Africentric Resilience Training: A Prevention Program for African American Soldiers

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Africentric Resilience Training: A Prevention Program for African American Soldiers

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DISSERTATION

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AFRICENTRIC RESILIENCE TRAINING FOR SOLDIERS: A PREVENTION PROGRAM FOR AFRICAN AMERICAN SOLDIERS

presented on March 23, 2015

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Abstract

This study develops a mental health prevention program for African American soldiers called, Africentric Resilience Training (ART). The goal of ART is to train soldiers to be psychologically fit, just as they train to be physically fit in the military. The ART curriculum aims to increase soldiers’ resilience and capacity to flourish, while educating them on the occurrence and prevention of Posttraumatic Stress Disorder. This program is founded on the principles and structure of the current Comprehensive Soldier and Family Fitness (CSF2) program in the Army (CSF2, 2012). ART is unique in its utilization of a culturally and racially modified approach that addresses the culture-specific and contextual influences on African American soldiers, such as racism. In addition, the conceptual framework of ART incorporates positive psychology and multicultural competence principles. ART’s curriculum outlines both content and process changes to the original CSF2 program. The four pillars of ART include: (a) culturally sensitive assessments of African American soldiers, (b) culturally sensitive online training modules, (c) resilience training by multiculturally competent trainers, and (d) social justice advocacy town hall meetings. The fourth pillar of social justice advocacy—the most unique aspect of this program—is a professional attitude of psychologists regarding societal and institutional responsiveness to marginalized societies or oppressed communities by addressing racial disparity in access, equity, and mental health treatment, and in the case of ART, for African American soldiers.

Keywords: African American soldiers, PTSD, positive psychology, multicultural competence, social justice advocacy
Africentric Resilience Training (ART) for Soldiers: A Prevention Program

Chapter 1

This study is about the development of Africentric Resilience Training (ART) for African American Soldiers. ART is presented as a mental health prevention program for African American soldiers to increase their resilience and flourishing and to educate them on the prevention of Posttraumatic Stress Disorder (PTSD). PTSD remains a prominent and debilitating mental health issue for soldiers today (Moore & Penk, 2011). The existing Comprehensive Soldier and Family Fitness Program (CSF2, 2012) in the United States Army serves as the foundation for ART. The CSF2 program serves to increase resilience and one’s capacity to flourish in order to prevent psychopathology. The original CSF2 program is modified to provide culturally-sensitive resilience and flourishing training for African American soldiers in all military branches. Using a multiculturally competent lens to respond to the mental health needs of African American soldiers can be seen as both a science and an art, hence the use of the acronym ART.

My preventative approach to mental health service differs from the majority of military mental health programs utilized for the treatment of soldiers. ART trains African American soldiers to be psychologically fit, just as they train to be physically fit. Psychological fitness is indicated by higher levels of resiliency, flourishing, coping, and problem-solving skills (Casey, 2011). Resilience, the key to psychological fitness, can be taught to soldiers through resilience training (Seligman, 2011).

Statement of the Problem: The Invisible Wound of War

Military soldiers face a myriad of stressors, with PTSD resulting as one of the signature injuries (alongside traumatic brain injury) of Operation Iraqi Freedom (OIF) and Operation New
Dawn (OND) in Iraq, and Operation Enduring Freedom (OEF) in Afghanistan (Moore & Penk, 2011). Approximately 17% of active-duty soldiers had PTSD three to six months after deploying to Iraq and Afghanistan (Milliken, Auchterlonie, & Hoge, 2007). According to the literature, the prevalence of PTSD resulting from these two wars range from 4% to 45% (Shen, Arkes, Kwan, Tan, & Williams, 2010). PTSD remains a top priority illness for the Department of Defense because of the thousands of soldiers and millions of family members affected each year, moreover, billions of dollars are spent each year for research and treatment (Moore & Penk, 2011). More importantly, soldiers with PTSD have increased rates of suicidal behavior (Panagioti, Gooding, & Tarrier, 2009). Since OEF, OIF, and OND, military suicide rates have increased to their highest level, soaring to 29.7 deaths per 100,000 (well above the rate of 25.1-per-100,000 for civilians; Luxton et al., 2010).

PTSD rates in African American soldiers. Given that the diagnosis of PTSD was not officially recognized and classified in the Diagnostic and Statistical Manual of Mental Disorders until 1980 (American Psychiatric Association, ApA, 1980), racial and ethnic differences in PTSD rates have received less attention than other psychiatric conditions (Frueh, Brady, & de Arellano, 1998). See the end of Chapter 1, prior to the summary, for a definition of PTSD. While there have been some mixed findings, one study found that African American soldiers have higher rates of PTSD than their European American counterparts and a different presentation of PTSD symptoms (Ruef, Litz, & Schlenger, 2000). More specifically, according to the National Vietnam Veterans Readjustment Survey (NVVRS), 20.6% of racial and ethnic minority soldiers developed PTSD, compared to 13.7% of European American soldiers in the Vietnam War (Kulka et al., 1990). However, this study found that the differences in PTSD rates largely disappeared when factors such as pre-existing trauma and level of combat trauma were
taken into account (Kulka et al., 1990). The implications of this finding are that African Americans had greater exposure to war stresses and more predisposing factors than European American soldiers, such as personal experiences of racial prejudice or stigmatization. Additionally, being a racial and ethnic minority in the military may increase stress reactions due to the longstanding history of racism in the military.

Racial and ethnic minority soldiers are more likely to be diagnosed with PTSD by clinicians (Green, Grace, Lindy, & Leonard, 1990; Ruef et al., 2000) and are at an increased risk for PTSD (Brewin, Andrews, & Valentine, 2000). Research also points to the existence of racial differences in psychotic symptoms experienced by combat veterans with PTSD, with African American soldiers experiencing higher rates of psychosis and paranoid ideation (Frueh et al., 2002; Frueh et al., 1998), where cultural paranoia may be exhibited by African Americans (Ridley, 1984; Whaley, 2001). African American soldiers tend to experience more dissociative symptoms than European American soldiers (Frueh, Smith, & Libet, 1996). While some studies on racial and ethnic minority soldiers indicate that African American soldiers have higher rates of PTSD, it is important to mention that other studies have found more similarities than differences between ethnicities. For example, Monnier, Elhai, Frueh, Sauvageot, and Magruder (2002) evaluated combat veterans from an outpatient PTSD program and found that African Americans and European Americans did not differ on self-report measures of PTSD symptomology. The variation in symptom presentation highlights the importance of a tailored mental health prevention program for African American soldiers.

**What is a Mental Health Prevention Program?**

The purpose of a mental health prevention program is to prevent a psychological problem from occurring (Heller, Wyman, & Allen, 2000). Primary prevention refers to the activities that
healthy or at-risk populations can undertake to enhance their health or to prevent the dysfunction from occurring (i.e., keeping healthy people healthy; Moritsugu, Wong, & Duffy, 2010). As Harpine and Nitza (2010) stated, “To stop mental illness before it starts may become one of our most needed strategies” (p. 268). Cowen (1996) outlined three criteria for a true primary prevention program: (a) the program must be group-oriented, (b) it must occur before the maladjustment, and (c) it must have a primary focus on strengthening adjustment of the unaffected. See the end of Chapter 1, prior to the summary, for a definition of primary prevention. The ART program meets the above criteria by aiming to increase resilience and the capacity to flourish, while preventing the emergence of psychological symptoms.

A mental health prevention program can reduce mental health care costs and the load of the overburdened health care system in the military (Cornum, Matthews, & Seligman, 2011). Increasing military members’ resilience and capacity to flourish can reduce the pain, suffering, and mental health costs of full-blown psychopathology, such as PTSD. Additionally, a preventative program can help soldiers cope with the high demands and stressors of modern day warfare (Seligman, 2011). When military leaders focus on the health of soldiers before deployments, the military can help prevent future emergence of psychopathology and reduce the allocation of resources in treating PTSD, depression, anxiety, and suicide after the fact.

**Importance of a Prevention Program for African Americans Soldiers**

Most research on minorities has focused on psychopathology rather than strengths and normal development (Quintana et al., 2006). According to Downey and Chang (2012), “Multiculturalism in mental health practices has not to this point been fundamentally linked to positive psychology…within a clearly defined construct” (p. 373). It is important to link multiculturalism to positive psychology, so that racial and ethnic minority members can be
treated with a culturally sensitive and competent approach to mental health that embraces their strengths and virtues. African American soldiers would benefit from services that attend to their culture-specific characteristics, such as the Africentric worldview, religiosity and spirituality, family and kinship networks, communalism, and African American racial identity. Preventative mental health treatment programs need to be modified for different racial and ethnic groups in the same way that psychotherapy interventions need to be modified for clients of different backgrounds (Meichenbaum, 2011). African American soldiers represent a unique subculture of the military that needs to be studied separately in order to provide culturally-sensitive and multiculturally competent mental health care.

**Challenges Specific to African American Soldiers**

While military members constitute an at-risk population, African American soldiers face unique challenges and stressors. African Americans, a racial minority population, have historically faced slavery, racism, and discrimination (Mueser, Stanley, Rosenberg, & Rosenberg, 2009). Thus, one could consider African American soldiers a minority because of their status as racial and ethnic minority members (which represent about 13.1% of the total population) and because of their status as military members (which represent 1% of the total population; US Census Bureau, 2011; 2012). African American soldiers continue to face chronic social stressors that have resulted from a longstanding history of racism in the United States (Mays, Cochran, & Barnes, 2007). These stressors include “racism-related life events, vicarious racism experiences, daily racism microstresses, chronic contextual stress, collective experiences of racism, and the transgenerational transmission of group traumas” (Harrell, 2000, p. 45). Microaggressions (i.e., automatic or unconscious demeaning insults directed at minorities)
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constitute a common stressor for African Americans (Sue et al., 2007). See the end of Chapter 1, prior to the summary, for a definition of microaggressions.

**History of racism in the military.** Most accounts of war stories about African American soldier experiences were written by European American officers (Black & Thompson, 2012). Inevitably, with their biased lenses and experiences, these officers ultimately misreported and excluded African American soldiers’ contributions. Despite repeated evidence of successful African American soldiers, military officials held an overwhelming bias against African American soldiers that silenced their voices during this time period (White, 2012). During the World Wars, many African American soldiers deployed overseas to fight for freedom, even though they were denied freedom in their homeland. These soldiers saw the war as an opportunity to bring about democracy in the United States because it did not make sense to fight for democracy in Europe while they remained second-class citizens in the U.S. World War II was aptly referred to as a “war within a war” for African American soldiers, given concurrent military and civil rights battles (Black & Thompson, 2012).

**World War I: Army Alpha and Beta tests.** Robert Yerkes developed three tests for military recruits, along with the help of Lewis Terman and Henry Goddard: (a) Army Alpha, a written examination for literate recruits; (b) Army Beta, non-verbal intelligence examination for illiterate recruits; and (c) a third examination for those who failed the Army Beta (Gould, 1981). These tests served as prototypes for group intelligence tests as measures of inherent intellect. Summary reports revealed that the average mental age of European American soldiers was about 13 years of age, while African American soldiers scored an average of 10.41 years (Yerkes, 1923 as cited by White, 2012). It is interesting to note that testing policies allowed for anyone who
failed the group test to be given an individual examination as a safeguard, but African American soldiers were excluded from this policy (Samelson, 1977).

Problematic testing conditions existed during the wartime that contributed to the low test scores among all soldiers. There were problems with inconsistent administration and issues with validity because of the substandard testing conditions. For example, many military recruits had to take the tests while sitting on the floor in a crowded room and often had difficulty hearing testing instructions (Pickren & Rutherford, 2010). Additionally, the instructions for the Army Beta test were pantomimed with gestures instead of words for African American soldiers, which often led to confusion (White, 2004). Even with the unfair testing conditions, many European American officers concurred with these summary reports as facts, adding to their discriminatory views of African American soldiers. While the Yerkes testing project gave intelligence testing credibility in the United States, the profound impact of the project involved the legitimization of racism in the military and even supported the eugenics movement of the early 20th Century (White, 2012).

**World War II: Army General Classification Test.** After the Yerkes testing project, Harry Stack Sullivan designed and ran the Army General Classification Test (AGCT) to group new recruits into specific job classifications. However, these tests also proved to support institutional racism. The AGCT consisted of five categories, whereby category I consisted of the most skilled soldiers and category V consisted of the least skilled soldiers (i.e., categories I-III consisted of officers/enlisted specialists and categories IV-V consisted of laborers; White, 2012). Scores from European American soldiers formed a symmetric bell curve, while African American soldiers had the largest proportion in category V (McGregor, 1985). Specifically, 49.2% of African American recruits and only 8.5% of European American recruits scored in
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category V (Bailey & Farber, 1993). These score results meant that it was almost impossible for an African American soldier to become an officer (i.e., a higher ranking military member).

The AGCT provided support for racial segregation in the military. European American military commanders were able to utilize their racial privileges to promote racial inequalities under the auspices of scientific objectivity through the use of assessment tests. Commanders received test results from their soldiers and placed African American soldiers in labor-intensive jobs (i.e., non-combat roles), preventing a chance of battlefield success. Very few African American soldiers served in combat units, which were completely segregated. Most African American soldiers were forced into menial labor, serving in cavalry, infantry, and artillery units.

Even with the impact of the AGCT scores, racial segregation further complicated the training of African American soldiers. The Army had a limited number of training facilities, but still chose to implement segregated housing and facilities for African American soldiers. Instead of saving costs and maximizing the limited resources, the military decided to continue racial segregation. To make up for the unnecessary costs of segregated facilities, the military lowered the quota for African American recruits or deferred them out for “mental deficiency” (Turner & Bound, 2003).

**Substandard conditions and treatment.** African American soldiers also received substandard services, shelter, and clothing. African American soldiers were forced to wear improper military uniforms (i.e., old Civil War uniforms), to wear the same uniforms for months at a time, to eat outside in winter months, and to sleep outside of the barracks in cold, pitched tents (Bryan, 2003). Additionally, many European American soldiers refused to salute African American soldiers (a mandatory demonstration of respect) and even banned them from officers clubs and living quarters (Bryan, 2003). African American soldiers were also discriminated
against by the limitations placed on them regarding venereal diseases. Venereal disease occurred frequently among African Americans who were from a low socioeconomic status and who did not receive adequate medical care. The military found many African Americans with venereal diseases unfit for duty, even though they drafted European Americans with similar physical deficiencies (McGuire, 1983).

Current racial inequality/disparity in the military. Racial inequality still exists in the military today. Even though the military has remained an integrated institution for over 60 years, the majority of African American soldiers do not serve in top positions as General Officers (Black & Thompson, 2012). One study found that African American officers are falling behind European American officers in promotions at and above the rank of Lieutenant Colonel at a disconcerting rate (Butler, 1995). Iskra (2008) identified the phenomenon of particular groups’ failing to achieve upward professional mobility in the military as a “brass ceiling.” Butler (1999) identified four causes for African American soldiers hitting a brass ceiling: (a) education: African American officers are not getting a quality undergraduate military experience; (b) mentorship: young, African American officers are not receiving the type of mentorship required to be successful in the Army; (c) cultural differences: differences in cultural norms may be unfairly biased against African American soldiers, such as norms for dressing at civilian events; and (d) the “good old boy network”: whom one knows is equally important as one’s actual performance.

While a racial and ethnic disparity exists for top leadership positions in the military, it is important to note that the percentage of African Americans in the military exceeds the percentage of African Americans in the U.S. civilian population. In 2009, the percentage of African American enlisted soldiers in the active duty Army was 21% compared to 17% of the
U.S. population of 18 to 39-year-old African Americans with high school diplomas (Office of Army Demographics, 2009). High representation also occurs among military officers, with African Americans making up 13% of officers compared to 9% of the U.S. population of 25 to 54-year-old African Americans with college degrees (OAD, 2009). Thus, while the proportion of African Americans in the military exceeds that of the general population, they still do not hold top positions as frequently as European American service members.

**Changing demographics of the military.** The current one-size-fits-all approach to mental health care (e.g., standard questionnaires, manualized treatments, exclusion of outside healers, etc.) does not address the cultural characteristics and oppression experiences of minority soldiers. Minority populations have increased in the United States and will constitute up to 50% of the population by 2050 (Hall, 2001; Institute of Medicine, 2008). The current all-volunteer military values diversity and as a result, more minorities in the military have taken on leadership roles than their civilian counterparts (Hall, 2008). The military encourages minorities to enter the military, setting the standard for the successful integration of minority groups and their families into the workforce. The increasing presence of African American soldiers highlights the importance of a mental health prevention program.

**Shortage of culturally competent clinicians.** African American soldiers need a culturally and racially sensitive approach to mental health services. While there is a push for multicultural competency in psychologists (American Psychological Association, APA, 2003), soldiers have often not received culturally competent psychological services (Moore, 2011). African Americans tend to be excluded from research and services or have very low representation and not enough power for meaningful analyses to examine racial or cultural differences (Guthrie, 2004). African American soldiers constitute a distinct subculture in the
military and require multiculturally trained clinicians (Reger, Etherage, Reger, & Gahm, 2008). The multicultural competencies of clinicians include a clinician’s awareness of his or her own cultural values, biases, and assumptions; awareness of the client’s worldview; and knowledge of culturally appropriate intervention strategies (Arrendondo, 2003). Each of these competencies incorporates therapists’ attitudes, beliefs, knowledge, and skills (Arrendondo, 2003). With regard to knowledge, clinicians need to understand the accumulative effect of microaggressions on the daily lives of African American soldiers (Sue et al., 2007). They also need to be aware of the unique experiences of African Americans, including presentation of PTSD (Pole, Gone, & Kulkarni, 2008), culture bound syndromes (Paniagua, 2000), and rates of substance abuse (Wells, Klap, Koike, & Sherbourne, 2001). Clinicians need to understand the cultural contexts of African American soldiers, a subculture of the general African American population (Moritsugu et al., 2010).

**Stigma and mistrust in the military.** A stigma exists in the military for talking about feelings and seeking emotional help (Hall, 2008) because displaying psychological symptoms is perceived as an indication of weakness of character (Pols & Oak, 2007). Military members are taught by their leaders to hide emotional problems that limit resilience (Hall, 2008). Instead, stoicism constitutes a valued trait in the military culture and further promotes the stigma of psychological weakness (Moore & Penk, 2011).

In addition to the general stigma of receiving mental health care, African American soldiers may face an even greater feeling of stigma due to limited use of mental health services by African Americans in general and cultural mistrust of clinicians (Hall, 2008; Whaley, 2001). African American clients may withhold trust in the therapeutic relationship with a European American therapist until the therapist proves his or her trustworthiness (Griner & Smith, 2006;
Terrell & Terrell, 1981; Vontress, 1971). As a result, many African Americans are more likely to visit their primary care physician or the emergency room, as opposed to seeking psychotherapy (Cooper-Patrick, Crum, & Ford, 1994; Morris, 2001). Researchers found that African Americans often seek therapy only when they have severe issues and they commonly terminate services prematurely (Lester, Artz, Resick, & Young-Xu, 2010; Rosenheck & Fontana, 1996). Thus, one cannot only see that a general stigma of mental health needs exists in the military, but also that African American soldiers face an even greater stigma because of additional socio-cultural barriers to receiving health care.

**Conceptual Framework #1: Positive Psychology**

Martin Seligman developed the positive psychology model, which focuses on the study of strengths, virtues, and nurturing what is best (Seligman & Csikszentmihalyi, 2000). In contrast, mainstream mental healthcare is founded on the traditional disease model of human behavior. The disease model flourished after WWII, when clinicians focused solely on repairing psychological damage in individuals instead of building positive qualities. Proponents of positive psychology believe that the absence of illness does not reflect the presence of mental health (Keys, 2007). Thus, this model bypasses the disease model to help people flourish. Positive psychology aims to help people enjoy life, engage in activities that lead to flow states, and find meaning through positive institutions (Matthews, 2008). Essentially, positive psychology seeks to imbue people’s lives with meaning and purpose, by identifying and cultivating fundamental strengths.

**Resilience.** The goal of the prevention program is to enhance African American soldiers’ resilience and capacity to flourish. Numerous definitions to resilience exist and there is some debate if resilience refers to the return to one’s baseline functioning after a trauma, the
persistence of functioning despite a trauma, or growth after a trauma exposure (McGeary, 2011). Despite the range of definitions, one prominent definition of resilience put forth by Reivich, Seligman, and McBride (2011) includes persisting in spite of adversity. Bonanno (2013) re-labeled this concept as minimal impact resistance, which refers to a stable trajectory of continuous healthy adjustment (i.e., consistently low levels of symptoms and distress or consistently positive adjustment), from before to after the potentially traumatic life event (PTE). These definitions state that a stressor is a necessary prerequisite for resilience and that resilience is the process of stabilizing after a stressor.

**Flourishing.** Flourishing, on the other hand, goes beyond resilience. The goal of Seligman’s (2011) well-being theory includes increasing the amount of flourishing in one’s life and in the world. According to Seligman, flourishing consists of positive emotions, engagement, relationships, meaning-making, and achievement (PERMA). *Positive emotions* make up the subjective pleasant life, happiness, and life satisfaction. *Engagement* consists of a subjective state of flow with limited thoughts or feelings. *Positive relationships* involve the importance of other people and how they are necessary for all of the principles in positive psychology. *Meaning-making* refers to connectedness to something bigger than the self that is both subjective and objective. *Accomplishment* pertains to pursuing achievement for its own sake, even when it brings no meaning or emotions.

Seligman’s (2011) well-being theory also promotes 24 signature strengths (i.e., relatively stable virtues that people have), that are valued for their own right in almost every culture. Data to support Seligman’s well-being theory originates from the Penn Resiliency Program (PRP) and the Strath Haven Positive Psychology Curriculum (Seligman, 2011). ART utilizes a positive
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psychology framework by focusing on the strengths and virtues of African American soldiers to increase resilience and flourishing.

**Importance of cultivating resilience and flourishing.** Resilience and flourishing can be taught to soldiers, cultivated through training, and measured through self-report measures (Seligman, 2011). Resilience remains a top priority when studying the effects of a traumatic event because resilient individuals are less likely to develop PTSD, depression, or alcohol abuse (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Butler et al., 2009). Soldiers face a myriad of stressors and traumatic events in the combat zone, whose effects could be ameliorated by prevention training in resilience and flourishing. Furthermore, researchers have found that resilience must be cultivated and practiced in order to become an automatic coping response (Muraven & Baumeister, 2000). Resilience develops gradually over time and varies across contexts, creating the need to practice skills that enhance resilience before, during, and after a deployment (Meichenbaum, 2011). Resilience training also involves family members and the community, so any preventative mental health program should incorporate family and community relationships (Meichenbaum, 2011).

**Conceptual Framework #2: Multicultural Competence**

In addition to a positive psychology framework, the proposed program design will incorporate a multicultural competence framework. Multicultural competence refers to appreciating, recognizing, and effectively working with people from other cultural groups (Sue, 1998). Sue, Arredondo, and McDavis (1992) formulated a conceptual framework for understanding multicultural counseling competencies (MCCs) that incorporated a 3 x 3 design of characteristics and dimensions for clinicians (Roysircar, 2003). Roysircar, Arredondo, Fuertes, and Ponterotto (2003) labeled this framework accordingly as the “tripartite MCC model” (p. 3).
The characteristics of the design include the clinician’s awareness of personal assumptions, values, and biases; understanding of the client’s personal worldview; and developing culturally appropriate treatment interventions. Each of these characteristics relates to the dimensions of attitudes, knowledge, and skills. An important concept related to multicultural competence includes culture-specific expertise (Sue, 1998). Culture-specific expertise relates the worldview of the client and understanding the sociopolitical forces and skills needed to work with a specific culture; this culture-specific expertise has been shown to have positive clinical outcomes with minority groups (Griner & Smith, 2006; Sue, 1998). ART applies Africentric worldview and contextual influences on African Americans because its preventative outreach is modified for the African American soldier population.

**Using a (mostly) emic perspective.** Emic and etic are terms that denote two categories frequently used in research to classify behaviors. Emic identifies behaviors from within a culture system (e.g., culture-bound syndromes), while etic identifies behaviors from outside a particular system across various cultures (e.g., PTSD; Triandis & Marin, 1983). An emic perspective incorporates constructs, behaviors, or contexts that are unique to an individual (an idiographic case) or focuses on the values and goals intrinsic to a given society (e.g., communalism of African Americans; Draguns, 1996). Thus, an emic approach focuses on studying the uniqueness of a culture and the ideographic differences within a culture, while an etic approach focuses on studying similarities and differences among cultures by using a framework of comparison. It is important to highlight that ART mostly uses an emic perspective because a true emic prevention program would have been created from scratch and not modified from a pre-existing program.
Social justice advocacy. Social justice advocacy is a key element complementary to multicultural competence to adequately address systems of oppression that negatively affect client development (Lee, 2007). Social justice advocacy involves the process of informing and helping decision makers (Lee, 2007), creating citizen psychologists who support clients, public health, welfare issues, health care, and professional psychology (Aldarondo, 2007). Psychologists also become citizen psychologists when they move beyond the safety and comfort of their psychotherapy office to better serve their constituencies (Ratts & Hutchins, 2009). Similarly, psychologists can serve as active agents of societal change and can create a culture of community involvement. Social justice advocacy must be a professional identity for all psychologists. Goodman et al., (2004) articulated this sentiment by stating “unless fundamental change occurs within our neighborhoods, schools, media, culture, and religious, political and social institutions, our work with individuals is destined to be, at best, only partially successful” (p. 797). Implementing social justice advocacy complements multicultural competence by creating a socially responsive voice for marginalized and oppressed populations, such as African American soldiers.

Knowledge, skills, and attitudes. One of the original models of multicultural counseling competency (MCC) was the tri-componential model of MCC, originally developed by Sue and his colleagues (1982). This model was later revised multiple times (e.g., Sue et al., 1992). The original model outlined three components of cross-cultural counseling competencies: (a) beliefs/attitudes, (b) knowledge, and (c) skills (Sue et al., 1982). The components were later revised to the following three components: (a) counselor awareness of own assumptions, values, and biases (i.e., awareness); (b) understand the worldview of the racial/ethnic minority client
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(i.e., knowledge); and (c) developing appropriate intervention strategies and techniques (skills; Sue & Sue, 1990). These components became the foundation for the awareness-knowledge-skills tri-componential model of MCC (Sue & Sue, 2008).

Green, McCollum, and Hayes (2008) applied the awareness-knowledge-skills model to social justice advocacy when working with marginalized populations. In this model, awareness is the acceptance of social justice philosophy, which begins with an introspective self-exploration of one’s values, biases, and societal limitations in relationship to others with less power and social privilege than the clinician. Knowledge relates to understanding social justice tenets when treating marginalized populations (i.e., knowledge to empower the self and others). The term also relates to psychologists recognizing the impact of social, societal, political, and economic factors on human development. Skills involve social justice-infused actions, such as individual counseling, group work, and community psychoeducation for violence prevention, or political action against human trafficking in settings where poor and oppressed communities live. This model of awareness of injustice; knowledge to empower the self and others; and skills to perform and teach others can be applied to help marginalized individuals, such as African American soldiers (Green et al., 2008).

Furthermore, Roysircar, Dobbins and Malloy (2009) outlined competencies in three areas that professionals should strive for when addressing individual and cultural diversity: (a) knowledge, (b) skills, and (c) attitudes (KSAs). In the KSA framework, clinicians should gain knowledge of the unique worldview of diverse clients and understand the historical and sociopolitical influences that shape the client’s cultural group. The therapist should also be flexible to devise and provide adequate interventions or skills that are suited to the client’s cultural values, needs, and group. Third, clinicians should be aware of their biases and attitudes...
that they might hold toward a particular group. Having an awareness of one’s knowledge, skills, and attitudes can improve clinical services for a culturally diverse population, such as African American soldiers.

**Four Pillars of ART**

ART utilizes a multicultural competence framework by incorporating the following four pillars: (a) culturally sensitive assessments of African American soldiers, (b) culturally sensitive online training modules, (c) resilience training by multiculturally competent trainers, and (d) social justice advocacy town hall meetings. All four pillars of ART are presented with culture-specific expertise on African Americans and with an emic approach to serve the unique needs and experiences of African American soldiers.

**ART Research Questions**

The prevention program design presented here uses positive psychology principles and training in multicultural competencies to address the following ART research questions:

- What are the protective and risk factors of African American soldiers’ mental health?
- How can the Comprehensive Soldier Family and Fitness program be modified to be responsive to the culture-specific and contextual influences of African American soldiers?
- How can positive psychology interventions be applied in a PTSD prevention program for African American soldiers?
- How can resilience and flourishing be measured in African American soldiers to evidence the effectiveness of the ART prevention program?
- How can resilience and flourishing be increased in African American soldiers?
- How can multicultural competence be applied to training African American soldiers?
- How can social justice advocacy empower African American soldiers?

**Personal Statement of Interest**

As an avid reader of positive psychology, I have found that there is a scarcity of information on positive psychology in relation to minority populations, and as a result, minority service members. Researchers have slowly begun to incorporate elements of positive psychology with multicultural competence (Chang, Downey, & Kim, 2012), but the field of positive psychology needs to be inclusive of issues of contextual influences, such as cultural diversity, racism, social class and privilege, poverty, and gender identity. My interest in ART stems from a personal interest in understanding and serving African Americans. This project serves as a microcosm for me to work clinically with clients from different racial, ethnic, and cultural groups. The purpose of my research is to study the intersection of my European American worldview with worldviews of other cultures. As a former Captain in the Air Force, I did not receive any military training about working with soldiers from different racial and ethnic backgrounds and the ways in which their mental health and illness presentations may differ from those of the “soldier-in-general.” As an individual of Scandinavian, Italian, and French ancestry, I will never truly know what it feels like to be a minority member in the country in which I live. This research provides me an opportunity to learn the mental health concerns of African American soldiers. I want to share this learning with other military-related personnel to increase their understanding of African American soldiers’ mental health.

**Definition of Terms**

**Microaggressions.** Microaggressions are automatic, unconscious, but sometimes also conscious demeaning comments directed at minorities (Sue et al., 2007). The most common types of microaggressions include (a) microinsults (i.e., intended verbal or nonverbal attacks);
microassaults (i.e., rude verbal and nonverbal communications or jokes that demean someone’s racial heritage); and (c) microinvalidations (i.e., verbal and nonverbal communications that negate the experiential reality of a person of color).

**Primary prevention.** Primary prevention differs from secondary prevention (i.e., treating a problem at its earliest moment before it becomes severe) or tertiary prevention (i.e., reducing the severity of an established problem) because it protects healthy people from developing or experiencing problems in the first place (Moritsugu et al., 2010). Primary prevention aims to keep healthy people healthy, by working to maintain health or preventing dysfunction from occurring in at-risk populations (Moritsugu et al., 2010). Secondary prevention interventions occur after an illness has been diagnosed in at-risk individuals, and the goal is to slow down the illness in its earliest stages. Tertiary prevention interventions focus on managing long-term problems and preventing future deterioration. Many argue that tertiary prevention is not really a form of prevention.

**Posttraumatic stress disorder.** Clinicians first officially recognized the term PTSD in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III; ApA, 1980).* A later edition of the *DSM,* the *DSM-IV-TR,* described PTSD as the exposure to a traumatic event that involved a threat to one’s integrity, where one’s response involved intense horror or fear (ApA, 2000). The diagnostic criteria for PTSD includes re-experiencing of the event (e.g., flashbacks, nightmares, and intrusive thoughts); avoidance of stimuli associated with the event (e.g., emotional numbing, dissociation, or avoidance of feelings, people, places associated with the event); and increased physiological arousal (e.g., hyper-alertness, irritability, exaggerated startle response). The symptoms must cause significant impairment and persist for at least one month. In contrast, for acute stress disorder, the duration of the disturbance is three
days to 1 month after the trauma exposure and may or may not precede the development of PTSD (ApA, 2013).

The DSM-5, the latest edition, consists of the following criteria for PTSD: (a) exposure to actual/threatened death, injury, or sexual violence through direct experiences, witnessing, learning that a close family or friend was in danger, or repeatedly experiencing aversive details of the traumatic event(s); (b) intrusive thoughts in the form of distressing memories, dreams, dissociation reactions, distress/physiological reactions at exposure to related internal/external cues related to the traumatic event(s); (c) avoidance of stimuli associated with the traumatic event(s) such as thoughts, external reminders, feelings, etc.; (d) negative alternations in cognitions and mood related to the traumatic event(s) such as an inability to remember parts of the trauma; exaggerated negative beliefs about oneself, others, or the world; blaming; chronic negative emotional states; diminished interest in activities; feeling detached; and inability to experience positive emotions; and (e) alterations in arousal such as irritability, self-destructive behavior, hypervigilance, concentration problems, and sleep disturbances (ApA, 2013). The duration of the disturbances (criteria B-E) lasts more than a month, causes significant distress, and is not due to physiological effects of a substance or medical condition.

Summary

In summary, the goal of the program development is to provide a rationale, description, and a plan for implementation and evaluation of ART, a mental health prevention program for African American soldiers. ART aims to increase African American soldiers’ resilience and capacity to flourish, while educating soldiers on preventing post-combat PTSD. The existing CSF2 program in the Army serves as the foundation of the program and is modified into a
culturally sensitive, appropriate, and effective mental health program for African American soldiers.

This chapter outlined the importance of ART in the military, as well as some stressors and adversities unique to African American soldiers. The chapter explained the conceptual frameworks of positive psychology and multicultural competence for the development of ART. After presenting research questions for the prevention program’s implementation, assessment protocol and outcome evidence, the chapter included a personal statement of interest in African American mental health and concluded with definitions of terms. Chapter 2 outlines a literature review on risk factors and protective factors for African American soldiers’ mental health and PTSD. Chapter 2 also provides an overview of the CSF2 program and a description of additional mental health programs in the military.
Chapter 2:

A Review of the Literature

This chapter presents a review of the literature on psychopathology, risk factors, and protective factors of African American soldiers. An overview of the Comprehensive Soldier and Family Fitness (CSF2) program, which serves as the foundation for ART, is provided. The evidence for the effectiveness of CSF2 program is presented, along with several criticisms of the program. The chapter concludes with a description of the current mental health programs in the military, including the Battlemind prevention program, the Real Warriors program, the Deployment Anxiety Reduction Training program, and the Air Force Suicide Prevention Program.

PTSD Rates and Manifestation of Symptoms in African Americans Soldiers

Several studies suggest higher rates of PTSD for African American soldiers than European American soldiers, while other studies reveal more similarities than differences. In one of the largest studies of veterans, the National Vietnam Veterans Readjustment Study (Kulka et al., 1990) found that minority combat veterans experienced higher rates of PTSD (20.6%) compared to their European American counterparts (13.7%). They also found that African American soldiers had more predisposing characteristics (e.g., previous traumas and substance abuse) and were exposed to higher war-zone stress than European American soldiers. Another study also found increased rates of a PTSD diagnosis in African American Vietnam veterans, with 47% of the African American soldiers reporting PTSD versus 30% of the European American soldiers (Green et al., 1990). Self-report inventories have also shown increased symptomology in African American Vietnam veterans. For instance, these soldiers have indicated higher scores on the Dissociative Experience Scale (DES) than European American
Vietnam veterans (Zatzick, Marmar, Weiss, & Metzler, 1994). On the Minnesota Multiphasic Personality Inventory (MMPI-2), African American soldiers scored higher than European American soldiers on scales 1, 2, 3, 4, 6, 7, and 8, suggesting a higher endorsement of somatization, depression, histrionic traits, antisocial traits, anger, paranoid ideations, anxiety, and disturbed thinking, respectively (Penk, 1989). Penk concluded that African Americans faced more turmoil than European Americans during the Vietnam War years, including the loss of leaders (e.g., Martin Luther King, Jr.), loss of communities through racial conflicts, and loss of neighborhoods through busing.

Despite potential conclusions about psychopathology drawn from the aforementioned studies, there are inconsistent findings on differences between PTSD in African Americans and European Americans. Several studies have found that there are no significant differences in PTSD symptoms for African American and European American soldiers (Monnier, Elhai, Frueh, Sauvageot, & Magruder, 2002; Frueh, Elhai, Hamner, & Knapp, 2004; Trent, Rushlau, Munley, Bloem, & Driesenga, 2000). Nonetheless, PTSD remains a prominent psychopathology in African American combat soldiers returning from war. Further research is needed to sort out these mixed results, especially regarding attention to cultural variables like stigma, acculturation, and racial identity.

**Additional Psychopathology among African Americans**

It has long been documented that African Americans have higher rates of mental illness and disability (Robins & Regier, 1991; Williams et al., 1997), and more morbidity and mortality rates than European Americans (Neville, Tynes, & Utsey, 2009). One study found that African Americans have a more debilitating and persistent psychopathology compared to European Americans (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). For example, 55% of
African Americans indicated that their depression episodes were severe and disabling, compared to 38.6% of European Americans (Williams, Gonzalez, & Neighbors, 2007).

Clinicians have also been found to over-diagnose as well as under-diagnose psychopathology in African Americans. For example, clinicians have diagnosed African Americans with schizophrenia more frequently than European Americans (Garb, 1997), where cultural paranoia may be exhibited by African Americans (Ridley, 1984; Whaley, 2001). Clinicians have also under-diagnosed African Americans with depression more than their European American counterparts (Baker & Bell, 1999; Brown, Ahmed, Gary, & Milburn, 1995). Clinicians may underdiagnose African Americans with depression because African American men tend to conceal feelings of depression from the public, manifesting their feelings as anger instead (Wade, 2006). Additionally, 15% of African Americans reported somatic complaints to their physicians, compared to 9% of European Americans (Robins & Reiger, 1991). Therefore, symptom presentation may account for some of the difficulty in appropriately diagnosing psychopathology in African Americans.

Although there are some inconsistencies in the psychopathology literature regarding African Americans, it is important to be aware of within-group variability, especially when considering socioeconomic status, geographic location, and socialization (Neville et al., 2009). In order to prevent misdiagnoses of African American individuals, clinicians need to be aware of different diagnostic patterns of African Americans. Overall, this population tends to have more persistent and debilitating psychopathology than European Americans for which they need the necessary treatment interventions.

**Risk Factors of African Americans**

African Americans have several risk factors for maintaining their mental health, ranging
from racism to having a cultural mistrust of clinicians to poverty. These risk factors are described below.

**Explicit and implicit racism.** Racism remains one of the most prominent risk factors for maintaining the mental health of African Americans. One subtle form of racism is racial microaggressions, a common stressor for African Americans. Microaggressions have been shown to occur within the therapeutic relationship (Constantine, 2007). Therapists that are culturally unaware can unknowingly carry out microaggressions with African American clients (Constantine, 2007), such as engaging in color blindness (i.e., minimization of race and racism in the client’s experience) or making attributions to the client’s intrapersonal characteristics (i.e., blaming the victim). Constantine (2007) found that perceived racial microaggressions by African American clients were negatively associated with their perceptions of the therapeutic relationship with European American clinicians, as well as the clinicians’ level of multicultural competence.

Various forms of racism diminish the sense of self in African Americans and can create internalized feelings of inferiority or marginalization. High levels of discrimination correlate with a poorer mental health status (Williams et al., 2003). Racism-related stress has been related to obsessive-compulsive disorder (Klonoff, Landrine, & Ullman, 1999), anxiety (Harrell, Hall, & Taliaferro, 2003), depression (Taylor & Turner, 2002), feelings of hopelessness (Nyborg & Curry, 2003), and psychological distress (Pieterse & Carter, 2007). Physically, experiences of racism and discrimination have been correlated with heightened blood pressure and hypertension (Bonham, Sellers, & Neighbors, 2004). Thus, the stress of racism has been shown to have many physical and psychological effects on African Americans.
One study (Dovidio, Kawakami, & Gaertner, 2002) examined how self-report measures predicted bias in interactions by European Americans when interacting with African Americans. They found that European Americans explicit racial attitudes (i.e., deliberate behaviors utilized in a discussion) were reflected in the bias of their verbal communication towards African Americans, while their implicit evaluative associations (i.e., spontaneous behavior during a response latency task) predicted their nonverbal behaviors. Steele (1997) described how a negative stereotype about a group (i.e., stereotype threat) influenced the intellectual functioning and identity development of the group members, often leading students to engage in dis-identification with academic domains. Ryff, Keyes, and Hughes (2003) found that African Americans would have higher levels of eudaimonic well-being (e.g., purpose in life, environmental mastery, autonomy, personal growth, positive relations with others, and self-acceptance) if they did not experience discrimination. Thus, in addition to having physical and physiological effects, racism can also affect interpersonal interactions, racial attitudes, and well-being.

Racial bias of mental health clinicians. A prominent risk factor for African Americans is the long-standing history of racial bias in the psychological profession, such as in research, clinical assessment, and treatment. Essentially, most of Western psychology has a foundation in the European American (“White”) culture (Guthrie, 1998; Mills, 2000). Assessment screening measures are based on research with European American participants, in both clinical and non-clinical studies (Baldwin, 1992; Sue, Cheng, Saad, & Chu, 2012). Research in the past has involved “psychometric racism,” which is the exclusion of African Americans from instrument development samples and the promotion of attitudes of superiority and supremacy of the White race (Guthrie, 1998, p. 55). African Americans remain less likely than European Americans to
receive quality mental health care (Lakes, López, & Garro, 2006). As a whole, African Americans have largely been ignored in studies until the fairly recent push for multicultural competency research (Roysircar et al., 2003; Sue et al., 1992) and publications on African American psychology (Parham, Ajamu, & White, 2010; White & Cones, 1999).

**African American cultural mistrust of clinicians.** Racism and the long-standing racial bias of clinicians have led African Americans to have a cultural mistrust of mental health services (Terrell & Terrell, 1981; Whaley, 2001). The field of psychology has historically been plagued with racism, characterizing African Americans with *drapetomania* (i.e., madness or insanity caused by flight from home) when they tried to escape their oppression as slaves (Neville et al., 2009) and as having low intelligence in the context of developing tests with European American populations, norms, and values (Terman, 1916). One famous experiment that has contributed to African American cultural mistrust of clinicians includes the Tuskegee Syphilis Study, which was the longest non-therapeutic study in medical history (Gamble & Fletcher, 1996). Conducted by the U.S. Public Health Service, the Tuskegee Syphilis Study followed the natural history of syphilis in 399 African Americans without intervening with penicillin, causing the deaths of 28-100 men. Taking the Tuskegee Syphilis study into account, it is not surprising that African Americans report more negative attitudes about mental health services than European Americans do (Diala et al., 2000). Additionally, African American clients, especially male clients, tend to withhold trust in the therapeutic relationship with a European American therapist until the therapist demonstrates trustworthiness (Vontress, 1971).

**Negative perception and decreased use of services.** African Americans tend to underutilize the mental health care system because of barriers to access (e.g., cost of treatment, accessibility of clinic hours, etc.) and distrust of mainstream mental health services (Snowden,
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2001; Snowden & Lonnie, 1998). Many African Americans remain more likely to visit their primary care physicians or emergency rooms, than to engage in psychotherapy with a counselor (Cooper-Patrick et al., 1994; Morris, 2001). Additionally, African Americans often seek therapy only when they have severe issues and commonly terminate services prematurely (Lester et al., 2010; Rosenheck & Fontana, 1996). African American children are more likely to have their mental health care needs go unmet when compared to European American children (Flisher et al., 1997). Lastly, many African Americans prefer informal social supports to the mental health system, such as extended family, religious support systems, and community members (Mills & Cody-Rydzewski, 2012). Clinicians must take these support preferences into consideration when designing mental health programs and preventative measures.

Poverty. An additional risk factor for decreased mental healthcare service use is poverty. The poverty rate for African Americans in the United States was 27.2% in 2012, while the national average was 15% (U.S. Census Bureau, 2012). Economic disparities between African Americans and European Americans persist, and the financial standing of African Americans has worsened with regard to incomes and rates of home ownership (Williams et al., 1997). Socioeconomic status is correlated with well-being (McLeod & Nonnemaker, 2000), and a strong connection exists between low socioeconomic status and poor health (Raphael, 2000). It is also important to highlight that military rank is a measure of socioeconomic status; the higher the rank, the more money the military member makes. Officers (i.e., Lieutenant through General of the Army) in the military occupy higher positions than enlisted members (Private through Sergeant Major of the Army); in fact, the highest enlisted member in the military is still lower in rank than the lowest officer. Thus, it is important to have an awareness of the differences in socioeconomic statuses between African American officers and enlisted members in the military.
Meaning and presentation of symptoms. Another barrier to treating African Americans includes the meaning and presentation of mental health symptoms. For example, African Americans may view mood disorders (e.g., depression) as personal weaknesses or character defects, rather than illnesses with an organic origin (Mills & Cody-Rydzewski, 2012). Additionally, many African Americans view mental health problems as internal spiritual problems instead of being biologically driven (Mills, Alea, & Cheong, 2004). Thus, psychopathology is viewed as a personal flaw or spiritual distress, rather than caused by genetics. On the other hand, Kleinman (1989) found that African Americans tended to engage in somatization and attributed their psychological distress to physical problems. As a result of these perceptions of psychopathology, many African Americans turn to their faith and use prayers to cope with mental health problems (Mills, 2000).

Protective Factors of African Americans

Similar to their risk factors to mental health, African Americans have several protective factors (e.g., the Africentric worldview, racial identity, religiosity, family, and communalism) that sustain their resilience through various life stressors. For example, the church, a prominent protective factor for African Americans, is referred to as “the pulse of the African American community” (Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005, p. 147). Protective factors for African Americans are discussed below.

The Africentric worldview. In contrast to the Western ideology of independence, autonomy, survival of the fittest, and control over nature (Sue & Sue, 1982), many African Americans adopt an Africentric worldview that embraces relationships, communalism, connectedness, interdependence, cooperation, and survival of the tribe (Neville et al., 2009). African Americans utilize their various relationships and support systems as primary coping
mechanisms and resources when enduring hardships or challenges (Wallace & Constantine, 2005). The Africentric worldview or belief system promotes resilience to cope with oppression, communal support, and spiritual growth (Neville et al., 2009; Parham et al., 2010). Adherence to this worldview correlates with high self-esteem and life satisfaction (Constantine, Alleyne, Wallace, & Franklin-Jackson, 2006).

The Afrocentric perspective discounts many Western values, with its holistic focus on relationships, harmony with nature, and the mind-body connection. One perspective of Africentric values involves the seven principles of Kwanzaa (i.e., Nguzo Saba), which include (a) unity, (b) self-determination, (c) collective work and responsibility, (d) cooperative economics, (e) purpose, (f) creativity, and (g) faith (Karenga, 1965). Africentric values can be measured using the Africentric Scale (Grill & Longshore, 1996). The Africentric Scale is a 15-item, 4-point Likert type, self-report scale used to measure Africentric values and behaviors as articulated through the seven principles of the Nguzo Saba. Accordingly, the Afrocentric worldview is attended to and promoted by the ART program.

**African American racial identity.** Another protective factor for African Americans is a strong racial identity (i.e., one’s identification being an African American). There are three prominent African American racial identity models. Several of the models have expanded on the previous editions, adding more depth and clarity. Cross’s and Helm’s racial identity models focus on the developmental progression of reactions of African Americans to oppression from European Americans, while the Sellers et al. model focuses on the importance of being African American, internal feelings, and perceptions of others (Cokley & Williams, 2005). Their models are described in depth below.

developed the Nigrescence Model of African American Racial Identity. This model describes the process by which an African American develops a positive Black identity in a society in which negative messages about being Black are prevalent. Cross’s (2001) expanded Nigrescence Model of Racial Identity consists of themes of various exemplars of Black racial identity attitudes, which differs from the original developmental stage model (Cross, 1971). In Cross’s (2001) expanded Nigrescence Model of Racial Identity, individuals can hold multiple attitudes simultaneously across three thematic categories: (a) pre-encounter (i.e., attitudes that have negative feelings or low race salience attributed to being Black, where exemplars consist of assimilation, miseducation, and self-hatred); (b) encounter (i.e., an awakening to racial consciousness, where an exemplar is the first time a child is treated differently because of his or her skin color); (c) immersion/emersion (i.e., an identity in transition, where exemplars consist of anti-White attitudes and intense Black involvement); and (d) internalization-commitment (i.e., individuals who experience race as a positive attribute, where internalized attitudes consist of Africentric, Biculturalist, and Multiculturalist Inclusive).

**Helms’s African American racial identity model.** Subsequent to Cross’s development of the Nigrescence Model, Helms (1995) developed an African American racial identity model. Helm’s (1995) People of Color Racial Identity Model describes five statuses: (a) conformity (i.e., allegiance to White standards of merit); (b) dissonance (i.e., ambivalence and confusion over own socio-racial group); (c) immersion-emersion (i.e., idealization of one’s own socio-racial group and denigration of that which is perceived White); (d) internalization (i.e., positive commitment to one’s own socio-racial group); and (e) integrative awareness (i.e., capacity to value one’s own racial group, as well as empathize with members of other groups).
Sellers’s Multidimensional Model of Racial Identity. Sellers, Smith, Shelton, Rowley, and Chavous (1998) developed the third model known as the Multidimensional Model of Racial Identity (MMRI). This model consists of several dimensions of racial identity: (a) racial centrality (i.e., the degree to which race is a part of an individual’s self-concept over time), (b) racial salience (i.e., the extent to which a person’s race is relevant to his or her self-concept at a particular moment in time), (c) racial regard (i.e., a person’s affective and evaluative judgment of his or her race), and (d) racial ideology (i.e., an individual’s beliefs, opinions, and attitudes regarding the ways in which African Americans should interact with society). The MMRI combines the mainstream approach of universal properties related to racial identities as well as the underground approach related to the unique cultural experiences of African Americans (Sellers et al., 1998). This model differs from the previous racial identity models because it does not define a psychologically healthy or unhealthy identity.

Cokley’s observations on racial identity. Another prominent researcher on African American identity models is Kevin Cokley. Cokley (2002) reexamined Cross’s revised racial identity model and found that the earlier and middle stages of the model (i.e., pre-encounter and immersion/emersion) would predict internalized racism but not the later stage (i.e., internalization). He found the concept of racial identity to be problematic because of the focus on racial attributes, preferring a focus on cultural attributes instead. Cokley believed that the African American identity should have a focus on an ethnic and cultural identity, founded on the Africentric worldview that affirms African American cultural values.

Having a positive identification with one’s racial and ethnic group is important because it can buffer against discrimination, racism, and prejudice (Sellers & Shelton, 2003). Additionally, adopting a healthy African American racial identity can lead to a positive self-image and
personal well-being (Thomas, Townsend, & Belgrave, 2003). African American racial identity is promoted by the ART program.

Religiosity and spirituality. When African Americans turn to religion and spirituality, they are increasingly able to adapt to challenging times (Neville et al., 2009). One study (Ellison, Boardman, Williams, & Jackson, 2001) found that African American churchgoers reported lower levels of family, financial, and work stresses than those African Americans who did not attend church services. Many African Americans regard prayer as the most important coping method (Neighbors, Jackson, Bowman, & Gurin, 1983), often utilizing religion to cope with racism (Bierman, 2006). Thus, it is to be expected that many African Americans prefer to talk about their problems with religious leaders (e.g., pastors; Martin, 2007). Clinicians must be aware of this potential preference for religious counseling and make efforts to collaborate with pastors and ministers (when appropriate) when serving African American churchgoers in need of psychotherapy or preventative interventions.

Additionally, spirituality has been demonstrated to reduce stress, reduce the risk of depression, and increase self-esteem among caregivers (Picot, Debanne, Namazi, & Wykle, 1997). Religion also serves as a protective factor against suicide in many African Americans (Greening & Stoppelbein, 2002). Religious institutions provide a social support system, social activities, the recognition of personal achievements of members, and an alternative family system for African Americans (Neville et al., 2009). The church community can serve as a source of informal assistance to African Americans at times of mental health distress (Neighbors, Hudson, & Bullard, 2012). Historically, the church facilitated political solidarity among African Americans, the emancipation movement during slavery; and served as a think tank and organizational resource for the start and sustenance of the Civil Rights movement (Lincoln &
Clinicians working with African Americans should be cognizant of these supports and encourage their utilization. Religiosity and spirituality are addressed and promoted in the ART program.

**Family and kinship networks.** Related to the Africentric worldview is the strong reliance on the family. African Americans believe that the family is crucial to the existence of the individual (APA, 2008). Many African Americans live with extended family members or intergenerational family networks, such as grandparents, that provide support for the family and African Americans remain more likely to care for older adults instead of placing them in institutions (Tennstedt & Chang, 1998). Family members can particularly help to modulate against the effects of stress, racism, and oppression (LaTaillade, 2006; Utsey, Lanier, Williams, Bolden, & Lee, 2006). African Americans are more likely than European Americans to rely on family members before seeking psychotherapy (Constantine, Lewis, Conner, & Sanchez, 2000). Family support can bolster a healthy racial identity for African Americans (Sellers, Copeland-Linder, Martin, & Lewis, 2006). Thus, mental health clinicians working with African Americans must have an awareness of the profound influence of the family and incorporate the family into preventive treatment interventions when possible. The protective factor of family and kinship networks are addressed in the ART program.

**Communalism/-collectivism.** In addition to the family, African Americans tend to place a high value on communalist or collectivist ideologies. Communalism may serve as a protective factor against stress (Moore & Penk, 2011). In collectivistic cultures, the motivation for behavior stems from social context or interdependence (Markus & Kitayama, 1991). This perspective emphasizes attending to others, role relationships, fitting in with the community, and interpersonal harmony. This communal perspective, valuing the group over the individual, may
AFRICENTRIC RESILIENCE TRAINING FOR SOLDIERS: A PREVENTION

serve to mitigate symptoms of depression in African Americans (Penninx et al., 1998). The composition of African American social support networks may consist of extended family members, best friends, fictive kin (i.e., non-biological), and church members. Additionally, high level of engagement in familial and community relationships (e.g., the neighborhood, church, and school) reinforces a sense of pride in African American identity (Utsey, Howard, & Williams, 2003). The ART program addresses the protective factor of communalism.

**High levels of flourishing and hope.** Studies have found that African Americans reported higher levels of flourishing (i.e., positive emotions/emotional well-being, positive psychological functioning/psychological well-being, and positive social functioning/social well-being) than their European American counterparts (Keyes, 2007). This is fortunate since African Americans remain exposed to high levels of life stressors (Gibbs, 1997). Additionally, higher levels of hope (an emotional state that promotes the belief in a positive outcome) in African Americans have been found to correlate with higher levels of life satisfaction (Adams & Jackson, 2000). Researchers have found that African Americans with high levels of hope tend to cope better with racism because they can develop new routes to success (Adams, 2003). Furthermore, African American children have been found to have higher self-esteem than European American children do, despite poverty, single mother homes, and societal barriers (Cokley, 2002). These African American strengths of hopefulness and flourishing are utilized in the ART program to validate pride in their well-evidenced resilience.

It is important to highlight the possibility of ceiling effects (Lammers & Badia, 2005) for African Americans that have higher levels of flourishing and hope. If African Americans are already utilizing protective factors (e.g., Africentric worldview, strong faith, collectivism, etc.) and strengths, there may be the possibility of limited flourishing above the level that they
Lower suicide rates. Research shows that African Americans have relatively low suicide rates in comparison to the European American population (Davidson, Wingate, Slish, & Rasmus, 2010). African American youth also reported lower rates of suicidal ideation (Thompson, 2005) and more negativistic attitudes towards suicide than the dominant society (Morrison & Downey, 2000). It appears, therefore, that many African Americans have a cultural and religious foundation in resilience and hope, despite or because of having to face many life stressors that are specific to minorities. As Neville and her colleagues (2009) stated:

This ability to cope and adapt, to seek truth in the midst of falsehood and deceit, to find hope in the midst of despair, to maintain one’s sense of African consciousness in the face of hostile threat, and to ‘keep on keepin’ on’ despite life’s hardships is characteristic of the most profound display of African Psychology in action. (p. 12)

The ART program reinforces African Americans’ capacity by promoting individual and community resilience.

Comprehensive Soldier and Family Fitness Program

The Comprehensive Soldier and Family Fitness (CSF2) program serves as the foundation and inspiration for the proposed prevention program. The CSF2 program is a new preventative and integrative training program aimed at increasing resilience in United States Army soldiers, family members, and Army civilians (Casey, 2011). It has a foundation in the evidence-based practices of positive psychology, replacing the traditional disease model of treatment with a proactive approach to the prevention of psychopathology and enhancement of wellbeing in soldiers. Through the CSF2 program, soldiers learn to identify and cultivate their strengths to increase their resilience and well-being. The CSF2 program consists of four pillars of training:
(a) the Global Assessment Tool; (b) Comprehensive Resilience Modules; (c) Master Resilience Trainers; and (d) a mandatory resilience school. These four pillars of training measure resilience and psychological health on four dimensions of human health: emotional, family, social, and spiritual (Lester, Harris, Herion, Krasikova, & Beal, 2011).

**Global Assessment Tool.** The Global Assessment Tool (GAT) is an online survey instrument administered annually to soldiers to give feedback on their resilience level as well as overall psychological health and well-being (Lester et al., 2011). The GAT describes the psychological fitness of soldiers in its results, introduces a common vocabulary for strengths and assets of soldiers, provides immediate feedback, and reduces stigma around mental health because all military members are required to take the assessment (Peterson, Park, & Castro, 2011). The GAT consists of 105 questions and measures four dimensions of health (emotional, family, social, and spiritual) through the use of 18 subscales: Adaptability, Bad Coping, Good Coping, Catastrophizing, Character, Depression, Negative Affect, Positive Affect, Optimism, Family Satisfaction, Family Support, Engagement, Friendship, Loneliness, Organizational Trust, Spiritual Fitness, Transformational Leadership, and Unit Cohesion. The GAT produces a resilience and psychological health score (R/PH) that is discussed in Chapter 4.

**Comprehensive Resilience Modules.** The second pillar of the CSF2 program consists of self-help modules that provide individualized training. The Comprehensive Resilience Modules (CRMs) consists of computer-based distance learning modules for soldiers (Lester et al., 2011). Each of these online self-help modules take approximately 15 to 20 minutes to complete and are tailored to the individual based on the individual’s GAT results. The modules can only be accessed after completing the GAT. See Appendix A for a list of the online module titles.
**Master Resilience Trainers.** The third pillar of the CSF2 program consists of Master Resilience Trainers (MRTs), who promote resiliency training at the local unit level. MRTs serve as the core foundation of the program. The MRT course serves as a training-the-trainer course, where soldiers learn resiliency training to bring back to their units. The course takes 10 days to complete, with approximately 80 hours of classroom time. Trainers learn six core competencies: self-awareness, self-regulation, optimism, mental agility, strengths of character, and connection (Lester et al., 2011; Reivich et al., 2011). These six competencies are taught via four modules. See appendix B for a description of each module.

**Resilience training program.** The final pillar of the CSF2 program is a mandatory resiliency training program at every leader development school in the Army (Casey, 2011). Since information about this part of the training program has limited descriptions available to the public, this author presents only a brief outline. This institutional resilience training aims to ensure that resilience training continues throughout the military career of every soldier. This training includes education on reducing barriers to seeking mental health care.

The CSF2 program provides progressive training on resilience techniques for any member in the military, regardless of rank. The program has been presented as a universal form of training for all soldiers. However, professionals who designed this program did not tailor its content and form to different ethnic and racial populations in the military. As a result, this program uses a one-size-fits-all approach.

**Evidence supporting the effectiveness of the CSF2 program.** Evidence exists supporting the effectiveness of the CSF2 program to date. According to the military technical reports of the CSF2 program, soldiers who received resilience training taught by a MRT improved more than soldiers who did not receiving the training, especially regarding 18 to
24-year-old soldiers (CSF2, 2014). Additionally, units with MRTs had significantly lower rates of diagnoses for mental health problems (e.g., PTSD, anxiety, depression, and substance abuse) compared to units without MRTs (CSF2, 2013). Thus, early pilot study data supports the effectiveness of this program for Army soldiers.

**Criticisms of the CSF2 program.** The C2F2 program has faced some criticism in the media. Several psychologists have found fault with the mandatory training component of the CSF2 program, advocating for soldiers to have an option to participate (Eidelson et al., 2011). While this is a valid argument, soldiers go through mandatory physical fitness training at the same time, without their consent. The founders of this program view psychological training as just as important as physical training in the military.

Critics of the program also discuss the limited discussions of ethical concerns of the program, the speed at which the program was initiated, limited evidence for the program’s effectiveness, and the lack of randomly controlled trials (Eidelson, Pilisuk, & Soldz, 2011). See Eidelson and colleagues (2011) for a review of critiques of the CSF2 program. For example, no provision has been made for a long-term control group because the Army Chief of Staff General George Casey decided that CSF2 would be applied to every soldier (Seligman, 2011). Military leaders viewed the existence of a control group as a moral problem because it would mean withholding resilience training from soldiers that will be deployed (Lester, McBride, Bliese, & Adler, 2011). A natural wait-list was formed by units that did not have MRTs in place to provide resilience training (Lester et al., 2011). Another concern of the CSF2 program is the lack of transparency with the program. Since the CSF2 program is not accessible to the public, including the academic research community, this creates a barrier for performing an assessment or critique of the program design.
Additional Mental Health Programs

A variety of mental health programs exist in the military for soldiers’ potentially experiencing psychopathology. The majority of these programs are designed to help treat soldiers after they have deployed to a combat zone. The programs are described below.

**Battlemind prevention program.** Battlemind, developed by the Walter Reed Army Institute of Research, is another prevention program for resilience-building before deployment and also intends to help soldiers re-adjust to family life after deploying (Meichenbaum, 2011). Battlemind represents inner strength for challenges in the combat zone. The acronym *Battlemind* stands for the coping skills necessary in battle: buddies (vs. withdrawal), accountability (vs. controlling), targeted aggression (vs. inappropriate aggression), tactical awareness (vs. hypervigilance), lethally armed (vs. locked and loaded), emotional control (vs. anger or detachment), mission operational security (vs. secretiveness), individual responsibility (vs. guilt), non-defensive combat driving (vs. aggressive driving), and discipline (vs. conflict). These coping skills can help soldiers survive in a combat zone, but they can be maladaptive for returning soldiers. Battlemind focuses on four areas of training: (a) emotional, (b) social, (c) spiritual, and (d) family well-being (Meichenbaum, 2011).

**Real Warriors program.** The Real Warriors program, a multimedia public awareness campaign, was launched in 2009 by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and records firsthand accounts from soldiers of their trauma experiences in the combat zone (Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, 2009). These recordings promote the notion that getting mental health care is a sign of strength as opposed to weakness. The campaign features various stories of soldiers who have sought out mental health care and had successful outcomes (e.g., maintaining
their careers, keeping their security clearances, and learning coping skills). Soldiers help one another by sharing their stories and providing support and information to others in need.

**Deployment Anxiety Reduction Training program.** The Deployment Anxiety Reduction Training (DART) program, initiated in 2010 by researchers at the UCSF-affiliated San Francisco Veterans Affairs Medical Center, aims to reduce the initial stress reaction to combat trauma (Deployment Anxiety Reduction Training, 2010). This program was launched as a small pilot program in Afghanistan and involves providing psychoeducation about the stress response and skills training to monitor and reduce stress. This program emphasizes aspects of resilience and cognitive performance in the combat zone, while also promoting relaxation techniques. Through this program, medical personnel train soldiers in the combat zone within hours of experiencing a traumatic event.

**Air Force Suicide Prevention Program.** The Air Force Suicide Prevention Program (AFSPP), founded in 1996, emphasizes a multifaceted, community approach to reducing suicide related deaths by utilizing leadership involvement (Knox et al., 2010). The foundation of this program includes 11 initiatives: (a) leadership involvement, (b) addressing suicide prevention through professional military education, (c) guidelines for commanders on the use of mental health services, (d) community preventative services, (e) community education and training, (f) investigative interview policy, (g) trauma stress response, (h) integrative delivery system and community action information board, (i) limited privilege suicide prevention program, (j) integrated delivery system consultation assessment tool, and the suicide event surveillance system (Knox et al., 2010). This program aims to reduce the stigma of receiving mental health care, encourage help-seeking behaviors, normalize distress, teach coping skills, and provide outcome measurements through investigation of every suicide that occur in the Air Force.
Summary

Overall, studies have found mixed results for the varying rates and manifestations of psychopathology for African American soldiers, compared to European American soldiers. Several risk factors for African American soldiers’ mental health include racism, racial bias of clinicians, cultural mistrust of clinicians, negative perception of mental health care, low use of services, poverty, and presentations of symptoms that differ from those noted in the DSM-5. Several protective factors for African American mental health include the Africentric worldview, African American racial identity, religiosity/spirituality, family and kinship networks, communalism/-collectivism, levels of hope and flourishing, and low suicide rates.

Positive psychology remains a fitting approach to increase resilience and flourishing and prevent PTSD in African American soldiers. However, positive psychology principles have not been culturally adapted to meet the culture-specific needs and environmental stressors of African American soldiers (Chang et al., 2012). Many programs exist for the mental health care of soldiers, as described in this chapter, but none are designed especially for African American soldiers. The CSF2 program is one of the few preventative mental health program that occurs before soldiers deploy, training them to become psychologically fit. However, the CSF2 program does not address culture-specific mental health needs of any ethnic minority group (e.g., African Americans, Latinos, Asian Americans, Native Americans, or Middle Easterners; Westhuis, Fafara, & Oullette, 2006). Chapter 3 describes the core structure of ART, the content and process changes that make ART culturally sensitive and appropriate for African American soldiers, and the four pillars of ART.
Chapter 3

This chapter describes the content and form of Africentric Resilience Training (ART), a proposed mental health prevention program for African American soldiers serving in the Army. The author first presents the core structure of ART, which is modeled after the CSF2 program. The author then outlines the specific content and process changes that make ART culturally sensitive and appropriate for African American soldiers through the use of an emic perspective. The author then presents the four pillars of ART. Each pillar is described, and specific curriculum information, questionnaires, focus group questions, and other materials are presented.

Core Structure of ART

Similar to the original CSF2 program’s four pillars of training (i.e., the Global Assessment Tool, the Comprehensive Resilience Modules, the Master Resilience Trainer course, and the mandatory resilience training school), ART contains four pillars of training. These pillars include: (a) Culturally Sensitive Assessment of Soldiers, (b) Culturally Sensitive Online Training Modules, (c) Resilience Training by Multiculturally Competent Trainers, and (d) Social Justice Advocacy Town Hall Meetings. In addition to incorporating the original pillars of training, ART also includes culture-specific modifications and social justice advocacy. See Table 1 for a depiction of the differences between the CSF2 program and ART. See Table 2 for a depiction of the timeline for ART.
Table 1

Comparing the Components of the Original CSF2 Program with ART

<table>
<thead>
<tr>
<th>CSF2 Program</th>
<th>ART Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Outcome measures</td>
</tr>
<tr>
<td></td>
<td>b. Cultural context questionnaires</td>
</tr>
<tr>
<td></td>
<td>c. General Resilience Measure (GRM)</td>
</tr>
<tr>
<td>2. Online Comprehensive Resilience</td>
<td>2. Culturally Sensitive Online Training Modules</td>
</tr>
<tr>
<td>Modules</td>
<td>a. Curriculum for African American psychoeducation</td>
</tr>
<tr>
<td></td>
<td>b. Culturally sensitive resilience training</td>
</tr>
<tr>
<td></td>
<td>a. Resilience training for soldiers</td>
</tr>
<tr>
<td></td>
<td>b. Training the trainers to be multiculturally competent</td>
</tr>
<tr>
<td>School</td>
<td></td>
</tr>
</tbody>
</table>

Table 2

*ART Timeline for African American Soldiers in the Army*

<table>
<thead>
<tr>
<th>Schedule</th>
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</thead>
<tbody>
<tr>
<td><strong>General ART Timeline</strong></td>
</tr>
<tr>
<td>Monthly social justice advocacy team meetings.</td>
</tr>
<tr>
<td>Annual culturally sensitive assessment.</td>
</tr>
<tr>
<td>Biennial online and in-person training.</td>
</tr>
<tr>
<td><strong>Program Updates</strong></td>
</tr>
<tr>
<td>ART will be modified each year with current developments in positive psychology, multicultural competence, and African American psychology literature, as well as program evaluation feedback.</td>
</tr>
<tr>
<td><strong>New Recruits</strong></td>
</tr>
<tr>
<td>Start ART, following bootcamp.</td>
</tr>
<tr>
<td>Start schedule below for “active duty personnel” in January before the two-year mark.</td>
</tr>
<tr>
<td><strong>Active Duty Personnel</strong></td>
</tr>
<tr>
<td>Monthly:</td>
</tr>
<tr>
<td>Attend social justice advocacy town hall meetings the first Friday of every month.</td>
</tr>
<tr>
<td>Annually:</td>
</tr>
<tr>
<td>Take ART assessment battery in January.</td>
</tr>
<tr>
<td>Biennially:</td>
</tr>
<tr>
<td>Take online training modules January-April.</td>
</tr>
<tr>
<td>Attend 10-day resilience training (offered monthly).</td>
</tr>
<tr>
<td><strong>Deployed Soldiers</strong></td>
</tr>
<tr>
<td>Take ART assessment battery in deployed location.</td>
</tr>
<tr>
<td>Take online training modules in deployed location.</td>
</tr>
<tr>
<td>Attend 10-day resilience training upon return.</td>
</tr>
<tr>
<td>Attend monthly social justice advocacy town hall meetings upon return.</td>
</tr>
</tbody>
</table>

*Note: Soldiers have the option to choose ART or CSF2.*
Content Changes

The first type of modification in ART includes content changes. Content changes refer to modifications or additions made to psychological assessment and information or learning provided in the program. Soldiers are presented with assessment and information through online training modules and program trainers.

**Mental health psychoeducation for African American soldiers.** The first modification of ART is the addition of psychoeducation about African American mental health. In ART, African American soldiers receive psychoeducation about the presentation of psychopathology (e.g., PTSD symptoms), the mental and physical effects of racism (including relevant information to challenge institutional racism) and microaggressions, reducing the existing stigma of mental health care, overcoming cultural mistrust, ways to reduce this barrier to seeking help, and the military’s efforts to provide access to mental health services for racial and ethnic minorities. Psychoeducation about African American mental health is paramount because lack of this knowledge, along with the stigma of receiving mental health care, creates significant barriers to treatment and to help-seeking behaviors among African Americans (Alim, Charney, & Mellman, 2006). Psychoeducation about African American mental health is presented in the culturally sensitive online training modules. A curriculum outline of the mental health psychoeducation for African American soldiers is provided in this chapter.

**Multicultural competence training for ART trainers.** The second modification offered by ART is that trainers receive multicultural competency training for the mental health care of African American soldiers. The training of the trainers focuses on rates of psychopathology in African Americans, the physical and psychological effects of a longstanding history of racism in the United States, the cultural mistrust of clinicians that African Americans
may harbor, the negative perceptions and low use of mental health services by African Americans, the meaning that African Americans ascribe to psychological symptoms, and the presentation of psychological symptoms in African Americans. A curriculum outline on the mental health of African American soldiers complements the psychoeducation of African American soldiers (see previous section) and is provided in this chapter. All ART trainers receive multicultural competence training in the form of online training modules and monthly focus groups.

**Psychoeducation on social justice advocacy for soldiers.** The third modification to the CSF2 program made within ART includes separate and lengthy discussions about social justice advocacy for marginalized groups within the military. Social justice advocacy is imperative for African American soldiers because studies have found that oppression causes stress, which can produce dramatic consequences for one’s physical and mental health (Lantz, House, Mero, & Williams, 2005). Additionally, chronic stress (in the form of oppression) has been shown to cause physiological changes in the immune system and in the brain, causing psychological distress, substance abuse, psychiatric disorders, and even suicide (Turner & Lloyd, 1999). Studies have also found that the rates of depression, anxiety, and other problems were higher among disadvantaged groups than among advantaged groups because of the adversity and stress inherent in ethnic and racial discrimination and prejudice (Dohrenwend, 2000). Turner and Avison (2003) found that African Americans reported higher occurrences of negative major life events and chronic stressors (e.g., daily discrimination, death events, and witnessing violence) over their lifetimes compared to non-Hispanic Whites. Zyromski (2007) found African Americans have higher rates of PTSD than in European American youth, which is not surprising, considering the high exposure to violence and oppression that racial and ethnic minorities face.
Thus, literature has demonstrated that chronic and destructive stress exposure and oppression are directly related to mental health disorders (Harrell, 2000). Thus, social justice advocacy is necessary to combat the physical and mental effects of marginalization for African Americans.

Psychoeducation about social justice advocacy for African American soldiers occurs during the monthly social justice advocacy town hall meetings. African American soldiers attend these meetings once per month to brainstorm, answer questions, and discuss how to promote social justice advocacy in their professional military lives, as well as within their personal-social lives with family, friends, and community members. Guest speakers at the meeting provide resources and information about social justice advocacy. Guest speakers consist of national and local experts on social justice advocacy. Various definitions of social justice and illustrations of social justice actions are provided in this chapter. A resource list of books and readings on social justice with regard to access, civil rights, human rights, and equity is provided in Appendix J.

**Inquiry about cultural contexts.** The fourth modification that will be made to the CSF2 program includes a focus on the cultural contexts of African American soldiers. For example, communalism, family and kinship networks, church involvement, and mentors all serve as various cultural contexts in the lives of African American soldiers. An individual’s cultural context remains a pertinent factor in fully comprehending the development, maintenance, and treatment of PTSD (Zayfert, 2008). Resilience is internally and contextually influenced, so personality traits and external resources must be taken into consideration when designing resilience training for individual soldiers (Agaibi & Wilson, 2005; Masten & Powell, 2003). Additionally, cultural factors that include strengths (e.g., Africentric worldview, communalism, extended family and kinship networks) and risk factors (e.g., history of discrimination, cultural
mistrust of clinicians, low use of services, etc.) are discussed in relation to the treatment of PTSD among African Americans of low socioeconomic status (Madrid & Grant, 2008).

While PTSD can develop after exposure to a traumatic event, cultural contexts can affect the manifestations of these symptoms. Attention to the cultural context of individuals may prevent future onset of PTSD. The culturally sensitive assessment pillar of ART includes the Cultural Context Questionnaire (CCQ), a measure developed from the *DSM-5* about cultural contexts for African Americans (see Appendix C). The results from the measure can inform clinicians of additional cultural contexts that may be important for mental health treatment.

**Recording soldier narratives.** African Americans tend to have an interpersonally-focused communication style as part of their Africentric worldview (Morris, 2001), so the use of personal narratives is a unique and culturally sensitive modification within ART. African American soldiers videotape or record a narrative from any point in their life when they were at their best, for a maximum of one hour. The goal of this activity is to promote their resiliency. Retelling the ideal self (i.e., when soldiers felt at their very best) is a common positive psychology technique that promotes resiliency because it encourages individuals to think about their strengths and virtues (Seligman, Steen, Park, & Peterson, 2005). Seligman et al. (2005) found that participants who engaged in this exercise were happier and less depressed at the immediate post-test.

The narrative is preserved on tape and added to the electronic medical records for soldiers and staff to review after any reports of emerging symptoms of Acute Stress Disorder or PTSD. Narratives are recorded during the resilience training component of ART by multiculturally competent trainers. A sample self-narrative is presented to the soldiers and included in Appendix F. If soldiers do not feel comfortable recording a self-narrative, then they have the
option to reflect on their resiliency in writing. See Pennebaker (1997) for a discussion of the benefits of writing about emotional experiences.

**Using religious and spiritual language.** The original CSF2 program involves spiritual components, but ART proposes an increase in discussions about the relationship of faith with motivation for African American soldiers. Religiosity and spirituality strengthen the psychological fitness of a soldier, as well as the psychosocial fitness of the soldier’s unit. The culturally sensitive online training modules and trainings by multiculturally competent trainers incorporate spiritual and religious concepts and language. Queener and Martin (2001) described that the training focuses on a sense of balance and harmony with the self, world, and higher powers. Trainers present resilience training as a way to restore inner and outer balance to prevent psychopathology, such as PTSD, depression, and alcohol abuse. An example of an African American religious invocation for peace and blessings is provided in this chapter.

**Using communalist/-collectivist examples.** Since African Americans value communalism, another modification to the CSF2 program is the addition of extensive references to communalist/-collectivist examples and concepts in the training sessions. For instance, the online training modules and information by multiculturally competent trainers include communalist examples as well as item samples from scales on individualism/collectivism, interdependence/independence, humanism/normativism, worldview, and locus of control/-attribution. In order to encompass a wide variety of perspectives within the military, some examples provided in these training formats reflect an individualistic worldview and ideology, though communalist examples are prominent. These examples include using ethnic names and discussions about the importance of family members, kinship networks, and community
members (APA, 2008) for completing the military mission at hand, as well as discussions about the importance of group members in relation to group leadership.

**Using alternative labels for therapy.** A seemingly trivial but important aspect of ART is the name of the program. This program should not include the words “treatment” or “therapy” because the use of such terms could deter service members, who are resistant to medical terms and interventions (Gray et al., 2012). The name of this prevention program focuses on the psychological fitness of the soldier. Thus, the use of the name, *Africentric Resilience Training* (ART), does not deter soldiers from participating because of the stigma attached to “treatment” or “therapy.” ART is an inviting name that suggests the inclusion of art and personal expression in training.

**Process Changes**

In addition to content changes made to the CSF2 program for ART, process changes are also made. Process changes refer to any modifications or additions made to the procedures, methods, or personnel involved in the CSF2 program. Process changes are necessary to ensure the culturally competent delivery of ART.

**Including informal social support systems.** Henderson (2006) stated that the military consists of a three-legged stool of training, equipment, and family members, all of which depend on each other like the legs of a stool. Accordingly, another modification to the African American mental health prevention program includes a strong focus on informal social support systems (i.e., the family leg of the stool). Therefore, ART includes an internet webpage that provides links to informal social support systems. The website offers resources, online support groups, and contact information for family readiness centers on military bases. Additionally,
family members and community members are invited to attend the quarterly social justice advocacy town hall meetings for African American soldiers.

**Including clergy.** Although the original CSF2 program involves spiritual components, there is an increase in discussions about spirituality and religiousness for soldiers. Church leaders are incorporated into the ART program’s curriculum on religion and spirituality. In order to encourage the use of religious networks, church leaders are included in ART’s psychoeducation for multiculturally competent trainers. Church leaders receive the same multicultural competence training as the rest of the trainers to ensure adherence to the multicultural competence framework of ART. Church leaders are also invited to attend the quarterly social justice advocacy town hall meetings, to direct discussions, give sermons, or answer any questions about spiritual distress or resilience through interpretations of faith.

**Employing diverse program trainers.** Another modification to the CSF2 program for ART includes incorporating a core team of diverse trainers (both military members and civilians) who are multiculturally competent. All leaders receive training in multicultural competence prior to their training of soldiers. Each training session is led by African American leaders, as well as individuals from other culturally diverse racial and ethnic backgrounds. The leaders of the training program come with various experiences, perspectives, and socioeconomic statuses, in order to avoid the further perpetuation of the division of power.

**Providing accessible resources.** Lack of knowledge of mental health services and where to find them constitutes a significant barrier to the utilization of mental health care by African Americans (Department of Health and Human Services, 1999), so providing understandable and easily accessible resources can help with utilization (Whaley, 2009). ART’s online modules are user-friendly and contain resources that are easily accessible to African
American soldiers. The culturally sensitive online training modules and information provided by the multiculturally competent trainers are written at the level of a high school graduate or someone that has obtained a General Equivalency Diploma (GED). All psychoeducation materials for soldiers in the dissertation, such as handouts, case examples, questionnaire items, appendices, and outlines are at the 12th grade reading level. The online training modules are easy to navigate on government computers. Additionally, there is an online teacher’s aide support available to answer questions or provide clarifications on the culturally sensitive online training modules.

**Psychological training during the work day.** Since African Americans underutilize the mental health care system, ART allows time during the workday to engage in psychological resilience training, just as physical training is part of their day. This component of the program will require command support and approval on base. By allowing time during the workday to complete the culturally sensitive online training modules, African American soldiers can receive the help they need and are prevented from dropping out. This process change may give many African American soldiers permission to attend to their psychological health at work that they may otherwise have ignored, not having extra time outside of their work schedule to focus on psychological training. Engaging in this program during the workday may also decrease the stigma attached to mental health care. African American soldiers also have the option of working in groups in computer laboratories on base to complete the online training modules, which provides an additional form of social support. While this shift may decrease stigma towards mental health for African American soldiers, it may increase negative feelings from members of other racial and ethnic groups that do not have this privilege during the work day.
Embedding psychologists in primary health care. In addition to providing time during the workday to engage in the program, ART pushes for embedding psychologists in primary health care stateside. This change reduces the stigma of receiving mental health care. In this model, psychologists are able to provide brief assessments (e.g., PTSD Checklist for the DSM-5) and schedule longer-term, mental health interventions in the outpatient mental health clinic (e.g., Prolonged Exposure, Cognitive Processing Therapy, Eye Movement Desensitization or Reprocessing Therapy) to soldiers after receiving a referral from a primary care physician (Cigrang et al., 2011). This way, soldiers could receive immediate mental health care following a primary health care appointment instead of making a separate appointment at the mental health clinic on base. This process change may reduce the numbers of people in the emergency room, which remains one of the preferred treatment methods of many African Americans. This change may reduce concerns that one’s peers and leaders would judge mental health help-seeking behavior because less time is spent out of the office. Likewise, the risk of being seen by other military members in the mental health clinic is reduced because all appointments would take place in the primary health care setting.

Providing online psychoeducation for the general society. Another change to the CSF2 program includes the addition of psychoeducation about African Americans for the general society. The program advertises an internet webpage that provides information about the mental health of African American soldiers. Clinicians, military personnel, and others interested in gaining more knowledge about African Americans and their healthcare could utilize this site. The website offers psychoeducation on psychopathology in African American soldiers, multicultural competence, and culture specific factors. For example, the website could educate society about the continuing forms of racism (e.g., microaggressions) that may occur
unintentionally in daily social contexts and provide links to implicit association tests. Additionally, ART highlights specific concepts related to African Americans, such as cultural mistrust of members of the dominant society that could impede communication between a soldier and provider. The website presents the information on multicultural competence as a way of promoting bonds and respectful interactions among military members and increasing camaraderie by understanding one another’s worldview.

Pillar 1: Culturally Sensitive Assessment

The first pillar of ART, culturally sensitive assessment of African American soldiers, consists of three types of online questionnaires: (a) baseline/outcome measures of mental health symptoms and well-being; (b) Africentric assessments of clients’ racial identities and cultural contexts; and (c) the original assessment found in the CSF2 program of the four dimensions of strength: social, emotional, family, and spiritual (adapted for African American soldiers and their family members by African American assessment experts). The addition of the baseline and cultural assessment provides a rich and holistic description of each soldier. The information obtained from these questionnaires is available for medical providers in the electronic medical records so that culturally sensitive informed decisions and treatment interventions can be provided based on each soldier’s assessment profile. Several critical components of culturally sensitive assessments are discussed before a description of the specific baseline measures.

Critical components of culturally sensitive assessment. When assessing personality characteristics and baseline mental health status of racial and ethnic minority soldiers, clinicians need to understand four critical issues that African American soldiers contend with: (a) racism (Friedman, Schnurr, & McDonough-Coyle, 1994); (b) their relationship with the dominant culture in the military (Lusted, 2013); (c) the retention of their cultural heritage in both
Multicultural competence. Multicultural competence is necessary for cross-cultural personality assessment. Multicultural competence refers to appreciating, recognizing, and working effectively with people from diverse cultural groups (Sue, 1998). Three important concepts related to multicultural competence include scientific mindedness, dynamic sizing, and culture specific expertise (Sue, 1998). Scientific mindedness refers to formulating and testing cultural hypotheses in the therapeutic relationship in place of settling on premature clinical judgments. Dynamic sizing refers to knowing when to generalize and when to individualize in case conceptualization and treatment. Last, culture specific expertise relates to knowing the worldview of a client and understanding the sociopolitical forces operating in the client’s contexts, and having skills needed to work with specific cultural groups that have a history and culture specific to the group (i.e., African American experience is different from Latino immigrant experience). These three characteristics aid the clinician in providing culturally competent assessment. ART trainers will assess their level of multicultural competence by taking the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), along with their reflections made during the journal writing portion of the monthly focus groups.

Acculturation. It is important to understand the concept of acculturation when performing personality assessments. Acculturation refers to a dynamic and contextual process that involves (a) the acquisition of the dominant group’s (mainstream acculturation) cultural
beliefs, behaviors, and values and (b) the relinquishment or retention of one’s culture of origin (Hwang, Wood, & Fujimoto, 2010). Acculturation is important to consider when assessing and understanding foreign-born, first generation immigrants who attempt to adapt (a) to mainstream European American ideologies and cultural practices and (b) to different family dynamics and communications, as these are related to parental relationships with U.S-born, second generation children of immigrants (Roysircar, in press). It is important to distinguish between acculturation and ethnic identity: “Acculturation adaptation is a response to the dominant group, while ethnic identity is a response to one’s ethnic group” (Sodowsky & Lai, 1997, p. 213), with regard to affiliating and having a sense of belonging with one’s culture of origin, ethnicity, or ethnic group (Roysircar-Sodowsky & Maestas, 2000).

According to Berry’s (2001) acculturation model, there are two dimensions to cultural adaptation: the rejection or retention of one’s native culture and the rejection or retention of the dominant group. These dimensions are understood in terms of (a) integration (i.e., when clients identify with their native culture and the dominant culture, indicating biculturalism); (b) assimilation (i.e., interactions only with the dominant culture and rejection of the native culture); (c) separation (i.e., avoidance of dominant culture while holding onto the native culture); and (d) marginalization (i.e., low connection with both cultures with regard to cultural identity and social interactions; Berry, 2001). It is imperative to understand clients’ acculturation adaptation and level of such an adaptation style (e.g., high, medium, low) when assessing for personality traits, because acculturation may moderate personal, social, emotional, and cognitive responses (Berry, 2001).

**Using emic and etic perspectives.** Clinicians should utilize both an emic and an etic perspective when performing cross-cultural assessment to understand unique cultural contexts of
clients, as well as similarities of clients across cultures (Draguns, 1996). As a review, an emic perspective identifies behaviors from within a culture system, while etic identifies behaviors from outside the system across various cultures (Triandis & Marin, 1983). An emic perspective incorporates constructs, behaviors, or contexts that are unique to an individual and focuses on the values and goals intrinsic to the person’s society (Draguns, 1996). Thus, an emic approach focuses on studying the idiographic differences within a culture, while an etic approach focuses on studying similarities and differences among people from different cultures by using a framework of comparison.

**Ethics code.** According to the American Psychological Association (2002; 2010), the Ethical Principles of Psychologists and Code of Conduct (i.e., the Ethics Code) provides clinicians standards of professional conduct. Within the Ethics Code is the standard to (a) aspire to the highest possible standard of ethical conduct within one’s expertise and (b) take steps necessary to resolve conflicts that prevent the clinician from upholding the ethical standard (Principle A: Beneficence and Non-maleficence and Principle B: Fidelity and Responsibility; APA, 2010). Thus, clinicians must aspire to uphold the highest possible standards when assessing personality characteristics of clients from racial and ethnic minority groups. Clinicians must make efforts to utilize multicultural competency and cultural sensitivity, while also taking steps to further their knowledge, consulting with other professionals in the mental health field, and obtaining knowledge about the client’s cultural contexts (APA, 2003).

**DSM-5.** One way that clinicians can gather more information about the client’s cultural context includes the use of the *Diagnostic and Statistical Manual of Mental Disorders, 5th* edition (*DSM-5*; ApA, 2013). This manual includes criteria to reflect cross-cultural variations in manifestations of disorders, provides structured information about cultural concepts of distress,
and includes a clinical interview tool. The clinical interview tool, the Cultural Formulation Interview (CFI), helps clinicians to assess cultural factors (i.e., cultural definition of the problem, causes, stressors, support, role of cultural identity, self-coping, past help-seeking, barriers, and preferences), that influence the client’s perspectives, behaviors, responses, and treatment options. Clinicians can utilize this interview in addition to personality assessments to obtain a more holistic view of the client.

**ART assessment battery.** The assessment portion of ART is divided up into three parts: (a) baseline measures to assess distressing symptoms as well as measures of well-being and protective factors; (b) cultural context measures that assess for racial identities, acculturation adaptation and their levels, and contextual information; and (c) the original resilience assessment measures described in the CSF2 program. The addition of the assessment of protective factors and cultural contexts provides a holistic snapshot of each African American soldier that takes into account the Africentric perspective of communalism and religiosity/spirituality, racial identity, as well as extended family and kinship networks. See Table 3 for a depiction of the ART assessment battery.
Table 3

*Structure of the ART Assessment Battery*

<table>
<thead>
<tr>
<th>Measures for African American Soldiers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Outcome Measures of Psychopathology and Well-being</strong></td>
</tr>
<tr>
<td>a. Symptom Checklist-90-R (SCL-90-R)</td>
</tr>
<tr>
<td>b. PTSD Checklist from DSM-5 (PCL-5)</td>
</tr>
<tr>
<td>c. Brief Resilience Scale (BRS)</td>
</tr>
<tr>
<td>d. Flourishing Scale (FS)</td>
</tr>
<tr>
<td>e. Steen Happiness Index (SHI)</td>
</tr>
<tr>
<td><strong>2. Cultural Context Measures</strong></td>
</tr>
<tr>
<td>a. Cultural Context Questionnaire (CCQ)</td>
</tr>
<tr>
<td>b. Multidimensional Model of Racial Identity (MMRI)</td>
</tr>
<tr>
<td>c. African Self-Consciousness Scale (ASC)</td>
</tr>
<tr>
<td>d. Multicultural Experience Inventory (MEI)</td>
</tr>
<tr>
<td><strong>3. Original CSF2 Resilience Assessment</strong></td>
</tr>
<tr>
<td>a. General Resilience Measure (GRM), formerly known as the Global Assessment Tool</td>
</tr>
</tbody>
</table>
Part one of Pillar 1: Outcome measures of psychopathology and well-being. The first pillar of ART consists of outcome measures of psychopathology and well-being. The assessment measures and psychometric properties are described below.

*Symptom Checklist-90-R.* The first portion of the assessment battery determines one’s current level of functioning and serves as a baseline for future assessment tests. Soldiers will take two types of assessment questionnaires: those focusing on psychopathology and those focusing on well-being and protective factors. The first set of questionnaires includes the Symptom Checklist-90-R (SCL-90-R; Derogatis & Savitz, 2000). The SCL-90-R measures nine primary symptom dimensions that cover a broad range of mental health conditions: somatization (i.e., experiencing psychological distress in the form of somatic symptoms); obsessive-compulsive (i.e., intrusive thoughts and repetitive behaviors); interpersonal sensitivity (i.e., the ability to accurately assess others’ abilities, states, and traits from nonverbal cues); depression (i.e., a mood disorder that causes persistent feelings of sadness and loss of interest); anxiety (i.e., an unpleasant state of inner turmoil, often accompanied by nervous behavior, somatic complaints, and rumination); hostility (i.e., a form of emotionally charged angry behavior); phobic anxiety (i.e., fear and anxiety that is triggered by a specific stimulus or situation); and paranoid ideation (i.e., intense beliefs of mistrust or the malicious intentions of others).

The SCL-90-R can be useful for monitoring a client’s progress over time. This relatively brief self-report instrument consists of a 5-point Likert rating scale with 90 items. The measure takes 12-15 minutes to administer, yielding nine scores along the nine primary symptom dimensions. Regarding internal consistency and reliability, The SCL-90-R has a Cronbach’s alpha of .85 and a test-retest reliability of .84 for the instrument development study (Derogatis & Savitz, 2000).
Three global indices can also be obtained by the SCL-90-R: (a) Global Severity Index (GSI), which is designed to measure overall psychological distress; (b) Positive Symptom Total (PST), which is designed to report the number of self-reported symptoms; and (c) Positive Symptom Distress Index (PSDI), which is designed to measure the intensity of symptoms. The test results produce a profile of raw and normalized T scores for the nine symptom scales and three global indices. T score profiles are based on one of four norm groups: (a) adult psychiatric outpatients, (b) adult psychiatric inpatients, (c) adult non-patients, and (d) adolescent non-patients. In addition to a profile of scores, a narrative report provides an overview of the client’s symptoms. If soldiers obtain a high GSI (i.e., 2 standard deviations above the mean), then further assessment will verify symptom severity using instruments such as the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) or the Beck Anxiety Inventory (BAI; Beck & Steer, 1993).

**PTSD Checklist for DSM-5 Diagnosis.** In addition to the SCL-90-R, all soldiers will take the PTSD Checklist for DSM-5 diagnosis (PCL-5; Weathers et al., 2013). See the definition of terms section in Chapter 1 for a comprehensive definition of PTSD according to the *DSM-5* (ApA, 2013). The PCL-5 is the newest self-report measure that assesses 20 *DSM-5* symptoms of PTSD that can be used to screen clients for PTSD, make a PTSD diagnosis, and monitor symptom change before, during, and after treatment. The PCL-5 is a 20-item self-report measure with a Likert scale of 0-4 for each symptom, with 0 representing “not at all” and 4 representing “extremely.” The measure takes approximately 5-10 minutes to complete. The measure produces a total symptom severity score (ranging from 0 to 80) by summing the scores for the 20 items. A PTSD diagnosis can be made by noting items rated as a 2 (i.e., “moderately”) or higher, as well as noting items selected that have the *DSM-5* diagnostic criteria of 1 cluster B
item/intrusion (items 1-5), 1 cluster C item/avoidance (items 6-7), 2 cluster D items/negative alterations in cognitions and mood (items 8-14), and 2 cluster E items/alterations in arousal and reactivity (items 15-20). There is a PCL-5 cut-off score of 38 for a PTSD diagnosis. The psychometrics are not available yet for the PCL-5 but the previous edition (PCL) has a Cronbach’s alpha between .94 (Blanchard, Jones, Alexander, Buckley, & Forneris, 1996) and .97 (Weathers et al., 1993), and a test-retest reliability of .96 (Blanchard et al., 1996).

The PCL-5 does not have the previous three versions for different groups with PTSD: PCL-M (military), PCL-C (civilian), and PCL-S (specific). Instead, only one version of the PCL-5 exists, but three formats of the measure exist: (a) one without the Criterion A component (i.e., a stressor); (b) one with the Criterion A component (i.e., a stressor); and (c) one with the revised Life Events Checklist (LEC-5) and the Criterion A component. Since the PCL-5 represents the DSM-5 criteria for PTSD (and is not compatible with the previous DSM-IV-TR edition), it is important to distinguish the criteria for PTSD in both diagnostic manuals. There are several changes made regarding PTSD symptom criteria. See Tables 4 and 5 for a depiction of the PTSD criteria changes.
Table 4

*Changes in DSM PTSD Criteria*

<table>
<thead>
<tr>
<th>DSM-IV-TR (3 Clusters)</th>
<th>DSM-5 (4 Clusters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Re-experiencing</td>
<td>1. Intrusion</td>
</tr>
<tr>
<td>2. Avoidance/Numbing</td>
<td>2. Avoidance</td>
</tr>
<tr>
<td>3. Increased Arousal</td>
<td>3. Negative Alterations in Cognitions and Mood</td>
</tr>
<tr>
<td></td>
<td>4. Alterations in Arousal and Reactivity</td>
</tr>
</tbody>
</table>
Table 5

Changes in *DSM PTSD Criteria*

<table>
<thead>
<tr>
<th>DSM-IV-TR</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PTSD listed under anxiety disorders chapter.</td>
<td>1. PTSD listed in a separate chapter on Trauma or Stress-Related Disorders.</td>
</tr>
<tr>
<td>2. 3 diagnostic clusters.</td>
<td>2. 4 diagnostic clusters.</td>
</tr>
<tr>
<td>3. Explicit subjective emotional reaction to a traumatic event required.</td>
<td>3. Criterion A2 (subjective reactions) has been eliminated, along with specifiers.</td>
</tr>
<tr>
<td>4. Specifiers: Acute PTSD (&lt;3 mo.) Chronic PSTD (&gt;3 mo. or more) Delayed Onset PTSD (onset of symptoms is 6 months+).</td>
<td>4. The 1st criterion is more explicit than the DSM-IV-TR for what constitutes a traumatic event (e.g., sexual assault is included).</td>
</tr>
<tr>
<td>5. Axis I diagnosis on multiaxial assessment system.</td>
<td>5. Diagnostic thresholds have been lowered for children and adolescents.</td>
</tr>
<tr>
<td></td>
<td>6. Subtypes: PTSD Preschool Type (&lt;6-years-old). PTSD Dissociative Type.</td>
</tr>
<tr>
<td></td>
<td>7. No Axis I diagnosis (no multiaxial assessment).</td>
</tr>
</tbody>
</table>
**Brief Resilience Scale.** The Brief Resilience Scale (BRS; Smith et al., 2008) measures resilience, which is the ability to bounce back or recover from stress. This scale is one of the first of its kind to measure resilience directly by measuring the ability to recover from stress (most scales measure protective factors that might facilitate a resilient outcome, but do not measure resilience per se). Smith et al. (2008) believed that resilience consists of a meaningful life (purpose), perseverance, self-reliance, equanimity, and coming home to oneself (i.e., similar to existential aloneness). The BRS is a six-item questionnaire that measures the above constructs and takes less than two minutes to complete. The BRS is scored by reversing items 2, 4, and 6, and then finding the mean of the six items. High scores reflect high levels of resilience. Specific cut-off scores and population norms are not available for this measure. However, researchers have found that a mean BRS score ranged from 3.53 in an undergraduate sample to 3.98 in a sample of cardiac patients (Smith et al., 2008). The BRS has a Cronbach’s alpha of .86 and a test-retest reliability of .69 for the instrument development study (Smith et al., 2008).

In a literature review of resilience scales, the BRS was one of three resilience scales that had the strongest psychometric properties (Windle, Bennett, & Noyes, 2011). However, the reviewers noted that this measure reflects a sense of personal agency focusing on resilience at the individual, intrapersonal level only. This measure does not account for an individual’s resilience competencies resulting from a person’s interactions with contextual factors (e.g., social support, family, religious institutions, mentors; APA, 2008; Masten & Powell, 2003; Windle et al., 2011).

**The Flourishing Scale.** The Flourishing Scale (FS; Diener et al., 2010) is a measure of a client’s self-perceived success in psychosocial flourishing. Flourishing refers to a respondent’s self-perceived success in important areas such as relationships, self-esteem, purpose, and optimism (Diener et al., 2010). The FS is an eight-item questionnaire that consists of a Likert
scale (ranging from 1-7), with a 1 representing “strongly disagree” and 7 representing “strongly agree”). The scale provides a single psychological well-being score, which is obtained by adding the responses for all eight items. The score may range from 8 to 56. A high score is indicative of a client with many strengths and resources. The FS has a Cronbach’s alpha of .87 and a test-retest reliability of .71.

The FS describes important aspects of human functioning (e.g., positive relationships, feelings of competence, and having purpose in life). The developers of this scale believe that several universal human psychological needs exist, such as the need for relatedness, self-acceptance, and competence; which are all measured by this scale. The FS is a trait measure and does not cover a person’s strengths, skills, and competencies when responding to contexts.

**Steen Happiness Index.** The Steen Happiness Index (SHI; Seligman et al., 2005) was developed to capture upward changes in levels of overall happiness. Happiness refers to experiencing and savoring pleasures (i.e., the pleasant life); losing the self in engaging activities (i.e., the engaged life); and participating in meaningful activities (i.e., the meaningful life) (Seligman et al., 2005). The SHI measures changes in happiness based on how the client experiences positive emotions, engagement, and a sense of meaning in one’s life (i.e., Seligman’s original theory of happiness and well-being). This questionnaire can be used as a baseline of measure of authentic happiness (i.e., real, lasting happiness), as well as an indicator of change. The SHI is currently referred to as the Authentic Happiness Inventory and has changed from a 20 item questionnaire to a 24 item questionnaire (Seligman et al., 2005). The scores range from a 1 to a 5, with a 5 indicating the highest levels of authentic happiness. The online report profile provides a percentage comparison of a person’s score to all web-based test takers, gender, race/ethnicity, age group, occupational group, education level, and zip code. The
SHI has a Cronbach’s alpha of .88 and a test-retest reliability of .87 in the instrument development study (Seligman et al., 2005).

**Part two of Pillar 1: Cultural context questionnaires.** After taking the outcome measures on negative symptoms and well-being, African American soldiers will take a battery of questionnaires to measure cultural and contextual functioning for treatment considerations. These questionnaires focus on racial identity, acculturation level, and African self-consciousness. These assessment measures provide a holistic assessment of an African American soldier and provide contextual information on values, beliefs, perspectives, and identity self-conceptualization.

**Cultural Context Questionnaire.** The first questionnaire given to African American soldiers serves to educate medical professionals on how to better understand certain cultural contexts of a soldier. The rest of the cultural context measures assess the soldiers’ racial identity and experiences as an American racial minority person. The Cultural Context Questionnaire (CCQ) has been adapted from the Cultural Formulation Interview (CFI) in the *DSM-5* (ApA, 2013) to meet the needs of African American soldiers. This assessment has been modified from the CFI to better capture the assessment needs of African American soldiers. The CCQ is a 30-item questionnaire, addressing cultural factors such as one’s social support networks, church affiliation, and culture-specific stressors. Some of the items from this questionnaire include: (a) Briefly describe your social support system, (b) Describe your particular church affiliation (if applicable), (c) What are some of your family traditions, and (d) What are the most important aspects of your background or identity? See Appendix C for the CCQ. This questionnaire is not scored quantitatively, but rather informs about protective factors or risk factors to aid in the soldier’s treatment.
**Multidimensional Model of Racial Identity.** The next measure in this series is the Multidimensional Model of Racial Identity (MMRI), which synthesizes ideas from several existing models of African American racial identity (Sellers et al., 1998). The MMRI defines racial identity as the part of the client’s self-concept that is related to race. The MMRI embodies a phenomenological approach because it focuses on self-perceptions. Thus, the most valid indicator of racial identity is assumed to be the client’s own perception.

This measure proposes four dimensions of African American racial identity: (a) the centrality of the identity (i.e., the extent to which one normatively defines oneself with respect to race); (b) the salience of identity (i.e., the extent to which one’s race is relevant to one’s self-concept at a particular point in time); (c) the ideology associated with the identity (i.e., the client's beliefs, opinions, and attitudes with respect to the ways how African Americans should act); and (d) the regard in which a person of color holds African Americans (a client's evaluative judgment of his or her race). Thus, the first two dimensions focus on race regarding a client’s self-definition while the second two dimensions focus on the qualitative meaning of being African American.

**African Self-Consciousness Scale.** In addition to the MMRI, the African Self-Consciousness Scale (ASC; Baldwin, 1985) is used. The ASC is a 42-item, 8-point Likert scale (1=very strong disagree, 8=very strongly agree) used to assess four basic components of African American self-consciousness: (a) awareness of one’s collective African American identity and heritage; (b) general ideological priorities placed on African American survival and pro-affirmative development; (c) specific activity priorities placed on African self-knowledge, rituals, customs, and institutions; and (d) resistance toward anti-African American forces and threats to African American survival in general. The ASC also involves six dimensions that
include education, family, religion, interpersonal relations, cultural activities, and political orientation. Thus, this scale measures personal adherence to the Africentric worldview. The ASC has strong test-retest reliability, with a Cronbach’s alpha of .90 (Baldwin & Bell, 1985).

**Multicultural Experience Inventory.** The last cultural and contextual assessment for African American soldiers is the Multicultural Experience Inventory (MEI; Ramirez, 1998). This 16-item questionnaire serves to help clients explore and to become more aware of the extent of their early and present day experiences with cultural diversity. The first eight items cover early life experiences while the last eight items cover current experiences with various racial and ethnic groups. The results of this questionnaire are especially helpful for clinicians and mental health professionals to gain a clearer picture of a soldier’s early experiences and current preferences. This open-ended questionnaire serves to help clinicians obtain a holistic view of the soldier’s experiences, as well as to increase personal awareness of contact with racial and ethnic diversity within the soldier.

**Part three of Pillar 1: The original CSF2 resilience assessment.** The last section of the culturally sensitive assessment of ART consists of the original resilience assessment found in the CSF2 program. The CSF2 program uses the Global Assessment Tool (GAT) as a self-report that measures psychosocial fitness in emotional, social, family, and spiritual domains. The GAT has been renamed the General Resilience Measure (GRM) in ART. The GRM, following the same format of the GAT, consists of 16 subscales to measure these four dimensions above. The emotional fitness domains includes the following subscales: (a) adaptability, (b) bad coping, (c) good coping, (d) catastrophizing, (e) character, (f) depression, (g) negative affect, (h) positive affect, and (i) optimism. The family fitness domain includes (j) family satisfaction and (k) family support, while the social fitness domain includes (l) engagement, (m) friendship, (n)
loneliness, and (o) organizational trust. Last, the spiritual domain consists of one subscale of spiritual fitness. The GRM produces a single score of soldier reported resilience and psychological health, also known as the R/PH score. This score is used for program evaluation. Unlike the BRS, a trait measure, the GRM measures a person’s resilience outcomes when interacting in certain contexts.

The original GAT is not accessible to the public, so the author cannot further describe this measure. The CSF2 program has recently granted immediate family members access to their program (e.g., spouses with military identification cards). The name has been changed from the Comprehensive Soldier Fitness Program (CSF) to the Comprehensive Soldier and Family Fitness Program (CSF2) within the past two years. However, siblings, extended family, and kinship networks do not have direct access to the CSF2 program material. ART, on the other hand, is accessible to all extended family members of the soldier, to accommodate African American kinship networks.

**Pillar 2: Culturally Sensitive Online Training Modules**

After soldiers complete the culturally sensitive assessment that measures baseline symptoms and wellbeing, cultural contexts, and psychological strength, they will participate in culturally sensitive online training modules. The culturally sensitive online training modules have a two part focus: (a) psychoeducation on African American soldiers’ mental health issues and (b) resilience training.

**Part one of Pillar 2: Curriculum for African American psychoeducation.** The curriculum for African American psychoeducation is based on the literature review in Chapter 2, which describes the protective factors and risk factors for African Americans. Protective factors are taught first to re-assure African Americans about common capacities and strengths, in an
empowering and positive psychology based approach. This research is used to educate African American soldiers on ways in which their strengths can be used in clinical treatment, as well as to educate them on varying psychopathology and symptom manifestation. See Table 6 for a depiction of the psychoeducation curriculum procedures.
Table 6

*Online African American Psychoeducation Curriculum Process*

<table>
<thead>
<tr>
<th>Procedures</th>
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| How        | 12 total online training modules.  
|            | 6 modules on risk factors for African American soldiers.  
|            | 6 modules on protective factors for African American soldiers.  
|            | Online certificate of completion awarded at the end of 12 modules.  
|            | Certificates to be emailed to military personnel in charge of records.  |
| When       | Annual online training to be completed January-February.  
|            | Soldiers have up to 2 months to complete the training.  |
| Where      | Administered on Department of Defense computers.  
|            | All soldiers to have personal online ART account to log into.  |
Protective factors for African American soldiers’ mental health. The first part of the psychoeducation curriculum on African American mental health includes protective factors, which are described below.

I. The Africentric worldview. This section discusses the importance of the Africentric worldview and how this is a protective factor for many soldiers. Soldiers will learn about how the Africentric worldview or belief system promotes resilience through communal support and spiritual growth (Neville et al., 2009; Parham et al., 2010) and how adherence to this worldview correlates with high self-esteem and life satisfaction (Constantine et al., 2006). See Chapter 2 for a more comprehensive description of the Africentric worldview. Soldiers are also provided references for books that describe the Africentric worldview (cf. Myers, 1993), Understanding an Afrocentric Worldview: Introduction to an Optimal Psychology. The purpose of this section is to describe the Africentric worldview and teach soldiers how to cultivate a deeper appreciation of the perspective, both for those African American soldiers who have had a limited exposure to African cultural constructs and those who deeply identify with their original African cultural heritage.

II. Having an African American racial identity. This section discusses the positive effects and health benefits of having a positive racial identity and how this identity orientation makes one strong when facing different forms of racism or discrimination. Soldiers will learn about the three prominent racial identity models. Soldiers will learn about Cross’s (2001) and Helms’s (1995) racial identity models that focus on an African American’s developmental progression when responding to oppression by European Americans. Soldiers will also learn about Sellers and his colleagues’ (1998) model that focuses on multidimensional aspects including the meaning and importance of being African American. See Chapter 2 for a more
comprehensive description of these racial identity models. The purpose of this section is to introduce African American racial identity models to help soldiers use their racial identity as a source of strength during difficult times.

**III. Turning to faith.** This section describes the many health benefits of following an institutionalized religion or engaging in an individualistic spiritual practice. Soldiers will learn that when African Americans turn to religion and spirituality, they are increasingly able to adapt to challenging times (Neville et al., 2009) and that African American churchgoers reported lower levels of family, financial, and work-related stressors than those African Americans who did not attend church services (Ellison et al., 2001). Soldiers also learn that spirituality has been demonstrated to reduce stress, reduce the risk of depression, and increase self-esteem among caregivers (Picot et al., 1997). They also learn how religion serves as a protective factor against suicide in many African Americans (Greening & Stoppelbein, 2002) and that religious institutions provide a social support system, social activities, the recognition of personal achievements of members, and an alternative family system for African Americans (Neville et al., 2009). Soldiers will also receive information on religious services on post and church services in the local community. See Chapter 2 for a more comprehensive description of the benefits of religiousness and spirituality. The purpose of this section is to educate soldiers on the many benefits of religious practice and spirituality and to provide resources for religious practice.

**IV. Importance of family and community.** This section describes the health benefits of family, extended family, and community members. Soldiers will learn that many African Americans believe that the family is crucial to the existence of the individual (APA, 2008). Moreover, soldiers learn how many African Americans live with extended family members or
intergenerational family networks that provide support for the family and African Americans remain more likely to care for older adults instead of placing them in institutions (Tennstedt & Chang, 1998). They learn that family members can particularly help to modulate against the effects of stress, racism, and oppression (LaTaillade, 2006; Utsey et al., 2006) and how many African Americans are more likely than European Americans to rely on family members before seeking psychotherapy (Constantine et al., 2000). See Chapter 2 for a more comprehensive description of the importance of extended family and kinships for African Americans. The purpose of this section is to educate soldiers on the many benefits of extended family members and kinship networks and provide printable resources and websites to trace one’s family tree and to reach out to family members. This section will help soldiers gather information about their own extended family and help them use their networks as a source of strength.

**V. Collectivism.** This section describes the protective factors involved with having a collectivism orientation and the differences soldiers may encounter when dealing with someone with an individualistic orientation. Soldiers will learn how communalism may serve as a protective factor against stress (Moore & Penk, 2011). They will learn how in collectivistic cultures, the motivation for behavior stems from social context or interdependence (Markus & Kitayama, 1991) and how this communal perspective (i.e., valuing the group over the individual) may serve to mitigate symptoms of depression in African Americans (Penninx et al., 1998). See Chapter 2 for a more comprehensive description of communalism/collectivism for African Americans. The purpose of this section is to educate soldiers on the benefits of communalism/collectivism and to help differentiate the cultural barriers to communalism and individualism in U.S. societies. Soldiers are taught how to effectively engage with individuals from both perspectives through taped role-plays and psychoeducation.
VI. More hope, less suicide. This section reports research on protective factors of African Americans well-being, along with their lower suicide levels. Soldiers will learn that African Americans have reported higher levels of flourishing (i.e., positive emotions/emotional well-being, positive psychological functioning/psychological well-being, and positive social functioning/social well-being) than their European American counterparts (Keyes, 2007). They will also learn that higher levels of hope in African Americans have been found to correlate with higher levels of life satisfaction (Adams & Jackson, 2000) and that African Americans with high levels of hope tend to cope better with racism stressors because they can develop new routes to success (Adams, 2003). See Chapter 2 for a more comprehensive description of high levels of flourishing and hope in African Americans. The purpose of this section is to educate soldiers on the protective factor of hope and to provide them with resources on base for suicide prevention and emergency psychiatric services.

Risk factors for African American soldiers’ mental health. The second part of the psychoeducation curriculum on African American mental health includes risk factors, which are described below.

I. Mental Illness in African Americans. This section provides an overview of the rates of psychopathology in African American soldiers. Soldiers will learn how African Americans have higher rates of mental illness and disability (Robins & Regier, 1991; Williams et al., 1997), and more morbidity and mortality rates than European Americans (Neville et al., 2009). Additionally, soldiers learn that African Americans have more debilitating and persistent psychopathology than European Americans (Breslau et al., 2005). Next, this section highlights that clinicians have diagnosed African Americans with schizophrenia more frequently than European Americans (80% in African Americans vs. 55% in European Americans; Garb, 1997)
and have under-diagnosed African Americans with depression more than their European American counterparts (Baker & Bell, 1999; Brown et al., 1995). See Chapter 2 for a more comprehensive description of psychopathology assessed in African Americans. The purpose of this section is to introduce the varying rates of mental illness in African Americans and to highlight the importance for African Americans to discuss symptoms with their medical professionals to receive a correct diagnosis.

II. The different faces of PTSD. This section provides an overview of the different rates of PTSD and how African American soldiers display the symptoms differently than other soldiers. Soldiers will learn that African American soldiers have higher rates of PTSD (20.6%) than their European American counterparts (13.7%), and present PTSD symptoms differently (Kulka, et al., 1990; Ruef et al., 2000). This section also describes how racial and ethnic minority soldiers are more likely to be diagnosed with PTSD by clinicians (Green et al., 1990; Ruef et al., 2000) and are at an increased risk for PTSD (Brewin et al., 2000). Additionally, soldiers learn about the existence of racial differences in psychotic symptoms experienced by combat veterans with PTSD, with African American soldiers experiencing higher rates of psychosis and paranoid ideations (Frueh et al., 1998; Frueh et al., 2002). Soldiers learn that other African American soldiers have experienced more dissociative symptoms than European American soldiers in the past (Frueh et al., 1996). Last, soldiers learn about the National Vietnam Veterans Readjustments Survey, which found that the differences in PTSD rates in African Americans and European Americans largely disappeared when factors such as pre-existing trauma and level of combat trauma were taken into account (Kulka et al., 1990). See Chapter 1 and 2 for a more comprehensive description of PTSD in African Americans. The purpose of this section is to highlight the different manifestations of PTSD in African American
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soldiers and how to discuss their PTSD symptoms with clinicians with clarity (e.g., focusing on both mental and physical aspects of the disorder).

II. The lasting effects of racism. This section provides an overview of the history of discrimination in the military, different kinds of racism and discrimination practices that exist in today’s society, and a description of the lasting physical and psychological effects. For example, soldiers are taught that high levels of discrimination correlate with a poorer mental health status (Williams et al., 2003). Additionally, soldiers learn how racism-related stress has been related to obsessive-compulsive disorder (Klonoff, Landrine, & Ullman, 1999), anxiety (Harrell et al., 2003), depression (Taylor & Turner, 2002), feelings of hopelessness (Nyborg & Curry, 2003), and psychological distress (Pieterse & Carter, 2007). Physically, experiences of racism and discrimination have been correlated with heightened blood pressure and hypertension (Bonham, Sellers, & Neighbors, 2004). See Chapter 1 for a more comprehensive description of the history of racism in the military and Chapter 2 for a description of the effects of racism. The purpose of this section is to learn about racism in the military and coping methods, such as assertiveness training and taped role-plays, to demonstrate how to deal with inappropriate communications in the military. Soldiers are also given resources for a patient advocate to talk to on base in this section.

III. When it is hard to trust my clinician. This section normalizes the healthy mistrust of clinicians that many African Americans hold. Soldiers will learn that most African American clients may withhold trust in the therapeutic relationship with a European American therapist until the therapist proves his or her trustworthiness (Griner & Smith, 2006; Terrell & Terrell, 1981; Vontress, 1971). As a result, many African Americans are more likely to visit their primary care physician or the emergency room, as opposed to seeking psychotherapy.
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Soldiers also learn that many African Americans often seek therapy only when they have severe issues, and they commonly terminate services prematurely (Lester et al., 2010; Rosenheck & Fontana, 1996). See Chapter 1 for a more comprehensive description of cultural mistrust of clinicians and Chapter 2 for a history of cultural mistrust of clinicians. The purpose of this section is to name the phenomenon of cultural mistrust and teach soldiers coping methods (e.g., assertiveness training) to talk with their doctors in a way that makes them feel more secure and trusting in their communications. This section also includes a discussion on cultural contexts and how to talk to a clinician about the importance of cultural contexts, using the Cultural Context Questionnaire (CCQ). The CCQ is described at the beginning of this chapter as part of culturally sensitive assessment of soldiers in Pillar 1 of ART.

**IV. Importance of utilizing mental health care.** This section discusses the common negative perceptions of and decreased use of services by many African Americans. Soldiers will learn that many African Americans tend to underutilize the mental health care system because of systemic barriers to access and racial distrust of mainstream mental health services (Snowden, 2001; Snowden & Lonnie, 1998). Soldiers also learn that many African Americans remain more likely to visit their primary care physicians or emergency rooms, than to engage in psychotherapy with a counselor; often seek therapy only when they have severe issues; and commonly terminate services prematurely (Cooper-Patrick et al., 1994; Lester et al., 2010; Morris, 2001; Rosenheck & Fontana, 1996). Last, soldiers learn that many African Americans prefer informal social supports to the mental health system, such as extended family, religious support systems, and community members (Mills & Cody-Rydzewski, 2012). See Chapter 2 for a more comprehensive description of the use of mental health care by African Americans. The
The purpose of this section is to teach soldiers about the importance of seeking mental health treatment early on and staying in treatment. Soldiers are also taught to effectively express their needs in therapy through assertiveness training and taped role-plays when things are not going as planned.

**V. The meaning of my symptoms.** This section discusses the variety of ways in which African Americans view their symptoms. Soldiers will learn that many African Americans may view mood disorders (e.g., depression) as personal weaknesses or character defects, rather than illnesses with an organic origin (Mills & Cody-Rydzewski, 2012) or due to contextual influences, such as racism and disempowerment. Soldiers also learn that many African Americans view mental health problems as internal spiritual problems instead of being biologically driven (Mills et al., 2004) or socially-based. See Chapter 2 for a more comprehensive description of the meaning and presentation of symptoms for African Americans. The purpose of this section is to describe the variety of reasons for mental illness symptoms, both biologically- and environmentally-based. Soldiers learn which problems are biologically-based (e.g., schizophrenia) and which problems are a combination of both nature and nurture (e.g., depression, PTSD, anxiety disorders). Soldiers are also provided resources (e.g., spiritual healing literature) to address treatment in a holistic way.

**Part two of Pillar 2: Culturally sensitive online resilience training.** Following the culturally sensitive online modules on African American soldiers’ mental health, soldiers will engage online in culturally sensitive resilience training. These training modules are modeled on the original training modules in the CSF2 program, but they are modified to meet the needs of African American soldiers through content changes. The resilience training consists of 20 online
modules that cover four dimensions of health: emotional, family, social, and spiritual. See Table 7 for a depiction of the culturally sensitive online resilience training process.
### Culturally Sensitive Online Resilience Training Process

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**Religious invocation.** The beginning of the resilience training has several optional religious invocations to click on before soldiers start the resilience training. The religious invocation involves elements of resilience in it. The following passage by Coretta Scott King (1960), the wife of Reverend Martin Luther King Jr., includes several lines from a public prayer from a divine perspective:

Eternal and everlasting God, who art the Father of all mankind, As we turn aside from the hurly-burly of everyday living, may our hearts and souls, yea our very spirits be lifted upward to Thee, for it is from Thee that all blessing cometh. Keep us ever mindful of our dependence upon Thee, for without Thee our efforts are but naught. We pray for Thy divine guidance as we travel the highways of life. We pray for more courage. We pray for more faith and above all we pray for more love.

See Appendix D for the full, optional invocation that is included at the start of the online resilience training modules.

**Collectivist examples.** The examples in the resilience training include various collectivist examples to portray the collectivist perspective of many African American soldiers. For example, the exercises in the culturally sensitive online training modules refer to groups of community members, family members, coworkers, or church members. One specific example is socially resilient teams, where soldiers learn how to build a cohesive unit that uses everyone’s unique characteristics and diversity to its advantage. Emphasis is placed on the collective team, where the whole group is greater and stronger than each individual member alone.

**African American names.** To be culturally responsive, a wide variety of African American male and female names are used throughout, when providing examples. Several common African American female names used (obtained from websites on popular African
American baby names) include Jasmine, Yolanda, Ashanti, Shanice, Terri, and Zima; while several common African American male names used include Demetrius, Tyrone, Jamal, Darnell, Andre, Darryl, and Maurice. The uses of these particular names are representative of the African American population.

**Optional materials to read.** At the conclusion of the online culturally sensitive resilience training, there is an optional link to click on inspiring and empowering novels with African American heroes. The list includes books to read, along with a short description of each piece of literature. Books are uploaded online and copies will be available at base libraries for easy access. Several book titles include *Black Heroes* (Smith, 2001), *The Words of African American Heroes* (Villarosa, 2011), *A History of African-American Leadership* (Dierenfield & White, 2012), and *Answering the Call: African American Women in Higher Education Leadership* (Bower & Wolverton, 2009). See Appendix E for a list of optional reading materials for soldiers.

**Pillar 3: Resilience Training by Multiculturally Competent Trainers**

The third pillar of ART entails a two part process: (a) resilience training and (b) training the trainers to be multiculturally competent. This part of the program requires multiculturally competent instructors because they must have the awareness of their own values, biases, and assumptions, in addition to understanding the client’s worldview in order to instruct African American soldiers in a multiculturally competent fashion. The more knowledgeable, skilled, and aware these instructors are on diversity issues, the more positive impact they can make on African American soldiers. See Table 8 for a depiction of the process for training the ART trainers to be multiculturally competent.
Table 8

*Process for Training ART Trainers to be Multiculturally Competent*

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| **How** | Monthly meeting:  
(a) 10 minutes for check-ins  
(b) 30 minutes for discussions/experiential activities/lectures  
(c) 10 minutes of reflective journal writing.  

Quarterly meeting:  
Trainers record their reflections and opinions of ART. |
| **When** | Trainings to be held on a monthly basis over a 1-year period.  
50-minute monthly meetings on the first Thursday of each month. |
| **Where** | Meetings to be held in a conference room on the military base or nearby. |
Part one of Pillar 3: Resilience training for soldiers. The third pillar of ART includes in-person resilience training for African American soldiers. The core foundation of the resilience training curriculum closely mirrors the CSF2 program’s curriculum. The CSF2 curriculum primarily uses a Cognitive Behavioral Therapy (CBT) approach, educating soldiers on modifying dysfunctional thinking and catastrophizing, while learning skills such as problem-solving and breathing techniques (CSF2, 2012). See Appendix B for a complete description of the CSF2 resilience training curriculum. See Table 9 for a depiction of the resilience training for ART.
Table 9

**Process for In-Person Resilience Training for African American Soldiers**

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Content changes. The core resilience training curriculum for soldiers follows the standard curriculum found in the CSF2 program. However, there are some positive psychology exercises (content changes) that are specifically tailored for African American soldiers. These exercises are described below.

Narratives. In addition to the standard resilience training curriculum found in the CSF2 program, the curriculum also includes positive psychology exercises tailored for African American soldiers. African Americans have a rich history of storytelling, so narrative communications about their positive mental health states may be especially effective. The first inclusion of tailored positive psychology exercises includes a detailed recording of when each soldier felt that they were “at their best” (i.e., when they were at their top mental, physical, social, or spiritual best). Soldiers will choose to perform a video recording, an audio recording, or a written account of this narrative. Soldiers have the option of recording with their family members or including excerpts from family members when recounting their best moment in history. Through the use of this narrative exercise, African American soldiers can express their Africentric worldview and racial identity by describing their strengths and virtues at a time when they felt at their absolute best. The following passage is an excerpt from a narrative of a female soldier when she was at her best:

Upon reflection, I was at “my best” when I graduated from field training (i.e., bootcamp) in the United States Air Force. I was in my sophomore year of college and I had just completed a rigorous, six-week program that involved physical fitness, weapons training, and survival training. I had never been happier in my life, riding home on the bus en route to the airport on the last day of field training. One trick that helped me get through field training was maintaining a mindset that I was serving in prison. This mindset
helped me mentally justify and accept the chronic punishment of physical exercise and yelling, while also dealing with the loss of personal freedom. I had never been more challenged physically, mentally, and spiritually in my life and I was proud of myself for persevering. Physically, I was in the best shape of my life after losing 30 pounds from the training and gaining additional muscle mass. Mentally, I felt confident that I could accomplish anything that I set my mind to. Emotionally, I felt connected to my field training team, as well as to my family members. My family and friends served as a strong support system, sending me countless letters and packages to keep me going through their words of encouragement.

See Appendix F for the complete narrative of a female soldier when she was at her best.

**Gratitude letter to a family member.** The next tailored positive psychology exercise includes writing a gratitude letter to the soldier’s family member (which includes extended family members and kinship networks). This exercise can be written to anyone, but it embodies the collectivism perspective and importance of family and kinship networks that many African American soldiers value. Soldiers will be asked to describe in great detail why they are thankful for having a particular family member and then are asked to present the letter in person to that family member. The following passage is an excerpt from a female soldier expressing writing about her gratitude towards her father.

I am grateful to my father because he has been there for me. He has always made me feel loved, appreciated, and respected. He gave me the space to be myself and was present as a supportive listener during my hardships, challenges, and struggles. He believes in me, even when I do not. He reminds me of my strengths when I forget them. He encourages me to pursue my dreams and to reach my goals. I am grateful for my father because he is
my rock. He has always made time for me. So I want to thank you “daddio” for all the time that you have spent with me. Thank you for showing up for so many events and being a large presence in my life. Thank you for all of the memories and the new ones to come. Thank you for being you.

See Appendix G for the complete narrative of a female soldier expressing her gratitude towards her father.

**Three good things exercise.** The next positive psychology exercise for African American soldiers includes writing down three positive interactions each night for a week. Soldiers will be asked to record positive events that they had each day and then write an explanation for why each event happened, incorporating elements from a list of protective factors for African Americans. The list includes the following protective factors: Africentric worldview, African American racial identity, religiosity and spirituality, family and kinship networks, communalism/collectivism, higher levels of hope and flourishing, and lower suicide rates. This exercise reminds African American soldiers about the myriad of strengths and virtues that they have, which are specific to them. The following passage is an excerpt from the three good things exercise:

Upon reflection, three good things happened today: (1) connecting with my clients during the day (2) receiving a package from a close friend and (3) going to see a movie and eating at a restaurant with another close friend. During the day, I saw several clients at my practicum site and I felt good about my interactions with all of them. I had been particularly worried about one of my clients recently because he was hospitalized for detoxification. However, we had an effective session today where he discussed his feelings towards his upcoming medical treatments that could be potentially fatal. It was
one of those days that went by quickly and effortlessly. When I got home from work today, I found a package in the mail from my close friend Jen. I laughed out loud when I felt the slightly lumpy, bright red package: my friend had mailed me a large bag of jelly beans! I had mentioned to her the other day that I was craving jellybeans but could not find any at the local store. She also sent me a thoughtful card for Valentine’s Day, which expressed her appreciation for our friendship. Her card was animated, filled with exclamation points, underlined words, and drawings. Receiving mail from Jen always puts a smile on my face and warms my heart. I truly appreciate her friendship, thoughtfulness, and kindness towards me. Later tonight, I went out to eat at a restaurant and see the movie “That Awkward Moment” at Dedham Legacy Place with my close friend Linda to celebrate her 33rd birthday. We enjoyed the dinner as well as the movie. My friend and I talked for hours and were the last ones to leave the restaurant at the end of the night. We did not notice our surroundings for a while because we were so engaged in our conversation; it felt like we were in the state of “flow” that Csikszentmihalyi writes about. It was so nice to connect with her again and hear about all her new house, relationship with her fiancé, family members, coworkers, and future plans. We always have a fun time when we get together and can easily relate to one another. I appreciate her humor, generosity, and authenticity.

See Appendix H for the full narrative from this exercise.

Values in Action questionnaire. The next positive psychology exercise for African American soldiers includes taking the Values in Action Inventory of Strengths (VIA-IS; Peterson & Seligman, 2004). The VIA is a 240-item self-report measure for adults in the United States. This inventory uses a five-point Likert style format to measure the degree to which clients
endorse items describing 24 signature strengths of character. The inventory produces a description of the top five signature strengths of the client, along with a ranked order of the remaining 19 strengths. This questionnaire takes about 25 minutes to complete. African American soldiers will take this inventory as a group and then discuss their results together. Soldiers discuss their top five signature strengths and the process of identifying these strengths. They have several questions to answer, such as, if their results surprised them, what it is like to identify these strengths, etc.

**Part two of Pillar 3: Training the trainers to be multiculturally competent**

ART trainers will consist of a diverse group of both military soldiers and civilian personnel. The initial group of trainers will consist of a core group of diverse trainers, including a majority of African American individuals. Clergy members are also included in the core group of trainers. All trainers meet once per month for a year to receive multicultural competence training that incorporates assessment, knowledge about African American culture, sociopolitical experiences, strengths, disorders, experiential activities, journal writing, and reflections on identity. They will also share their understanding and discuss challenges, diversity issues, and ethical situations that arise during these meetings.

**Psychoeducation about African American soldiers.** The first feature of the training curriculum includes learning the same curriculum that the African American soldiers receive: information on protective factors and risk factors for mental health. Trainers must be taught the same information that the soldiers receive so that they can be resources for questions or explanations on the contents of the curriculum. See Pillar 2 for a description of ART’s curriculum for African American soldiers. Trainers take the same online curriculum that African American
American soldiers engage in. Psychoeducation is further expanded on during monthly focus groups.

**Monthly focus groups.** The majority of the training occurs during monthly focus group meetings. Trainers will attend a monthly 50-minute focus group at the beginning of each month for a one-year period. The focus groups for trainers have a three-part process: (a) check-ins for 10 minutes; (b) discussions, experiential activities, discussions, or lectures for 30 minutes; and (c) reflective journal writing for 10 minutes. The check-ins consist of checking in with the status of every trainer in the group to see what questions may have come up during the training and to serve as an outlet for sharing news or venting frustrations.

**Experiential activity, discussions, and lectures.** The next part of the monthly focus group consists of 30 minutes of an experiential activity, a structured discussion, or a lecture on a topic. This time slot usually involves an element of psychoeducation for the trainers. An example of an experiential activity includes the Token Economy Game (Roysircar, 2011). The Token Economy Game helps to bring awareness of power differential in a social system by creating a social microcosm which involves experience of low access for those that do not have power and high access to those who have power. Another example of an experiential activity around diversity awareness includes asking the group questions such as: “What was your first experience feeling different?” “What do you like about your racial identity?” “What are your earliest memories about people from cultural backgrounds, socioeconomic classes, and religions other than your own?” Discussions and lectures focus on challenges or struggles with training African American soldiers, as well as successes and protective factors.

**Reflective journal writing.** The last 10 minutes are dedicated to reflective journal writing, where trainers write in a personal journal about their thoughts about the training of the
day and the current focus group. The reflective journal writing serves to allow space for trainer reflections on their values, biases, and assumptions that could affect their training in multicultural competence. Just as clinicians need to evaluate their individual perspective and viewpoints, so that they practice cultural empathy for clients’ diverse worldview, trainers need to reflect on their belief systems and biased thoughts as instructors in order to provide culturally competent training to African American soldiers.

**Provider evaluations.** Every four months (i.e., three times a year) during specifically designated meetings, ART trainers are asked to reflect and write on their opinions of ART as multiculturally competent trainers. Trainers are asked to reflect on the challenges, areas needing improvement, and successes of ART. This reflection and evaluative writing time occur during the experiential activity time period of the focus group meeting. The written reflections of the ART trainers are used for provider evaluation, an element of program evaluation.

**Pillar 4: Social Justice Advocacy Town Hall Meetings**

The addition of the social justice advocacy town hall meetings is the most unique aspect of ART. This pillar of the program extends beyond content and process changes and incorporates the application of social justice advocacy into the curriculum. Attendance at these meeting is not mandatory but highly recommended in order to inspire and empower African American soldiers towards societal change.

**Advocacy through the promotion of knowledge, skills, and awareness.** The social justice advocacy portion of ART will focus on the knowledge, skills, and awareness related to advocating for African American men and women in the Army. Since social justice advocacy is a professional attitude toward or activism about the acquisition of knowledge, skills, and awareness, the town hall meetings focus on guest speakers educating the audience on these
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concepts (i.e., knowledge, skills, and awareness). Speakers will discuss racial disparity in diagnosing African American mental health presentations. Speakers will also address racism, limited African American soldiers in top military positions, and triple minorities in the military (African American females and African American LGBTQ soldiers). Meetings will also focus on social justice advocacy at the public policy level, advocating for better services for African American soldiers. See Table 10 for a depiction of the social justice advocacy town hall meeting process.
### Process for Holding Social Justice Advocacy Town Hall Meetings

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**Structure of meetings.** The social justice advocacy town hall meetings will occur the first Friday of every month. Meetings are held at the end of the day on Fridays to allow for service members to attend after work and to promote the attendance of family members as well. All extended family members and friends are welcome to attend the meeting, as well as local clergy members and holistic healers. Meetings are advertised on base through base-wide emails, as well as through local advertisements in the community newspapers and flyers around the military base. The meetings last for two hours from 1600-1800. The first hour consists of a speaker (e.g., invited guest speaker, motivational speaker, clergy member, local politician, community member, family member, or service member), followed by a social gathering for the second hour. Food and coffee/tea are available during the meetings as well, to allow for extended socializing and the promotion of camaraderie.

**Religious invocation to start meeting.** The social justice advocacy town hall meetings will begin with a religious invocation for peace and blessings for all that attend. The following passage is an example of a religious invocation written by Reverend Martin Luther King Jr. (Baldwin, 2012, p. 139):

> O God, we thank you for the fact that you have inspired men and women in all nations and in all cultures. We call you different names: some call you Allah; some call you Elohim; some call you Jehovah; some call you Brahma; some call you the Unmoved Mover. But we know that these are all names for one and the same God. Grant that we will follow you and become so committed to your way and your kingdom that we will be able to establish in our lives and in this world a brother and sisterhood, that we will be able to establish here a kingdom of understanding, where men and women will live
together as brothers and sisters and respect the dignity and worth of every human being.

In the name and spirit of Jesus. Amen.

See Appendix I for more examples of religious blessings. Every meeting will begin with a
general invocation to celebrate and promote the collectivist culture of African American soldiers.

After a brief invocation for peace and blessings, the audience will listen to guest lecturers on the
following topics over a one year period. See Table 11 for a depiction of the social justice
advocacy town hall meeting schedule for the year.
Table 11

Yearly Schedule for Social Justice Advocacy Town Hall Meetings

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<td><strong>(j) November</strong></td>
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<td><strong>(k) December</strong></td>
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**Social justice advocacy town hall meeting schedule.** The following is a description of an example of a yearly schedule for the social justice advocacy town hall meetings for African American soldiers, their families, and community members. The topic for each meeting are described and linked to social justice advocacy for African American soldiers.

**January: What is social justice advocacy?** The purpose of the first social justice advocacy town hall meeting is to define social justice advocacy as it relates to African American soldiers. The speaker at this meeting will describe how social justice advocacy is a professional attitude of multicultural competence with regard to acquiring awareness, knowledge, and skills, as related to issues of access, equity, justice, human rights, employment, environmentally safe conditions, and proper housing for African American soldiers. This meeting explains the link between social justice advocacy and increasing the well-being and flourishing of African American soldiers. See Chapter 1 for a review of social justice advocacy under the multicultural competence framework. After the town hall meeting, the audience has an optional social hour to celebrate Martin Luther King Jr. day.

**February: What resources exist for African American soldiers?** The purpose of the second meeting is to present an overview of existing mental health resources and organizations for African American soldiers. This meeting serves to provide information (i.e., knowledge) about local groups. There will be several booths set up from different organizations that soldiers and their families can connect with and gather information packets and pamphlets. There will be a guest speaker from one organization committed to social justice advocacy for African Americans (e.g., the National Association for the Advancement of Colored People; NAACP). The speaker will present on current social justice advocacy topics (e.g., the elimination of racial and ethnic disparities in our healthcare system that deprive care to people of color in the U.S. or
the workforce development to increase the number of racial and ethnic minorities represented in
the medical and public health profession). See the end of this chapter for a review of local
groups. After the meeting, there will be an optional social hour to celebrate Black History
Month.

**March: Inspiring African American leaders in the military.** The purpose of the third
meeting is to inspire and influence African American soldiers by introducing African American
military leaders of the past and present. A speaker will highlight personal accounts from various
successful African American leaders of the military, such as La’ Shonda Holmes (the first
African American female helicopter pilot in the U.S. Coast Guard, Benjamin O. Davis, Sr. (the
first African American to become a General in the U.S. Army), Benjamin O. Davis, Jr. (the first
African American to become a General in the U.S. Air Force), Harriet Ida Pickens and Frances
Wils (the first African American WAVES officers), Daniel James (the first African American
four-star General in the U.S. Air Force), Hazel Johnson (the first African American woman to
become a General in the U.S. Army), Samuel L. Gravely, Jr. (the first African American to
command a U.S. warship), Henry O. Flipper (the first African American to graduate from West
Point Military Academy), William Carney (the first African American to be awarded the
Congressional Medal of Honor), and/or Daniel James III (the first African American to serve as
Director of the Air National Guard).

**April: Our future? Opinion poll of future social justice advocacy projects.** The purpose
of the April meeting is to take a poll, where meeting members can vote on social justice
advocacy projects of interest. Group members will discuss options in a group format and then
have the opportunity to fill out a form with their preferences. This meeting also serves to
introduce the highlights of the future meetings of the year. An optional social gathering occurs afterwards to connect with friends, family, and community members.

**May: How to handle racism and microaggressions in today’s military.** The purpose of the next meeting is to brainstorm effective ways to respond to microaggressions in the workplace and the community. The guest speaker will introduce the concept of microaggressions and role-play several scenarios for the attending soldiers. There will also be a difficult dialogue session to discuss any previous uncomfortable or offensive interpersonal interactions that soldiers have encountered. The audience will be asked to brainstorm effective responses to these difficult encounters, based on previous experiences. See Chapter 1 and 2 for a review of microaggressions. The discussion is followed by an optional social hour.

**June: The relationship between structural conditions and distress.** The purpose of the June meeting is to educate the audience on the relationship between structural conditions in which African American soldiers live (e.g., societal and institutional racism and exclusion) and their psychological distress (e.g., anxiety, depression, trauma, somatization, and suicidal ideation) (Roysircar, 2012). The guest speaker will serve to raise awareness about this contextual relationship and explain the physiological reactions to microaggressions. See Chapter 2 for a review of the physiological effects of microaggressions. After the presentation, there will be a skills presentation on mindfulness for African American soldiers and their families. This skills presentation will be a group mindfulness exercise designed to increase awareness about being present in the moment without judgment. This mindfulness exercise will be taught to provide a coping method to reduce physiological reactions to microaggressions. The audience will be taught an exercise that they can practice on their own, so they will be better equipped to cope with any difficult interpersonal interactions in the future. The group will also brainstorm
additional healthy ways to cope with microaggressions, after sharing personal experiences and solutions in the previous meeting. The exercise is followed by an optional social hour.

July: Social justice advocacy through clinical workshops. The purpose of the next meeting is to promote social justice advocacy for African American soldiers at the national level. This national level of advocacy will occur by promoting clinical workshops on all military bases for mental health professionals about advocacy for African American soldiers. A guest speaker at this meeting will discuss the importance of social justice advocacy for African American soldiers, to create socially responsive voices for these marginalized members of society. See Chapter 1 for a review of social justice advocacy. Relevant military commanders on base will be invited and encouraged to attend this meeting. The end of the discussion will be followed by a celebration to commemorate the day President Truman Harry ordered the desegregation of the armed forces on July 26, 1947 with the Executive Order 9981.

August: Social justice advocacy through mentorship and networking. The purpose of the August meeting is to promote social justice advocacy for African American soldiers at the national level, by raising awareness about the limited number of African American soldiers in top positions in the military (i.e., making rank above Colonel to include Brigadier General, Major General, Lieutenant General, and General of the Army). A speaker will describe the current statistics of limited African American General Officers. See Chapter 1 for a review of this racial and ethnic disparity in the top ranks of military officers. The speaker will discuss ways to rise above the disparity by introducing African American mentors in the military, providing networking opportunities with top African American military commanders, and discussing African American protective factors (i.e., the Africentric worldview, African American racial identity, religiosity and spirituality, family and kinship networks, and
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communalism). See Chapter 2 for a review of these protective factors. The speaker will be followed by a meet and greet with high ranking (i.e., Colonel and above) African American soldier mentors on base.

**September: Social justice advocacy for African American soldiers in the media.** The purpose of the next meeting is to focus on social justice advocacy in the media. African American soldiers will be interviewed to discuss improvements in the military for African American soldiers at their base, as well as general improvements that still need to occur for African American physical and mental health. The film will conclude with several local success stories by publicly recognizing individual African American soldiers for significant achievements at work and in the community. The speaker at this meeting will announce the local media project, select soldiers from the base to be interviewed and recognized, and arrange the interview date at the meeting. The film will be shown at the last meeting of the year, as well as sent to various local television stations to broadcast. Military leaders could eventually vote for the top video from all Army bases and promote the video for public broadcasting at a national level. An optional social hour will occur at the end of the discussion.

**October: Social justice advocacy for African American Female Soldiers.** The purpose of the October meeting is to highlight social justice advocacy issues for African American female soldiers. Since African American female soldiers may be viewed as double minority members (i.e., female and African American), they will be celebrated through psychoeducation and awareness. An African American female soldier will give a presentation on specific challenges (e.g., masculine culture norms in the military; racism against African American female soldiers vis-à-vis their White female counterparts) and statistics (e.g., statistics of single mothers) of the African American female soldier. The speaker will also highlight several
African American female soldiers on base and recognizes them for their outstanding work in their job or in the community. An optional social hour concludes the meeting.

**November: Social justice advocacy for African American LGBTQ soldiers.** The purpose of the November meeting is to highlight social justice advocacy issues for African American LGBTQ members (i.e., triple minority members). The speaker of this meeting will be an African American LGBTQ member, who will give a presentation on specific challenges (e.g., discrimination/homophobia) and statistics of African American LGBTQ members. The former “Don’t Ask Don’t Tell” policy will be revisited and the speaker will explore how the ban on this previous law has impacted the LGBTQ community in the military. The local Gay Pride festival (e.g., the Boston Pride Festival) will be advertised at the meeting and members will be encouraged to attend. An optional social hour will conclude the meeting.

**December: Social justice advocacy for African American Soldiers with PTSD.** The purpose of the last meeting of the year is to highlight social justice advocacy issues for African American soldiers with PTSD. The guest speaker will highlight prominent issues for treatment (e.g., cultural mistrust, early terminations, and use of emergency room visits instead of primary care), current programs in the military for soldiers with PTSD, and resources for family members. The purpose of this meeting is to promote awareness and acknowledgement of African American soldiers with PTSD, while providing support and a community presence. The discussion will conclude with an optional holiday party to celebrate the winter season, the end of the year, and Kwanzaa (where applicable).

**Social justice information packets.** In addition to the social justice advocacy meetings, all soldiers and their family members will receive a packet of information on social justice advocacy information. This packet will highlight information learned during the meetings and
provides specific resources and information that were discussed. Resources include local and national groups dedicated to social justice advocacy, especially regarding African Americans in the military and in the community. This packet will help facilitate effective discussions during the social justice advocacy meetings because attendees do not have to worry about taking notes or writing down names for future reference. The social justice information packet will be available both online and as hard copies for participants to choose from. Several examples of local resources in Massachusetts include The Professionals Network Organization Boston/New England Chapter (http://www.meetup.com/BostonBlackProfessionals-TPNOBoston/), the Urban League of Eastern Massachusetts (http://www.ulem.org/), Concerned Black Men of Massachusetts (http://cbmm.net/), and the Museum of African American History (http://www.afroammuseum.org/). Several international organizations include the National Association for the Advancement of Colored People (http://www.naacp.org/), The Links (http://www.linksinc.org/), the National Council of Negro Women, and 100 Black Men of America (http://www.100blackmen.org/hunchapters.aspx). See Appendix J for an example of a social justice information packet geared toward a military base located in Massachusetts.

Summary

In summary, Chapter 3 discussed the core structure of ART, which consists of a culturally sensitive assessment of soldiers (to include measures on cultural contexts), culturally sensitive online training modules (to include psychoeducation and resilience training), resilience training by multiculturally competent trainers (who undergo their own multicultural competence training), and social justice advocacy town hall meetings to promote advocacy for African American soldiers. Content and process changes to the original CSF2 program were also
presented, in order to make ART more culturally-sensitive and appropriate for African American soldiers.
Chapter 4

The evaluation process of ART includes both qualitative and quantitative measures. The proposed method of evaluation consists of a multifaceted approach recommended by Nelson and Steele (2006) that targets four areas of evaluation: (a) outcome evaluation, (b) provider evaluation, and (c) consumer satisfaction. See Table 12 for a depiction of the ART evaluation process.
### Table 12

**ART Evaluation Process**

<table>
<thead>
<tr>
<th>Evaluation of ART</th>
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<tr>
<td><strong>How</strong></td>
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<tr>
<td>Outcome evaluation:</td>
</tr>
<tr>
<td>(a) Change in outcome measures</td>
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<tr>
<td>(b) Longitudinal analysis</td>
</tr>
<tr>
<td>Provider evaluation:</td>
</tr>
<tr>
<td>(a) Quarterly focus groups</td>
</tr>
<tr>
<td>(b) Multicultural Counseling Inventory (MCI)</td>
</tr>
<tr>
<td>Consumer satisfaction:</td>
</tr>
<tr>
<td>(a) Client Satisfaction Questionnaire (CSQ-8)</td>
</tr>
<tr>
<td>(b) Semi-structured interview for soldiers</td>
</tr>
<tr>
<td><strong>When</strong></td>
</tr>
<tr>
<td>Quarterly:</td>
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<tr>
<td>Focus groups for ART trainers (providers). ART trainers take MCI.</td>
</tr>
<tr>
<td>Annually:</td>
</tr>
<tr>
<td>Outcome evaluation, consumer satisfaction, economic evaluation.</td>
</tr>
<tr>
<td><strong>Where</strong></td>
</tr>
<tr>
<td>ART evaluations to occur online (assessment), on base (focus groups), on paper or electronic means (writing), in confidential meeting room areas (interviews), or through the use of electronic medical records (frequency of visits).</td>
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Area 1: Outcome Evaluation

Repeated measures dependent pre-post t-tests (both univariate and multivariate) for an identified intervention may be applicable to study the changes in improvement in samples of soldiers. A sample’s critical change score at 1.5 standard deviations above the mean of the baseline score, for example, on flourishing or resilience would be another evidence of the effectiveness of ART. Simple multiple regression analysis could examine Time 1, Time 2, Time 3; the contribution of the four pillars of ART (through the use of effect coding); demographic variables; racial identity; Africentric consciousness; or social networks to the criterion variables of PTSD, resilience, flourishing, etc. Single and groups of predictors that account for significant variance in the dependent variables could be studied.

However, a single-subject design will be the main analysis of the study, which refers to an experimental design that focuses on the behavior of an individual subject (Bordens & Abbott, 2008). It can be used to test the success of a treatment or intervention on a particular case (i.e., a person or community), including a group of individuals involved in a single experiment. As in the CSF2 program, the individual soldier is the unit of analysis, showing a line graph or profile over time of the soldier’s scores. The practical usefulness of showing individual scores changes is that small increases in a soldier’s reported level of resilience and psychological health, and studied across other individual participants can lead to benefits for the entire Army (CSF2, 2012). The outcome evaluation of ART consists of two parts: (a) change in outcome measures and (b) longitudinal analysis.

Change in outcome measures. The outcomes of African American soldiers’ participation in ART will be evaluated through the use of measures. The measures will assess resilience and flourishing prior to starting the program, during the program, at the end of the
program, and prior to separating from the service (either through retirement, early separation, or an honorable/dishonorable discharge). The goal of ART is to increase resilience and flourishing and prevent future psychopathology. Thus, African American soldiers’ mental health outcomes will be measured for the following dependent variables: (a) the Symptom Checklist 90 (SCL-90-R; Derogatis & Savitz, 2000), (b) the PTSD Checklist for the DSM-5 (PCL-5; Weathers et al., 2013), (c) the Brief Resilience Scale (BRS; Smith et al., 2008), (d) The Flourishing Scale (FS; Diener et al., 2010), and (e) the Steen Happiness Index (SHI; Seligman et al., 2005). These five measures assess for both psychopathology and well-being.

Soldiers have also self-reported their resilience and psychological health (R/PH score) on the General Resilience Measure (GRM; formerly known as the Global Assessment Tool in the CSF2 program). The GRM is given to soldiers annually to detect any changes in negative symptoms or well-being. The data analysis will focus on the pattern of scores on the variables over time, looking at the stability, level, and trend of the variables of interest across individual cases (Kazdin, 2003). Thus, the scores from the five measures, along with the R/PH score generated, are evaluated against themselves for any positive or negative fluctuations for individuals. If the program is successful, resilience and flourishing levels (i.e., BRS, FS, SHI, and R/PH scores) should improve over time or remain stable (i.e., strong African American resilience is sustained over time), while symptoms of psychiatric distress and PTSD (i.e., SCL-90 and PCL-5 scores) should decline over time. If levels do not improve, a case review will be initiated to adjust the training. It is important to note that scores for psychopathology may remain stable in the event that no psychopathology is present (e.g., soldiers that fall below the threshold for PTSD).

The scores from the cultural contexts assessment measures (i.e., the Cultural Context
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Questionnaire, the Multidimensional Model of Racial Identity, the African Self-Consciousness Scale, and the Multicultural Experience Inventory) will also be monitored yearly to see if there are any changes in the African American soldiers’ cultural contexts, self-perceptions about racial identity, personal adherence to the Africentric worldview, and experiences with cultural diversity.

**Longitudinal analysis.** The second form of outcome evaluation concentrates on the resilience training for soldiers (i.e., the training of the trainers’ component) in ART. The R/PH scores of African American soldiers will be compared. More specifically, scores of soldiers who have received ART (the treatment condition) will be compared to those who have not had the ART (the control condition). It is important to note that the treatment and control conditions are not true treatment and control conditions because soldiers are not randomly assigned into ART (they are self-selecting whether they choose ART or the CSF2 program). However, Army posts could randomly select when soldiers start ART out of the self-selecting pool of participants. Another option would be to use multiple baseline measurements as different Army units take ART at different times.

Researchers will obtain scores from eight to ten Army posts around the country for the initial longitudinal analysis. The mean differences of each condition will be compared, as well as the rates of change in R/PH scores over time. Thus, this is a longitudinal analysis as the R/PH scores are taken annually. This longitudinal analysis is paramount to provide empirical evidence of the effectiveness of the ART program at resilience and flourishing in soldiers.

**Area 2: Provider Evaluation**

Provider evaluation refers to the assessment of the trainers’ opinions about the program. The multiculturally competent trainers provide resilience training to the African American
soldiers, so they consist of the main providers of ART. Provider evaluations of the program and their individual multicultural competence are assessed through: (a) quarterly focus group discussions and reflections and (b) the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994).

**Quarterly focus group discussions and reflections.** ART trainers will attend monthly focus groups to receive multiculturally competence training for a minimum of one year. In addition to receiving multicultural competence training, trainers will reflect on their opinions of ART on a quarterly basis and record their opinions during the reflective journal writing time. Members will discuss the struggles, challenges, barriers, and successes of the program. They will be provided with several open-ended questions such as: (a) What has been working well in ART? (b) What has been an area of weakness in ART? (c) Where can you see us implement change? (d) If you were attending this program, what parts do you like the best or least? (e) What did you learn from the psychoeducation provided on African American mental health? Each member incorporates specific examples into their reflective journal writing when answering these open-ended questions.

The process notes from the journal writing time will be analyzed through Consensual Qualitative Research (CQR) method developed by Hill, Thompson, and Williams (1997) and Hill and colleagues (2005). According to Hill et al. (2005), there are five essential CQR components. CQR utilizes: (a) open-ended, semi-structured questionnaires, (b) multiple judges for data analysis, (c) a consensual decision-making process among judges to make meaning of the data, (d) an auditor to review the analysis, and (e) the grouping of data into domains and core ideas, with a cross-analysis of the core ideas to produce categories or themes. CQR researchers review the process notes written by the multiculturally competent trainers (providers) during the
focus groups to assess for themes and subthemes. Changes will be implemented on an ongoing basis, depending on the themes and subthemes that arise each quarter.

**Personal evaluations as providers.** In addition to supplying evaluations of ART, trainers (i.e., providers) will also supply an evaluation of their own competence as multiculturally competent trainers. All ART trainers will take the Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994) on a quarterly basis. The MCI is a 40-item inventory that uses a 4-point scale to measure self-reported multicultural counseling competency in four subscale areas: (1) multicultural counseling skills, (2) multicultural knowledge, (3) multicultural awareness, and (4) multicultural relationship. Subjects rate how accurately each statement describes them when applying multicultural counseling competencies of skills, knowledge, awareness, and relationship, with 1= *inaccurate*, 2= *somewhat inaccurate*, 3= *somewhat accurate*, and 4= *very accurate*. Answers are averaged over items in each subscale to obtain four subscale scores. An MCI total scale score ranges from 40 to 160. Sodowsky et al. (1994) found that the reliability coefficients of .80, .80, .81, and .67 were reported for the awareness, knowledge, skills, and relationship subscales in a validation sample. The MCI has been positively correlated with other self-report measures of multicultural counseling competence (Constantine & Ladany, 2000). The full MCI has shown a mean Cronbach’s alpha of .87 (Sodowsky et al., 1994; Sodowsky et al., 1998).

**Area 3: Consumer Evaluations**

In addition to assessing outcomes and provider evaluations, the program will also assess soldier satisfaction. Assessing African American soldiers’ satisfaction with ART’s interventions is paramount because soldiers’ attitudes towards and satisfaction with interventions can greatly
impact the success of the program (Nelson & Steele, 2006). Client satisfaction of ART is assessed with a quantitative measure and a qualitative interview.

**Client Satisfaction Questionnaire.** African American soldiers will take the Client Satisfaction Questionnaire (CSQ-8; Attkisson & Zwick, 1982) on an annual basis after starting ART to assess their perception of the program. The CSQ-8 is an 8-item, self-report questionnaire designed to measure client satisfaction with services. It has a 4-point Likert scale and produces a scale ranging from 8 to 32, with higher scores indicating greater satisfaction. The CSQ-8 has a Cronbach’s alpha of 0.92 to 0.93 for the 8-item scale. This scale can be used in a variety of treatment settings but is mainly used for health and human services. While this measure is not necessarily a measure of a client’s perceptions of gain from treatment, it elicits the client’s perspective on the value of the services rendered.

**Interviews.** In addition to taking the annual CSQ-8, soldiers will also be randomly selected to take part in a semi-structured interview to assess their opinions about ART. Subjective interviews are paramount to assessing soldiers’ opinions of the program and to improve the quality of the program. Soldiers will be asked general, open-ended questions about the program such as: (a) What do you like about the program? (b) What would you change about the program? (c) Would you attend the training again? (d) Would you refer your friends and family members to the program? All interviews are recorded on a compact disc and transcribed.

Themes are extracted from the interviews for program evaluation purposes using the Consensual Qualitative Research (CQR) method developed by Hill et al. (1997) and Hill et al. (2005). The collaborative process of the CQR approach is particularly useful for understudied populations because of the iterative and repeated analyses of individuals’ narrated experiences (Hill et al., 1997; Hill et al., 2005).
Summary

Chapter 4 described the evaluation process for ART, as well as the ways in which the program is implemented and fidelity is observed. The ART evaluation process includes outcome evaluations through baseline measures and longitudinal analysis; provider evaluations to include quarterly focus group reflections and a self-report inventory on multicultural counseling competencies; and consumer evaluations to include a measure on client satisfaction and open-ended interviews for soldiers. Chapter 5 provides the author’s evaluation of the challenges, lessons learned, future directions, and personal reflections on the program development process.
Chapter 5

This chapter outlines a reflection on the realistic implementation of the ART program, barriers to program implementation, limitations to the program design, program implications for public policy, future directions of research, and experiences and learning of the author. This chapter describes the difficulties inherent in starting a mental health prevention program in the military, as well as the profound importance of this program in the military. The chapter concludes with the author’s personal reflection on the lessons learned, challenges, and the writing experience.

Implementation of ART

This section examines the implementation of ART, discussing what elements of the program can be implemented with ease and what elements of the program may face some barriers. The strengths and weaknesses of the program are addressed, as well as barriers, limitations, and future directions for ART.

Realistic Areas of Implementation

The first two pillars of the ART program are the most realistic elements of the program for implementation: (a) the culturally sensitive assessment battery and (b) the culturally sensitive online training modules. The first pillars of the program only requires that questionnaires and information are uploaded into ARTs website for African American soldiers. This first pillar can be fairly easily created for soldiers. The second pillar, online training modules, does not require a clinician or a monitor to deliver the program’s information; soldiers can easily access the materials through the website. However, the web design has the potential to be costly, time-consuming, and cumbersome if there are any technical glitches. A pilot test could be implemented with a handful of active duty bases around the United States. Soldiers in these test
programs provide direct feedback about the elements of the program through the Client Satisfaction Questionnaire. Last, cost effectiveness for the military can be monitored by looking at the rates of emergency room visits and inpatient hospitalizations outside of regularly scheduled appointments. This information is tracked by the last question on the Cultural Context Questionnaire (CCQ), where it asks for the number of times the soldier has visited an emergency room or been admitted to an inpatient unit.

**Difficult Areas of Implementation**

The third and fourth pillars of the ART program (the resilience training by multiculturally competent trainers and the social justice advocacy town hall meetings) may be more difficult to implement. The third pillar of the program, resilience training by multiculturally competent trainers, may be difficult to implement because there may be a lack of diverse trainers available at each base, especially in geographic areas that are culturally homogenous. Additionally, trainers attend a monthly focus group and there needs to be a facilitator for each meeting. Members of the monthly focus groups need to follow a standardized meeting format but also remain flexible when questions or challenges arise from members.

The fourth pillar of the program, social justice advocacy town hall meetings, may be difficult to implement because there is an additional meeting to attend at the end of the work day for soldiers. Many service members already have a hectic schedule and it may be difficult for some soldiers to attend every meeting. Moreover, African American soldiers may face negative reactions from members of other racial and ethnic groups that do not have a specialized mental health prevention program outside of CSF2. They may view African American soldiers as receiving special privileges.
Next, the qualitative outcome measures may be more difficult to obtain than the quantitative surveys. Providers discuss and record their opinions of the program during the monthly focus groups, while consumers are interviewed with semi-structured questions. Each base requires a small team of researchers to analyze this data using the CQR approach (Hill et al., 2005). The qualitative evaluation takes more energy, time, and resources than the quantitative evaluation but provides a rich and more in-depth feedback than the standardized questionnaires.

Another factor related to difficulties in program implementation may include getting buy-in from the Army about changing the existing CSF2 program. Officials in the Army may have concerns about special treatment for African American soldiers. Military officials may not have a background in multicultural competence or social justice advocacy and may not initially understand the importance or necessity of ART.

**Barriers to Program Implementation**

Several barriers to the implementation of ART may include the military budget, extra personnel required for the outcome evaluation, decisions about the program being mandatory or not, and potential dilemmas for biracial minority soldiers. First, as with all programs and trainings in the military, the added cost of creating a mental health prevention program constitutes the first barrier. While the setup cost for the online assessment and training portion will be minimal, it costs money to train the culturally sensitive trainers that are involved in the resilience training, as well as the additional members that attend the social justice advocacy meetings (e.g., fees for guest speakers, etc.). Providing the military with the literature review of the importance of such a program is paramount to conveying the usefulness and significance of the program. One could argue that ART could reduce mental health care costs by preventing the
emergence of psychopathology in African American soldiers, drastically reducing the need for long-term mental health care. Thus the cost of the ART prevention program may outweigh the risks of psychopathology in soldiers.

Next, a barrier may exist because ART is voluntary for African American soldiers. The current CSF2 program is mandatory in the Army. ART is a choice for African American soldiers to attend instead of the CSF2 program. The fact that two programs exist for African American soldiers may create some resistance for other soldiers that do not have an additional/alternative training to attend. Last, soldiers that are biracial (or African American soldiers that appear biracial) may face some barriers because they may not “appear” to be African American by their physical appearance. Soldiers that appear biracial will have the option of taking ART but they may feel hesitant because they may not be warmly welcomed into the program by other African American soldiers. African American soldiers adopted by European American parents may also feel hesitant to engage in ART, especially if they have a European American identity and worldview (while physically they are people of color). Advertising for the program to include biracial soldiers will help to decrease the potential discomfort for biracial soldiers.

**Limitations to the ART Program Design**

Several limitations exist to this program design: (a) My race and culture as European American of Scandinavian, Italian, and French descent and (b) My status an Air Force veteran (vs. an Army veteran). First, my racial background may serve as a limitation to this program design. While this limitation fueled my interest in the program and I examined countless articles, journals, and books about African Americans, I still lack an inherent, personal knowledge and lived experience that an African American graduate student may have.
I tried to remedy this limitation by attending multicultural conferences (e.g., the National Multicultural Summit and Conference in Texas (2013) and in Georgia (2015) and the Winter Roundtable at Columbia University in New York (2012). I have consulted with psychologists that are African American (e.g., Dr. Brittany Hall-Clark) and written manuscripts on multicultural research within a racially and ethnically diverse research team. I have co-authored a recently revised and re-submitted article to the Journal of Black Psychology on African American male leaders in a counseling organization and their successes and strengths (Roysircar, Thompson, Smith, & Boudreau, 2015). I have co-presented a research poster at the 2015 National Multicultural Conference and Summit on student process notes written during a disaster mental health practicum in Haiti. In the past, I have co-presented research on Chinese Americans, Asian Indian Americans, Filipino Americans, and Korean Americans at the Winter Roundtable Conference at Teachers College, Columbia University. Focusing on Korean Americans, I integrated positive psychology interventions into my case conceptualization of a Korean American male. I have also worked with culturally diverse individuals, including my dissertation chair, my committee members, and her my co-presenters. I was also a leader in the Support for Ethnic and Racial Diversity (SERD) at Antioch University New England in Keene, NH. This group was advised by Dr. Gargi Roysircar, a forward thinker in multicultural competencies and practices. The student organization supports multiculturalism on the school campus, in the local community, as well as internationally through social justice outreach.

My second limitation is my status as an Air Force veteran versus an Army veteran. While I understand the military culture, acronyms, and language of the Air Force, the Army has a different military culture (as do all military branches). Thus, I designed ART as someone with an Air Force perspective. However, I come from a military family with two immediate family
members that serve/have served in the Army and several friends that are currently serving in the Army. I have consulted with a variety of people about the Army culture, including my dissertation committee member Brittany Hall-Clark, Ph.D. who currently works at an Army post with a diversity of soldiers.

Even with these personal limitations, I am an ally and advocate for the underserved and underrepresented African American community. I have a passion to use my White privilege to give a voice to African American soldiers to bring awareness to microaggressions against African American service members, and to promote equal mental health services for all racial and ethnic minority members of the military. I have served alongside many African American service members in the Air Force and have witnessed microaggressions against peers who are diverse. I would like to take a stand to correct this injustice by designing a program that meets the needs of African American soldiers.

**Program Implications for Public Policy**

This program design has important implications for public policy, and in turn, potential positive changes for racial and ethnic military members. Public policy consists of a system of law, regulatory measures, courses of actions, and funding priorities surrounding a given community-based topic or action; so the aim of public policy is to improve the quality of life for community members (Moritsugu et al., 2010). People can attempt to shape public policy through education or advocacy. This program helps to promote the mental health needs of African American soldiers because of its’ education, lobbying, and political pressure for a multiculturally competent prevention program that intends to increase resilience and flourishing in African American soldiers, a marginalized community. ART emphasizes a culturally sensitive
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format based on multicultural competence and positive psychology frameworks for the public good.

An important concept relevant to public policy includes social justice advocacy. This program seeks to advocate for African American soldiers through the dissemination of knowledge, skills, and awareness at the monthly town hall meetings. This program educates the military, the general public, and public policy makers about the mental health of African American soldiers and about including culturally competent assessment, culturally competent online resilience training, and social justice advocacy via monthly town hall meetings. Thus, public policy priorities (e.g., the mental health of military soldiers) can be influenced by social justice advocacy. Additionally, both quantitative and qualitative data can be directly brought to the Army that supports the importance of a specialized mental health prevention program for African American soldiers. Data will be collected to measure the baseline mental health needs of African American soldiers, as well as the changes that occur in soldiers that participate in the ART program.

Future Directions

The next step is to complete a pilot study of ART at a handful of Army military posts across the country. Results from the pilot study will highlight the strengths of ART, as well as areas in need of modification. As the program-implementation continues, accompanied by evaluation of its components and processes, a request for improved ART programs in other military branches and those that are culturally modified for other racial and ethnic minority soldiers could be justified. Over time, ART could be applied in the sister branches of the military: the United States Marines, Air Force, Navy, and Coast Guard. Additionally, there could be mental health prevention programs for soldiers of other racial and ethnic backgrounds,
such as American Indian, Hispanic, and Asian American soldiers. Eventually, with varied samples of sufficient size, comparisons could be made between programs and within programs to study the effectiveness and need of the programs. ART could occur regularly, in conjunction with the CSF2 program. African American soldiers will have the option of taking ART or the CSF2 program, as would other racial and ethnic minority soldiers in different programs.

**Experiences and Learning of the Author: Personal Reflections**

This dissertation project has reinforced my advocacy for and commitment to a multiculturally competent perspective in my practice as a European American psychologist hoping to serve the U.S. military. Focusing on service to African American soldiers has helped me learn about the African American culture and sociopolitical contexts, as well as the importance of studying and immersing oneself in other cultures with an emic perspective. Performing a literature review and designing a mental health prevention program to meet the specific needs of African American soldiers have helped me understand and respect a worldview different from the one that I am socialized in. This dissertation has inspired me to advance my therapy skills with African American clients and to seek out training opportunities through research, national conferences, and collaboration with African American professionals within the military and in the academic community.

**Using White Privilege to Empower Others**

I was first introduced to the uncomfortable concept of White privilege during my first year of graduate school. My doctoral training has provided me immersion in multicultural and diversity issues. Experiential activities, symposia, and research literature have helped me learn about minority mental health and about entitlement and social privileges of European Americans. I have also learned about the struggles of racial and ethnic minority individuals as they face
microaggressions, implicit racism, the invisibility syndrome, marginalization, and the English language proficiency requirement. Training in multicultural competence has added contextual layers to my case conceptualizations. I have learned to treat clients by first understanding my own cultural values and biases, then understanding a client’s worldview, and combining these two worlds to generate culturally appropriate intervention strategies. This program design in an accumulation of all of my interests: (a) multicultural competence (b) positive psychology and (c) military members. The knowledge and its applications that I learned from the dissertation can be carried over to my individual and group clients in therapy.

**Experiencing Cultural Mistrust from African American Psychologists**

Researching African Americans has presented several uncomfortable and important challenges for me that have led to my growth in multicultural competence. Attending clinical psychology predoctoral internship interviews at various Veteran Affairs Healthcare Systems and discussing my research interests has been both well-received and ill-received by African American psychologists. The majority of African American psychologists have embraced my ideas wholeheartedly, accepting my genuine interest in studying a marginalized cultural group. However, several psychologists’ non-responsiveness or reluctance to further discuss my dissertation topic suggested to me a cultural mistrust of my interest in African American psychology. My understanding of African American psychology (e.g., Vontress, 1971) has made me realize that some African Americans would question my motives and depth of empathy for African Americans experiences. My newfound knowledge about the Africentric worldview, communalism, the importance of spirituality, and family and kinship networks has heightened my awareness of the differences that exist between cultures, including among racial and ethnic minority cultures, and how my status as a European American female can be viewed as one with
privilege and power. I want to take this knowledge for the empowerment of African American soldiers, and attempt to reduce racial disparities in access, equity, and resources.

**Multicultural Competence vs. Social Justice Advocacy**

One major lesson that I learned was the difference between multicultural competence and social justice advocacy. Multicultural competence refers to appreciating, recognizing, and effectively working with people from other cultural groups (Sue, 1998). Similarly, social justice advocacy is the process of informing and helping decision makers, which involves creating citizen psychologists that support clients, public health, welfare issues, healthcare, and professional psychology (Kenkel & Peterson, 2009). Thus, social justice advocacy represents a vision of society that addresses systems of oppression that negatively affect client development (Lee, 2007). Multicultural competence and social justice advocacy are linked through their shared purpose of removing institutional, systemic, and social oppression, ensuring equity and equality for all individuals (Constantine & Sue, 2005).

Just as flourishing rises beyond resilience as the goal of well-being (Seligman, 2011), social justice advocacy appears to rise beyond the concept of multicultural competence; as psychologists give voice to marginalized populations as citizen psychologists. Social justice advocacy is about taking action and actively supporting and promoting those individuals in need. Clinicians need to ask themselves the following questions: What marginalized populations can I serve as a social justice advocate? How do I address my own multicultural competencies in working with a particular African American client? What roadblocks exist in my efforts as a psychologist in the role of a social justice advocate? How do I overcome these roadblocks to social justice advocacy? I have answered these questions in this dissertation by designing ART.
It is important to note that I struggled initially when applying the concept of social justice advocacy to African American soldiers because initially I focused mostly on volunteer efforts with African Americans. Volunteerism is different from social justice. One is free philanthropic service; the other is advocacy for social and policy change. Through literature reviews and research writing, I was able to connect social justice advocacy to the goal of helping African American soldiers flourish in a culturally competent manner. Only through research, active participation in conferences, and discussions was I able to understand the distinctions between multicultural competence and social justice advocacy and how they may be connected as well. I am now able to utilize my own multicultural competence when working with African American soldiers, as well as serve as a social justice advocate for African American soldiers.

**Importance of Keeping Current with Research**

When reflecting on areas of possible improvement in my prevention program for African American soldiers, I need to follow the research results carefully of the CSF2 program, as this program is still being evaluated since its inception. Keeping up to date with the research on the CSF2 program can keep me well informed of any modifications to this program—for instance, if the military presents information on elements of the program that did not work effectively. Additionally, I need to be current with literature on African American psychology to make sure I am creating a program that meets the specific needs of the African American population. More collaboration with African American psychologists and soldiers would be helpful to make modifications to the program. As with most programs, ART is subject to the outcome evaluations and may need future modifications. The hope is to run a pilot test in the military to incorporate positive psychology principles and multicultural competence to increase resilience and flourishing, while educating African American soldiers on the prevention of PTSD.
Overall, designing ART for African American soldiers has surpassed my goals for my dissertation project: to completely immerse myself in another culture in order to learn and grow as citizen psychologist. This dissertation project has helped me apply multicultural competence and positive psychology principles to African American soldiers, in order to support and empower this marginalized population as a social justice advocate. I am proud to have been part of this academic process and have felt empowered to continue to use my White privilege to promote the psychological well-being and mental health of racial and ethnic minority soldiers.
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Violence, 6*, 121-137.
Appendix A: Comprehensive Resilience Modules (Online)

The Comprehensive Resilience Modules consists of computer-based distance learning modules for soldiers (Lester et al., 2011). Twenty modules exist that cover the four dimensions of health: emotional, family, social, and spiritual. The module titles that educate soldiers on emotional health include the following: Put it in Perspective, What Emotions Do, What Good are Negative Emotions, What Good are Positive Emotions, and What is an Emotion. The module titles covering family health include the following: Effective Communication, Hostile Interactions Following Arrival Home, Stranger in My Home, Trust and Insecurity, and Who’s in Charge. The module titles under social health include the following: Active Constructive Responding, Building Resilience Teams, Team Diversity and Resilience, The Dynamics of Socially Resilient Teams, and The Importance of Team Chemistry. Lastly, the module titles under spiritual health include the following: Hunt the Good Stuff, Making Meaning, Meditation, Rituals, and Spiritual Support.
Appendix B: Master Resilience Trainer Modules

Master resilience trainers learn six core competencies: self-awareness, self-regulation, optimism, mental agility, strengths of character, and connection (Lester et al., 2011; Reivich et al., 2011). These six competencies are taught via four modules. Module 1 consists of two units: unit one introduces resilience and the six competencies, while unit two focuses on identifying and creating positive emotions and experiences. Module 2 consists of seven units, which involve mental toughness. Unit one consists focuses on an Activating event-Thought-Consequence (ATC) model based on Ellis’s (1962) adversity-belief-consequence cognitive model, to identify the relationship between events, thoughts, and emotions. Unit two focuses on thinking traps (identifying and correcting dysfunctional thinking patterns). Unit three focuses on icebergs (identifying deeply held beliefs about the world that influence initial reactions to an event). Unit four focuses on stress and energy management, teaching controlled breathing, progressive muscle relaxation, meditation, and distraction techniques. Unit five focuses on problem-solving, helping soldiers recognize factors that cause problems and to identify solutions. Unit six focuses on reducing catastrophic thinking and anxiety reduction, teaching about the inefficiencies related to rumination and the focus on worst case scenarios. Lastly, unit seven focuses on real time resilience, applying the above units in various contexts faced by soldiers.

Module 3 consists of two units which focus on character strengths. Unit one focuses on identifying character strengths (Peterson & Seligman, 2004). Unit two focuses on utilizing strengths to overcome challenges. Module 4 consists of two units and teachers soldiers to strengthen their relationships through effective communication strategies. Unit one focuses on different communication strategies, while unit two focuses on sharing positive experiences with others, as well as giving and receiving praise.
Appendix C: Cultural Context Questionnaire

The Cultural Context Questionnaire (CCQ) has been adapted from the Cultural Formulation Interview (CFI) in the DSM-5 (ApA, 2013) to meet the needs of African American soldiers. The author has tailored this assessment from the CFI to better capture the assessment needs of African American soldiers.

Cultural Context Questionnaire

(1) Briefly describe your social support system

(2) If applicable, describe your particular church affiliation

(3) What are some of your family traditions?

(4) How important is the individual in the culture? How important is the group?

(5) What are the cultural attitudes towards aging and the elderly?

(6) How important is hierarchy in your family?

(7) How are gender roles perceived in your family?

(8) How is time understood and measured (e.g., how late can you be to a business appointment before you are considered rude?)

(9) How is space used (e.g., how close should two people who are social acquaintances stand next to one another when they are having a conversation)?

(10) How is divine power viewed in relation to human effort?

(11) Are people encouraged to be more action-oriented or contemplative in your family?

(12) Is change considered positive or negative?

(13) What are the criteria for individual success?

(14) What is the role of luck in your culture?
(15) For you, what are the most important aspects of your background or identity?

(16) Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

Proceed to the next set of questions if you are currently facing any mental/psychological distress.

(17) What is currently distressing to you?

(18) Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?

(19) What troubles you most about your problem?

(20) Why do you think this is happening to you? What do you think are the causes of your problem?

(21) What do others in your family, you friends, or others in your community think is causing your problem?

(22) Are there any kinds of support that make your problem better, such as support from family, friends, or others?

(23) Are there any kinds of stresses that make your problem worse, such as difficulties with money, or family problems?

(24) Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

(25) Sometimes people have various ways of dealing with problems like yours. What have you done on your own to cope with your problem?

(26) Often people look to help from many different sources, including different kinds
of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your problem?

(27) Has anything prevented you from getting the help you need? For example, money, work, or family commitments, stigma or discrimination, or lack of services that understand your language or background?

(28) What kinds of helps do you think would be most useful to you at this time for your problem?

(29) Are there any other kinds of help that you family, friends, or other people have suggested would be helpful for you now?

(30) Have you visited the emergency room or been admitted to the inpatient unit on post (or off-post) this year? How many times?
Appendix D: Example of a Religious Prayer for the Online Resilience Modules

The following invocation is a spiritual essay written by Coretta Scott King (Moore, 2008, p. 125), the wife of Reverend Martin Luther King Jr. This invocation demonstrates her abiding faith in God. Soldiers will be encouraged to replace any religious wording that they do not feel comfortable with, with their own personal beliefs about religiosity and spirituality.

**Religious Prayer**

**A Public Prayer for Divine Perspective**

Eternal and everlasting God, who art the Father of all mankind, As we turn aside from the hurly-burly of everyday living, may our hearts and souls, yea our very spirits be lifted upward to Thee, for it is from Thee that all blessing cometh. Keep us ever mindful of our dependence upon Thee, for without Thee our efforts are but naught. We pray for Thy divine guidance as we travel the highways of life. We pray for more courage. We pray for more faith and above all we pray for more love. May we somehow come to understand the true meaning of Thy love as revealed to us in the life, death, and resurrection of Thy son and our Lord and Master, Jesus Christ. May the Cross ever remind us of Thy great love, for greater love no man hath given. This is our supreme example, O God. May we be constrained to follow in the name and spirit of Jesus, we pray.
Appendix E: Optional Inspiring Reading Materials for African American Soldiers

Books on African American Leaders

The following books discuss literature about inspiring African American heroes and leaders. These are some examples of recent novels written about famous and empowering African American leaders.

**Black Heroes**

The book, *Black Heroes* by Smith (2001) describes the lives of 150 African Americans that have made a profound impact on society (e.g., Colin Powell, W.E.B. Du Bois, Rosa Parks, Josephine Baker, etc.). This book celebrates the achievements of African Americans over the past 100 years and includes over 200 pictures of individuals.

**The Words of African American Heroes**

The book, *The Words of African American Heroes* by Villarosa (2011), provides a collection of notable quotations from a range of African American heroes (e.g., Frederick Douglass, Jackie Robinson, Harriet Tubman, Martin Luther King Jr., Oprah Winfrey, and President Barack Obama. Organized by themes, this book explores key concepts such as life challenges, overcoming adversity, and cultivating creativity.

**A History of African-American Leadership**

The book, *A History of African-American Leadership* by Dierenfield and White (2012), describes six outstanding racial leaders, the Black protest movement in America, civil rights, racism, poverty, murder, and heroism. This book explores the movement for freedom, while describing the constraints leaders of the time period faced.
50 of the Worlds’ Most Inspiring African Americans


Answering the Call: African American Women in Higher Education Leadership


African American Healers

The book, African American Healers by Cox (1999), describes African American doctors, nurses, and scientists as they fought for equal treatment as well as for the rights of their patients. The book includes of many heroes, includes Dr. James Durham, the first African American doctor that saved countless lives of yellow fever victims.

African American War Heroes

The book, African American War Heroes by Martin (2014), describes the unsung African American war heroes that defended freedom in the face of racial prejudice. The book outlines biographical data and profiles of individual’s heroic actions. The book also includes a description of the famous Tuskegee Airmen.

Fighting for America: Black Soldiers – The Unsung Heroes of World War II

The book, Fighting for America: Black Soldiers – The Unsung Heroes of World War II
by Moore (2005), describes the African American soldiers of World War II. The author, a son of two black WWII veterans, provides letters, oral histories, rare documents, and photographs of the war, along with a detailed description of unsung African American heroes.
Appendix F: When I was at My Best

Assignment: Discuss a time when you were “at your best” (e.g., mentally, physically, socially, or spiritually). Consider the strengths that you were using at the time.

Upon reflection, I was at “my best” when I graduated from field training (i.e., bootcamp) in the United States Air Force. I was in my sophomore year of college and I had just completed a rigorous, six-week program that involved physical fitness, weapons training, and survival training. I had never been happier in my life, riding home on the bus en route to the airport on the last day of field training. One trick that helped me get through field training was maintaining a mindset that I was serving in prison. This mindset helped me mentally justify and accept the chronic punishment of physical exercise and yelling, while also dealing with the loss of personal freedom. I had never been more challenged physically, mentally, and spiritually in my life and I was proud of myself for persevering. Physically, I was in the best shape of my life after losing 30 pounds from the training and gaining more muscle mass. Mentally, I felt confident like I could accomplish anything that I set my mind to. Emotionally, I felt connected to my field training team, as well as to my family members. My family and friends served as a strong support system, sending me countless letters and packages to keep me going through their words of encouragement.

I will never forget the night that I received the first letter from my father. It was the night before I had to run my first physical fitness test at field training. I was nervous about my running speed compared to the rest of my teammates. The night of receiving my first letter, I had to sneak into the bathroom in the middle of the night to read it because we were not allowed any down time. Reading the letter from my father gave me an extra boost of confidence.
knowing that there were people back home supporting and rooting for me. It was a sign that everything was going to be okay.

I remember that the best feeling after graduating from field training was the gratitude that I felt for everything that I left behind at home. I will never forget the feeling of my first long shower (we had to take 10 second showers when getting ready for the day) and sleeping in my comfortable bed. I did not realize the extent to which I took these simple physical luxuries for granted. Attending field training without these luxuries increased my gratitude and appreciation for the material things that I use on a daily basis. Additionally, I had difficulty dropping other habits and activities that I had picked up during training, like eating too fast or getting ready with extreme agency (i.e., “superman drills”). I performed these activities with urgency for weeks after graduating, having difficulty being present in the moment without rushing on to the next activity.

My favorite recollection of graduating field training was reuniting with my family members. My family members welcomed me home with open arms, full of pride and respect for my accomplishment. They all knew how this program would push me both mentally and physically. My family showed me through their actions and their words how much I meant to them. I have saved every letter that they wrote me during those six weeks and they mean a great deal to me. Returning back to the love and support of my family was the most important part of me feeling like my best, because I could not have survived the training without their words of encouragement and faith in me. My father had given me a good luck charm before I left for field training to secretly carry with me every time I had to do a physical fitness test. He even had the necklace spiritually blessed for me. I have this special token hanging up in my car till this day, to remind me of his love for me and to serve as my constant protector and good luck charm.
Appendix G: Gratitude Letter to my Father

Upon reflecting on an important person in my family, I choose to write my gratitude letter to my father. My father is my biggest supporter, listener, and fan. Growing up as a “daddy’s girl,” I always looked forward to spending quality time with my father. When I was young, my father took me to the local pond to feed the ducks freshly popped popcorn. When I would get sick, he bought my favorite flavor of ice-cream (Butter Crunch) from the local Friendly’s restaurant. He saved every handmade card that I ever made him in a folder in his office. As I grew older, he took me to the circus every year and always bought me a thick booklet of all of the acts. We went roller-skating together on most Sundays, and I always invited a friend to come with us. I will always remember his sleek black roller-skates and that time when his front wheels fell off while he was turning a corner at the skating rink!

In high school, he would never hesitate to drop me off to the mall, a friend’s house, or to an event. He was always happy and willing to give me a ride to wherever I needed to go. He took me to get my driver’s test and helped talked the instructor into letting me pass, after I had difficulty driving backwards in a straight line. We would occasionally go out to play billiards together or play in his poolroom. He always let me multiple my billiards score to equal his skill level. Most teenagers are commonly embarrassed to be seen with their parents in public, but I always enjoyed my father’s company and never hesitated to go out to a movie, restaurant, or to sing karaoke with him. In high school, he attended all of my field hockey games. He edited my essays for school with a red pen, making the same corrections over and over. He helped me with my math homework, even when he could not understand the answer at first.

When I started attending college at Boston University (BU), he drove to see me every other month to visit for the weekend. He loved getting food together at the BU cafeteria. He
was always happy and willing to give me rides to the airport whenever I had to fly out of state. I talked to him on the phone every other day, as I do now as a graduate student.

When I was on active duty and lived in Ohio, my father slipped on some water in his kitchen and hit his head on the refrigerator nearby. He did not think anything of the accident, until he started losing feeling in the left side of his body the following week. He went to the hospital and the doctor told them that his brain has been filling up with blood ever since his fall in the kitchen. The doctor scheduled an emergency surgery for him and said that he might not have survived if he had come in the following day. My father had a subdural hematoma. I remember receiving the call from my family about his situation and feeling like I was dreaming. I immediately went into problem-solving mode, called my military commander to get approval for taking leave, and booked a plane ticket to come home. I flew back to Massachusetts just as his doctors finished up the surgery. My family did not tell me until months afterwards that he had difficulty waking up from the anesthesia. The doctors had to repeatedly shout his name to wake him up for an extended period of time. When I saw him, he remembered me but he had difficulty with his short-term memory for weeks. He could not recall why he was staying at the hospital and could not remember the name of the place. I brought him balloons with smiley faces on them to comfort him. The doctors had shaved half of his head to perform the surgery and he made countless jokes about having a combed-over hairdo. I will forever remember the date of February 12, 2007 because I almost lost my father on this day. From this time period on, I vowed that I would always live close by to my immediate family.

As a graduate student, I try to visit my parents to check in with them every couple of weeks, as they only live an hour away from me. My father is getting ready to have knee surgery soon. We have several sporting events planned this month to take his mind off of the surgery.
Occasionally, he comes with me when I go to a local clinic for veterans to receive acupuncture. He always connects with the other veterans, especially with Emilio, the endless chatterbox. His friendliness to strangers always puts a smile on my face.

I am grateful to my father because he has been there for me. He has always made me feel loved, appreciated, and respected. He gave me the space to be myself and was present as a supportive listener during my hardships, challenges, and struggles. He believes in me, even when I do not. He reminds me of my strengths when I forget them. He encourages me to pursue my dreams and to reach my goals. I am grateful for my father because he is my rock. He has always made time for me. So I want to thank you “daddio” for all the time that you have spent with me. Thank you for showing up for so many events and being a large presence in my life. Thank you for all of the memories and the new ones to come. Thank you for being you.
Appendix H: Three Good Things and Why Exercise

Upon reflection, three good things happened today: (1) connecting with my clients during the day (2) receiving a package from a friend and (3) going to see a movie and eating at a restaurant with another friend. During the day, I saw several clients at my practicum site and I felt good about my interactions with all of them. I had been particularly worried about one of my clients recently because he was hospitalized for detoxification. However, we had an effective session today where he discussed his feelings towards his upcoming medical treatments that could be potentially fatal. It was one of those days that went by quickly and effortlessly.

When I got home from work today, I found a package in the mail from my close friend Jen. I laughed out loud when I felt the slightly lumpy, bright red package: my friend had mailed me a large bag of jelly beans! I had mentioned to her the other day that I was craving jellybeans but could not find any at the local store. She also sent me a thoughtful card for Valentine’s Day, which expressed her appreciation for our friendship. Her card was animated, filled with exclamation points, underlined words, and drawings. Receiving mail from Jen always puts a smile on my face and warms my heart. I truly appreciate her friendship, thoughtfulness, and kindness towards me.

Later tonight, I went out to eat at a restaurant and see the movie “That Awkward Moment” at Dedham Legacy Place with my close friend Linda to celebrate her 33rd birthday. We enjoyed the dinner as well as the movie. My friend and I talked for hours and were the last ones to leave the restaurant at the end of the night. We did not notice our surroundings for a while because we were so engaged in our conversation; it felt like we were in the state of “flow” that Csikszentmihalyi writes about. It was so nice to connect with her again and hear about all her new house, relationship with her fiancé, family members, coworkers, and future plans. We
always have a fun time when we get together and can easily relate to one another. I appreciate her humor, generosity, and authenticity.

The next part of this exercise is to write about why these three events happened and to discuss any strengths or protective factors that may have contributed to the events occurring. I find it much hard to reflect on why these three events occurred, than providing the initial description. Describing three good events that happened today does not require a person to write about their strengths and virtues. I find the task of explaining why I had a good day much harder because I grew up with the phrase “self praise is no praise.”

My thoughts immediately drift to the Values in Action (VIA) questionnaire designed by Peterson and Seligman (2004). The VIA questionnaire serves to identify five signature strengths that people use on a daily basis. I have taken this questionnaire several times and my top five signature strengths remain: (1) gratitude (2) creativity (3) capacity to love and be loved (4) generosity and (5) love of learning.

These top five signature strengths relate to the three good things that happen to me today. First, I relate my connection to my clients with my strength of creativity. I find my strength of creativity useful when connecting with clients, finding different ways to collaborate with them that may not always follow a manualized treatment. I also tend to use my love of learning when working with clients, always trying to find the most up to date research on evidence-based practices.

Next, my strengths of gratitude, capacity to love and be loved, and generosity relate to receiving the care package as well as meeting my friend for dinner. Just the week before I sent my friend Jen a book that I thought she would appreciate “The Artists Way: A Spiritual Path to Higher Creativity” by Julia Cameron. I had sent her the book as a birthday present to show my
gratitude for our friendship. I also thought that we could participate in the self-reflection exercises in the book together and discuss the process afterwards.

Regarding my friend Linda, we both show gratitude and generosity towards each other whenever we get together. We make an effort to connect every month or so and make time to share personal experiences with each other. We never hesitate to show generosity on birthdays, holidays, or other celebrations, taking each other out to eat at a restaurant or to watch a movie. Lastly, I try to show both of these friends my capacity to love as a close friend through my words, actions, and handmade cards.

Overall, it was pleasant experience to reflect on three good things that happened to me today. This exercise reminded me of my close friends that serve as my strong social support system. This exercise helped me highlight and bring awareness to several signature strengths that I can use on a daily basis to increase my resilience and my capacity to flourish. This exercise also helped to focus my awareness on positive aspects of my life, instead of focusing in on any negative events that may have happened during the day. Practicing positive thinking can lead to increased positive affect.
Appendix I: Example of a Religious Blessing

The following script contains examples of religious prayers for peace and blessings for all African American soldiers and their families that attend the monthly social justice advocacy town hall meeting. The following prayers were written by Martin Luther King, Jr. and collected by Baldwin (2011).

**Prayer 1**

O God, we thank you for the fact that you have inspired men and women in all nations and in all cultures. We call you different names: some call you Allah; some call you Elohim; some call you Jehovah; some call you Brahma; some call you the Unmoved Mover. But we know that these are all names for one and the same God. Grant that we will follow you and become so committed to your way and your kingdom that we will be able to establish in our lives and in this world a brother and sisterhood, that we will be able to establish here a kingdom of understanding, where men and women will live together as brothers and sisters and respect the dignity and worth of every human being. In the name and spirit of Jesus. Amen.

**Prayer 2**

God, we thank you for the inspiration of Jesus. Grant that we will love you with all our hearts, souls, and minds, and love our neighbors as we love ourselves, even our enemy neighbors. And we ask you, God, in these days of emotional tension, when the problems of the world are gigantic in extent and chaotic in detail, to be with us in our going out and our coming in, in our rising up and in our lying down, in our moments of joy and in our moments of sorrow, until the day when there shall be no sunset and no dawn. Amen.

**Prayer 3**

Thou Eternal God, out of whose absolute power and infinite intelligence the whole universe has come into being, we humbly confess that we have not loved thee with our hearts, souls and minds, and we have not loved our neighbors as Christ loved us. We have all too often lived by our own selfish impulses
rather than by the life of sacrificial love as revealed by Christ. We often give in order to receive. We love our friends and hate our enemies. We go the first mile but dare not travel the second. We forgive but dare not forget. And so as we look within ourselves, we are confronted with the appalling fact that the history of our lives is the history of an eternal revolt against you. But thou, O God, have mercy upon us. Forgive us for what we could have been but failed to be. Give us the intelligence to know your will. Give us the courage to do your will. Give us the devotion to love your will. In the name and spirit of Jesus, we pray. Amen.
Appendix J: Example of a Social Justice Advocacy Town Hall Meeting Handout

Resources for African American Soldiers and Their Families

TPNO Boston/New England Chapter

The Boston Black Professional Meetup Group merged with The Professionals Network Organization USA (TPNO) in New York City, which is now known as the TPNO Boston/ New England Chapter http://www.meetup.com/BostonBlackProfessionals-TPNOBoston/. The mission of this group is to provide an outlet for young upwardly mobile multi-cultural professionals to network and obtain access to resources and information for becoming part of an ownership society.

Urban League of Eastern Massachusetts

The Urban League of Eastern Massachusetts (ULEM; http://www.ulem.org/) serves to be a champion of civil rights dedicated to helping people improve their lives by providing local residents with free education, job training, and job placement.

Concerned Black Men of Massachusetts

The Concerned Black Men of Massachusetts (CBMM; http://cbmm.net/) was formed in 1989 by a group of ten Black men to discuss quality of life issues for African Americans. This non-profit organization is dedicated to asserting the Black male’s importance to the perpetuation of the family and of the community.

Museum of African American History

The Museum of African American History (http://www.afroammuseum.org/) in Boston serves to preserve and conserve the contributions of African Americans in New England from the colonial period throughout the 19th century.
National Association for the Advancement of Colored People

The *National Association for the Advancement of Colored People* (NAACP; http://www.naacp.org/) serves as the nation’s oldest and largest civil rights organization since 1909 that fights for social justice for all Americans. This association ensures the political, educational, social, and economic equality of rights or all persons and strives to eliminate race-based discrimination.

The Links

*The Links* (http://www.linksinc.org/) is an international, non-profit volunteer service organization of women committed to ensuring the culture and economic survival of African Americans. The Links has been in operation since 1946 and consists of 12,000 professional women of color in 41 states.

National Council of Negro Women

The *National Council of Negro Women*, Inc. (NCNW; http://www.ncnw.org/about/mission.htm) serves to lead, develop, and advocate for African American women as they support their families and communities. The NCNW has 39 national affiliates, 240 sections, and consists of four million members.

100 Black Men of America

*100 Black Men of America* (http://www.100blackmen.org/hunchapters.aspx) serves to improve the quality of life for African Americans, while enhancing educational and economic opportunities for them. This organization is based on the following precepts: respect for family, spirituality, justice, and integrity.