YOU CAN'T POUR FROM AN EMPTY CUP: A PHENOMENOLOGICAL STUDY EXPLORING EXPERIENCES OF BLACK COUNSELOR WELLNESS PRACTICES AND BARRIERS TO WELLNESS

by

CHA'KE'SHA S. SPENCER

A Dissertation Submitted to the Faculty
in the Counselor Education and
Supervision Program of the College of
Professional Advancement
at Mercer University
in Partial Fulfillment of the
Requirements for the Degree

DOCTOR OF PHILOSOPHY

Atlanta, GA
2024

YOU CAN'T POUR FROM AN EMPTY CUP: A PHENEMENOLOGICAL STUDY EXPLORING EXPERIENCES OF BLACK COUNSELOR WELLNESS PRACTICES AND BARRIERS TO WELLNESS

by

CHA'KE'SHA S. SPENCER

Approved:

Morgan E. Kiper-Riechel, Ph.D. Dissertation Committee Chair	Date
Tyler Wilkinson, Ph.D. Chair, Department of Counseling/Dissertation Committee Member	Date
Sonja Sutherland, Ph.D. Dissertation Committee Member	Date
Priscilla R. Danheiser, Ph.D. Dean, College of Professional Advancement	Date

©2024
CHA'KE'SHA S. SPENCER
All Rights Reserved

DEDICATION

For Gregory.

ACKNOWLEDGEMENT

There are so many people that have been instrumental in making my dream a reality and providing unwavering support. Thank you to my chair, Dr. Morgan Kiper-Riechel and my committee members, Dr. Tyler Wilkerson and Dr Sonja Sutherland for guiding me through this process. I'm grateful for my parents for always giving me an encouraging word and as my mother likes to remind me, for helping me write this little paper. Huge thank you to my husband for not allowing me to quit, for helping me talk through things and always having my back, and to my children who sacrificed so much so that I could follow my dreams. You are amazing and Mommy loves you.

I appreciate the #BestCohortEver for walking with me since the beginning and fellow doc students who also journeyed with me. Thank you to Shaketa and Deondra for sacrificing your weekends to assist me in my research and allowing me to only pay you in food. To all of my Sorors and friends who kept me laughing, telling me to keep going and spending countless brunch hours with me. Thank you to all of the doctors I have met along the way, especially Dr. Teresa Fletcher who supported me and encouraged me for 22 years and never let me waiver in my goals. Finally, thank you to my other kids, my dogs, Diesel, Gambit, and Loki for laying at my feet while I write, offering hugs and kisses when I needed them, and for welcoming me home with a smile every time.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

ABSTRACT

CHA'KE'SHA SPENCER
YOU CAN'T POUR FROM AN EMPTY CUP: A PHENEMENOLOGICAL STUDY EXPLORING EXPERIENCES OF BLACK COUNSELOR WELLNESS PRACTICES AND BARRIERS TO WELLNESS
Under the direction of MORGAN E. K. RIECHEL, PHD

Myers et al., (2000) define wellness as "a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community." Occupational hazards such as burnout, compassion fatigue, vicarious trauma and the COVID-19 pandemic may contribute to counselors' vulnerability regarding a lack of wellness practices (Blount et al., 2016). Black counselors face these risks and unique barriers to wellness such as racial stressors, stigma associated with mental health, and cultural myths and misconceptions around emotional wellness and self-care. The literature is limited regarding wellness models for Black Americans and the theoretical framework for this study does not focus on one model, instead explores several traditional wellness models including those that center cultural relevance. The Strong Black Woman Schema and John Henryism concepts and their relationship to Black counselor wellness practices were also explored. This qualitative study utilized Interpretive Phenomenological Analysis (IPA) to interview 9 practicing master and doctoral level counselors, who practice independently and identify as Black. The purpose of this study was to understand the lived experiences of Black counselors' wellness practices and possible barriers to wellness. Results indicate that Black counselors are able to define wellness as being holistic, balancing mind, body and spirit and self-care as activities that are enjoyable and promote optimal wellness. Results also indicate that participants acknowledged their history of prioritizing work and family and treating their self-care as an afterthought, which resulted in feelings of exhaustion, guilt, being overwhelmed.

Participants admitted that history and cultural beliefs played a role in how they cared for themselves, and they recognized the need for community in their wellness journey.

CHAPTER 1

INTRODUCTION

This chapter provides an overview of the qualitative study that was conducted and presents the statement of the problem, purpose of the study, theoretical framework, research questions, delimitations, and definition of terms.

Wellness is the philosophical foundation of the counseling profession and covers several dimensions, including physical, emotional, intellectual, occupational, spiritual, social, and sometimes financial (Myers, 1991; Swarbrick, 2012; Hettler, 1984). The concept of wellness has a longstanding history. The Greek philosopher Aristotle posited that one should do things in moderation and not in excess (Myers & Sweeney, 2008). The idea of wellness dates as far back as 3000-1500 B.C. with Ayurveda, an Indian natural system of medicine that promotes holism and Traditional Chinese Medicine (TCM) with roots in Taoism and Buddhism (SRI International, 2010). The term wellness was coined and applied to modern culture when the term by Halbert Dunn, whom many consider the father of wellness (Ohrt et al., 2018). Other early wellness influencers include Jerry Lafferty, a health education professor, who's focus on total person wellness, and Donald Ardell, a sociologist, who emphasized that wellness was a movement and a growth industry, not a fad, and encouraged the concept of wellness on a personal and national level (Ardell, 1985).

Regarding wellness from a psychological perspective, Alfred Adler, Carl Jung, and Abraham Maslow were theorists who began to consider wellness as more than a medical model (Ohrt et al., 2018). The preamble of The World Health Organization's (WHO) constitution defines health and wellness as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," a statement that dates back to as early as 1947

(World Health Organization [WHO], n.d.). Myers et al. (2000) defined wellness as "a way of life oriented toward optimal health and well-being in which body, mind and spirit are integrated by the individual to live more fully within the humans and natural community."

Practitioner Well-being

Traditional health programs typically focus on feeling better physically, including concentrating on weight loss and exercise (Journal of the American Medical Association [JAMA], 2021). However, several wellness aspects need to be considered, including maintaining one's mental health. According to the National Alliance on Mental Illness (2019), statistics reveal that a little over 50 million people have experienced mental illness in the U.S., 9.5 million struggle with substance use and mental illness, 19.1% have symptoms of anxiety, and 7.8% of adults have had a major depression episode. Counselors are not immune to physical and emotional challenges. Many mental health disciplines have created professional standards related to the well-being of professionals. The American Counseling Association's (2014) ethical code sets a standard for how counselors should care for themselves. Section C.2.g of the code states, "counselors monitor themselves for signs of impairment from their physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work." It is the counselor's responsibility to maintain wellness, so it does not affect their work with clients. Several factors impact a counselor's ability to practice personal or professional wellness. Professional factors include burnout, compassion fatigue, vicarious trauma, and, more recently, the COVID-19 pandemic.

Although holistic wellness (physical, emotional, spiritual) is the standard, this section focuses primarily on counselors physical and emotional wellbeing.

Counselor Impairment

Healing professionals are susceptible to occupational hazards such as burnout, compassion fatigue, and vicarious trauma, which may contribute to their lack of overall wellness (Blount & Lambie, 2018). The nature of the counselors' job is to care for others, and sometimes this is done at a cost to the therapist (Figley, 2002). Clinicians spend their time providing empathy and compassion for their clients, and this work can be taxing (Gutierrez & Mullen, 2016). Additional work stressors include managed care issues, high caseloads, and high acuity clients. (Posluns & Gall, 2020).

Burnout

Burnout, a term introduced by Freudenberger (1980), describes occupational stress that may impact one's personal and professional life. Burnout primarily focuses on occupational stressors or work demands, work conditions, and workload (Jenkins et al., 2011). Burnout can happen in counselors who work in high-stress environments. Carrola et al. (2016) studied burnout in counselors who work in a correctional setting, which suggested higher burnout rates in counselors who work in maximum security settings compared to those who work in less restrictive settings. Burnout may be partly caused by a helper's ability and necessity to care for others (Blount et al., 2016). Despite concerns for burnout and compassion fatigue, having more experience and using specific treatment modalities can offer some protective factors for mental health clinicians. Craig and Sprang (2010) found that therapists who specialize in trauma treatment using evidence-based practices had reduced burnout, compassion fatigue, and

increased compassion satisfaction (the gratification felt when a person is able to work effectively.

There are some concerns for novice therapists or those in training. Counselors new to the field are especially susceptible to burnout due to lack of experience, minimal ways of coping, including a lack of self-care of the personal and professional self, and lack of adequate supervision (Bressi & Vaden, 2017). The Craig and Sprang (2010) study also showed that younger professionals, those with limited trauma training, being an inpatient provider, practitioners having a caseload of clients diagnosed with PTSD and those not using evidence-based treatments were at risk for burnout. Burnout not only impacts the practitioner and potentially harms the client, but it also impacts the workplace, which could lead to productivity loss, staff turnovers, and a lack of effective care for clients (Carrola et al., 2016).

Compassion Fatigue

Compassion fatigue is a concern for counselors. Figley (2002) considers compassion fatigue a "function of bearing witness to the suffering of others." Figley (2002) outlined eleven predictors of compassion fatigue; empathetic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollection, and life disruption. Vicarious trauma, or the impact on a helping professional after bearing witness to others suffering, can also present a barrier to counselors' well-being (McCann & Pearlman, 1990). Lanier and Carney (2019) found that the frequency of vicarious trauma symptoms and subthreshold PTSD symptoms among counselors contributed to vicarious trauma symptoms in practicing counselors. McCann and Pealman (1990) explain that dependency/trust, safety, and the feeling of power is impacted when therapist are exposed to vicarious trauma.

Vicarious Trauma

Similar to burnout, Vicarious trauma can be found more often in therapists new to the field (Halevi & Idisis, 2018). Some studies show that wellness can positively impact counselors and their exposure to vicarious trauma. Foreman (2018) examined independently licensed counselors whose caseload included those with a trauma history to study how exposure to client's with a traumatic history impacts counselors. The study found that counselors who practice wellness had lower levels of vicarious trauma.

Covid-19 Pandemic

The COVID-19 pandemic has also posed a risk to counselor wellness. Early in the pandemic, social distancing created isolation for most of the country, cutting off traditional mental health treatment methods (in-person therapy, access to other forms of care) (Pfefferbaum & North, 2020). Many mental health professionals provided therapy via telemental health, which presented a different set of challenges, such as providing effective therapy in a new way that seemed to change abruptly and creating a safe and private space (Békés et al., 2021). Therapists have been invisible frontline workers during the pandemic, many of whom have seen an increase in clients and community needs (Miu & Moore, 2021). Further research is needed to study the pandemic's impact and possible long-term effects as it continues to impact the globe.

While ample research has focused on wellness models, counselor burnout, compassion fatigue, vicarious trauma, and counselor impairment, there is not much research devoted to wellness practices and wellness maintenance among counselors (Neswald-Potter et al., 2013). Seeing a need for wellness promotion among counselors, supervisors, and counselors in training, Gibson et al (2021) developed the Chi Sigma Iota (CSI) Counselor Wellness Competencies. The competencies address nine wellness areas: self-care, personal relationships, boundaries, stress,

burnout and impairment, professional support practices, wellness promotion, wellness research, wellness assessment, and wellness-based goal setting and plans (Gibson et al., 2021). The nine competency areas are based on a continuum of wellness that focuses on three main counselor roles; counselor-centered wellness (personal and proactive self-care to address mental, emotional, spiritual, social and cultural needs), professional-centered wellness (stress management, boundary setting, awareness and avoidance of burnout and other impairments), and client-centered wellness (educating clients on wellness research and wellness assessments to aid in treatment progress) (Gibson et al., 2021). These competencies are necessary to assist counselors in awareness and implementing personal and professional wellness. However, there is limited research centered on the lived experiences of the Black counselor, their wellness practices, and barriers to following through with wellness. This research seeks to study this phenomenon.

Wellness in Black Americans

The health disparities among the Black/African American population in the U.S. is well documented. In 2017, the leading cause of death for Black men and women in America was heart disease, and diabetes is among the top ten. Homicide was the leading cause of death (35.3%) in Black males aged 1 to 19 and 20 to 44 years old (27.6%) and the second leading cause of death in Black women aged 1-19 years (14.9%) (CDC, 2017). The mental health statistics for Black Americans are equally staggering. In 2019, suicide was the second leading cause of death in Black men and women aged 15-24, and the suicide death rate for Black men is reportedly four times higher than of Black women. Black Americans living below the poverty level are twice as likely to experience psychological distress, and Black adults are more likely to report feelings of hopelessness and sadness compared to White adults (OMH, n.d.).

Socio-economic status (SES) can impact wellness in Black Americans. In 2020, the poverty rate for Black Americans was 19.5%, or roughly 8.5 million people, making the Black community the racial group with the highest poverty rate, followed by Hispanics (15.7%) and Caucasians (8.2%) (Shrider et al., 2021). Those in poverty may live in areas with limited resources and are more likely to witness violence, trauma, and exposure to substance abuse. People living in poverty are more likely to be uninsured or underinsured, limiting their access to adequate mental health services (Santiago et al., 2013).

Black counselors may experience these health disparities and other challenges directly related to race, including racial inequities, racism, and discrimination. Over the last few years, the United States has seen an increase in hate crimes based on race, and the incidents have been more violent (U.S. Department of Justice - Federal Bureau of Investigation [FBI], 2020). In 2019, the Federal Bureau of Investigations (FBI) reported that 57.6 % of crimes committed were based on race/ethnicity/ancestry (U.S. Department of Justice - Federal Bureau of Investigation [FBI], 2020). The death of George Floyd propelled an ongoing fight for justice related to racially incentivized police killings in the U.S. to the national spotlight. In 2020, protests were seen throughout the country and abroad (Bartholomew et al., 2018). Political uncertainty, racial and civil unrest, and a global pandemic may have contributed to increased mental health symptoms of Black Americans (Waters, 2020). Attempting to navigate work stress and burnout, the current social climate, and personal challenges may impede a Black counselor's ability to engage in consistent wellness practices. Although there is a smaller number of African American practitioners in the field, African American health care providers experience higher stress due in part to racism, high acuity of patients, high job demands (Evans, 1997).

Strong Black Woman

Black women navigate many roles and experience various stressors, which may result in their taking on the archetype of the Strong Black Woman (SBW), also referred to as the Strong Black Woman Schema (SBWS). Woods-Giscombe (2010) describes SBWS as managing multiple roles and obstacles, including family and professional obligations, racism, and misogyny that are presented to Black women (Peterson-Rochon, 2020). The SBWS may add additional pressure to Black women as they are sometimes the primary household income source and the main caregiver while battling ongoing injustices and stereotypes (Peterson-Rochon, 2020). Black female counselors may embody this stereotype, contributing to their lack of self-care. The SBWS can be viewed as a coping method, but it can impact a Black woman's wellness. Bey et al. (2018) studied allostatic load, how chronic stress impacts the body, and how the stress may be associated with systems of depression in Black and White women. The authors found high-risk inflammation due to a protein in the body and depression to be higher among Black women compared to White women, and the Black women participants' inflammation was not associated with depression. Blood pressure rates predicted black men participants' depression. These results indicate that physical illness can be associated with and a predicting factor of stress and depressive symptoms. The literature attributes the pressures of the SBW archetype to poor health outcomes in Black women, such as heart disease and obesity (American Cancer Society [ACS], 2022). Black women are disproportionately affected by health conditions, including higher breast cancer rates (ACS, 2022). Poverty and SES impact the health of Black women. Long et al. (2019) conducted a qualitative study on the impact of poverty on the wellness and self-care of single mothers. Participants reported a lack of self-care, poor nutrition, and physical

health. Participants also expressed concerns related to discrimination, stigma, and lack of support.

John Henryism

Similar to the Strong Black Woman Schema, Black men who experience stress, especially racial discrimination, can suffer from "John Henryism." John Henryism suggests that African Americans coping at a high level due to emotional stressors may have adverse health reactions (Hudson et al., 2016). The term John Henryism is rooted in the folklore of John Henry. Various versions of this folklore exist, but most report that Henry needed to win a race against a machine using a hammer on a railroad. While Henry won the race, he died soon after, and it is believed that the stress related to saving others and attempting to beat the machine contributed to his death (Wade, 2002; Flaskerud, 2012). John Henryism is a coping style that suggests one's determination and hard work will equal success (Kiecolt et al., 2009). Early studies on John Henryism focused on the association between high-level coping as a result of stress and socio-economic status and hypertension (James et al.,1983). The literature suggests that stress associated with SES can impact physical and mental health. Santiago et al. (2012) explain that low SES is associated with psychological distress, and an individual's stress levels due to poverty are linked to increased risk for mental health and physical health issues. Stressors include community and family violence, financial strain, unstable housing, discrimination, and trauma exposure. Although the stress factors are present, and the statistics show that Black men and women struggle with mental health, there remain concerns in the Black community regarding mental health help-seeking.

Stigma

The stigma associated with mental health in the Black community may contribute to Blacks not seeking treatment when symptoms of mental illness arise (Shantell, 2017). Many African Americans do not like to share their struggles as they were taught "what happens at home stays at home," and personal problems are not to be shared with others (Watson & Hunter, 2015). When African Americans attend treatment, they are likely to be misdiagnosed or receive an inaccurate diagnosis (American Psychological Association [APA], 2020). The literature suggests that a working alliance may be more challenging, and the African American client may be less trusting of the therapist (Watson & Hunter, 2015). Having providers who are culturally aware and culturally humble may make a difference. However, only 4% of psychologists identify as Black, making it difficult for Black people to find providers they feel are culturally competent and can relate to their plight (APA, 2020).

Wellness barriers, which can include various stressors, societal pressures, racism, and disenfranchisement, can impact African American male's ability to practice wellness. However, literature shows that hypertension decreases as SES opportunities increase (better education, improved/increased income, occupation) (James, 1994). Kiecolt et al. (2009) studied how a sense of control and John Henryism can influence mental health in those with varying SES. Authors reported that men with higher levels of coping reported lower depressive symptoms and that a sense of control and John Henryism were positively related to mental health, regardless of SES in Whites, Hispanics, and African Americans. Positive resources and community engagement can encourage a person's ability to practice wellness. Spurgeon and Meyers (2010) studied the relationship between racial identity and wellness in college junior and senior African American men. The researchers studied young men at Historically Black Colleges and Universities

(HBCU's) and Predominantly White Institutions (PWI's) and found that HBCU students scored higher than the norms on the Coping Self scale of the 5F-Wel and the authors reported this could be due to the positive social environment HBCU's provide. Those attending PWI's seemed to be at higher risks for wellness impairment on this same scale. Both groups had lower scores on the Physical Self section. Interestingly, the study found no significant relationship between racial identity and wellness. The concept of John Henryism is not exclusive to African Americans, but it has been shown to be more prevalent in the Black population (Neighbor et al., 2007). By studying John Henryism, researchers can better understand African Americans' ways of coping and health challenges (Duke Medicine News & Communication, 2006). This research aims to understand the wellness practices of Black counselors and barriers that may prevent one from engaging in wellness and self-care activities.

Statement of the Problem

Although wellness undertones have been consistent since the founding of the counseling profession, there has been limited research on the wellness practices and unique barriers counselors of color, particularly Black counselors, face regarding maintaining their well-being. Health disparities, poverty, lower SES, racial inequities, racism, and discrimination coupled with occupational stressors such as burnout, compassion fatigue, vicarious trauma, and the recent Covid-19 pandemic can present barriers to wellness and practices of wellness (CDC, 2017; OMH, n.d.; Santiago et al., 2012; McCann & Perlman; Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.-a).

Purpose of the Study

This study sought to explore the lived experiences of Black counselors' wellness practices and possible barriers to wellness, and how the lack of wellness practices can impact the

work of counselors. This qualitative study incorporated a phenomenological approach using a constructivist view. Masters and doctoral level Black counselors, defined as counselors who identify as Black and represent the African diaspora (African American, Afro-Caribbean, Afro-Latinx, or African) and are independently licensed to practice in their respective states, were studied.

Theoretical Framework

The theoretical framework for this study does not center on one wellness model but instead looks at what the literature considers traditional models of wellness. There is a plethora of wellness models and assessments, and a common trait is that they all seem to include dimensions, which are typically interconnected (Blount et al., 2020). Historically, wellness models seem to build upon one another while expanding understanding and incorporating new domains (Oliver et al., 2019).

Halbert Dunn's (1961) High-Level Wellness Model seemed to spark a shift in how wellness was conceptualized. Dunn, who is considered the father of the wellness movement, moved from wellness just being the absence of illness to a more holistic approach (Ohrt et al., 2018). Early theorist Jeffery Lafferty (1979) defined wellness as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning." Lafferty referred to wellness as "the total person" who continuously strives to improve their health, no matter their current health status, and the goal of health is never achieved, as it remains on a continuum. Later, Donald Ardell (1985) suggested wellness is more than a fad, or a short-lived experience, but a movement. Ardell also acknowledged that wellness practitioners, at the time, were White, educated, upper-

middle-class, healthy individuals, which suggested a limitation to the wellness concept. Ardell described wellness as a "conscious and deliberate approach to an advanced state of physical and psychological/spiritual health" and suggested this state of being is not stagnant but constantly changing. This multidimensional, continuous wellness journey holds true to most prominent wellness models.

Bill Hettler's Holistic Wellness Model or the Six Dimensions of Wellness Model is another prominent model as he focused on factors that can impact one's health (Oliver et al., 2019). Hettler defined wellness as "an active process through which people become aware of, and make choices toward, a more successful existence" (Hettler, 1980). Hettler's (1980) model focused on six dimensions of wellness (occupational, physical, social, intellectual, spiritual, and emotional) that are interdependent and interconnected. One of the most significant wellness models to develop over the last few decades is the Wheel of Wellness Model introduced by Witmer and Sweeney (1992). The Wheel of Wellness is the first of its kind and is a lifespan model with tenets of Adlerian theory and was created to measure wellness in counseling professionals, the first of its kind. The Wheel of Wellness highlights five life tasks (spiritual, self-regulation, work-life, friendship, and love) that interact with one another. The model is "continually shifting" as the life tasks, life forces (8 elements that are on the outer bands of the life tasks), and the healthy person cope and strive toward well-being (Sweeny & Whitmer, 1991; Oliver et al., 2019). Drawing from the Wheel of Wellness concept, the Indivisible Self Evidence-Based Model of Wellness (ISWEL) was born through testing for reliability and validity of the Wellness of Evaluation of Lifestyle (WEL) measure that was developed to assess wellness. ISWEL has a single higher-order wellness factor, five second-order factors (Creative self, Coping self, Social self, Essential self, and Physical self), and 17 discrete wellness scales.

Strawbrick's Eight Dimensions of Wellness is used by the Substance Abuse and Mental Health Services Administration (SAMHSA). This model outlines physical, spiritual, emotional, environmental, occupational and leisure, intellectual, and financial as essential wellness factors (Swarbrick, 2009). Oliver et al. (2018) comprehensively examined several theoretical wellness models. Models covered several areas, including counseling, higher education, adolescents, young adults, and the aging population. Several models focused on different interpretations of up to 8 different dimensions, and all models centered on holistic wellness but offered different explanations for holism and how to achieve wellness. The most common dimensions seen among most models include physical, social, spiritual, emotional, intellectual, occupational, environmental, and financial (Brown & Applegate, 2012; Blount et al., 2020; Oliver et al., 2018).

This author could not locate a wellness model specifically for Black counselors; however, Constantine and Sue's (2006) Optimal Human Functioning (OHF) model seemed the most relevant. The OHF model comes from positive and optimal psychology to address the wellness of the Black, Indigenous, and People of Color (BIPOC) community that is missing in Westernized, Eurocentric wellness models (Constantine & Sue, 2006). The OHF model focuses on five cultural values, beliefs, and practices that align with various cultures: Collectivism, Racial and Ethnic Pride, Spirituality and Religion, Interconnectedness of Mind, Body, and Spirit, and Family and Community. Of note, Hodge et al.'s (2009) Native Model of Wellness and Myers et al.'s (2018) Optimal Conceptual Theory (OTC) are significant models of wellness that address the concept of well-being in Native Americans and people in the African Diaspora, respectively. Though these models are culturally relevant, there are some wellness dimensions (intellectual, financial, occupation) that this author feels could be expanded upon, as they are also relevant to overall well-being. As no one model encompasses holistic dimensions of

wellness (spirituality, emotional well-being, physical health, social connectedness, occupation, environmental, financial security and intellectual) and centers the cultural importance of those in the African Diaspora, the theoretical framework for this study does not follow one wellness model, but rather pulls from those that are essential to the topic of the lived experiences of Black counselors' wellness practices and barriers to wellness.

Research Questions

What are the lived experiences of Black counselors' wellness practices?

What lived experiences prevent wellness practices in Black counselors?

Delimitations

The study delimited to professional counselors currently practicing, independently licensed, and identifying as Black/African American.

Definition of Terms

Counselor: Professional Counselor, independently licensed to practice in the counselor's state(s) where the license is held.

Wellness: A belief system that focuses on the act of being well; mind, body, and spirit.

Black: Those a part of the African Diaspora, including those who identify as Black, African American, Afro-Latinx (a person of African descent who identifies their ethnicity as Latino and their race as Black, Afro-Caribbean (a person of African descent who was born in or living in a Caribbean nation. This also includes those born of Afro-Caribbean heritage), and African.

Independently licensed: The ability to practice without supervision based on the guidelines identified by a state licensing board.

Self-Care: The practice of wellness

LPC: Licensed Professional Counselor.

CACREP: The Council for Accreditation for Counseling and Related Programs.

ACA (code of ethics): American Counseling Association.

Practice: Actively practicing as a counselor and providing therapeutic services to clients.

CHAPTER 2

LITERATURE REVIEW

This chapter will provide a comprehensive examination of the literature on the history of wellness, wellness models and assessments, wellness of the counselor, including challenges counselors face in the profession, and wellness of the Black counselor, which discusses barriers to wellness and wellness practices.

Historical Context of Wellness

The concept of well-being can be found in literature as far back as 3,000BC with Ayurveda, a holistic healing approach centered on harmony between the body, mind, and spirit and how the treatment of ailments is individually tailored (SRI International). Traditional Chinese Medicine (TCM), with roots in Taoism and Buddhism, also dates back to 3,000BC, has a holistic approach and promotes harmony within one's life (Gamby et al., 2021). Even ancient Greeks, such as Hippocrates, and ancient Romans, focused on prevention instead of sickness and felt diet and lifestyle were keys to wellness (SRI International, 2010). Although early mental health pioneers like Sigmund Freud wrote about wellness (Freud, 1937), the concept of modern wellness gained traction in the 1950's and decades thereafter. Theorists Alfred Adler, Carl Jung, Carl Rogers, and Abraham Maslow discussed the tenets of wellness and have been credited with steering the helping professions away from medical-based treatment models, which focus primarily on addressing physical illness and disease. Alfred Adler centered on holism, self-actualization, and growth of the individual (Adler, 1956). Jung suggested that people desire integration, balance, and wholeness (Jung, 1958). Rogers focused on the strength and capacity of humans and is credited with the term 'fully-functioning' (Blount et al., 2020), and Maslow focused on self-actualization and self-awareness (Blount et al., 2020).

The concept of wellness differs from medical-based models as it is an overarching term that refers to holistic health that integrates mind, body, and spirit (Oliver et al., 2018). The World Health Organization's (WHO) definition states that "health is a state of complete physical, mental and social well-being and. not merely the absence of disease or infirmity" (World Health Organization [WHO], n.d.). Myers et al. (2000) define wellness as "a way of life oriented toward optimal health and well-being in which body, mind and spirit are integrated by the individual to live more fully within the human and natural community." While there is no universal wellness definition, for this study, this author defines wellness as a belief system that focuses on the act of being well; mind, body, and spirit.

Wellness Models

The literature suggests several models of wellness are used across disciplines, with Dunn, Ardell, and Lafferty being some of the early pioneers. Halbert Dunn considered an early originator of the wellness movement, focused on wellness instead of illness (Ohrt et al., 2018). Dunn coined the term "high-level wellness," in which health was measured on a "health grid" of physical, biological, and socio-economic status on an environmental axis that could impact health. The health access ranged from death to optimal physical wellness (Oliver et al., 2018). Wellness was considered "high-level" if the environmental and health access were on the positive end of the measure. Ardell approached wellness from a medical model perspective but pivoted to interrelationships of the whole person (Oliver et al., 2018). Lafferty made the distinction that an individual is responsible for their health and their decisions regarding personal wellness. Lafferty posited that optimal health was not attainable, and one would spend a lifetime attempting to achieve it. Lafferty created the total person concept, where his dimensions were all interconnected (Oliver et al., 2018). The Wheel of Wellness, Swarbrick's Eight Dimensions of

Wellness, Hettler's Six Dimensions of Wellness, and Optimal Human Functioning models will be explored in this section. This author chose not to focus on one model, as no models specifically address the wellness needs for the Black/African American community.

Wheel of Wellness

Wellness has been the hallmark of the counseling profession since its founding. Several wellness models have been introduced over the last several decades; however, only two evidence-based models are used primarily in the counseling profession; The Wheel of Wellness and the IS-WEL models. Ensuring counselors maintain wellness is embedded in the ethical code, not only for counselors but also for clients' safety and well-being (Neswald-Potter et al., 2013) (American Counseling Association [ACA], 2014). Whitmer and Sweeny (1992), whose work was based on Alfred Adler's theory of life tasks, developed the first wellness model and spotlighted the importance of wellness in counseling. This model is based on theoretical constructs from psychology, anthropology, sociology, religion, education, and behavior medicine (Witmer & Sweeny, 1992). The Wheel of Wellness spotlights five life tasks that interact with one another. The Spiritual life task is explained as "life-enhancing beliefs about human dignity, human rights and reverence for life" (Witmer & Sweeny, 1992). Witmer and Sweeny (1992) also discuss spirituality as the lens through which ones purpose, optimism, and values are viewed, lived, or expressed. Self-regulation characterizes aspects of a healthy person; self of worth, realistic beliefs about self, life, and others, self-control, sense of humor, spontaneity and emotional responsiveness, intellectual stimulation, physical fitness and health habits, and psychological, social, and economic benefits. The Work-Life task highlights well-being benefits through economic, psychological, and social activities/interactions/purpose. The last two tasks, Friendship and Love, refer to social relationships, connection to others, intimacy, trust, and

commitment. The five life tasks connect to global life forces located on the outer bands; family, community, religion, education, government, media, and business/industry. Sweeny and Whitmer (1991) describe the paradigm as "dynamic, multidimensional and continually shifting in proportionality as human beings cope within their individual life spaces." The Wellness Evaluation of Lifestyle (WEL), a 114-item instrument with 17 scales, was developed by Myers et al. (2000) to assess wellness for this model (Blount et al., 2020). This model has been studied and found valid by several researchers (Hermon & Hazler, 1999).

Indivisible Self Evidence-Based Model of Wellness

Hattie et al. (2004) wanted to further investigate the Wheel of Wellness model for reliability and validity. Gaps were discovered, and the Indivisible Self Evidence-Based Model of Wellness (ISWEL) model was created. ISWEL is an evidence-based model using factor analysis focusing on five second-order factors. ISWEL has a single higher order wellness factor, five second-order factors (Creative self, Coping self, Social self, Essential self, and Physical self), and 17 discrete wellness scales. To measure this new wellness model, the Five-Factor Wellness Inventory (5F-WEL) was developed by Myers and Sweeny (2008). The 5F-WEL is a 73-item instrument that uses a 4-point Likert scale. This instrument measures total wellness, which identifies one's well-being once the composite score of the instrument is assessed. The 5F-WEL has been adapted into five languages and has versions for children, adolescents, and teens (Cooke et al., 2016). Noticing a need for this wellness model to address the cultural wellness of others, Chang and Myers (2003) recognized the WEL's need for a cultural adaptation and translated the measurement from English to Korean. The authors explained how several words and phrases of the instrument had to be changed due to there not being a Korean translation for English words such as gender, how the word peace is conceptualized, and how a Korean test

taker interprets certain phrases such as the words “illicit drugs.” The authors found differences in subscales that could be attributed to cultural and language differences. The interesting part of this research underscores how cultural differences can create different testing outcomes, which could limit conclusions drawn from the results, as it relates to the population under consideration.

Swarbrick’s Eight Dimensions of Wellness

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed a wellness initiative based on Margaret “Peggy” Swarbrick’s Eight Dimensions of Wellness model. The eight dimensions include physical, spiritual, emotional, environmental, social, occupational and leisure, intellectual and financial. Physical focuses on physical activity, diet, nutrition, and avoiding alcohol and drugs. Spiritual focuses on one’s values and beliefs that give meaning and purpose. Emotional focuses on feelings management and coping abilities. Environment focuses on living, learning, and working spaces that promote well-being and encourage community. Social focuses on effective communication and supportive relationships. Occupational and Leisure focus on participating in meaningful activities. Intellectual focuses on creativity and knowledge expansion, and finally, financial focus on satisfaction with financial situations (Swarbrick, 2009). A systematic literature review involving this model determined that the framework had not been used to study adults aged 45 and above and suggested more studies be done in older adults to support comprehensive wellness (Zechner et al., 2019). There is no instrument based on this model to measure wellness, and there seems to be little research on the effectiveness of this model. However, Swarbrick’s model has been adopted by government agencies as an effective wellness framework.

Hettler's Six Dimensions of Wellness Model

Bill Hettler expanded Dunn's work and, in collaboration with Dennis Elsenrath, started the National Wellness Institute in the 1970's and based their focus on Hettler's six dimensions of wellness (NWI). Hettler defined wellness as "an active process through which people become aware of, and make choices toward, a more successful existence" (Hettler, 1980). Hettler's Six Dimensions of Wellness is an interdependent model where all dimensions are interconnected, and a person is "well" or healthy when all domains are fully optimized (Oliver er al., 2018). In many ways, Hettler's existential approach to wellness is an active process where the individual's choices can determine their level of wellness. (Oliver et al., 2018).

The dimensions in Hettler's model are based on a continuum of high-level wellness to premature death. The occupational dimension includes using skills, gifts, and talents so that one's work is rewarding and meaningful. This is done by choosing a career that aligns with personal values and developing transferable skills. Physical refers to regular physical activity, proper diet and nutrition, and avoiding alcohol, tobacco, and drugs. Social encourages an understanding of one's role in society and contributing to one's environment and community by living in harmony with others. Intellectual emboldens creativity and intellectual growth, spirituality supports the search for meaning and purpose in one's life, and finally, emotional encourages feelings of awareness and acceptance (Hettler, 1980). To assess wellness, the Lifestyle Assessment Questionnaire (LAQ), now referred to as the Holistic Lifestyle Questionnaire (HLQ) and at times TestWell, was developed by Hettler. The LAQ is a 100-item assessment on a 5-point Likert scale that focuses on four sections; wellness inventory, personal growth, risk of death and medical alert (Hettler, 1980, National Wellness Institute [NWI], n.d.; Oliver et al., 2018). This self-administered assessment has 11 subscales (exercise, nutrition, self-

care, vehicle safety, drug usage, environment, awareness, emotional management, intellectual, occupational and spiritual.

Multicultural Wellness Wheel

The National Wellness Institute developed the Multicultural Wellness Wheel to support practitioners in understanding wellness concepts and multicultural competency related to its three pillars; Personal and Family Wellness, Community Wellness, and Worksite Wellness. Personal & Family Wellness focused on Integral Wellness, based on Hettler's Six Dimensions of Wellness and centers on healthy daily habits and self-efficacy. Integrative Medicine spotlights integrating conventional and alternative medicine to focus on mind, body, and spirit (National Wellness Institute [NWI], n.d.).

The second pillar, Community Wellness, focuses on healthcare disparities in communities and how policies can be implemented to reduce these issues, including collaborations, resources, and grassroots efforts. The third pillar, Worksite Wellness, centered diversity, values, work/life balance, time management, and resources to support these efforts. This author has been unable to find peer-reviewed articles to support this model, and while it speaks to some aspects of diversity, essential components of culture seem to be missing.

Optimal Human Functioning

Constantine and Sue (2006) developed the Optimal Human Functioning (OHF) model to speak to the need for the importance of culture to be centered in other wellness models. Eurocentric models of wellness typically do not address the cultural and social justice or equity needs of the Black, Indigenous, and People of Color (BIPOC) community. The authors wanted to make sure minorities were represented in the area of positive psychology and optimal human functioning. As it relates to cultural competency, Constantine and Sue (2006) stated a disconnect

between therapists and their clients pertaining to cultural values, worldview, and conceptualization of well-being. Constantine and Sue (2006) describe OHF as “a function of optimism and hope, resilience and subjective well-being.” The authors assert that previous definitions of optimal human functioning ignore cultural importance and focus on the “good life” as societal values instead of cultural importance and understanding that culture plays a pivotal role in optimal human functioning. OHF pulls from optimal psychology and is more applicable to people of color as a wellness model. This model centers on five cultural values, beliefs, and practices that align with various cultures; Collectivism, Racial and Ethnic Pride, Spirituality and Religion, Interconnectedness of Mind, Body and Spirit, and Family and Community.

Collectivism refers to tailoring interventions that focus on the client's culture and community rather than individualism. Racial and Ethnic Pride uplifts that people of color can experience increased collective self-esteem, positive self-image, and high levels of well-being, despite discrimination and racism. Spirituality and Religion suggest many cultures have spirituality or religion at the center of their wellness worldview. Constantine and Sue (2006) reported the Black church is viewed as a place of social, psychological, and political spaces for the community. Further, some Native American culture's wellness includes confession, good standing with family, and community acts of atonement. Interconnectedness of Mind, Body, and Spirit are interwoven and interdependent, and Constantine and Sue (2006) give the example that some people of color experience somatic symptoms when they are in emotional distress. Finally, Family and Community speak to the value of connection to family and friends in several communities, including African American, Native American, and Latinx American cultures. The social aspect of these connections allows for coping strategies that highlight their importance.

Other Wellness Models

This author has highlighted a few wellness models, however there are several others that should be noted, including the Lifespan Development Model, which was the basis for the Wheel of Wellness, Zimpher's Wellness Model, the Model of Spiritual Wellness, the Perceived Wellness Model and the Clinical and Educational Model (Blount et al., 2020). This researcher brought attention to several models as there does not seem to be a wellness model that speaks specifically to Black wellness practices. The models discussed in this chapter highlight similar tenants of wellness; spirituality, emotional well-being, physical health, social connectedness, occupation, environmental, intellectual, and financial security (Blount et al., 2020). Two wellness models incorporate the importance of culture, the Native Model of Wellness and Optimal Conceptual Theory.

Hodge et al. (2009) developed the Native Model of Wellness with spirituality at its center. The authors suggests "we are spirits on a human journey" and we will exist once our bodies are dead. The authors posited that we are in relationship with the Creator, and we grapple with negative and positive forces. Spirituality is exhibited through ceremonies, rituals, dreams, and prayer. Along with spirituality, body, mind and context are explained. Body relates to the physical condition of self, including nutrition, sleep, and exercise. The mind is connected to the body and spirit and encompasses cognitive abilities, intellectual abilities, experience, and judgment. The mind is exhibited through storytelling, reminiscing, remembering and memorials. Finally, context refers to people being community focused and contexts such as climate, work, family, culture and history are important. Context is carried through by elders, family, culture and traditions. The Native Model of Wellness focuses on interconnectedness and balance to achieve optimal health and well-being. Spirit, mind, body, and context operate on a circular

continuum, where one is healthy or in harmony when these four areas are balanced (Hodge et al., 2009).

Optimal Conceptual Theory (OTC), also referred to as liberation psychology or optimal psychology, is rooted in deep African thought (Myers et al., 2018). The goal of OTC is to "provide psychological knowledge capable of not only enhancing capacities for critical thinking, moral reasoning, and spiritual enlightenment but also the transformation of human beings, individually and collectively (Myers et al., 2018)." OTC asserts that an optimal way of living includes one creating a world that creates the likelihood of good health. The authors explain that people cannot separate themselves from their sociocultural perspectives, which may impact how they see themselves and others. The author posits that an unhealthy or suboptimal worldview competes with a healthy or optimal worldview. OTC suggests a suboptimal worldview, which includes racism and other oppressive and Westernized perspectives, impacts the wholeness and healing of those of African descent. A suboptimal worldview and oppression can create emotional distress. Ways of working toward an optimal worldview include Belief System Analysis (BSA), a holistic tool "that does not separate cognitive, affective, behavioral, spiritual, unconscious and metaphysical spheres" (Myers et al., 2018). BSA was designed for mental health professionals to practice African-centered-based therapy, a method that allows the client's African-centered belief system to be explored. BSA allows for movement from suboptimal to optimal worldview through self-awareness and increased self-knowledge (Myers et al., 2018). While OTC is not exclusively a wellness model, it does position itself to focus on optimal living for descendants of the African diaspora, centering African indigenous practices.

Wellness of the Counselor

Counselors have an ethical duty to maintain a healthy focus on wellness, so their impairment does not cause harm to those they serve (American Counseling Association [ACA], 2014). Although it is known that wellness undertones have been central to the counseling profession, the term wellness is only stated in the ACA Code of Ethics (2014) Preamble but not in an actual code, and the term wellness counseling is not referenced at all. Brubaker and Sweeney (2020) point out gaps in the code as it relates to wellness. The authors identified limited use of the terms wellness and well-being in the code, and when the term well-being is used, it typically refers to client well-being and does not seem to take a holistic approach. The code does not focus on wellness from a counselor-specific perspective or on the counselor's relationships with others (Brubaker and Sweeney, 2020). Section C of the ethical code does encourage counselors to "engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (ACA, 2014). While self-care is referenced in the ethical code, given the wellness philosophy of the counseling profession, it is surprising that counselor wellness is not centered in tandem with client well-being. Despite this, the promotion of counselor wellness can be seen in the literature. Newswald-Potter et al. (2013) conducted a study of post-graduate practicing counselors and found that most participants engaged in personal wellness activities that integrated throughout their lives that supported their professional wellness. In another study, Lawson and Myers (2011) sampled over 500 members of the American Counseling Association (ACA) to measure professional quality of life, career sustaining behaviors (CSB) and wellness, and found that counselors who scored high on wellness engaged in more CSB's and reported a higher and more positive professional quality of life.

To highlight the importance of counselor wellness, Gibson et al. (2021) provided a breakdown of the three aspects of wellness as it relates to the counselor. Counselor-centered wellness focuses on the counselor's mental, emotional, physical, spiritual, social, cultural needs and self-care practices. This wellness aspect also encourages a support system and other trusting relationships, including establishing and maintaining personal and professional boundaries, such as having a referral source in cases of crisis, separating work from home by not accepting calls outside of business hours, not bringing work home and cease ruminating on clients once the counselor leaves the office. Professional-centered wellness focuses on self-awareness and self-monitoring for impairment to prevent or manage burnout, compassion fatigue, or vicarious trauma. This can be practiced proactively through consultation and supervision. This also includes promoting wellness to colleges and clients. Finally, client-centered wellness encourages counselors to promote wellness through current research that discusses best practices and assessments to assist clients with optimal living.

It is safe to posit that wellness models can be used to promote counselor wellness. However, wellness models seem to focus on how counselors can conceptualize the client's wellness and not on how counselors conceptualize their wellness in relation to their professional and personal selves. The Counseling Profession as Advocates for Optimum Health and Wellness, adopted in 1989 by ACA (then American Association for Counseling Association, AACD), was viewed as a renewal of the profession's commitment to wellness as its foundation (Myers & Sweeny 2008). Several competencies address various areas within the counseling profession, including the Multicultural and Social Justice Counseling Competencies (MJSCC) established in 1992 and revised in 2015, and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling's (ALGBTIC) (currently known as the Society for Sexual, Affectional,

Intersex, and Gender Expansive Identities (SAIGE)) Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex and Ally Individuals, established in 2012.

There has been a need to develop a foundational guide for all counselors and supervisors that gives structure on how to serve clients and implement personal wellness practices. There did not appear to be a universally identifiable counselor competency regarding wellness until recently. However, the CSI Counselor Wellness Competencies introduced in 2020 by Chi Sigma Iota Counseling Academic and Professional Honor Society (CSI) intend to fill that gap. The purpose of the model is "to highlight and delineate specific knowledge and expertise that is necessary for professional counselors to effectively support their own well-being as well as their clients' efforts to achieve optimal wellness" (Gibson et al., 2021).

The CSI Counselor Wellness Competencies focus on the self-reflective aspect of the MJSCC and acknowledge the diversity among counseling professionals and encourage ongoing self-awareness so self-care and wellness practices can be implemented (Gibson et al., 2021). The CSI Counselor Wellness Competencies model has three pillars; counselor-centered, professional-centered, and client-centered, and nine competency areas that fall on that continuum (Gibson et al., 2021). Self-Care: monitoring personal wellness and implementing self-care strategies that promote optimal well-being. Personal Relationships: developing and maintaining relationships with support system. Boundaries: establishing and maintaining personal and professional boundaries. Stress, Burnout, and Impairment: be self-reflective and aware. Professional Support Practices: seeking consultation, supervision, mentorship, or personal counseling. Wellness Promotion: model and encourage wellness practices. Wellness Research: incorporate theoretical and evidence-based wellness models to counseling, supervision, instructional, and leadership roles. Wellness Assessment: utilize empirically based assessments to assist clients in optimal

well-being. Wellness-based Goal-setting and Plans: utilize assessment data to help clients develop a "personal wellness plan" and create goals to increase holistic wellness. Blount et al. (2020) Believe that helping professions have gotten away from a wellness focus and encourage helping professionals to "re-introduce" themselves to a wellness orientation and encourage professions to center wellness models and assessments in supervision, practices, and personal lives.

Wellness of Counselors in Training

Wellness is discussed in counseling programs and encouraged, but some programs do not seem to center wellness and there is limited research on wellness, institution promotion and counselors in training (Roach &Young, 2007; Gleason & Hays, 2019). Wellness may be taught or discussed as an elective class, but it may not be woven through all aspects of the program (Roach &Young, 2007). Brubaker and Sweeney (2020) report that the term wellness is only found three times in the Standards but is not defined in the Glossary to Accompany the 2016 CACREP Standards. When stated, wellness seems to be focused on outcomes instead of holistically. Further, wellness counseling is not mentioned, but it seems implied in practice, and while wellness is referenced in the CACREP Standards, there are no instructions on how wellness practices can be implemented (Foster, 2010; Gleason & Hays, 2019). Students, particularly non-traditional graduate students, experience stress that traditional graduate students may not, such as family, financial and parental obligations, employment and academic workload, and time constraints (Ramos, 2011). Ramos (2011) studied perceived stress levels and coping in non-traditional graduate students in distance learning and on-campus programs and found no significant difference, meaning both on-campus and distance learning students have high-stress levels and various ways to cope. In another study, Wardle and Mayorga (2016) conducted a

study to determine indicators of burnout among counseling students and found that 85% of the participants indicated an awareness of burnout or that they were experiencing burnout. Despite there being a limited spotlight on wellness in supervision models, wellness-based supervision can help counselors and counselors in training focus on their wellness and their professional and clinical growth (Meany-Walen et al., 2016).

Wellness in counselor preparation programs and supervision and potential impairment areas should be discussed between educators, supervisors, and supervisees/students. In a qualitative study, Blount et al. (2016) examined clinical supervisors' perception of their supervisee's wellness and found themes of intentionality, self-care, humanness, support, and wellness identity, which can aid supervisors in areas of wellness support for supervisee's. Blount and Mullen (2015) suggest that when considering wellness in counselors in training, the supervisor relationship plays a vital role in the discussion and suggested the Integrative Wellness Model as a guide. Counselors in training, especially those in practicum and internship who are under supervision, could benefit from a wellness-focused perspective to help them navigate managing expectations of a counselor while navigating a student/internship /family role/life balance. It is vital to include counselor-in-training wellness and efforts put forth by supervisors and faculty to aid students in optimizing their wellness. Students become professionals, and when there is a wellness foundation for students, it can then be carried into their professional lives upon graduation.

Wellness Impairment

There is robust literature regarding counselor impairment (Blount et al., 2016; Craig & Sprang, 2010; Figley, 2002; Wardle & Mayorga, 2016). Specifically, burnout, emotional exhaustion related to one's job (Bressi & Vaden 2017); compassion fatigue, noticing and being

impacted by another person's pain (Figley, 2002); and vicarious trauma, the effects of working with those who have experienced traumas (Craig & Sprang, 2010), can impact counselor well-being. This may be because maintaining wellness of self is integral to being healthy and present for the client. An impaired counselor can pose a risk in the healing journey of the clients with whom they work (Lawson & Myers, 2011). Lawson et al. (2007) state that therapeutic impairment "occurs when there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client." The impairment can include substance dependency, traumatic events, vicarious trauma, physical illness, burnout, or other types of personal crises. Lawson et al. (2007) distinguish that a stressed counselor may have significant stressors, but their work is not impacted, whereas an impaired counselor's work may suffer. Lawson et al, (2007) also reported that wellness is a continuum and identified well, stressed, distressed, and impaired as points on that continuum. The ACA ethical code discusses counselor impairment in Section C, which states "counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired" (ACA, 2014). Supervision, including consultation, is a great way for colleagues to gatekeep. The profession and the Code of Ethics state, "through initial and ongoing evaluation, supervisors are aware of supervisee limitations that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed" (ACA, 2014). This section will highlight factors often discussed in the literature that lead to counselor impairment; burnout, compassion fatigue, vicarious trauma, and COVID-19.

Burnout

The term burnout was coined by Freudenberger (1980). Burnout is defined as "a person overcome by fatigue and frustration which are usually brought about when a job, a cause, a way of life or relationship fails to produce the expected reward." Since the term became widely known, there have been many definitions of burnout, but most include emotional exhaustion and feeling disconnected from one's job (Bressi & Vaden 2017). Burnout is often viewed as an occupational hazard that can impact one's physical and emotional health (Maslach & Leiter, 2016; Testa & Sangganjanavanich, 2016). Physically burnout can present as fatigue, muscle tension, sleep disturbances, and exhaustion (Testa & Sangganjanavanich, 2016; Wardle & Mayorga, 2016). As it relates to one's mental health, burnout can impact one's ability to identify joy and increase negative attitudes (Wardle & Mayorga 2016). Maslach and Leiter (2016) describe burnout in three dimensions; exhaustion, cynicism, and inefficacy. The exhaustion dimension is where there is a loss of energy, and one feels fatigue that can feel debilitating. The cynicism dimension, also called depersonalization, is described as a negative attitude toward others, including clients, withdrawal and irritability. Finally, the inefficacy dimension, also known as personal accomplishment, describes productivity reduction, low morale, and an inability to cope. The authors go on to identify six primary risk factors of burnout. Work overload (employees struggle to rest, recover and balance when they feel too depleted to meet job demands), Control (employees who feel they have an input in their work lives and levels of autonomy are more likely to be engaged in their jobs), Reward (positive reinforcements and recognition. When rewards are not in place or consistent, employees are at risk for burnout), Community (work relationships that are not supportive, conflictual lack of trust are at risk for burnout), Fairness (equity and social justice) and Values (related to how ppl are motivated and if

there is a conflict, burnout can arise). Those in the helping professions are more susceptible to burnout, including counselors.

Burnout may be more likely for mental health professionals who work with high acuity clients (suicidal ideation, crisis) and others due to the demands of their work. (Carrola et al., 2016). Pulson and Gall (2020) explain that mental health professionals have a one-way relationship with their clients that involves "one-way caring," meaning practitioners extend empathy, compassion, and support towards clients that is not reciprocated. Empathy allows the counselor to grasp the clients' needs and respond accordingly. It is a skill to learn not to over-identify with the client while remaining attuned and connected (Butts & Gutierrez, 2018). This level of caring can lead practitioners to not focus on their wellness. Burnout can lead to worker errors (documentation or client care), poor attitudes toward clients, and struggles with maintaining personal or professional relationships (Blount et al., 2020).

Maslach and Leiter (2016) suggest some recommendations for burnout, including taking breaks, working fewer hours, changing schedules, having a work-life balance, coping skill development, identifying social supports, maintaining good health, self-awareness and therapy. The authors also suggest therapists working with the trauma population and palliative care should not only practice wellness in the form of physical (eating well, working out) but focus on their emotional wellness to prevent secondary trauma. Methods of suggested self-care include therapy, centering spirituality and focusing on positive aspects of professional and personal life to prevent being overwhelmed by misery and tragedy.

Compassion Fatigue

Along with burnout, compassion fatigue can occur in counselors and impact their work with clients. In a meta-narrative review of healthcare literature, Sinclair et al. (2017) concluded

that all healthcare providers studied, who suffered from compassion fatigue, had difficulty providing quality care to patients. Figley (2002) defined compassion fatigue as “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent arousal (e.g., anxiety) associated with the patient.” Figley (2002) goes on to say that compassion fatigue is a “function of bearing witness to the suffering of others.” In other words, it is the cost of caring. Figley identified eleven variables in his etiological model that are predictors for compassion fatigue. Empathetic ability explains the therapist's ability to notice others' pain, and the ability to be empathetic not only helps the therapist be effective but is also a cost of caring. Empathic concern refers to our motivation to respond to those in need.

Exposure to the client refers to direct exposure to the suffering of others. Empathic response refers to the effort the therapist extends to reduce another's suffering through empathic understanding. Compassion stress is a “residue of emotional energy from the empathic response to the client and is the ongoing demand for action to relieve the suffering of a client.” Sense of achievement lowers compassion stress and measures the therapist's satisfaction with their efforts to help their client. Disengagement also reduces compassion stress and allows the therapist to create an emotional distance from clients' suffering. This is a form of self-care and can be helpful in a therapist's well-being. Prolonged exposure refers to a therapist caring for others over an extended time period and an “ongoing sense of responsibility.” Traumatic recollection may be a PTSD trigger of memories that may lead to anxiety and depression. Life disruption refers to life responsibilities and routines that may be changed unexpectedly. These changes, coupled with the above factors, can create challenges for the therapist and increase the potential for compassion fatigue. Figley (2002) believed that this model's components could predict compassion fatigue

symptoms and possibly prevent them. Figley's goal was to bring awareness to the therapist so compassion fatigue could be identified and mitigated. Occupational hazards such as proximity to others suffering and holding space for someone's traumatic experiences contribute to counselor's vulnerability to a lack of wellness practices (Blount et al., 2016). Being aware of compassion fatigue can be a preventative measure.

Vicarious Trauma

Despite wellness being undergirded in the counseling profession, counselors may struggle to center wellness in their personal and professional lives. This could be due to their proximity to suffering, vicarious trauma, and the occupational hazard of therapy (Blount et al.,2016). The literature suggests that vicarious trauma can occur with those in the helping profession, particularly mental health professionals that work with clients who have experienced trauma (Craig & Sprang, 2010). The term vicarious traumatization was first coined by McCann and Pearlman (1990) and described helpers who work with those who have experienced traumas and therapists "may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons." McCann and Pearlman's work is based, in part, on Figley's identification of secondary traumatic stress, which he defines as "the natural consequence behaviors and emotions resulting from helping or wanting to help a traumatized or suffering person." McCann and Pearlman (1990) developed the Constructivist Self-Development Theory (CSDT) framework for vicarious trauma and believed that a therapist's schema is disrupted when they work with clients who have experienced trauma. The authors identified seven schema disruptions (dependency/trust, safety, power, independence, esteem, intimacy and frame of reference) that focused on psychological

needs and cognitive schemas (belief and assumptions about the world and how others make sense of their experiences) as it relates to vicarious traumatization.

Although burnout, compassion fatigue, and vicarious trauma have similar tenants, vicarious trauma has a long-lasting impact on the mental health professionals' beliefs and worldview (McCann & Perlman, 1990). Foreman (2018) assert, “Vicarious traumatization occurs when counselors engage with clients who have been traumatized and results in a transformation within the counselor that disrupts and potentially alters the counselor’s view of their self as competent, of others as trustworthy, and of the world as a safe place.” In a study that examined wellness and counselor exposure to client trauma, Foreman (2018) discovered that greater exposure to client trauma did not impact total counselor wellness; however, counselors who practiced wellness at a higher level did have significantly lower levels of vicarious traumatization. In other studies, it was determined that counselors, despite knowing the risks for working with clients who experience trauma, do so for altruistic reasons, and even though counselors had their trauma histories, the impact was positive, and counselors were motivated by “a sense of personal meaning and higher purpose” (Jenkins et al., 2011).

While vicarious trauma can affect any mental health professional, Black therapists are affected by other traumas, including race-based traumas. Shell et al., (2021) found that race-related stress significantly predicted burnout and secondary traumatic stress in Black mental health therapists. It is essential for counselors to be mindful of the impact of vicarious trauma and how it can affect their wellness goals. Later in the chapter, race-based traumas and their effect on the wellness of Black Americans will be discussed.

COVID-19 Pandemic Impact on Wellness

Given the recent climate, the impact of the COVID-19 pandemic cannot be overlooked. The global pandemic has affected lives across the globe, but the U.S. in particular, has also dealt with a financial crisis, uncertainty related to the effectiveness of the government due to inconsistent messaging and communication, and racial unrest due to the death of George Floyd, whose murder was captured on video and went viral. (Pfefferbaum & North, 2020). Initial reports of the pandemic focused on physical health, but many soon realized that the isolation from others during the early months of the pandemic and the toll of caring for others was just as impactful. In the early stages of the pandemic, social distancing was implemented to reduce or stop the spread of the disease. Due to this, many people were isolated from physical interactions with others, treatment availability became limited, and there were concerns that there could be a widespread impact of mental health concerns in the community (Pfefferbaum & North, 2020). One study reviewed the internet searches related to mental health and the COVID-19 pandemic and found that during the period of stay-at-home quarantine, there was an increase in inquiries regarding suicidal ideation, insomnia, negative thoughts, and anxiety (Jacobson et al., 2020). A cross-sectional study was done to examine the impact of the pandemic on the mental health of women professionals working from home and found that mental health was affected severely in 27% of participants, and over 45% reported physical ailments (Sharma & Vaish, 2020). According to a CDC report, "during June 24–30, 2020, U.S. adults reported considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use and elevated suicidal ideation" (Centers for Disease Control and Prevention [CDC], 2020).

COVID-19 Impact on People of Color

COVID-19 disproportionately impacted people of color, and the pandemic highlighted gaps in mental health care and resources for Black and Latino people living in the U.S. (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.-a). At the pandemic's start, there was no playbook on navigating through it as there had been nothing similar in 100 years. The pandemic of 1918, however, gave insight into some of the challenges the sick and healthy had to deal with while being isolated from others (Centers for Disease Control and Prevention [CDC], n.d.). Literature on how healthcare workers dealt with the 1918 pandemic is seemingly non-existent; however, the COVID-19 pandemic research is just beginning. Martin et al., (2021) conducted a study measuring the mental health and health quality of life of healthcare workers in Spain and found symptoms of depression, anxiety, stress, and insomnia in healthcare workers during the pandemic. COVID-19 is a global crisis that, for some, created daily stressors and exposure to traumatic experiences, and mental health professionals may have been exposed to these stressors in their personal and professional lives (Aafjes-van Doorn et al., 2020). Literature regarding the pandemic is still limited; however, Aafjes-van Doorn et al. (2020) examined vicarious trauma in psychotherapists practicing during the pandemic. The study found moderate levels of vicarious trauma compared to other studies. Higher levels of vicarious trauma were found in therapists who were newer to the field and had less experience. Other studies have been conducted on the impact of mental health professionals who experience vicarious trauma alongside clients on a major scale, such as Hurricane Katrina (Culver et al., 2011) and 9/11 (Boscarino et al., 2004).

Therapists have also had to adjust to being primary telemental health providers, and for many, this transition was abrupt. Telemental health services have been on the rise in recent years, but many therapists were still seeing clients face to face. The pandemic's early months and subsequent years created a necessary space for providers to practice behind a screen (Békés et al., 2021). There are positive effects on wellness for using and providing telehealth services, such as creating a safe space to provide services to those with medical challenges or transportation issues, reducing travel costs and commute challenges, the need for childcare, and wider accessibility (Békés et al., 2021; Madigan et al., 2021). The usefulness of telehealth services can be seen in minority communities. A study by McCall, Schwartz and Khairat (2019) examined the accessibility of telehealth services such as video conferencing in African American women and found a high acceptance of telehealth service usage among professionals suffering from depression and anxiety. The study also showed that the acceptance rate was higher in women under 50.

Therapists were considered the “invisible front line workers” as there was little acknowledgment of their role in supporting other healthcare and frontline workers and the community during an emotionally strained period (Miu & Moore, 2021).

Further research is needed to measure the impact of the COVID-19 pandemic on our physical, mental and spiritual health and the wellness of mental health professionals. Black mental health professionals have been dealing with burnout from the occupational stressors of their jobs, the emotional weight of the COVID-19 pandemic, and the racial uprising during the period of protests following the deaths of George Floyd and Breonna Taylor. This study will focus on wellness practices and barriers to wellness among Black counselors.

Wellness of the Black Counselor

Counselors navigate many barriers to wellness, including stress, burnout, compassion fatigue, vicarious trauma, the current pandemic, financial challenges due to low salaries, and focusing on others' well-being instead of their own (Blount et al., 2020; McCann & Perlman, 1990; Foreman, 2018). Black counselors encounter the aforementioned barriers as well as those specific to the Black community and other racial minorities. Black people face several obstacles that their White counterparts do not. Racial discrimination, microaggressions, stereotypes, systemic and institutional racism, lower socio-economic status (SES), lack of trust in the health community, myths and misconceptions about mental health and treatment, racial profiling, and community violence are just a few factors that may impact a Black counselor's ability to practice wellness (Stewart et al., 2021; Griffith et al., 2018).

Barriers to Wellness and the Impact of Racism and Discrimination on Wellness

Black people are disproportionately disenfranchised economically, physically, mentally, and in education. According to the U.S. Census Bureau (2019), over 13 percent of the population identify as Black with a median household income of about $45,000, compared to Hispanic Americans of $55,000 and over $71,000 for White Americans. Shrider et al., (2021) report a staggering wealth gap, with the median wealth of African Americans in the U.S. being $13,460 compared to White American's median wealth of $142,180. These startling statistics may contribute to housing insecurity as 39% of the homeless population is Black. One in five Black people lived below the poverty line in 2020 (Shrider et al., 2021). Lack of resources and economic hardship can impact one's physical health. According to the CDC (2017), the current leading cause of death in African American’s is heart disease, cancer, and COVID-19. Blacks are more likely to be diagnosed with diabetes and heart disease and more likely to die of a stroke

(American Psychological Association [APA], 2016). Compared to their White counterparts, Black/African Americans have a higher death rate involving heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide (Centers for Disease Control and Prevention [CDC], 2021). Other staggering statistics report Black women die from breast cancer more than other cancers and are twice as likely to die from uterine cancer as White women (American Cancer Society [ACS], 2022). Lack of adequate health insurance also contributes to poor health outcomes in African Americans (American Cancer Society [ACS], 2022). Health is often tied to available resources such as green spaces in the community to walk or do other physical activities, access to healthy foods, quality education, and employment (Shrider et al., 2021; American Cancer Society [ACS], 2022)

Several factors may lead to increased emotional suffering in Black Americans, including but not limited to systemic and institutional racism, low socio-economic status, redlining, mass incarceration, racial profiling, microaggressions, and untreated traumas such as collective, cultural, complex, and historical trauma (Griffith, 2018). The need for mental health resources and education continues to grow in the Black community. According to a 2019 report, between 2008 to 2019, serious thoughts of suicide increased in Black Americans from 3.6% to 4.0%, serious mental illness increased in Black Americans from 2.5% to 4.0%, and the need for mental health services for those with serious mental illness increased in Black Americans from 55.4% to 57.9% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Low wages and poverty contribute to mental health challenges such as depression and anxiety and are linked to high-stress levels (Santiago et al., 2013). Black Americans below the poverty line are more likely to report psychological distress than Whites (Shattell & Brown, 2017), and Black Americans are more likely to experience feelings of depression (sadness, hopelessness,

worthlessness) compared to White adults (U.S. Department of Health and Human Services; Office of Minority Health, n.d.).

Racial discrimination may also contribute to mental health stressors in minorities. The effects of racism on Black people living in the U.S. have been widely studied. From slavery to the Jim Crow Era to the current racial climate, overt and covert acts of racism have historically impacted the African American community (Bartholomew et al., 2018). The Southern Poverty Law Center (2020) reports hate groups have increased by 60% since 2000. Blacks report higher levels of racial discrimination than other minority groups, and research suggests that racial discrimination can impact mental health (Assari et al., 2017). Brownlow et al. (2019) suggest that racial discrimination is a significant public health concern due to physical and mental health threats for racial and ethnic minorities.

Despite this data, there continues to be stigma associated with mental health in the Black community, which may contribute to Blacks not seeking treatment when symptoms of mental illness arise (Shattell & Brown, 2017).

Historically, Black Americans have a long-standing mistrust of the medical and research community. This mistrust stems from mistreatment, dismissal of concerns, and lack of adequate care (Melissa et al., 2018). Black men and women have a history of being the subject of medical experiments against their will. The cells of Henrietta Lacks, a Black woman diagnosed with cervical cancer in 1951, were used without her or her family's permission after her death, which led to clinical research and medical breakthroughs such as chemotherapy and in vitro fertilization (Henderson, 2014). Mrs. Lacks' cells are still being used and have recently played a role in developing the COVID-19 vaccines (John Hopkins Medicine, n.d.). Another example of medical mistrust is Dr. Marion Sims, who is considered the father of modern gynecology. Most are

unaware that he earned that moniker, in part, due to his unethical clinical practices and cruel experiments on unwilling enslaved Black women to help White women (Melissa et al., 2018). The Tuskegee Experiment, a study that started in the 1930's, was conducted by the U.S. government for decades on poor Black men. The diagnosis of syphilis was left untreated, without the participant's knowledge, so that researchers could study the effects of the disease. The study continued until the early 1970's and only stopped when a reporter broke the story (Reverby, 2009). A similar experiment conducted by the U.S. government in Guatemala purposefully infected over 700 people, including prisoners and psychiatric patients, with syphilis without their knowledge or consent. One of the researchers, John Cutler, was involved in this and the Tuskegee experiment (Semeniuk, 2010).

The tragic life and death of Sarah Baartman, on the surface, does not seem tied to the medical community. Baartman, a woman of African descent, was paraded around in a sideshow, nearly naked, for years as White people ogled, poked, and prodded at her without permission. It is believed that Sarah was either duped into the show or sold and may have been prostituted during private home viewing of her naked body. In death, a full cast of her body, brains, genitalia, and skeleton was preserved and on display in a French museum until the 1980's. Parts of Baartman's body were in the basement of that museum until 2002 (Henderson, 2014). The erroneous misconception that Black do not feel pain (physical or emotional) the same as other races continues today, as evidenced by the racial disparities related to birth trauma, maternal death rates, and other medical challenges (MacDorman et al., 2021; Hoffman et al., 2015).

These stories of the mistreatment of Blacks in America and abroad may not seem relevant to this research, however, it speaks to how Black people have been oppressed and dehumanized without cause, care, or remorse. Historical forms of racial trauma and discrimination has had an

impact on how Black people living in America view the medical community, and at times, White people in general (DeGruy, 2017). These stories also feed into myths and sometimes facts surrounding the White-centered treatment of physical and mental health, lack of cultural competence and humility by providers, and mistrust in the medical/research community.

Black counselors are at risk for racial discrimination and disparities and can experience these in the workplace. Black health care providers experience stress at a higher level due in part to racism, high acuity of patients, high job demands, and a smaller number of African American practitioners in the field (Evans, 1997). Access to culturally competent providers is essential to people of color as African Americans are more likely to be misdiagnosed (Gara et al., 2019), and race may play a factor in how high acuity patients are viewed by clinicians (Spector, 2001). Lin et al. (2018) reported that only 4 percent of psychologists in the US were African American, compared to 86 percent who were White, which could suggest a potential lack of cultural understanding when working with Black patients. A social work report in 2018 noted that 22.9% and 25.7% of new MSWs and BSWs, respectively, are African American (The George Washington University Health Workforce Institute, 2019). Demographic data for marriage and family therapists were unclear. When this author attempted to obtain demographic information from ACA regarding counselors, the information could not be obtained at the time of the writing of this study.

Strong Black Woman Schema

The Strong Black Woman (SBW) is a schema that is described as culturally and gender-specific that depicts Black women as strong, resilient, and self-sacrificing for those they love and their community (Woods-Giscombe, 2010). The Superwoman schema construct traces back to the late 1970's or early 1980s when this concept was introduced by Michelle Wallace and later

Linn Spencer Hayes (Huddleston-Mattai, 1995). These authors posited that women navigate several roles, such as being an employee, a caretaker, and managing their social and community life. This can lead to women feeling burnout because they try to be "all things to all people." The original conceptualization was not created for Black women specifically, but there were several aspects that Black women can identify with and expand upon, making way for the SBW schema. Although the SBW schema can be viewed positively by Black women (Woods-Giscombe, 2010), it can also serve as a way of coping (Harrington et al., 2010) and may not be conducive to wellness (Jones et al., 2020). The concept of strength is cultivated in Black girls, even at an early age (Anyiwo et al., 2022), and Abrams et al. (2014) state aunts, grandmothers, and mothers socialize the female relatives to be strong and resilient. These traits may continue into adulthood and may contribute to the development of SBW schema.

The SBW is characterized as someone who has emotional restraint, independence and focuses on the caretaking of others (Jones et al., 2020). Other SBW characteristics include self-sacrifice, extreme independence, emotional silencing, resiliency, survival despite life challenges, emotional suppression, physical strength, a limited display of vulnerability, and assertiveness (Davis & Jones, 2021; Carter & Rossi, 2019). Historically, women like Sojourner Truth, Harriet Tubman, and Michelle Obama are examples of the SBW archetype (Watson & Hunter, 2016). The literature suggests positive aspects of the SBW schema, such as increased self-esteem and the ability to manage life stressors despite limited resources (Davis & Jones, 2021). Jones et al. (2020) studied 220 Black college-age women between the ages of 18 and 48 and their perception of the SBW schema and found that the participants believed that SBW were seen as angry, independent, nurturing, hardworking, emotionally contained, and resilient. However, the participants felt being self-identified as a SBW was important so they could see themselves as

strong and resilient, and to a degree, this allowed them to cope. The researchers also found that Gendered-Racial Pride was associated with being a SBW among college-age women as it is an important aspect of identity when educational environments are non-affirming. To that end, strength in African American's is sometimes seen as a way of resistance against stressors (Jones et al., 2020). Davis and Jones (2021) conducted a conceptual review of literature on the SBW image and concluded that Black women had used this archetype for survival and resilience despite its harmful nature

Despite their strength and resilience, including being the most educated group in the U.S. (National Center for Education Statistics, 2020), Black women continue to struggle with physical and emotional challenges, which some attribute to the SBW schema (Carter & Rossi, 2019), such as anxiety related to cultural expectations (Watson & Hunter, 2015). Black women have shorter life expectancies and higher maternal mortality rates and are more likely to suffer from chronic illnesses such as heart disease, obesity, and diabetes. These health disparities are closely linked to social-economic and environmental challenges. (Chinn et al., 2021). Black women are less likely to be physically active, typically because their focus is on the care of others (Carter & Rossi, 2019). Even maintaining beauty standards of hair and nail care is rooted in the idea of strength. Even though African American women look "put together" on the outside, they may struggle in areas others cannot see and therefore be viewed as strong and resilient, showing performative strength (Carter & Rossi, 2019). Black women may not seek mental health services because they do not want to be perceived as "weak", not capable or have a negative perception by others (Watson & Hunter, 2015; Watson & Hunter, 2016). Watson and Hunter (2015) studied if the SBW race-gender schema predicted anxiety and depression, and help-seeking attitudes. The authors found the SBW race-gender schema influenced anxiety recovery, but the schema

also triggered psychosomatic symptoms of anxiety because of cultural expectations. The study also found the SBW race-gender schema predicted symptoms of depression, and high indifference to stigma negatively predicted anxiety but did not negatively predict depression, which may be consistent with participants feeling judged by others for seeking mental health services and may be associated with feelings of worry. Black women have navigated life with many stereotypes, misconceptions, and misogynoir, a term coined by Moya Bailey to describe misogyny directed towards Black women based on their race and gender (Bailey, 2021).

Historically, terms used to describe black women included “Mammy”, “Jezebel” and “Sapphire” (West, 2008). The Mammy stereotype is self-sacrificing while caring for others. Mammy served as a cook or housekeeper, whose role was also to care for the needs of the mistress of the house and often the children while neglecting her own needs and her family's needs (Thomas, 2001). Mammy is typically described as an overweight Black woman who is seen as strong, resilient, and able to handle life’s challenges without fatigue (West, 2008). Mammy has been depicted for years in consumer products. Aunt Jemima, a pancake mix and syrup brand, had the Mammy image on its products, based on former slave Nancy Green, a dark-skinned, wide nose older Black woman with a bandana on her head was the image most associated with the product. This image stood firm for 130 years. The company changed the image in 1989 to a more “sophisticated” look. The brand finally removed the image and changed the name in 2020, soon after the protests following the murder of George Floyd (Warren-Gordon & McMillian, 2015).

Hattie McDaniel played the character Mammy in the revered movie, Gone with the Wind, in which she was the first Black person to win an Academy Award. Despite her seeming success, Ms. McDaniel was not allowed to attend the movie's premiere, was seated, segregated

from others at the side of the room at the Oscars ceremony, and was denied the final resting place of Hollywood Cemetery due to segregation (Encyclopedia Britannica, n.d.). Even the most famous “Mammy” was present only to entertain, and her thoughts, feelings, and needs were dismissed. The myth of “Mammyism " is connected to wellness and the SBW because Black women will focus on others, often at the expense of self, and will feel a sense of guilt when there is a need to prioritize themselves, which in turn, they choose not to do (Thomas, 2001). Further, this stereotype suggests that Black women are only suitable for serving others, especially White women and men, and their needs and families are less than significant.

African American women have been sexually exploited since slavery by being raped, molested, and degraded by the White men and women who owned them. The Jezebel stereotype is perceived as a manipulative, seductive woman with no control over her sexual desires (Thomas, 2001; Warren-Gordon & McMillan, 2015). This stereotype was created in part to justify the actions of those who took advantage of Black women (Thomas, 2001). This stereotype plays out when Black women are seen as “welfare queens” who have children they cannot care for and “demand” they be cared for by the government (Thomas, 2001; Warren-Gordon & McMillan, 2015). Social media can also influence the SBW schema and the Jezebel stereotype (Warren-Gordon & McMillan, 2015). Black women and their images are often sexualized, even with athletes like butt shots of Serena Williams, and focus on the hair, nails, and attire of the late Olympic gold medalist Florence Griffith Joyner (Flo-Jo) (Warren-Gordon & McMillan, 2022). These stereotypes can negatively impact the way Black women are perceived and how a Black woman sees herself, values herself and her self-esteem is sometimes tied to these images, especially in young children and teens (Warren-Gordon & McMillian, 2022). This impacts Black

women's wellness when they are not allowed to be sexually expressive or accept their sexual identity for fear of being viewed negatively (Thomas, 2001).

The sapphire stereotype derives from a character from Amos and Andy that was verbally aggressive, loud, and argumentative. The image assumes African American women are hostile, arrogant, and obnoxious (Thomas, 2001). Black women who embody this characteristic may feel the only way they are heard is if they are loud, while other Black women may not express feelings of fear that they are seen as aggressive (Thomas, 2001). This stereotype impacts wellness because Black women can be misunderstood and not allowed to express feelings like anger without being viewed as "mean" to others. The "Angry Black Woman" stereotype is a modern term for Sapphire (Warren-Gordon & McMillan, 2022). Embodying the SBW schema can impact a Black woman's mental health. Black women's internalized expectations of strength and resilience can result in poor psychological outcomes (Watson & Hunter, 2015). Lack of boundaries, boundary setting, and boundary maintenance can lead to increased stress and expectations that the SBW should/must put others first (Carter & Rossi, 2019). The SBW schema impacts a Black woman's ability to express herself fully. The Sisterella Complex explains characteristics of functional depression in women who display traits of SBW. They suffer in silence and internalize their struggle, and have shame and guilt due to sacrificing themselves for others (Jones & Shorter-Gooden, 2003).

There are positive aspects of the of the SBW. Anyiwo et al. (2021) examined the association of the SBW schema endorsement and racial experiences in Black girls and found that participants who experienced more racial discrimination had a higher SBW endorsement. Meaning they saw themselves as strong and resilient against racial discrimination. Abrams et al. (2014) sought to study how Black women from various backgrounds perceive the SBW persona

and define the roles, and the researchers concluded those who possess the SBW persona identifies as resilient and independent and juggle several roles, including being a woman, a Black person and juggle personal and professional obligations and prioritize others and their spiritual life. Taking on characteristics of the SBW can be beneficial to Black women counselors as their strength and resilience can benefit them in work they do with clients, however, counselors need to be mindful of the negative wellness impact of the SBW schema and not put others before themselves in their personal and professional lives.

John Henryism

John Henryism (JH) is a term that suggests African Americans cope at a high level due to emotional stressors, and this construct may impact Black males. Some barriers Black men face related to wellness include dealing with racism, high levels of stress, chronic health conditions and limited resources (James, 1993; Angner et al., 2011; Duke Medicine News & Communication, 2006). John Heryism was coined by James (1993), after interviewing a sharecropper named John Henry Martin, a man in his late 50's, who had a myriad of health challenges that could be attributed to a sharecropper's difficult job. John Henryism comes from the folklore of a Black laborer who reportedly was a man of great strength that worked on the railroad. Henry's origins are unclear, but many believed he was formerly enslaved, and several versions of songs have been written about him (Wade, 2002). Henry's steel driver job was hammering rock to make tunnels for the railroad tracks. One legend says that the railroad owner buys a steam-powered hammer to speed up the process. Henry races the machine and wins to prove that he and his fellow workers' jobs were needed. Other versions of this tale state that Henry needed to drive the steel to save a town from a train. Regardless of the version, Henry dies from exhaustion and stress soon after the race with the hammer in his hand (Wade, 2002;

Flaskerud, 2012). John Henryism is defined as an "individual's self-perception that they can meet demands of their environment through hard work and determination" (James et al.,1983). Meaning, despite the stressors of their psychosocial environment, they are predisposed to cope (Angner et al., 2011).

The initial concept of JH was used to study hypertension in Black men (James et al.,1983), and later studies have been conducted on the association between JH, blood pressure, and socio-economic status (SES) and found those with higher SES and ways of coping with stress had lower hypertension while those with lower SES and limited ways of coping had higher blood pressure levels (Merritt et al., 2004). SES and hypertension are associated in Black and White Americans; however, the exact causes are unknown. Speculation is that stress, un/underemployment, financial and food insecurities, lack of educational opportunities, and limited resources may play a part (James, 1994). Literature suggests prolonged high-effort coping, paired with SES stressors, can account for the association (Duke Medicine News & Communication, 2006). African American males' ability to cope with various stressors, including societal pressures, racism, and disenfranchisement, may contribute to wellness barriers impacting their ability to practice wellness.

The well-being of Black men in America is worthy of study as it has been reported that African American men have worst health than any other group in America (Arias et al., 2021). Among the leading causes of death in African American men in 2018 were heart disease, cancer, stroke, diabetes, and hypertension (Heron, 2021), with COVID-19 being the leading cause of death in 2020, which is considered to be due to racial and ethnic disparities (Arias et al., 2021). This data indicates the differences in healthcare availability in the U.S., especially during the pandemic, where Black and Hispanic Americans were more likely to work jobs requiring face-

to-face interactions (Centers for Disease Control and Prevention [CDC], 2020). SES also impacts well-being. Those with more resources are less stressed and have the means to address stressors related to physical and mental health (Kiecolt et al., 2009). The JH hypothesis suggests that despite their best efforts and hard work, those who are less educated and have limited resources will struggle to cope with stressors. Those stressors, coupled with insufficient resources, lead to physical health problems (Kiecolt et al., 2009).

Stressors present themselves inside and outside of the community. Black people are overrepresented in U.S. jails and prisons. Black Americans make up 13% of the U.S. population but make up 40% of the prison population (Prison Policy Initiative, n.d.), and in 2016, Black men were imprisoned six times more than White men (Bureau of Justice Statistics [BJS], n.d.). These statistics indicate that racial disparities in the U.S. affect the health and well-being of the African American community.

The amount of psychological stress Black men face and its impact on their physical and mental well-being is documented, yet sometimes ignored (James et al., 1983; Hudson et al., 2016). According to the Office of Minority Health (nd), Black men have a high rate of suicide; it the second leading cause of death among 15-24-year-olds in 2019, and Adult African Americans are more likely to have feelings of sadness, hopelessness, and worthlessness. According to SAMHSA's 2018 national survey, 16% of African Americans reported having a mental illness, and 22.4% of this population reported a serious mental illness. Binge drinking, smoking, illicit drug use, and prescription medication for pain misuse were more frequent in Adult African Americans with mental illness. Despite the prevalence of mental health concerns among Black men, they do not always seek treatment. 63% of Black Americans believe having a mental health

condition is a sign of personal weakness, and Black men, in particular, are concerned about mental health stigma (Ward et al., 2013).

John Henryism's high level of coping could impact mental health. Research is limited on the impact of mental health in those with higher SES and on mental health professionals, who may have access to wellness resources because of their occupation. However, Robinson and Thomas (2021) investigated whether JH was a health risk or a resource for Black Americans and confirmed other research that JH is associated with poor physical health outcomes in Black Americans. The study also showed the allostatic load (burden of chronic stress and life events) was highest among those with high school or less education, which is in line with other research that suggests physical health is impacted by SES stressors, which can be associated with JH. The study found JH symptoms of depression in those who engage in high-level coping were 20% lower in those with lower levels of JH, but JH was still associated with depressive symptoms overall. These results indicate that JH can be a protective factor for Black Americans' mental health, although more research is needed. In other studies related to the link between JH and depression, Neighbors et al. (2007) found that although JH decreased symptoms of depression in White participants, it did not do so for Black participants, which may have been due to racial disparities or higher SES.

Black men also deal with racial discrimination and use high-effort coping strategies to deal with racism and lack of upward mobility in the workplace (Hudson et al., 2016). Matthews et al. (2013) found that racial discrimination and masculine self-reliance were positively associated with depressive symptoms and the ability to cope at a high level in African American men. Other studies have shown that imposter phenomenon, JH, and racial composition may negatively influence well-being (Bernard et al., 2020). Black men face police brutality,

microaggressions, and blatant racism, which impacts their ability to practice wellness. Psychologists recognize JH as a coping style for African Americans to "deal with psychosocial and environmental stressors such as career issues, health problems and even racism" (Duke Medicine News & Communication, 2006). Consistently coping at high levels, racism, discrimination, lower SES, propensity for higher levels of chronic health conditions, disproportionately limited resources for healthcare, lack of trust in the healthcare system, and stigma related to mental health are all barriers to practicing wellness for Black men.

Wellness Assessments

The literature suggests that there have been some difficulties in evaluating wellness concepts empirically due to several definitions of wellness and well-being based on different health disciplines (Cooke et al., 2016). Although there are several definitions of wellness, many theorists agree that the concept of wellness is multidimensional and typically encompasses eight dimensions: spirituality, emotional well-being, physical health, social connectedness, occupation, environmental, financial security and intellectual (Blount et al., 2020). So, how is wellness measured? Several quantitative assessments have already been mentioned related to the wellness models discussed above; The Wheel of Wellness (WEL), Indivisible Self Model of Wellness (5F-WEL), and Hettler's Eight Dimensions of Wellness (LAQ). The literature suggests Quality of Life (QoL) assessments are used among several disciplines including counseling, sociology, psychology, and medicine. The concept of QoL is often used interchangeably with the term wellness and wellbeing (Cooke et al., 2016). Cooke et al., (2016) report there are four ways to conceptualize well-being as it relates to assessments; hedonic, eudemonic, QoL and wellness. Hedonic refers to pleasure and happiness and most models center life satisfaction when assessing for wellness. Instruments include the Australian Unity Index of Subjective Well-Being

(Cummings et al., 2003), Midlife Development in the United States (MIDUSII) (Ryff et al., 2007), and the Subjective Happiness Scale (Lyubomirsky & Lepper, 1999). Eudemonic models center life domains that focus on fulfilling potential and optimize functioning at a high level. These models usually originate from the psychology discipline. Examples include Basic Needs Satisfaction in General (Johnston & Finney, 2010), Questionnaire for Eudemonic Well-Being (Waterman et al 2010), and Scales of Psychological Well-Being (Ryff, 1989; Cooke et al., 2016). QoL is defined as "broad range concept affected in a complex way by the persons' physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment" (WHOQOL Group, 1998, p. 1570). Measurements for QoL include the WHO Quality of Life Scale (WHOQOL Group, 1998) and the Comprehensive Quality of Life Scale (Cummings et al., 1994; Cooke et al., 2016).

Finally, the counseling profession focuses on wellness and uses the terms wellness and well-being interchangeably. The conceptualization of this construct is multifaceted, but most models focus on living a holistic life that includes physical, spiritual, and mental/emotional parts of self (Cooke et al., 2016). A few wellness instruments are the Five-Factor Wellness Evaluation of Lifestyle (5F-WEL), the Life Assessment Questionnaire-Wellness Assessment Questionnaire (Hettler and NWI), and the Wellness Evaluation of Lifestyle (WEL) (Myers et al.,1998). Cooke er al., (2016) reviewed self-report instruments used to measure well-being, QoL and wellness and found that several instruments vary in how well-being is operationalized and conceptualized. Researchers also found differences in the length of the instruments and psychometric properties. These findings suggest ongoing differences in how the concept of wellness is perceived and assessed. While there are several ways to measure wellness, there are limited instruments that measure wellness of Black Americans and this author was unable to find a measurement

specifically for Black Counselors. The lack of measurements could be due to the Black experience being a complex and unique one that has not been conceptualized. A qualitative exploration of wellness practices and barriers to wellness related to Black Counselors' is an appropriate next step. The methodology of this study will be qualitative, specifically phenomenology, to explore the lived experiences of Black counselors' barriers to wellness and their wellness practices.

Chapter Summary

Wellness has been practiced for centuries and has been central to the counseling profession since its inception. Several models were introduced to conceptualize wellness, including the Wheel of Wellness, Swarbrick's Eight Dimensions of Wellness, and Hettler's Six Dimensions of Wellness Model. This author was unable to find a model that focused on the unique wellness needs of people of color however, the Optimal Human Functioning model centers five cultural values, beliefs, and practices that align with various cultures: Collectivism, Racial and Ethnic Pride, Spirituality and Religion, Interconnectedness of Mind, Body, and Spirit, and Family and Community. Other models, such as the Native Model of Wellness and the Optimal Conceptual Theory, focus on wellness through a Native American and African Indigenous lens. Assessments associated with wellness models are also discussed. This study does not focus on one model as a theoretical framework but several models, as each model discussed presents a different but necessary aspect of overall wellness.

The purpose of this chapter was also to explore wellness of the counselor, wellness of the Black counselor, and barriers that inhibit a Black counselor from practicing wellness. Counselors have an ethical duty to maintain wellness for themselves and the well-being and protection of their clients (American Counseling Association [ACA], 2014). Although there were

competencies in the counseling profession that spoke to the need of various groups, there were no competencies until recently with the development of the CSI Counselor Competencies, which focuses solely on the wellness competency of counselors (Gibson et al., 2021). These competencies address counselors maintaining and setting boundaries in their professional lives. Counselors in training (CIT) were highlighted, as wellness promotion begins in counseling training programs and can extend to supervision post-graduation.

This chapter also paid attention to wellness impairments that can impact counselors, such as stress, burnout, compassion fatigue, vicarious trauma, and the recent COVID-19 pandemic. The latter portion of the chapter discussed the wellness of the Black Counselor and barriers that are unique to this minority population, such as disenfranchisement, racial disparities, lower socio-economic status, and chronic health challenges. The Strong Black Woman (SBW) schema was reviewed as a possible distinctive barrier for Black women who often carry the burden of others and forgo their wellness. Finally, John Henryism (JH) was explored to shed light on the high-level coping of Black men that can have implications on their physical and mental well-being. The information in this chapter highlights the current study's aims to understand the lived experiences of Black counselors related to their wellness practices and barriers that may prevent Black counselors from engaging in wellness activities.

CHAPTER 3

METHODOLOGY

The purpose of this chapter is to discuss the research design and methodology of the study. This section focuses on philosophical framework, theoretical approach, research questions, epistemological and ontological assumptions, participant features, ethical considerations, instrumentation, procedures, data collection techniques, and data analysis and methods for establishing trustworthiness.

Qualitative Inquiry

This phenomenological qualitative study researched Black professional counselors' lived experiences related to wellness and barriers to those practices. The term qualitative methods refer to "assumptions and the use of interpretive theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem" (Creswell & Poth, 2018). Qualitative research is a collaboration between researcher and participant, and it reflects meaning that is made by individuals or groups related to a social or human problem (Creswell & Creswell, 2018). Qualitative methods involve several characteristics to ensure high-quality research, such as understanding the audience's knowledge, interacting with participants directly, using multiple data sources, and identifying the researcher as a key instrument in the process (Creswell & Creswell, 2018, p. 181).

Levers et al. (2008) report that qualitative research is "hypothesis-generating," involving a more in-depth look into certain phenomena. A qualitative approach also encourages participant meaning-making; the research continues to emerge throughout the process, having a holistic account of the participant and inductive and deductive data analysis with the documentation being written with a flexible structure (Creswell & Creswell, 2018, p. 181). Other key

components of qualitative research involve understanding the participant's lived experiences and bringing awareness to any researcher bias or assumptions through activities such as journaling and field notes.

There are four philosophical assumptions made by qualitative researchers: ontology, epistemology, axiology, and methodology. Ontology refers to "the nature of reality" and how one can view reality through several perspectives (Creswell & Poth, 2018). Ontology asks the research to explore how we come to know, realize or accept that things exist, whether we see them or not, and whether we sense them. As it relates to qualitative research, Hays and Singh (2012) describe ontology as "the degree to which a "universal truth" is sought about a particular construct or process." In phenomenology, the goal of retelling a lived experience is not to focus on the experience exactly as it happened but to reflect on the possibilities of meaning (Rashotte & Jensen, 2007). These stories are ontological because the storytelling allows for authenticity, moral development, and viewing these experiences from different perspectives (Rashotte & Jensen, 2007). My ontological position is there are multiple truths. This is due to my belief that one's truth is tied to their value, belief system and the context in which that truth occurs.

Crotty (1998) defines epistemology as "a theory of knowledge embedded in the theoretical perspective and thereby in the methodology." Epistemology refers to ways of knowing, what we can know and how we can know it. It focuses on the relationship between the "knower" or the researcher and the "would be knower" or the participant (Ponterotto, 2005). My epistemological position is that knowledge is unlimited but is also co-constructed between the researcher and participant (Hays & Singh, 2012). This is due to my belief that knowledge is not stagnant and can be expanded. Further, I believe the researcher and participant cannot be separated as they are interconnected in the research process. Axiology refers to the values of how

we do research and the ethical consideration we apply to our discussions and conclusions (Ponterotto, 2005). My axiological stance is that value plays a role in the researcher's views and cannot be ignored as I believe the researcher-participant relationship is collaborative, and there is value in all roles in the research process. Methodology refers to the act of doing qualitative research. The researcher's ontological, epistemological and axiological assumptions influence the research process including research questions, paradigms and data collection (Hays & Singh, 2012).

Hays and Singh (2012) also consider rhetoric a philosophical assumption that focuses on language in research. Terminology in the study, including the data collection, findings, and the use of voice from the researcher and participant, are all important (Hays & Singh, 2012). My stance is that the researcher ensures the participant's voice is heard throughout the data. This study also assumes a social constructivist view. Social constructivists believe the world one sees is reality based on social exchanges (Denzin & Lincoln, 1988). There is no “one truth” as there are multiple beliefs about truth depending on one’s worldview and experiences. As it relates to qualitative inquiry, the researcher and the participants cannot be free of bias based on their cultural identities and perspectives.

This study explored Black counselors' experiences of practicing wellness and self-care, the meaning of wellness practices, and barriers to wellness. The literature suggests mental health practitioners are at risk for compassion fatigue and burnout due to the high acuity level of clients, high caseloads, managed care issues, and personal concerns (Posluns & Gall, 2020). Black professional counselors have these challenges and, due to being a marginalized group, are faced with stereotypes, racial discrimination, microaggressions, and physical and mental health disparities (CDC, 2017; Woods-Giscombe 2010). This author studied barriers to Black

counselors' wellness practices and barriers to wellness. Qualitative methodology was deemed appropriate for this study to examine these experiences more closely.

Interpretive Phenomenological Analysis

Once the ontological and epistemological assumptions were made, this researcher determined Interpretive Phenomenological Analysis (IPA) was best suited for this study. IPA is a newer methodological approach that has become increasingly popular in the social sciences in recent years (Murray & Holmes, 2014). IPA is an inductive reasoning approach that travels from specific to broader generalizations. Inductive reasoning does not attempt to prove, disprove, hypothesize or validate. IPA involves evocative descriptions and pathos-laden narratives or deep emotions. The goal is to bring out the essence of the experience. The researcher draws meaning from the participant making meaning of the experience (Miller et al., 2018).

IPA is the process of meaning-making in relation to the participant's experience or how people make sense of their major life experiences (Murray & Holmes, 2014). The researcher does not give the meaning but follows the meaning given by the participant (Murray & Holmes, 2014). There is a hands-on bilateral relationship between the researcher and the participants, whereas the researcher is impacted by the participant and the participant is impacted by the researcher. The researcher is engaged with the participants and does not take an observational stance (Smith & Osborn, 2003). In order to make sense of the participant's experience, the researcher needs to understand the context (economic, political, social-cultural) within which the participant lives. The IPA researcher focuses on the details of a major experience, transition, or the decision-making of the participant. While there is no “pure” or “true” experience, as there are multiple perspectives on what is “true,” the IPA researcher tries to get as close as they can to the

participants “true” experience. IPA has three theoretical underpinnings: phenomenological, hermeneutic and idiographic.

Phenomenology

Moustakas (1994) defines phenomenology as “the first method of knowledge,” and it “begins with things themselves” (Moustakas, 1994). Moustakas (1994) goes on to say that phenomenology is a “step by step attempt to eliminate everything that represents a pre-judgement.” Phenomenology is defined as “knowledge as it appears to consciousness, the science of describing what one perceives, senses, and knows in one’s immediate awareness and experience. The process leads to an unfolding of phenomenal consciousness thought science and philosophy “toward the knowledge of the absolute” (Moustakas, 1994). Developed by Edmund Husserl, phenomenology is a multilayered, complex context where the researcher takes information, seen and unseen, and peels away layers to discover the phenomenon (Guillen, 2019). Husserl contended that consciousness is involved in all human experiences and sought to understand how bias can hinder pure consciousness (Wojnar & Swanson, 2007). Moustakas (1994) asserts first-person account brings validity to phenomenological research. In an effort to narrow down Husserl's initial concepts, IPA also draws from Heidegger’s more existential phenomenology of hermeneutics and the research of Merleau-Ponty, Sartre, Gadamer and Schleiermacher (Wagstaff et al., 2014; Smith et al., 2009). The pillars of IPA phenomenology are the importance of an experience (ones lived process and how they find meaning), the participants perception of that experience, and the importance of culture and socio-economic climate that can impact ones view of the world (Smith et al., 2009).

Hermeneutics

The philosophical framework for this research is a hermeneutic approach. The study will use an interpretive paradigm based on Heidegger's hermeneutic phenomenology and other modern philosophers and methodologies. Moustakas (1994) states, "hermeneutic science involves the art of reading a text and that the intention and meaning behind appearances are fully understood." Rashotte and Jensen (2007) explain hermeneutic inquiry refers to "what it means to be human," and that meaning is shared through the participant's stories. Hermeneutics encourages the researcher to bring compassion and a sense of togetherness as the dialog between researcher and participant occurs (Rashotte & Jensen, 2007). Hermeneutic inquiry also focuses on what is considered significant as the lived experience is told to another (Rashotte & Jensen, 2007). The retelling of one's story allows for "coherence and continuity" that the participant may not have been able to recognize during the experience (Rashotte & Jensen, 2007). Hermeneutics is not concerned with determining which truths are more important than the other; rather, every story has meaning, and the experience of the participant may hold multiple meanings (Crowther et al., 2017). In other words, hermeneutics is the study of interpretation so that misinterpretation can be avoided (Moustakas, 1994).

Interpretation is necessary to the qualitative research approach and is considered the "basic structure of the experience" (Moustakas, 1994). Hermeneutic inquiry does not focus on the "right" and "wrong" way of research but encourages a dialectical approach that spotlights areas of phenomena that have not been noticed (Crowther et al., 2017). Heidegger believed in seeing the world wholly and did not feel there was a separation of consciousness from the world an individual lives in (Horrigan-Kelly et al., 2016). Heidegger believed that an individual's everyday interactions with others and with themselves help one understand their place in the

world (Horrigan-Kelly et al., 2016). Heidegger emphasized that all beings are connected, despite an individual's tendency to focus their attention on their jobs or what needs to be done for the day. Heidegger encouraged the ‘unity of being’, an understanding that there are other entities in existence with you at the present moment (Horrigan-Kelly et al., 2016). IPA also centers on dual hermeneutics, how one understands another's worldview can influence one's values and understanding. In other words, there is a two-way relationship between the researcher and participant. The researcher is trying to make sense of the participant's experience, while the participant is trying to make sense of their experiences (Rodham et al., 2015).

In researching Heidegger's work, it should be noted that despite his philosophical prowess, he is reported have been anti-Semitic and supported the German Nazi movement. Given this study focused on a racially marginalized group, this author wanted to acknowledge the challenge of Heidegger’s racial standpoint and the need to include Heidegger's work in this research. This author assumes that bias cannot be dismissed and will explore the essence of meaning-making related to wellness (Heppner & Heppner, 2004). With this interpretive lens, the author recognizes her position as a Black, female, professional counselor and the bias that may be present. The author has experienced several barriers to practicing wellness, including family and parental obligations, financial struggles due to inadequate pay, burnout, compassion fatigue, and feeling overworked. The author was aware of possible bias as this research topic was explored.

Idiography

Idiography refers to the individual's experience from their perspective. The researcher would gather details of the participants' lives related to the experience to understand the phenomena (Miller et al., 2018). Participant selection is important so that subjects have a vested

interest in their experiences and there are common identifiers among the sample (identify as Black, currently a licensed professional counselor) (Miller et al., 2018). Miller et al. (2018) also define idiography as "the study of the particular versus the general". Traditional phenomenology focuses on a semblance of a phenomena across cases. Idiography spotlights that every participant and their experiences have value, outlook or 'universe of inquiry' (Miller et al., 2018). Every participant has their own "retrospective" account of their experience, and they are sharing their past experiences on their own terms. Each participant's transcript is analyzed in detail before the researcher looks for similarities (convergence) across cases and while participants experience similar phenomena, their descriptions and interpretations may differ (divergence) (Miller et al., 2018).

Research Question

1. What are the lived experiences of Black counselors' wellness practices?
2. What do Black counselors experience as barriers to wellness?

Participants

The targeted population of this study was professional counselors who are independently licensed in at least one state, have been counseling practitioners at least within the last year, and identify as Black. Research suggests 5-25 participants are needed for individuals who share the same phenomenon (Heppner & Heppner, 2004) however, it is recommended that IPA studies retain a small sample size that is purposively homogeneous due to the detailed nature of data analysis (Smith & Osborn, 2003). Smith and Osborn (2003) and Vagle (2018) state there is no "right way" to determine the needed sample size, as it varies in phenomenological research. There were nine participants in this study. Criteria for participation in this study included holding an independent license as a professional counselor, currently practicing mental health counseling

and identify as Black. The participants are limited to Black independently licensed counselors, so it was important to recruit participants with various characteristics and backgrounds to spotlight their common experiences. Snowball and purposive sampling was used. Purposive refers to a particular group of participants that share insight about a phenomenon (Smith & Osborn, 2003). In line with these sampling strategies, participants were recruited through the American Counseling Association, Association for Multicultural Counseling and Development, state counseling professional organizations, and Facebook groups for mental health professionals of color (Black Girl Clinician Collective and Clinicians of Color in Private Practice).

Ethical Considerations

To maintain ethical integrity, this researcher received approval from the Institutional Review Board (IRB) at Mercer University to ensure the rights and welfare of the participants are being protected (Creswell & Poth, 2018). Given the nature of this research, attention was placed on ensuring the participants feel supported, respected and represented (Creswell & Poth, 2018). The researcher also provided an informed consent form to participants prior to their participation in the study. The informed consent form was discussed at the beginning of each interview, so participants are aware that their participation was voluntary and there were no undue risk (Creswell & Poth, 2018). Thoughtfulness was given to participants as there was a possibility of discomfort when sharing personal experiences (van Manen, 2015). Cultural, spiritual, religious and other considerations were also respected. Through a research grant provided by the Association for Counselor Education and Supervision, subjects received a gift card for their participation in the study. It was clearly stated in the informed consent that participation in the study was not required and gift cards were given to participants who fully completed the study (completed all interviews).

Role of the Researcher and Reflexivity

The role of the researcher also needs to be explored as it is important to the qualitative process. In IPA, the researcher's role is an integral part. IPA researchers are encouraged to be mindful of their beliefs and perceptions to enhance their interpretation, instead of allowing those beliefs to become an obstacle during the data collection and analysis phase of the study (Peat et al., 2019). This researcher recognized the possible bias that could have been brought to this study due to positions of being a Black, female, independently licensed professional counselor. This author has experienced many barriers to wellness, including lack of financial resources to practice self-care, lack of adequate health insurance to manage physical ailments, and not prioritizing wellness due to the many roles and responsibilities that were taken on. This researcher has also had experiences with healthy wellness practices such as meal planning, following a workout schedule, spending quality time with friends and family, participating in therapy, and setting boundaries. This author was mindful of over-identifying the participant's perspectives as a Black person, independently licensed professional counselor, and those who identify as women. This author does understand some of the cultural concerns related to being a Black independently licensed counselor and a woman who has experienced SBWS. This author was able to balance being sensitive to the cultural perspectives of the participants, while being mindful not to insert my own views.

Reflexivity is also an integral part of establishing trustworthiness. Givropoulou and Tseliou (2021) describe reflexivity as “a process of self-reflection or self-awareness concerning the ways in which one constructs the context of their activity.” The process of examining researcher judgements and beliefs can be explored during the data collection and analysis process. Reflexivity aims to reduce researcher bias and improve credibility (Smith & Luke,

2021). This researcher used a reflective journal over the course of the study to describe any biases, judgments and self-reflection, including thoughts related to how perspectives and interpretations were framed, feelings of comfortability or discomfort, tensions that may show up, and how the process may shape who I become (Smith & Luke, 2021).

Instrumentation

One-hour semi-structured interviews were used to gather information about the participants' lived experiences related to barriers to wellness and wellness practices. Moustakas (1994) encourages researchers to create a calm and inviting atmosphere so participants will openly and honestly answer questions. To support this process, participants were asked to provide demographic information prior to the interview, including license type, state(s) in which they are licensed, age, gender, ethnicity, and race. Following Moussakas (1994) and Creswell and Poth's (2018) guidelines, interview questions were created. Smith and Osborn (2003) suggest establishing rapport with participants and following the participants interests and concerns as they arise. Smith and Osborn report the respondent is the expert in their experience and the researcher allows space for them to share their story so empathy can be shown to the participant, more of the experience is uncovered which leads to richer data. Interviews were conducted via Zoom video conferencing (video and audio) and a device for a back-up audio recording was also used (Vagle, 2018). The interviews were transcribed and thematically coded.

Procedure

The author submitted an application to the university's institutional review board (IRB) and approval was given. Convenience and snowball sampling was used to identify participants who are appropriate for the study. The researcher recruited participants from the American Counseling Association, the Association for Multicultural Counseling and Development, state

counseling professional organizations and Facebook groups for mental health professionals of color (Black Girl Clinician Collective and Clinicians of Color in Private Practice) to identify participants.

Data Collection

The author collected data through virtual interviews with participants. The participant demographic questionnaire and semi-structured interview questions can be found in appendices A and B, respectively. Data saturation was attained when no new insighted emerged after nine participants (Heppner & Heppner, 2004; Smith & Osborn, 2003). Participants were sent informed consent forms, including demographic questions, via email and were asked to complete and sign prior to the interview. According to Creswell and Poth (2018), an interview protocol should be established. The researcher reviewed informed consent and consent to record prior to the interview for each participant. Responses from participants were de-identified and participants were assigned pseudonyms to protect the identity of the participants. Interviews were audio-recorded, transcribed, and coded by this researcher. Calls to participate in the study were posted in the American Counseling Association's state division and the Association for Multicultural Counseling and Development newsletters, state counseling professional organizations, and Facebook groups for mental health professionals of color (Black Girl Clinician Collective and Clinicians of Color in Private Practice).

Data Analysis

Once nine participants were interviewed and data saturation was reached, the researcher analyzed the data through transcribing and coding participant interviews. Vagle (2018) suggests a holistic reading of the entire text. The transcript was read one time through, in its entirety, without taking notes to get an understanding of the material (Vagle, 2018). Next, the researcher

read the text line by line, taking notes, and writing down initial meanings and exploratory comments (Vagle, 2018; Smith & Osborn, 2003). The researcher read the text line by line again, marked large passages, wrote any questions the researcher may have about that portion of the transcript, and the researcher made in the left-hand margin about significant statements made by the participants. (Smith & Osborn, 2003). The text was re-read multiple times and the video of the participant was also played as the text was read. The researcher identified phrases and sentences relevant to the research to assist in finding meaning and describe the phenomenon (Creswell & Poth, 2018). The transcript was re-read multiple times, a process similar to free textual analysis, so the author became familiar with the data as each reading revealed new insights and meaning (Smith & Osborn, 2003). The researcher returned to the beginning of the transcript and the right margin was used to identify emerging themes (Smith & Osborn, 2003).

It was important for the researcher to keep quotes close to avoid losing sight of the participants' interpretation as the researcher is making their own. The process was followed for each individual transcript and the researcher continued journaling so that the researcher's thoughts continued to develop (Vagle, 2018). Once all transcripts had been read and notes had been made, cross case analysis was conducted, which is the process of looking for threads that may link each individual participants experiences together (Smith et al., 2009). In a separate document, the superordinate themes, words that are repeatedly appearing, and subordinate themes, participants indirectly talking about the phenomenon, were identified in all transcripts (Smith et al., 2009). Excerpts were pulled from the transcript to highlight the statements that inform the emerging themes. Trustworthiness was established by ensuring participant confidentiality to avoid harm; reflexivity is used to account for researcher bias, journaling and to validate findings (Saldana, 2021). The audit team met to enhance rigor and trustworthiness. This

team consisted of two doctoral students and a faculty mentor and provided an external review of the research process and data interpretation to ensure the data's conclusions were valid and reliable.

Trustworthiness

Trustworthiness refers to how much confidence can be placed in the data to ensure quality of a study (Connelly, 2016). Creswell and Poth (2018) propose methodological rigor can be achieved through verification (literature review, bracketing, ensuring saturation, field note-keeping) and validation by using a senior, more experienced researcher to analyze data and use several methods to collect data such as interviews and observations. Lincoln and Guba (1985) provide a framework by identifying five major techniques for establishing trustworthiness in qualitative research. This study will focus on four of those techniques: credibility, dependability, conformability, and transferability.

Credibility

Credibility, similar to internal validity in quantitative research, references the confidence of a study (Lincoln & Guba, 1985). A study should use standard procedures so research using similar methodologies can be conducted. Method triangulation, a process of collecting multiple forms of data, will be used for this study. This author interviewed nine participants who seem to share a phenomenon and maintained a self-reflective field journal to capture thoughts and feelings related to interviews, biases, and the research process (Korstjensa & Moser, 2018). This researcher also utilized persistent observation and peer-reviewing/debriefing to establish credibility. Persistent observation refers to focusing on details that emerge in the transcript to provide more depth, which can be done with multiple readings of the transcripts and analyzing the data (Lincoln & Guba, 1985, p. 304). Creswell and Poth (2018) describe peer reviewing as an

‘external check’ that allows for someone other than the author, who is familiar with the research or phenomenon, to ask questions about methodology and interpretation. The audit team served the purpose of the peer reviewing and debriefing. This researcher used member checking that allowed for accuracy of the transcript with the participants (Smith et al. 2009)

Dependability and Confirmability

Dependability refers to how a study holds up over time and conditions (Connelly, 2016). It is comparable to reliability in quantitative research and describes the study's consistency (Connelly, 2016). Connelly (2016) defines confirmability, similar to objectivity, as “the neutrality or the degree findings are consistent and could be repeated.” In other words, the data should not be interpreted to fit an author's viewpoint (Korstjensa & Moser, 2018). An account of the research process was taken to include research notes (how decisions were made, step by step process of coding and interpreting the data, etc.), to an audit trail was conducted, and peer debriefing through dialogue engagement were be utilized (Connelly, 2016).

Transferability

Transferability, similar to external validity in quantitative research, describes how useful findings can be in other settings, the generalizability of results (Connelly, 2016). A way to ensure transferability is through the technique of providing a thick description (Lincoln & Guba, 1985, p. 316). This study provided a thick description or a detailed account of not only the participant's experiences but the researchers as well.

Chapter 4

RESULTS

This chapter provides an account of the interpretations of the participants' experiences from the data collected in order to address the research aim. The aim was to explore the research questions: What are the lived experiences of Black counselors' wellness practices? and What lived experiences prevent wellness practices in Black counselors? The purpose of this chapter is to report the findings that emerged with nine participants who identified as Black counselors who are independently licensed in their state(s), as well as provide an in -depth idiographic illustration of the data.

Participants

Nine participants agreed to participate in this study. Participants were professional counselors who are independently licensed in at least one state, had been a counseling practitioner at least within the last year, and identified as Black. Eight participants were female and one male. All participants identified as Black, four participants identified as Black/African American, one participant identified as Haitian American, and two participants reported roots in Kenya and another part of Africa. Participant's average age range was 30-39. Six participants reported the highest degree earned was a Master's degree and three reported a doctoral degree. Eight participants reported being licensed as a Licensed Professional Counselor (LPC), one participant reported being licensed as a Licensed Mental Health Counselor (LMHC), and one participant held three license designations. Participants are licensed in several states including Alabama, Colorado, California, Georgia, Michigan, Mississippi, Louisiana, Utah, and Florida. Participant's years in practice ranged from five years to eighteen, with the average being eight. Table 1 provides demographic information for participants.

Table 1

Participant Name	Gender	Age	Racial Identity	Highest Degree Earned	License (s)	State(s) if Licensure	Years in Practice
Cynthia	Female	40-49	Black/African American	Doctorate	LPC	AL	18
Gregory	Male	30-39	Black/African American	Doctorate	LPC	MI, MS, GA	17
Jolene	Female	30-39	Black	Doctorate	LPC	GA	10
Sharon	Female	30-39	Black (from Kenya)	Masters	LMHC	CO	5
Nadia	Female	30-39	Black	Masters	LPC	GA, LA	Over 10
Gwendolyn	Female	21-29	Black (Mom from Africa)	Masters	LPC	CA	6
Christine	Female	50-59	Black/African American	Masters	LPC	GA	8
Minnie	Female	30-39	Haitian American	Masters	LPC, LMHC, CMHC	UT, GA, FL	6
Diane	Female	30-39	Black/African American	Masters	LPC	GA	Over 5

The analysis of nine participants' responses revealed eight key themes: 1) Holistic Well-being, 2) Working from a Deficit, 3) Professional Self, 4) Collectivism/Community/Culture, 5) Guilt, 6) Strong Black Woman, 7) Black Tax, and 8) Letting Go. Subthemes emerged in several key themes. Table 2 provides and overview of themes and subthemes across participant transcripts.

Table 2

Superordinate Theme	Subtheme
Holistic Well-being	Wellness vs. Self-Care Current Priorities Acceptance
Working from a Deficit	Knowing Better but not Doing Better
Professional Self	Burnout/Compassion Fatigue Career Experiences
Collectivism/Community/Culture	Stigma Healthcare Mistrust Access to Care Positive Collectivism Culture vs. Wellness
Guilt	
Strong Black Woman	Suffering in Silence All Things to All People Self-Sacrificing Expectations of Others Self-Care as an Afterthought
Black Tax	Fighting Stigma and Stereotypes Proving Self Perceptions and Expectations
Letting Go	Affordability of Self-Care Intentionality Setting Boundaries Protecting my Peace Sinking into the Clouds Authenticity

Theme 1: Holistic Well-being

Based on the first research question, 'What are the lived experiences of Black counselors' wellness practices?' the results indicate that Black counselors are able to identify what wellness means to them, the importance of wellness and self-care in their lives, as well as share their lived experiences with wellness and self-care. Some participants reported that wellness is known and understood, but not always practiced.

Participants were asked to describe their definition of wellness, self-care, and wellness vs. self-care. Many participants identified wellness as "holistic" and others described wellness as

a “work/life balance,” or being “healthy and whole.” Seven participants reported holistic wellness as including physical and mental well-being, but only two participants included spirituality as an identifier in overall wellness. However, several participants discussed their spirituality later in the interviews.

When asked to identify the definition of self-care, some participants reported self-care involved doing “enjoyable activities,” is “individualized” and “personal,” includes “healthy habits” and a “deeper connection with self.” Other participants reported self-care involved being “self-focused” and having “self-love.” Almost all participants described wellness as focusing on overall health and self-care was the active practice of wellness. The subthemes that emerged in this section were Wellness vs. Self-Care, which breaks down the participants definitions and differences of wellness and self-care and self-care, Current Priorities and Acceptance.

Wellness vs. Self-care

Cynthia

Wellness

> I think most of us think about our physical wellness first. We will go to the doctors and make sure that we are good overall, physically. But we, even as therapists, forget to, kinda do that same thing with our mental and emotional. So, when I think about it, I think about it collectively. Making sure you are in a good space and/or healthy space mentally, emotionally, as well as physical. You know, being healthy overall.

Self-Care

> Doing things that we enjoy doing, that bring us happiness, allows us to get grounded. Not so much things that we do for maintenance. Cause a lot of times I hear people say, well ‘I go and get my hair done’ but then that becomes maintenance. It is self-care, but it also

can be seen as a chore. Things that bring us happiness and things that allow us to take a break from our everyday hustle and bustle.

Wellness vs Self-Care

I believe the self-care will allow us to be in a space…in wellness. Taking a 30-minute walk or watching a 30-minute television show will allow us to work toward the space of being in wellness.

Cynthia highlights the tendency, even among counselors to neglect their mental and emotional health and places an emphasis on collective well-being. The importance of being healthy overall suggests a call for a more holistic approach to health among counselors. Regarding self-care, engaging in activities that bring happiness helps in grounding oneself. The mention of getting one's hair done, highlights the potential dual nature of self-care activities that can be both self-care and a chore, depending on one's perspective or experience. Activities that provide a break from the daily grind and those that allows one to finding joy in self-care practices rather than viewing them as obligations contributes to overall wellness.

Gregory

Wellness

It's a level of acceptance of yourself, the way that you present in the world. Just from my experience, a lot of people, they reject parts of themselves. If my voice is too loud I don't like that part of myself, as opposed to this acceptance of okay, I have a loud voice and this is how…I use it. So, for me, wellness is about just an acceptance of myself and how I exist in the world.

Self-Care

> I think self-care and self-awareness are connected. Because…I know what I need. Going along with the whole self-acceptance thing, I know that I need to take a break between sessions, as opposed to back-to-back sessions. So, I'm being aware of myself, knowing that I need a break, is also taking care of myself. I think that those two things are closely connected for me.

Wellness vs Self-Care

> Going back to accepting myself, I can know these things about me, and then not really do anything with it. I could know that I don't do very well with back-to-back sessions, but then I do back-to-back sessions, you know? The knowing of it, and the actual practicing of it is for me, the distinction between the two. Yeah, I can have all the information to be well, but self-care is actually implementing those things that I know.

Gregory's statements imply that true wellness involves acknowledging and appreciating all parts of oneself, understanding how these traits manifest in different situations, and ultimately accepting one's existence in the world without judgment. It also emphasizes a holistic approach to well-being that includes both physical and psychological self-acceptance. Gregory's views on self-care ties together the concepts of self-care and self-awareness by highlighting the understanding of personal needs and how self-awareness informs self-care choices. Embracing one's needs is an integral part of self-care and for Gregory, self-awareness has becomes a guiding force for nurturing him through intentional self-care practices.

Jolene

Wellness

> Making sure that you're in a place where you're taking care of your mind, body, and spirit. I would consider that wellness. I do feel that those three components are really connected. So, if you're missing one, your wellness is gonna be off. Making sure that you're finding ways to address all three, which is your whole being so that you're well across the board.

Self-Care

> Self-care is you making sure you get what you need. So, that can look like anything, it depends on the individual person. Like for me, its traveling, massages, taking a break, that's kind of my way of making sure that I'm taking care of myself. I talk to my clinicians about this all the time. It looks different for every person, but for me, self-care in general, is just making sure that you're taking care of you, you're getting you what you need before you go try to pour into anyone else.

Wellness vs Self-Care

> Wellness is you making sure your mind, body, and spirit are together. But that self-care, to me it looks more recreational and I could be wrong (laugh), but that's just how I'm thinking of it. When I say self-care, I'm thinking like, what's fun and exciting for me. The wellness piece, taking care of your mind, body, spirit is not always fun.

Jolene outlines a holistic view of wellness and focuses on the balance of mind, body and spirit and stresses that neglecting any one of these aspects can disrupt overall well-being. Jolene also identifies the uniqueness of preferences regarding self-care, highlighting that what constitutes self-care varies from one person to another. Importance is placed on prioritizing one's own needs

before tending to others. Jolene does perceive self-care as activities that are enjoyable and not those that will cause more stress or pressure.

Sharon

Wellness

> I define it as the mental wellness itself. The physical wellness, how you use your body. It's more of how I'm functioning well in terms of me mentally. Am I mentally stable? Am I physically fit? Am I emotionally stable? I can be able to give my full potential.

Self-Care

> I'll define it as that process of physically, like establishing holistic wellbeing in oneself. Like how you promote your own health, like how you constantly manage to keep it at par. Cause you want to ensure your self-care behaviors are at par, you're able to follow them on a daily to day basis.

Wellness vs Self-Care

> The difference I think, wellness, it's more of like for example, there is that feeling of taking care of yourself and also I feel it's more focused on mental health. While self-care, I feel like it’s taking time to do things. Start with improve you physically and mentally.

Sharon viewed wellness as being mentally well and physically fit and this implies that mental and emotional stability, and physical fitness are interconnected and important components for achieving optimal wellness. Sharon views wellness as an ongoing effort to promote one's own health, a continuing commitment to wellness, and maintaining a balance that ensures self-care behaviors are implemented on a daily basis.

Nadia

Wellness

I would define wellness as taking care of yourself mentally, physically, and emotionally. And I think that's a hard concept to learn and to have. Wellness to me is that mental, physical and emotional check-in, care, health and I don't feel like many mental health professionals do that.

Self-Care

Self-care is doing something that you enjoy for you. Self-care to me is just doing something that you enjoy doing for you. Not because someone else can invite you on their self-care, right, like, oh, let's go get our nails done. Yeah. But maybe that's not really your thing, so then that's not self-care. And I think we go to that default a lot.

Wellness vs Self-Care

Self-care is just the action of taking care of yourself, doing something for you to decompress. I think that is a conscious thing that should be done on a daily basis. I think that wellness is your overall health. Are you managing your depression and anxiety? Are you healthy as far as your physical health? You know, are you taking care of yourself? I'm in the year of taking care of myself. I'm making doctor's appointments to get things checked that I should have been checked. Whether that's therapy appointments, your physical health, whether that's exercise or doctor's appointments, dental appointments and your emotional health, conversations with friends, support groups. That's what wellness is. Whereas self-care I think is, needs to be a conscious, at least 30 minutes daily thing that you do just to decompress from the day.

Nadia's responses offer a holistic approach a shift towards actively scheduling time for health-related matters illustrates the commitment to holistic well-being. The challenges of learning and embodying this concept as a professional counselor were also highlighted. Self-care was identified as fun or enjoyable activities that can change depending on the individual and an emphasis was placed on not defaulting to popular or socially influenced self-care activities but focusing on authentic and personally fulfilling practices for true well-being.

Gwendolyn

Wellness

> I would say wellness is that practicing of the good healthy habits on a daily basis to improve your physical wellbeing, mental wellbeing to keep yourself at par in terms of how you'll be doing your things. Maybe having this good plan or timetable for yourself for the activities that you might be engaging in.

Self-Care

> Eating well, diet, exercise.

Wellness vs Self-Care

> I would say the difference between the two is that wellness, for example, you get to maybe talk to someone sometimes, maybe it can be an activity that will involve other people around you. When self-care is more of individual, you are doing these activities on your own. Maybe at your own area…or by engaging in like good choices of good exercises, good dental care.

Gwendolyn discusses daily practices of healthy habits to enhance both physical and mental well-being. Structuring activities through planning seemed important as well as focusing on connections with others.

Christine

Wellness

> I define wellness as being healthy and whole. Taking good care of yourself, putting yourself first, making yourself a priority. And…realizing that's not being selfish because when you're being good to yourself, you're able to be good to other people. So, it's always a benefit for yourself and someone else. So, I define wellness as being healthy and whole.

Self-Care

> Basically how you take care of yourself, how you choose to take care of yourself, what makes you feel good, helps you rejuvenate, recharge your battery. I've said that it was basically individualized. So, it is how you make yourself a priority and take care of yourself to make you become more rejuvenated and recharged and making yourself a priority. However, you decide to take care of yourself. I like showers and I like reading and I like just going on walks. Whatever works for that person to be able to rejuvenate themselves so they can feel more balanced.

Wellness vs Self-Care

> I think when we think about wellness, we think about basically how a person is feeling. We think about health…is the person health mentally and physically intact? But when I think about self-care, what are we doing so we can be well?

Christine's comments focus on being proactive about the goal of healthy living by prioritizing oneself. Christine also notes the reciprocal benefits to both the individual and others when one is in a state of well-being. Self-care is seen as an individualized practice that focuses on what makes a person feel good and helps them recharge.

Minnie

Wellness

> I think wellness is whatever you want it to be. And so, for me, it took intentionality. Wellness in every single way and…it really has to do with whatever feels good to you.

Self-Care

> Self-care is the intentional part. It is for me, the working out, it's the time alone. For me, it's the reading, or the journaling, or the listening to music, or having a solo dance party. It's the extra mile that you go for yourself, whether that's soaking in the tub, whether that's having a delicious meal, having a big breakfast, just because, you know what? I'm in the mood to have a big breakfast today, (laugh).

Wellness vs Self-Care

> Self-care to me is the intentional seeking out to take care of yourself. Whereas wellness is like the base, the baseline of the day-to-day looking out for yourself.

Minnie's comments offer a flexible perspective on wellness and self-care as she defines wellness as something subjective that provides individual autonomy in determining what contributes to wellness. Being intentional is important and a purposeful and conscious effort towards self-care is highlighted.

Diane

Wellness

> I define wellness as stability comes to mind. Just stability mentally, physically caring for yourself, focusing on yourself. Just the overall state of being stable and healthy.

Self-Care

> Allotting time and activities to focus on your own wellness and well-being and, to use as a method of dealing with stress.

Wellness vs Self-Care

> Well, I guess I'll preface it by saying there's a lot of overlap, but I guess the difference would be, again, wellness, to me, it's like a state of being and self-care is like the action, the doing.

Diane seemed to define wellness as the stability of physical and emotional self. Self-care is viewed as intentional activities that can manage stress levels.

Current Priorities

All nine participants reported either family or work as a current priority. Many participants reported caring for others as a priority, yet despite this, participants were choosing to prioritize their wellness and practice self-care. These results indicate that participants are aware of what is needed to care for themselves, and they understand the importance of prioritizing their wellness and self-care. Five participants experiences are highlighted. Cynthia defended her dissertation recently and reported her priority had been school, work and her private practice. Cynthia noted she was working to identify new priorities as school had come to an end:

> Um, right now, I think just, this sounds like I've been locked up, but being reintegrated into society, but also still being very intentional about self-care. And so, one of the ways I'm doing that… so we have the holiday break that starts [soon]…but I'm taking another week so that I can do some real hardcore self-care over the next three weeks. I've been going pretty hard for the last probably four or five years. And so, this is my way to kind of decompress from this whole experience,

Gregory reported his priority was to his partner and how his behavior could impact their well-being:

> My relationship is first, so everything revolves around that. That's my number one priority. So, I set my schedule around what works for us. I set my workout routine around what works for us, you know? Everything kind of goes through this question of 'how's that gonna affect my relationship?'…because that is my number one priority.

Gwendolyn shared that her priorities are varied:

> My priorities are my work, my family. I would say my personal growth as a person, my spiritual growth, my mental health, physical health, like also my financial growth as a person, and also being productive, and to my family and my community.

Jolene spoke about her spirituality and relationship with God as part of her self-care but, also part of her current priorities. Her family is a priority, but she looks to God to help her navigate where she should place her time day to day:

> I incorporate a lot of spirituality just into my day. So, I try to start my day by asking God, like, what's important to you, Lord, that I do today? How should I order my day? Because I found that when I don't do that, it can get chaotic sometimes cause I have so much to do, it's impossible to do it all. So, it's like, Lord, you just help me to pick out what's a priority and the order that I should do it in. And I found that to be easier than to try to figure it out myself or to try to get everything done because it's unrealistic.

Minnie talked about questioning how she practiced wellness after realizing she was focusing on other areas of her life instead of herself:

> So, before it was whatever my responsibilities were, that was the primary, the priority. And then whatever self-care or wellness could fit in that, that's what fit in like the small spaces. I had to literally flip that for myself. Not all the things that my family needed of me, or my friends needed of me, not what work needed of me. It was just, like, what do I

need? How do all these other things, all these other roles that I play, fit into that? And if they don't fit well, they don't fit.

In each of these accounts, participants experienced a lack of self-care and wellness and noted the impact (feelings of exhaustion, sense of chaos) of not caring for oneself. Participants were self-aware regarding their lack of prioritization of self-care and participants also recognized the need for attention to self. After some challenges, participants seemed to be more intentional about not only acknowledging their need for self-care, but the activities that they engaged in to optimize their wellness.

Acceptance

Several participants mentioned acceptance and authenticity. Some participants shared their need to be accepted effected their wellness and other participants explained that they had to learn to accept themselves and did not need to prove themselves to others. Acceptance emerged as a subtheme due to participants discussing how they had to learn to accept all parts of themselves before they were able to set boundaries and make their wellness a priority. Gregory put a spotlight on acceptance and noted how they relate to self-care and wellness. Gregory discussed accepting all of who he is and how this deep level of acceptance has aided him in his view of himself:

> It's a lot to accept and all that because there's so much history within this body that I own, that I'm occupying. There's so much to accept in terms of what I can and cannot control. It's a level of acceptance of yourself. The way that you present in the world. Just from my experience, a lot of people, they reject parts of themselves. So, for me, wellness is about just an acceptance of myself and how I exist in the world.

Theme 2: Working from a Deficit

Unhealthy self-care practices were discussed across all participants. All nine participants were able to identify feelings or behaviors they experience when they do not practice self-care. There was an overwhelming acknowledgement of experiences related to not prioritizing wellness or not practicing self-care, which resulted in emotional depletion or deficit. Feelings of irritability, depression and being "moody" were noted. Important factors of experience were financial strain, the impact of working in a high stress environment, impaired thinking when wellness and self-care is not practiced as well as difficulty sleeping and feeling of exhaustion.

Some participants also seemed to struggle with finding a solution to the problem of sleep, when the solution itself is sleeping. However, what appeared to be an underlying cause was the lack of self-care and prioritizing themselves. While "just go to sleep" seems like an easy solution, many participants did not put themselves first and focused on the needs of others, thus adding to the exhaustion. Wellness was an afterthought due to focusing on work, school, or family. When asked what happens when self-care is not practiced, Diane commented:

> Things usually do not go very well. Historically, the psychiatrist puts me off work and I get medications changed and I stay in the same spot. I end up in like a depressive episode and stay in the same spot for like weeks. And don't fulfill my obligations and all of that.

Diane also reported that when she does practice intentional self-care, it is because she is in crisis and feels that it's necessary. "Honestly, usually when I practice certain self-care things it's because I'm already in a state of crisis or like a state of desperation. So, I have to do something to try and get myself out of it."

Minnie talked a lot about lack of sleep and how feeling tired and exhausted contributed to her working at a deficit. When asked what happens when she doesn't practice self-care, Minnie explained that she does not operate at full mental capacity:

> Ooo, Chile (laugh). So, when I don't practice it, I realize my thoughts move slower. It takes a little bit for the thoughts to come. I am more fatigued just physically. When I get a full night's sleep, I wake up bright-eyed and bushy tail and that lasts through the whole day. When I'm not getting enough sleep, I struggle to get up, I'm just slower throughout my day. I'm just tired. I tend to have headaches when I'm tired or when I haven't had enough sleep.

Christine talked about feeling "irritated" when she is unable to practice self-care.

"I crash miserably (Laugh). I just become very frustrated and irritated because everything's like getting on my nerves." Gwendolyn reported feeling stressed, purposeless and a lack of productivity when working from a deficit:

> Mostly there is that feeling of lack of purpose. You feel like you are purposeless or maybe like you're not doing something productive with yourself. You're not taking care of yourself. Obviously, you are feeling stressed because you know you are at risk of maybe like being like overweight and not being able to be productive at work. Maybe sometimes you are tired and you can't deliver well. In terms of family [there is] disconnection.

Nadia explained that working from a deficit included not taking necessary breaks throughout the day. She reported that she has noticed many therapists do not take time out for lunch and work through it, instead of focusing on their basic necessities. She also reported she has noticed some

mental health professionals delay taking time off, don't work out or "take time to decompress." Nadia also reported feeling irritability when self-care isn't practiced:

> Oh, I am irritable (laugh) and I am tired. Like, really tired. I find myself feeling like the days are running together. So, because I don't get that rest my mind gets outta whack with my schedule. And it becomes noticeable…I feel like I'm not firing on all cylinders. When I'm checking in and I'm doing a session for instance, my mind is going 60 different ways because I'm like, 'did I do this? Did I do that?' And I'm trying to focus, listen, but I find myself thinking about all the things because everything feels out of order.

Sharon explained her experience when she does not practice self-care:

> What happens when I don't practice is I get to backslide (laugh). I feel like by the time I'm gaining the energy to go, to start again, I feel like I'm starting from fresh. Cause sometimes you feel like you have forgotten some steps or processes that you are supposed to do…and I think those are some of the demotivation factors…you even feel like you have lost interest in the maybe the activity that you are doing prior.

Jolene reported feeling "out of sorts" and internal struggles that can sometimes be seen physically when she is working from a deficit:

> It really looks like a meltdown. It may look like more arguments at home. More misunderstandings between my husband and I. It may look like literally…lack of organization. So, like, my desk unorganized, my room unorganized. So, when you start to see Jolene kind of meltdown, it's like, girl, 'what's going on? What do you have on? What's going on with your hair?' Like oh, 'this isn't really you, what happened?' (Laugh). You see it physically. I feel it. It probably actually starts internally before you see it physically.

Jolene later explained that when she is working from a deficit due to not caring for herself, others are impacted:

> So, I'm fighting a battle inside like, look, I'm tired, this is too much. I got all this going on. Then that starts to turn into me being short, and that's why it leads to more arguments in the home. Cause I'm like, 'well, you should have did it,' and 'well, you cook dinner then' [referring to her husband] (Laugh). So, it can affect my whole household. And then typically for me, it really shows in how the house looks. My house can only get to a certain level of like, uncleanliness before I have a whole meltdown. So, I found for me, I found a big correlation between the two.

Gregory discussed his cognitive abilities being impacted when he is working from a deficit:

> Um, can't think clearly, I'm tired. I'm not interested in what people are talking about. I feel like I need to do something. I need to fill time with something, whether it's working on something, doing a puzzle. Just jittery and antsy. I just need to move and need to do something. But that's a sign that I'm not giving myself what I need, because the energy is there. I'm using dance and movement as a form of release. So, when I'm not taking care of myself, all the energy just kind of gets stored up and it's like, my mind is not clear, and I'm just all over the place.

When discussing not using self-care practices, Cynthia commented:

> My anxiety is super high. I'm very irritable (laugh), um, you're just tired all the time. It doesn't matter how much rest I get, I still feel tired. My motivation is to do the practice so that I don't put myself in that space. Because previously, what I would do is wait until I'm in that space and then say, oh, I need to do self-care, (laugh). So I'm a little bit more

> intentional about trying to avoid getting to that place, [I'm] trying to have a work life balance.

Knowing Better but not Doing Better

Some participants, while acknowledging the importance of self-care and wellness, admitted they are not consistent with the practice, did not practice when they reached burnout or a crisis level, or they do not practice as often as they should. Some participants reported self-care or wellness is not practiced due to putting other responsibilities first. Participants reflected a sense of overwhelm and exhaustion, a feeling of taking on too much which resulted in a lack of time and energy for personal self-care. There also seemed to be a common challenge regarding balancing personal needs and self-care with familial responsibilities. Participants acknowledged the conflict between the advice they give their clients about self-care (putting on the oxygen mask first) and the reality of not being consistent with their own self-care, which seems like a "double standard" of wellness. Many participants considered these challenges a barrier to self-care and wellness.

Cynthia explained:

> Just kind of taking on too much and not really feeling as though you have time, to spend on yourself or even just being too exhausted to do things for yourself. I, at one point had a gym membership all over the state of [Alabama] (laugh), but I wasn't going (laugh). I'm supposed to go today, but we'll see what happens.

Jolene's perspective was a little different as she felt there were times when it was necessary to put her own self-care to the side and focus on her family/children:

> Because a lot of times they [children] take a priority over me. Now I know that might sound bad because that's the opposite of what I tell clients to do (Laugh). I always give

> the analogy of ‘if you're on the airplane, you gotta put the oxygen mask on yourself before you put it on the baby’ and I get it. But in some situations, it doesn't quite work out that way, especially when there are circumstances out of your control, illnesses, sickness, that type of thing, they come first. So, I'm having to put myself on hold, work on hold, everything else is on hold because my family is a priority over that.

Sharon explained that there are distractions in life that will hinder self-care practices. Sharon also shared that when clear goals are not present, self-care isn’t practiced:

> There is distraction, maybe sometimes, from your normal schedule. Sometimes you have worked extra hours and I feel there is obviously that distraction from the normal activities that you usually do. Also, sometimes people don't have clear goals of what they want and it can interfere with their wellness practices.

Diane, who manages a sleep disorder and mental health diagnosis, reported that despite knowing that practicing self-care is imperative for her health, she commented that she does the “bare minimum” when practicing self-care, despite knowing its importance:

> I'm gonna be honest, but I do enough to make sure that I can continue to at least do my daily activities. Like for me, self-care is going to therapy once a week and taking my medication and seeing my psychiatrist and sleeping and doing things that I know are beneficial for my diagnoses. Making sure I eat, like the real basics. Making sure I do my ADLs because surprisingly, well, not surprisingly, that can be a struggle too sometimes.

The experiences of these participants in this superordinate theme indicate that they are aware of the deficits that can impact their wellness (exhaustion, shouldering excessive work and personal loads, lack of prioritizing physical, emotional and mental self-care). Participants were able to identify how their wellness is impacted if self-care is not practiced. Despite the participants

understanding how a lack of self-care can impact them, it seems, at times, they do not implement wellness practices to combat the negative experiences.

Theme 3: Professional Self

Participants discussed wellness from a professional standpoint and two subthemes emerged; Burnout/Compassion Fatigue, where participants explored feeling burnout or compassion fatigue related to the responsibilities of their jobs, and New Counselor/Workplace Concerns, where participants explained how there is stress related to being a new counselor, which can be a barrier to their well-being.

Burnout/Compassion Fatigue

Cynthia recently defended her dissertation for her Ph.D., is a teacher and a counselor. Cynthia explained how navigating those roles proved difficult and her desire for self-care to be more of a focus in school:

> I'm in two professions that I have to give of myself. How can I do that if I'm not taking the time to pour into myself? One regret that I have for undergraduate [graduate], whether it's psychology or counseling programs, is that self-care is not talked about more. Because I do believe that's why in the social work field, education, as well as the counseling field, burnout happens so quickly because the focus is not on taking care of yourself.

Jolene talked about dealing with compassion fatigue due to working in a field that is focused on other's healing. Jolene spoke from the stance of why she now chooses to practice self-care, given the high stress level of her job:

> It used to be that self-care was kind of an afterthought. Now, I try my best to be proactive with it. Let me do this before I get to that point of I'm about to quit. Cause I do think we

> work in a high paced field. We are seeing clients with heavy levels of trauma and that affects us. So, we have to be real and honest and say like, okay, what do I have to do to make sure that I'm not taking on all of that weight? [To make sure] I'm not bringing it home with me. So, I have learned to leave work at work and anticipate what I need. So, I'm gonna be more intentional about putting that self-care in place, even if that means I have literally at times, put on my schedule, like, go get a massage. I'm going to carve that time out because otherwise I may not do it.

Minnie shared that work was a barrier for self-care:

> I'd say work was a big one. Because work asks a lot of you without consideration for the rest of you, you know, when you're not outside of those eight hours. And I'd be working the full eight hours, barely taking a break, and it's like, yeah, you should take a break. Well, how am I supposed to take a break when you want me to do all this stuff within the span of eight hours and then you gonna look at me like you not meeting expectations.

Nadia explained how clients can become the counselors focus over their own self-care. Nadia also shared how her experience related to the COVID-19 pandemic, how she experienced the impact on the mental health field and her colleagues:

> I think sometimes pushing yourself to the point where you're not always doing the best self-care because you're making sure that you have clients, you're making sure your clients understand that you're reliable and you're consistent and those are all things that you should do as a counselor. When COVID hit, we know that the mental health field, referrals, requests [went up] like 200%. But then at the same time, because of the financial piece, we were expected to take clients but to not charge certain fees. I understand they need support, but free? (Laugh). You know, this is how I make my living

right? (Laugh). But it was just that continued perception of, in mental health, like, we work so hard and we sacrifice a lot we don't get paid a lot. And that's why people go into private practice so they can get paid what they think that they're due.

So, then our mental health was taking a hit and then we're having to turn down clients and because of the nature of the field we went into, that is hurtful for us. Not eating…I know that's a big one in the mental health field. Most of my peers, like lunch is whenever you can grab it. We pretty much run on coffee, (held up coffee cup) (Laugh).

Sharon acknowledged the reality of burnout in the mental health field and noted preventing burnout by sticking to a routine:

> I practice these activities during my free times, the wellness. I can try to create that time for myself because I know like, there is real burnout in my profession because sometimes you really concentrate on other people's need, not yours. And I want to really ensure I'm having a strict routine, which I'm working with on a day-to-day basis. Like, sometimes you can take 30 minutes to one hour and that's okay.

Gregory spoke about having an awareness of self and how this can impact the work that he does with clients. Gregory shared that when he is aware of his self-care needs, he can better serve his clients. The participant's experiences are significant as they bring attention to the challenges counselors face in the profession. Wellness is a core philosophy of the counseling profession, and it is important for a counselor to ensure they are caring for themselves (Carrola et al., 2016). These experiences also support the literature that suggest counselors have a one-way caring relationship (Pulson & Gall, 2020) where the participants are caring for their clients more than themselves.

Career Experiences

Four participants talked about the stress of being a new counselor and working to establish themselves in their career. Participants shared about demanding job expectations and how their jobs had become a barrier to their self-care practices. These experiences indicate there is a disconnect between self-care being taught in counseling programs and how self-care is encouraged in the when a new counselor enters the field. Minnie talked about self-care and the financial struggle many new counselors face that lead to a lack of wellness practices:

> Professionally, they teach you in school, you gotta take care of yourself and look after yourself. Self-care is a great pop culture word right now. But they don't actually tell you how to do that within the context of the work. Instead, you're coming out of graduate school, diving into community mental health, visiting people in their homes, completing sessions in homes, driving, I mean, miles and miles, just to see clients. Rest seemed frivolous. It seemed out of touch because there were expectations that needed to be met. Although the field talked a good game in school, when it came down to it, it wasn't just me. We were all like burning that midnight candle. And I also had colleagues who had second jobs just to make ends meet. It [self-care] was just non-existent. It didn't happen. And over time I realized just physically…I can't maintain this. This isn't what I signed up for.

Some participants shared about the need to prove themselves as new counselors, which led to a lack of boundary setting while on the job. Taking on more than one can handle and overextending oneself seemed to be consistent across participants. Nadia explained how these experiences impacted her self-care:

> I think when you're younger you're really just trying to make a name for yourself. You're trying to prove that you can do what you say you can do. You're trying to get jobs, you're trying to get experience and I think that's really your hustle phase. They're like, you got 25 clients, you wanna take 10 more? Yeah! (Laugh) Why not? You don't even think about it. But you're over here not being able to go places and do things or you're still in your phase where you are going places and doing things, but you're getting zero sleep because you got 16 notes to do and 14 treatment plans. So, that was my hustle phase of just like, I have to get this experience, get this training, make them know I'm a good employee. And it worked. I got all the experience, I had to go to all the trainings, I got to go from contract to salary. It was great, but I was tired. I was like, this is not sustainable. I'm burning the candle on both ends.

Gregory had a different perspective as it relates to being a counselor early in his career and how his worth and value came out of the work he did with his clients:

> So, at first, I felt like I was taking care of myself by taking care of my clients. And so, if I'm helping them, then that means I'm doing a good job. And I would look for signs of like, progress and growth from them to validate my existence or my place as a therapist. But then over time, I started to realize that that's more of an external thing. So, the way that I saw myself was contingent on how my clients define their experience in therapy.

Diane considered work a direct barrier to practicing wellness due to a lack of time management:

> Before I got in private practice and the overnight position that I have now, I was working like a typical Monday through Friday, nine to five, and it was difficult to make appointments with my providers because of their hours of operations. So, I would like,

run outta medication and I've always worked two and three jobs since I graduated, so that's another thing, just not having a lot of time.

Theme 4: Collectivism/Community/Culture

Five participants discussed community, collectivism and culture from not just a personal experience but from a perspective of the Black community in general. Stigma, Lack of Trust in the Healthcare System, Access to Care, Positive Collectivism, and Culture vs. Wellness were the subthemes that emerged.

Stigma

Participants shared struggles with stigma that they experienced and messages about how the mental health field. Jolene talked about mental health stigma related to being raised in a Black household and being told 'what happens in our house stays in our house.' These experiences can contribute to suffering and a lack of help seeking (Griffith, 2018). The challenges with being a Black therapist and serving Black clients was also discussed. Jolene shared about the emotional weight that role carries:

> I do feel like there is a heaviness that comes with being a Black counselor. You come in already having to fight the population that we serve. A lot of times there is a stigma related to counseling within Black culture. I serve people of different backgrounds. But when it comes to Black culture and trying to serve the Black population, I find it's more of a fight because of that stigma. So, there are barriers there that you have to come in fighting, which can create a sense of what I'm referring to as heaviness, a weight is like, I really want to help the Black culture. I really wanna help those that can identify with me, but at the same time, it's so many barriers, can I really make a difference?

Jolene also shared:

> As a black counselor, it's like a higher level of expectation from clients, from even our colleagues. So, there's a level of pressure there that I'm not sure if other cultures feel. I don't know that they feel the pressure and the weight that a Black counselor does.

Healthcare Mistrust

Some participants discussed a lack of trust in the healthcare system from a systemic and racial perspective. Jolene's comments are highlighted in this section. Jolene talked about mistrust from a personal and community perspective:

> I think Black culture in general may run into mistrust. And I have experienced that with my own journey too. Can I trust this person to really share what's going on in my heart? To share the secrets that maybe I'm not sharing with other people? So, there is cultural mistrust of, I wouldn't say just helping professionals, maybe healthcare professionals in general. Because of the historical things that have happened in the Black community. So, there's an overall mistrust, a mistrust of leadership, a mistrust of healthcare providers. Like, I don't know what you're going to be doing, and I'm not sure if it's really going to help me.

Access To Care

Participants shared their experiences regarding the lack of resources that impact the Black community, particularly a lack of access to care, specifically mental health care. Jolene and Nadia's comments are highlighted in this section. Clients not having the financial resources to get the care they need, navigating insurance issues and accessing counselors who share their cultural values were identified as barriers to self-care in the Black community. Jolene discussed empathy she now has for her clients as they attempt to find a therapist. Jolene shared:

> Finances. Having insurance. Even feeling like they can afford the service is a barrier that I found. I do some pro bono work. I try to keep a few people on my caseload that are pro bono and so, when I tell people that, they're like, oh, if I'd known, I would've tried to reach out sooner. Trying to find a Black counselor is like trying to find a unicorn. It is not a whole lot of us out here. For that reason, access to someone that you feel can relate or that you feel will be culturally competent you may not have that high level of access as other cultures may have.

Jolene explained the difficulty in finding a therapist as a therapist:

> I'm going through something similar now, just trying to find a therapist is like, oh my goodness, it shouldn't be this hard! Because I'm in the field, it cuts some of the therapists out because I know them. But it still just shouldn't be that hard to find what I need. That's scary for me. And if I'm someone that's well-versed in this arena and I'm still struggling, I can only imagine the struggles that someone else may be having when they're like, hey, I don't even know exactly what I need. I just need help.

Nadia shared her experience with not being able to maintain a professional therapist/client relationship when she is the client:

> Another barrier I've had is I had a therapist and once we got the heavy stuff situated and we got towards the just like maintenance of like, okay, I just need a place to decompress, it started to become more like a peer situation. In the sense of like, we're supposed to have a session, I'm waiting to do the session virtually, no response. Checks in, 'hey, you're not here, what's going on?' 'Oh, something came up with my daughter's school. I'm sorry I forgot to tell you.' Would you have done that to a regular client, a non-therapy client? It's happened more than one time to where it causes me to delay that part of

wellness and self-care because now I have to find the right fit and disclose everything again and hope that you treat me as a client and not as a peer.

Positive Collectivism

Five participants talked about community being important to their wellness. Participants mentioned family as a motivator for caring for themselves. Minnie commented about community from a familial perspective as she strives to be a role model for her nieces and nephews and her despite for them to "see something different" as it relates to how wellness is practiced.

The strength of not only the Black community but the internal fortitude that Black people possess was discussed. Minnie shared:

> When we think about us as Brown and Black skinned people, from wherever it is that you come from, we're some hardworking people (Laugh). We are survivors, through and through, right? No matter what the circumstances, we gonna make something work. When I think about rest and why it matters for me to rest as a Haitian American, as a Black clinician, as a female entrepreneur, I am my motivation. Because as a private practitioner, I know that people see what I do and I want people to be inspired by that. But for that to happen, I have to be able to give my best work all the time. I have to be able to provide quality. My clients have to see progress in the work that they're doing with me. And so that's what motivates me. The better I am, the better I can be for everyone and not just professionally.

Gwendolyn reported her wellness journey was inspired by seeing others make their well-being a priority. When discussing what self-care feels like, Gwendolyn stated how becoming more self-aware can benefit the community. "...You are able to help others around you, and you are more

aware of your emotions and able to express your feelings in good ways and also how to manage your stressors of life."

The importance of Black counselors pouring back into one another, holding one another accountable and supporting each other, specifically around wellness was also shared. Participants explained that there has been an increase in community events that focused on Black counselors connecting outside of the office, but there was a desire for more bonding, connectedness and safe spaces to talk about the unique experience of the Black counselor.

Culture vs. Wellness

Two participants spoke specifically about the differences in the approach to wellness related to their cultures. These experiences highlighted how different cultural experiences and views of wellness can impact the counselor. Minnie shared how culturally, wellness was not centered in her household growing up and Sharon talked about growing up with family that were not born in the U.S. Minnie commented:

> As a Haitian who was raised in the States, it didn't exist; wellness, resting. It was something you did if you had the means to, but my parents didn't have the means. Even time off or vacation was spent catching up on cleaning that hadn't gotten done because Monday through Friday was just a busy day of making sure we went to school [and were] fed and things like that. And so, summer breaks, winter breaks, all of those things were used to clean up (Laugh). Even to this day, my parents did not, we don't [take breaks] and so they worked through many of the traditional American holidays where you would spend the time with family. That wasn't my experience growing up. Wellness wasn't…that resting piece, just didn't exist. As an American, it's really an interesting divide. It's seeing people rest and be able to take time off and want that. It's a resenting of

like, wow, they get to rest. Why do they get to go on family vacations or why do they get to go on a family cruise or whatever it is that they're doing and not really be able to engage in that.

Sharon explained:

> I have been raised in the U.S. and yes, my parents, we sometimes visited Africa, Kenya. And for me, I think you get to have a wide view of cultures. There are maybe like for example, back at home issues on mental health, there are [unintelligible] priorities and where we are, they are more prioritized. I think those are some of the comparisons that I get being in Africa, which is more like a 3rd world country. Also, being in Colorado, I think there are differences in even the services.

Theme 5: Guilt

Guilt appeared in various forms during the interviews and can be seen in other themes. Almost all of the participants discussed feelings of guilt relating to either not caring for themselves or not having enough time to spend with family. Cynthia's experience is highlighted in this theme, and she talked about feeling guilty for prioritizing school and missing out of activities with friends and family:

> A lot of people have asked in the last couple days, like, how do you feel, since you defended [dissertation]? Exhausted, that's number one. But two, I feel like the weight of the world has now been lifted. So, people are sending invites, I'm there, whereas before (Laugh), oh, let me check my calendar, or I can't make it. Even if I didn't have plans of writing that day, it was almost, I guess like a guilt feeling, like, okay, you're not supposed to have fun. You're supposed to be sacrificing. It's the weirdest thing ever. It felt almost like a guilt of, your fun should be limited.

Theme 6: Strong Black Woman

All of the female participants (eight in total) discussed the Strong Black Woman schema and how it impacted their wellness practices. The Strong Black Woman theme included the subthemes Suffering in Silence, All Things to All People, Self-Sacrificing, Expectations of Others, and Self-Care is an Afterthought.

Suffering in Silence

This subtheme focuses on the emotional labor, household duties and childcaring that women take on, while juggling work and other duties, often without their partner's understanding their load or willingness to step in and share the load. Jolene discussed the emotional labor of caring for the household and her children, despite having a partner:

> I would say there's a major responsibility there. I have a one-year-old and a 10-year-old and then my husband. I would say that about 70% of the care of the children kind of falls on me in the home. My husband definitely helps, but I think it's just a level of like, unknowing (Laugh) and feeling like that's not his role (Laugh). So, some of that definitely falls on me. If anybody's sick, yeah, that falls on me.

All Things to All People

Three participants shared how they take on several roles and responsibilities at work and at home. The participants discussed their obligations to these roles, despite knowing their wellness can be impacted by taking on several roles and responsibilities. Cynthia explained the importance of her role as a Black counselor in the school system, supporting Black children and how the expectation can be exhausting:

> I work in a Title One school, so most of the students look like me. And so, you're more likely to understand some of the things that these students are experiencing. You're a little

> bit more relatable than some of our counterparts. You're having to give of yourself because you are this Black woman. Being a therapist, even the times that I'm not supposed to be a therapist, it seems like it's on the forehead. And people are telling their life problems. And then just all of the things that we experience as Black women, Black people in our communities. But then also the things that we hear and see in the news. Each of those identities can be very draining and emotionally exhausting.

Sharon shared about her responsibility as a working mother and wife:

> I'm a mom and I'm a wife and yes, that calls for responsibility. You have to be there for your family. You have to be there to cook the dinner, you have to ensure that the kids get to school, have to ensure you are productive to the community around you. You attend church and also you have to live like you are in the community setting. You have to interact with other people. And for me, I feel like that's my major role because I think I want to be productive around the people I'm living.

Minnie talked about a self-care barrier is the need to do "all the things." "I'd say the biggest thing is the need, or it felt like a need or the want, the want to do all the things. So having too many things on my plate, that was a huge barrier."

Self-Sacrificing

Three participants discussed how they practice self-care so they can be there for others. These comments were interesting, as it seemed the participants focused on caring for themselves, so the needs of others would be met, instead of practicing self-care so they can feel/be emotionally well. Jolene explained navigating her responsibly to her family and to herself from a spiritual perspective:

> So, it's me both saying like, my family needs me and without this self-care, they aren't going to get the best Jolene. My family is a big motivation because I recognize how bringing my work home can affect them. Just knowing you need breaks and again, pulling in my own spiritual thoughts about it is like, if God rested on the seventh day of creating the world, then why do we as humans think that we can just push through and not rest? So, it's me both saying like, my family needs me and without this self-care, they aren't going to get the best Jolene. And then also recognizing like, hey, my journey is much bigger than me and if I don't rest, I could miss my assignment that God is trying to send me on.

Christine reported that even though she is aware that she has to care for herself, her later statements seem to express that her need for self-care is so she can "pour into others."

> Because it's a necessity. Because if I don't take care of myself, I can't expect somebody else to do it. I want to be there for my family, my friends, my clients and give them the best of me. But if I'm not pouring into me, I can't pour into them.

Christine also shared:

> I think as a woman, as a mother, as a wife, and having a career, we are doing all things. And because we're doing all things, we're not taking care of ourselves like we need to because we put everybody first.

Minnie talked about being a better version of herself for her family and learning to be more present:

> The better I can be for my nieces who want me to play with them, the better I can actually play without worrying. The more I can just hang out with my family and just hang out without like, having the ball and chain of work trailing behind me. And so, I realize I can

> show up better when my wellness and my self-care is a priority. I have to realize that taking care of myself is taking care of other people. It's not that I take care of all the other people and all the other things, and then I go without, and then I am frustrated or I'm worn out. I realize I can show up better when my wellness and my self-care is a priority.

Expectations of Others

Six participants discussed the pressure that they feel society places on women. Struggles with managing different roles and responsibilities, including being a mother, wife, aunt, and a professional were shared. Gwendolyn talked about what society expects from mothers and wives:

> I feel like working and also [being] a woman sometimes those [are] constraints because sometimes people, society has these expectations. I should be a stay-at-home mom, taking care of my family, my husband. Like, you can hear the family side of my husband, asking me 'why don't you stay at home and raise kids instead of leaving your kids with a house help all these times?' Also, being a Black woman who has excelled in a career, I think people are very surprised when you really introduce yourself and you say like what you do. It's like maybe people undermine oneself or they don't expect that I'll be there at that level. Also, the daily routines of a person. I find my timetable is fixed. There is no free time for maybe fun activities for myself and even like, taking care of myself."

Minnie lives with her brother, sister-in-law and their children. Minnie discussed setting boundaries despite familial expectations of her time:

> It's just a different dynamic of me being here as a single person, being within the context of a family on top of that and realizing that, yeah, auntie's here, but she's not necessarily going to do all the things you want her to do or be a part of that family unit. Although I'm

> a part of the greater family, the extended family…communicating what I need with my family, communicating when I won't be available to help out, making sure I'm not overextending myself in terms of helping with the little ones.

Diane spoke about living up to others' expectations, even as a professional. Diane shared that as a professional woman with several challenging diagnosis, she is "expected to be ok all the time" "I also have Bipolar Disorder and Generalized Anxiety Disorder, and I have Obstructive Sleep Apnea and Narcolepsy. And so that is a barrier in itself sometimes. And the thoughts that I'm supposed to be okay all the time it's difficult to keep up with." Diane also explained expectations from family, friends and work:

> With my family, they expect me to babysit and help raise my nephews. And then because I don't have kids, so I'm supposed to be available to help with that. And then at work, ever since I started working, I was in management when I was 19, and they felt like I was the young, impressionable, spunky manager. So, I'm supposed to be able to handle all these tasks, so I got assigned the heavier workload. My friends. I'm the trauma dumpster. So, sometimes I don't take care of myself the way that I need to. Even though they're [nephews] not in the house with me, there is this unwritten rule that Tee Tee, Mama Tee Tee, is supposed to take care of these boys. All her free time is supposed to go to dropping kids off at school and watching them and those different things. I have a difficult time setting boundaries with that.

Nadia discussed Black mental health professional women learning to let go of the Strong Black Woman troupe and lean on one another. Nadia also explained that other perceiving that Black female counselors can handle more than their peers:

> I feel like we are becoming more respectful and understanding of that, not having to be that Black strong woman trope and it being okay to lean on others. But I think because of that trope, there is a perception that we can handle more than our peers. I've been in many settings and it becomes like, 'you're handling your workload so well.' Like, 'you can take on more' type thing. And it's like, no, I'm handling it because I was taught to handle what I'm given and do what I need to do, not because I'm handling it way better than her. I just feel like I don't have a choice. I have to maintain to show you or actually go above to be considered maintaining.

Self-Care is an Afterthought

Three participants discussed not prioritizing their self-care due to not having enough time, focusing on other responsibilities and feeling exhausted. Cynthia explained, "Feeling like you don't even have the time to do whatever it is. I would even just say exhaustion, whether that's physical exhaustion or mental exhaustion, mental and emotional exhaustion." Cynthia also talked about making self-care a priority once she realized her goals had an impact on her wellness:

> I would say that it [self-care] now can come before anything because what I realized is that we put so much effort and pride in doing our best and being productive and being the boss chick (Laugh). We can do any of that stuff and we don't take care of ourselves. And so, the very thing that we're striving for, we're kind of working against ourselves if we don't take care of ourselves. Now that I can see and hear and think clearly, I still plan to make that [self-care] a very high priority in my life.

Nadia reported she learned poor self-care habits from her parents, who prioritized work over self:

> My parents are workaholics (Laugh) and they're now just getting to, well my mom, my dad is gonna work until he can't like move anymore. But my mom is getting to a point now where she'll be like, sick and she's like, I'm not gonna work. And we're like really? (Laugh) And that's in her fifties. And I'm like, not you not going to somebody's job! And she was like, I don't feel well, I'm not pushing it. But like five years ago, she would not have said that. We also didn't learn self-care so me and my sister have had to teach ourselves self-care. Our, parents were really just not developing self-care. I'm not waiting until I'm 50 to have self-care.

Diane discussed how her identities as a counselor and Black woman impact her wellness. Diane shared that her wellness and self-care are not prioritized because she is trying to be what she perceives others expect her to be:

> I think it impacts my wellness because, I get caught up. Well, first I get caught up, and then other people perceive me as the strong Black woman. I'm not (Laugh). Woo! (laugh). I think I try to be like Wonder Woman or something because I feel like people expect me to like, always be okay and always be on point. And so, I typically don't care for myself the way that I need to because I'm so busy trying to meet obligations and do different things that are expected of me.

Theme 7: Black Tax

This theme describes experiences of Black men and women that feel they have to pay a higher emotional tax than their White counterparts in the workplace (Bloomberg, nd). This can often look like working longer hours or taking on more tasks to prove themselves worthy to be in the positions or jobs they are in and even dealing with misogyny. Subthemes that emerged were Fighting Stereotypes, Proving Self, and Perceptions and Expectations.

Fighting Stereotypes

This subtheme focuses on participants navigating stigma and stereotypes in the workplace. Cynthia's experiences are highlighted in this section. Cynthia talked about giving more of herself to her job than her White peers and being mindful of how she presents to others, so she is not labeled negatively:

> In the workplace, as a Black woman, we have to give 250% (Laugh), especially compared to some of our counterparts. I feel like sometimes we have to adjust sometimes so that we're not viewed as the angry Black woman. We can be discussing something and be very passionate about it, but then can be confused or deemed as the angry Black woman. Or you're just being upset. No, I'm not upset. I'm just explaining something, you know?

Cynthia also discussed experiences with misogyny:

> I work in career tech, and so, our personnel population is majority males. It may be half and half as far as African American males and Caucasian males, but even that is draining to be perfectly honest. Because men have their own vocabulary, or lack thereof (Laugh), and it's a little bit more acceptable amongst themselves. Whereas there are some things that I feel should not be said in the presence of a woman. And so, I'm thinking of a particular experience where you know, it's that I guess dirty locker room talk. This particular time the dirty locker room talk involved me, which was not true. And so, it made it to me and I had to address it. It's almost like it's welcome with men.

Proving Self

This subtheme focuses on participants experiences with proving themselves in the workplace, often to show others their worth. Nadia's experience is highlighted in this section. Nadia talked about proving oneself in the workplace and its impact on counselor wellness:

> I think there's always a sense of needing to prove that you're on the same level as your White peers. And so, what comes with that is trying to make sure you're always on top of everything the same way that they are. And I think sometimes pushing yourself to the point where you're not always doing the best self-care because you're making sure that you have clients, you're making sure your clients understand that you're reliable and you're consistent. Those are all things that you should do as a counselor, but I feel that there's another level to proving that we have that same stability and we have that same reliability then other counselors. And so, because of that, you put your self-care and your wellness to the side sometimes and you overdo it and then you can feel less than because of that mantra of like, keep going until you can't go. Then when you feel like you need to take a break and step back, sometimes you get that added feeling of maybe you're being looked at as less than again, even though your peers can do the same thing, you just feel like you have to achieve at a different level because you are Black.

Nadia later discussed how Black women tend to work harder than their peers in order to be seen as valuable. The thought here is that Black women continue to have to operate at a higher pace than White women due to try to prove themselves to the dominate culture that they are worthy:

> I think there's always this excel, and sometimes by our White peers, I feel like it is seen as either being incredibly excellent and phenomenal. Keep doing it. [But] don't realize that maybe we should tell you to take a break and slow down and you don't have to prove

> to us. Or it's considered ‘you're doing it because you can’, like you have the ability to do that, but you're still put on the same level as your white peers. Instead of saying, ‘well no, I'm really, actually doing way above them and that recognition should be considered as such.’ And I'm burning the candle on both ends.

Nadia also talked about navigating the mental health field as a Black woman and pushing beyond your comfort zone professionally:

> You're battling so many fronts. I mean this was initially a very, very White field. It was a very male field. Now, the majority of mental health professionals are women. Even still, when you look at conferences and researchers and things like that, you still see a lot of White males and White females. So, I just say, lean on your supports, reach out to your supports, build a support network. And then if you think you can’t do it, try it. I mean, I think that's the biggest thing is sometimes we don't see a lot of us doing things, so we don't think we can. Just because you never have doesn't mean you can't.

Perceptions and Expectations

Two participants in this subtheme shared being viewed differently and how this can impact their work with others and their wellness. Sharon shared:

> I feel like sometimes people view you differently. The way people view you, it's different for you. Because even in a place where the majority of the people are White, maybe someone would prefer someone over you. Maybe in terms of if they're seeking the services relating to their mental health issues.

Gregory explained wearing a “mask” depending on the environment he was in and learning to be vulnerable for his emotional well-being:

> I know that there's a lot of perceptions of Black Men in the world, what that could look like, what type of mask I need to wear in this space versus another space. And so, the practice of self-care, wellness for me is like, having a safe space to practice being vulnerable.

Sharon talked about balancing professional and personal expectations, including dealing with discrimination:

> Being a Black woman in such a profession, there is a lot of stressors revolving around age sometimes. Remember you are a mom and there is a lot going on in your life. You have other people who you are dealing with on a daily to day basis. Like, you have many clients who you are attending on daily. And also, you are living in a community where sometimes being Black, you experience discrimination. Living in a place where the majority of the people are White or it's like you are somehow the minority.

Theme 8: Letting Go

This theme centers on the experiences and practices of self-care. Participants share their experiences of realizing finances can be a self-care barrier, letting go of guilt, being proactive about their wellness, and how they were able to make decisions to focus on their wellness and self-care despite their responsibilities. The subthemes in this section are Affordability of Self-Care, Intentionality, Setting Boundaries, Protecting my Peace, Sinking into the Clouds, and Authenticity.

Affordability of Self-Care

Two participants in this section shared about finances being a barrier to wellness practices and finding affordable ways to engage in self-care activities. Cynthia explained that finances can be a self-care barrier, “I guess depending on what it is a person wants to do for self-

care, finances could be a barrier. I'd like to have a wide scope of things that are free and things that I have to pay for." Minnie discussed practicing self-care in an affordable way and reframing what self-care can look like:

> Self-care as a pop culture word can, especially depending on what socials you're on, what you're saying, it can look like you have to spend a whole bunch of money to get a mani or pedi, or whatever it is. It doesn't have to be any of that. It can be very close to low cost if no cost at all. Like sleeping, it'll cost nothing to get an extra hour of sleep. Drinking more water, which is great for all of you. Your hair, your skin, your nails, your energy, all that kind of stuff. When you don't have a lot, you work a lot, which can impede that self-care and that wellness piece, even though you want to be a part of that, it can feel unattainable if you're constantly working.

Intentionality

Being intentional with their self-care in their work and personal lives was mentioned throughout interviews. Many participants shared that they chose to be more intentional about their self-care practices after experiencing burnout, making poor choices, and not prioritizing themselves. Participants also shared that self-care may look different depending on the person and can include taking time off, outsourcing household chores, asking for support from friends and family or making lifestyle changes. Cynthia talked about promoting wellness with her clients and herself after realizing she was not prioritizing herself:

> I am very intentional about making sure that regardless as to why a client is seeing me, that we are talking about self-care. Sometimes I fall off the wagon with putting everything first, especially now coming off of this doctoral journey. You put that at the top of the list, and so, sometimes your self-care tends to fall by the wayside and then you

begin to feel it. I'm a little bit more intentional about trying to get myself back on track as opposed to doing it a little bit more regular, even though I preach it (Laugh). But in most things, teachers are the worst students and counselors are the worst clients (Laugh).

Minnie talked about the importance of being intentional about wellness and self-care practices:

> So, for me, it took intentionality. It took me including other people, like friends and family into the conversation. I was talking to a friend and I was trying to drink more water, trying to eat healthier and she was like, Minnie, you're probably just not getting enough sleep. I didn't even think about that. It's so simple. I started just like doing an experiment with myself, letting myself sleep, seeing how I felt in the morning and it turns out I need eight to nine hours of sleep at night. I was really intentional with doing this experiment and that was a game changer when I realized I need to be sleeping more. It was hard because other people's input, 'oh girl, are you sleeping that much?' 'Like you really do that?' Like, everybody has something to say. But I really just had to focus on, okay, 'what is it that I need for my wellness?'

Sharon talked about being intentional with her physical wellness to ensure a positive emotional outcome:

> I really try a lot of things in terms of physical fitness. I ensure I'm engaging in a good diet. I also ensure I take good rest, I sleep well, like maximum hours. And also, have to ensure I follow a certain routine of doing my activities to ensure like, there is no burnout in times of work. I also have to prioritize and have time for myself. Try use of my meditation. Like, just try to relax my mind and also engage in physical exercises like planning and even walks to just clear my mind.

Setting Boundaries

Two participants' experiences with setting boundaries are highlighted in this section. Boundary setting was seen as a way to practice self-care. Minnie talked about learning to set boundaries with herself and putting herself first:

> The other thing that became really important was saying no. Saying no to myself and to others in the sense of, I was very much a busy body, in a good way. I was really involved in doing a lot of different things all the time. But I was also very tired a lot. I was doing it all but not enjoying all the things that I was doing. I had to get really specific with, okay, if I'm gonna focus on me, I can't do like all the things. Whether or not my supervisor's happy with it, whether or not church people are happy with it. I have to think about me first. And so, realizing that every hour of the day is not meant for me to fill it with a task

Nadia discussed boundaries from a supportive standpoint. She explained that her husband's support is needed in order for boundaries to be honored and she would ask for him to take the children out of the house so she can enjoy alone time. She also shared it was important for her extended family to invest in her self-care by supporting her boundaries. Nadia also explained the importance of setting professional boundaries:

> Just making sure to maintain those boundaries, set the boundaries, communicate them, and maintain them. Well, I will add with clients especially. I do have clients that are therapists and that is one of their biggest struggles is that self-care piece and clients showing up 20 minutes late. Clients wanting to meet at eight o'clock at night. Clients wanting to meet at five o'clock on a Saturday. If that's your schedule, that's your schedule. But you have to do what you have to do for you. And so, if that's the only time you can have family time, well, I'm sorry, I can't schedule you during that time. I have

clients that'll be like, ‘oh, I'm sorry, my week is packed, do you have anything open on Friday?’ When it comes to clients, set those boundaries. Set aside your time. Especially if you make your own schedule. Make your own schedule and please, please block off lunch (Laugh).

Protecting my Peace

Similar to boundaries, participants discussed how they are protecting their peace by safeguarding her spiritual and emotional self from others. Minnie shared how her experiences seem to come from a spiritual place, where she is protecting her emotional self from anything that may not be safe or good for her:

> The people around me, as I've grown and matured, I've just grown as an individual and as professional. I’ve realized that I gotta watch the people that are around me. I have to protect my space. I have to protect what I'm hearing. Because it's not that people don't care about my wellness, it's that they don't understand my path and they don't understand my journey. I realized that if I'm going to choose wellness and self-care, I don't have to tell people and wait for their approval to do it. I have to do it because it's what I need to do. I had to get to a point where I no longer considered what other people thought of what I needed for self-care. It's one thing to want to do self-care, but it's another thing to like, ‘how do I filter all the comments and all the noise?’ Because if I listened to all of that, I wouldn't do it.

Sinking into the Clouds

This subtheme highlights six participants experiences with practicing wellness and self-care. Emotional and physical feelings associated with their wellness and self-care practices were

positive. Many participants explained feelings of calm, peace and being able to let go of the stressors they endure on a regular basis. Minnie shared:

> It's this serene, calm, this like, you don't have to hold up, you don't have to fight gravity. You can just let your body just be, it's the sinking feeling, but not sinking, like you're drowning. It's like sinking into a cloud. It's breathing deep without even trying to breathe deep because you realize, wow, I don't know if have been breathing all this time? It's noticing the sensations of my body It's silence. It's being able to read through a book, take a break, reflect on it, keep reading, reflect some more. It's journaling, its writing, it's the turning of pages, it's having a thought and being able to like write it down. Unhindered creativity. It's warm, it's like a hug, but not too long, not too tight, but it's there if you need it. It's noticing like, oh, I might need a nap right now. It's taking a nap. It's this huge sense of relief that I don't have to do anything right now but be here in this space. Yeah. And it's great. It's smooth. It's relaxing. It's not sharp. It's that sinking feeling into that cloud.

Nadia explained:

> I physically feel relaxed. Emotionally, I feel a weight lifted. When I do my self-care, I've got something on the TV, I might be on my phone looking something up or I'm on my phone playing. So, I'm not thinking about any responsibilities or obligations that I have.

Sharon shared:

> There is that feeling of reprieve. You feel there is rest. When I'm practicing all these things like practicing meditation and relaxation techniques, I usually feel like there is that

> feeling of stress relief. I also feel I'm calm inside, like my body's functioning well, not exhausted. Also, I can be able to work productively the next day because I feel reenergized with all these self-care activities.

Jolene explained:

> Oh, release. Yes. Relaxation for sure. And just a deep breath. And sometimes it literally is like me deep breathing, but whatever it is, regardless of the activity, it is just like (Exhale). Like I made it, I'm alive, I'm okay. And I get a break in whatever I'm doing for self-care.

Gregory commented:

> Feels like a release. Feels like this letting go of the barriers from earlier, like the perception, just being in a space where none of that matters. So, I'm able to just kind of exist and allow my body to do whatever it's doing or if I'm writing allow my thoughts to flow however they're flowing. Not worried about someone saying, 'this is not a good thought, that's not a good movement.' It's just a relief, you know?

Cynthia shared:

> I don't even know if I can describe it. I guess peace. Just to feel like you're not having to be an adult (Laugh) in that moment. All of the cares of the world, with the program, work, all of that for that brief time, it's not a concern.

Authenticity

Several participants talked about being authentic with their thoughts and feelings related to wellness. Gregory's comments are highlighted regarding learning how to be authentic with himself:

> It looks more like am I prepared for my sessions for my clients. My preparation, it looks like reading, it looks like doing things that stimulate my inner child, it looks like working out. It just looks like me surrounding myself with things that kind of go back to my definition of wellness, of this is who I am. This is how I express myself, and so allowing myself to be that. So, when I do those amounts in my own space, when I show up to therapy, I'm showing up as a person who is like, 'I'm good', you know, I'm good with me.

Chapter Summary

The purpose of this chapter was to introduce and examine the findings of the wellness practices and barriers to wellness practices of independently licensed Black counselors. The findings were detailed in accordance with the two research questions: What are the lived experiences of Black counselors' wellness practices? and What lived experiences prevent wellness practices in Black counselors? Nine participants who met criteria were included in this study. Interviews were recorded, transcribed and analyzed with recommended analytic methods for IPA research. Through thematic analysis of the data across participants, eight themes emerged: 1) Holistic Well-being, 2) Working from a Deficit, 3) Professional Self, 4) Collectivism/Community/Culture, 5) Guilt, 6) Strong Black Woman, 7) Black Tax, and 8) Letting Go. Several subthemes also emerged.

Chapter 5

DISCUSSION

The current study aimed to explore Black counselors' wellness practices and barriers to wellness. Nine participants were included in this study and using IPA, eight superordinate themes emerged from the present study's findings to address the research questions: What are the lived experiences of Black counselors' wellness practices? and What lived experiences prevent wellness practices in Black counselors? Findings related to these research questions will be outlined in this section. Strengths and limitations, and implications and future research will be delineated.

Summary of Findings

Research Question #1: What are the lived experiences of Black counselors' wellness practices?

The purpose of the first research question was to capture the participants' lived experiences related to their wellness practices. This research question was answered through the superordinate themes Holistic Wellness, Collectivism/Community/Culture, and Letting Go. Holistic Wellness is the first theme that emerged in this section. Analysis revealed that the participants' view of holistic wellness aligned with the definition outlined in chapter 1: A belief system that focuses on the act of being well; mind, body, and spirit. Participants reported wellness as "holistic," feeling "whole," and having a "work/life-balance." Some participants explained that wellness involved paying attention to ones "overall health," "practicing good healthy habits," and being or feeling "stable." A few participants viewed wellness as being intentional and as the act of fully accepting oneself. Participants also described the difference between wellness and self-care, explaining that wellness involved the physical, emotional, and

spiritual parts of self being nurtured, while self-care described the activities that contribute to their wellness. Most wellness models dimensions of wellness include spirituality, emotional well-being, physical health, social connectedness, occupation, environmental, financial security and intellectual (Blount et al., 2020). These findings are in line with several wellness models, particularly the Wheel of Wellness model that promotes the wellness of counselors (Witmer & Sweeny, 1992).

Current priorities emerged as a subtheme and all nine participants stated they have prioritized work and family over their wellness in the past. However, many participants stated they are being more intentional about making themselves a priority. One participant who recently defended her dissertation admitted that school and work had become her priorities for the past few years and her own wellness and acts of self-care were not as important. She explained that now that she is done with school, she is being intentional about making time for wellness. Another participant shared that she realized she was not the center point in her life and once she made herself a priority, she focused on self-care practices and her wellness improved. Acceptance of self was also a subtheme and several participants shared how they have had to learn acceptance during their wellness journeys. These results suggest that Black counselors have a willingness to participate in self-care activities to promote their wellness (ACA, 2014). Acceptance was the last subtheme in this section and one participant's experience was highlighted in the previous chapter. This participant shared his journey with accepting himself, as he is and letting go of the desire to control what others think or feel about him. For this participant and others, acceptance was a major part of their wellness journey and experience.

Collectivism/Community/Culture emerged as a theme that centered on how culture, community and collectivism have an impact on a Black counselors' wellness. Several

participants talked about their experiences with the concepts of collectivism and community, as well as how their culture has played a role in how they view and practice wellness and self-care. Stigma was a challenge that Black counselors related to, not just from a historical perspective, but from a professional one. Hesitancy to seek mental health care and stigma related to the healthcare system as a whole is an ongoing issue in the Black community (Shattell & Brown, 2017). Participants shared about their resistance to seek mental health services at one point due to messages they received while growing up. Participants also explained that they experience the result of stigma firsthand as a counselor. One participant shared that she feels there is a "fight" to dismantle the stigma associated with mental health and feeling helpless regarding her ability to help others. This participant also talked about the heaviness associated with being a Black counselor to Black clients. Feelings of heaviness, coupled with high expectations of others, heavy workload, limited counselors of color to service the community and the pressure felt to uphold the community can weigh on a Black counselor and impact their wellness (Evans, 1997).

Healthcare mistrust also contributes to Black people not seeking mental health services (Melissa et al., 2018; DeGruy, 2017). Mistrust can be especially high for counselors who have a more insightful or behind the scenes view of the healthcare system. One participant shared her experiences with not trusting providers due to a history of cultural mistrust in the Black community and questioning if providers and leaders in healthcare can be helpful, despite her being a part of the healthcare community.

Several participants discussed access to care and lack thereof as an important part of their lived experience. Lack of financial resources, including not having insurance or being under insured can present barriers to wellness (ACS, 2022; Santiago et al., 2013). Participants further

explained that having access to other Black counselors can be an obstacle. In several areas of the U.S., finding a therapist that share ethnicity and common cultural values can be difficult (Lin et al., 2018; The George Washington University Health Workforce Institute, 2019). One participant contributed finding a Black therapist to "finding a unicorn." Due to their profession and network, finding a therapist that they did not know also proved to be difficult. In areas that may not have many Black therapist, finding a provider can seem impossible. Participants also shared that once a provider was identified and a relationship established, they had to terminate with their therapist due to unprofessional conduct and being seen as a peer rather than a client. All of these issues can contribute to a lack of wellness practices.

Collectivism and community are positive aspects of culture and participants felt it was important to their wellness journey. Being a role model and inspiring others seemed to be key in participants decisions to be well. The strength of the Black community and Black people collectively was also highlighted. Participants explained that Black people are survivors and will "make something work" as it relates to navigating a world that was not set up for them to prosper (Melissa et al., 2018; Bartholomew et al., 2018). The need for community was present for Black counselors. Participants shared how talking about wellness with other Black counselors, holding one another accountable regarding their wellness goals and developing safe spaces for Black counselors has emerged recently but more connection is still needed.

Culture vs wellness was a subtheme for a few participants. One's childhood experiences and the messages they receive from their community can play a pivotal role in how they view wellness and self-care (Constantine & Sue, 2006; Myers et al., 2018). One participant shared that growing up Haitian American included not assimilating to American culture, which meant working hard and not celebrating American holidays. This participant shared that she had to

learn to care for herself and how resting has been beneficial. Another participant, who has familial roots in Kenya, shared how mental health was not prioritized in her community. These experiences highlight that although we are shaped by our experiences, we can choose a different path that is more suitable for our current selves.

Letting Go is the last superordinate theme that emerged for this research question. This theme focused on self-care experiences and practices and participants shared how they were able to focus on their own well-being, despite their responsibilities. Similar to access to care, affordability of self-care was a subtheme. The ability to afford mental health services and self-care activities was shared by some participants. Participants explained that seeking low cost or free forms of self-care was important to their wellness journey and reframing their definitions of self-care to expand beyond conventional ways of dealing with stress. One participant shared how sleep and drinking more water are no cost ways to care for one's physical and emotional well-being. This participant also shared that managing money well is an act of self-care because it can relieve some stress and allow for self-care activities that do cost, to be accomplished. Literature suggests that wellness and self-care may not be practiced due to affordability, however, for some self-care practices, could a mind shift be needed as well? This study's data suggest it is possible to care for oneself in many ways (improving sleeping and eating habits, incorporating physical activity, engaging in spiritual practices, setting boundaries, taking intentional time for self) to improve professional and personal wellness (Newswald-Potter et al., 2013). The results also suggest that Black counselors are in line with the Counselor Wellness Competencies introduced by Gibson et al. (2021).

Research Question #2: What lived experiences prevent wellness practices in Black counselors?

There were several themes that answered the research question 'what lived experiences prevent wellness practices in Black counselors?' Working from a Deficit was a theme that seemed to resonate with all participants. Every participant talked about current or past unhealthy wellness practices. Many participants shared that exhaustion was prevalent, not just physical exhaustion, but mental exhaustion as well. One participant shared how exhaustion was impacting her life and how the "simple" act of prioritizing rest was the solution, but it seemed difficult to implement given the weight of her responsibilities. When asked what happens when self-care isn't practiced, one participant reported cognitive deficits, feeling sluggish, and light and sound sensitivities. Other participants reported increased anxiety, feeling "irritable" and "out of sorts." Participants also shared their relationships with others are impacted as they may "snap" at family members or have more conflicts due to negative thoughts and feelings. Participants explained that they were inconsistent with their self-care practices even in times of crisis or burnout and explained they felt they did not have enough time in the day to get everything done, so the focus was on work, school or their family and not themselves. Participants shared that even though they "know better" they do not always "do better" and that it was not until they made the decision to be more intentional about their self-care practices that their wellness improved.

Guilt was a subordinate theme that was strongly infused throughout the interviews. Feelings of guilt were expressed by almost all of the participants and many shared they felt guilt related to spending time working and not with family as well as feeling guilty because they have not prioritized their wellness or have not practiced self-care. One participant shared how she made school and work a priority but felt guilty for not going out with friends or being a part of

their lives as much as she wanted because they were not her priority at the time. This participant shared that she felt she wasn't "supposed to have fun," "should be sacrificing" and all her time and energy should be focused on working or being a student. These experiences and views of self-sacrificing presented in other subordinate themes and subthemes highlighted the emotional weight that many Black counselors carry.

The Professional Self theme emerged as many participants discussed their experiences with burnout and compassion fatigue. Participants explained they have several personal and professional roles they manage and often self-care is not centered. Participants reported their jobs do not make self-care a reality due to the job demands and shared that self-care was a "pop culture word" but not realistically implemented or supported. Participants shared how they did not experience self-care being discussed in the profession as much as it should be and how they are learning to set boundaries, so their intense client work does not "follow" them home. One participant shared how the workload increased during the COVID-19 pandemic and they were sometimes asked to work for little to no cost. They shared that clients were struggling with their mental health during the pandemic, but so were mental health professionals who had to continue to work despite their intense feelings. This participant shared how self-care was not a priority at that time, so much so, that basic self-care was not practiced. They and other colleagues did not take breaks or eat lunch during the workday. This experience was supported by the literature that suggested there was limited support given to other front-line workers during the COVID-19 pandemic (Miu & Moore, 2021). Participants also talked about the emotional space that clients take up in a therapist life. Participants shared that even though the session is over, the client remains with the therapist and treatment options, or homework may be researched in an effort to ensure the client progresses through therapy. These experiences explain a one-way caring

relationship explained by Pulson and Gall (2020), where empathy and compassion is extended to clients but not reciprocated. The result of burnout and compassion fatigued varied, but many participants shared that their high demand jobs and the responsibilities that came with them (Carrola et al., 2016), including their lack of wellness practices while working at these jobs, were not sustainable and lead to their decision to enter private practice, where they could control their schedule and have a positive work/life balance.

New Counselor/Workplace Concerns was a subtheme that underlined the stress participants experienced while establishing themselves as a new professional. Although participants were told about the potential for a demanding job in the mental health field, participants seemed unprepared for the workload, job expectations and the impact that the stress would have on their lives. One participant shared about the disconnect between being told to care for herself during her Master's program, but upon graduation the profession did not seem to support a wellness stance, as evidenced by the job demands and sometimes unrealistic expectations of the new counselor (Roach &Young, 2007; Maslach and Leiter (2016). This participant explained that she was working long hours and was expected to drive miles to client's homes while maintaining other job duties. The participant stated "rest seemed frivolous. It seemed out of touch because there were expectations that needed to be met." Along with job expectations, participants were attempting to prove their competence and abilities as a new counselor. They shared that they were in their "hustle phase" which included working more than one job, going to several trainings, or being asked to do more than others, which led to them taking on more than they could handle. Participants were not caring for their well-being due to the job demands and their personal lives were impacted (not attending doctor appointments, failing to take prescribed medications consistently and not setting boundaries in their

professional life) (Lawson et al., 2007). One participant shared how he tied his self-worth into how well his clients were progressing in therapy and he shared that he had to learn to separate how he viewed himself in relation to his professional life. These findings are in line with the review of the literature which found that despite the CACREP standards mentioning wellness, there are no instructions for counseling programs on how wellness can be implemented during and after graduation (Brubaker and Sweeney, 2020; Foster, 2010; Gleason & Hays, 2019). Further, the ACA code of ethics emphasizes counselor impairment and the importance of being well for the benefit of the client, but not for the counselor.

The Strong Black Woman (SBW) theme was prevalent throughout the interviews. Every female participant shared their experiences with the SBW schema. Participants shared about suffering in silence, which included being the primary caregiver for their children, managing household duties, working, taking on other responsibilities as well as most of the emotional labor (Davis & Jones, 2021; Carter & Rossi, 2019). Participants shared how they are "all things to all people" by taking on personal and professional responsibilities and are often expected to be fully present for others (Huddleston-Mattai, 1995; Woods-Giscombe, 2010). One participant shared how she is a Black counselor in an underserved school and the importance of that role for kids who look like her. She explained that she may take on other roles for students and people in the community may expect her to be their therapist as well. This participant as well as others shared that their experiences of navigating others' expectations and being "all to everyone" have been "emotionally exhausting" and "draining." Some participants experienced levels of self-sacrificing. This subtheme focused on participants who saw their self-care as a way to care for others. One participant shared that there are times that her children take priority over her if they are sick or there are other issues. She shared that work and other concerns are on hold when she

has to care for her children. Another participant explained that she has to be her "best" self so she can be present for others in her life. She also shared that her roles as a mother, wife and professional can take centerstage in her life and cause her to not focus on her own wellness. These experiences seem to highlight the literature that Black women are less physically active and will not care for themselves but instead but their focus on the care of others (Woods-Giscombe, 2010).

Participants talked about their experiences managing pressures they feel society is placed on women and navigating the expectations of others. One participant talked about feeling "constrained" regarding the expectations of being a working mother. She shared that others expect her to be a stay-at-home mother, care for her children, the household and her husband. Another participant, who lives with her brother and his family, shared how she had to put boundaries in place as there was an expectation that because she is single with no children, that her time will be spent caring for her nieces. Another participant shared that due to her mental health diagnosis and being a counselor, she is expected to be "ok all of the time." She shared that she is also expected to babysit her nephews and be available when her family calls because she is single with no children. This participant also shared that she is the "trauma dumpster" for her friends and has had more responsibilities at work starting at a young age because she was seen as responsible. Another participant shared her experiences being given more responsibilities than her peers because it is perceived she can handle more. This participant explained that the perception of her as a SBW is false and she was not handling more responsibilities well but felt she had no choice but to perform above and beyond on a consistent basis. These experiences spotlight the misconception that Black women can handle more than others and life's challenges without consequence (West, 2008).

Often self-care is seen as an afterthought. Participants shared experiences with not making their wellness and self-care a priority due to lack of time and making other responsibilities their priority. Participants shared they did not have enough hours in the day to manage all of their roles and responsibilities and this left them emotionally, mentally and physically exhausted (Jones & Shorter-Gooden, 2003). Participants acknowledged that wellness and self-care were necessary for them to manage the stress in their lives, but admitted that despite this, wellness took a back seat. One participant shared that she learned unhealthy self-care habits from her parents, whom she called "workaholics." Another participant shared that self-care has been an afterthought because she attempted to be "Wonder Woman" and "always be on point" as it relates to how others perceive her. This participant explained that her lack of self-care comes from her being too "busy" and focusing on what others expect from her.

Black Tax was the final superordinate theme identified in relation to the second research question. The term Black Tax refers to Black people feeling they are being held to a higher standard and typically pay a higher emotional tax, particularly in the workplace, than their White counterparts (Bloomberg, nd). Although this definition is related to the workplace, Black Tax also relates a Black person's emotional labor. Participants shared their experiences with navigating stigma and stereotypes in the workplace. One participant shared that she feels she must give "250%" on her job compared to her White peers because she can be viewed as a stereotypical "angry Black woman." When Black women experience stereotyping, emotional suppression, limited display of vulnerability and emotional silencing can happen (Davis & Jones, 2021; Carter & Rossi, 2019). Participants explained they felt they had to prove they were "on the same level" with their White peers, which also contributed to them taking on more tasks than others. Participants also shared experiences of discrimination, feeling discredited and "wearing a

mask" to protect themselves emotionally from others. These results indicate there is ongoing stigma, stereotyping, discrimination which can impact the wellness of the Black counselor (Ward et al., 2013; Stewart et al., 2021; Griffith et al., 2018).

Strengths and Limitations

This study contributes to the limited research on Black counselor wellness practices and barriers to wellness. Previous research has focused on wellness of the person, which led to the development of various wellness models (Oliver et al., 2018). Other research has centered on counselor wellness from an impairment perspective (Blount et al., 2016; Craig & Sprang, 2010; Figley, 2002; Wardle & Mayorga, 2016). Recent research related to counselor wellness competencies (Gibson et al, 2021) is promising, however, there is not a breadth of literature related to the experiences of Black counselors and their wellness. This study adds to the literature gap by providing a rich and detailed exploration of the data through IPA. The findings suggest that Black counselors are aware of their wellness needs and understand the implications of burnout and compassion fatigue as well as other challenges when wellness is not consistently implemented. The findings also suggest that there are several barriers that can hinder a Black counselors wellness journey (systemic issues, expectations of others, work and family obligations) and ability to practice self-care on a regular basis. Despite these issues, Black counselors continue to thrive and focus on caring for their own needs in an effort to support themselves, their families and their clients.

Limitations within this study are notable. There were nine participants in this study but only one male participant. Results may have been different if the participant genders were balanced. Future research could consider a study of Black male counselors and their wellness and self-care practices as their perspectives are unique. It should be noted that there was a

concern regarding two participants with roots in Africa. This researcher and the audit team were concerned that the two participants were the same person however this could not be verified, and it was decided that the participants experiences would remain in the study. Their participation in the study did not take away from the data and there were no concerns regarding validity, however this researcher felt that the concerns should be acknowledged. Future research could consider requiring participants to have their cameras on during interviews that are done virtually to validate participant identity. Another limitation of this study could be regarding the region where participants were located. Participants were from the West and Southeast regions of the U.S. Further research can either include participants from all regions or focus on one region to analyze data and region trends.

Implications and Future Research

Findings from this study can provide insight into how Black counselors practice wellness and the barriers they may face in their efforts to practice wellness and self-care. This study indicates that there is a need for a wellness model for Black, Indigenous and other counselors of color. The wellness models mentioned in previous chapters (Wheel of Wellness, Swarbrick's Eight Dimensions of Wellness, Hettler's Six Dimensions of Wellness) had similar dimensions that spoke to overall wellness of a person. The Optimal Human Functioning Model was the only model this researcher was able to locate that incorporates collectivism, racial and ethnic pride, and community, all aspects that most people of color infuse into their daily lives (Constantine & Sue, 2006). The CSI Counselor Wellness Competencies is the first known competencies that speaks to the wellness needs of the counselor, not just the client (Gibson et al., 2021). However, there are cultural aspects of a counselor's wellness journey that are important to include. This researcher was unable to find a model that incorporates important cultural relevance and there

does not seem to be a wellness model that infuses a counselor's culture, professional, and personal life. Future research is needed to speak to the unique struggles that Black counselors navigate that can impact their wellness and ability to practice self-care.

This study highlighted the gaps in wellness promotion in counselor training programs and CACREP standards. Counseling programs encourage wellness and self-care however there does not seem to be a clear instruction on how wellness can be promoted (Bronco & Patton-Scott 2020). Centering wellness throughout the counseling program could promote wellness among students, who may continue to incorporate the wellness philosophy post-graduation. Research that places attention on the wellness practices of students of color as well as faculty of color can be helpful. This study has also called attention to systemic issues within the counseling profession related to wellness. Many participants shared concerns regarding having the financial resources early in their career to be able to practice wellness. Participants were also burdened by the heavy workload and lack of support post-graduation from their counseling program. Research that brings attention to the gap between wellness that is supported in counseling programs and the reality of working in the counseling field can be beneficial. Further studies that focus on the systemic barriers that can impact a counselor's wellness such as lack of adequate pay for advanced degree holders, improved work environments when working with high acuity clients and stressful jobs, could assist in increased advocacy for the counselor, which can lead to more positive wellness outcomes.

This research focused on Black counselors who were independently licensed. All participants had been in practice for five or more years. Future research could include new counselors who have graduated their programs, working in the mental health field but are not yet fully licensed. New counselors have a unique perspective to the profession and studies that focus on emerging

Black counselors can add to the literature. Additionally, research on counselors who have been in the field over 10 years may have add different viewpoint. This study did not focus on wellness of the supervisors or counselor educators of color, but these areas are worthy of research, as these roles are integral to the counseling profession.

This qualitative study provided rich data. A quantitative study may allow for more participants to be examined across several regions of the U.S. and expand the scope of knowledge with a larger population sample size. While this study focused on Black counselors, studies involving other BIPOC communities can be beneficial and add to the understanding of counselor wellness and self-care practices. Further, expanding the research to other disciplines of not only mental health professionals, but other helping professionals can be helpful.

References

Aafjes-van Doorn, K., Békés, V., Prout, T. A., & Hoffman, L. (2020). Psychotherapists' vicarious traumatization during the COVID-19 pandemic. *Psychological Trauma*, *12*(S1), 148–150. https://doi.org/10.1037/tra0000868

Abrams, J. A., Maxwell, M., Pope, M., & Belgrave, F. Z. (2014). Carrying the world with the grace of a lady and the grit of a warrior: Deepening our understanding of the "Strong Black Woman" schema. *Psychology of Women Quarterly*, *38*(4), 503–518. https://doi.org/10.1177/0361684314541418

Adams, T., Bezner, J., & Steinhardt, M. (1997). The conceptualization and measurement of perceived wellness: Integrating balance across and within dimensions. *American Journal of Health Promotion*, *11*(3), 208–218. https://doi.org/10.4278/0890-1171-11.3.208

Adler, A. (1956). *The individual psychology of Alfred Adler* (H. L. Ansbacher, Ed.). Basic Books.

American Cancer Society. (2022, February 14). *More Black women die from breast cancer than any other cancer*. www.cancer.org. Retrieved April 16, 2022, from https://www.cancer.org/latest-news/facts-and-figures-african-american-black-people-2022-2024.html

American Counseling Association. (2014). *Code of Ethics*. Author.

American Psychological Association. (2016). *African Americans have limited access to mental and behavioral health care*. www.apa.org. Retrieved June 4, 2022, from https://www.apa.org/advocacy/civil-rights/diversity/african-american-health

American Psychological Association. (2020). *Demographics of the U.S. psychology workforce*. www.apa.org. Retrieved June 1, 2022, from https://www.apa.org/workforce/data-tools/demographics

Amjad, F., & Bokharey, I. Z. (2015). Comparison of spiritual well-being and coping strategies of patients with generalized anxiety disorder and with minor general medical conditions. *Journal of Religion and Health*, *54*(2), 524–539. https://doi.org/10.1007/s10943-014-9834-2

Angner, E., Hullett, S., & Allison, J. (2011). ‘‘I’ll die with the hammer in my hand’’: John Henryism as a predictor of happiness. *Journal of Economic Psychology*, *32*(3), 357–366. https://doi.org/10.1016/j.joep.2011.01.002

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

Ardell, D. B. (1985). The history and future of wellness. *Health Values*, *9*(6), 37–56.

Arias, E., Tejada-Vera, B., Ahmad, F., & Kochanek, K. D. (2021). *Provisional life expectancy estimates for 2020* (ital Statistics Rapid Release; no 15). National Center for Health Statistics. https://doi.org/10.15620/cdc:107201

Assari, S., Moazen-Zadeh, E., Howard-Caldwell, C., & Zimmerman, M. A. (2017). Racial discrimination during adolescence predits mental health deterioration in adulthood: Gender differences among Blacks. *Front Public Health*, *5*(104). https://doi.org/10.3389/fpubh.2017.00104

Bailey, M. (2021). *Misogynoir transformed black women's digital resistance*. New York University Press.

Bartholomew, M. W., Harris, A. N., & Maglalang, D. D. (2018). A call to healing: Black Lives Matter movement as a framework for addressing the health and wellness of Black women. *Community Psychology in Global Perspective*, *4*(2), 85–100. https://doi.org/10.1285/i24212113v4i2p85

Békés, V., Aafjes-van Doorn, K., Zilcha-Mano, S., Prout, T., & Hoffman, L. (2021). Psychotherapists' acceptance of telepsychotherapy during the COVID-19 pandemic: A machine learning approach. *Clinical Psychology and Psychotherapy*, *28*(6), 1403–1415. https://doi.org/10.1002/cpp.2682

Bernard, D. L., Jones, S. C., & Volpe, V. V. (2020). Impostor phenomenon and psychological well-being: The moderating roles of John Henryism and school racial composition among Black college students. *Journal of Black Psychology*, *46*(2-3), 195–227. https://doi.org/10.1177/0095798420924529

Bey, G. S., Jesdale, B. M., Ulbricht, C. M., Mick, E. O., & Person, S. D. (2018). Allostatic load biomarker associations with depressive symptoms vary among US Black and White omen and men. *Healthcare (Basel)*, *6*(3), 105. https://doi.org/10.3390/healthcare6030105

Blount, A. J., Dillman, T., Delena, L., & Glenn, W. (2020). Wellness in the helping professions: Historical overview, wellness models, and current trends. *Journal of Wellness*, *2*(2), Article 6. https://doi.org/10.18297/jwellness/vol2/iss2/6

Blount, A. J., Dillman Taylor, D., Lambie, G. W., & Anwell, A. (2016). Clinical supervisors' perceptions of wellness: A phenomenological view on supervisee wellness. *The Professional Counselor*, *6*(4), 360–374. https://doi.org/10.15241/ab.6.4.360

Blount, A. J., & Mullen, P. R. (2015). Development of an intergrative wellness model: Supervising counselors-in-training. *The Professional Counselor*, *5*(1), 100–113. https://doi.org/0009644553; 10.15241/ajb.5.1.100

Blount, A., & Lambie, G. W. (2018). Development and factor structure of the helping professional wellness discrepancy scale. *Measurement and Evaluation in Counseling and Development*, *51*(2), 92–110. https://doi.org/10.1080/07481756.2017.1358060

Boscarino, J. A., Figley, C. R., & Adams, R. E. (2004). Compassion fatigue following the September 11 terrorist attacks: A study of secondary trauma among New York City social workers. *International Journal of Emergency Mental Health*, *6*, 57–66.

Bressi, S., & Vaden, E. (2017). Reconsidering self care. *Clinical Social Work Journal*, *45*(1), 33–38. https://doi.org/10.1007/s10615-016-0575-4

Brown, C., & Applegate, B. (2012). Holistic wellness assessment for young adults psychometric analysis. *Journal of Holistic Nursing*, *30*(4), 235–243. https://doi.org/10.1177/0898010112453327

Brownlow, B. N., Sosoo, E. E., Long, R. N., Burford, T. I., & Hill, L. K. (2019). Sex differences in the impact of racial discrimination on mental health among Black Americans. *Current Psychiatry Reports*, *21*(112). https://doi.org/10.1007/s11920-019-1098-9

Brubaker, M. D., & Sweeney, T. J. (2021). Wellness and wellness counseling: History, status, and future. *Counselor Education and Supervision*, *61*(1), 25–37. https://doi.org/10.1002/ceas.12222

Bureau of Justice Statistics. (n.d.). *Prisoners in 2016*. www.bjs.gov. Retrieved June 25, 2022, from https://www.bjs.gov/content/pub/pdf/p16.pdf

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu, S., & Kane, R. (2016). *Improving cultural competence to reduce health disparities* (AHRQ Comparative Effectiveness Reviews, Report No.16-EHC006-EF) [Report]. Agency for Healthcare Research and Quality.

Butts, C. M., & Gutierrez, D. (2018). Dispositional mindfulness and personal distress as predictors of counseling self-efficacy. *Counselor Education & Supervision*, *57*, 271–284.

Carrola, P. A., Olivarez, A., & Karcher, M. J. (2016). Correctional counselor burnout: Examining burnout rates using the Counselor Burnout Inventory. *Journal of Offender Rehabilitation*, *55*(3), 195–212. https://doi.org/10.1080/10509674.2016.1149134

Carter, L., & Rossi, A. (2019). Embodying strength: The origin, representations, and socialization of the strong Black woman ideal and its rffect on Black women's mental health. *Women & Therapy*, *42*(3-4), 289–300. https://doi.org/10.1080/02703149.2019.1622911

Catastrophes: An overview of family reactions. (1983). In Figley, C. R. (Ed.), *Stress and the family II: Coping with catastrophe* (pp. 3–20). Brunner/Mazel.

CDC. (2017). *Leading causes of death - males - Non-Hispanic Black - United States, 2017*. The Center for Disease Control. Retrieved June 23, 2021, from https://www.cdc.gov/healthequity/lcod/men/2017/nonhispanic-black/index.htm

Centers for Disease Control and Prevention. (n.d.). *1918 Pandemic (H1N1 virus)*. Cdc.gov. Retrieved February 5, 2022, from https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

Centers for Disease Control and Prevention. (2020, December 10). *Risk of exposure to COVID-19: Racial and ethnic health disparities*. Cdc.gov. Retrieved June 6, 2022, from

https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/increased-risk-exposure.html#:~:text=Neighborhood%20and%20physical%20environment%3A,may%20vary%20between%20counties.

Centers for Disease Control and Prevention. (2021). *Underlying cause of death 1999-2020* (Multiple cause of death files, 1999-2020). National Center for Health Statistics. http://wonder.cdc.gov/ucd-icd10.html

Chang, C. Y., & Myers, J. E. (2003). Cultural Adaptations of wellness evaluation of lifestyle: An assessment challenge. *Measurement and Evlauation in Counseling and Development*, *35*(4), 239–250.

Chinn, J. J., Martin, I. K., & Redmond, N. (2021). Health equity among black women in the United States. *Journal of Women's Health*, *30*(2), 212–219. https://doi.org/10.1089/jwh.2020.8868

Connelly, L. M. (2016). Trustworthiness in Qualitative Research. *Medsurg Nursing*, *25*(6).

Constantine, M. G., & Sue, D. W. (2006). Factors contributing to optimal human functioning in people of color in the United States. *The Counseling Psychologist*, *24*(2), 228–244. https://doi.org/10.1177/0011000005281318

Cooke, P. J., Melchert, T. P., & Conner, K. (2016). Measuring well-being: A review of instruments. *The Counseling Psychologist*, *44*(5), 730–757. https://doi.org/10.1177/0011000016633507

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, *23*(3), 319–339. https://doi.org/10.1080/10615800903085818

Creswell, J. W., & Creswell, J. D. (2018). *Research design* (5th ed.) [Yuzu]. Sage Publications . Thousand Oaks, CA

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage .

Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process* (1st ed.). Sage Publications.

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative Health Research*, *27*(6), 826–835. https://doi.org/10.1177/1049732316656161

Culver, L. M., McKinney, B. L., & Paradise, L. V. (2011). Mental health professionals' experiences of vicarious traumatization in post-Hurricane Katrina New Orleans. *Journal of Loss & Trauma*, *16*(1), 33–42. https://doi.org/10.1080/15325024.2010.519279

Cummins, R. A., Eckersley, R., Pallant, J., Van Vugt, J., & Misajon, R. (2003). Developing a national index of subjective wellbeing: The Australian unity well- being index. *Social Indicators Research*, *64*(2), 159–190.

Cummins, R. A., McCabe, M. P., Romeo, Y., & Gullone, E. (1994). Validity studies the Comprehensive Quality of Life Scale (COMQOL): Instrument development and psychometric evaluation on college staff and students. *Educational and Psychological Measurement*, *54*(2), 372–382. https://doi.org/10.1177/ 0013164494054002011

Czeisler, M. E., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. (2020). *Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United Sates, June 24–30, 2020* (Morbidity and Mortality

Weekly Report (MMWR)). Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

Dahlberg, K., Dahlberg, H., & Nystrom, M. (2008). *Reflective lifeworld research* (2nd ed.). Studentlitteratur.

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

DeGruy, J. (2017). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*.

Denzin, N. K., & Lincoln, Y. S. (1988). *The landscape of qualitative research: theories and issues*. Sage Publications.

Duke Medicine News & Communication. (2006, March 4). *John Henryism" key to understanding coping, health*. Conference of the American Psychosomatic Society, Denver, CO, USA. https://corporate.dukehealth.org/news/john-henryism-key-understanding-coping-health

Dunn, H. L. (1961). *High-Level Wellness: A Collection of Twenty-Nine Short Talks onDifferent Aspects of the Theme "High-Level Wellness for Man and Society"*. R. W. Beatty.

Encyclopaedia Britannica. (n.d.). *Hattie McDaniel: American actress and singer*. Britannica.com. Retrieved March 4, 2022, from https://www.britannica.com/biography/Hattie-McDaniel

Evans, K. M. (1997). Wellness and coping activites of African American counselors. *Journal of Black Psychology*, *23*(1), 24–35.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice*, *58*(11), 1433–1441.

Figley, C. R., & Ludick, M. (2017). Secondary traumatization and compassion fatigue. In *APA handbook of trauma psychology: Foundations in knowledge* (pp. 573–593). American Psychological Association. https://doi.org/10.1037/0000019-029

Flaskerud, J. H. (2012). Coping and health status: John Henryism. *Issues in Mental Health Nursing*, *33*(10), 712–715. https://doi.org/10.3109/01612840.2012.673695

Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. *Journal of Mental Health Counseling*, *40*(2), 142–155. https://doi.org/10.17744/mehc.40.2.04

Foster, T. (2010). Encouraging student wellness: An expanded role for counselor educators. *Journal of Counselor Preparation and Supervision*, *2*(1). https://doi.org/10.7729/21.0112

Freud, S. (1937). *The standard edition of the complete psychological works of Sigmund Freud* [Analysis terminable and interminable] (S. Strachey, Ed.; A. Freud, A. Strachey, & A. Tyson, Trans.). The Hogarth Press ; The Institute of Psycho-anaylsis.

Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues*, *30*(1), 159–165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Freudenberger, H. J., & Richelson, G. (1980). *Burnout: the high cost of achievement* (1st ed.). Anchor Press.

Gamby, K., Burns, D., & Forristal, K. (2021). Wellness decolonized: The history of wellness and recommendations for the counseling field. *ournal of Mental Health Counseling*, *43*(3), 228–245. https://doi.org/10.l7744/mehc.43.3.05

Gara, M. A., Minsky, S., Stevenson, S. M., Miskimen, T., & Strakowski, S. M. (2019). A naturalistic study of racial disparities in diagnoses at an outpatient behavioral health clinic. *Psychiatric Services*, *70*(2), 130. https://doi.org/10.1176/appi.ps.201800223

Gibbons, R. J., Thorsteinsson, E. B., & Loi, N. M. (2015). Beliefs and attitudes towards mental illness: an examination of the sex differences in mental health literacy in a community sample. *PeerJ*, *3*. https://doi.org/10.7717/peerj.1004

Gibson, D. M., Pence, C., Kennedy, S. D., Gerlach, J., Degges-White, S., & Watson, J. (2021). Development of the counselor wellness competencies. *Journal of Counselor*, *8*(2), 130–145. https://doi.org/10.1080/2326716X.2021.1925997

Givropoulou, D., & Tseliou, E. (2021). Developing reflexivity through group processes in psychotherapy training: An interpretative phenomenological analysis of systemic family herapy trainees' experience. *Family Process*, *60*(2). https://doi.org/doi:10.1111/famp.12600

Gleason, B. K., & Hays, D. (2019). A phenomenological investigation of wellness within counselor education programs. *Counselor Education & Supervision*, *58*, 177–194. https://doi.org/10.1002/ceas.12149

Granello, P. (2000). Integrating wellness work into mental health private practice. *Journal of Psychotherapy in Independent Practice*, *1*(1), 1–16. https://doi.org/10.1300/J288v01n01_02

Griffith, E. E., Jones, B. E., & Stewart, A. J. (2018). *Black mental health: Patients, providers, and systems*. American Psychiatric Publishing.

Guillen, D. E. F. (2019). Qualitative research: Hermeneutical phenomenological method. *Monographic: Advances on Qualitative Research in Education*, *7*(1), 201–229. https://doi.org/10.20511/pyr2019.v7n1.267

Gutierrez, D., & Mullen, P. R. (2016). Emotional intelligence and the counselor: Examining the relationship of trait emotional intelligence to counselor burnout. *Journal of Mental Health Counseling*, *38*(3), 187–200. https://doi.org/10.1774/mehc.38.3.01

Hakkaura, K. (2019). Insight medicine lacks: The continuing relevance of Henrietta Lacks. *The New England Journal of Medicine*, *381*(9), 800–801. https://doi.org/10.1056/NEJMp1905346

Halevi, E., & Idisis, Y. (2018). Who helps the helper? Differentiation of self as an indicator for resisting vicarious traumatization. *Psychological Trauma*, *10*(6), 698–705. https://doi.org/10.1037/tra0000318

Hannon, M. D., & G, L., Vereen. (2016). Irreducibility of Black male clients: considerations for culturally competent counseling. *Journal of Humanistic Counseling,*, *55*(3), 234–245. https://doi.org/10.1002/johc.12036

Harrington, E. F., Crowther, J. H., & Shipherd, J. C. (2010). Trauma, binge eating, and the "strong Black woman". *Journal of Consulting and Clinical Psychology*, *78*(4), 469–479. https://doi.org/10.1037/a0019174

Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis, and practice. *Journal of Counseling and Development*, *82*(3), 354–364. https://doi.org/10.1002/j.1556-6678.2004.tb00321.x

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. The Guilford Press.

Henderson, C. E. (2014). AKA: Sarah Baartman, The hottentot venus, and Black women's identity. *Women's Studies*, *43*(7), 946–959. https://doi.org/10.1080/00497878.2014.938191

Heppner, P. P., & Heppner, M. J. (2004). *Writing and publishing your thesis, dissertation and research: A guide for students in the helping professions*. Brooks/Cole, Cengage.

Hermon, D. A., & Hazler, R. J. (1999). Adherence to a wellness model and perceptions of psychological well-being. *Journal of Counseling and Development*, *77*(3), 339–343. https://doi.org/10.1002/j.1556-6676.1999.tb02457.x

Heron, M. (2021). *Leading causes for 2018. National Vital Statistics Reports* (vol 70 no 4). National Center for Health Statistics. https://doi.org/10.15620/ cdc:104186

Hettler, B. (1984). Wellness: Encouraging a lifetime pursuit of excellence. *Health Values*, *8*(4), 13–17.

Hinds, W. C. (1983). *Personal paradigm shift: A lifestyle intervention approach to healthcare management*. East Lansing: Michigan State University .

Hodge, D. R., Limb, G. E., & Cross, T. L. (2009). Moving from colonization toward balance and harmony: A Native American perspective on wellness. *Social Work (New York)*, *54*(3), 211–219. https://doi.org/10.1093/sw/54.3.211

Hoffman, S., Marsiglia, F. F., & Ayers, S. L. (2015, April 14). Religiosity and migration aspirations among mexican youth. *International Migration & Integration*, 173–186. https://doi.org/DOI 10.1007/s12134-014-0342-8

Hoffman, S., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between

blacks and whites. *Proceedings of the National Academy of Sciences - PNAS*, *113*(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113

Horrigan-Kelly, M., Miller, M., & Dowling, M. (2016). Undersanding the key tenets f Heidegger's philosophy for interpretive phenmenological research. *Internaional Journal of Qualitative Methods*, 1–8. https://doi.org/10.1177/1609406916680634

Huddleston-Mattai, B. (1995). The Black female academician and the "superwoman syndrome". *Race, Gender & Class*, *3*(1), 49–64.

Hudson, D. L., Neighbors, H. W., Geronimus, A. T., & Jackson, J. S. (2016). Racial discrimination, John Henryism, and depression among African Americans. *Journal of Black Psychology*, *42*(3), 221–243. https://doi.org/10.1177/0095798414567757

Jacobson, N. C., Lekkas, D., Price, G., Heinz, M. V., Song, M., O'Malley, A. J., & Barr, P. J. (2020). Flattening the mental health curve: COVID-19 stay-at-home orders are associated with alterations in mental health search behavior in the United States. *JMIR Mental Health*, *7*(6), 19347–19347. https://doi.org/10.2196/19347

James, S. A. (1993). The narrative of John Henry Martin. *Southern Cultures*, *1*(1), 83–106.

James, S. A. (1994). John Henryism and the health of African Americans. *Culture, Medicine, and Psychiatry*, *18*, 163–182.

James, S. A., Hartnett, S. A., & Kalsbeek, W. D. (1983). John Henryism and blood pressure differences among Black men. *Journal of Behavioral Medicine*, (6), 259–278. https://doi.org/10.1007/BF01315113

Jenkins, S. R., Mitchell, J. L., Baird, S., Whitfield, S. R., & Meyer, H. L. (2011). The counselor's trauma as counseling motivation: Vulnerability or stress inoculation? *Journal of Interpersonal Violence*, *26*(12), 2392–2412. https://doi.org/10.1177/0886260510383020

John Hopkins Medicine. (n.d.). *The legacy of Henrietta Lacks*. Retrieved February 20, 2022, from https://www.hopkinsmedicine.org/henriettalacks/

Johnston, M. M., & Finney, S. J. (2010). Measuring basic needs satisfaction: Evaluating previous research and conducting new psychometric evaluations of the Basic Needs Satisfaction in General scale. *Contemporary Educational Psychology,*, *35*(4), 280–296. https://doi.org/10.1016/j.cedpsych.2010.04.003

Jones, C., & Shorter-Gooden, K. (2003). *Shifting: The double lives of Black women in America*. Harper Collins.

Jones, M. K., Harris, K. J., & Reynolds, A. A. (2020). In their own words: The meaning of the Strong Black Woman schema among Black U.S. college women. *Sex Roles*, (84), 347–359. https://doi.org/10.1007/s11199-020-01170-w

Journal of the American Medical Association. (2021). *The Leading Cause of Death in the US for 2020*. https://doi.org/10.1001/jama.2021.5469

Jung, C. G. (1958). *The undiscovered self* (R. F. Hall, Trans.). Mentor Books.

Kiecolt, K. J., Hughes, M., & Keith, V. M. (2009). Can a high sense of control and John Henryism be bad for mental health? *Sociological Quarterly*, *50*(4), 693–714. https://doi.org/10.1111/j.1533-8525.2009.01152.x

Korstjensa, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Lafferty, J. (1979). A credo for wellness. *Health Education*, *10*(5), 10.

Lanier, B. A., & Carney, J. S. (2019). Practicing counselors, vicarious trauma, subthreshold PTSD: Implications for counselor educators. *The Professional Counselor*, *9*(4), 334–346. https://doi.org/10.15241/bal.9.4.334

Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling and Development*, *89*(2), 163–171. https://doi.org/10.1002/j.1556-6678.2011.tb00074.x

Lawson, G., Venart, E., Hazler, R. J., & Kottler, J. A. (2007). Toward a culture of counselor wellness. *The Journal of Humanistic Education and Development*, *46*(1), 5.

Levers, L. L., Anderson, R. I., Boone, A. M., Cebula, J. C., Edger, K., & Kuhn, L. (2008). Qualitative research in counseling: Applying robust methods and illuminating human context. *Vitas Online*. Retrieved January 1, 2022, from https://www.counseling.org/resources/library/vistas/2008-V-Online-MSWord-files/Levers.pdf

Limb, G. E., & Hodge, D. R. (2008). Developing spiritual competency with Native Americans: Promoting wellness through balance and harmony. *Families in Society*, *89*(4), 615–622. https://doi.org/10.1606/1044-3894.3816

Lin, L., Stamm, K., & Christidis, P. (2018). How diverse is the psychology workforce?. *APA Monitor*, *49*(2). Retrieved July 6, 2021, from

Lincoln, Y. S., & Guba, E. G. (1985). *Natualistic inquiry*. Sage Publications.

Long, S. M., Clark, M., Ausloos, C. D., Jacoby, R., & McGhee, C. (2019). The wellness and self-care experiences of single mothers in poverty: Strategies for mental health counselors. *Journal of Mental Health Counseling*, *41*(4), 343–358. https://doi.org/10.17744/mehc.41.4.05

Lyubomirsky, S., & Lepper, H. S. (1999). A measure of subjective happiness: Preliminary reliability and construct validation. *Social Indicators Research*, *46*(2), 137–155.

MacDorman, M. F., Thoma, M., Declcerq, E., & Howell, E. A. (2021). Racial and ethnic disparities in maternal mortality in the United States using enhanced vital records. *American Journal of Public Health*, *111*(9), 1673–1681. https://doi.org/10.2105/AJPH.2021.306375

Madigan, S., Racine, N., Cooke, J. E., & Korczak, D. J. (2021). COVID-19 and telemental health: Benefits, challenges, and future directions. *Canadian Psychology = Psychologie Canadienne*, *62*(1), 5–11. https://doi.org/10.1037/cap0000259

Martin, J., Padierna, Á., Villanueva, A., & Quintana, J. (2021). Evaluation of the mental health of health professionals in the COVID-19 era. What mental health conditions are our health care workers facing in the new wae of coronavirus? *International Journal of Clinical Practice*, *75*, 1–11. https://doi.org/10.1111/ijcp.14607

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103–111. https://doi.org/10.1002/wps.20311

Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). D. Van Nostrand.

Matthews, D. D., Powell Hammond, W., Cole-Lewis, Y., Nuru-Jeter, A., & Melvin, T. (2013). Racial discrimination and depresive symtpoms among African American men: The mediating and modertating roles of masculine self-reliance and John Henryism. *Psychol Men Masc.*, *14*(1), 35–46. https://doi.org/10.1037/a0028436

McCall, T., Schwartz, T., & Khairat, S. (2019). Acceptability of telemedicine to help African American women manage anxiety and depression. *Studies in Health Technology and Informatics*, *264*, 699–703.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. https://doi.org/10.1007/BF00975140

Meany-Walen, K. K., David-Gage, D., & Lindo, N. A. (2016). The impact of wellness-focused supervision on mental health counseling practicum students. *Journal of Counseling & Development*, *94*. https://doi.org/DOI: 10.1002/jcad.12105

Melissa, W. B., Harris, A. N., & Dale, D. M. (2018). A call to healing: Black Lives Matter movement as a framework for addressing the health and wellness of Black women. *Community Psychology in Global Perspective*, *4*(2), 85–100. https://doi.org/10.1285/i24212113v4i2p85

Merritt, M. M., Bennett, G. G., Williams, R. B., Sollers, 3rd, J. J., & Thayer, J. F. (2004). Low educational attainment, John Henryism, and cardiovascular reactivity to and recovery from personally relevant stress. *Psychosomatic Medicine*, *66*(1), 49–55.

Miller, J., Donohue-Dioh, J., Larkin, S., Niu, C., & Womack, R. (2018). Exploring the self-care practice of practicum supervisors: Implications for field education. *Field Educator*, *8*(2).

Miller, R. M., Chan, C. D., & Farmer, L. B. (2018). Interpretative phenomenological analysis: A contemporary qualitative approach. *Counselor Education and Supervision*, *57*. https://doi.org/10.1002/ceas.12114

Miu, A. A., & Moore, J. R. (2021). Behind the masks: Experiences of mental health practitioners of color during the COVID-19 pandemic. *Academic Psychiatry*, *45*(5), 539–544. https://doi.org/10.1007/s40596-021-01427-w

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology*, *23*(2), 129–142. https://doi.org/10.1037/trm0000122

Moustakas, C. (1994). *Phenomenological research methods* (1st ed.). SAGE Publications, Inc.

Murray, S. J., & Holmes, D. (2014). Interpretive phenomenological analysis (IPA) and the ethics of body and place: Critical methodological reflections. *Human Studies*, *37*, 15–30. https://doi.org/10.1007/s10746-013-9282-0

Myers, J. E. (1990). *Wellness throughout the lifespan*. Guidepost.

Myers, J. E. (1991). Wellness as a paradigm for counseling and development: The possible future. *Counselor Education and Supervision*, *30*(3), 183–193. https://doi.org/10.1002/j.1556-6978.1991.tb01199.x

Myers, J. E., & Sweeney, T. J. (2008). Wellness Counseling: The eveidence base for practice. *Journal of Counseling Development*, *86*(4).

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling and Development*, *78*(3), 251–266. https://doi.org/1002/j.1556-6676.2000.tb01906.x

Myers, L. J., Anderson, M., Lodge, T., Speight, S., & Queener, J. E. (2018). Optimal theory's contributions to understanding andsSurmounting global challenges to humanity. *Journal of Black Psychology*, *44*(8), 747–771. https://doi.org/10.1177/0095798418813240

National Alliance on Mental Illness. (n.d.). *Mental health by the numbers*. www.nami.org. Retrieved November 12, 2021, from https://www.nami.org/mhstats

National Center for Education Statistics. (2020, June). *Degrees conferred by race*. www.nced.ed.gov. Retrieved June 5, 2022, from https://nces.ed.gov/fastfacts/display.asp?id=72

National Wellness Institute. (n.d.). *Multicultural competency in wellness*. nationalwellness.org. Retrieved December 13, 2021, from https://nationalwellness.org/resources/multicultural-competency-in-wellness/

Neighbors, H. W., Njai, R., & Jackson, J. S. (2007). Race, ethnicity, John Henryism, and depressive symptoms: The national survey of American life adult reinterview. *Research in Human Development*, *4*(1-2), 71–87. https://doi.org/10.1080/15427600701481004

Neswald-Potter, R. E., Blackburn, S. A., & Noel, J. J. (2013). Revealing the power of practitioner relationships: An action-driven inquiry of counselor wellness. *Journal of Humanistic Counseling*, *52*(2), 177–190. https://doi.org/10.1002/j.2161-1939.2013.00041.x

Ohrt, J. H., Clarke, P. B., & Conley, A. H. (2018). *Wellness counseling: A holistic approach to prevention and intervention*. American Counseling Association \.

Oliver, M. D., Baldwin, D. R., & Datta, S. (2019). Health to wellness: A review of wellness models and rransitioning back to health. *International Journal of Health, Wellness & Society*, *9*(1), 41–56.

OMH. (n.d.). *Mental and behavioral health - African Americans*. US Department of Health and Human Services Office of Minority Health. Retrieved June 23, 2021, from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24

Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *Evidence Based Nursing*, *22*(1). https://doi.org/10.1136/ebnurs-2018-103017

Peterson-Rochon, G. M. (2020). *The strong black superwoman phenomenon* (28318621) [Doctoral dissertation, Michigan School of Psychology]. ProQuest. https://www.proquest.com/docview/2502867767?pq-origsite=primo

Pfefferbaum, B., & North, C. S. (2020). Mental health and the Covid-19 pandemic. *The New England Journal of Medicine*, *383*(6), 510–512. https://doi.org/10.1056/NEJMp2008017

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Posluns, K., & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling*, *42*(1). https://doi.org/1-20.DOI:10.1007/s10447-019-09382-w

Prison Policy Initiative. (n.d.). *United States profile: Racial and ethnic disparities in prisons and jails*. www.prisonpolicy.org. Retrieved June 25, 2022, from https://www.prisonpolicy.org/profiles/US.html#disparities.

Purdy, M., & Dupey, P. (2005). Holistic flow model of spiritual wellness. *Counseling and Values*, *49*(2), 95–106. https://doi.org/10.1002/j.2161-007X.2005.tb00256.x

Ramos, J. A. (2011). A comparison of percieved stress levels and coping styles of non-traditional graduate students in distance learning versus on-campus programs. *Contemprary Educational Technology*, *2*(4), 282–293.

Rashotte, J., & Jensen, L. (2007). Validity in hermeneutic phenomenological inquiry: Towards an ethics of evaluation. *Canadian Journal of Nursing Research*, *39*(4), 94–115.

Reese, R. F., & Myers, J. E. (2012). EcoWellness: The missing factor in holistic wellness models. *Journal of Counseling and Development*, *90*(4), 400–406. https://doi.org/10.1002/j.1556-6676.2012.00050.x

Reverby, S. M. (2009). *Examining Tuskegee: The infamous Syphilis study and its legacy* (1st ed.). University of North Carolina Press.

Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education & Supervision*, *47*, 29–45.

Robinson, M. N., & Thomas Tobin, C. S. (2021). Is John Hernyim a health risk or resource? Exploring the role culturally relevant coping for physical and mental health among Black Americans. *Journal of Health and Social Behavior*, *62*(2), 136–151. https://doi.org/10.1177/00221465211009142

Rodham, K., Fox, F., & Doran, N. (2015). Exploring analytical trustworthiness and the process of reaching consensus in interpretative phenomenological analysis: lost in transcription. *International Journal of Social Research Methodology*, *18*(1), 59–71. https://doi.org/10.1080/13645579.2013.852368

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, *57*(6), 1069–1081.

Ryff, C. D., Almeida, D. M., Ayanian, J. Z., Carr, D. S., Cleary, P. D., Coe, C., Davidson, R. J., Krueger, R. F., Lachman, M. E., Marks, N. F., Mroczek, D. K., Seeman, T. E., Seltzer, M. M., Singer, B. H., Sloan, R. P., Tun, P. A., Weinstein, M., & Williams, D. R. (2007). Midlife in the United States (MIDUS 2), 2004-2006. *Inter-university Consortium for Political and Social Research*. https://doi.org/10.3886/ICPSR04652.v6

Saldana, J. (2021). *The coding manual for qualitative researchers* (4th ed.). Sage Publications.

Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low-income adults and children fare in psychotherapy. *Jounral of Clinical Psychology*, *69*(2), 115–126.

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry*, *4*(4), 113–140. https://doi.org/10.5498/wjp.v4.i4.133

Semeniuk, I. (2010). A shocking discovery. *Nature*, *467*(7316), 645. https://doi.org/10.1038/467645a

Shannonhouse, L., Erford, B., Gibson, D., O'hara, C., & Fullen, M. (2020). Psychometric synthesis and review of the 5F-WEL. *Journal of Counseling & Development*, *98*, 94–106.

Sharma, N., & Vaish, H. (2020). Impact of COVID-19 on mental health and physical load on women professionals: an online cross-sectional survey. *Health Care for Women International*, *41*(11-12), 1255–1272. https://doi.org/10.1080/07399332.2020.1825441

Shattell, M., & Brown, P. (2017). Black mental health matters: What nurses need to know about chronic stressors of persons of color. *Journal of Psychological Nursing and Mental Health Services*, *55*(9), 3–5. https://doi.org/DOI:10.3928/02793695-20170818-07

Shell, E. M., Teodorescu, D., & Williams, L. D. (2021). Investigating race-related stress, burnout, and secondary traumatic stress for black mental health therapists. *Journal of Black Psychology*, *47*(8), 669–694. https://doi.org/10.1177/00957984211033963

Shrider, E. A., Kollar, M., Chen, F., Semega, J., & U.S. Census Bureau. (2021). *Income and poverty in the United States: 2020*. U.S. Government Publishing Office, Washington, DC.

Shurts, W. M., & Myers, J. E. (2008). An examination of liking, love styles, and wellness among emerging adults: Implications for social wellness and development. *Adultspan Journal*, *7*(2), 51–68. https://doi.org/10.1002/j.2161-0029.2008.tb00046.x

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies*, *69*(9-24). https://doi.org/10.1016/j.ijnurstu.2017.01.003

Smith, E. B., & Luke, M. M. (2021). A call for radical reflexivity in counseling qualitative research. *Counselor Education and Supervision*, *60*. https://doi.org/10.1002/ceas.12201

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenemological analysis: Theory, method and research*. Sage Publications .

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In *Qualitative psychology: A practical guide to research methods* (pp. 51–80). Sage Publiations.

Spector, R. (2001). Is there racial bias in clinicians' perceptions of the dangerousness of psychiatric patients? A review of the literature. *Journal of Mental Health*, *10*(1), 5–15. https://doi.org/10.1080/09638230020023570

Spurgeon, S. L., & Myers, J. E. (2010). African American males: Relationships among racial identity, college type, and wellness. *Journal of Black Studies*, *40*(4), 527–543. https://doi.org/10.1177/0021934708315153

SRI International. (2010). *Global spa summit, spas and the global wellness market: Synergies and opportunities*. https://www.sri.com/wp-content/uploads/pdf/gss_sri_spasandwellnessreport_rev_82010.pdf

Stewart, III, S., Chui, M., Manyika, J., Julien, J., Hunt, V., Sternfels, B., Woetzel, J., & Zhang, H. (2021). *The economic state of Black America: What is and what could be* (June 17, 2021) [Report]. McKinsey Global Institute.

Substance Abuse and Mental Health Services Administration. (n.d.-a). *Double jeopardy: COVID-19 and behavioral health disparities for Black and Latino communities in the U.S.* U.S. Department of Health and Human Services. https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf

Substance Abuse and Mental Health Services Administration. (n.d.-b). *2018 National Survey on Drug Use and Health (NSDUH): African Americans.* www.samhsa.gov. Retrieved June 25, 2022, from https://www.samhsa.gov/data/sites/default/files/reports/rpt23247/2_AfricanAmerican_2020_01_14_508.pdf

Substance Abuse and Mental Health Services Administration. (2020). *Behavioral health barometer: United States, volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment*

Services (HHS Publication No. 07-02-001). https://www.samhsa.gov/data/report/behavioral-health-barometer-united-states-volume-6

Substance Abuse and Mental Health Services Administration. (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

Swarbrick, M. (2012). A wellness approach to mental health recovery. In *Recovery of people with mental illness: philosophical and related perspectives* (pp. 30–38). Oxford University Press. https://doi.org/10.1093/med/9780199691319.003.0003

Swarbrick, P., & Yudof, J. (2014). *Wellness in eight dimensions*. Wellness Instituite. Retrieved July 16, 2002, from https://www.state.nj.us/humanservices/dmhas/resources/mental/CSP_Wellness_8_Dimensions.pdf

Swarbrick, P., & Yudof, J. (2014). *Wellness in eight dimensions*. Wellness Institute. Retrieved July 16, 2002, from https://www.state.nj.us/humanservices/dmhas/resources/mental/CSP_Wellness_8_Dimensions.pdf

Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimal health and wellness. *Individual Psychology*, *47*, 527–540. Https://www.ebscohost.com

Testa, D., & Sangganjanavanich, V. F. (2016). Contribution of mindfulness and emotional intelligence to burnout among counseling interns. *Counselor Education and Supervision*, *55*(2), 95–108. https://doi.org/10.1002/ceas.12035

Thomas, A. J. (2001). African American women's spiritual beliefs: A guide for treatment. *Women & Therapy*, *23*(4), 1–12. https://doi.org/10.1300/J015v23n04_01

U.S. Department of Justice - Federal Bureau of Investigation. (2020). *Hate crime statistics, 2019* [Report]. U.S. Department of Justice.

U.S.Department of Justice, Office of Justice Programs, Bureau of Justice Statistics & Carson, E. A. (2020). *Prisoners in 2019* (NCJ 255115) [Report]. U.S. Department of Justice.

United States Census Bureau. (2019). *Quick facts* (July 1, 2019) [Report]. United States Census Bureau .

Vagle, M. D. (2018). *Crafting phenemological research* (2nd ed.). Routledge.

van Manen, M. (2015). *Researching lived experience* (2nd ed.). Routledge.

Wade, S. (2002, September 2). *John Henry: Present at the creation*. Npr.org. Retrieved February 1, 2022, from https://www.npr.org/2002/09/02/1149349/john-henry

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedlie, J., Phillips, E., Senu, H., & Holland, F. (2014). The accordion and the deep bowl of spaghetti: Eight researchers' experiences of using IPA as a methodology. *The Qualitative Report*, *19*(47), 1–15. http://www.nova.edu/ssss/QR/QR19/wagstaff47.pdf

Ward, E., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing Research*, *62*(3), 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533

Wardle, E., & Mayorga, M. G. (2016). Burnout among the counseling profession: A Survey of future professional counselors. *Journal on Educational Psychology*, *10*(1).

Warren-Gordon, K., & McMillan, D. M. (2015). Analysis of Black female Belizean stereotypes in visual media: Jezebel, Mammy, Sapphire, and their contributions to violence against women. *Journal of International Women's Studies*, *21*(4), 604–612. https://doi.org/10.1037/cdp0000015

Waterman, A. S., Schwartz, S. J., Zamboanga, B. L., Ravert, R. D., Williams, M. K., Agocha, V. B., Kim, S. Y., & Donnellan, M. B. (2010). The Questionnaire for Eudaimonic Well-Being: Psychometric properties, demographic comparisons, and evidence of validity. *Journal of Positive Psychology*, *5*(1), 41–61. https://doi.org/10.1080/17439760903435208

Waters, J. (2020). Is mental health the new pandemic? *Community Practioner*, *93*(4), 34–39.

Watson, N. N., & Hunter, C. D. (2015). Anxiety and depression among African American women: The costs of strength and negative attitudes toward psychological help-seeking. *Cultural Diversity & Ethnic Minority Psychology*, *21*(4), 604–612. https://doi.org/10.1037/cdp0000015

West, C. (2008). Mammy, jezebel, and sapphire: Developing an 'oppositional gaze' toward images of black women. In *Lectures on the psychology of women* (pp. 286–299). McGraw-Hill.

Whitmer, J. M., & Sweeney, T. J. (1992). *Journal of Counseling and Development*, *71*(2), 140–148. https://doi.org/10.1002/j.1556-6676.1992.tb02189.x

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology An exploration. *Journal of Holistic Nursing*, *25*(3). https://doi.org/10.1177/0898010106295172

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

World Health Organization. (n.d.). *WHO remains firmly committed to the principles set out in the preamble to the constitution*. https://www.who.int/about/who-we-are/constitution. https://www.who.int/about/who-we-are/constitution

Zechner, M. R., Pratt, C. W., Barrett, N. M., Dreker, M. R., & Santos, S. (2019). Multi-dimensional wellness interventions for older adults with serious mental illness: A systematic literature review. *Psychiatric Rehabilitation Journal*, *42*(4), 382–393. https://doi.org/10.1037/prj0000342

APPENDICIES

APPENDIX A

PARTICIPANT DEMOGRAPHIC QUESTIONAIRRE

Appendix A

Participant Demographic Questionnaire

- Participant name
- Participant email
- Gender
    a. Male
    b. Female
    c. Non-Binary
- What category below includes your age?
    a. 21-29
    b. 30-39
    c. 40-49
    d. 50-59
    e. 60-69
    f. 70+
- Do you identify as Black, African American, Afro-Latinx, Afro-Caribbean, African or another Black identifying group?
    a. Black
    b. African American
    c. Afro-Latinx
    d. Afro-Caribbean
    e. African
    f. Other Black identifying group

- What is the highest counseling-related degree you have earned?
    a. Master's degree
    b. Doctoral degree
- When did you complete your degree?
- In what state(s) are you professionally licensed?
- What professional license do you currently hold?
    a. Licensed Professional Counselor (LPC)
    b. Licensed Clinical Professional Counselor (LCPC)
    c. Licensed Professional Clinical Counselor (LPCC)
    d. Licensed Mental Health Counselor (LMHC)
    e. Licensed Clinical Mental Health Counselor (LCMHC)
- How many years of experience do you have as a counselor?

APPENDIX B

SEMI-STRUCTURED INTERVIEW QUESTIONS

Appendix B

Semi-Structured Interview Questions

1. How would you define wellness?
2. How would you define self-care?
3. How would you describe the difference between wellness and self-care?
4. What are your experiences with practicing wellness/self-care?
5. What are your responsibilities at home as it relates to care for others?
6. Has your approach to wellness/self-care changed over time?
7. What is your experience with wellness/self-care barriers?
8. When you are experiencing self-care, what do you do?
    a. What does it feel like?
9. What are your motivations for self-care wellness?
    a. What happens when you don't practice self-care/wellness?
10. How do your identities (Black, counselor, gender) impact your wellness?
11. What are the priorities for your time right now?
    a. To what degree does wellness/self-care fit in?
12. Is there anything I did not mention that you would like to add?

APPENDIX C

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

Appendix C

Institutional Review Board Approval Letter

MERCER UNIVERSITY
Institutional Review Board
For Research Involving Human Subjects

Monday, November 28, 2022

Cha'Ke'Sha Spencer
3001 Mercer University Drive, Suite 214
Counseling & Human Sciences
Atlanta, GA 30341

RE: You Can't Pour from an Empty Cup: A Phenomenological Study Exploring Experiences of Black Counselors' Wellness Practices and Barriers to Wellness (H2211279)

Dear Spencer:

On behalf of Mercer University's Institutional Review Board for Human Subjects Research, your application submitted on 11-Nov-2022 for the above referenced protocol was reviewed in accordance with the 2018 Federal Regulations 21 CFR 56.110(b) and 45 CFR 46.110(b) (for expedited review) and was approved under category(ies) _6, _7 per 63 FR 60364.

Your application was approved for one year of study on 28-Nov-2022. The protocol expires on 27-Nov-2023. If the study continues beyond one year, it must be re-evaluated by the IRB Committee.

Item(s) Approved:
Student application for counseling research using an interview to explore the lived experiences of Black counselors' wellness practices and possible barriers to wellness, and how the lack of wellness practices can impact the work of counselors.

NOTE: You **MUST** report to the committee when the protocol is initiated. Report to the Committee immediately any changes in the protocol or consent form and **ALL** accidents, injuries, and serious or unexpected adverse events that occur to your subjects as a result of this study.

We at the IRB and the Office of Research Compliance are dedicated to providing the best service to our research community. As one of our investigators, we value your feedback and ask that you please take a moment to complete our Satisfaction Survey and help us to improve the quality of our service.

It has been a pleasure working with you and we wish you much success with your project! If you need any further assistance, please feel free to contact our office.

Respectfully,

Ava Chambliss-Richardson, Ph.D.
Director of Research Compliance
Member
Institutional Review Board

"Mercer University has adopted and agrees to conduct its clinical research studies in accordance with the International Conference on Harmonization's (ICH) Guidelines for Good Clinical Practice."

Mercer University IRB & Office of Research Compliance
Phone: 478-301-4101 | Email: ORC_Mercer@Mercer.Edu | Fax: 478-301-2329
1501 Mercer University Drive, Macon, Georgia 31207-0001