mental health counselors.

**Section 2 - Articles**

**Study 1:**

**Development of Race-Based Resilience Scale (RBRS)**

Race relations in the United States has demanded increased responsiveness from local, state, and federal entities. According to Pew Research Center (2019), a nationally representative survey of 6,637 adults reported nearly 80% of the respondents felt as if the United States has not done enough to support equal rights between Black and White people, while 50% reported feeling racial equality will never exist. Additionally, almost 52% of Black respondents reported their race negatively impacts their ability to achieve success (Pew Research Center, 2019).  An explosive cry for equity, equality, and swift justice has been heard across the United States as the murders of unarmed Black people by law enforcement becomes more publicized in recent years. In August 2014, 18-year-old Michael Brown was murdered by police officers in Ferguson, Missouri (Mike Brown, 2022). A few short months later, 12-year-old Tamir Rice was murdered while playing with his toy gun at a local park (Dewan & Oppel Jr, 2015). In 2020, Breonna Taylor was killed in her home after the wrong home was raided by police (Oppel Jr. et al, 2021). Sadly, two months later, a major catalyst was camera-recorded murder of George Floyd by a Minnesota police officer.  The president of the American Psychological Association (APA) – Dr. Sandra L. Shullman – defined this era as a racism pandemic with a great psychological impact on Black people (American Psychological Association, 2020). The impact of racial discord could exacerbate mental health concerns in a population that is highly predisposed to developing serious mental health conditions with debilitating symptomology (LeCook et al., 2014; Lo et al., 2014).  Nevertheless, the Substance Abuse

and Mental Health Services Administration (SAMSA) reported Black people were less

likely to seek treatment for mental health concerns.

Bamgbade et al. (2020) noted cultural factors impact the ability of Black people to

seek help.  According to Awosan et al. (2011), a lack of cultural understanding and

mistrust of the healthcare system prevent Black people from attending counseling

services. When Black people did receive services, previous literature inferred they are

overall dissatisfied with the mental health services they receive and have higher

termination rates compared to non-Hispanic Whites (Holden et al., 2012; Woods-

Giscombe et al., 2016). Williams et al. (2018) attested discrimination is a factor that

hinders racial and ethnic minority groups from engaging in mental health treatment.

Social and cultural barriers, negative thoughts, and beliefs about mental health have been

cited as major implications for lack of mental health treatment utilization in Black

communities (Gaunt et al., 2018; Samuel, 2015). In a qualitative study of 54 Black male

adolescents released from juvenile custody, many participants refused to see their mental

health concerns at a similar level as other illnesses, therefore, did not see a need for

services or even consider utilizing them. Another cited reason in the study was that

participants felt their mental health concerns were a direct result of racism,

discrimination, and various environmental factors (i.e., poor neighborhoods). They felt

the cause of these issues should be addressed versus offering counseling services to the

individuals impacted. Additionally, most participants took the position that Black men

have internalized racism that cause mental health problems as a result of feelings of

hopelessness and powerlessness and perceived these emotions as a normal thought

process. (Samuel, 2015). A recent study conducted amongst Black college students

showed an increase in the occurrence of mental health problems within this group, yet most did not seek treatment due to negative thoughts about mental health (DeFreitas et al., 2018). Results of a study conducted by Ward and Besson (2012) yielded contradictory results to Samuel (2015).  In their qualitative study focused on beliefs about mental health amongst Black men, participants were optimistic about seeking professional treatment for mental health conditions.

While the need for counseling services for Black communities is apparent, Black people prefer to utilize Black service providers (Cabral & Smith, 2011). Recent data by the American Psychological Association (APA) found that only 4% of psychologists are Black (American Psychological Association, 2020). Though other mental health professions such as counselors were not included in the data, the assumption is that there is an insufficient percentage of Black mental health professionals in general. Consequently, there are not enough Black mental health counselors to service Black people seeking counseling services. Black mental health counselors are not immune to systemic barriers such as racism and disparities in healthcare due to their professional knowledge. Often, their risk of impact can be substantially elevated as they have first-hand (their own) and second-hand (hearing client narratives) experiences of racism and race-related stress. Resilience is a protective factor that can support Black mental health counselors' well-being (Dupree et al., 2015). Resilience has been broadly studied in various populations including international, minority children, and adolescent populations. Windle and colleagues (2011) conducted a methodical review of nineteen resilience scales. Using a quality assessment framework (i.e., content validity, internal consistency, criterion validity, construct validity), they found the Connor-Davidson

Resilience Scale (CD-RISC) and two other resilience scales demonstrated the strongest

psychometric ratings.

**Racial Trauma & Race-based Traumatic Stress**

Racial Trauma, also referred to as Race-Based Traumatic Stress (RBTS) refers to

emotional and/or psychological stress related to negative racial encounters and other

race-related stressors (i.e., stereotypes, derogatory statements) (U.S. Department of

Veteran Affairs, 2022). Racism and discrimination are forms of RBTS that may cause

Black people to feel separated from American society leading to racial trauma (Carter et

al., 2017). Researchers have described racism as the use of privilege to act on a racial

belief that oppresses a designated group and the placement of value on an individual

based on phenotypic properties (Smedley, 2012; Williams et al., 2017). Historical

literature defines racism as "a social attitude propagated among the public by an

exploiting class for the purpose of stigmatizing some group as inferior so that the

exploitation of either the group itself or its resources or both may be justified" (Cox,

1959, p. 393).  To provide a more distinct picture of racism, Carter and Helms (2002)

deconstructed and reconceptualized it into three distinct types of racism: racial

discrimination, racial harassment, and discriminatory harassment.  Racial discrimination

is defined as a form of avoidant racism where policies are put into place that creates

distance between members of the dominant racial group and members of non-dominant

racial groups. Contrarily, racial harassment is considered hostile racism where policies

are purposely created to subjugate the inferiority of non-dominant racial groups (Carter et

al, 2005). There is consistency in research on how Carter and Helm (2002) denoted racial

discrimination and racial harassment.  Additionally, another aspect called discriminatory

harassment was a newly introduced racism descriptor.  This type of racism was described "as aversive hostile racism, which involves thoughts, behavior, actions, feelings, or policies and procedures that have strong hostile elements intended to create distance among racial group members after a person of Color has gained entry into an environment from which he or she was once excluded" (Carter, 2007, pg. 79).

Carter (2007) formed a conceptual model called Race-Based Traumatic Stress (RBTS) to illustrate the emotional effects of various racial events and their psychological impact. Carter denotes RBTS is a non-pathological, emotional response resulting from a racial encounter. Racial encounters can be either direct or subtle, occurring on an individual or systemic level. These events can differ in intensity and duration. Carter and Piertese (2020) argued the use of the DSM-V definition of PTSD to comprehend racial impact primarily focuses on the physical impact of trauma such as exhaustion or dissociation. While trauma is individualized distress, the trauma definition in the DSM-V as an actual versus perceived injury dismisses the experiences of Black people in that racial trauma does not always align with the PTSD diagnosis criteria (Carter & Pieterse, 2020, p. vii; Nadal, 2019).  In other words, traditional approaches that define trauma overlook racialized experiences (Carter & Pieterse, 2020, p. 93). In a differing view, Chioneso et. al (2020) classifies racial traumatization as an ongoing consequence of historical trauma (also known as multigenerational trauma). Reid et al. (2004) asserted Black people have endured mental and emotional injury as a direct result of slavery, systemic inequality, and racism and can have lasting effects on an individual's self-concept and identity causing psychological damage (Carter & Pieterse, 2020, p. 95; Hemmings & Evans, 2018, p. 27; Sotero, 2006). For a Black person in a predominantly

White nation who questions their self-individuality (what it means to be Black) and their

place within the Black culture (who I am as a Black person within my culture), may

consequently cause assimilation towards Eurocentricity.

Hemmings & Evans (2018) identified a significant relationship between racially

traumatic incidents and the development of adversarial symptomology (i.e., anxiety,

hopelessness, shame). Any form of racism can lead to racial traumatization (Carter, 2007;

Comas-Diaz, et al., 2016). Overt racism, known as explicit racism, is intentionally

demeaning to a minority group based on their skin color (Elias, 2015).  As a product of

White supremacy, this form of racism is easier to detect as it manifests in the form of

attacks and insults. A subtler form of racism, namely microaggressions, may be difficult

to provide tangible proof of its existence. Sue et al. (2007) explained microaggressions

are "the everyday slights, insults, putdowns, invalidations, and offensive behaviors that

people of color experience in daily interactions with generally well-intentioned White

Americans who may be unaware that they have engaged in racially demeaning ways

toward target groups". Microaggressions have proven to be equally, and sometimes more

detrimental than overt and intentional interpersonal racial discrimination, nonetheless,

nominal research has assessed the effects of racial microaggressions on traumatic stress

(Nadal et al., 2019; Williams et al., 2018a). Several studies have linked perceived stress

and depressive symptoms with lower wellness and self-esteem (Kim et al., 2017; Nadal et

al., 2014; Torres & Taknint, 2015) Regardless of the type, racism can lead to

traumatization.

**Experiences of Racial Trauma for Black People**

Though minimally represented in literature, there are common threads woven

throughout research explaining the experiences of Black people related to racial trauma. Black people report a higher prevalence of racial discrimination compared to other racial-ethnic minority groups (Carter & Pieterse, 2020, p. 7; Chou et al., 2012). According to a recent poll guided by Kaiser Family Foundation (2020), a vast majority of Black people (71%) experienced racial discrimination by law enforcement, and nearly 50% felt endangered due to their race. Black students who attend Predominantly White Institutions (PWIs) often complain of overt and covert racism (Anderson, 2020). Lack of diversity in college counseling centers may cause Black students to isolate themselves failing to seek help and support.  In turn, debilitating anxiety and poor mental health outcomes may affect academic performance (Anderson, 2020).

Results of a research study that included Hispanic/Latinx, Asian, and Black groups, Black people reported a significantly higher degree of perceived racial discrimination compared to the other represented groups. Additionally, results revealed Black people were more likely to experience Panic Disorder without Agoraphobia (PD), Panic Disorder with Agoraphobia (PDA), and Posttraumatic Stress Disorder (PTSD). Black participants who reported perceived racism were more likely to experience PTSD over a lifetime (Chou et al., 2012).  Nadal and colleagues (2019) conducted a correlational research study to analyze the relationship between racial microaggressions, racial trauma, and PTSD symptoms. Findings yielded a significant correlation between racial microaggressions and trauma. Higher amounts of microaggressions translated into a higher number of traumatic symptoms (Nadal et al., 2019).  This connection was also supported by an earlier study that found racial microaggressions were significant predictors of other mental health variables such as depression (Nadal et al., 2014).

Understanding the high prevalence of racism experienced by Black people not only provides awareness of the potential lasting effects impacting personal and professional life, but it also provides insight on how systems can be eradicated to reduce racial inequalities and disparities.

**Resilience**

Conceptualized through present literature, racism causes a wide range of responses, however, the majority of research focuses on the detriments to one's mental well-being. Long-lasting behavioral changes and adverse mental health effects could occur when Black people experience trauma based on their race or ethnicity (Carter & Sant-Barker, 2015; Pieterse et al., 2012). Outcomes can be psychological (anxiety, depression, lack of emotional regulation), biological (weathering), and social (substance abuse) (Coogan et. al, 2014; Farahmand, 2020; Mekawi et al., 2020, Villines, 2020). Williams et al. (2017) denoted racial traumatization has analogous symptomology to post-traumatic stress syndrome (PTSD) (i.e., flashbacks, heightened reactions, hypervigilance), however, it may extend beyond traditional PTSD symptoms as it may include paranoia, excessive worry, and somatic complications (Williams et al., 2018b).

The promotion of resilience in Black populations frequently focuses on youth and adolescents who encounter high trauma situations. In a 2018 research study, DiClemente and colleagues conducted a study on Black adolescents who attended school and lived in high crime areas. The purpose of the study was to better understand protective factors that produce positive outcomes relative to self-esteem, ethnic identity, and positive affect. Results indicated that greater family, school, and community cohesion related to more positive outcomes (DiClemente et al., 2018). Cunningham et al. (2018) conducted a study

to address resilience and coping in Black adolescents that encountered discrimination. Girls who demonstrated low racial identity had increased vulnerability to beliefs about aggression when exposed to negative experiences, whereas boys with higher racial identity had increased beliefs about aggression as their negative experiences increased. Racial identity presents as a protective-enhancing effect for girls and a protective-reactive effect for boys. Other studies on resilience in Black youth focus on academic achievement, socialization, racism, mentorship, risk factors, and race-related stressors.

While resilience research is broadly studied in various disciplines, a significant literature gap is found in the helping profession. Social work is one of the oldest helping professions, however, resilience research is scarce (Collins, 2007; Crowder & Sears, 2017).  For the newest mental health helping profession, counseling, empirical research on counselor resilience is even more sparse (Roebuck & Reid, 2019), primarily focusing on behaviors that enhance the work experience (McCann et al., 2013) and seldomly on refining it within themselves (Thomas & Morris, 2017).  Arañez Litam and colleagues (2021) posited resilience assists individuals with decision-making that can benefit their wellness and health. Counselors who managed their self-care demonstrated higher levels of job satisfaction and lower work-related stress levels versus counselors who did tend to their self-care (Bellamy et al., 2019). In a pilot study on wellness, exposure to trauma, and vicarious traumatization, results revealed higher levels of wellness when being exposed to clients' trauma narratives were correlated with decreased levels of vicarious traumatization (Foreman, 2018).

Ethically speaking, the 2014 American Counseling Association (ACA) Code of Ethics mandates that "counselors engage in self-care activities to maintain and promote

their own emotional, physical, mental, and spiritual wellbeing to best meet their

professional responsibilities" (American Counseling Association, 2014). The National

Association of Social Workers (NASW) 2021 revision of ethical codes notes that self-

care is "paramount for competent and ethical social work practice" (National Association

of Social Workers, 2021). American Psychological Association (2021) supports self-care

as an ethical imperative (Abramson, 2021). Skill-building in resiliency as part of

counselor wellness can be utilized to change the trajectory of foreseen job dissatisfaction,

compassion fatigue, and burnout, as well as mental health concerns (Sadler-Gerhardt &

Stevenson, 2012). Black counselors who cultivate their resiliency can create the buffering

effect when experiencing racial trauma and helping their Black clients through their racial

trauma (Lambert & Lawson, 2013; Sadler-Gerhardt & Stevenson, 2012).

**Measurements of Resilience**

Scholars have developed numerous scales of measurement to conceptualize

resilience across various disciplines. A thorough analysis of existing measures of

resilience and literature discussing resilience relative to race was conducted. Windle et al.

(2011) conjectured most resilience scales examined in a methodological review were

missing some psychometric properties which are necessary for validation. All currently

available resilience scales fail to include race-specific questions and ignore the inclusion

of race-based trauma dismissing the experiences of racially marginalized groups.

Furthermore, researchers have developed their instruments predominantly on a client-

centered perspective and may not be effective for a therapist-centric self-reported

approach. Three different scales developed in an attempt to measure resilience were

reviewed. Below, a brief description of each assessment and its limitations is provided to

lay a foundation for the development of the Race-Based Resilience Scale (RBRS).

The Connor-Davidson Resilience Scale (CD-RISC) is a 25-item measure used to assess resilience (Connor & Davidson, 2003). Description of questions include the ability to adapt to change, past success gives confidence for a new challenge, coping with stress strengthens, and strong sense of purpose.  The Vicarious Resilience Scale (VRS) was developed to measure vicarious resilience (Killian et. al, 2017). The 27-item scale includes seven subscales based on experiences upon (a) changes in life goals and perspectives, (b) increased self-awareness and self-care, (c) client-inspired hope, (d) increased recognition of spiritual as a client resource, (e) increased capacity for resourcefulness, (f) increased consciousness around social location and power, and (g) increased capacity to remain present during trauma narratives. Lastly, the Resilience Scale (RS) is a 25-item scale that measures the degree of individual resilience after a measure life event. Two factors were focused on (a) personal competence (self-reliance, independence, determination, invincibility, mastery, resourcefulness, perseverance) and (b) acceptance of self and life (adaptability, balance, flexibility, and a balanced perspective of life).

One limitation of each measure is the exclusion of the multicultural context (i.e. race/ethnicity). The development of existing scales did not include race as a factor of resilience. Past research studies corroborate that cultural context (i.e., race/ethnicity, age) is paramount in resilience research (Johnson et al., 2014; Khanlou & Wray, 2014; Stumblingbear-Riddle & Romans, 2012; Vindevogel, 2017). Another limitation was the norm population. The VRS was normed on clinicians with varying education experience representing various fields of study, however, the cultural context was also omitted.

Additionally, perspectives may differ based on profession and education level. Yet another limitation is the variable length of time in which resilience is measured. Items of the RS required the participant to have a major life event in mind (Wagnild, 1993), while the CD-RISC scarcely focused on resilience over the last month (Connor & Davidson, 2003). The VRS was not time specific. Many scales of resilience have been developed, however, various approaches to how resilience is measured trigger inconsistencies in the assessment of risk and protective processes (Windle et al, 2011). Though previous resilience scales have been studied using international samples, minority children and adolescent populations, and immigrant populations, current scales may be limited in their validity from the Black counselors' purview. To date, no resilience scale has discussed the strength-based approach of resilience connected to navigating racism.

### *Significance of Measuring Resilience*

Counselor resilience and well-being are essential in the prevention of counselor impairment in Black mental health counselors. It is paramount for Black counselors to protect themselves from becoming overwhelmed by internal and external threats to their well-being while helping their clients build resilience. In recent years, emphasis has been placed on the prevention of burnout and compassion fatigue in counselors through self-care (Bradley et al., 2013; Coaston 2017; Friedman, 2017). However, few studies examine the positive personal qualities of counselors relative to the quality of their professional lives (Blocker et. al, 2019; Browning et al., 2019). To better understand how Black people collectively navigate racism, a close examination of the protective factors utilized within this culture are required (Brown, 2008).

***Race-Based Resilience (RBR)***

While there is no conceptual framework for Race-Based Resilience (RBR), the construct is partially adopted from Carter's (2007) definition of Race-Based Traumatic Stress (RBTS). Race-Based Resilience (RBR) is defined as the ongoing process of a positive inborn trait based on a response to a racial event or encounter that may cause traumatic injury. The traumatic injury manifestations differ in pathology (or non-pathology), type (individual or system), intensity, and duration. How one responds to a racial encounter currently may not be the same response at a different point in the future. The racial encounter can be real or perceived which aligns with racial discrimination and trauma definitions. If one responds in a manner that may not be socially acceptable based on Western culture, does not mean the individual is not resilient. It could potentially mean at this given point their resilience is lower, however, contextual factors (i.e., race/ethnicity, culture) must be considered.

For example, a Black woman walks into a department store just behind a White woman. The White woman is acknowledged and greeted by a non-Black salesperson; however, the Black woman is not. The Black woman allows a few minutes to go by just to see if she will be acknowledged. She still has not been greeted nor acknowledged, so she proceeds to confront the salesperson who greeted the White woman who entered before her. She informed them that she should be treated and greeted the same as the White person who walked into the store just before her.  She informs the salesperson that she was racially discriminated against and informs she will be filing a formal complaint with the president of the company. She then walks out of the store, dismissing the explanation the salesperson attempts to give her. Based on her response, some could say

her resilience is lower because of her response and the words she used, while others, may see her with a high level of resilience as she advocated for herself.

**Present Study**

The purpose of this study is to investigate and validate the psychometric properties of a new quantitative instrument, the Race-Based Resilience Scale (RBRS), that measures Race-Based Resilience (RBR) within a group of Black mental health counselors.  The research questions guiding this study are:

1. What is the factor structure of the Race-Based Resilience Scale (RBRS)?

2. Does the Race-Based Resilience Scale (RBRS) demonstrate evidence of internal consistency?

3. How well does the Race-Based Resilience Scale (RBRS) correlate with the Vicarious Resilience Scale (VRS)?

The inferred hypotheses to address the above research questions are:

1. The Race-Based Resilience Scale (RBRS) will yield good factor loading for most items.

2. The Race-Based Resilience Scale (RBRS) will demonstrate high internal consistency of Race-Based Resilience (RBR) in Black mental health counselors.

3. The Race-Based Resilience Scale (RBRS) will positively correlate with the Vicarious Resilience Scale (VRS).

## Methods

**Respondents**

The respondent sample consisted of Black-identified mental health professionals

with a minimum of a master's level education. Black is defined by individuals who are

descendants of native Africans or people from Africa. Mental health professions included

counseling, marriage and family therapy, social work, psychology, psychiatry, and

substance abuse. Master-level means post-secondary education with an awarded master's

degree. After the data was cleaned, the final sample was 300. Most respondents identified

as woman ($n = 276$, 92%) and working in the counseling profession ($n = 169$, 56.3%).

Approximately 45% ($n = 137$) of respondents worked from 10 – 25 hours per week with

private practice identified as the major work setting (n = 145, 48.3%). The Southern

region was the most represented region ($n = 131$, 43.7%) followed by the Midwest

Region ($n = 66$, 22%). In terms of ethnicity, only 7% of the respondent sample identified

as multiracial (Black and another ethnicity) ($n = 21$, 7%). Ninety-eight respondents

(32.7%) had under 2 years of licensed experience, whereas ninety respondents (30%) had

2 – 4 years of unlicensed experience.  Nearly 55% ($n = 164$) spent 2 – 4 years in their

master's and/or doctoral training program before becoming fully licensed (see Table 1.).

**Instrumentation**

The study was interested determining the validity, reliability, and factor structure

of a newly constructed scale, the Race-Based Resilience Scale (RBRS), to measure Race-

Based Resilience (RBR).

**Demographic measure.** The following demographic information was collected:

(a) age, (b) gender, (c) racial/ethnic background, (d) immigration status, (e) level of

education (master's, specialist [post master's], doctoral), (f) professional identity

(counseling, marriage and family therapy, psychiatry, psychology, social work, substance

abuse), (g) years of licensed professional experience in mental health counseling, (h)

years of licensed professional experience in mental health counseling, (i) amount of time

spent in training, (j) number of clinical hours worked per week, (k) current work setting,

(l) region of the U.S. resided in, (m) country of residency if outside of the United States,

(n) experiences of being Black in the United States, and (o) referral source of completing

the survey.

**Scale Development**

      **Race-Based Resilience Scale.** Since there is no conceptual framework for Race-

Based Resilience (RBR), the construct is partially adopted from Carter's (2007) definition

of Race-Based Traumatic Stress (RBTS). To measure Race-Based Resilience (RBR), a

new instrument, the Race-Based Resilience Scale (RBRS) was developed; the scale

development was mainly informed by the Connor-Davidson Resilience Scale (CD-RISC)

measuring resilience with strong psychometrics in various translations and populations

(Connor-Davidson, 2018). Results differ among various studies (Anjos et al., 2019),

suggesting age, gender, culture, etc. may play a role in these differences (Prince-Embury,

S., 2013, p. 165).  The factor structure is necessary to address the variation in results

(Anjos et al., 2019).

      In the initial step of scale development, items of the Connor-Davidson Resilience

Scale (CD-RISC) (Connor & Davidson, 2003) were analyzed to determine whether race

could be incorporated without changing the intent of the question. For example, "I am

able to adapt when changes occur" was customized to read "I am able to adapt when I am

faced with racism". The focus of this question is adaptability. Next, an initial pool of 25

items was sent to seven expert reviewers. Each reviewer earned a master's level degree in

a mental health profession, with one expert with a Doctoral level education. Additionally,

each reviewer identified as Black and was a practicing clinician with a minimum of five years of direct experience in resilience, racial trauma work, minority mental health, and/or research. Reviewers were sent an email correspondence with abbreviated definitions of race-related stress, racism, resilience, and Race-Based Resilience (RBR). Experts were requested to review the content validity of each customized question and rate the intent in which the question measures Race-Based Resilience (RBR), using a 5-point Likert scale (1 = *strongly disagree*, 2 = disagree, 3 = neither disagree nor agree, 4 = agree, 5 = strongly agree). They are also asked to provide recommendations for revision and other comments. In cases where there were no recommendations or comments, they were asked to note, "N/A".

Expert reviewers were provided one week to review the items and provide feedback. Five experts responded by the defined deadline. A review of collected data was conducted with a doctoral student research assistant. All suggestions offered by experts were considered, with most being incorporated after coming to a consensus with the research assistant. For example, one expert suggested that "I am able to deal with race-related stress" and "Having to cope with racism and race-related stress can make me stronger", be modified and condensed into one item to read "I am able to cope/function to deal with race-related stress. Some questions were deleted for varying reasons. For example, "I have at least one close and secure relationship which helps me when I encounter race-related stress" was removed as it presented as an outlier focused on support systems. "I try to see the humorous side of things when I am faced with race-related stress" can be interpreted as a defense mechanism versus resilience. Similarly, "I like challenges relative to my race" was removed as it did not seem to measure resilience.

Since Race-Based Resilience (RBR) is defined as an innate trait that all people have, "I tend to bounce back after illness, injury, and other hardships related to my race" contradicts how the construct is defined. One item – "I can make unpopular or difficult decisions about racism that affect other people if it is necessary" was removed due to possible differences in interpretation. Additionally, a new question was created based on collective feedback to note, "I am able to advocate for myself when I am faced with racism". The final instrument consisted of 20 new items, with higher assessment scores indicating higher levels of resilience.

To test hypothesis 1, an Exploratory Factor Analysis (EFA) was run using the principal axis factor and direct oblimin rotation on the remaining 20-item survey that measured Race-Based Resilience (RBR) in 300 Black-identified mental health counselors. Debates about an adequate sample to run an EFA are ongoing in quantitative research. Tabachnik and Fidell (2001), recommended aiming for a sample of 300. Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) (.890) and Bartlett's test of sphericity score ($p < .000$) yielded suitability to proceed with the EFA.

**Validation**

**Vicarious Resilience Scale.** The Vicarious Resilience Scale (VRS) was used for convergent validity as it was normed in diverse helping professions working with trauma (Killian et al., 2017). The VRS was developed to measure Vicarious Resilience (VR) (Killian et. al, 2017). The VRS is comprised of 27 items, scored on a 6-point Likert scale of measurement, ranging from (0) did not experience this, (1) experienced this to a very small degree, (2) experienced this to a small degree, (3) experienced this to a moderate degree, (4) experienced this to a great degree, and (5) experienced this to a very great

degree. Questions are nestled in seven subscales: (1) the changes in life goals and perspectives, (2) increased self-awareness and self-care, (3) client-inspired hope, (4) increased recognition of spirituality as a client resource, (5) increased capacity for resourcefulness, (6) increased consciousness around social location and power, and (7) increased capacity to remain present during trauma narratives. The total score ranges from 0 to 135, with higher scores reflecting greater VR (Killian et al., 2017). Example questions assess one's ability to handle stress and self-awareness of distressing thoughts. VRS possessed an internal consistency reliability of .92. The Cronbach's alpha of the seven subscales ranged from .65 to .88 (Killian et al., 2017). In a study sample of 147 participants who work with trauma survivors, results supported an overall Cronbach's alpha reliability of the VRS at .92 (Killian et al., 2017). In the present study, Cronbach's alpha reliability was .93.

**Marlowe-Crowne Social Desirability – Short Form (Form C).** The Marlowe-Crowne Social Desirability – Short Form, Form C (MCSDS Form C) was used for discriminant validity as it has been previously used in diverse populations (Middleton & Jones, 2000). The MCSDS Form C is an abbreviated version of the original Marlowe-Crowne Social Desirability (MCSDS) (Reynolds, 1982). Reynolds (1982) created three different forms A, B, and C. Form C is comprised of 13 items using a dichotomous scale of measurement with true and false responses. The total score ranges from 1 to 13, with higher scores indicating the tendency to respond in a socially desirable manner (Reynolds, 1982). Samples questions include *I sometimes feel resentful when I don't get my way* and *I'm always willing to admit to it when I make a mistake*. Findings of a research study with female and male juvenile respondents supported MCSDS Form C has

good internal consistency reliability of .61 (Pechorro et al., 2016). The 13-item short

version was selected due to good psychometrics, internal consistency, and correlation

with the original scale (Verardi et al., 2010). Two factors in an African sample were

deemed replicable across cultures (Verardi et al., 2010). In the present study, Cronbach's

alpha reliability was .66.

**Procedure**

Items on the Race-Based Resilience Scale (RBRS) were entered into an electronic

survey platform, Qualtrics. Three doctoral-level students reviewed the survey before

distribution to ensure the information was free of errors. Following the Institutional

Review Board (IRB) approval, recruitment to the targeted population occurred using

convenience and snowball sampling. Several thousands of Black mental health

professionals were invited to participate in this research study primarily through mass

invitation on social media.  The call for respondents was distributed through four main

social media platforms: Meta (formally Facebook), Instagram, LinkedIn, and Twitter.

Counselor directories (i.e., Therapy for Black Girls, Clinicians of Color, and Psychology

Today) and listservs designated for counselors and counselor educators were also

utilized.  Data collection occurred between December 2021 to March 2022.

According to previous research, a large respondent sample assists in concluding

the sampled population (Heppner et al., 2016, p. 176). Lower statistical power is a threat

to statistical validity that increases the risk for Type II errors (Heppner et al., 2016, p.

143). An a priori alpha level was established at $\alpha = .05$, $1-\beta = .95$, $H_0: p = 0$ and $H_1: p \neq 0$.

G∗Power, version 3.1.9.7 was used to determine the minimum sample size (Faul et al,

2009; Faul et al., 2017). A minimum of 138 respondents was deemed as sufficient to detect a medium effect size ($p = .30$) (Cohen, 1988, p. 80).

Respondents were presented with informed consent with an option to decline participation at any time throughout the study. Next, demographic information was collected followed by the presentation of the six separate surveys. Respondents were given the option to participate in a raffle for a chance to win one of fifty $25 gift cards. Preliminary data was gathered from 522 respondents. Once downloaded, variables were renamed, then relabeled to identify the correct categorical level of measurement. All MIBI subscales except for Centrality were deleted as they were unnecessary for the dissertation study series. Gender was the only variable that was dummy coded. Rows that were not pertinent to the data were removed. These included start date, end date, IP address, finished, recorded date, response ID, recipient last name, recipient first name, recipient email address, external reference, location longitude, location latitude, distribution channel, user language, and score. Additionally, the progress, status, duration in seconds, and Q_ReCAPTCHA were reviewed for abnormalities, then removed. One respondent was removed with a reCAPTCHA score of .40 due to the likelihood of being a bot (Qualtrics, 2022).

Demographic questions were reviewed to confirm respondent eligibility to participate in the study. Seven respondents were removed as the age was not provided. Two respondents were removed due to not providing a race/ethnicity and four were removed due to not identifying as Black. The education level was missing for three respondents, therefore, removed. Thirty-nine respondents did not confirm whether they were mental health professionals and were discarded. Fifty-three respondents only

completed demographics with an additional twenty-six being removed for only completing the demographic and Race-Base Resilience Scale. The first quality check question was disregarded if answered incorrectly as there was an error noted during the creation process. Twenty-three respondents answered at least one of the quality check questions incorrectly and were removed. Sixty-one respondents were missing all responses to critical variables for study two and were discarded.

The next step in data cleaning was to recode applicable items and calculate scores. Excluding the MIBI Centrality subscale, all scales were added as sum scores. The MIBI Centrality subscale was calculated by the mean score of the individual subscale. In the following step, data were examined to determine if there were missing values in any fields. To address the missing values, mean scores were plugged into the MDSDS Form C, VRS, MIBI Centrality subscale, and VTS scales. Next, a search for outliers was conducted. Since the data was ungrouped, the entire set was reviewed to determine univariate outliers. Descriptives were examined to determine z-scores $> 3.29$ and $< 3.29$ (Tabachnick & Fidell, 2013). Two respondents were detected as univariate outliers on the MIBI Centrality subscale (-3.80006, -3.67127) and removed. Mahalanobis was used to detect multivariate outliers. The numeric expression 1-CDF.CHISQ(MAH_1) with 6 degrees of freedom was used. One respondent larger than the critical value of .001 was removed (.00195).

Skewness and kurtosis values for each variable were reviewed. While each variable denoted skewness and kurtosis were within the acceptable range of absolute value 2 depicting mesokurtic distribution (George & Mallery, 2010). The MIBI Centrality subscale presented as platykurtic, however, skewness and kurtosis values were

within an acceptable range (less than absolute value 2). Q-Q plots were examined with

most points falling close to the fit line. To assess linearity, bivariate scatterplots were

reviewed to ensure points were grouped in an oval-shaped formation. Minimal points for

the VRS and MIBI Centrality subscale were not grouped within the cluster, however,

they fell close to the cluster. A Levene's test was run to assess for homoscedasticity ($p <$

0.05). No violations of homogeneity of variance were detected. Frequencies were run to

determine if there were any missing values. None were detected.

 Four tests were run to determine the presence of multicollinearity. First, the

correlation analysis revealed there was not a high correlation among predictors. Next, the

value of tolerance noted tolerance was not $< 0.1$ and VIF was not $> 10$. Lastly, the

condition index in collinearity diagnostics was examined. Belsley and colleagues (1980)

asserted multicollinearity should be further assessed if the condition index is above 15.

Conditions above 30 indicate strong multicollinearity. The condition index for the MIBI

Centrality subscale was slightly above (16.696). Variance proportions were assessed to

determine if at least two were above .90. Only one was above (.98) indicating

multicollinearity is not a concern.

**Data Analysis**

*Factor Analysis*

 An exploratory factor analysis (EFA) of the 20 items on the Race-Based

Resilience Scale (RBRS) was conducted using the principal axis factor and direct oblimin

(oblique rotation) in IBM SPSS 27. In counseling research, this structure allows

researchers to understand the underlining factor structure that exists in a set of variables

and to generalize to the population. Examination of the Kaiser-Meyer-Olkin (KMO)

measure of sampling adequacy and Bartlett's test of sphericity were conducted to

determine if the respondent sample was sufficient to conduct the factor analysis (Tinsley

& Tinsley, 1987). Kaiser (1960) recommended a Kaiser-Meyer-Olkin Measure of

Sampling Adequacy equal to or greater than 0.60 to proceed with an EFA. Additionally, a

significant Bartlett's test of sphericity score of $p < 0.05$ is also necessary (Barlett, 1954).

Further testing and examination were completed to determine initial eigenvalues, Catell's

scree plot test, and the interpretability of the factor solution. To determine usability of a

factor, loading should lie between .30 and .40 (Bandalos & Gerstner, 2016; Hair et al.,

2010).

### Results

**Factor Analysis**

Using a Pearson coefficient correlation, incidental findings noted a significant

correlation between demographic variables and the Race-Based Resilience Scale (RBRS).

Significant correlations were noted between years licensed and Race-Based Resilience

Scale (RBRS) ($r = .140$, $p < 0.05$) and between age and Race-Based Resilience Scale

(RBRS) ($r = .221$, $p < 0.01$). The determinant was reviewed and confirmed no

multicollinearity was detected ($p < 001$). Initial and extracted communalities were

inspected following the guidelines proposed by Mvududu and Sink (2013) and Beavers et

al. (2013). The following retention factors were utilized: factor loading > 0.40,

communalities ($h^2$) > 0.30, and cross-loading < 0.40. Inspection of the Total Initial

Eigenvalues for values greater than 1 was reviewed. Four factors were identified which

accounted for 54.74% of the variance and confirmed via Catrell's Scree plot (see Table

2.). Three items (2, 5, 6) displayed communalities < 0.30 and were removed from the

analysis. Upon recalculation, KMO increased to .900. Beavers (2020) suggested

researchers should review the structure and pattern matrices for interpretation of the results and to determine if there is any evidence of cross-loading. The new calculation revealed a three-factor solution with two items cross-loading (14, 10). These items were removed and the EFA was recomputed. KMO decreased to .879 and Bartlett's test of sphericity score ($p < .001$). Item 13 was not attached to any factor and was deleted from the data set. EFA was again recalculated with a KMO of .874. The final factor solution included 14 items with three factors. Factor one was marked by six items and accounted for 38.114% of the variance. Factors two and three were each marked by four items with a variance that accounted for 10.619 and 9.720, respectively. To examine the reliability of the Race-Based Resilience Scale (RBRS), the Cronbach's coefficients alpha values were computed for each factor: $\alpha = .817$, $\alpha = .788$, $\alpha = .761$, respectively. According to Cortina (1993), a Cronbach's alpha of $> .70$ is acceptable and $> .80$ is good.

To name each factor, a process similar to thematic coding in qualitative research was followed. Items in each factor were inspected for commonalities. After proposed themes were identified, the researcher and doctoral research assistant discussed the outcome to determine consensus. The first factor was named "Self-Efficacy" as all items were associated with positive outcomes despite challenges (e.g., …attain my goals, no matter what roadblocks; … present a barrier, I stay focused…). The second factor was named "Coping Mechanisms" as all items were focused on one's ability to cope with racism (e.g., …I am able to cope/function, … I am able to handle…). The third factor was named "Multicultural and Social Justice Advocacy" as all items were focused on advocacy when encountering racism (e.g., …I am able to cope/function, … I am able to handle…). Inter-factor correlations included Self-Efficacy and Coping Mechanisms, $r =$

.496, *p* < .001); Self-Efficacy and Multicultural and Social Justice Advocacy, *r* = .545, *p* < .001; and Multicultural and Social Justice Advocacy and Coping Mechanisms, *r* = .496, *p* < .001); (see Table 3). Hypotheses 1 was supported. Six items with low factors were removed with the remaining factors indicating good factor loading. Examination of Cronbach alpha and item correlation supported hypothesis 2; the Race-Based Resilience Scale (RBRS) yielded adequate to good internal consistency reliability.

**Validity Analyses**

Hypothesis 3 was tested and bivariant correlation was utilized to examine the evidence for the convergent validity between Race-Based Resilience Scale (RBRS) and Vicarious Resilience Scale (VRS) scales. To establish convergent validity of the scores, positive and distinct correlation is necessary when measuring the two instruments (Watson & Flamez, 2015). The Race-Based Resilience Scale (RBRS) total score yielded a significantly positive correlation with the Vicarious Resilience Scale (VRS) total score, supporting research question 3 (*r* = .288, p < .001). Each Race-Based Resilience Scale (RBRS) subscale correlated with the Vicarious Resilience Scale (VRS) total score. VRS total score included (a) Self-Efficacy (*r* = .231, *p* < .001) (b) Coping Mechanisms (*r* = .164, p < .001), and (c) Multicultural and Social Justice Advocacy (*r* = .255, p < .001). Additionally, closer examination of each Race-Based Resilience Scale (RBRS) subscale and each Vicarious Resilience Scale (VRS) subscale continued to yield a significant correlation (p < 0.01 or p < 0.05) between most items (see Table 3b). Hypotheses 3 was supported.

*Self-Efficacy*

Self-efficacy is often integrated within resilience literature and is a component of

social cognitive theory (Scoloveno, 2018). As a theory of human behavior, social

cognitive theory denotes the constant, interactional process between factors such as

cognitive, behavioral, and environmental. The way in which an individual responds or

behaves within a situation depends on these factors. Bandura (1977) describes self-

efficacy as one's belief that a difficult task can be completed with desirable results.

For example, if a counselor believes they can be effective in assisting a client to reduce

trauma responses, self-efficacy increases each time the counselor feels they are effective.

Conversely, if the counselor feels they have failed the client, self-efficacy is disrupted

(Bandura, 1993; Borgen & Lindley, 2003; Caprara et al., 2006). Only a small amount of

literature exists related to self-efficacy and vicarious traumatization (VT), though, clinical

supervision and feedback are two elements that can increase self-efficacy for counselors

(Larson et al., 1992; Lent et al., 2006). Since Black mental health counselors have

increased propensity to experience VT, graduate training programs should continuously

emphasize resiliency-building skills. Self-efficacy is a resiliency skill that moderates

coping and emotions, which consequently could result in reduction of negative effects

and upsurge well-being (Lightsey et al., 2013).

*Coping Mechanisms*

Coping sets the stage for social-emotional balance (Carver & Connor-Smith,

2010) and mediates how individuals address daily happenstances (Mayordomo et al.,

2016). Lazarus and Folkman (1984) defined coping as continuous change in cognitive

and behavioral realms to manage various situations, both internal and external, that may

devastate an individual's resources, in turn, increasing well-being. Their conceptual

model identified two types of coping: problem-focused coping and emotion-focused

coping. Problem-focused coping modifies the concern causing distress, whereas emotion-focused coping incorporates methods to regulate emotions caused by distressing situations. Both contribute to an individual's overall well-being, holding the same amount of value. Mayordomo and colleagues (2016) identified relationships between coping, resilience, and psychological well-being. They supported the idea coping and resilience can create adaptability to disparaging circumstances to accomplish psychological well-being. Results of a structural equation model (SEM) rendered psychological well-being is positively predicted by resilience and negatively by emotional coping (Mayordomo et al., 2016). For Black mental health counselors, development of effective coping mechanisms can address symptoms connected to VT, positively impacting clinical work.

*Multicultural and Social Justice Advocacy*

Competency in multicultural and social justice advocacy are necessary when working with diverse populations as multicultural acknowledges various aspects of an individual's cultural identity (Jackson, 1995), while social justice advocacy attempts to counteract oppression (Marbley et al., 2015). The American Counseling Association (ACA) holds counselors accountable to promote social justice and engage in advocacy (American Counseling Association, 2014). Sue et al. (1992) introduced a Multicultural Counseling Competencies (MCC) framework to integrate within counseling practice and research. Nearly 20 years later, the Association for Multicultural Counseling and Development (AMCD) commissioned committee, Multicultural and Social Justice Counseling Competencies (MSJCC) created a revised, more expansive version. The updated framework served three purposes: (1) to address the needs of the counseling profession, (2) to outline multicultural and social justice competencies in various aspects

of the counseling (i.e., supervision, training and education programs, theories, etc.), and (3) combining multicultural and social justice concepts to address the complex relationships between counselor and client (Ratts et al., 2016). At the nucleus of the model, is multicultural and social justice advocacy. Four quadrants illustrate identity intersections and includes ways power, privilege, and oppression can impact the counseling relationship (see Figure 2). Advocacy can build upon resilience by connecting individual power with social power creating change in individuals, micro, and macro levels.

To detect whether Race-Based Resilience Scale (RBRS) and MCSDS Form C were empirically distinct, bivariate correlations between the total Race-Based Resilience Scale (RBRS) score and the total MCSDS Form C score were conducted. A small correlation was detected, between respondents' responses on the Race-Based Resilience Scale (RBRS) and social desirability ($r = .193$, p $< .001$). Each Race-Based Resilience Scale (RBRS) factor was run individually with the total MCSDS score, supporting the statistical significance. In an inter-item correlation, all except for 8 items were correlated. Items that were reversed scored on the MCSDS were not correlated. According to Kim & Kim (2015), social desirability may be detected in self-reported surveys completed by racial-ethnic minority groups due to racial identity. Nevertheless, results noted numerous significant correlations between Race-Based Resilience Scale (RBRS) and Vicarious Resilience Scale, which is a strong indication of reliability and validity.

Supported literature aligns with the three factors of the Race-Based Resilience Scale (RBRS) noting that each accentuates resilience. The experiences of Black people differ from other racial groups. Black people continue to experience racial harassment,

racial discrimination, psychological trauma, and other systemic barriers at a higher-level Carter & Pieterse, 2020, p. 7; Chou et al., 2012; Nadal et al., 2019). The Race-Based Resilience Scale (RBRS) exceeds traditional measures of resilience by incorporating cultural influences, specifically race. Race is an important piece of one's identity that can inform who an individual understands their self to be. Various systems and structures use race as a means to substantiate oppression and privilege, taking a destructive toll on Black people. The Race-Based Resilience Scale (RBRS) provides insight into lives of Black mental health counselors and Black people in general by underlining the internal strength that assists them in balancing their psychological well-being.

## Discussion

This research study aimed to explore the factor structure and internal consistency reliability of the newly developed Race-Based Resilience Scale (RBRS) with a sample of Black mental health counselors. Implementation of a principal axis factoring with oblimin rotation yielded a 14-item instrument with a three-factor solution that reflected high factor loading accounting for nearly 60% of the variance. Three identified factors included (a) Self-Efficacy (6 items), (b) Coping Mechanisms (four items), and (c) Multicultural and Social Justice Advocacy (4 items). This study contributes to research on resilience measurement by incorporating race-specific items. Preliminary analysis indicates a high probability supporting the use of the Race-Based Resilience Scale (RBRS) as a measure of Race-Based Resilience (RBR) in Black mental health counselors, although additional research is necessary to confirm these findings.

### Implications for Counseling

Several defining features of this research study provide implications for

counselors, counselor educators, and counselor training programs as it contributes to both counseling literature and resilience research.  The Race-Based Resilience Scale (RBRS) focuses on assessing race-specific resilience in mental health professionals, expanding current scholarship on resilience and counselor wellness. Further development and validation of the Race-Based Resilience Scale (RBRS) will allow researchers to investigate the significant roles race and culture play in counselors' clinical work with their clients. Furthermore, the development and initial validation of Race-Based Resilience Scale (RBRS) supported a three-factor solution of how Black mental health counselors apply self-efficacy, coping, and advocacy in their personal lives, which could positively impact their professional work. The three factors provide subcategories of resilience consistent with previous studies on buffers to mental health (Lightsey et al., 2013; Lazarus & Folkman, 1984, p. 46).

Regular completion of the Race-Based Resilience (RBR) as a self-assessment tool by both supervisor and supervisee can teach them how to monitor their level of Race-Based Resilience (RBR) at various points throughout the supervision relationship. Supervision is a parallel process that involves transference and countertransference (Sumerel, 1994). These findings create implications for clinical supervisors to investigate their own Race-Based Resilience (RBR) to mitigate the potential impact on their supervisees. Before accepting new supervisees, supervisors can self-administer the Race-Based Resilience Scale (RBRS). Lower resilience scores may imply additional training and support are necessary to be more effective in their supervision work. It may also reveal the need to diversify the supervisees they support. In other words, not accepting all Black supervisees who work with Black populations. Conversely, supervisors can

administer the Race-Based Resilience (RBR) to their supervisees postulating insight

when building client loads. For instance, lower resilience scores may require the

supervisee to limit the number of trauma and Black clients they service.

The Race-Based Resilience Scale (RBRS) may be used as a starting place for

counselor educators and supervisors to help students and supervisees to focus on

resilience-building skills during their training program. Challenges within clinical work

are discussed in various courses, however, further exploration specific to Black mental

health counselors working with Black clients can better prepare them for foreseen

challenges connected to their race. Moreover, given the significance of how trauma

impacts Black people (Comas-Diaz, et al., 2019; Hemmings & Evans, 2018; Nadal et al.,

2019; Williams, et al., 2018a), counseling programs should consider adding a required

trauma course to programming with explicit discussion of racial trauma. Since Black

students and counselors who work with Black trauma survivors may be more likely to

experience burnout (Shell et al., 2021), it may be useful for incoming students to

complete a trauma assessment and an inventory identifying their susceptibility to burnout.

Ongoing assessment is necessary as results may change over time.

**Limitations**

Though this unique instrument addresses a gap in the literature, several limitations

were identified. First, respondents were predominantly women (n = 276). Men and

women are subjugated to experience different levels of racism.  An increased number of

men respondents could provide insightful information on their personal experiences of

Race-Based Resilience (RBR). Secondly, most respondents worked in private practice (n

= 145) eluding to some level of control in what presenting concerns they choose to serve.

Often, settings outside of private practice are not autonomous and require employees to maintain large, complex caseloads. Third, generalizing with a larger population poses a threat to external validity, as most respondents resided in the Southern and Midwest regions (n = 197). Furthermore, results may not be generalizable to Black counselors who do not utilize social media outlets or listservs. Fourth, a small correlation between social desirability and the Race-Based Resilience Scale (RBRS) was detected. Though self-reporting indicates some social bias, it may be significantly higher for Black people living in a Eurocentric nation. Previous studies on social desirability show a higher prevalence within racialized minorities due to cultural orientation and racial identity (Abrams & Trusty, 2004; Janus 2010; Kim & Kim, 2015).

**Future Direction**

The emergent factor solution in the EFA revealed three related dimensions of Race-Based Resilience (RBR). These results provide great promise as this is the first known race-specific resilience scale. Further investigation is needed to determine the influence of cultural factors that may have played a significant role. Social desirability is the propensity to under or overreport to be viewed as socially accepted. Paulhus (1984) identified two components of social desirability: impression management and self-deception. Impression management is described as a change in the presentation to fit a certain audience or situation. Self-deception is motivated by maintaining a positive position of the beliefs one holds about themselves and responses by others. Janus (2010) provided rationale for social bias in racial-ethnic populations when completing surveys is due to feeling pressured to conform to "normal" behavior, responses, or judgement. This position aligns with social scientists who believe social bias is standard behavior across

any social context. An (2014) argues the degree of exposure a racial-ethnic individual has within their group could guide the strength of social desirability. Furthermore, the scale selected to measure social desirability may not be culturally responsive. Often times, scales of measurements are not normed on racial-ethnic populations and cultural influences may not be a priority consideration when creating items. This creates grounds for new multicultural social desirability scales and/or modification of existing measurements.

Additional assessment of content validity of items may provide deeper insight into how items can be improved. DeVellis (2016) proposed a common practice in instrument development is to run multiple rounds of data collection.  It is also necessary to administer the Race-Based Resilience Scale (RBRS) and the MCSDS Form C to multiple racially minorized groups to revalidate the results. Eventually, a confirmatory factor analysis (CFA) is necessary to confirm to factor structure of the Race-Based Resilience Scale (RBRS). Mueller and Hancock (2001) identified a key advantage of CFA is making the connection between theory and observation. Using a CFA will help to identify potential shortcomings in specific items.

Throughout this research study, literature reiterated the significant role of culture. A qualitative study exploring how Black people define resilience may require modification of the Race-Based Resilience (RBR) definition, and consequently, a modified instrument. Since Race-Based Resilience (RBR) is a culmination of previous resilience definitions and Race-Based Traumatic Stress (RBTS), a longitudinal study surveying Race-Based Resilience (RBR) over a prolonged period could bolster (or require adjustment) to the Race-Based Resilience (RBR) definition. Continuing in the

vein of strength-based research, post-traumatic growth in Black professionals could provide additional insight into their resilience. Lazarus and Folkman (1984) suggest examining trauma recovery over an extended period can suggest patterns of strategies used to cope.

**Conclusion**

With this initial research, preliminary evidence indicates the Race-Based Resilience Scale (RBRS) is a reliable and validated measure of resilience in Black mental health counselors. Further analysis is needed to determine the scale discriminant validity relative to social desirability, though social desirability within racialized minority groups may be consistent in survey research. Additionally, a confirmatory factor analysis (CFA) is necessary to confirm the factor structure of the EFA. Nevertheless, the use of the Race-Based Resilience Scale (RBRS) will allow Black mental health counselors to self-evaluate their resiliency levels at various points in their training and career. The RBRS may also be a useful assessment tool for Black people in general and other racial-ethnic groups.

**Study 2:**

**Vicarious Traumatization and Resilience in Black Mental Health Counselors**

Black people have experienced oppression in ways that are different from other racial/ethnic groups who have endured persecution. Black people experience ongoing oppression even though chattel slavery has ended (Sellers et al., 1998; Vesely et al., 2019). Socioeconomic, cultural, systemic, and institutional structures can trigger daily reminders of how Black people in America and other Western nations experience disparities preventing them from living a fulfilling and successful life. Although Black culture is made up of various subcultures, commonalities exist within experiences of racial trauma (Anderson, 2019). Clark et al. (1999) noted examination of resilience within Black populations is necessary with the continued oppression they experience. Additionally, Black people have an increased susceptibility to experiencing numerous other negative life events such racial harassment, racial discrimination, and racial trauma that impact growth, life quality, and health (Cunningham et al., 2018). Forces that disrupt healthy functioning could cause lasting effects on health and well-being (Anderson, 2019).

Black people are ten times as likely to experience serious psychological disorders such as schizophrenia and bipolar disorder (LeCook et al., 2014). Black people experience posttraumatic stress disorder (PTSD) at higher rates (Sibrava, 2019) and at a higher level of severity and intensity (Trepasso-Grullon, 2012). Additionally, Lo et al. (2014) argued Black people have a lower prevalence of depression, whereas they experience chronic debilitating symptoms as a result of the depression. Scholars may have a poor understanding of the magnitude of Black people's psychological distress

when attempting to capture their experiences (Anderson, 2019).  Acknowledgment of the historical context of Black people is necessary for the conceptualization of how they adapt to emotional stressors.

### Racial Identity & Resilience

**Racial Identity & Resilience**

Race is a socially constructed term in the United States which characterizes people by their phenotypical features and language (Carter, 2007).  Race has played a significant role in the lives of Black people (Sellers et al., 1998).  In his works, *Strivings of the Negro People* (1897) and *Souls of Black Folks* (1901), W.E.B. Du Bois introduced a phenomenon that impacts Black people. Du Bois discusses the numerous complexities of the Black identity. He explains double consciousness is a "sense of always looking at oneself through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity" (Du Bois, 1897). Second sight is a term he used to illustrate Black people's self-awareness and sensitivity to the negative perceptions in the way they are perceived by White people, leading to the consolidation of two selves versus separation of them.

Racial identity is a frequently researched topic in social science that explores the psychological experiences of Black people (Sellers et al., 1998), though it does not exclusively focus on Black people.  In her White Identity Model, Helms (2008) challenged White people to become aware of their racial identity as it plays a significant role in racism citing it is their responsibility for ending it (Helms, 2008, p. v). She suggested that healthy White identity develops in two phases: internalization of racism and evolution of a nonracist White identity. Internalization of racism (contact,

disintegration, and reintegration) are used to hold firm to their current position, while evolution of a nonracist White identity (pseudo independence, immersion/emersion, autonomy) challenges White racial socialization norms (Helms, 1998, p. 29 – 30).

Two contrasting perspectives in the description of racial identity are identified as the mainstream approach and an underground approach (Gaines & Reed, 1994). Using a mainstream approach, early researchers such as Clark & Clark (1939) minimally addressed the role of culture in the Black experience, focusing on universal aspects and multiple identities to explain the development process of Black people. During the second civil rights movement, Black psychologists challenged the former perspective, including cultural experiences as a relevant piece of Black racial identity. The underground approach considered the lived experiences of Blacks to create a framework to explain what it means to be Black (Sellers et al., 1998).

An additional argument in defining racial identity is whether it is fixed or fluid. Former research identified racial identity as a static process (Saperstein & Penner, 2012). Contemporary researchers argue racial identity is a fluid process that changes over time (Cooley et al., 2018). In a 2015 research study implemented by Pew Research Center, 29% of the 1,557 multiracial participants at some point identified with one race but changed their perception. Alternatively, participants who once identified with multiple races switched to identify with a singular one (Pew Research Center, 2015). Malaysian and Singaporean participants in a study led by Reddy (2019) reinforced the idea as participants reflected on the evolution of multiple identities.

The Multidimensional Model of Racial Identity (MMRI) was created by Robert Sellers (Sellers et al., 1997) to address the incongruencies in the research of racial

identity. Supported by identity theory, MMRI attested that identity development is a continuous, cyclical process. This framework focuses on how Blacks identify themselves in terms of their race and how they identify within their racial group (Sellers et al., 1997). In the reconceptualization of the MMRI, Sellers and colleagues (1998) honored all previously discussed perspectives to provide a more comprehensive assessment of the Black racial identity. The four assumptions of MMRI are 1) identity is situationally influenced as well as stable 2) individuals have several hierarchical multiple identities, 3) an individual's perception of racial identity is the most valid indicator of their identity, and 4) is primarily concerned with the status of an individual's racial identity (see Figure 1).

To build upon the groundwork, four dimensions of the MMRI were developed. The first is *salience*, which involves a particular event that influences one's self-concept. For instance, a Black mental health counselor who only serves a white clientele might view their race as more salient in that context, versus another Black mental health counselor in a similar situation may not necessarily have the same level of racial saliency. Second, *racial centrality* is the more stable characteristic an individual possesses. Using the same example, the Black mental health counselor might examine body language or gestures a client demonstrates when they provide insight into the presenting concern. Racial centrality is not based on a particular situation; however, it is a consistent vantage point in how an individual sees themselves within their race. Third, *ideology*, represents the beliefs of how an individual feels people within their race should behave. In the final dimension, *regarding,* examines the positive and negative feelings that an individual has regarding their race. The MMRI was operationalized through the creation of the

Multidimensional Inventory of Black Identity (MIBI).  The MIBI is a hybrid of previous

identity scales including additions from Sellers and colleagues' previous work.  The

MIBI consists of three scales that measure centrality, ideology, and regard dimensions.

The ideology and regard scales have additional subscales included.  Salience was omitted

from the MIBI as it is best measured through experimental and quasi-experimental

methodologies (Sellers, et al., 1998).  Sellers et al (1998) proposed the new scale can be

used in a multi-method research approach when examining racial identity. The current

study adopts the MMRI theoretical framework to define racial identity as it acknowledges

the significance of race to the self-concept of Black people and the quantitative aspects of

being Black (Sellers et al., 1998).

Individuals with an unstable sense of identity may experience negative mental

health outcomes.  On the contrary, Black identity theorists agree that a positive identity

leads to healthier mental health functioning (Wilson et al., 2017).  Researchers have

noted racial identity can protect Black people from being overcome by systemic barriers

that can cause Race-Based Traumatic Stress (RBTS). In other words, racial identity can

bolster resilience. Indeed, Sellers et al. (2006) identified a correlation between

psychosocial well-being and racial identity. Other scholars reported connection with

other Black people counteracted depressive symptoms (M. Hughes et al., 2015) and

internalized racial identity attitudes have been associated with better psychological well-

being (Banks & Kohn-Wood, 2007; Franklin-Jackson & Carter, 2007; Mahalik et al.,

2006; Seaton, 2009). It can be presumed there is some resilience component embedded

within racial identity yet, only a few studies have investigated the relationship between

racial identity and resilience.  Likewise, most investigations about Black mental health

counselors and how their racial identity influences their resilience are either conceptual

pieces, unpublished dissertations, or uncharted territories in academic research.  To better

understand how Black people collectively negotiate obstacles related to race, a close

examination of the protective factors, such as personal vulnerabilities, external

influences, personal strengths, and racial socialization, are vital (Bowman, 2013; Brown,

2008).

## Differentiating Burnout, Compassion Fatigue, and Vicarious Traumatization

The professional quality of life of Black mental health counselors can be impacted

in numerous ways, therefore, describing counselor work stress can be complicated

(Newell, et al., 2016).  Commonly used terminology that investigates the professional

quality of life phenomenon is burnout, compassion fatigue (CF), and vicarious

traumatization (VT).  Burnout is a significant concern for mental health counselors as

well as their clients (Thompson et al., 2014; Viehl et al., 2017).  Pines and Maslach

(1978) introduced the concept of burnout as a psychological problem experienced by

social service professionals resulting from interpersonal distress.  Collings and Murray

(1996) concluded burnout is chronic stress that can impair work efficacy.  In an expanded

definition, Maslach (2003) conceptualized three dimensions of burnout: emotional

exhaustion, depersonalization, and feelings of ineffectiveness or lack of personal

accomplishment (Maslach et al., 1986).  Emotional exhaustion involves the perceived

inability to feel compassion, depersonalization is where the counselor disconnects from

the client to prevent empathy fatigue, and feelings of ineffectiveness or lack of personal

accomplishment involve the negative feeling of personal and career value (Lent &

Schwartz, 2012).  Bureaucracy (e. g. student-to-counselor ratio and resource limitations)

was seen as a contributing factor to burnout and hindered counselor work performance (Limberg, et al., 2017).

CF initially viewed as an interpersonal perspective similar to burnout, conversely, was attributed to working with trauma survivors (Molnar et al., 2017; Thompson et al., 2014). Sometimes labeled as secondary trauma or (VT), Figley (1995) declared VT as an organic response from knowing about trauma or doing trauma work. Stamm (2005) argued against the interchangeability of CF and VT. She identified two factors relative to CF as burnout and secondary traumatic stress. Burnout was defined as feelings of hopelessness and work impairment, while secondary traumatic stress was defined as work-related exposure (Laverdière et al., 2018). This study used the term VT defined by Figley (1995) as it speaks directly to trauma exposure Black mental health counselors experience when working with Black clients.

Using Constructivist Self-Development Theory (CSDT), Pearlman & Saakvitne, 1995 denoted VT is a different construct from other counselor impairments. Using CSDT, (Pearlman & Saakvitne, 1995) postulated people construct personal realities through the interpretation of life experiences. As they explore and develop themselves, they reconceptualize personal realities based on personal reference points and client trauma stories. Through past exposure to the material, counselors adapt their beliefs and worldviews to make sense of the trauma story (Pearlman & Saakvitne, 1995). Pearlman and Saakvitne indicated the counselor, type of work performed, and support factors determine the materialization of VT. Williams et al. (2012) examined the relationship between childhood trauma and the emergence of VT. Therapists who reported childhood trauma experiences were likely to experience VT, although, wellness activities mediated

the impact (Williams, et. al., 2012).  Clinical supervision was another variable considered, though the meditating effect was not significant.

A potential outcome of working with Black clients is Black mental health counselors experiencing VT through countertransference with their client or dissimilarities based on economic statuses and racial identity (Goode-Cross & Grim, 2016).  In a recent research study, Shell and colleagues (2021) investigated race-related stress, burnout, and secondary traumatic stress in Black mental health therapists. Researchers sought to determine if there was a correlation between race-related stress, secondary trauma, and burnout.  Of the 252 respondents, the average time employed in their current work setting for 5 years, with 8 years of professional experience in mental health.  Results revealed master's level counselors were more likely to experience exposure to traumatic events.  The more hours worked by a therapist, the more likely they were to experience VT (Shell et al., 2021).

There are notable literature gaps related to Black mental health professionals working in mental health.  First, investigation of how VT manifests is seemingly uncharted territory.  Secondly, little is known about Black mental health counselors' experiences working in same-race dyads (Goode-Cross & Grim, 2016).  Thirdly, a sizeable body of literature has surveyed work-related stress, nevertheless, there is only little available research on VT in racial-ethnic minority mental health professionals and how resilience is related (Burnett & Wahl, 2015).

**Racial Identity & Vicarious Traumatization**

Associations between racial identity and VT have only been minimally researched. A more commonly researched construct that can present similarly to VT is

posttraumatic stress disorder (PTSD). VT is perceived as a natural response when hearing or experiencing traumatic encounters (Figley, 1995). Categorized as an anxiety disorder, PTSD entails intense symptoms such as flashbacks, nightmares, and fear which may occur after witnessing, experiencing, or learning about a traumatic event (American Psychiatric Association, 2013). Previous research indicated racial-ethnic minorities experience a higher prevalence of PTSD symptoms than White counterparts. Various factors including socioeconomic (American Psychological Association, 2017), racial discrimination (Carter & Pieterse, 2020, p. 7; Chou et al., 2012), and higher incarceration rates (Nellis, 2021) could account for the differences. A 2012 study yielded contradictory results. Ghafoori and colleagues (2012) studied a group of 170 adults exposed to trauma and seeking treatment. Participants either experienced first-hand, witnessed, or was directly impacted by a traumatic event involving threat of death or severe injury. Results showed Black respondents were exposed to more trauma and religion than other groups, and their symptoms were less severe. Religion can be deemed an additional protective factor to manage trauma despite high exposure (Ghafoori, 2012; Trepasso-Grullon, 2012).

Scholars have investigated the role of racial identity in circumventing mental health conditions.  A stronger racial-ethnic identity is linked to higher levels of well-being (Hughes et al., 2015), while other empirical research has found no connection between ethnic identity as a protective factor for mental health conditions (Kaur & Kearney, 2013). The association was insignificant in a sample of youth in a state-administered residential facility and revealed no connection to ethnic identity and severity of PTSD symptoms (Kaur & Kearney, 2013). Racial identity concerning VT has

been investigated to a far lesser degree than PTSD. Research is needed to determine

whether a connection between the two constructs exists. When linked to resilience, racial

identity can be an additional protective factor that provides data on the experiences of

Black mental health counselors in same-race dyads.

### *Racial Centrality (RC)*

Individuals naturally tend to group themselves, as well as others, into social

groups (i.e., race/ethnicity, gender, age) (Tajfel & Turner, 1986). "A social group is a set

of individuals who hold a common social identification or view themselves as members

of the same social category" (Stets & Burke, 2000). Social identity theory supports the

idea contact with racial discrimination augments the importance of an individual's racial

group membership, therefore, mitigating the negative effects of the encounter (Tajfel &

Turner 1986). Seller et al. (1998) defined centrality as how an individual views

themselves within their racial group, not based on a specific situation. According to a

study conducted by Pew Research Center (2019), 74% of Black participants saw their

race as an important aspect of what they think about themselves. Some Black people may

seek to redefine negative societal perceptions of their group membership and themselves.

This may be a particularly challenging task for Black people who hold their race as a

central part of their identity. On the other hand, Black people who do not hold their race

as a focal point of their social identity may experience less impact of the stigma

associated with the group. A more specific form of racial centrality is gendered racial

centrality, which implies the saliency of race and gender intersections (Thomas et al.,

2011). In a recent study examining race and gender intersectionality, centrality moderated

the relationship between gender-specific racial microaggressions and negative mental

health outcomes (Lewis et al., 2017). Findings of another study supported the positive effects of racial socialization. Racial socialization, or verbal and nonverbal racial communication about racial experiences, has been identified as a safeguard to racial trauma (Lesane-Brown, 2006). Parents who frequently use racial socialization with their children can produce positive well-being factors including psychosocial and identity (Hughes et al. (2006). While intergroup connections promote resilience, Black mental health counselors still remain highly susceptible to traumatization. Hearing trauma narratives can reshape personal views and beliefs due to trauma exposure, in a similar way that their clients are impacted by trauma (Sabin-Farrell & Turpin, 2003).

### *Factors that Influence Vicarious Traumatization in Helping Professionals*

Past research proposes several factors that contribute to VT. For the purpose of this research, discussion about countertransference, personal trauma history, and compassion fatigue will be examined due to their psychological implications. VT may inhibit Black mental health counselors' work with their clients resulting in poor treatment planning or decision making, dissociation or disconnection from the therapeutic relationship, poor quality of client care, trauma responses, and ethical concerns.

Countertransference is a concept that suggests how VT could manifest (Pearlman & Saakvitne, 1995). Corey (1991) describes countertransference as a process a counselor over identifies with the client. Long-term effects could negatively influence a counselor's self-concept or expectations of themselves (McCann & Pearlman, 1990). Pearlman and Saakvitne (1995) explain countertransference and VT as two different processes that simultaneously interact with one another. Countertransference is specific to the experiences within the therapeutic relationship while VT is focused on the changes taking

place, for example, in the counselor's belief system. Other interactive processes may include defensiveness, reduction in self-awareness, and changes in counselor identity. Lack of acknowledgment of countertransference can create susceptibility to VT, consequently, increasing the counselor's vulnerability to complex levels of countertransference (Blair & Ramones, 1996; Pearlman & Saakvitne, 1995).

Personal experiences of trauma have compelled many mental health professionals to work with trauma survivors (Bray, 2018). Carl Jung coined the term "wounded healer" to signify unconscious pain counselors may experience triggered by a client's experience (Miller and Baldwin, 1987). To address personal pain, Black mental health counselors may pursue healing by helping others. (Rudick, 2012, p. 559). Client descriptions of their personal traumatic experiences can cause Black counselors to be triggered resulting in feelings of helplessness, hopelessness, and shame (Dunkley & Whelan, 2006; Williams et al., 2012). Past studies have concluded counselors with a trauma history have a significant risk to of experiencing VT than those with no reported trauma history (Leung et al., 2022; Sprang et al., 2007; Williams et al., 2012). In a recent systematic literature review, Leung et al. (2022) identified a clear association between personal trauma and VT. Though some studies support personal trauma as a risk factor for VT, counselors with no reported trauma are still at risk (Miller & Sprang, 2017). Williams and colleagues (2012) added counselors should remain attuned to their mental and physical well-being when being exposed to client trauma.

An additional factor that contributes to VT is compassion fatigue (CF). Distinguishable from burnout which is focused on environmental and organizational stressors, CF refers to psychological and emotional exhaustion due to interactions with

others (Turgoose and Maddox, 2016). CF was introduced by Joinson (1992) in a written piece on nursing. In her article, *Coping with Compassion Fatigue,* she identified some characteristics including, lack of enjoyment in life, helplessness, and irritability, that nurses experienced as a result of working with patients with chronic and long-term illness. Figley (1995) described CF as "the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). Similar to nurses, in a study of 236 social workers who worked in New York City during the 9/11 terrorist attacks, results supported CF yielded a positive correlation with victims of the terrorist attack (Boscarino, et al., 2004). CF has been shown to be compounded if the mental health professional has a family history of substance abuse or having family members with mental illness (Perkins & Sprang, 2013; Shell et al., 2021). Hearing trauma narratives as a profession, experiencing intergenerational and historical trauma, further intensifies the susceptibility of VT for Black mental health counselors and justifies the need for resiliency skill-building.

**Resilience in the Helping Profession**

Several studies have been conducted assessing student resilience within health professions. An analysis of resilience amongst dental students investigated the relationship between resilience and demographic characteristics using the Resilience Scale for Adults (RSA). Resilience was found to be statistically significant based on gender, race, and mental health (Smith et al., 2020). Females reported higher rates of resilience. Less than 40% of the participants identified as a racial-ethnic minority, while Black people made up only 7% of the data.  Black people also reported less

resilience than their white counterparts. The data could not provide a rationale, yet it indicated membership of the non-dominant group could have a relationship with resilience. In addition to the Resilience at University (RAU) scale, the RSA scale was also utilized in a study of occupational therapy students with predominant ages ranging from 20 – 24. Students were predominantly women who enrolled full-time in the occupational program, with most not enrolling directly after high school. Findings revealed a correlation between resilience, stress management, coping strategies, and performance (Brown et al., 2019).

Counselor resilience research in social science is sparse, with a primary focus on behaviors that enhance the work experience (McCann et al., 2013). Viehl et al. (2017) found perceptions of workplace support predict resilience among sexual minority mental health professionals. In an international research study conducted amongst 610 psychological counselors in the Kingdom of Saudi Arabia, a structural equation model (SEM) was used to assess the correlation between gratitude, resilience, well-being, and counselor creativity. The findings yielded gratitude and resilience predict creativity. Resilience can be defined differently in contexts outside of the United States. An additional limitation of this study noted psychological counselors do not encompass psychologists, psychotherapists, and psychiatrists and that further study is necessary for these other helping professionals (Arnout & Almoeid, 2020), therefore, resilience could potentially be exhibited in different ways in the excluded mental health professionals.

### Resilience in Black Mental Health Professionals

Being Black automatically predisposes Black people to traumatic injury regularly, given that they are highly susceptible to elevated levels of adversity (Roberts et al.,

2011). The study of resilience in Black mental health counselors is paramount as these counselors are dually exposed when working with their Black clients.  Black liberation psychology notes a healthy mental state is an essence of what is needed to battle discriminatory environments (Thompson & Alfred, 2009). A lack of resilience could advance to VT. This negative outcome can cause impairment of work functioning, job contentment, poor performance, inability to function at optimal levels, and leaving professional positions (O'Connor et al., 2018; Viehl et al., 2017).

Resilience is a response to trauma (Bonanno, 2005); however, trauma responses can differ. Not all Black mental health counselors are impacted by the traumas of their clients. Many find great rewards working in with clients from the same racial background. In a phenomenological analysis of Black psychologists, a mutual theme amongst participants was understanding the cultural context of working with Black clients. Therapists related to the challenges of facing racial discrimination and microaggression. The experiences of working with Black clients invigorated them and made the work meaningful (Goode-Cross & Grim, 2016). Empirical research examining and explaining resilience in Black mental health counselors and what inoculates them from VT when working with their Black clients are underdeveloped.

**Present Study**

This study aims to assess the relationship between VT, racial identity, and Race-Based Resilience (RBR) in Black mental health counselors. The research questions guiding this study are:

1. Is there a difference in Vicarious Traumatization (VT) for Black mental health counselors with moderate and high levels of Racial Centrality (RC)?

2. Is there a difference in Race-Based Resilience (RBR) for Black mental health counselors with moderate and high levels of Racial Centrality (RC)?

The inferred hypotheses to address the above research questions are:

1. Black mental health counselors with moderate to high levels of Racial Centrality (RC) are strong predictors of lower levels of Vicarious Traumatization (VT).

2. Black mental health counselors with moderate to high levels of Racial Centrality (RC) are strong predictors of higher levels of Race-Based Resilience (RBR).

## Methods

**Respondents**

The sample included Black-identified mental health professionals with at least a master's level education. In this study, Black is defined as individuals who are descendants of native Africans or people from Africa. Mental health professions included counseling, marriage and family therapy, social work, psychology, psychiatry, and substance abuse. Master-level means post-secondary education with an awarded master's degree. After the data was prepared, the final sample consisted of 300 participants. A majority of the respondents identified as woman (n = 276, 92%) working predominantly in the counseling profession (n = 169, 56.3%). About 45% (n = 137) of respondents worked between 10 – 25 hours per week with the private practice sector (n = 145, 48.3%). Respondents largely represented the Southern region (n = 131, 43.7%) followed by the Midwest Region (n = 66, 22%). A small portion of respondents identified as multiracial (Black and another ethnicity) (n = 21, 7%). Ninety-eight respondents (32.7%) had under 2 years of licensed experience. Approximately 55% (n = 164) spent 2 – 4 years

in their master's and/or doctoral training program before becoming fully licensed (see

Table 1.).

**Instrumentation**

This study was interested the predictability of Racial Centrality (RC) related to

Vicarious Traumatization Scale (VTS) and Race-Based Resilience (RBR). An

independent samples t-test using the Racial Centrality (RC) subscale as an independent

variable at two levels with the Vicarious Traumatization Scale (VTS) and Race-Based

Resilience (RBR) as dependent measures.

*Demographic Measure*

Demographic information was collected relative to the following characteristics:

(a) age, (b) gender, (c) racial/ethnic background, (d) immigration status, (e) level of

education (master's, specialist [post master's], doctoral), (f) professional identity

(counseling, marriage and family therapy, psychiatry, psychology, social work, substance

abuse), (g) years of licensed professional experience in mental health counseling, (h)

years of licensed professional experience in mental health counseling, (i) amount of time

spent in training, (j) number of clinical hours worked per week, (k) current work setting,

(l) region of the U.S. resided in, (m) country of residency if outside of the United States,

(n) experiences of being Black in the United States, and (o) referral source of completing

the survey.

*Race-Based Resilience Scale (RBRS)*

To measure Race-Based Resilience (RBR), a new instrument, the Race-Based

Resilience Scale (RBRS) was predominantly informed by the Connor-Davidson

Resilience Scale (CD-RISC) which yielded strong psychometrics in various translations

and populations (Connor-Davidson, 2018). Normed on Black mental health counselors, the Race-Based Resilience Scale (RBRS) measures Race-Based Resilience (RBR). the Race-Based Resilience Scale (RBRS) encompasses a three-factor solution consisting of 14-items with three subscales (a) Self-efficacy, (b) Coping mechanisms, and (3) Multicultural and Social Justice Advocacy. During initial construction, Cronbach's coefficients alpha values for each factor were $\alpha = .817$, $\alpha = .788$, $\alpha = .761$, respectively. In the present study, the Cronbach's alpha reliability was .868.

### *Multidimensional Inventory of Black Identity – Racial Centrality subscale*

The Multidimensional Inventory of Black Identity (MIBI) was created to operationalize Multidimensional Model of Racial Identity (MMRI) (Sellers et. al, 1998) and measure Black identity (Vandiver et al, 2009). This 56-item inventory consists of three scales that measure centrality, ideology, and regard dimensions. The ideology scale consists of four subscales (nationalist, assimilation, minority, and humanist) and the regard dimension has two subscales (private regard and public regard). Description of questions includes better able to reassess dimensions of problems and better able to assess level of stress. A 7-point Likert scale of measurement, ranging from (1) strongly disagree to (7) strongly agree.  Since the MIBI is based on the multidimensional conceptualization of racial identity, it is not appropriate to calculate a total score (Sellers et al, 1998). Cronbach's alpha range is .60 to .80 range for the MIBI subscales (Sellers et al., 1997; Simmons et al., 2008). Only the Racial Centrality (RC) subscale of the MIBI was utilized in the present study and yielded a Cronbach alpha reliability of .736.

### *Vicarious Traumatization Scale*

The Vicarious Traumatization Scale (VTS) is used to measure vicarious trauma

(Vrklevski & Franklin, 2008).  This eight-item measure uses a 7-point Likert scale,

ranging from (1) strongly disagree to (7) strongly agree. Description of questions include

"My job involves exposure to distressing material and experiences" and "It is hard to stay

positive and optimistic given some of the things I encounter in my work." A total

Vicarious Traumatization Scale (VTS) score can be obtained by summing responses to

items, with higher scores indicating more VT.  Low VT is indicated by a range of 8 to 28,

moderate VT with a score range of 9 to 42, and high VT is indicated by a range of 43 to

56 (Aparicio et al., 2013).  In the present study, the Cronbach's alpha reliability was .721.

**Procedure**

After modification, items were entered into an electronic survey platform,

Qualtrics. Three doctoral-level students analyzed the survey before distribution.

Following the Institutional Review Board (IRB) approval, convenience and snowball

sampling were used for recruitment to the targeted population. The call for respondents

was distributed through four main social media platforms: Meta (formally Facebook),

Instagram, LinkedIn, and Twitter. Counselor directories (i.e., Therapy for Black Girls,

Clinicians of Color, and Psychology Today) and listservs designated for counselors and

counselor educators were also utilized. Data were collected from December 2021 to

March 2022. Approximately 30,000 mental health professionals were invited to

participate in this research study. A large participant sample assists in concluding the

sampled population (Heppner et al., 2016, p. 176). Lower statistical power is a threat to

statistical validity that increases the risk for Type II errors (Heppner et al., 2016, p. 143).

An a priori alpha level was established at $\alpha = .05$, $1-\beta = .95$, $H_0$: $p = 0$ and $H_1$: $p \neq 0$.

G*Power, version 3.1.9.7 was used to determine the minimum sample size (Faul et al,

2009; Faul et al., 2017). To achieve medium effect size, a minimum of 138 participants was necessary ($p = .30$) (Cohen, 1988, p. 80).

Participants were presented with informed consent and given the option to decline participation at any time throughout the study. Demographic information was collected followed by six separate surveys. Participants were given the option to participate in a raffle for a chance to win one of fifty $25 gift cards. Once downloaded into IBM Statistical Package for Social Sciences (SPSS) 27, variables were renamed and relabeled, then updated to depict the appropriate level of measurement. All MIBI subscales except for Centrality were deleted. Gender was dummy coded followed by removal of rows not pertinent to the data. These included start date, end date, IP address, finished, recorded date, response ID, recipient last name, recipient first name, recipient email address, external reference, location longitude, location latitude, distribution channel, user language, and score. Additionally, the progress, status, duration in seconds, and Q_ReCAPTCHA were reviewed for abnormalities before being removed. One participant was removed with a reCAPTCHA score of .40 due to being a suspected bot (Qualtrics, 2022).

Demographic questions were reviewed to confirm eligibility for participation Seven participants were removed due to failure to provide their age. Two participants were removed due to not providing a race/ethnicity and four were removed due to not identifying as Black. The education level of three participants was missing, consequently, data was deleted. Thirty-nine participants did not confirm their professional identity as mental health professionals and were discarded. Fifty-three participants only completed demographics and an additional twenty-six only completed the demographic and Race-

Base Resilience Scale (RBRS). These participants were removed. The first quality check question was disregarded if answered incorrectly as there was a noted error. Twenty-three participants were removed for answering at least one of the quality check questions incorrectly. Sixty-one participants were missing all responses to critical variables for study two and were removed.

Applicable items were recorded and scores were calculated. Excluding the MIBI Centrality subscale, all scales were added as sum scores. The MIBI Centrality subscale was calculated by the mean score of the individual subscale. Examination of missing values in any field was reviewed. To address the missing values, mean scores were plugged into the MDSDS Form C, VRS, MIBI, and VTS scales. Descriptives were examined to determine z-scores $> 3.29$ and $< 3.29$ (Tabachnick & Fidell, 2013). Two univariate outliers on the MIBI Centrality subscale (-3.80006, -3.67127) were detected and removed. Using Mahalanobis to detect multivariate outliers, one respondent larger than the critical value of .001 was removed (.00195).

While each variable denoted skewness and kurtosis were within the acceptable range of absolute value 2 (George & Mallery, 2010). Though the MIBI Centrality subscale presented as platykurtic, the values were in an acceptable range (less than absolute value 2). Q-Q plots were examined with most points falling close to the fit line. Bivariate scatterplots were grouped in an oval-shaped formation, with minimal points for the VRS and MIBI Centrality subscale close to the cluster. A Levene's test was run to assess for homoscedasticity ($p < 0.05$), with no detected violations of homogeneity of variance noted. Frequencies were run to determine if there were any missing values. None were detected.

To determine the presence of multicollinearity, four tests were run. First, the correlation analysis did not yield a high correlation among predictors. Next, the value of tolerance noted tolerance was not < 0.1 and VIF was not > 10. Lastly, the condition index in collinearity diagnostics was examined. Research supports multicollinearity should be further assessed if the condition index is above 15 (Belsley et al., 1980). Conditions above 30 indicate strong multicollinearity. The condition index for the MIBI Centrality subscale was 16.696. Variance proportions were assessed to determine if at least two were above .90. Multicollinearity was not a concern as only one score was above .90 (.98).

**Data Analysis**

*Main Analysis*

For each hypothesis, an independent t-test was used to compare groups of Black mental health counselors with moderate to low levels of Racial Centrality (RC). Independent-samples t-test are used when the research wants to compare the mean score of two independent groups of respondents (Pallant, 2016, pp. 470). Racial Centrality (RC) was the independent variable in each hypothesis, while VT and Race Based Resilience (RBR) were dependent variables in hypothesis one and hypothesis two, respectively. Prior to selecting this parametric technique, several assumptions were satisfied. First, each group was reviewed to ensure they were independent of one another. Data was grouped into two categories. Group 1 consisted of respondents with a mean score of 3 to 5 on the Racial Centrality (RC) subscale, while respondents in Group 2 had a mean score of 6 to 7. Though there is no formal cu-off point of low, moderate, and high levels of Racial Centrality (RC), this study denotes Group 1 as having moderate Racial

Centrality (RC) and Group 2 is considered to have high levels of Racial Centrality (RC). Next, the Vicarious Traumatization Scale (VTS), Race-Based Resilience Scale (RBRS), and Racial Centrality (RC) level of measurement were examined for accuracy. Pallant (2016) denoted the dependent variable should be continuous whenever possible which allow for flexibility in technique when analyzing the data. Both the VTS and Race-Based Resilience Scale (RBRS) were updated to scale, while the independent variable, Racial Centrality (RC) remained nominal. Finally, during the cleaning process, data was identified as normally distributed with no detected homoscedasticity.

## Results

Preliminary analyses were conducted to detect violations in normality, linearity, multicollinearity, and homoscedasticity. No violations were detected. Using a Pearson coefficient correlation, incidental findings noted a significant correlation between demographic variables and the Race-Based Resilience Scale (RBRS), significant correlations were noted: years licensed and Race-Based Resilience Scale (RBRS) ($r =$ .140, $p < 0.05$); age and Race-Based Resilience Scale (RBRS) ($r = .221, p < 0.01$); age and Vicarious Traumatization (VT) ($r = -.116, p < 0.01$); number of hours worked and Vicarious Traumatization (VT) ($r = .235, p < 0.01$); Race-Based Resilience Scale (RBRS) and Vicarious Traumatization (VT) ($r = -.248, p < 0.01$).

### Racial Centrality (RC) and Vicarious Traumatization (VT)

To test the first hypothesis that Black mental health counselors with moderate to high levels of Racial Centrality (RC) experience lower levels of VT, an independent samples t-test was conducted to compare the VT scores for Group 1 (moderate) and Group 2 (high) in Racial Centrality (RC). There is no significant difference in scores for

Group 1 (*M = 34.48, SD = 6.871*) and Group 2 (*M =33.99, SD =7.501*); *t* (180) = .551, p

= .58, two-tailed). Hypothesis 1 was not supported (see Table 4). See Table 5 for means,

standard deviations, and correlations between Race-Based Resilience (RBRS) factors,

Vicarious Traumatization (VT), and Racial Centrality (RC).

**Racial Centrality (RC) and Race-Based Resilience (RBR)**

To test the second hypothesis that Black mental health counselors with moderate

to high levels of Racial Centrality (RC) are a strong predictor of higher levels of Race-

Based Resilience (RBR), an independent samples t-test was conducted to compare the

Vicarious Traumatization (VT) scores for Group 1 (moderate) and Group 2 (high) in

Racial Centrality (RC). There was not a significant difference in scores for Group 1 (*M =*

*57.30, SD = 10.303*) and Group 2 (*M =58.22.99, SD =9.356*); *t* (152) = -.721, p = .47,

two-tailed). Hypothesis 2 was not supported (See Table 4). See Table 5 for means,

standard deviations, and correlations between Race-Based Resilience (RBRS) factors,

Vicarious Traumatization (VT), and Racial Centrality (RC).

## Discussion

This research study explored predictors of Vicarious Traumatization (VT) and

Race-Based Resilience Scale (RBRS) in relation to Racial Centrality (RC) in a sample of

Black mental health counselors. Findings from the current study suggested there is no

significant difference in the levels of Vicarious Traumatization nor Race-Based Resilience

(RBR) for Black mental health counselors with moderate to high levels of Racial Centrality

(RC). Although the hypotheses were not supported, it proves the need for synthesis on

protective factors in Black mental health counselors. Additional investigation will expand

this body of growing literature while providing insight on potential cultural influences.

Hypothesis 1, that Black mental health counselors with moderate to high levels of Racial

Centrality (RC) are strong predictors of lower levels of VT, was not supported.

Hypothesis 2, that Black mental health counselors with moderate to high levels of Racial

Centrality (RC) are strong predictors of higher levels of Race-Based Resilience (RBR)

was not supported. These findings were supported by Kaur and Kearney (2013) and

suggest that ethnic identity is not identified as a protective factor.  Contrarily, studies by

several scholars oppose these results.  In a sample national survey of 3,570

institutionalized Black people, M. Hughes et al. (2015) supported social identity theory in

that Black people who strongly identify with other Black people view the group more

positively. Additionally, Black people who are more closely connected to their group

experience few depressive symptoms and higher self-esteem. Sellers et al.

(2006) identified a positive correlation between psychosocial well-being and racial

identity. Black people with higher public regard (other groups attitudes about another

group) were linked to positive psychological functioning. Yet another study of using a

sample of 333 Black, young adults revealed high racial identity bolsters protective

characteristics (Brook & Pahl, 2005).

**Implications for Counseling**

This study yields various implications for Black mental health counselors,

counselor educators, and counselor training programs. A myriad of studies emphasizes

the importance of mental well-being for mental health professions and support the need

to build resiliency skills. Since Black mental health counselors may be able to over relate

to similar experiences of their clients of the same racial-ethnic background, there is a

high probability for countertransference to occur, and essentially, lead VT if unaddressed.

Countertransference is a basic principle that is sprinkled through several courses in

counseling, however, its connection to VT may be missing. Counseling training programs are obligated to stress the importance of well-being as an ethical practice. Ethical codes created by ACA, APA, and NASW amongst others, have been amended to include self-care and well-being components demanding mandatory attention.

Going into a counseling training program, students may have a general understanding or speculation of what VT is. Providing real-life examples of how vicarious traumatization develops through various facets allows students to connect with the material and foreshadow how certain situations could impact them personally. Clinical supervisors supervising Black practicum or internship supervisees need to be aware of the overarching narratives of Black cultures. This knowledge not only allows for stronger cohesion within the supervisor-supervisee relationship, but it helps supervisors detect early warning signs of VT and their level of resilience. Resilience building techniques, such as self-awareness, increasing self-confidence, and identifying strong support alliances, can be incorporated throughout supervision meetings times. Furthermore, Black counselors in practice that serve as mentors and support figures have an impactful position by providing first-hand experience of their work with Black clients. It is beneficial for them to share the highs and the lows of the work as they may be sought after before a course instructor.

Though the degree of susceptibility varies depending on various factors (i.e., personal trauma history, direct practice, providing supervision), is it vital for new and future Black mental health professionals to be on the defense and develop a personal self-care plan early in their training programs. Some components of the plan can include engaging in personal therapy. Personal counseling is encouraged to enhance self-

awareness of issues that could both positively and negatively impact clinical work with trauma survivors. Often times, it is a requirement in graduate training programs. Administering self-assessments like the Race-Based Resilience Scale (RBRS), Pro-QOL, and VRS can was help assess one's ability to find balance in their clinical work. Creating a support system of individuals at different levels in their mental health profession can provide diverse perspectives of how to prevent and counteract automatic challenges that come along with the territory of being a Black mental health professional.

**Limitations**

Like all research, limitations were identified. First, neither hypothesis was supported. One reason may be due to the element of social desirability. Social desirability or bias when respondents completing self-reported surveys answer in favorable manner. One speculation is the researcher's Black identity could have influenced responses. For example, a Black researcher seeking to obtain experiences of Black people allows potential respondents to feel connected to the researcher, though, there is a high probability the relationship will not extend beyond data collection. Additionally, Black researchers targeting Black populations may experience great success in obtaining the desired number of respondents. On the other hand, since the racial identity of the researcher was similar to the identity of the respondents, respondents may have felt compelled to any questions in a way that was more appealing to the researcher. Although the research is anonymous, respondents may have felt the need to answer questions in a way that proves their security and confidence level in their "blackness". Another speculation supports An (2014) the degree of exposure to one's group could include the strength of social desirability within that group.

Another group of limitations lie with the scales of measurement. The Vicarious Traumatization Scale (VTS) only sampled a small subset of people during scale development. While all respondents were identified as working with trauma, cultural influences may not have been captured. One measure utilized in this study was a new constructed measure, Race-Based Resilience Scale (RBRS). While there was a confirmatory factor analysis (CFA) was conducted during initial construction, several runs and potentially modifications are necessary to strengthen the content validity (DeVellis, 2016). Since there is no formal way to categorize low, moderate, and high levels of Racial Centrality (RC), groups may not have been divided in a way that captures the intent of study. Surprisingly, no respondent answered questions in a way indicative of low Racial Centrality (RC) (mean scores under 3). An extensive search of existing literature could assist in grouping the data appropriately.

Yet another group of limitations focus on demographics. Respondents were predominantly women (n = 276) who work in a private practice setting (n = 145). Capturing perspectives of Black men, as well as Black mental health counselors working outside of private practice could provide insightful information on their personal experiences of mental health counselors, reducing the bias in the results that may exist. Past literature supports Black people typically seek services from Black providers, however, demographic questions did not capture specific characteristics of the Black counselors' clientele (i.e., racial-ethnic background, sexual orientation, insurance status, etc.). Overrepresentation of the Southern and Midwest regions (n = 197) may make it difficult to generalize to a larger population and is a threat to external validity. Additionally, since most respondents were captured via social media, directories, and list

servs, results may not be generalizable to Black counselors who do not utilize these outlets to obtain clientele.

**Future Direction**

The hypotheses of the current study did not support racial centrality (RC) as a predictor for vicarious traumatization (VT). However, Kaur & Kearney (2013) supported the hypothesis in a similar construct in racially diverse adolescents. Ethnic identity was unrelated to PTSD symptoms. An element of consideration for future study is to examine how the role of race influences vicarious traumatization (VT). The researcher identified the cut-off points that denote low, moderate, and high levels of racial centrality (RC), though these cut-off points may not be an appropriate. Running the current analysis at different cut-off points could yield different results.

Racial centrality (RC) did not predict Race-Based Resilience (RBR) in this study. During the initial development of the Race-Based Resilience Scale (RBRS), social desirability was detected. The element of social desirability is linked to impression management (Paulhus, 1984). Impressment management is the intentional way one presents their self to satisfy a certain audience (Paulhus, 1984). More research is needed in various occupational settings and racialized minority groups as social desirability is more commonly studied in college students (Perinelli & Gremigni, 2016). Though social bias is noted to negatively impact study results (Latkin et al., 2017), for racial-ethnic groups it could be perceived as a protective factor. Since research supports higher levels of social desirability in racial-ethnic groups (An, 2014), a new line of research investigating social desirability related to racial centrality and resilience in Black mental health counselors can provide useful insight into their experiences. An additional theme

of study could be focused on self-monitoring theory. Furthermore, revalidation of the

Race-Based Resilience Scale (RBRS) in other racial minority populations is needed. The

Race-Based Resilience Scale (RBRS) was the only scale in this study that was normed on

a racialized minority group. Many scales used in social science are normed of White

populations and fail to consider culture. The results of studies using these scales may not

accurately depict the true experiences of the respondents. Prior to using any scale of

measure in Black or other racial minority groups, researchers must go beyond using a

scale based on reliability and validity. Cultural influences should be addressed in content

validity. If not, the scale should not be used in its current form. Modification to fit the

research audience is necessary.

**Conclusion**

Despite the limitations of the current study, examining the connection between

Vicarious Traumatization (VT), Race-Based Resilience (RBR), and Racial Centrality

(RC) is essential in the professional life of Black mental health counselors that service

predominantly Black clients. Previous research supports the positive influence racial

identity and group cohesion has on well-being and mitigating effect of mental health

related to Race-Based Traumatic Stress (RBTS), self-esteem, and mental health

conditions (Cunningham et al., 2018; Sellers et. al., 2006). This study found that moderate

to high levels of Racial Centrality (RC) did not predict lower levels of Vicarious

Traumatization (VT), nor did they predict higher levels of Race-Based Resilience (RBR).

These results justify the need for further exploration of protective factors that may influence

the professional work of Black mental health counselors.

<div align="center">

**Section 3 - Conclusion**

</div>

The research presented in this dissertation series expands current literature on Vicarious Traumatization (VT) and Racial Centrality (RC). Additionally, it introduces a new construct and scale, namely, Race-Based Resilience (RBR). Article 1 revealed a three-factor solution with good factor loading for the Race-Based Resilience Scale (RBRS). The Cronbach alpha and item correlation of the scale yielded preliminary evidence of adequate to good internal consistency reliability. Findings were overall positive with all hypotheses being supported, though there a small correlation between to the Race-Based Resilience Scale (RBRS) and **t**he Marlowe-Crowne Social Desirability – Short Form, Form C (MCSDS Form C). Existing scales that measure social desirability may exclude the experiences of racial-ethnic groups and more specifically, Black people. New and modified social bias measures could be needed. Nevertheless, social desirability within racialized minorities may be a constant in survey research. Article 2 showed no significance between moderate to high levels of Racial Centrality (RC) and levels of Vicarious Traumatization (VT) and Race-Based Resilience (RBR). Contradictory studies supported by Sellers et al. (2006) and Hughes et al. (2015) amongst numerous other scholars confirm the need for further validation of the results. There may be opportunity to conduct replicative studies on older studies to validate the findings.

This dissertation studies increased available literature of Black mental health counselors, however, there is much ground to cover over a large amount of uncharted territory. Several runs of the new Race-Based Resilience Scale (RBRS) with different racial-ethnic groups will provide opportunity to perfect the measure. A deeper dive into the available data may provide opportunity to create a conceptual framework as a foundation for conducting resilience research using racial-ethnic minority samples. Existing scales used in the study series can be further examined to ensure cultural influences are embedded

throughout. The possibilities are innumerable.

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**Tables**

**Table 1.**

*Demographic Variables*

| Variable | n | % |
| --- | --- | --- |
| Age | | |
| 18 - 24 | 2 | 0.7% |
| 25 - 34 | 95 | 31.7% |
| 35 - 44 | 116 | 38.7% |
| 45 - 54 | 61 | 20.3% |
| 55+ | 26 | 8.7% |
| Gender | | |
| Woman | 276 | 92.0% |
| Man | 23 | 7.7% |
| Non-binary | 1 | 0.3% |
| Race | | |
| African American/Black | 279 | 93.0% |

| | | |
|---|---|---|
| Multiracial (with Black) | 21 | 7.0% |
| **Immigration Status** | | |
| Recent Immigrant | 1 | 0.3% |
| First Generation | 9 | 3.0% |
| Second Generation | 9 | 3.0% |
| Third Generation | 1 | 0.3% |
| Fourth Generation | 2 | 0.7% |
| Other | 2 | 0.7% |
| Unsure | 7 | 2.3% |
| Not an Immigrant | 269 | 89.7% |
| **Education Level** | | |
| Master's | 211 | 70.3% |
| Specialist (post Master's) | 23 | 7.7% |
| Doctoral | 66 | 22.0% |
| **Professional Identity** | | |
| Counseling | 169 | 56.3% |

| | | |
|---|---|---|
| Marriage & Family Therapy | 28 | 9.3% |
| Psychiatry | 1 | 0.3% |
| Psychology | 25 | 8.3% |
| Social Work | 66 | 22.0% |
| Substance Abuse | 2 | 0.7% |
| Other | 9 | 3.0% |
| # of Years Licensed | | |
| Under 2 | 98 | 32.7% |
| 2 - 4 | 59 | 19.7% |
| 5 - 7 | 59 | 19.7% |
| 8 - 10 | 23 | 7.7% |
| Over 10 | 58 | 19.3% |
| No response | 3 | 1.0% |
| # of Years Unlicensed | | |
| Under 2 | 67 | 22.3% |
| 2 - 4 | 90 | 30.0% |

| | | |
|---|---|---|
| 5 - 7 | 57 | 19.0% |
| 8 - 10 | 22 | 7.3% |
| Over 10 | 57 | 19.0% |
| No response | 7 | 2.3% |
| # of Years Training | | |
| Under 2 | 18 | 6.0% |
| –2 - 4 | 164 | 54.7% |
| –5 - 7 | 78 | 26.0% |
| –8 - 10 | 24 | 8.0% |
| Over 10 | 15 | 5.0% |
| No response | 1 | 0.3% |
| # of Clinical Hours/Week | | |
| Under 10 | 30 | 10.0% |
| –0 - 15 | 46 | 15.3 |
| –6 - 20 | 45 | 15.0% |
| –1 - 25 | 46 | 15.3% |

| | | |
|---|---|---|
| −6 - 30 | 32 | 10.7% |
| −1 - 35 | 22 | 7.3% |
| −6 - 40 | 43 | 14.3% |
| Over 40 | 35 | 11.7% |
| No response | 1 | 0.3% |
| Work Setting | | |
| Private Practice | 145 | 48.3% |
| Mental Health Agency | 57 | 19.0% |
| Hospital | 17 | 5.7% |
| Children's Division | 2 | 0.7% |
| In-home | 2 | 0.7% |
| School | 30 | 10.0% |
| Other | 47 | 15.7% |
| Region of Residence | | |
| New England (ME, RI, VT, CT, NH, MA) | 9 | 3.0% |
| Mid-Atlantic (NY, NJ, PA) | 38 | 12.7% |

| | | |
|---|---|---|
| Southern (VA, WV, KY, DE, MD, NC, SC, TN, AR, LA, FL, GA, AL, MS) | 131 | 43.7% |
| Midwest (MI, ND, SD, IA, MN, KS, NE, OH, IN, IL, WI, MO) | 66 | 22.0% |
| Southwest (TX, AZ, NM, OK) | 39 | 13.0% |
| Rocky Mountains (MT, ID, CO, UT, WY, NV) | 4 | 1.3% |
| Pacific Coastal (CA, OR, WA) | 10 | 3.3% |
| Alaska | 1 | 0.3% |
| Other | 1 | 0.3% |
| No response | 1 | 0.3% |

**Table 2.**

*Results from Factor Analysis of the Race-Based Resilience Scale (RBRS)*

| RBRS Item | Factor Loading | | |
|---|---|---|---|
| | 1 | 2 | 3 |
| Factor 1: Self-Efficacy | | | |
| 18. I work to attain my goals, no matter what roadblocks related to my race I encounter along the way. | **.898** | .00 | .00 |
| 16. I have a strong sense of purpose in life, regardless of the racism I may encounter. | **.698** | .00 | .00 |
| 19. I take pride in my achievements regardless of the misconceptions about my race. | **.617** | .00 | .00 |
| 9. Even when things look hopeless because of my race, I don't give up. | **.602** | .00 | .00 |
| 8. I believe I can achieve my goals, even if there are obstacles related to my race. | **.554** | .00 | .00 |
| 11. When my race presents a barrier, I stay focused and on task. | **.326** | .00 | .00 |
| Factor 2: Coping Mechanisms | .00 | .00 | .00 |
| 3. I am able to cope/function in order to deal with race-related stress. | .00 | **.805** | .00 |
| 1. I am able to adapt when I am faced with racism. | .00 | **.784** | .00 |

| | | | |
|---|---|---|---|
| 4. Past successes in navigating racism and race-related stress gives me confidence in dealing with new challenges and difficulties with racism and race-related stress. | .00 | **.569** | .00 |
| 15. I am able to handle unpleasant and painful feelings related to race-related stress like sadness, fear, and anger. | .00 | **.515** | .00 |
| Factor 3: Multicultural and Social Justice Advocacy | .00 | .00 | .00 |
| 20. I am able to advocate for myself when I am faced with racism. | .00 | .00 | **.749** |
| 7. When encountering racism, I give my best effort to address it, no matter what the outcome may be. | .00 | .00 | **.749** |
| 12. I take initiative to handle race-related stress. | .00 | .00 | **.645** |
| 17. I feel in control of my life when faced with racism and race-related stress. | .00 | .00 | **.339** |

*Note. N = 300.* The extraction method was principal axis factoring with an oblique (oblimin with Kaiser normalization) rotation.

Factor loading above .30 are in bold. Adapted from "Using Factor Analysis in Test Construction", by D.L. Bandalos and J.J. Gerstner, 2016, *Principles and Methods of Test Construction: Standards and Recent Advances*, pp. 26 – 51 and "Factor Analysis" by J.F. Hair, W.C. Black, B.J. Babin, R.E. Anderson, 2010, *Multivariate Data Analysis* (7th ed.), pp. 91 – 152.

**Table 3.**

*Intercorrelations Between Race-Based Resilience Scale (RBRS) factors and Vicarious Resilience Scale (VRS)*

| Variable | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| 1. Self-Efficacy | ___ | .496** | .545** | .231** |
| 2. Coping Mechanisms | .496** | ___ | .468** | .164** |
| 3. Multicultural and Social Justice Advocacy | .545** | .468** | ___ | .255** |
| 4. Vicarious Resilience Scale | .231** | .164** | .255** | ___ |

*Note. N = 300*

[*]$p < 0.01$

**Table 3b.**

*Intercorrelations Between Race-Based Resilience Scale (RBRS) factors and Vicarious Resilience Scale (VRS) subscales*

| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Self-Efficacy | ___ | .496** | .545** | .783** | .204** | .779** | .212** | .218** | .151** | .075 | .093 | .231** |
| 2. Coping Mechanisms | .496** | ___ | .468** | .787** | .204** | .565** | .123* | .203** | .028 | .049 | .159** | .164** |
| 3. Multicultural/SJ Advocacy | .545** | .468** | ___ | .787** | .207** | .804** | .220** | .198** | .230** | .099 | .198** | .230** |
| 4. *RBRS Total Score* | .783** | .787** | .787** | ___ | .245** | .862** | .260** | .260** | .223** | .076 | .194** | .288** |
| 5. Increased..Resourcefulness | .204** | .204** | .207** | .245** | ___ | .193** | .551** | .461** | .386** | .447** | .558** | .826** |
| 6. Changes in Life Goals | .779** | .565** | .804** | .862** | .193** | ___ | .230** | .226** | .195** | .069** | .142* | .242** |
| 7. Increased Self-Awareness | .212** | .123* | .220** | .260** | .551** | .230** | ___ | .481** | .420** | .281** | .422** | .748** |
| 8. Client-Inspired Hope | .218** | .203** | .198** | .260** | .461** | .226** | .481** | ___ | .554** | .421** | .467** | .722** |
| 9. Increased Recognition of.. | .151** | .028 | .230** | .223** | .386** | .195** | .420** | .554** | ___ | .424** | .451** | .676** |
| 10. Increased Consciousness.. | .075 | .049 | .099 | .076 | .447** | .069 | .281** | .421** | .424** | ___ | .530** | .623** |
| 11. Increased Capacity | .093 | .159** | .198** | .194** | .558* | .142* | .422** | .467** | .451** | .530** | ___ | .708** |
| 12. *VRS Total Score* | .231** | .164** | .255** | .288** | .826** | .242** | .748** | .722** | .676** | .623** | .708** | ___ |

*Note. N = 300*

**p < 0.01

*p < 0.05

(1) self-efficacy, (2) coping mechanisms, (3) multicultural and social justice advocacy, (5) increased capacity for resourcefulness, (6) changes in life goals and perspectives, (7) increased self-awareness and self-care, (8) client-inspired hope, (9) increased recognition of spiritual as a client resource, (10) increased consciousness around social location and power, and (11) increased capacity to remain present during trauma narratives

**Table 4.**

*Results of independent sample t-test for Racial Centrality groups*

| Variable | Group 1 (moderate) | | Group 2 (high) | | *t* | *p* | Cohen's d |
|---|---|---|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* | | | |
| Vicarious Traumatization Scale (VTS) | 34.48 | 6.871 | 33.99 | 7.501 | .551 | .410 | .067 |
| Race-Based Resilience Scale (RBRS) | 57.30 | 10.303 | 58.22 | 9.356 | -.721 | .395 | -.095 |

*Note. Mean values for each of the analyses are shown for Group 1 (n = 89) and Group 2 (n = 211), as well as the results of t tests*

*(assuming unequal variance) comparing the two groups.*

**Table 5.**

*Means, standard deviations, and correlations between Race-Based Resilience (RBRS) factors, Vicarious Traumatization (VT), and*
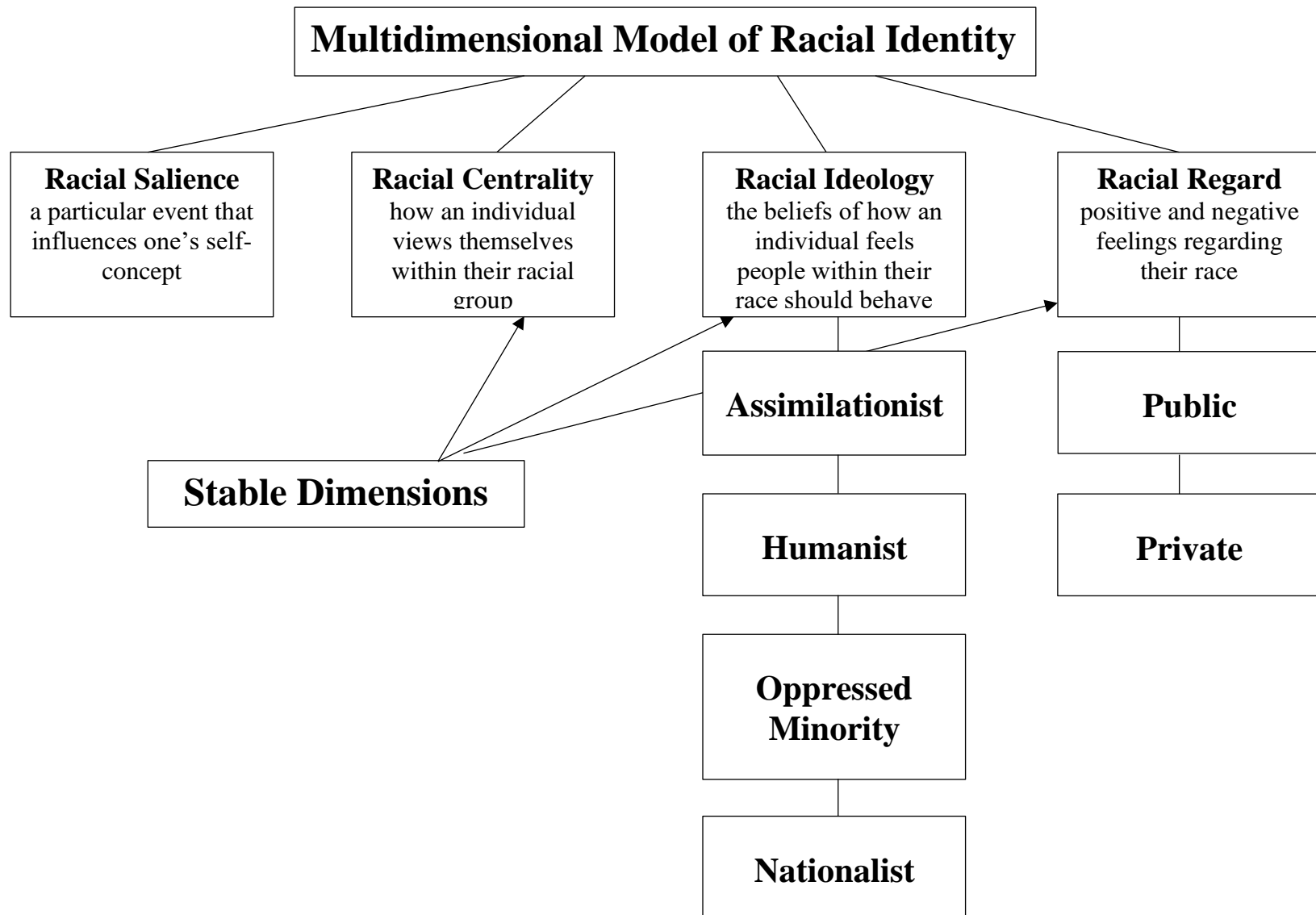
*Racial Centrality (RC)*

| Variable | Mean | SD | N | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|---|---|
| RBRS Factor 1: Self-Efficacy | 20.7633 | 2.94441 | 300 | ___ | .496** | .545** | -.194** | .041 |
| RBRS Factor 2: Coping Mechanisms | 11.2200 | 2.65741 | 300 | .496** | ___ | .468** | -.229** | -.005 |
| RBRS Factor 3: Multicultural/SJ Advocacy | 10.9433 | 2.78676 | 300 | .545** | 468** | ___ | -.160** | .028 |
| Vicarious Traumatization (VT) | 34.14 | 7.312 | 300 | -.194** | -.229** | -.160** | ___ | .041 |
| Racial Centrality (RC) | 5.84 | .929 | 300 | .041 | -.005 | .028 | .041 | ___ |

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

**Figures**

**Figure 1.**

*Theoretical framework of the Multidimensional Model of Racial Identity (MMRI)*



```
                    Multidimensional Model of Racial Identity

  Racial Salience      Racial Centrality     Racial Ideology      Racial Regard
  a particular event   how an individual     the beliefs of how   positive and negative
  that influences      views themselves      an individual feels  feelings regarding
  one's self-concept   within their racial   people within their  their race
                       group                 race should behave

          Stable Dimensions         Assimilationist            Public

                                     Humanist                  Private

                                     Oppressed
                                     Minority

                                     Nationalist
```

**Appendix – Measures**

**Demographic Survey**

What is your age?
Under 18
18 – 25
26 – 33
34 – 41
42 – 49
50 and over

What is your gender?
Woman
Man
Transgender
Non-binary
Other: _____

What is your racial/ethnic background?
African American/Black
Native American
Hispanic or Latino/a/x
Asian
White
Other: _____

What is your immigration status?
Recent immigrant (less than a year) [you were born outside of the U.S. and move to the U.S]
First-generation immigrant (1 or more years) [you were born outside of the U.S. and move to the U.S.]
Second generation immigrant
Third generation immigrant
Fourth generation immigrant
Other: _____

What is your education level?
Master's Level
Specialist (post-masters)
Doctoral Level
Other: _____

What is your professional identity in mental health?
Counseling
Psychology

Psychiatry
Social Work
Substance Abuse
Other: _____

How many years of LICENSED professional experience in mental health counseling do you have?

How many years of UNLICENSED professional experience in mental health counseling do you have?

How many years have you spent in your training program (include any time in training prior to full licensure)?

Number of clinical work hours per week
Under 10
10 – 15
16 – 20
21 – 25
26 – 30
31 – 35
36 – 40
Over 40

Current work setting
Private practice
Mental health agency
Hospital
Children's Division
In-home
School
Other: _____

What part of the region do you live in?
New England (ME, RI, VT, CT, NH, MA)
Mid-Atlantic (NY, NJ, PA)
Southern (VA, WV, KY, DE, MD, NC, SC, TN, AR, LA, FL, GA, AL, MS)
Midwest (MI, ND, SD, IA, MN, KS, NE, OH, IN, IL, WI, MO)
Southwest (TX, AZ, NM, OK)
Rocky Mountains (MT, ID, CO, UT, WY, NV)
Pacific Coastal (CA, OR, WA)
Alaska
Hawaii
Other: _____

If outside of the United States, please provide your country of residence

_____

What has your experience been like specifically being Black in the United States?

How did you hear about this survey?
        Facebook
        LinkedIn
        Therapy for Black Girls
        Clinicians of Color
        Psychology Today
        ListServ
        Colleague
        Other: _____

**Connor-Davidson Resilience Scale (CD-RISC)**

Please indicate how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

1. Able to adapt
2. Secure attachment
3. Sometimes fate or God could help
4. Can deal with adversities
5. Past success gives confidence for future
6. Humor
7. The strength that stress could bring on
8. Recovery from illness or hardship
9. Things happen for a reason
10. To give the best effort
11. Goals achievement
12. When things look hopeless, I don't give up
13. Know where to turn for help
14. How I act under pressure
15. Prefer to take the lead in problem-solving
16. Not discouraged by failure
17. Consider of self as strong person
18. Make difficult decisions
19. Can handle unpleasant feelings
20. To act on a hunch
21. Strong sense of purpose
22. In control of my life
23. Challenges
24. Acting work to attain goals
25. Pride in achievements

**Vicarious Resilience Scale (VRS)**

Please reflect on your experience working with persons who have survived severe traumas. Since you began this work, you may have undergone changes in how you view your clients, your approach to this work, and/or your own experience or worldview. Please read each of the following statements about your attitudes, experiences, and how your view of life since you began this work, and indicate the degree to which you disagree or agree:

For each statement, respondent indicates if they: did not experience this (0), experienced this to a very small degree (1), experienced this to a small degree (2), experienced this to a moderate degree (3), experienced this to a great degree (4), experienced this to a very great degree (5) changes in life goals and perspective

1. I am better able to reassess dimensions of problems
2. I am better able to keep perspective
3. I see life as more manageable
4. I am better able to cope with uncertainties
5. I am more resourceful
6. I have learned how to deal with difficult situations (increased capacity for resourcefulness)
7. I am more connected to people in life
8. My life goals and priorities have evolved
9. I have more compassion for people
10. I put more time and energy into relationships
11. My ideas about what is important have changed
12. I am more mindful and reflective (Increased self-awareness and self-care practices)
13. I am more in tune with my body
14. I make more time more meditative, mindful, or spiritual practices
15. I am better able to assess my level of stress
16. I am better at self-care (Client-inspired hope)
17. I am inspired by people's capacity to persevere
18. I am hopeful about people's capacity to heal and recover from trauma
19. I am more hopeful and engaged when focusing on strengths (Increased recognition of clients' spirituality as a therapeutic resource)
20. I see my clients' spiritual practices as a source of inspiration
21. I recognize spirituality as a component of clients' survival
22. I highlight clients' spiritual/religious beliefs to promote resilience (Increased consciousness about power and privilege relative to clients' social location)
23. I am more aware of ethnicity, gender, sexual orientation, and religion
24. Race, class, gender, sexual orientation and privilege, access, resources (Increased capacity for remaining present while listening to trauma narratives)
25. When I experience distressing thoughts, I am able to just notice them
26. I am better able to remain present when hearing trauma narratives

27. I notice client trauma narratives without getting lost in them

## Marlowe-Crowne Social Desirability Scale – Short Form (Form C)

The Marlowe-Crowne Social Desirability Scale (MCSDS – SF) is a brief measure to assess respondents' tendency to answer questions in a socially desirable manner.

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide how it pertains to you.

Please respond either TRUE (T) or FALSE (F) to each item. Indicate your response by circling the appropriate letter next to the item.

1. It is sometimes hard for me to go with my work if I am not encouraged.
2. I sometimes feel resentful when I don't get my way.
3. On a few occasions, I have given up doing something because I thought too little of my ability.
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.
5. No matter who I am talking to, I'm always a good listener.
6. There have been occasions when I have taken advantage of someone.
7. I'm always willing to admit to it when I make a mistake.
8. I sometimes try to get even rather than forgive and forget.
9. I am always courteous, even to people who are disagreeable.
10. I have never been irked when people express ideas very different from my own.
11. There have been times when I was quite jealous of the good fortune of others.
12. I am sometimes irritated by people who ask favors of me.
13. I have never deliberately said something that hurt someone's feelings.

## Multidimensional Inventory of Black Identity (MIBI)

The Multidimensional Inventory of Black Identity (MIBI) was developed to measure the three stable dimensions of the MMRI (centrality, ideology, and regard) in African American college students and adults.

**Centrality Scale**
1. Overall, being Black has very little to do with how I feel about myself. (R)
2. In general, being Black is an important part of my self-image.
3. My destiny is tied to the destiny of other Black people.
4. Being Black is unimportant to my sense of what kind of person I am. (R)
5. I have a strong sense of belonging to Black people.
6. I have a strong attachment to other Black people.
7. Being Black is an important reflection of who I am.
8. Being Black is not a major factor in my social relationships. (R)

**Vicarious Trauma Scale (VTS)**

The Vicarious Trauma Scale (VTS) is a brief measure designed to assess distress resulting from such exposure and has the potential as a screening tool for Vicarious Traumatization (VT) in practice and educational settings.

Please read the following statements and indicate on a scale of 1 (strongly disagree) to 7 (strongly agree) how much you agree with them.

(1) Strongly disagree (2) Disagree (3) Slightly disagree (4) Neither agree nor disagree
(5) Slightly agree (6) Agree (7) Strongly agree

1. My job involves exposure to distressing material and experiences.
2. My job involves exposure to traumatized or distressed clients.
3. I find myself distressed by listening to my client's stories and situations.
4. I find it difficult to deal with the content of my work.
5. I find myself thinking about distressing material at home.
6. Sometimes I feel helpless to assist my clients in the way I would like.
7. Sometimes I feel overwhelmed by the workload involved in my job.
8. It is hard to stay optimistic given some of the things I encounter in my work.