INEQUALITIES IN MENTAL HEALTH TREATMENT RELATED TO RACE AMONG SEEKERS OR RECIPIENTS OF SERVICE AT NAVY FLEET AND FAMILY SUPPORT CENTERS

Abstract

A cross-sectional design and regression analysis were used to test the hypotheses that negative racial climate and perceived racism outside of treatment setting would significantly impact the odds of self-referring to treatment, that negative racial climate and perceived racism outside of treatment setting would significantly impact the odds of completing treatment, that negative racial climate and perceived racism outside of treatment setting would significantly predict the number of sessions attended, and that treatment-specific negative racial climate and perceived racism would impact the odds of treatment completion. **Methods**: 79 Black male sailors completed an online survey consisting of the Racial Microaggressions in Counseling Scale (RMCS), the Everyday Discrimination Scale (EDS), and the Racial Microaggression Scale (RMAS). Demographic questions about age and rank in the Navy were solicited, as was the number of sessions attended. **Results**: There was no significant relationship between perceived racism outside of treatment, negative racial climate, the number of treatment sessions, and treatment completion. However, the hypothesis that treatment-specific negative racial climate and perceived racism would impact the odds of completing treatment was supported. A total of N=79 men identifying as Black or African American and are currently or had been active members of the Navy qualified for the study. Of those, n=35 sought or received services from the Navy Fleet and Family Support Centers and were included in these analyses. Less than 30% of participants reported completing 7-8 or more treatment sessions (n=9, 27%) - did not attend the minimum number for completed treatment. Only 7 (21%) reported completing treatment. Placing the sample's median scores within the context of the scale range suggest that the sample as a whole experienced high rate of racial discrimination and microaggressions in their everyday lives as well as high rates of treatment-specific microaggressions. Median score (midway point) for the EDS scale = 23, the median score for the sample = 42. Median score for the RMCS scale = 10, median score for the sample = 24. Median score for the RMAS scale = 64, median score for the sample = 121. Significant results were: RMCS and completing treatment: odds of completing treatment decreased by 23% with each addition ¼ of a point increase in racial microaggression in counseling score. Age significantly predicted a 1-2 session increase in the number of treatment sessions with every 17 to 20-year increase in age. Agreeing on a treatment plan was associated with significantly higher rates of completing treatment. Lastly, the race of the counselor results, despite the small number, indicated that more respondents who reported completing treatment and had a counselor they believed to be of Asian descent. **Conclusion**: Results point to the importance of both the client and the therapist agreeing on the course of treatment and addressing racial microaggressions within the treatment dyad as major elements determining treatment success.

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INEQUALITIES IN MENTAL HEALTH TREATMENT RELATED TO RACE AMONG SEEKERS AND RECIPIENTS OF SERVICE FROM NAVY FLEET AND FAMILY SUPPORT CENTERS.

Walter Kelly, Jr.

University of Pennsylvania School of Social Policy and Practice

A DISSERTATION

in

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DEDICATION

This project is dedicated to all those working to end racism and inequalities in mental health treatment. And to all the Black male sailors serving their country with honor, courage, and commitment while battling mental health concerns and roadblocks hindering them from treatment. Lastly to my mother, Ms. Betty Jean Solomon, and to my ancestors for providing an example of courage, selflessness, and service.

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To my immensely supportive and loving family, C.S., thank you for all your support, humor, and unconditional love. Thank you to Honour, and Ethan, my loving children; may the best I achieve in this life be the worst for you. To PENN 2019 cohort…the best cohort any doctoral student could ask for!

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clinician. Finally, thank you to all the clients I have had the immense privilege to serve over the years.

ABSTRACT

A cross-sectional design and regression analysis were used to test the hypotheses that negative racial climate and perceived racism outside of treatment setting would significantly impact the odds of self-referring to treatment, that negative racial climate and perceived racism outside of treatment setting would significantly impact the odds of completing treatment, that negative racial climate and perceived racism outside of treatment setting would significantly predict the number of sessions attended, and that treatment-specific negative racial climate and perceived racism would impact the odds of treatment completion. **Methods**: 79 Black male sailors completed an online survey consisting of the Racial Microaggressions in Counseling Scale (RMCS), the Everyday Discrimination Scale (EDS), and the Racial Microaggression Scale (RMAS). Demographic questions about age and rank in the Navy were solicited, as was the number of sessions attended.

Results: There was no significant relationship between perceived racism outside of treatment, negative racial climate, the number of treatment sessions, and treatment completion. However, the hypothesis that treatment-specific negative racial climate and perceived racism would impact the odds of completing treatment was supported. A total of N=79 men identifying as Black or African American and are currently or had been active members of the Navy qualified for the study. Of those, n=35 sought or received services from the Navy Fleet and Family Support Centers and were included in these analyses. Less than 30% of participants reported completing 7-8 or more treatment sessions (n=9, 27%) - did not attend the minimum number for completed treatment. Only 7 (21%) reported completing treatment. Placing the sample's median scores within the context of the scale range suggest that the sample as a whole experienced high rate of racial discrimination and microaggressions in their everyday lives as well as high rates of treatment-specific microaggressions.

Median score (midway point) for the EDS scale = 23, the median score for the sample = 42. Median score for the RMCS scale = 10, median score for the sample = 24. Median score for the RMAS scale = 64, median score for the sample = 121. Significant results were: RMCS and completing treatment: odds of completing treatment decreased by 23% with each addition ¼ of a point increase in racial microaggression in counseling score. Age significantly predicted a 1-2 session increase in the number of treatment sessions with every 17 to 20-year increase in age. Agreeing on a treatment plan was associated with significantly higher rates of completing treatment. Lastly, the race of the counselor results, despite the small number, indicated that more respondents who reported completing treatment and had a counselor they believed to be of Asian descent.

Conclusion: Results point to the importance of both the client and the therapist agreeing on the course of treatment and addressing racial microaggressions within the treatment dyad as major elements determining treatment success.

CHAPTER ONE: BACKGROUND AND SIGNIFICANCE

Title

Inequalities in mental health treatment related to race among seekers or recipients of service from Navy Fleet and Family Support Centers.

Problem Statement

Abraham Lincoln said, "To care for him who shall have borne the battle and for his widow, and his orphan." This quote was from Lincoln's second inaugural address and is the Department of Veterans Affairs motto. Black men in North American have faced systemic racism since 1619 and into the present. Despite this, Black men have fought in every war or conflict since the inception of the United States. Crispus Attucks (c.1723 – March 5, 1770), a Black slave who earned his freedom, was the first martyr for the American republic's cause, a fact Americans do not widely know. From the Revolutionary War (1775-1783), in which 25% of soldiers were Black men, to the War in Afghanistan (2001 to 2021), Black men have served honorably and with distinction. Nevertheless, racism in the military remains a constant and has a deleterious effect on the mental health of Black servicemen (Paradies, Ben, Denson, Elias, Priest, Pieterse, et al. 2015). Black men are less comfortable with the idea of seeking treatment for mental illness due to the stigma in the Black community associated with counseling (Rubin & Babbie, 2017). Recently, an increase in suicides among Black males in the United States Navy has been noted; Black men, meanwhile, have the lowest national suicide rate (6.85) per 100,000,

which makes the spike in the Navy significant (Curtin, & Hedegaard, 2019). The number of suicides in the Navy rose from 41 in 2013 to 68 sailors in 2018. This increase reflects a rate of 12.7 sailors per 100,000 sailors in 2013 to 20 deaths per 100,000 in 2018 (Phillips, 2019). Sailors require mental health services. When considering the increase in suicides by Black sailors, it is clear that they are in critical need.

When Black men receive mental health services, they are more likely to drop out or not trust the providers. Many suffer in silence or seek mental health assistance from Black providers with whom they feel understood. Some studies suggest that Blacks have learned to seek mental health services from other community sources, namely, religious organizations, primary care physicians, and online resources (Thompson et al., 1994; Babbie & Rubin, 2017). Moreover, Black men seeking services within traditional mental health channels are often classified as hostile, uncooperative, or viewed with suspicion by service providers (Babbie & Rubin, 2017). Some are more likely to be misdiagnosed with severe mental illnesses (schizophrenia) instead of mood disorders (Schwartz & Blankenship, 2014). Their study suggested that Black Americans are three to five times more likely to be diagnosed with schizophrenia than European Americans. Since the 1970s, researchers have noted that Black American clients with affective disorders are at a higher risk of being misdiagnosed with schizophrenia than White clients (Trinh, Shtasel, Williams, & Medlock, 2018). As for those who seek assistance, many encounters occur when Black men react to stereotypical or racially insensitive questions from providers or simply request an informed explanation about counseling and its possible impact on their careers. This mistreatment and culturally biased malpractice add to the marginalization and reinforce negative interactions with service providers (Clark, Anderson, Clark, &Williams, 1999; Meyer, 2003;

Williams & Williams-Morris, 2000). Additionally, Black sailors are 40% more likely than Whites to be administratively separated from naval service for disruptive acts related to interpersonal or behavioral problems (Christensen, 2017).

This data demonstrates that Black male sailors are not completing mental health treatment in the Navy, thereby increasing the potential for harsher discipline consequences. Suppose those Black male sailors had received mental health services to address their concerns and had successfully completed treatment, would an administrative separation be likely? Black male sailors face discrimination and derision throughout their military careers, whether they have their orders questioned when they are in leadership or have their struggles categorized as malingering. Being a victim of discrimination can lead to health problems, mental health concerns, and disciplinary issues (Christensen, 2017).

Counseling interventions are means to address mental health concerns, thereby mitigating further disciplinary punishment. This quantitative research project identifies barriers restricting Black male sailors from completing treatment and recommends measures to reduce those barriers. Fleet and Family Support Centers (FFSC) are the Navy's hubs for mental health treatment for service members and their families. The centers focus on less severe mental health concerns. To address this lack of research, we explored the following question: To what extent do perceived racial climate, perceived racism, and provider mistrust among Black male sailors affect their seeking and remaining in treatment at Navy Fleet and Family Support Centers? This researcher included one inductive question: What is the experience of Black men sailors seeking and staying in mental health treatment at the Navy Fleet and Family Support Centers?

Literature Review

Racial discrimination, clinician-client treatment dyad, critical race theory, and racially charged workplace climates have been studied since 1970. As studies proliferated, the concepts of prejudice, discrimination, and climate have been better honed, conceptualized, and operationalized for measurement and consistency to ensure both internal and external validity. Recently, clinical provider/interracial treatment client dyad and the concept of racial microaggressions have come to the attention of clinical practice due to that previous research and scholarship (Redmond, Galea, & Delva, 2009). These concepts and the application thereof will be further illuminated in the sections below.

Perceived Racism and Discrimination

Perceived discrimination is defined as "a behavioral manifestation of a negative attitude, judgment, or unfair treatment toward members of a group" (Pascoe & Smart Richman, 2009, p. 533). It is a complex concept to operationalize and measure; however, many researchers have produced measures to capture what victims of discrimination have been trying to clarify for years. Clark et al. (1999) indicated that perceptions of racism are associated with psychological distress and occupational problems. These researchers utilized the *Everyday Discrimination Scale* to measure the concept of perceived racism. Other studies concluded that the best measures to capture perceived racism include: the aforementioned *Everyday Discrimination Scale* (Williams, Yu, Jackson, & Anderson, 1997), the *Experiences of Discrimination Scale* (Krieger, 1990), the *Index of Race-Related Stress* (IRRS: Utsey & Ponterotto, 1996), and *Perceived Racism Scale* (McNeilly et al., 1996). The literature also suggested that perceived racism's

operationalization has significant variability due to the nature of the concept – from several racist incidents to stress associated with racism and microaggressions when seeking assistance (Pieterse, Todd, Neville, & Carter, 2012). Therefore, a comprehensive measure to capture all the levels is needed to encompass the concept entirely.

When it comes to the cross-racial treatment dyad (Black client/White therapist), Sue et al. (2003, 2008) posit that counselors should be aware of their worldviews and the standards they used to judge normality and abnormality; the implicit values and assumptions about human behavior, and the biases, prejudices, and stereotypes inherited from their societal conditioning. Sue et al. (2007) introduced the new face of racism in the form of racial microaggressions. "Racial microaggressions are brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group, and are expressed in three forms: microassaults, microinsults, and microinvalidations (p. 72)." Sue's qualitative research helped explain an unexplained and often mystified phenomenon many racial minorities have faced in their daily lives, giving it a vocabulary and operationalizing its concepts. This inductive approach was utilized to gain more information about racial microaggressions and is commonly employed when researching phenomena affecting marginalized groups.

Sue (2007) also studied microaggressions in everyday life. In this study, he focused on the phenomenon's invisibility and dynamics. He stated that the perpetrator is often unaware that they are employing microaggressions (microaggression, microassault, microinsult, microinvalidation), and the recipient is unaware as well. Sue (2005) stated that most White

Americans believe themselves to be fair, moral, and decent people believing in democracy and equality. As such, they find it hard to believe that they harbored racist biases that harm people, which may appear to be somewhat contradictory to the deliberate racial assaults because one is dealing with microaggressions and not overt acts of racial violence. However, those on the receiving end of the microaggressions are troubled about the event, wondering if it really happened (Crocker & Major, 1989). For this study, the Racial Microaggression Scale (RMAS) (Sue et al., 2008) was utilized to operationalize perceived racism and prejudice. The measure also possesses a concept to capture climate (institutional racist environment). Moreover, the RMAS is a commonly utilized scale in most studies regarding African Americans and perceived racial discrimination.

When it comes to perceived racism and the resulting impact, Pascoe and Smart (2009) conducted a meta-analytic review that cited 134 studies and concluded that perceived racism has a deleterious effect on its victims' physical and mental health. Many victims suffered from depression and anxiety. The authors' study sought to establish a quantitative relationship between perceived racism and health problems. Their research tracked lifetime, recent, and chronic discrimination and suggested that recent exposure to discrimination had a more significant adverse effect on victims' mental health than a lifetime of chronic discrimination.

Paradies et al. (2015) identified physical health illnesses like hypertension, breast cancer, high blood pressure, and obesity. Other studies indicated harmful physical ailments associated with a stress response to perceived racism (Clark, Anderson, Clark & Williams, 1999).

Some disregard perceived racism/discrimination as a construct because subjects perceive and report it without verifying actual events. Notably, this is very convenient for dissenters. This disregard can further gaslight the victim of racism and potentially cause mental distress. Regardless of verification or not, these experiences are a form of stress. Lee and Ahn's (2011) study identified among Asians a small average correlation between perceived racism and mental distress. However, there was no association between Black Americans and mental health problems from perceived racism and discrimination. Other studies focused uniquely on African Americans. Pieterse, Todd, Neville, & Carter (2012) focused uniquely on Black Americans using empirical literature. These researchers wanted to distinguish Blacks from other minorities and found that perceived racism significantly affected Black Americans' psychiatric symptoms and general distress. Williams and Williams-Norris (2000) posited that variations in findings could be associated with the matter in which racism and mental illness are operationalized. Thus, findings might vary depending upon whether researchers assessed only exposure (frequency of racial encounters), perceptions of stress associated with racism (appraisal of the racial encounter), or both.

Works by DuBois (1898), Fanon (1963; 1967), and Feagin (2001) focused on the theme of racism's psychological effect on Black People. However, Carter (2007) definition encompasses the societal dynamics of racism:

> Racism is … the transformation of racial prejudice into individual racism through the use of power directed against the racial group and their members, who are defined as inferior by individuals, institutional members and leaders, and which is reflected in policy and

> procedures with the intentional and unintentional support and participation of the entire race and dominant culture (p. 24).

Discrimination are the negative actions and behaviors directed at a person or group because of their marginal social status (Jones & Carter, 1996). Perceived racism and discrimination have been well defined and studied by many researchers providing literature and a framework for this proposed study. However, when seeking treatment for perceived racism, discrimination, or other mental health concerns, the therapist's fit tends to be an important indicator of successful treatment. That therapeutic relationship will be discussed in the next session.

Client-therapist Treatment Dyad

The client-therapist treatment dyad is the cornerstone of psychotherapy. Trust in one's therapist is considered vital to a successful relationship (Marmor, 1976; Rogers, 1942) and the best indication of favorable psychotherapeutic outcomes (Constantine, 2007; Orlinsky, Grawe, & Parks, 1994). Studies also indicate that gender and race concerns are essential determinants of successful treatment outcomes. Bhatti (2014) found that women preferred female therapists, and even male clients preferred female therapists to males. The study concluded that both female and male clients reported a higher treatment alliance with female therapists across all therapy stages. Her research suggested that female-to-female gender matching supported the "female effect" in which female clients had a better therapeutic alliance while the male-to-male matching dyad did not share the same findings. Interestingly, this study reported male clients with a female therapist with the highest treatment alliance.

Other studies have suggested attachment as an influential factor for successful treatment completion. Attachment theory has been utilized to explain the treatment dynamic within the client-therapist treatment dyad. Hillman (2020) suggested John Bowlby's *secure base* (Bowlby, 2005) as essential to therapeutic change. Bowlby posited that the therapist is an attachment figure for the client, similar to the infant-caregiver relationship. Mallinckrodt (2010) suggested that clients seek proximity to their therapist, who serves as a haven providing a secure base for the client to explore their past painful memories. He concluded that clients experience separation anxiety associated with treatment termination (Hillman, 2020; Mallinckrodt, 2010; Shaver & Mikulincer, 2016). Wisman and Tishby (2014) linked the client-therapist treatment alliance to their attachment style. Studies on attachment and the therapeutic alliance suggest securely attached clients reported higher treatment alliance scores on research measures (Satterfield & Lyddon, 1998). Equally, Diener & Monroe's (2011) research indicated that insecure attachments among clients were reflected in weaker client-therapist treatment alliances.

Regarding insecure attachment to therapists as healers and the African American community, Washington (2009) asserts that in the African American community, there is a fear of the healer entitled iatrophobia, due to the past abuses between healer and the African American community in the history of the United States medical system. Washington (2006) derived Iatrophobia from Iastros-healer and phobia-fear. According to Holley (2011), African Americans were exploited and denied fundamental human rights, and this pattern of mistreatment manifests today in how African American men have viewed the mental health profession. Also, Black men established other insecure attachments with therapists. Baker and Bell (1999) suggest that African American men were mistreated by mental health professionals

and labeled as "hostile" or having "poor motivation" when they arrived home from the Vietnam war.

Another consideration impacting the treatment dyad is personality similarity between the client and the therapist associated with the working alliance and goal formulation. Bordin (1979) suggested that the working alliance in therapy consisted of three facets – goals, tasks, and bond, and the treatment alliance is forged based on the mutual agreement on those treatment goals. He added that tasks or objectives were means to reaching or achieving those goals, and the bond is solidified in mutual trust, respect, and the requisite mutual liking for goal attainment (Obegi, 2008; Taber, Leibert, & Agaskar, 2011). Bordin's theory focused more on forming goals and objectives and less on racial and sociodemographic information.

Similarly, Holland's (1997) Person-environment (PIE) Fit theory focused primarily on the interpersonal relations that impact the client-therapist treatment alliance and, consequently, the treatment outcome. Holland concluded that the degree to which people, in this case, client and therapist, have positive interactions with one another reflected positive outcomes in treatment (Taber, Leibert, & Agaskar, 2011). Other studies suggested that the therapist's years of experience indicated an excellent treatment alliance for the therapist and client. Baruch et al. (2009) found that therapeutic experience was more conclusive for client dropout than any client factor. Experienced therapists were also able to offer additional sessions for their clients resulting in more goal attainment (Goldenberg, 2002). In addition to the therapist's experience, the client's social-economic status (SES) was researched, and the data indicated that successful completion of treatment was positively correlated to SES. Roos and Werbart (2013) found that certain client factors are indicators of treatment dropout, namely, low SES. The researchers also found that

clients with higher SES were more likely to continue treatment to completion. Attachment style, personality similarity, therapist experience, PIE Fit, and social-economic status are factors that impact the client-therapist treatment dynamic; however, race is another determinant factor and is the focus of this research project.

Constantine (2007) suggested that race impacts the client-therapist dyad and is one of the most useful indicators of successful treatment, to a significant degree. She suggested that even well-meaning and culturally sensitive White therapists can unwittingly negatively affect the treatment alliance. Constantine (2007) authored several studies on cross-racial counseling relationships. Her research focused on the pernicious effect of racial discrimination in the counseling dyad with White therapists and Black clients. Despite their efforts to provide effective treatment, White therapists may display racial microaggressions that could prevent a healthy therapeutic working alliance and client's satisfaction with counseling. Despite allegations of plagiarism and dismissal from Columbia University, Constantine's work concerning racial microaggression perceptions is beneficial. Few studies have examined cross-racial therapeutic relationships, and her qualitative work unlocked essential concepts about this phenomenon, namely, twelve racial microaggression categories (2007). These important categories are (a) colorblindness, (b) overidentification, (c) denial of personal or individual racism, (d) minimization of racial-cultural issues, (e) assignment of unique or special status based on race or ethnicity, (f) stereotypic assumptions about members of a racial or ethnic group, (g) accused hypersensitivity regarding racial or cultural issues, (h) the meritocracy myth, (i) culturally insensitive treatment considerations or recommendations, (j) acceptance of less than optimal behaviors based on racial-cultural group membership, (k) idealization, and (l) dysfunctional

helping or patronization. A measure was developed from this research and piloted with the participant group. The measure is called *Racial Microaggressions in Counseling Scale (RMCS)*, which is a 10-item measure scale with a Cronbach's alpha of .73 for reliability. This scale was used in this study.

In addition to race, Black Americans have skepticism of White mental health professionals embodied in the idea of "healthy cultural paranoia" (Terrell & Terrell, 1981). This healthy cultural paranoia stems from Blacks' oppression in America and hideous medical experiments. This cultural mistrust affects the client-therapist treatment dyad. It could very well lead to premature termination of counseling services, lower expectations of a White therapist, lower amounts of self-disclosure, and negative attitudes about men seeking mental health assistance (Constantine 2007; Terrell & Terrell, 1984; Thompson et al., 1994). Chang and Berk (2009) investigated what elements could make cross-racial therapy work despite these gloomy prognostications. They conducted a phenomenological inductive study of clients' cross-pessimistic therapy experiences. The researchers had 16 minority clients matched with 16 White therapists in this study. The results reported were that 8 of the 16 thought the experience was a positive one. The other eight were unsatisfied with their therapists. The findings for positive therapeutic relationships were that the client met goals; the client felt connected to the therapist; the termination process was sufficient, and the client wanted to remain in a relationship after the treatment. For the unsuccessful outcomes, participants indicated that the therapist misunderstood them; the therapy was a waste of their time; their needs were not met; the therapist was not engaged in the treatment process, and the therapeutic relationship degenerated over time. Our

study inductive question yielded comparable results and will be discussed in the conclusion section of this study.

As reviewed above, race, gender, bond, goals, objectives, and attachment are all cogent elements to a successful client-therapist dyad. As therapy occurs in the context of a treatment environment, the following section explores the literature on how the facility's racial climate intersects with successful treatment outcomes.

Environmental or Racial Climate

The concept of person-in-environment provides a framework for this study. "The PIE perspective emphasizes social work knowledge and skills that improve the contextual goodness-of-fit, mutual transactions between, and adaptations of individuals and their environment (Rogge & Cox, 2002, p. 49)." “PIE distinguishes social work as a profession that seeks to change and enhance the lives of people and the greater society creating the micro and macro approaches addressing personal care and social justice respectively" (Wetzel, 1980, p. 1). PIE's dual focus on psychological (individual) and sociological (environmental) theory supports social work's unique perspective in providing a foundation for examining the workplace or business climate of FFSC. Climate refers to how individuals perceive a workplace or business environment. It is a judgment of an organization's environment based on different observation levels ranging from friendly to hostile. The concept of climate explains how environmental variables (i.e., observations) may affect psychological ones (i.e., perceptions) (Tannenbaum, 1982; Naylor, Pritchard, & Ilgen, 1980).

Reid and Radhakrishnan (2003) studied the relation between race and general campus climate. Although this study does not address a mental health treatment facility, some climate concepts are beneficial. The organization's climate is a judicial process that an individual determines by aggregating her perception and observation of the organization's environments at multiple levels (Naylor, Pritchard, & IIgen, 1980). Their study examined how the environment or one's perception of it could affect one's psychology. Their study sought to examine students' perceptions of the racial and academic climates as indicators of the general campus climate. The focus was on the indicators of a racially charged environment. Their study concluded that racial minorities evaluated the general climate environment as unfavorable, whereas White students did not. Racial minority students' satisfaction with the university rested mainly on academic concerns. These results echoed the previous study by Graham and Gisi (2000), which predicted that academic success was the best indicator of satisfaction, not necessarily the environmental or social climate. The authors suggested that a longitudinal study is needed to track the effects of a racially charged climate over time. This research study, however, explores the racial climate of FFSC to see if clients are affected in any way or detoured from treatment.

Other researchers focused on the outcome of victims exposed to a racially charged climate. Triana, Jayasinghe, & Pieper (2015) looked at cultural diversity with relative deprivation theory as a framework to examine employee reaction to perceived workplace racial discrimination. They aimed to determine if perceived racial discrimination negatively impacted job attitudes, physical health, psychological health, organizational citizenship behavior, perceived diversity climate, and positive coping behaviors. Their research concluded that

perceived workplace racial discrimination is related to many adverse outcomes for minority employees regarding job attitudes and physical and psychological health.

As this project focuses on the military and its workplace environment, a look at the military measures is suggested. The military has periodically administered racial climate surveys to ascertain if racial discrimination occurs, and the instrument utilized was the Racial Attitudes and Perceptions Survey (Hiett et al., 1978). This survey measured service members' perceptions in four areas: perceptions of discrimination against African Americans, attitudes toward racial interaction, feelings of reverse racism by Whites, and racial climate. The survey evaluates discriminatory behaviors and tension levels perceived by service members. The coefficient alphas for the scales ranged from .74 to .92 with a test-retest reliability coefficient range of .66 to .76 (Pike 2002). This measure is no longer in use. The Military Equal Opportunity Climate Survey (MEOCS) is in current use. The MEOCS surveys racial climate and discrimination, sexual assault and harassment, and hazing within units. Both surveys are internal documents limiting them to official use only. Moreover, these surveys are administered per unit, listing demographic information within each unit, limiting confidentiality and anonymity. If a unit has one female sailor, her answers to the survey are de facto, not anonymous. Nevertheless, these surveys are the military's attempt to address racialized climate within its ranks. In this attempt to address climate, missing is an appraisal of the climates at the varying services for military members seeking assistance, namely medical and mental health services.

Scales uniquely measuring the climate in a mental health facility were not found for veterans or naval personnel. A few were found in civilian sectors; namely, the microaggression

in health care (MHCS) scale in conjunction with the Depression, Anxiety, and Stress Scale (DASS-21) was utilized to measure the racial climate of healthcare facilities (Cruz, Rodriguez, & Mastropaolo, 2019). Within the conceptualization of climate, civilian researchers studied the actual physical environment in terms of the color of the room, the smell of the room accessories within the counselors' room, style of furniture and décor, as well as lighting to see if those elements affected the counseling process (Pressly, & Heesacker, 2001). These researchers found that the tweaking of the counseling environment could promote healing and enhance the counseling relationship and process. Nevertheless, no identified study measured the mental health treatment facility's racial climate. As explained above, most military-oriented studies focused on sexual assaults, sexual harassment, racial discrimination and hazing within units, and workplace climate in individual units. Nevertheless, contemporary studies have been formulated to operationalize the concept of the environmental climate or invalidations. The Racial Microaggression Scale (RMAS) has developed five questions to measure the racial climate (Torres-Harding et al., 2012). These items assess the perceptions of negative messages derived from being unwanted or excluded from the cultural representation of the workplace or environment. This study adopted the environmental subscale for sailors seeking treatment at Fleet and Family Support Centers.

The history of medical and mental health mistreatment may explain the reluctance of Blacks in seeking treatment from non-Black providers. Viewing medical and mental health through the lens of mistrust shapes the experience. The next section explores medical and mental health treatment vis-à-vis Black Americans.

The History of Racism and How it relates to Mental Health

The United States officially began July 4, 1776, with the Declaration of Independence. The Founders of the American republic were in opposition with the British Empire's authority to levy taxes without providing parliamentary representation. King George V wanted to assert his dominance over the 13 colonies by enforcing an excise tax on imperial goods and commodities to pay for the French and Indian war's exorbitant costs. King George V reasoned that since the war took place primarily for the colonists, they should pay via increased taxes. The American colonists fought back and unified around the idea of ridding themselves of the vestiges of an empire that is tyrannical, distant to their shores and concerns, and myopic to the notion of a burgeoning colony developing its own identity (British reforms and colonial resistance 1763-1766, 2010).

However, long before this polemic between the American colonists and the British Empire, in 1619, the first of many particular "commodities" arrived at the shores of North America. Captured Africans, mainly from West Africa, were brought to America and forced into slavery. Slaves were considered mere cargo on these vessels to be sold to work on coffee, tea, sugar plantations, gold and silver mines, rice fields, and construction industries. The Portuguese were the first to transport Africans to South America (Brazil) in 1526 (Sweet, 2003). Portugal and Spain briefly united as an empire to capitalize on this lucrative venture. Pope Alexander VI served as arbiter in the Treaty of Tordesillas 1493, which divided the new world into areas of influence. The demarcation line would be halfway between the Republic of Cabo Verde Islands and the islands entered by Christopher Columbus's first exploration of the new world.

Lands west of the division would belong to Spain and lands east to Portugal. One could see the imprint of that decision in that Portuguese is spoken in Brazil and Spanish in Argentina. Other European powers joined in to exploit this new commerce. All who participated in this "peculiar enterprise" are listed in order of their volumes of selling kidnapped Africans. Portugal was first followed by England, Spain, France, The Netherlands, and Denmark (Klein, 2010; Rawley, 2005). One does not associate the Danes with slave trading and imperialism; however, they were quite active selling enslaved African people during the Transatlantic slave trade from early 1600 until 1792. Officially, the Danes ended their role in the peculiar enterprise in 1792; however, the slave trade persisted in its West Indies colonies until July 1848, roughly 56 years of activity despite abolishment.

The Assiento was a treaty between the British Empire and Spain in 1713 in which the latter granted the former a virtual monopoly of the slave trade for thirty years. During that time, England supplied the American colonies roughly 144,000 slaves at a rate of 4,800 per year (DuBois, 1898). England referred to its slaves as indentured servants and added a provision that extended slavery to the slave's offspring, thereby creating a permanent racial caste in its colonies. Slaves were considered property or "chattel" with no rights, which could be bought, sold, or bartered with no regard for the slaves' humanity or self-determination. This development was a stark contrast to indenture servitude other colonial powers extended to European debtors irrespective of the British's euphemistic nomenclature. In its real sense, indenture servitude consisted of debtors paying off their financial obligations by submitting themselves voluntarily to servitude for a discrete period.

To further anesthetize slaveholders from the bestial nature of chattel slavery, Carl Linnaeus (1753) "Species Plantarum" classifications and Johan Blumenbach (1775) "The Natural Varieties of Mankind" were used to establish and justify a racial hierarchy with African people situated at the bottom with no accorded humanity (Lang, 2000, p. 229). Certain religionists referred to Blacks as "beasts of the field" and used the Leviticus 18:23 reference for the prohibition of sex with animals to prohibit interracial sex. It is not clear if these two scientists were the progenitors of a specific racial hierarchy or caste. Granting them purely scholarship alone, however, their ideas were propagated and used by empires to perpetuate the practice of slavery until its and other various forms of slavery's abolishment in the western world in 1888 by Brazil. In the United States alone, racism in the form of chattel slavery persisted for 246 years. The by-products of racism – Jim Crow, segregation, Black codes, ghettoes, remain a part of America's history. Employing the end of official discrimination with the 1964 Civil Rights Act to the United States' founding in 1776, American slavery and discrimination has a history of 188 years. To put this in perspective, the year 2152 would be the year when America has more years as a free republic than its history of slavery. Since the inception of White hegemony or ascendancy and its subsequent permeation to every aspect of human life – economics, education, entertainment, labor, law, politics, religion, sex, war/counter-war (Fuller, 1984), racism has ensured special treatment for those classified as White. Fuller did not list medical and mental health in his human activities; however, racism in medical and mental health domains has been well documented. Racial and ethnic mythologies informed theories routinely taught in medical schools in the 18th, 19th, and 20th centuries (Byrd & Clayton, 2000).

> From the American Health system's very beginnings, race has been and remains a pervasive yet enigmatic issue. Race is important in American health and care, whether viewed from the perspective of racism adversely affecting clinical decision-making regarding patients; White indifference to the African-American Health Crisis; continuation of discriminatory barriers to African American entry into the prestigious health professions, and unfair and biased treatment after Black become physicians, dentists, nurses, etc. (p. 11S).

In other words, racist ideas, concepts, ideology, and beliefs created, held, and promulgated by the American Health system continue to negatively impact Blacks' health in America.

In her book, Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present, Harriet Washington (2006) documents a history of mistrust from Black American patients to White physicians based on inhumane practicing and experiments done on Black patients. The author catalogs a history of maltreatment – from slave owners not providing adequate or thoroughly cleaned living quarters to the Tuskegee syphilis experiment (1932 to 1972) in which Blacks were denied treatment in a controlled experiment to track the progression of the disease through stages. This experiment lasted 40 years until a social worker brought it to the attention of the authorities. Washington highlighted James Marion Sims, who used Black slave women to conduct experiments in the name of science. Sims, regarded as the "father of gynecology," is known for his research on vesicovaginal fistulas in which he used four female slaves to pursue a cure for the malady. He justified his study by stating the common

mythology floating around the "scientific community" that Blacks did not feel pain in the same way as Whites.

Mental Health and Racism

In the mental health sector, Fernando (2017) researched the history of mental health treatment and how it shifts to new forms based on the epoch's ethos, which has consistently pathologized Black people's behaviors and illnesses. Cushman (1995) speaks about psychoanalysis and how its concept of the unconscious was used to justify anti-Semitism in Europe. He highlighted Carl Jung, who wanting to escape possible recriminations from the Nazis, capitalized on Freud's Jewishness, hijacked Freud's ideas and collaborated with the Nazis going so far as to call Freudian psychoanalysis a "Jewish science". It is unclear if Jung was antisemitic; however, his actions must be analyzed in a society filled with intolerance and rampant anti-Semitism. Cushman added that the unconscious concept was used to sell sex, commodities, promote racial thoughts and ideals, and acceptable discriminatory behaviors and actions.

> “One way Americans addressed this absence (of communal identity) was by developing a negative identity. American society developed a concept of the self, the proper way of being human, by constructing "the other" – the Negro slave, the Native American, The Jew, The Irishman, the woman – in such a way as to define and justify the white self by demonstrating what it was not" (p. 346).

In her book, "When Getting Along Is Not Enough," Walker (2020) commented on Jung and his ideas of closeness to lower races leading to degeneration in the White race. In an address to the 1928 Psychoanalytic Conference, Jung remarked:

> “The different strata of the mind correspond to the history of the races. Black primitiveness so infects American behavior in general. What is more contagious than to live side by side with a rather primitive people? The cause of repression can be found in the specific American complex, namely to the living together with lower races, especially with Negros” (Walker, 2020 p. 9; Thomas & Sillen, 1972, pp. 13-14).

Pinderhughes (1969) likened racism to paranoia projection in which Whites protect themselves from experiencing cognitive dissonance by projecting it onto Blacks, who are then devalued and cast as the origin of the problem. This process is likened to Klein's projective identification in which Whites consciously or unconsciously project their feelings unto Blacks, and the latter starts to identify and behave in like manner to the accusation (Abram, 2018).

In psychiatry, Dr. Samuel Cartwright (1851) posited a diagnosis unique to Black slaves attempting to escape their captivity. He termed the ailment "drapetomania”. In this so-called psychiatric diagnosis, slaves seeking to flee their masters and the legal institution of slavery must be experiencing an emotional or psychiatric impairment. The implication is that the institution of slavery is benign, harmless, and beneficial to both society and slaves, and human beings desirous of agency or freedom from this institution must possess weakened mental acuity. Cartwright also theorized that laziness, lethargy, and various unrelated skin ailments or conditions among slaves were caused by what he dubbed "dysaesthesia aethiopica or hebetude of mind and obtuse

sensibility of body." In this supposed disease, Cartwright proposed that freed Blacks could not care for themselves without a White person to direct them (Tobe, Tobe, & Tobe, 2017). Contemporary scientific practices deemed Cartwright's conceptions as pseudoscience; nonetheless, his theories and writings profoundly affected the conventional wisdom for the treatment of slaves and their attempts to escape slavery in his era. Jackson (2002) emphasized how Cartwright's pseudoscience conventions informed the daily medical treatment of slaves in America. In particular, she discussed how pseudoscience interpretations justified certain slavery practices and conventions in the slaveowners' minds. Lesions on the backs of slaves were interpreted as a symptom related to dysaesthesia aethesia, which had a prescribed cure. Back lesions could be quickly healed or treated by whipping the slave. Jackson concluded that Cartwright's justifications for these illnesses and their treatments are products of fallacious circular reasoning. Cartwright started with his conclusion (slaves should be beaten if they are obstinate) and looked for an argument to justify actions or treatment (they have dysaesthesia aethesia).

In psychology's history, racist conventions and theories have also been promulgated. Raymond B. Cattell, the so-called father of dispositional theory (trait theory) and the author of more than 57 books about psychology, was a staunch proponent of racial segregation and used 'science' to justify his theories. Cattell posited that the biological union of individuals from different racial backgrounds would produce genetic disharmonies in the offspring (Tucker, 2010). He wrote, "in a pure race, adapted to its conditions by long ages of selection, the inheritance of impulses in each individual is bound to be well balanced (p. 84)." He continued, "The innate forces which are the innate material of character-building must have reached a

certain mutual compatibility and potential power of good integration. If two such races interbreed, the resulting reshuffling of impulses and psychic forces throws together in each individual a number of items which may or may not be compatible and capable of being organized into a stable unit." (p. 84).

His proponents could allege that Cattell was a man of his era; however, in 1987, Cattell suggested that "plant hybridization are 90 percent unsuccessful due to unfortunate combinations, and unfortunate combinations are the reasons for higher crimes and insanity rates in the United States as opposed to its parent country (England)" p. 109 (Tucker, 2005; Cattell, 1987). This statement implies that racial mixing is the source of aberrant behavior and mental illness. Cattell's ideas were prevalent in the 1930s, coinciding with the rise of Nazism in Germany. His contribution to psychology is unquestionable; however, how does one read his theories without contemplating his personal, political, and world views? Cattell's Trait theory is considered a fundamental building block in psychology, upon which many personality inventories and questionnaires were developed.

Lombardo (1978) posited two tropes for Black male stereotypes – "brute" and "sambo." Under the guise of science, these two stereotypes were used to propagate the idea of Black mental dullness and lack of self-discipline and Black infantilization or child-like manner (Hall, 2001; Lombardo, 1978). As a result, Black men were not fit for leadership and should be regarded as unintelligent children in need of guidance and discipline. These two themes have a long history in psychological literature. Jensen (1969) published an article in the Harvard Educational Review. He states that the government's attempts to address the intelligence deficits

in children of African/Black descent have been a failure and should be eliminated. He concluded that since these efforts have not bridged the gap, the only conclusion is that Blacks are intellectually inferior to Europeans. One need only point to environmental factors (poverty, racism, and discrimination) and the questionable validity of the Intelligence Quotient (IQ) tests that measure intelligence and legacy admissions to universities to point out Jensen's argument from ignorance fallacy. In short, racialist theories based on faulty science have done tremendous harm to Blacks in America.

Finally, within the clinical practice domain, inequalities of treatment can be demonstrated by provider bias, whether unintended or purposeful. Clinical practice is the crucible in which research and theories converge, and their effectiveness is evaluated. Clinical practice literature has acknowledged the importance of addressing racial and cultural differences between therapist and client (Arredondo, 1999; Harley, Jolivette, McCormick, & Tice, 2002). Other factors are essential and should not be neglected when considering racial and cultural components. Thompson and Jenal (1994) found that Black clients preferred having the topic of race broached during the first sessions as it creates a level of comfort for them and a non-Black therapist. Provider mistrust based on the history of illegal experiments and racist philosophies will undoubtedly hinder the treatment alliance between provider and client; however, the seminal works of Pierce (Pierce 1969; Yasso 2001) on microaggressions in a chapter entitled “Is bigotry the Basis of the Medical Problems of the Ghetto?”, to Sue’s (2003) conception and measurement of racism in form has greatly assisted victims of racism and providers with identifying and fleshing out what has been challenging to verbalize in the past.

Lastly, the over-diagnosing of Blacks with psychotic disorders has been egregiously wanton. Schwartz and Feisthamel (2009) conducted a study of 10 countries' community mental health agencies with 1648 participants revealing that African Americans were significantly more likely to be diagnosed with a psychotic disorder than White Americans (27% to 17%). The researchers concluded that African Americans' symptomologies were more associated with disruptive or socially defiant patterns of behaviors. Perry et al. (2013) studied data from 129 randomly selected evaluations and found that White Americans were 78% less likely to be diagnosed with a psychotic disorder than Blacks. Interestingly, his data was collected from pre-trial evaluations at a correctional facility, which could have implications for criminal justice outcomes. Schwartz and Blankenship (2014) conducted a meta-analysis study that reflected over 24 years of data and found that African Americans were 3-5 times more likely to be diagnosed with schizophrenia than Euro- Americans. They added that race was the strongest predictor of inpatient admissions for schizophrenia when controlling for other variables.

Despite its commitment to eliminating oppression in any form, and affirming equal treatment and respect for all, social work has a history of anti-Black racist practices. The National Association of Social Workers (NASW) officially apologized to Blacks and other racial minority groups in America for its role in systemic racism. Focusing on anti-Black racism, the NASW acknowledged perpetuating segregation in the settlement houses, blocking the right to vote to Black Americans, supporting the eugenics theories and program, and assisting with the recruitment of Black males in the Tuskegee Experiment (Arendt, 2021).

From theories and their racists implications to mental health practices based on those theories, the history of mental health and racism has had a pernicious effect on the lives of Black

people the impact of which has persisted to the present. In the next section, we will add the framework for this study, critical race theory.

Critical Race Theory and how it relates to Mental Health Treatment for Black Americans

To understand racial discrimination related to mental health treatment, one must first understand the fundamental theory that sought to explain American social inequalities. In the 1970s, a movement sought to understand race, racism, and power differentials. The movement came to be known as critical race theory (CRT). CRT is "a collection of activists and scholars engaged in studying and transforming the relationship among race, racism, and power. The movement considers many of the same issues that that conventional civil rights and ethnic studies discourses take up but places them in a broader perspective that includes economics, history, setting, group and self-interest, emotions and the unconscious." (Delgado, 2017, p. 3). The movement wanted to continue the gains of the civil rights movement by linking it to scholarship and legislation. The movement sought to change incrementalism (achieving slow gained working within the system's paradigm), Enlightenment rationalism, and the neutral principles stance of constitutional law utilized to effect change in American jurisprudence (p. 4).

The foundations of CRT are myriad. Jacques Derrida's Deconstructionism (irreconcilable contradictory meanings in concepts), Michel Foucault's Discourses on knowledge and power with a society (power uses knowledge to shape it to power's desired end or purpose), and Antonio Gramsci's Culture Hegemony (the power of ideology to reproduce itself in societal institutions) served as critical structures in CRT's development (Delgado, 2017). Black Americans such as Frederick Douglass, Sojourner Truth, W. E. B. DuBois, and Martin Luther

King, Jr. contributed to CRT by stressing the urgency and immediate need for change. CRT borrowed heavily from two previous movements in implementation and social change: critical legal studies and radical feminism. From critical legal studies, the idea of legal indeterminacy was borrowed. This idea implies that not every legal case has one officially correct outcome. This is to say that cases can be argued based on authority lines or hierarchy of legal authority. From radical feminism, CRT also incorporated the sense of counter-incrementalism, listing that radical change is needed now. In sum, CRT is the work of progressive legal scholars of color who are attempting to develop a jurisprudence that accounts for the role of racism in American law with the ultimate goal of eliminating racism in all forms (Matsuda, 1991).

Although several tenets have been suggested, Crenshaw, Delgado, Lawrence, and Matsuda (1993), in connection with Delgado and Stefancic (2001), reach agreement on six basic tenets of Critical Race Theory:

1. Critical Race Theory recognizes that racism is endemic to and a part of everyday American life.
2. Critical Race Theory supports the theory of interest-convergence.
3. Critical Race Theory challenges ahistoricism and insists on a contextual/historical analysis.
4. Critical Race Theory insists on recognizing the experiential knowledge of people of color and our communities of origin and often takes the form of storytelling or counterstorytelling.
5. Critical Race Theory is interdisciplinary and intersectional, and
6. Critical Race Theory works toward social transformation—eliminating racial oppression as part of the broader goal of ending all forms of oppression.

Tenet One: Racism is normal.

The first tenet deals with racism's prevalence: "Racism is normal, not aberrant in American society" (Delgado, 1995, p. xiv; Delgado & Stefancic, 2001, p. 7). It is how society does business and is the standard, everyday experience of most people of color in this country. Solórzano and Yosso (2001b) concur that racism is typical. "Racism is ordinary, not aberrational— "normal science," the usual way society does business, the common, everyday experience of most people of color in this country" (Delgado & Stefancic, 2001, p. 7). Because of the United States' social order, racism appears normal, natural, and an everlasting fixture of American lifestyles (Bell, 1992). Minorities experience racism every day; therefore, the dominant group—Whites—are blinded that it exists unless it is obvious (Delgado & Stefancic, 2001; Harrell, 2000). "Critical Race theorists are less surprised by the actual presence of racism as by the rare instances of its absence or decreased influence" (Broido & Manning, 2002, p. 440).

Tenet Two: Interest-Convergence

The second tenet is often denoted as interest-convergence, implying that the dominant group or culture will change only when it benefits them. Delgado and Stefancic (2001) state that "White-over-color ascendancy" serves the dominant group's essential purposes in several features. The first feature is "ordinariness," meaning that racism is difficult to address or cure because it is not acknowledged, and the second feature is "interest convergence" (material determinism), meaning that racism advances the interests of both white elites (materially) and working-class whites (psychically), so large segments of society have little incentive to get rid of it unless there is some benefit for whites, (p. 9). Bell (1980) describes interest convergence as a means where

conditions for White people and minorities intersect. Bell argues that minorities should begin to set the conditions of interest convergence instead of accepting or compromising based on Whites' recommendations. For example, to get Whites to desegregate, special programs or incentives (e.g., magnet schools, advanced placement (AP), before/after school care) must be implemented to ensure the best interest of the majority (Norman, 2013).

Tenet Three: Contextual-Historical Analysis

The third Critical Race Theory tenet is the necessity of historical analysis authenticated in a historical context. This tenet offers essential information about the past and how it affects the future. According to Critical Race theorists (CRITS), history has influenced present inequalities and social traditions constituting a gain and challenge to social groups based on race (Matsuda et al., 1993). CRITS suggest that taking historical accounts and grasping the opportunity to include or celebrate marginalized groups are necessary for a complete picture of society. Social construction holds that race and races are products of social thought and relations, not objectively fixed or inherent, related to any biological or genetic reality. Race and races are categories created and abolished when done by the society (Delgado, 2017). Last and recently added in the historical analysis tenet is "differential racialization". This distinction deals with how the dominant society racializes minority groups at different times based on the labor market's dictates (p. 10). For example, America replaced Black labor with immigrants, mostly Mexicans, as a significant labor force, thereby leaving Blacks disenfranchised and subject to derision or scapegoating (lazy or unproductive).

Tenet Four: Storytelling – Counterstorytelling

The fourth tenet explains how underrepresented groups or cultures can use storytelling to describe their experiences with racism (Delgado & Stefancic, 2001). Black Americans have a "unique voice of color—because they are able to communicate to their white counterparts matters that the whites are unlikely to know" (Delgado & Stefancic, 2001, p. 9). These stories grant others the ability to see inside the storyteller, who has a different view of the story, offering an understanding of the individual and what she has endured. Counterstories effectuate four roles that are categorized as theoretical: they build community among those at the margins of society by putting a human and familiar face on educational theory and practice; they challenge the perceived wisdom of those at society's center by providing a context to understand and transform established belief systems; they open new windows into the reality of those at the margins of society by showing the possibilities beyond the lives of the hearers, showing that they are not alone in their position; and they teach others that by combining elements from both the story and current reality, one can construct another world that is richer than either the story or the reality alone (Solórzano & Yosso, 2001a, p. 475).

Solórzano and Yosso (2001a) argue that "traditional claims [referencing colorblindness] act as a camouflage for the self-interest, power, and privilege of dominant groups in United States society" (p. 472). Colorblindness affirms the contradictive notion that one recognizes race but ignores its existence. Delgado and Stefancic (2001) describe the injustice behind colorblindness as CRITS hold that colorblindness will allow us to redress only extremely egregious racial harms, ones that everyone would notice and condemn. However, suppose racism is embedded in our thought processes and social structures as profoundly as many CRITS

believe. In that case, the 'ordinary business' of society—the routines, practices, and institutions that we rely on to affect the world's work—will keep minorities in subordinate positions (p. 22). CRITS regard colorblindness as an ineffective technique for combating racial subordination and a way to conserve domination over minorities (Bell, 1992; Delgado & Stefancic, 2001; Gotanda, 1991).

Colorblindness supports whites' interest and supports oppression for Black Americans. This tenant also criticizes liberalism as a framework to address racial problems because most liberals believe in color blindness and neutral principles of law (Delgado, 2017). This focus is also an attempt to eliminate the historical aspect of social injustices. Believing in equality, and equal treatment irrespective of those peoples' history or current situations, causes people to draw faulty conclusions like equating the election of Barack Obama as a signal of a post-racial America. CRITS believe that color blindness is not an advantageous position to hold as it only recognizes egregious acts of racism. Hence, the ordinary business of racism continues to exist or persist. CRITS also believe that Constitutional Rights are used to impede substantive process in America. One focuses on procedural rather than substantive rights; thus, one is afforded equal opportunity but denies a vehicle to realize that opportunity.

Tenet Five: Interdisciplinary and Intersectionality

This is the fifth tenet is a synthesis of discourses and ideologies that facilitate the creation of meaningful spaces for inclusion (Munoz, 2009). Matsuda et al. (1993) state that Critical Race Theory's interdisciplinary nature derives from "liberalism, law and society, feminism, Marxism, poststructuralism, critical legal theory, pragmatism, and nationalism" (p. 6). Critical Race Theory uses "ethnic studies, women's studies, sociology, history, law, and other fields to guide research

that better understand the effects of racism, sexism, and classism in education" (Solórzano and Yosso, 2001a, p. 473). The primary focus of this tenet is to investigate the historical and present perspectives of racism employing interdisciplinary techniques (Matsuda et al., 1993).

Tenet Six: Social Transformation

This is the sixth tenet that deals with eliminating oppression (Delgado, 2017). Matsuda et al. (1993) state that "Critical Race Theory works toward eliminating racial oppression as part of the broader goal of ending all forms of oppression through social transformation" (p. 6). This tenet is dedicated to eradicating all forms of subordination. The primary goal and purpose of CRITS are to bring all forms of oppression to an end (i.e., race, gender, and class). This tenet also focuses on structural components within a society. Structural determinism points to built-in structural limitations, not necessarily discriminative purposely, that do not lend to redressing certain types of grievances heavily noted in lexicon or vocabulary structures. For example, having only one word describes a complex phenomenon as racism (Delgado, 2017). The word racism does not cover the vast types and application of racism, i.e., biological, intentional, unconscious, microaggressions, nativism, institutional, racism with homophobia or sexism, the racism of indifference, coldness, or implicit associations, white privilege, reserving favors, smiles, and kindness.

CRT's themes and theories inform this research regarding racism's prevalence in American societal institutions, structural determinism, contextual-historical analysis, and the colorblindness fallacy. Seekers or recipients of counseling services will face these and other obstacles procuring mental health services, most commonly from the people they encounter first,

secondly from the facility's environment or climate, and lastly from the therapist. Therefore, having CRT as a prism or lens lends a framework for comprehending and analyzing Black sailors' experiences and obstacles when seeking assistance for mental health concerns. The next session of this literature review will examine identifying and measuring racism conceptualized in racial microaggressions. We will also briefly discuss the concept's criticism by opponents.

The Concept of Racial Microaggressions and its critics

"Racism can be defined as beliefs, attitudes, policies, and acts that denigrate or disadvantage individuals or groups because of presumed racial or ethnic-group affiliation" (Schimid, 1996; p. 1). Experiencing a microaggression signals a dangerous environment, resulting in corresponding psychological and physiological responses (Clark et al., 1999). "Racial discrimination is a pervasive phenomenon among African Americans, who experience it in both blatant and subtle ways almost daily" (Constantine, 2007; Feagin & Sikes, 1994; Sellers & Shelton, 2003; Swim, Cohen, & Hyers, 1998; Williams, Neighbors, & Jackson, 2003). The above cited researchers focused on attitudes, beliefs, and behaviors. Chester Pierce (1974) was the first to conceptualize hidden or covert acts of subtle racism as microaggressions. He defined microaggression as "Black-White racial interactions characterized by white put-downs, done in an automatic, preconscious, or unconscious fashion (p.515)." Since Pierce's initial study, Sue et al. (2007) codified the concept into nine microaggressions categories. "… nine categories, described as (a) assumptions that a person of color is not a true American; (b) assumptions of lesser intelligence; (c) statements that convey colorblindness or denial of the importance of race; (d) assumptions of criminality or dangerousness; (e) denial of individual racism; (f) promotion of the myth of meritocracy; (g) assumptions that one's cultural background and communication

styles are pathological; (h) the experience of being treated as a second-class citizen; and (i) environmental messages of being unwelcome or devalued. These are specific to the types of microaggressions experienced by people in our culture as a result of race or ethnicity" (Sue et al., 2007; Williams, 2019, p.4).

The concept of racial microaggression has its critics. Lilienfeld (2017) criticized the concept stating that its foundation is faulty, the terms are not well defined, and the concept is immeasurable and does not correlate to measuring racism. Haidt (2017) echoed Lilienfeld's assertion that the concept derives from a faulty premise and lacks a clear definition or agreement on what constitutes a microaggression. Moreover, critics consider the concept is too subjective, and no harm is directly linked to victims of these aggressions. However, Williams (2019) addressed these criticisms in her empirical study. Her research demonstrated that microaggressions are well defined, agreed upon by expert researchers, measured racism objectively, and can be linked to damaging mental health ailments (Williams, 2019). As for the assertion that microaggressions are harmless, the following studies linked mental and physical illnesses to people who are the targets of microaggressions. Huynh (2012), Nadal, Griffin, Wong, Hamit, & Rasmus (2014) linked depression; Banks et al., (2006); Blume et al. (2012) linked anxiety. Suicide and serious mental illnesses (Hollingsworth et al., 2017; O'Keefe, Wingate, Cole, Hollingworth & Tucker, 2015), and Post-Traumatic Stress (Williams, Printz, & DeLapp, 2018) have been linked to microaggressions. Harm does befall people who are recipients of racial microaggressions. There remains some irony that the experience of microaggressions can cause significant mental health challenges, and microaggressions also happen as one seeks and finds treatment.

In terms of seeking mental health treatment, whether conscious or unconscious, microaggressions can hinder or impede racial minorities and dissuade them from seeking assistance in the future for serious mental health conditions (Walls et al., 2015). Constantine (2007) linked treatment dissatisfaction to perceived microaggressions from the therapist as well. Therefore, many facets must be considered and addressed to provide quality services to those racial minorities who are seekers and recipients of mental health services. Moreover, when it comes to mental health services in the military, a brief review of history is necessary to encapsulate the struggles of Black service members seeking mental health assistance.

<u>The history of mental health philosophy and treatment in the military from 1900 to the present day</u>.

The hazardous occupation of being a sailor, soldier, airman, or marine exposes one to mild to severe deprivation and upsetting situations. War is the total breakdown of diplomacy, and before the Geneva Convention, there were no outlined rules of conduct during conflicts. Witnessing chaotic conditions, i.e., constant bombings, death of compatriots, property destruction, and even torture, poses severe threats to warriors' mental health. Those experiencing mental fortitude deficits were often characterized with pejorative labels, i.e., lacking moral fortitude or even cowardice. The military did not want this perceived weakness to spread amongst the troops, so officials highly criticized any disruptive mental behavior to dissuade combatants from coming forward. Even the presence of mental health practitioners, mainly psychiatrists, was thought to indicate troubling portents and misadventure. The mission is always paramount in the military, and any potential harm to its accomplishment needs to be addressed and mitigated. As a result, during both World Wars, the military instituted screening programs to

search out those likely for a "nervous breakdown" during deployments based on what the military judged to be sound characteristics, namely, constitution, genetic disposition, temperament, and early childhood experiences (Pols & Oak, 2007).

As early as the beginning of the 1900s, positive childhood experiences were linked to favorable outcomes during deployments. The prominent innovator of psychological screening and military psychiatry was Thomas Salmon. As the medical director of the National Committee for Mental Hygiene, a precursor to military psychiatry (the Bureau of Medicine and Surgery in the Navy), Dr. Salmon advocated for more research into the causes and prevention of severe mental illnesses. In short, he advised the army to screen out recruits who suffered from insanity, feeble-mindedness, psychopathy, and neuropathy (Pols & Oak, 2007). Harry Sullivan, a psychiatrist, joined the Selective Service System during World War II and developed a screening program. He added neurosis and maladjustment to the list of exclusions, reasoning that those sufferings from mere quotidian life problems in America would not survive the demands and rigor of army life (Pols & Oak, 2007). The military officials were also concerned about screening for same-sex attraction because it was viewed as degenerative and destroyed combat readiness and morale. As a result, same-sex attraction was added to the disqualification list. It was clear that certain recruits were eliminated from military service due to perceived challenges or prejudices about so-called innate abilities related to military service rather than utilizing an objective measure to determine military service suitability. Effective or scientific treatment strategies were not the priority or at the forefront. In other words, recruits were disqualified post hoc from service based solely on perceptions about same-sex attraction and the demands of everyday life. Mental illness treatment was an after-thought and not considered essential for

those members ruled eligible for military service. As for active-duty service members who required support to manage psychological distress, army psychiatrists developed treatments. During the first World War, military officials became concerned about an ailment with symptoms ranging from crying, trembling, paralysis, mutism, deafness, anxiety attacks, confusion, stupor, hallucinations, nightmares, gastrointestinal problems, heart palpitations, and insomnia. This disease came to be called "shell shock" – a precursor to PTSD (Pols & Oak, 2007). As there was no cure for this collection of symptoms, sufferers could not fight and constituted an existential problem for the army. The leading theory was that the ailment was psychological in nature, so psychotherapeutic measures were introduced as solutions (Crocq & Crocq, 2000).

As shell shock became a significant concern for the British and American armies, the focus switched to early intervention to prevent the symptoms. Another factor for the concentration change was attrition or loss of soldiers discharged from active service due to mental unfitness. Salmon went to the United Kingdom to learn the British methods for treating shell shock. Based on his survey of the British treatment protocol, he concluded that war neurosis, as he dubbed it, was an unconscious escape from an intolerable situation, which is a conflict between the instinct of self-preservation and one's duty (Salmon, 2019). In short, shell shock was a psychological response to war demands. Salmon proposed a three-phase solution to address the syndrome:

1. The first phase was immediate treatment after the onset, which should occur in or near the theatre of war, far away from the front. A place in which the combatants could decompress, rest, and have adequate food rations. This concept is very much similar to what is occurring now

in the Navy and other branches where the redeployers (the Navy's term for sailors returning from deployment) are debriefed in theatre, afforded time to relax and adjust to home life, and provided psychoeducational information about return and reunion themes. Lastly, Salmon proposed that psychotherapy consists of supportive, positive, and normalizing problematic symptoms.

2. The second phase was to set up psychiatric hospitals located a safe distance from the front where patients could stay up to three weeks, and

3. The final phase was to set up an additional hospital for severe shell shock patients. This hospital would be located roughly 50 miles from the front and serve as the base of the other two hospitals. Sufferers could stay up to 6 months in this facility. If patients showed no improvements, they were returned home and relieved of war duty (Salmon, 2019). This comprehensive proposal occurred during WW1 and still used today. Minor adjustments were made during WW2, and essential treatments were introduced: rest, healthy food, hot showers, and sedation. The focus was on returning combatants to the front lines in the least recovery time possible.

A common anecdotal belief was that every soldier had a breaking point that began at 100 days and ended with a year of active combat. This concept of the breaking point prompted psychiatrists to shift the abnormal mind paradigm in normal times to the normal mind in abnormal times (Pols & Oak, 2007). Concurrently, the social scientist’s perspective of focusing on environmental sources was added to the paradigm switch. Army psychiatry began to incorporate environmental factors into treatment and focused less on the patient's predisposition. This quote, by Herbert Spiegel, a psychiatrist observing soldiers suffering from war neurosis, stated the following. "Soldiers were not primarily motivated by hatred for the enemy or the

ideals of liberty and democracy, but by the bonds with their buddies and regard for their officers." (Pols & Oak, 2007, p.2). Therefore, he believed that group solidarity was essential to eliminating war neurosis as a preventative measure.

Signs of racial discrimination related to mental health were noted during this period as well. Unwittingly, the treatment of Black Americans aided in the diagnosis differential of PTSD. Apart from the Harlem Hell Fighters, who spent more time in combat than any other American unit during WWI – Black and White (Wright, 2014), Black service members were segregated, isolated, and given labor-oriented missions primarily, and were not posted at the front. Nevertheless, they recorded higher incidences of psychiatric syndromes. Dwyer (2006) reported, "… these findings indicate that psychiatric disorder was not primarily related to extended frontline duty but a variety of other factors, including lack of morale. African American soldiers, whose battalions were segregated from the rest of the armed forces, recorded a high incidence of psychiatric syndromes, which was most likely related to their low status and the discrimination they suffered in the army" (Dwyer, 2006, p. 1705).

After World War II, mental health treatment focused on reintegration into society. The GI Bill, which provided educational benefits, access to mortgages, and disability insurance for those needing financial assistance due to physical and psychiatric disabilities greatly assisted with reacclimating. Sadly, these benefits were denied to Black service members returning to America (Blakemore, 2019; Mencke, 2010) pointing out a need for critical race theory's tenets of storytelling and counterstoryingtelling and contextual-historical analysis. After World War II, the most momentous change in society was the advent of veterans' hospitals and related medical

training programs, spearheaded by Omar Bradley in 1945 (Pols & Oak, 2007). Bradley wanted to ensure veterans were provided with the best up-to-date medical science available.

The significant contribution after the Vietnam war to the present has been the study of post-traumatic stress and its prevalence. The syndrome or collection of associated ailments started as shell shock during World War I. During the interwar period up until World War II, it was termed battle fatigue, and in 1952, the American Psychiatric Association (APA) added the diagnosis 'gross stress reaction' which embodied the same syndrome with the time limit of 6 months added to complete return to normal functioning. In the third edition of the Diagnostic Statistic Manual of Mental Disorders in 1980, the diagnosis of Post-Traumatic Stress Syndrome was officially added listing symptoms as well as adding the delayed onset category for the disease. The military's primary focus has been these collections of stress-related reactions to its service members, whether near or following combat operations (Crocq & Crocq, 2000). The primary theme of exposure and contextual factors have assisted with proper diagnosis, detection, and treatment. Schnur et al. (2004) summed up the evolution of PTSD in this quote:

> These findings are further reinforced by recent research into the etiology of post-traumatic stress disorder (PTSD), which has deemphasized the role of the original traumatic event and has highlighted the importance of a variety of contextual factors, among them the perception of social support, preexisting anxiety or depression, and a family history of anxiety" (Schnur et al., 2004, p. 85).

In the Navy, the idea of non-medical mental health treatment developed as a division of labor. The Navy Bureau of Medicine and Surgery commonly referred to as BUMED, decided to divide psychiatric or mental health services. Serious mental illnesses would be under the auspices of BUMED, and non-medical counseling would be assigned to Fleet and Family Support Centers (FFSC) currently under the sponsorship of Commander Navy Installations Command (CNIC). The Navy does not explain why this decision to divide the labor in said fashion. Nevertheless, one could surmise that BUMED wanted to maintain its budgetary influence in service delivery for serious mental health injuries apart from CNIC or "Big Navy"- the warfighters, where decisions are made based on fighting and winning wars.

Navy Family Service Centers (NFSC), as FFSC was called at its inception, was developed out of the Family Awareness Conference held in Norfolk, VA, in November 1978 (Hafley, 2019). Out of this conference, the Navy decided to focus its resources on the needs of the family. To meet this concern, the Navy centralized resources at FFSC. In the beginning, volunteers offered casework follow-up, child welfare services, financial counseling, relocation information, and ancillary services as needed. Other supportive services were added during the next ten years, namely, non-medical counseling services for sailors and their beneficiaries. FFSC staff manages the programs, policy, training, information and referral, individual clinical and non-clinical consultation, educational classes, and workshops (Hafley, 2019). FFSC is considered a one-stop resource center where sailors can get their needs met.

Summary

Perceived racism and discrimination, client/therapist treatment dyad, perceived racial climate or environment, the history of racism in America and racism related to mental health practices, critical race theory, racial microaggression and the history of mental health philosophy and practice within the military are all factors that inform contemporary mental health practice. In this study, we focused on Black male sailors and found that one of the critical components to effective counseling treatment is unconditional positive regard (Rogers, 1959). The client must feel accepted for whom she is irrespective of race, gender, and presenting clinical attention problems. It is the bedrock of any therapeutic relationship. Clients must feel properly esteemed and welcomed before establishing rapport and building a successful counseling treatment alliance. Perceived racial prejudice and discrimination intentional or not may hinder the therapeutic alliance resulting in unsuccessful completion of clinical treatment.

CHAPTER TWO: RESEARCH DESIGN AND METHODS

This study used a correlational, cross-sectional design to determine if there was a relationship among the independent variables: perceived racism, provider mistrust/therapist-client treatment dyad, and perceived discrimination at FFSC and our dependent variable- Black male sailors' completion of treatment at the facility. Data was collected at one point via Qualtrics Survey submission. This online survey design allowed for greater participation across the fleet. As such, sailors from all over the world participated. This innovation also afforded participants the opportunity to voice their opinions without fear of reprisal.

Study Design

The literature indicated that the primary method of assessing perceived racism among Black Americans involved using a self-report measure or an interview format that allowed for the documentation of the frequency and appraisal of each perceived experience's stressfulness (Kressin et al., 2008; Utsey, 1998). In this study, as FFSC's are located on each naval base and installation (81 total sites worldwide), conducting a face-to-face interview for the participants was not feasible in terms of time, location, and sample size. However, an online survey questionnaire with a proven moderate coefficient alpha would render quality data for analysis.

This researcher also added one inductive question: What is the experience of Black men sailors seeking and staying in mental health at the Navy Fleet and Family Support Centers?

Sample Size and Recruitment Procedures

Participants in this study were Black sailors who have sought or received treatment from the Navy Fleet and Family Support Centers (FFSC) voluntarily or as mandated by unit

commands. Participants were recruited via Facebook, Instagram, and other social media platforms (See Appendix for recruitment text or electronic mail). The targeted sample size for medium effect was 184 sailors based on previous studies about perceived racial prejudice and discrimination (Clark, Anderson, Clark, & Williams, 1999; & Harrell, 2000; Reid & Radhakrishnan, 2003; Williams, Yu, Jackson, & Anderson, 1997). Our study had 78 participants despite all our efforts to recruit the targeted amount. Data analysis results are located in the results section of this study.

Retention, Subject Payments, Tracking Procedures

Participants were not paid for this study. The study's results will be posted on the University of Pennsylvania's School of Social Policy and Practice database. The survey took roughly 18 minutes to completed based on Qualtrics statistics.

Data on Refusers and Drop-outs

Only completed surveys were considered, which resulted in 34 total participants. Incomplete surveys were not analyzed in the aggregated data, as a majority of the 78 participants did not tick the box indicating that they received services at FFSC. This researcher attempted to minimize attrition or incomplete surveys by encouraging participants to complete the entire survey to ensure their input is considered. Nevertheless, despite their completion of all other items on the survey, those participants could not be included in the analyses. Perhaps the placement of the box on the first instruction page to the survey developed was overlooked by the participants. In the revamped instructions at the beginning of the survey, more participants were included as the placement of the question about receiving services at FFSC were delineated into

three questions in lieu of a tick box. The topic of implicature and question placement within the survey will be further discussed in the discussion section.

Inclusive Criteria:

- African American or Black male sailors, ages 18 to 60, who serve or have served in the US Navy and sought or were mandated to seek treatment by their Navy Commands (workplace unit) at FFSC. Counseling services at FFSC commenced in 1979 at Norfolk, Virginia (hence the age range 18-60). Currently, there are 81 sites worldwide.

Exclusive Criteria:

- None.

Variables

Our independent variables are:

1. Perceived racial prejudice by Black male sailors,
2. Facility's climate or environment at Navy Fleet and Family Support Center Clinical Services,
3. Therapist-Client treatment dyad (provider mistrust).

The dependent variable is:

1. Completing clinical treatment by Black male sailors includes completing goals and objectives mutually agreed upon by therapist and sailor.

This study will control for the following variables to account for rival hypotheses:

Control variables:

1. Length of service
2. Rank (officer or enlisted),
3. Deployment status at the time of treatment (before, during, and after).

As few military-related studies controlled for length of service, the rank of the sailors, and whether the sailor was deployed before seeking treatment, this study attempted to gather this information. Length of service could indicate the sailor's maturity level, his ability to cope and manage stressful events, and his willingness to comply with military obligations. The rank of the sailors also suggests different expectations and possible treatment outcomes. Mental and physical health care treatment and other benefits in the military are positively correlated to rank (Maclean, 2018). In other words, the higher the rank, the better the treatment, and the less likely punitive disciplinary procedures (i.e., mandatory counseling) will be meted out. In an article, Joyner (2018) reported that during the entire history of the Air Force, not one officer with the rank of general has ever been court-martialed – they reported a quote from House Representative Jackie Speier from California. This is to say that out of the 70,000 courts-martial in the Air Force, not one was for an officer with the rank of general. It should be noted that only one general was court-martialed in the Army Air Corps, the precursor to the Air Force (Joyner, 2018). As such, rank was included as one of the controls in this study. Lastly, deployment status could suggest that the sailor may be suffering from mild to severe distress associated with deployment and the subsequent adjustment back to the home environment. This process is termed "The Military

Deployment Cycle" (Sheppard, Malatras, & Israel, 2010). As such, this deployment cycle variable was included in this study as a control measure.

Length of service:

Participants were asked to enter their length of services in years and months via drop-down boxes. Entering the years and months of service allowed for more accurate data analysis. Data were aggregated based on voluntary and command-mandated treatment, leading to further analysis.

Rank:

Rank was coded as either officer or enlisted.

Deployment Status:

Deployed is when a sailor is actively away from duty station (be it on a vessel or other military operations) at the time of clinical service request. Therefore, these categories were coded in a drop-down box as: before, during, and after deployment on the survey.

Additional information sought was:

Age:

Participants will provide their age in years.

Referral for service:

Participants were asked to indicate if they were mandated or self-referred (voluntary) for mental health services.

Conceptual Definitions:

Sailor:

A sailor is a Navy member, either active duty, active-duty reservist, or former sailor (retired included). Participants were asked by way of drop-down boxes coded: active duty, active-duty reservist (activated), and retired (former sailor).

Completion of Treatment:

Attended eight to twelve treatment sessions entirely from start to finish, successfully addressing clinical goals in the treatment plan, which was jointly developed with the counselor.

Measures

The concepts of perceived racism, client-therapist treatment dyad, and facility's racial climate will be operationalized in the following measures:

Perceived Racism:

Everyday Discrimination Scale (EDS)

Everyday discrimination will be assessed using the EDS (Williams, Yan, Jackson, & Anderson, 1977). The scale is a 10-item measure of perceived everyday interpersonal discrimination that assesses the occurrence and frequency with which the respondents endure routine and relatively minor experiences of unfair treatment (Williams et al., 1997). More specifically, respondents are asked how often (1) they were treated with less courtesy, (2) treated with less respect than others, (3) they received poorer service than others, (4) they believed others acted as if they were not smart, (5) others acted as if they were better than them, (6) others felt that they were dishonest,

(7) people acted like they were afraid of them, (8) people called them names or insulted them, (9) they felt threatened or harassed, or (10) they were followed in stores. The responses ranged from 1 to 6, with 1 being "almost every day" and six being "never." The scale was created by reversed coding each of the response category (1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1, 6 = 0) and then summing the responses of 10 items, which resulted in a scale that ranged from 0 to 50. Higher scores on the scale represent a higher frequency of experiences with discrimination. The alpha reliability coefficient is .87 for Black participants.

Client-Therapist Dyad (provider mistrust):

Racial Microaggression in Counseling Scale (RMCS)

The RMCS (Constantine, 2007) is a 10-item, 3-point Likert-type scale (0 = *this never happened*, 1= *this happened, but it did not bother me at all*, 2= *this happened, and I was bothered by it*). This scale measures respondents' perceptions of racial microaggressions that they have experienced in the context of counseling. Scores for RMCS range from 0 to 20, with higher scores indicating significant impact and number of perceived occurrences. The Cronbach's alpha for this measure is .73.

Climate or Environment:

The Racial Microaggressions Scale (RMAS)

RMAS (Sue et al., 2008) is a 32-item scale that encompasses eight microaggression themes: 1) alien in own land, 2) ascription of intelligence, 3) sexualization, 4) invalidation of interethnic differences, 5) denial of racial reality, 6) patronizing cultural values/communication styles, 7)

second class citizenship, and 8) invisibility. This measure refers to the racial indignities, slights, mistreatment, or offenses that people of color may face on a recurrent or consistent basis. The climate portion of the RMAS was tailored to focus on FFSC. Racial microaggressions may represent a significant source of stress endured by people of color. Torres-Harding et al. (2012) reported reasonable internal consistency estimates for each of the eight factors. The coefficient alpha is .949 for this scale (Torres, Aldrade, & Diaz, 2012). This instrument was used to assess the sailors' general impression of FFSC in terms of perceived racial climate at the facility.

Data Analysis

A multiple regression analysis was used to analyze the relationship among all variables in this study. All combinations of the independent, dependent, and control variables were examined to see if a positive or negative relationship affects the dependent variable. The study hypothesis is that the results would show a positive correlation among the independent variables and non-completion of treatment by Black sailors.

Administrative Arrangements

Permission from the United States Navy was not required to conduct this study. This author's knowledge of the internal culture and the possible fear of reprisal on behalf of the participants were the primary reasons for an anonymous online research study. No personal identification information was solicited in the study. All the measures and demographic information was assembled into an online survey by this author. The author monitored social media daily to track participants and reviewed the effectiveness of this recruitment process. As the recruitment measures were not yielding the projected numbers desired in this study, this

author incorporated additional methods (as permitted by IRB approval), including email lists, a solicitation to Black naval organizations, snowball sampling, and respondent-driven sampling. A statistician was hired to assist with the analysis of the aggregated data for this study.

Human Subjects

Approval was obtained from the University of Pennsylvania's Institutional Review Board (IRB) for this study. The survey included all the necessary consent questions, and participants were required to indicate that they have read, understood, and agreed to participate in the survey. There was also a statement of veracity requesting that the participants answer the questions truthfully and without intentions to compromise the data's integrity. Once informed consent was achieved, the participants were directed to the survey (See Appendix for a copy of the informed consent form).

The risks of participation in this study are improbable and minimal. This researcher safeguarded the data, and he alone had the password to retrieve the data. No personal identifiers were used in the study; therefore, risks associated with breaches were minimized. As some of the questions could engender emotional discomfort or recall bad experiences, a telephone line and an online link to a 24-hour helpline was provided on the survey. Informed consent also included the benefits of this study and how the data could address potential problems if indicated. This study sought to add to the general knowledge about the effects of perceived racism on those seeking mental health assistance in the Navy.

Timeline

As this study took place via the internet and not on a military facility, this author received an expedited approval from IRB on April 4, 2021. Best practices suggested six to nine months for the recruitment of participants. Our study took 7 months to recruit our participants and two months for analysis. The Gantt chart in the appendix lists tasks and projected times for their completion.

Methods

Data Preparation

In preparation for data analysis, a series of diagnostic tests were conducted to test the assumptions of linear regression analyses. These tests included tests of skew and collinearity for all continuous variables.

Skew

Skew diagnostics were conducted to test the assumption that the continuous variables, including age, number of treatment sessions, Racial Microaggression Counseling Score (RMCS), frequency of Racial Microaggression experiences (RMS Freq), Racial Microaggression stress scores (RMS Stress), frequency of FFSC Racial Microaggression experiences (FFSC Freq), FFSC Racial Microaggression stress scores (FFSC Stress), and Everyday Discrimination Score (EDS) were each normally distributed. As shown in Table 2.1, two variables were moderately skewed (RMCS and RMS Freq), and one variable (EDS) was highly skewed. Comparisons of the mean, median, and mode for each variables suggested that the sample as a whole experienced rates of racial micro-aggressions and discrimination at the higher end of the scale range. Additionally, RMS Stress was found to be bi-modal.

EDS was explored for the source of the skew to identify solutions that would allow it to be included in the analysis without increasing the likelihood of biased estimates. A histogram revealed two outliers at the low end of the distribution (score1 = 0, score 2=19), which were both Winsorized to the 10th percentile score (score = 25). This reduced the EDS skew statistic to the moderate range (-0.94), allowing it to be included in the analysis with more confidence. Additionally, because RMS Stress was found to be bi-modal and thus not normally distributed, it was not included in regression analysis.

Table 2.1

Skewness Statistics for Continuous Variables

	N	Skew	SE	Mean	Median	Mode	Scale Range
Age	34	0.13	0.40	37.56			
EDS	30	-2.22	0.43	38.47	42	45	9 to 54
RMCS	30	-0.64	0.43	21.97	24	26	10 to 30
RMS Freq	29	-0.75	0.43	113.66	121	122	32 to 160
RMS Stress	16	-0.49	0.56	104.69	109	85*	32 to 128
FFSC Freq	29	-0.14	0.43	16.66	17	25	5 to 25
FFSC Stress	24	-0.18	0.47	15.38	15	20	5 to 20

* Multiple modes exist. The smallest value is shown

Multicollinearity

A regression model was tested to identify any collinearity among continuous independent variables, with the number of treatment sessions included as the dependent variable and age, number of treatment sessions, Racial Microaggression Counseling Score (RMCS), frequency of Racial Microaggression experiences (RMS Freq), Racial Microaggression stress scores (RMS Stress), frequency of FFSC Racial Microaggression experiences (FFSC Freq), FFSC Racial Microaggression stress scores (FFSC Stress), and Everyday Discrimination Score (EDS) included as the independent variables. Table 2.2 displays the collinearity statistics, which suggested that all of the independent variables were collinear.

Table 2.2

Tests of Collinearity Among Continuous Variables

	B	SE	Beta	t	p-value	Collinearity Statistics Tolerance	VIF
(Constant)	-0.15	7.00		-0.02	0.98		
Age	0.05	0.05	0.45	0.88	0.43	0.34	2.99
EDS	0.07	0.16	0.21	0.44	0.68	0.37	2.71
RMCS	-0.02	0.12	-0.08	-0.13	0.90	0.25	3.96
RMS_Freq	-0.05	0.06	-0.69	-0.82	0.46	0.12	8.23
RMS_Stress	0.07	0.08	0.70	0.85	0.44	0.13	7.92
FFSC_Freq	-0.04	0.35	-0.16	-0.12	0.91	0.05	21.21
FFSC_Stress	-0.11	0.52	-0.34	-0.21	0.85	0.03	31.10

To help identify the collinear relationships behind the high VIF values, a correlational analysis was conducted with the seven independent variables. As seen in Table 2.3, age was not significantly related to any variable, suggesting that the age VIF = 2.99 value may not be specific to age. Ten of the relationships between independent variables were highly correlated: RMS Freq and EDS (r=0.84, p<0.01), RMS Freq and RMCS (r=0.71, p<0.01), RMS Freq and RMS Stress (r=0.89, p<0.01), FFSC Freq and RMCS (r=0.81, p<0.01), FFSC Freq and RMS Freq (r=0.81, p<0.01), FFSC Freq and RMS Stress (r=0.79, p<0.01), FFSC Stress and RMSC (r=0.75, p<0.01), FFSC Stress and RMS Freq (r=0.82, p<0.01), FFSC Stress and RMS Stress (r=0.88, p<0.01), and FFSC Stress and FFSC Freq (r=0.93, p<0.01). This suggested that the high VIF values were reflective of the multicollinear relationships among these six independent variables.

Although significantly correlated, the variables that were not highly correlated were EDS and RMCS (r=0.58, p<0.01), EDS and FFSC Stress (r=0.41, p<0.05), and RMCS and RMS Stress (r=0.53, p<0.05), and RMS Stress and EDS (r=0.66, p<0.01), FFSC Freq and EDS (r=0.60, p<0.01). To test the possibility that these variables, based on lower correlation

coefficients were not collinear, a second test was conducted with EDS, RMCS, FFSC Stress, FFSC Freq, RMS Stress, and age included as independent variables and the number of treatment sessions included as the dependent variable. Although lower, *VIF* scores continued to suggest multicollinearity among these variables except for age (*VIF* = 1.19). Therefore, to avoid biased estimated in hypothesis testing due to multicollinearity, the independent variables were tested in separate models testing along with the age control variable.

Table 2.3

Correlations Among Continuous Variables

	Age	EDS	RMCS	RMS Freq	RMS Stress	FFSC Freq	FFSC Stress
Age	1						
EDS	-0.12	1					
RMCS	-0.20	0.58**	1				
RMS Freq	-0.13	0.84**	0.71**	1			
RMS Stress	-0.12	0.66**	0.53*	0.89**	1		
FFSC Freq	-0.31	0.60**	0.81**	0.81**	0.79**	1	
FFSC Stress	-0.24	0.41*	0.75**	0.82**	0.88**	0.93**	1

* p< 0.05 level ** p< 0.01 level

Analysis Plan

Descriptive statistics were calculated to describe the sample as a whole. Means, standard deviations, minimum and maximum scores, and correlations were calculated for all continuous variables: age, number of treatment sessions, Racial Microaggression Counseling Score (RMCS), frequency of Racial Microaggression experiences (RMS Freq), Racial Microaggression stress scores (RMS Stress), frequency of FFSC Racial Microaggression experiences (FFSC Freq), FFSC Racial Microaggression stress scores (FFSC Stress), and Everyday Discrimination Score (EDS). Frequencies were calculated for each categorical variable, including age group, treatment referral, Rank, Deployment status, Race of counselor, whether a treatment plan was

discussed, whether a treatment plan was mutually agreed upon, and whether treatment was successfully completed.

Hypothesis Testing

A series of regression models were used to test the hypotheses that negative racial climate, perceived racism, and provider mistrust predicted decreases in help seeking and treatment retention. Logistic regression was used to test the models with binary outcomes (*Self-Referred* and *Completed Treatment*) and multiple regression was used to test models with the continuous outcome (Number of Sessions):

Self-Referred (binary: yes/no)

Model 1: Self-Referred = EDS + age

Model 2: Self-Referred = RMSFreq + age

Completed Treatment (binary: yes/no)

Model 3: Completed Treatment = EDS + age

Model 4: Completed Treatment = RMCS + age

Model 5: Completed Treatment = RMSFreq + age

Model 6: Completed Treatment = FFSC_Freq + age

Model 7: Completed Treatment = FFSC_Stress + age

Number of Sessions (continuous)

Model 8: Number of Sessions = EDS + age

Model 9: Number of Sessions = RMCS + age

Model 10: Number of Sessions = RMSFreq + age

Model 11: Number of Sessions = FFSC_Freq + age

Model 12: Number of Sessions = FFSC_Stress + age

Exploratory Analysis

Chi-Square Tests of Independence were used to explore relationships among participant demographics and treatment variables. The demographic variables *Age Group, Rank,* and *Deployment Status* were each included in with *Completed Treatment* (yes/no/unsure). The treatment variables *Self-Referred* (yes/no/unsure), *Discussed Treatment Plan* (yes/no/unsure), and *Agreed on Treatment Plan* (yes/no/unsure) were each included with *Completed Treatment* (yes/no/unsure). Finally, a Chi-Square Test of Independence was used to explore the relationship between counselor race and completing treatment that included *Counselor Race* (White, Black or African American, Asian, Native Hawaiian or Pacific Islander) and *Completed Treatment* (yes/no).

CHAPTER THREE: RESULTS

A total of *N*=79 men identifying as Black or African American and currently are or had been active members of the Navy qualified for the study. Of those, *n*=34 sought or received services from the Navy Fleet and Family Support Centers and were included in analyses. The average age of the sample was 34 years (*SD*=12.0) and ranged in age from 20 to 62. Over a quarter of the men (*n*=10, 29%) were in the 35-44 age group, with all but three of the remainder equally spread across the 18-24 age group, 25-34 age group, and 45-54 age group (*n*=7, 21% each). Two thirds of the men who sought services from FFSC self-referred (*n*=20, 74%), with almost half of them seeking services after deployment (*n*=14, 48%). Almost a third of the participants reported their rank as E1-E3 (*n*=13, 39%), with the next most common rank reported at E4-E6 (*n*=10, 30%). See Table 3.1 for additional detail.

Table 3.1

Demographic and Service Characteristics of Participants

		N	%
Age Group			
	18-24	7	20.6
	25-34	7	20.6
	35-44	10	29.4
	45-54	7	20.6
	55+	3	8.8
	Total	34	100
Deployment Status			
	Before	8	27.6
	During	7	24.1
	After	14	48.3
	Total	29	100
Rank			
	E1-E3	13	39.4
	E4-E6	10	30.3
	E7-E9	7	21.2
	O1-O3	2	6.1
	O4-O6	1	3
	Total	33	100

As shown in Table 3.2, less than 30% of participants reported completing 7-8 or more treatment sessions (*n*=9, 27%), which is important given that eight sessions is considered the minimum number for completed treatment. This is also reflected in the small number of participants who reported completing treatment (*n*=7, 21%). When reporting on their treatment experiences, the majority of participants (*n*=22, 67%) reported discussing a treatment plan with their counselor, although only a third (*n*=13, 40%) reported agreeing on a plan. Finally, 79% (*n*=26) of the participants reported having a counselor who was White, with 9% reporting having a counselor who was Black or African American (*n*=3), 9% reporting have a counselor who was Asian (*n*=3), and 3% reporting having a counselor who was Native Hawaiian/Pacific Islander (*n*=1).

Table 3.2

Treatment Characteristics

	N	%
Number of Sessions		
1 to 2	7	21.2
3 to 4	11	33.3
5 to 6	6	18.2
7 to 8	5	15.2
9 to 10	3	9.1
11+	1	3.0
Discussed Treatment		
Yes	22	66.7
No	8	24.2
Unsure	3	9.1
Agreed on Treatment Plan		
Yes	13	39.4
No	18	54.5
Unsure	2	6.1
Completed Treatment		
Yes	7	21.2
No	22	66.7
Unsure	4	12.1
Counselor Race		
White	26	78.8
Black/African American	3	9.1
Asian	3	9.1
Native Hawaiian/Pacific Islander	1	3.0

As seen in Table 3.3, the mean score on the *Everyday Discrimination Scale (EDS)* indicates that the men in the sample experienced discrimination, on average, a few times a month (M=4.27), ranging from a minimum of a few times a year to a maximum of at least once a week. The mean score on the *Racial Microaggression in Counseling Scale (RMCS)* indicates that the men in the sample experienced racial microaggressions in the counseling setting but that, on average these experiences did not bother them (M=2.20). However, there were specific experiences for which over 50% reported being bothered by, including: their counselor avoiding

discussing or addressing cultural issues in sessions (50%); their counselor thinking at times that they (the client) was overly sensitive about cultural issues (53%), their counselor sometimes seemed unaware of the realities of race and racism (62%), their counselor at times may have either overestimated or underestimated their (the client's) capabilities or strengths based on their cultural group membership (53%), and their counselor sometimes minimized the importance of cultural issues in sessions (53%).

On average, respondents experienced racial microaggressions outside of the counseling setting (*RMS Frequency*) often or frequently (*M*=3.55), ranging from experiencing microaggressions rarely to always. Respondents reported experiencing racial microaggressions at FFSC (*RMS-FFSC Frequency*) less frequently (*M*=3.33), though with a wider range from never experiencing racial microaggressions to always experiencing them. The overall stress of experiencing microaggressions was, on average reported to be moderate (*M*=3.27) outside of the counseling setting, ranging from a little stressful to highly stressful. The stress experienced due to racial microaggressions at FFSC was on average a little lower (*M*=3.08) though with a wider range from closer to not stressful at all to the highest level of stress on the scale.

Table 3.3

Descriptive Statistics of Continuous Variables

	N	Mean	SD	Min	Max
EDS	30	4.27	1.14	2.11	5.44
RMCS	30	2.20	0.63	1.00	3.00
RMS Frequency	29	3.55	0.70	1.84	4.75
RMS Stress	16	3.27	0.45	2.50	3.84
RMS - FFSC Frequency	29	3.33	1.19	1.00	5.00
RMS - FFSC Stress	24	3.08	0.79	1.80	4.00

Hypothesis Testing

As shown in Tables 3.4, neither everyday discrimination (*OR*=0.84, *p*>0.05) nor the frequency of experiencing racial microaggressions (*OR*=0.97, *p*>0.05) significantly predicted the likelihood of self-referring to treatment at FFSC. Based on this model, the hypothesis that negative racial climate and perceived racism outside of the treatment setting significantly impact the odds of self-referring to treatment is not supported.

Table 3.4

The Likelihood of Self-Referring to Treatment based on Experiences of Discrimination and Microaggressions

	Model 1				Model 2			
			95% C.I.				95% C.I.	
	B (SE)	OR	Lower	Upper	B (SE)	OR	Lower	Upper
Constant	5.11 (6.17)	166.12			1.77 (4.10)	5.86		
Age	0.08 (0.05)	1.08	0.98	1.19	0.08 (0.05)	1.08	0.99	1.19
EDS	-0.17 (0.14)	0.84	0.65	1.10				
RMS Freq					-0.03 (0.03)	0.97	0.91	1.03

Completed Treatment

As shown in Tables 3.5, neither everyday discrimination (*OR*=0.94, *p*>0.05) nor the frequency of experiencing racial microaggressions (*OR*=0.95, *p*>0.05) significantly predicted the likelihood of completing treatment at FFSC. Based on this model, the hypothesis that negative

racial climate and perceived racism significantly impact the odds of completing treatment is not supported.

Table 3.5

Logistic Regression Analysis of the Odds of Completing Treatment Based on Experiences of Discrimination and Microaggressions

	Model 1				Model 2			
			95% C.I.				95% C.I.	
	B (SE)	OR	Lower	Upper	B (SE)	OR	Lower	Upper
Constant	-1.8 (3.26)	0.07			-0.31(3.09)	0.73		
Age	0.09 (0.05)	1.09	0.99	1.20	0.09 (0.05)	1.10	0.99	1.22
EDS	-0.08 (0.07)	0.94	0.81	1.10				
RMS Freq					-0.05 (0.27)	0.95	0.91	1.01

While neither the frequency (*OR*= 0.52, $p>0.05$) nor resulting stress (*OR*=0.51, $p>0.05$) of experiencing racial microaggressions in the FFSC treatment setting significantly predicted the likelihood of completing treatment, experiencing racial microaggression in the counseling relationship did. As shown in Table 3.6, the odds of completing treatment decreased by 23% with each addition ¼ of a point increase in racial microaggression in counseling score (*OR* = 0.77, $p<0.05$). Based on these findings, the hypothesis that treatment-specific negative racial climate and perceived racism impact the odds of completing treatment is supported when measured within the counseling relationship.

Table 3.6

Logistic Regression Analysis of the Odds of Completing Treatment Based on Treatment-Specific Racial Microaggressions

	Model 1				Model 2				Model 3			
			95% C.I.				95% C.I.				95% C.I.	
	B (SE)	OR	Lower	Upper	B (SE)	OR	Lower	Upper	B (SE)	OR	Lower	Upper
Constant	2.76 (2.73)	15.85			4.46 (4.34)	86.86			-4.63 (8.16)	0.01		
Age	0.03 (0.04)	1.03	0.95	1.13	0.06 (0.06)	1.06	0.94	1.21	0.25 (0.20)	1.28	0.86	1.89
RMCS	-0.26 (0.11)	0.77*	0.62	0.95								
FFSC Freq					-0.65 (0.34)	0.52	0.27	1.01				
FFSC Stress									-0.66 (0.51)	0.51	0.19	1.41

**p* <0.05

Number of Sessions

The first set of multiple regression models shown in Table 3.7 tested negative racial climate and perceived racism on the number of treatment sessions completed. Model 1, which included everyday discrimination score (EDS) and age, explained 22% of the variance in treatment completion (R^2=0.22, *F*(2, 25)=3.45, *p*=0.05). Although *EDS* was not a significant predictor (*B*=0.04, *p*>0.05) of the number of treatment sessions, age significantly predicted a 1-session increase in the number of treatment sessions for every 0.05 of a year increase in age (*B*=0.05, *p*<0.05).

Model 2, also shown in Table 3.7, included frequency of experiencing racial microaggressions and age. The model explained 18% of the variance in treatment completion (R^2=0.18, *F*(2, 25) =2.77, *p*=0.08), though it was not significant. Again, while the independent variable, *RMS Freq*, did not significantly predict the number of treatment sessions (*B*=0.01, *p*>0.05) age did, with a 1 session increase in the number of treatment sessions for every 0.04 of a year increase in age (*B*=0.04, *p*<0.05).

Based on these two models, the hypothesis that treatment-specific negative racial climate and perceived racism predict the number of treatment sessions completed was not supported.

Table 3.7

Multiple Regression Analysis of the Number of Treatment Sessions and Experience of Discrimination and Microaggressions

	Model 1			Model 2		
	B	SE	*B*	B	SE	*B*
Constant	-0.79	1.61		0.15	1.47	
Age	0.05*	0.02	0.44	0.04*	0.02	0.43
EDS	0.04	0.03	0.23			
RMS Freq				0.01	0.01	0.13
	R2 = 0.22			*R2* = 0.18		
	F (2, 25)=3.45, *p* =0.05			*F* (2, 25)=2.77, *p* =0.08		

*p <0.05

The second set of multiple regression models shown in Table 3.8 tested treatment-specific negative racial climate and perceived racism on the number of treatment sessions completed. Model 1, which included racial microaggression in the counseling context and age, explained 12% of the variance in treatment completion (R^2=0.22, F(2, 26) =1.81, p=0.18), though it was not significant. Neither RMCS (B=0.01, p>0.05) nor age (B=0.04, p>0.05) significantly predicted number of treatment sessions.

Model 2, which included the frequency of racial microaggressions in the FFSC treatment setting and age, explained 10% of the variance in treatment completion (R^2=0.10, F(2, 25) =2.51, p=0.10), though it was not significant. Neither the frequency of FFSC Freq (B= -0.01, p>0.05) nor age (B=0.04, p>0.05) were significant predictors of the number of treatment sessions.

Model 3, which included the stress score associated with racial microaggressions in the FFSC treatment setting and age explained 32% of the variance in treatment completion (R^2=0.32, F(2, 20) =4.59, p=0.02). Although the stress of FFSC specific microaggressions was not

significant (*B*= -0.03, $p>0.05$), age significantly predicted increases in the number of treatment session, with an additional session associated with every 0.06 of a year increase in age (*B*=0.06, $p<0.05$).

Based on these models, the hypothesis that treatment-specific negative racial climate and perceived racism predict the number of treatment sessions completed was not supported.

Table 3.8

Multiple Regression Analysis of the Number of Treatment Sessions and Treatment-Specific Racial Microaggressions

	Model 1			Model 2			Model 3		
	B	SE	*B*	B	SE	*B*	B	SE	*B*
Constant	1.07	1.23		1.19	1.21		0.89	1.34	
Age	0.04	0.02	0.36	0.04	0.02	0.40	0.06*	0.02	0.53
RMCS	0.01	0.04	0.05						
FFSC Freq				-0.01	0.04	-0.03			
FFSC Stress							-0.03	0.06	-0.09
	$R2 = 0.12$			$R2 = 0.17$			$R2 = 0.32$		
	$F(2, 26)=1.81$, $p=0.18$			$F(2, 25)=2.51$, $p=0.10$			$F(2, 20)=4.59$, $p=0.02$		

$p<0.05$

Exploratory Analysis

Chi-square Tests of Independence found no significant relationship between completing treatment and age [X^2 (8, 33)=7.47, *p*=0.49], between completing treatment and rank [X^2 (8, 33) =2.88, *p*=0.33], or between completing treatment and deployment status [X^2 (8, 33)=2.88, *p*=0.33]. See Table 3.9 for more detail. It is plausible that the low cell counts, which violated the assumptions of Chi-Square Test of Independence, may have contributed to the lack of significant relationships between variable pairs.

Table 3.9

The Relationship Between Completing Treatment, Age, and Service Characteristics

			Completed Treatment		
			Yes	No	Unsure
Age Group	18-24	Count	2	5	0
		Std Res	0.42	0.15	-0.92
	25-34	Count	1	5	1
		Std Res	-0.40	0.15	0.16
	35-44	Count	1	7	1
		Std Res	-0.66	0.41	-0.09
	45-54	Count	1	4	2
		Std Res	-0.40	-0.31	1.25
	55+	Count	2	1	0
		Std Res	1.71	-0.71	-0.60
	Chi-Square (8, 33) = 7.47, *p* = 0.49				
Rank	E1-E3	Count	2	11	0
		Std Res	-0.46	0.79	-1.26
	E4-46	Count	2	6	2
		Std Res	-0.08	-0.26	0.72
	E7-E9	Count	3	2	2
		Std Res	1.24	-1.23	1.25
	O1-O3	Count	0	2	0
		Std Res	-0.65	0.58	-0.49
	O4-O6	Count	0	1	0
		Std Res	-0.46	0.41	-0.35
	Chi-Square (8, 33) = 2.88, *p* = 0.33				
Deployment Status	Before	Count	1	7	0
		Std Res	-0.32	0.63	-1.05
	During	Count	1	6	0
		Std Res	-0.19	0.53	-0.98
	After	Count	3	7	4
		Std Res	0.38	-0.85	1.49
	Chi-Square (4, 26) = 5.98, *p* = 0.20				

As shown in Table 3.10, Chi-square Tests of Independence found no significant relationship between completing treatment and having self-referred to treatment [X^2 (2, 26)= 2.88, *p*=0.24] or between completing treatment and having discussed a treatment plan [X^2 (4, 33)=4.62, *p*=0.33]. A significant relationship was found between completing treatment and agreeing on a treatment plan [X^2 (4, 33)=12.41, *p*=0.02]. Standardized residuals suggest that more respondents who reported completing treatment also reported having agreed on a treatment plan than would be expected by chance (*Std Res* = 2.0), suggesting that agreeing upon a treatment plan was associated with higher rates of completing treatment.

Table 3.10

The Relationship Between Completing Treatment and Treatment Characteristics

			Completed Treatment		
			Yes	No	Unsure
Self-Referred	No	Count	0	6	1
		Std Res	-1.27	0.67	0.21
	Yes	Count	6	11	2
		Std Res	0.77	-0.40	-0.13
	Chi-Square (2, 26) = 2.88, *p* = 0.24				
Discussed Treatment Plans	Yes	Count	6	14	2
		Std Res	0.60	-0.20	-0.40
	No	Count	0	7	1
		Std Res	-1.30	0.70	0.00
	Unsure	Count	1	1	1
		Std Res	0.50	-0.70	1.10
	Chi-Square (4, 33) = 4.62, *p* = 0.33				
Agreed on Treatment Plans	Yes	Count	6	5	2
		Std Res	2.00*	-1.2	0.3
	No	Count	1	16	1
		Std Res	-1.4	1.2	-0.8
	Unsure	Count	0	1	1
		Std Res	-0.7	-0.3	1.5
	Chi-Square (4, 33) = 12.41, *p* = 0.02				

As shown in Table 3.11, a significant relationship was found between completing treatment and the race of the counselor providing treatment [X^2 (3, 29)= 15.39, p=0.002]. Standardized residuals suggest that there were more respondents who reported both completing treatment and having a counselor they believed to be of Asian descent than would be expected by chance (*Std Res* = 2.18), suggesting that having a counselor of Asian descent was associated with higher rates of completing treatment. It should be noted, however, that more than 20% of the cells violated the assumption of minimum cell counts, and thus results should be taken with caution.

Table 3.11

The Relationship Between Completing Treatment and Race of Counselor

		Completed Treatment	
Counselor Race		Yes	No
White	Count	2	21
	Std Res	-1.51	0.85
Black/African American	Count	2	1
	Std Res	1.50	-0.85
Asian	Count	2	0
	Std Res	2.18*	-1.23
Native Hawaiian or Pacific Islander	Count	1	0
	Std Res	1.54	-0.87

Chi-Square (3, 29) = 15.39, p = 0.002

QUALITATIVE INQUIRY FINDINGS

Our inductive inquiry addressed the overall experience of Black male sailors seeking treatment at FFSC. The question was: What is the experience of Black men sailors seeking and staying in mental health treatment at the Navy Fleet and Family Support Centers? The participants included 43 responses to this qualitative inquiry. Interestingly, the 43 responses were almost commensurate with the number of respondents to the quantitative analysis of this study. We coded the responses for the major themes included in this report. The significant findings of this qualitative question fall into four coded categories: (1) Engagement, (2) Cultural insensitivity, (3) non-Beneficial, and (4) Therapist/Client lack of fit and or therapeutic incompetence. Below are the responses placed within the major findings.

1. **Engagement can be summed up as the lack of being properly greeted by administrative and clinical staff.**

“Therapist didn't listen to me. Her attitude was racist. She didn't even make eye contact. I left after a few times. I got in trouble with the ship for not staying (in counseling) and got NJPed (Non-judicial punishment). I got admin sep (separated) after that.”

"The place was not welcoming at all. No one engaged me when I walked in and I was ignored for about 2 minutes. I had no privacy to talk about my concerns. The people appeared to not want me there."

"At the reception, they act (sic) like they don't (sic) see me. I observed people do (sic) gossip at FFSC waiting room and outside of their work."

"People at FFSC are rude and believe you are bad when you come in for domestic violence. You are guilty without hearing your side of the story. This counselor was horrible. I will never go there again. Thank you for this time to say what I always wanted to say."

“My counselor was a black American male. He was excellent. He respected my Haitian culture and sought to understand me more in light of my culture. He was great! The building and people working there were terrible. They didn't notice me for some time; they asked me why I was visiting while other people could hear. They were not warm or welcoming. I came to that building for the counselor only. He was an excellent brother.”

2. **Cultural insensitivity was indicated by respondents reporting that their culture was not considered or included.**

"Fleet and Family Support Center is a great institution however, it lacks diversity of any real kind. My experience, being mandated to attend Fleet and Family Service Counseling taught me how American Institutions can be weaponized to disadvantage certain groups. Fleet and Family has a ton of resources (money). Leadership at commands place friends and family members into positions of power and influence. Having familial issues turned over to a members (sic)

command give undue influence to men and women who hold biases, and practice nepotism. Which seems to be an epidemic across many governmental institutions."

“It's run by the wrong people. Commanding Officers and CMCs (command master chiefs), having the type of power and influence they have over their Sailor's skews advancement opportunity and allows for further forms of discrimination when it comes to promotion. Being a Sailor is a tough craft. The numbers on diversity amongst senior leadership are abhorrent. Follow the money!”

3. **Non-beneficial was indicated by respondents saying that the services were a waste of time or even detrimental.**

"It was not helpful. I went to chaps (chaplain services) for better svc (services)."

“The job of the fleet and family support center is to put a band-aid on any problems many service members have if your (sic) black. Mental health issues.”

“In short it was a waste of time. I couldn't relate to most of it.”

“A waste of time. More of the navy's hypocrisy of offering help but it's not appropriate or effective.”

"My counselor was not interested in hearing me or my story. She talked at me and not to me. I left after a few sessions. I was not helped at all. She acted afraid of me as if I was (sic) violent.

Going there did not helped (sic) and may have made it worse for me. I got help for (sic) a black female therapist later in life. Thank you for this chance to give my opinion."

4. **The therapist/Client's lack of fit or incompetence was indicated by lack of clinical rapport and unsuccessful treatment.**

“Get better people.”

“I went about 3 times. Counselor was nice but she had no idea how to help me.”

“I was ordered by my command to get anger management services. The counselor assumed I had an angry (sic) problem without asking me. I went to learn strategies to manage my anger. I had one incident at work in which I walked out of the room when my supervisor started to yell at me. I didn't want to get in trouble, so I left the room. Why was I referred and not the ass hat who yelled at me? This is the kind of BS that happens to junior people. I rather not name names. Thank you for going (sic) this project.”

"Got into fights on the ship and at the command. Went to counseling. It didn't work because me and the counselor did not fit. I feel like people were trying to change me at work. I didn't want to "play the game" to get promoted. I wanted my work to speak for me without the extra *BS* on the ship. People are racist and rude but when it's time to fight, they used the system to protect them and punish me. Left the Navy will (sic) an honorable (discharge), but the shit was whack!”

“My experience in the Navy was then the most traumatic experience of my life. Although it was over 20 years ago, I still deal with that horrific experience to this day. Treatment received at Navel (sic) mental facilities over 20 years later remain (sic) an extremely traumatic for me and has affected my overall life path. Further details will have to be verbalized.”

"My counselor did not understand the issues I was having due to racism."

"It was the (sic) one of the worst experiences during my time in the Navy. I went and paid for counseling because of the privacy I got. The fleet family services often reported back to command about your counseling sessions, and they will use that against you. It actually worsened my standing in my command and made me persona non-Grada (sic) in My (sic) work center. It was the part of the reason I got a bad transfer eval, manipulation of my records, manipulation of PRT scores that force (sic) me out."

SUMMARY OF QUALITATIVE INQUIRY FINDINGS

The four major themes provide valuable information about the entire treatment process for our participants at Navy Fleet and Family Support Center. The findings strengthen the deductive results of our study and provide a comprehensive picture of the experiences of Black males seeking and remaining in treatment. The *engagement* findings indicate ways to improve the initial fundamental interactions with Black males seeking assistance. The *cultural insensitivity* points to training areas for both the clinical and supportive staff. The *non-beneficial* findings expressed regret of not getting those mental health needs met and even possibly incurring an additional injury when seeking assistance, and the *therapist/client's lack of fit* and *professional incompetence* indicate that our participants may have tolerated the perceived slights and indignities with engagement and cultural insensitivity provided they esteemed the treatment as effective or beneficial. This study's participants may have willingly tolerated three of the four coded themes - poor engagement, cultural insensitivity, and lack of therapeutic fit had they revered clinical services provided as beneficial, worthwhile, or valuable. Of course, the goal is to eliminate discomfort or perceived racism within the treatment dyad; however, the responses indicated a lost opportunity to provide vital mental health services to those in desperate need. Also, on the inquiry, several participants voiced their appreciation for the opportunity to respond and give their opinions about service delivery at FFSC. One can only hope those participants could get the mental health services they sought from other resources within the Navy.

CHAPTER FOUR: DISCUSSION AND CONCLUSION

This study set out to test if there were correlations among our independent variables – perceived racism, client-therapist treatment dyad, perceived environmental or racial climate, and our dependent variable completion of treatment at Navy Fleet and Family Support Centers (FFSC). Our study is the first known study to examine inequalities in mental health treatment among Black male sailors at FFSC. We sought to identify, specifically, if perceived racism, namely the interactions with both the providers and the treatment environment, affected the outcome of treatment for the participants. We controlled for several key variables, including race/ethnicity of the treatment provider, age of participants, length of service in the Navy, and deployment status at the time of treatment. Our study used well-validated measures to assess our independent variables.

We had a total of 79 participants in the study in a recruitment period of seven months. During the first two months of the study, we noticed that the wording of our survey could have unwittingly prevented more participants. When we investigated our survey with probable recruits, we learned that in naval culture implicature the question, “Did you receive counseling services at Fleet and Family Support Center?” was understood as “Did you receive satisfactory services at Fleet and Family Support Center?” As a result, we added the following phrase to ensure comprehension, "even if it was only one visit to the facility," to the eligibility questions. After the addition of the phrase "even if it was only one visit to the facility," the number of participants increased as well as the feedback to our inductive question at the end of the survey.

To our question "Tell us about your experience seeking assistance at Navy Fleet and Family Support Center." This study's findings emphasized several distinct characteristics surrounding treatment completion for Black male sailors and provided significant implications for clinical social work practice. Although the study hypotheses were not entirely supported, findings support the significant role of perceived racism within the treatment dyad and facility's treatment environment in the sample population.

The hypothesis that negative racial climate and perceived racism outside of the treatment setting would significantly impact the odds of self-referring to treatment was not supported. Our research was the first study of its kind and will serve as a launching point for further research around negative racial climate and perceived racism outside of Fleet and Family Support Center affecting self-referral for treatment. A longitudinal or inductive study needs to be conducted to explore why Black male sailors refused to utilize mental health services at Fleet and Family Support Centers. That said, the qualitative results indicate dissatisfaction, racism, mistreatment and other “missed opportunities” to get sailors the mental health care within the FFSCs. As social work practitioners, our person-in-environment framework could provide micro and macro approaches to tackling and creating a better goodness-of-fit for Black male sailors in the Navy (Rogge & Cox, 2002).

The hypothesis that negative racial climate and perceived racism outside of the treatment setting would significantly impact the odds of completing treatment was not supported. The literature is scarce on negative racial climate and perceived racism outside the treatment setting. This researcher believes that potential clients' perception of the treatment facility and its

therapists weigh heavily on whether they seek treatment to its conclusion. The reputation of the facility and the professional competence of its therapists are crucial elements. Judging from the responses to this study and the lack of participants, many Black sailors who have close relationships with family and communities of faith seek treatment from alternative providers such as chaplains, other clergy members, and extended family members. This is supported by previous research (Constantine, Wilton, & Caldwell, 2003; Constantine et al. 1997; Nickerson et al., 1994) (Constantine, Chen, & Ceesay, 1997) (Nickerson, Helms, & Terrell, 1994). Support systems and resources for Black sailors are critical. Program conception and design must consider cultural elements to support all of our sailors, including Black men.

The hypothesis that treatment-specific negative racial climate and perceived racism would predict the number of treatment sessions completed was not supported. This is not consistent with previous research, which predicts fewer treatment sessions attended by clients who reported negative racial climate and perceived racism. In contrast to our study, research has indicated that the negative effect of microaggressions is positively correlated with reduced visits for treatment. Owen et al. (2018) found that clients' experiences of microaggressions in therapy have negative implications for both therapeutic processes and outcomes, resulting in fewer visits to the treatment facility. Owen et al. (2014), in a previous study, reported that more than 50% of clients reported experiencing a racial microaggression in therapy; however, when those perceived microaggressions were discussed in therapy, more than 75% of those same clients reported a better working alliance than those where the microaggression was not discussed. This is in concurrence with research conducted by Constantine (2007), which concluded that racial microaggressions occurring within a cross-racial therapist/client dyad could be repaired if addressed within the therapeutic process. Although our study could not identify any association

among our independent variables and Black sailors self-referring for treatment, other research indicated that the fear of stigmatization regarding seeking mental health treatment, uncertainty about the expectations of mental health treatment, and a general mistrust of mental health professionals are factors that prevent Blacks from seeking treatment (Thompson et al., 2012). One of our participants indicated in the inductive section of the study that the staff was racist, and he stopped attending treatment sessions because of it.

The hypothesis that treatment-specific negative racial climate and perceived racism would impact the odds of completing treatment was supported. This is consistent with previous research studies that found that racial microaggressions by therapeutic providers reduced visits and impacted the treatment alliance and treatment completion. Drinane, Owen, and Tao (2018) examined the association between microaggression and the treatment process and discovered a negative association related to successful treatment and outcomes. Nevertheless, as stated above, microaggressions do not have to be the end of the treatment alliance. Chang and Berk (2009) identified practical elements that promote success across racial lines within the therapeutic alliance. Their work found that positive therapeutic relationships consisted of mutually identified therapeutic goals, the client's connection with the therapist, and the termination process was sufficient. Holland's (1997) PIE theory found that clients who experienced an attachment identified by positive interactions with their therapists resulted in positive outcomes in treatment. In sum, race does not have to be a barrier to successful treatment across racial lines if courtesy, honest communication, and proper apologies are made to repair therapeutic ruptures despite racial microaggressions.

Exploratory Findings

The exploratory analysis sought to identify relationships amongst the personal demographic characteristics of the participants. There was no significant relationship between completing treatment and personal characteristics such as age, rank, and deployment status. A significant relationship was found between completing treatment and agreeing on a treatment plan, suggesting that agreeing upon a treatment plan was associated with higher treatment completion rates. This is consistent with previous research, which found that goal formulation with the therapist and client resulted in higher successful treatment and satisfaction levels. Mo et al. (2003) found that agreeing with and understanding treatment goals were essential for a successful therapeutic relationship. The research indicated four elements that promoted clients to change were:

1. invitation to play an active role in determining the direction and focus of treatment,
2. respect as an expert in their own lives and know how to effect change,
3. in charge of determining their treatment goals with the parameters of their presenting problem, and
4. held accountable for current and future behaviors and not their past behaviors.

The researchers concluded that the therapy was viewed as relevant and valuable because the client participated in formulating treatment goals.

Our study found that mutually agreed-upon goals and the common factors approach may offer a practical, and more effective treatment modality for Black male sailors.

> Common factor theory is based on the premise that therapies could be designed to help broad classes of people rather than specific individuals defined by demographics and diagnosis. Some mental health problems might ultimately require specific treatment, but there appear to be elements of treatment common to diverse therapies across multiple diagnoses that, together, have a powerful influence on outcomes. This is in contrast to the medical model of mental health care (the "specific effects" approach), which proposes that illnesses first need to be defined and then treated with psychotherapeutic or pharmacologic interventions that are highly specific to the illness (Bickman, 2005 p. 309).

This approach seeks to minimize racial characteristics but not in a colorblind sense. More focus is placed upon treatment alliance and the relationship between therapist and client. The topic of race is broached and addressed when appropriate, and the focus of the therapeutic relationship is placed on rapport building skills. The common factors approach consists of five major categories: client characteristics, therapist qualities, change processes, treatment structure, and therapeutic alliance or relationship. Bickman (2005), Grencavage, and Norcross (1990) outlined *common factors* as

> Client characteristics include both demographic variables such as client race, socioeconomic status, and gender, and characteristics more directly related to therapy, such as client motivation, client hopefulness, and client expectancies of therapy. Therapist qualities comprise both demographic variables and more directly therapy-relevant characteristics, like the therapist's theoretical orientation, years of experience, and training. Change processes include general techniques or activities such as clients

> having catharsis, clients acquiring and practicing new behaviors, and therapists providing a treatment rationale. Treatment structure includes the use of specific therapy techniques; a focus on client emotions, thoughts, beliefs, etc.; and therapist adherence to a theory. Therapeutic relationship includes common factors such as therapeutic alliance, engagement, and transference (p. 1).

The three common factors of therapeutic alliance, engagement, and transference were highlighted in our study. Another principal element within establishing treatment parameters is addressing the power dynamic.

The power endemic in treatment relationships or interpersonal power is another cogent area for treatment planning negotiations between therapist and clients. The overt power in providing a diagnosis even if the client is not in agreement with it and possibly reporting client's progress or lack thereof to his command is astonishing and should be completely covered in the treatment planning and inform consent phases. Furthermore, after the mutually agreed upon treatment plan is completed, the nuanced power dynamics (professional, transferential, socio-political, and bureaucratic) will also be present throughout the therapeutic process and should be tackled in the professional counseling relationship as they occur (Fors, 2021). The researcher argues that these nuanced power interactions are more subtle and mostly unconscious to either party within the treatment dyad. Her power dynamic framework also provides a lens for improving treatment interventions and improving the therapeutic alliance. The willingness to confront the power differentials, engagement problems, transference, racial microaggressions and clinical ruptures help to mitigate potential problems as they may occur during the therapeutic

alliance. Further research about the intersection of these elements and the power deferential in treatment relationships may provide more knowledge about how to treat our target population.

In conclusion, in this researcher's experience, basic Aristotelian logic along with good rapport and the appropriate treatment modality assisted Black male sailors in maintaining gains achieved in treatment. Black male clients who were taught basic logic and how to identify fallacious thoughts and feelings both internal and from external forces propagated from various sources improved over the course of treatment. Since most clients stop attending sessions after four sessions if they find no benefit, it is essential to prepare them with basic therapeutic skills. Focusing on these three common factor practices, repairing therapeutic ruptures in the treatment process, talking about racial concerns, and not ignoring them under the guise of color blindness or fear of offending the client, and addressing microaggressions experienced within the treatment dyad may be the most effective elements of providing effective treatment to Black male sailors irrespective to the effectiveness of the evidence-based interventions utilized. To help clients, they must first continue to attend sessions and the therapeutic alliance based on mutual respect, unconditional positive regard, and true fidelity in our clients' ability to offer solutions and to participate in the therapeutic process are just as important as the treatment modality currently pushed as the panacea based on evidence-based studies. The problem's origin could be bidirectional or circular in nature; nevertheless, most clients are not going to subject themselves to incivility when they seek assistance. In short, our study highlighted the importance of first impressions and how they could affect the course of treatment.

Limitations

Our study focused on Black male sailors who received treatment at Navy Fleet and Family Support Centers, and the survey was at a single point in time cross-sectional design. This method of participation provides more opportunity for participants; however, it limits expansive responses to this study. Our study was only able to reach 79 Black sailors in the six to nine period despite safeguards taken to eliminate reprisals. Despite our efforts to increase participation via advertisements and other recruiting methods, the small number of participants also hinders generalizability for this study. Our research project was conducted outside of the auspices of the Navy and was anonymous; only demographic information was solicited. Our study was advertised throughout the continental United States and on various military installations worldwide; nevertheless, only 79 Black sailors chose to participate. Other studies could focus on Black female sailors and include other treatment facilities within the Navy, namely, Naval medical hospitals and religious organizations.

Implications for Social Work Practice

This study points out the importance of general courtesy and willingness to address perceived racism and microaggressions within the course of treatment. Believing clients, active listening, and repairing ruptures perceived by the clients are elements that predict a successful treatment alliance resulting in increased visits to treatment facilities and satisfied clients irrespective of race. Within the Navy, training evolutions should not only provide the most effective evidence-based treatment to social work practitioners, but commensurate attention should also focus on the importance of rapport-building activities occurring within the

therapist/client dyad that facilitate open communication and positive interactions between therapist and clients. This includes social work and client dyads of different racial backgrounds.

Importantly, the primary focus of training should include multicultural competency as well as racial and anti-racist education. Discussing racism in therapeutic exercises could create discomfort for White therapists. In her book, "Nice Racism," DiAngelo (2021) identifies how well-intentioned White people perpetuate harmful practices when discussing racial issues. The author posits that whites go through a process called "White Fragility," a defense mechanism consisting of minimization, defensiveness, anger, invalidation, hurt feelings, and guilt. She adds that this "White Fragility" shields Whites from the reality of racism and the necessity to self-educate themselves about it (DiAngelo, Dyson, & ProQuest eBook central, 2020).

To illustrate her thesis, in the book, she retells a story about her Black colleague and friend, who was asked to give a presentation on racism to a group of White people. DiAngelo explained her friend's dynamics contemplating this task as a Black woman. DiAngelo wrote about her friend's trepidation and past racial abuse. In the end, her friend decided to give the presentation. At the end of her presentation, a group member thanked the university for providing the seminar but took no responsibility for his ignorance about the subject matter, nor did he thank the Black presenter for preparing and giving the workshop. The author writes how "White Fragility" manifested in this group member's response. Because the social work profession has a large number of White practitioners (among other reasons), attention to this concept in social work education and practice is critical.

DiAngelo cites critical race scholar Sherene Razack's (1998) theory about the process of learning about people described as "different." Razack suggested that this learning process is the

"cornerstone of imperialism." She characterized this mental imperialism as, "… colonized people possess a series of knowable characteristics that can be studied, known, and managed accordingly by the colonizers whose own complicity remains masked" (DiAngelo, 2021, p. xi; Razack, 1998). White fragility and this "cornerstone of imperialism" provide a buffer and erect a wall from responsibility.

Although these events described by DiAngelo took place on a micro-level, they can provide insight for the future of social work practice on the meso and macro levels. Anti-racist education and multicultural competence training must continue to consider these two phenomena with an ongoing focus. As more data from studies are added to the general knowledge, social work practice and state licensing boards can require yearly continuing education units in these areas. Culture is a dynamic, livable phenomenon, and a college course taken in graduate school along with a field practicum taken at a point in time may be inefficient at addressing contemporary societal interactions Black men face when they seek mental health assistance. As Black males have a higher incidence of racial harassment and discrimination than Black women (Sellers & Shelton, 2003), special attention to racial microaggressions during their treatment experience is vital and must be considered during program design, and continuing education courses.

Another future implication for social work practice is building upon the foundation of CRT, which focuses on macro and meso levels of intervention with a more culturally responsive approach. The latter teaches students to look beyond norms and traditions of a particular culture and examine how the individual is treated in the larger context within that group and society. CRT as a framework places race and racism at the center, limiting the social worker's ability to

deal with interpersonal and interpsychic processes such as transference and countertransference during therapeutic interventions (Varghese, 2016). Social work must continue to use CRT as a framework; however, augmenting CRT with improved interrogative and reflective skills for its clinicians would better enhance their ability to manage interpersonal and interpsychic processes in therapy. When racial issues are broached, these skills would greatly improve the client/therapist's treatment dyad.

Lastly, to effect revolutionary change emphasizing eliminating inequalities in mental health treatment, our profession must desire to right the wrongs of our past on a national level by promoting a truth and reconciliation movement. We must fully confront our history of racism and racial discrimination. We must recommence where Reconstruction left off and convene congressional hearings with the aim of reconciliation. Leebaw (2002) suggested that a *truth and reconciliation* congressional hearing occur in America to promote equality, to accept responsibility for its racist and violent past, and to set a course for a future without racial discrimination. The researcher added, "suggesting that a critical approach to thinking about the idea of reconciliation must start with an investigation of the obstacles to communication and political change in the aftermath of mass atrocity." (P. xii). These policy efforts must cover a factual account of those atrocities and the means to repair them. These reparations should include punishment, authentic historical accounts, penalties for their denial, and forgiveness when applicable. These efforts will thereby eliminate efforts to revise historical events in light of contemporary political talking points, which seek to minimize the effects of racism and discrimination in the United States. In an act of boldness, The United States could prohibit

publicly denying slavery and disseminating historical racist propaganda both on- and offline, following Germany's lead in banning the denial of the Holocaust, wearing Schutzstaffel attire (SS) in public, and other atrocities committed by the Nazi Regime (Glaun, 2021). These atrocities include slavery, Jim Crow, Black Codes, lynchings, destruction of property, redlining, blockbusting, denial of Federal Housing Administration (FHA) loans, and the Federal-Aid Highway Act of 1956, to name a few (Fullilove & Wallace, 2011; Hanchett, 2001; Kuthy, 2017). These steps could eliminate the need to protest civil rights violations committed by government officials and curtail racist political talking points that purposely distort the research and wisdom of CRT and seek to diminish the racist historical context of this country.

Further study

Further research is necessary to understand racism's multilayered effects on Black male sailors seeking treatment within the Navy. The limitations of this study can serve as a nexus for such research. Based on the responses from the inductive question at the end of the survey, more extensive qualitative research should be conducted with Black male sailors to gain additional information about their experiences seeking treatment from a full P-I-E social work qualitative framework. This effort could explore the sailor's experience from the standpoint of his environmental interchanges at command, at home, during deployments, and within the Naval/military culture in general, as he seeks mental health treatment at Fleet and Family Support Center. In short, a P-I-E social work qualitative approach would provide additional information about possible challenges or reprisals he encounters from each of his roles within his environment.

Counselors/therapists must be interviewed about their experiences and willingness and ability to work across different racial and cultural groups within the military domain. They should be able to identify areas of weaknesses in training and ask if they sought to educate themselves about inequalities in treatment specific to the military members and anti-racism techniques in counseling or therapy sessions. The answers to these questions could provide valuable information about training needs and individual prospective employee initiatives. Lastly, hiring Black counselors trained in the above areas addresses the lack of Black counselors working within the counseling domain at FFSC. In addition, by hiring Black counselors, a subsequent study could be done to see if equivalent results occur with Black male sailors and Black counselors.

CONCLUSION

As demonstrated in this study, inequalities in mental health treatment for Black males have persisted since the inception of the United States, the standardization of mental health research and treatment practices, and since their acceptance and integration in the military, particularly the Navy. Black sailors continue to face challenges seeking and remaining in mental health treatment. Proper assessment and treatment need to occur on all levels of social work practice and within each social work practitioners, and that training must reflect the latest research. A comprehensive appraisal of inequalities in mental health and its prevalence is needed within the Navy. Innovative recruitment strategies must address organizational mistrust and fear of reprisals keeping in mind our country's history and the reticence of Black males to participate in mental health studies.

On a national level, a true history of racism and discrimination must be taught without prejudice or passion in all American schools as a requirement. The American government needs to confirm CRT as history that is not the subject of debate, derision, or revision. America needs only to look to Germany or South Africa, who both conducted truth and reconciliation hearings as positive examples of handling historical atrocities and ensuring those events are not reinterpreted for future generations. Acknowledging America's past wrongs could help govern social work practice at the macro, meso, and micro levels of interventions. Social Work's pioneer Jane Addams demonstrated how this approach could ignite revolutionary change with the success of Hull House and the Settlement Movement, which shaped social work practice for years to come.

This study also encapsulates how initial impressions, subsequent rapport-building techniques, and general unconditional positive regard were not afforded to the participants and how this lack of basic skills informed the entire treatment relationship and outcome. Anti-racism and multicultural competence are a start and provide a framework for positive interactions; however, a culturally responsive approach adds crucial elements about how a particular person interacts in the context of her cultural experience and expression.

As the research vis-à-vis Black males related to mental health treatment is practically non-existent in the Navy, this study highlights this client population's unique qualities, stressors, and challenges in seeking treatment and continuing in treatment until its conclusion. In addition, this study's results can be disseminated and added to existing cultural competencies and anti-racism educational standards, which must continue to be a lifelong journey that constitutes an ongoing learning process for social workers. In conclusion, this study highlights the need for a more comprehensive understanding of inequality in service delivery for Black sailors in the Navy in order for the mental health and social work fields can better serve these sailors who give so much to our country.

APPENDIX

Recruitment Flyer

“Are you a Black male sailor who got counseling services at Fleet and Family Services Center? Are you willing to confidentially share some of your experiences?”

Hello Shipmates,

My name is Walter John Kelly, and I served in the Navy from December 2001 to March 1, 2011. I am currently working toward a Doctorate in Clinical Social Work at the University of Pennsylvania’s School of Social Policy and Practice. I am seeking your assistance, colleagues, in completing my dissertation, which focuses on the relationship between perceived racism and mental health treatment at Navy Fleet and Family Support Center (FFSC) Counseling, Advocacy, and Prevention program.

You will find a link to a completely anonymous online survey at the bottom of this email. This current survey is intended solely for male sailors of African American or Black descent who have sought or were referred to counseling services at FFSC. If you fit these criteria and think you would like to participate, click on the link to learn more about the study. Once you have read the information provided there, you may choose to continue with the survey by clicking on the "I agree" button or choosing not to participate by simply closing the browser window. No personal information about you will be gathered, and you will not be penalized in any way should you choose not to participate in the study for any reason. More information will be provided on the website.

Whether or not you choose to participate, please forward this email to any of your friends or acquaintances whom you think would be appropriate for the study. If you have any questions or concerns about this project, you may contact me at wjk009@upenn.edu.

Thank you very much!

Walter John Kelly, Jr.

Letter of Informed Consent on the online survey.

Title of the Research Study: Inequalities in mental health treatment related to race among seekers or recipients of service from Navy Fleet and Family Support Centers.

Protocol Number: 848614

Principal Investigator:

Dr. Katherine C. Ledwith

Co-investigator: (name, address, phone, and email)
Walter John Kelly, Jr.
PSC 476 Box 807
FPO, AP 96322
(313) 653-1499
wjk009@upenn.edu

Emergency Contact: 911

You are being asked to take part in a research study. This study is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary, which means you have an option to participate or not. You can withdraw participation at any time. If you elect to participate, this study will ask about your experiences while in the Navy. Before you decide, you will need to know the study's purpose, the possible risks and benefits of being in the study, and what you will have to do if you decide to participate. If you do not understand what you are reading, do not consent. Please ask the researcher to explain anything you do not understand.

What is the purpose of the study?

The purpose of the study is to learn more about the relationship between racism, discrimination, and counseling received at the Navy Fleet and Family Support Center Counseling Services. In particular, as a former sailor, who is Black, I am interested in Black male sailors' experiences.

If you have questions, concerns, or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. Suppose a research team member cannot be reached, or you want to talk to someone other than those working on the study. In that case, you may contact the Office of Regulatory Affairs with any questions, concerns, or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you click "I agree" on this page, you agree to participate in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

I agree ____

Please answer each question. For your input to count, all survey questions need to be answered. At the end of the survey, we will ask you to describe your experience seeking counseling assistance at Fleet and Family Support Center (FFSC). I would like to thank you gentlemen for your input on this survey.

Age:

Rank at time of seeking counseling assistance:
Years of service at time of seeking counseling assistance:
Deployment status at time of seeking counseling assistance: Before, during, after, or not applicable.

Were you mandated to get assistance or self-referred?

How many sessions did you attend?

Did you successfully complete counseling services? (Did you reach all treatment goals and objectives you and your counselor mutually agreed upon satisfactorily) Yes or no.

GANTT Chart

Timeline in months					1	2	3	4	5	6	7	8	9	10	11	12	13
Activities																	
Formulation of measures for the online questionnaire		1	2		X												
IRB Expedited review process		2	3			X											
Recruitment of participants via social media		3	8				X	X	X	X	X	X					
Data collection		8	9										X				
Data analysis		9	10											X			
Author report and dissemination of results.		10	13												X	X	X

Surveys

Racial Microaggressions in Counseling Scale

The statements below are intended to represent some of the situations or events that may have transpired over the course of your counseling sessions. Using the scale below, please rate your counselor with regard to the following situations or events during counseling. Please note that the term "cultural" used in each of the statements refers specifically to racial or ethnic issues.

0	1	2
This never happened	This happened, but it *did not* bother me at all	This happened and I was bothered by it

___ 1. My counselor avoided discussing or addressing cultural issues in our session(s).
___ 2. My counselor sometimes was insensitive about my cultural group when trying to understand or treat my cultural concerns or issues.
___ 3. My counselor seemed to deny having any cultural biases or stereotypes.
___ 4. My counselor may have thought at times that I was overly sensitive about cultural issues.
___ 5. My counselor at times seemed to over-identify with my experiences related to my race Or culture
___ 6. My counselor at times seemed to have stereotypes about my cultural group, even if he or she did not express them directly.
___ 7. My counselor sometimes seemed unaware of the realities of race and racism.
___ 8. My counselor at times may have either overestimated or underestimated my capabilities or strengths based on my cultural group membership.
___ 9. My counselor sometimes minimized the importance of cultural issues in our session(s).
___ 10. My counselor may have offered therapeutic assistance that was inappropriate or unneeded based on my cultural group membership.

Everyday Discrimination Scale

In your day-to-day life, how often do any of the following things happen to you?

1. You are treated with less courtesy than other people are.
2. You are treated with less respect than other people are.
3. You receive poorer service than other people at restaurants or stores.
4. People act as if they think you are not smart.
5. People act as if they are afraid of you.
6. People act as if they think you are dishonest.
7. People act as if they're better than you are.
8. You are called names or insulted.
9. You are threatened or harassed.

Recommended response categories for all items:
(1) Never
(2) Less than once a year
(3) A few times a year
(4) A few times a month
(5) At least once a week
(6) Almost everyday

Racial Microaggression Scale

Answer each of the following questions by selecting one answer in the 1-4 scale:
(0 = Never, 1 = Little/Rarely, 2 = Sometimes/Moderate amount, 3 = Often/Frequently, 4= Always)

If you respond positively to the item, indicate how stressful, upsetting, or bothersome the experience was for you (0 = not at all, 1 = a little, 2 = moderate level, 3 = high level).

1. Because of my race, other people assume that I am a foreigner.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

2. Because of my race, people suggest that I am not a “true” American.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

3. Other people often ask me where I am from, suggesting that I don’t belong.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

4. Other people treat me like a criminal because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

5. People act like they are scared of me because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

6. Others assume that I will behave aggressively because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

7. I am singled out by police or security people because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

8. People suggest that I am “exotic” in a sexual way because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

9. Other people view me in an overly sexual way because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

10. Other people hold sexual stereotypes about me because of my racial background.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

11. Other people act if they can fully understand my racial identity, even though they are not of my racial background.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

12. Other people act as if all of the people of my race are alike.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

13. Others suggest that people of my racial background get unfair benefits.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

14. Others assume that people of my background would succeed in life if they simply worked harder.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

15. Other people deny that people of my race face extra obstacles when compared to Whites.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

16. Other people assume that I am successful because of affirmative action, not because I earned my accomplishments.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

17. Others hint that I should work hard to prove that I am not like other people of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

18. Others suggest that my racial heritage is dysfunctional or undesirable.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

19. Others focus only on the negative aspects of my racial background.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

20. Others prefer that I assimilate to the White culture and downplay my racial background.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

21. I am mistaken for being a service worker or lower-status worker simply because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

22. I am treated like a second-class citizen because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

PLEASE ANSWER QUESTIONS 23-27 BELOW IN LIGHT OF YOUR EXPERIENCE AT FFSC.
****

23. I receive poorer treatment at FFSC because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

24. Sometimes I feel as if people look past me or don't see me as a real person because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

25. I feel invisible because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

26. I am ignored at FFSC because of my race.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

27. My contributions are dismissed or devalued because of my racial background.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

****

28. When I interact with authority figures, they are usually of a different racial background.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

29. I notice that there are few role models in my racial background in my chosen career.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

30. Sometimes I am the only person of my racial background in my class or workplace.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

31. Where I work or go to school, I see few people of my racial background.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

32. I notice that there are few people of my racial background on the TV and in books and magazines.
(Never) 0 1 2 3 4 (Always)
0 = not at all, 1 = a little, 2 = moderate level, 3 = high level

Inductive question

Briefly tell us about your experience seeking treatment at Fleet and Family Support Center.

References

Abram, J., author. (2018). *The clinical paradigms of Melanie Klein and Donald Winnicott: Comparisons and dialogues /*. Abingdon, Oxon; Routledge. doi:10.4324/9780429466922

Anderson, K. F. (2013). *Diagnosing discrimination: Stress from perceived racism and the mental and physical health effects**. Austin, Texas, etc., Univ of Texas Press, etc. doi:10.1111/j.1475-682X.2012.00433.x

Atkins, R. (2014). Instruments measuring perceived racism/racial discrimination: review and critique of factor analytic techniques. *International journal of health services: planning, administration, evaluation*, *44*(4), 711–734. doi:10.2190/HS.44.4.c

Arendt, V. (2021). Undoing racism through social work. Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=29AYH9qAdXc%3D&portalid=0

Baker, F. M., & Bell, C. C. (1999). Issues in the psychiatric treatment of African Americans. *Psychiatric Services (Washington, D.C.), 50*(3), 362-368. doi:10.1176/ps.50.3.362

Baruch, G., Vrouva, I., & Fearon, P. (2009). A follow-up study of characteristics of young people that dropout and continue psychotherapy: Service implications for a clinic in the community. *Child and Adolescent Mental Health, 14*(2), 69-75. doi:https://doi-org.proxy.library.upenn.edu/10.1111/j.1475-3588.2008.00492.x

Bell, D. (1980). *Shades of brown*. New York: Teachers College Press.

Bell, D., & Alexander, M. (1992). *Faces at the bottom of the well*. Boulder: Basic Books. Retrieved from https://ebookcentral.proquest.com/lib/[SITE_ID]/detail.action?docID=5368873

Bhati, K. S. (2014). Effect of client-therapist gender match on the therapeutic relationship: An exploratory analysis. *Psychol Rep, 115*(2), 565-583. doi:10.2466/21.02.PR0.115c23z1

Bickman, L. (2005). *Common factors approach to improving mental health services*. New York, N.Y.: Kluwer Academic/Plenum Publishers. doi:10.1007/s11020-005-1961-7

Blakemore, E. (2019). How the GI bill's promise was denied to a million black WWII veterans. Retrieved from https://www.history.com/news/gi-bill-black-wwii-veterans-benefits “Combat exhaustion,” journal of nervous and mental disease 104 (1946): 358–89; 489–525.

Blume, A. W., Lovato, L. V., Thyken, B. N., & Denny, N. (2012). The relationship of microaggressions with alcohol use and anxiety among ethnic minority college students in a historically white institution. *Cultural Diversity & Ethnic Minority Psychology, 18*(1), 45-54. doi:10.1037/a0025457

Blumenbach, J. F. (1865). On the natural variety of mankind. In T. Bendyshe (Ed.), (pp. 69-143). London, Great Britain: Longman, Green, Longman, Roberts, and Green. doi:10.1037/13883-003

Bordin, E. S. (1979). *The generalizability of the psychoanalytic concept of the working alliance*. Washington, D.C.: American Psychological Association. doi:10.1037/h0085885

British reforms and colonial resistance 1763-1766. (2010). Retrieved from https://search.proquest.com/docview/1943844376

Broido, E. M., & Manning, K. (2002). Philosophical foundations and current theoretical perspectives in qualitative research. *Journal of College Student Development, 43*(4), 434. Retrieved from https://search.proquest.com/docview/195182448

Burrowes, A. (2019). Post traumatic slave syndrome A literature review on African American community healing and expressive arts therapy. *Expressive Therapies Capstone Theses,* Retrieved from https://digitalcommons.lesley.edu/expressive_theses/200

Byrd, W. M., & Clayton, L. A. (2000). *An American health dilemma: A medical history of African Americans and the problem of race*. New York: Routledge.

Byrd, W. M., & Clayton, L. A. (2001). Race, medicine, and health care in the United States: A historical survey. *Journal of the National Medical Association, 93*(3 Suppl), 11S. Retrieved from https://www-ncbi-nlm-nih-gov.proxy.library.upenn.edu/pmc/articles/PMC2593958/

Carter, R. T. (2007). Racism and psychological and emotional injury. *The Counseling Psychologist, 35* (1), 13-105. doi:10.1177/0011000006292033

Carter, R. T. (2007). Racism and psychological and emotional injury. *The Counseling Psychologist, 35* (1), 13-105. doi:10.1177/0011000006292033

Carter, R. T., Mazzula, S., Victoria, R., Vazquez, R., Hall, S., Smith, S., . . . Williams, B. (2013). *Initial development of the race-based traumatic stress symptom scale: Assessing the emotional impact of racism*. Washington, DC : American Psychological Association. doi:10.1037/a0025911

Cartwright, S. (1851). The diseases and physical peculiarities of the negro race. by Samuel A. cartwright, M. D. New-Orleans. *Charleston Medical Journal and Review, VI*(5), 643.

Cattell, R. B. (1987). *Beyondism: Religion from science*. New York: Praeger.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*(4), 521-536. doi:10.1037/a0016905

Christensen, S (2017). Diversity, Inclusion, and Equal Opportunity in Armed Services: Background issues for congress.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans. A biopsychosocial model. *The American Psychologist, 54*(10), 805-816. doi:10.1037//0003-066x.54.10.805

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1-16. doi:10.1037/0022-0167.54.1.1

Constantine, M. G., Chen, E. C., & Ceesay, P. (1997). Intake concerns of racial and ethnic minority students at a university counseling center: Implications for developmental programming and outreach. *Journal of Multicultural Counseling and Development, 25*(3), 210-218. doi:10.1002/j.2161-1912.1997.tb00331.x

Constantine, M. G., Wilton, L., & Caldwell, L. D. (2003). The role of social support in moderating the relationship between psychological distress and willingness to seek psychological help among Black and Latino college students. *Journal of College Counseling, 6*(2), 155-165. doi:10.1002/j.2161-1882.2003.tb00236.x

Corvalan, J. C., & Klein, D. (2011). PTSD: Diagnosis, evolution, and treatment of combat-related psychological/psychiatric injury. *Missouri Medicine, 108*(4), 296-303. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21905450

Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review,* 96, 608-630

Crocq, M. A., & Crocq, L. (2000). From shell shock and war neurosis to posttraumatic stress disorder: A history of Psychotraumatology. *Dialogues in Clinical Neuroscience, 2*(1), 47-55. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/22033462

Cruz, D., Rodriguez, Y., & Mastropaolo, C. (2019). Perceived microaggressions in health care: A measurement study. *PloS One, 14*(2), e0211620. doi:10.1371/journal.pone.0211620

Curtin, S.C., & Hedegaard, H. (2019). Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017. NCHS Health E-Stat. 2019.

Daniel G Solórzano, & Tara J Yosso. (2001, Oct 1,). From racial stereotyping and deficit discourse toward a critical race theory in teacher education. *Multicultural Education (San Francisco, Calif.), 9*, 2. Retrieved from https://search.proquest.com/docview/216501989

DeGruy, J. (2005). *Post traumatic slave syndrome: America's legacy of enduring injury and healing.* Oregon, Milwaukie: Uptone Press.

Delgado, R., & Stefancic, J. (2012). *Critical race theory* (Second edition ed.). New York; London: New York University Press.

DiAngelo, R. (2021). *Nice racism: How progressive white people perpetuate racial harm*. Boston, Massachusetts: Beacon Press.

DiAngelo, R., Dyson, M. E., & ProQuest eBook central. (2020). *White fragility: Why it's so hard for white people to talk about racism*. Boston, Massachusetts: Beacon Press. Retrieved from http://hdl.library.upenn.edu/1017.12/2547685

Diener, M. J., & Monroe, J. M. (2011). *The relationship between adult attachment style and the therapeutic alliance in individual psychotherapy: A meta-analytic review*. Washington, D.C.: American Psychological Association. doi:10.1037/a0022425

Drinane, J. M., Owen, J., & Tao, K. W. (2018). *Cultural concealment and therapy outcomes*. Washington, D.C. : American Psychology Association. doi :10.1037/cou0000246

Du Bois, W. E. B. (1898). *The suppression of the African slave-trade to the United States of America, 1638-1870*. New York: Russell & Russell.

Dwyer, E. (2006). Psychiatry and race during World War II. *Journal of the History of Medicine and Allied Sciences, 61*(2), 117-143. doi:10.1093/jhmas/jrj035

Feagin, J. R., & Sikes, M. P. (1994). *Living with racism: The black middle-class experience* Beacon Press.

Fernando, S. (2017a). *Institutional racism in psychiatry and clinical psychology: Race matters in mental health*. Cham, Switzerland: Springer Berlin Heidelberg.

Fernando, S. (2017b). *Institutional racism in psychiatry and clinical psychology: Race matters in mental health*. Cham, Switzerland: Springer Berlin Heidelberg.

Fors, M. (2021). Power dynamics in the clinical situation: A confluence of perspectives. *Null, 57*(2), 242-269. doi:10.1080/00107530.2021.1935191

Fuller, N., & Joanna Banks Collection of African American Books. (1984). *The united-independent compensatory code system concept: A textbook workbook for thought, speech, and or action, for victims of *racism (white supremacy)* (Revised.). Washington, DC; Washington, D.C.; ©1984: Published by author; Distributed by Liberation Information Distributing Co.

Fullilove, M. T., & Wallace, R. (2011). Serial forced displacement in American cities, 1916–2010. *Journal of Urban Health, 88*(3), 381-389. doi:10.1007/s11524-011-9585-2

Gibbons, M. B. C., Crits-Christoph, P., Barber, J. P., Wiltsey Stirman, S., Gallop, R., Goldstein, L. A., . . . Ring-Kurtz, S. (2009). Unique and common mechanisms of change across cognitive and dynamic psychotherapies. *Journal of Consulting and Clinical Psychology, 77*(5), 801-813. doi:10.1037/a0016596

Glaun, D. (2021). Germany's laws on hate speech, Nazi propaganda & holocaust denial: An explainer. Retrieved from https://www.pbs.org/wgbh/frontline/article/germanys-laws-antisemitic-hate-speech-nazi-propaganda-holocaust-denial/

Goldenberg, V. (2002). Ranking the correlates of psychotherapy duration. *Administration and Policy in Mental Health, 29*(3), 201-214. doi:10.1023/A:1015187324925

Gotanda, N. (1991). A critique of "our constitution is color-blind." *Stanford Law Review, 44*(1), 1. Retrieved from https://search.proquest.com/docview/1291705584

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology, Research and Practice, 21*(5), 372-378. doi:10.1037/0735-7028.21.5.372

Hafley, V. (2019). A brief history of 40 years of service by FFSC Norfolk: The oldest, the biggest, the best. *Military News of Hampton Roads,* Retrieved from https://www.militarynews.com/news/a-brief-history-of-40-years-of-service-by-ffsc-norfolk-the-oldest-the-biggest/article_8b5483f2-9c6d-11e9-8270-ef6938fe010e.html

Haidt, J. (2017). The unwisest idea on campus. *Perspectives on Psychological Science, 12*(1), 176-177. doi :10.1177/1745691616667050

Hall, R. E. (2001). *The bell curve: Racist psychology and stereotype of the "dumb black"*. Ile-Ife, Nigeria: Ife Centre for Psychological Studies. doi:10.4314/ifep. v9i2.23612

Hanchett, T. W. (2001). The other "subsidized housing": Federal aid to suburbanization. *Journal of Housing and Community Development, 58*(1), 18-22. Retrieved from https://proxy.library.upenn.edu/login?url=https://www.proquest.com/scholarly-journals/other-subsidized-housing-federal-aid/docview/59834657/se-2?accountid=14707

Harley, D. A., Jolivette, K., McCormick, K., & Tice, K. (2002). Race, class, and gender: A constellation of positionalities with implications for counseling. *Journal of Multicultural Counseling and Development, 30*(4), 216-238. doi:10.1002/j.2161-1912. 2002.tb00521.x

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress. *American Journal of Orthopsychiatry, 70*(1), 42-57. doi:10.1037/h0087722

Harris, G. L. A. (2011). Reducing healthcare disparities in the military through cultural competence. *Journal of Health and Human Services Administration, 34*(2), 145-181.

Helmenstine, Anne Marie, Ph.D. (2020, August 26). Linnaean Classification System (Scientific Names). Retrieved from https://www.thoughtco.com/linnaean-classification-system-4126641

Hiett, R.L., McBride, R. S, & Fiman, B. G. (1978). *The Racial Attitudes and Perceptions Survey (RAPS)* (Technical Paper 338). Monterrey, CA: U.S. Army, Research Institute for the Behavioral and Social Sciences

Hillman, J. W. (2020). *Changing attachments: The client-therapist relationship and outcome* (M.A.). Available from ProQuest Dissertations & Theses Global. (2434565553). Retrieved from https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/2434565553?accountid=14707

Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments, 3rd ed*. Odessa, FL, US: Psychological Assessment Resources.

Holley, L. D. (2011). *Help seeking behaviors of African American men, college of education theses and dissertations. 15.*

Hollingsworth, D. W., Cole, A. B., O'Keefe, V. M., Tucker, R. P., Story, C. R., & Wingate, L. R. (2017). Experiencing racial microaggressions influences suicide ideation through perceived burdensomeness in African Americans. *Journal of Counseling Psychology, 64*(1), 104-111. doi:10.1037/cou0000177https://digitalcommons.lesley.edu/expressive_theses/200 https://via.library.depaul.edu/soe_etd/15

Huynh, V. W. (2012). Ethnic microaggressions and the depressive and somatic symptoms of Latino and Asian American adolescents. *Journal of Youth and Adolescence, 41*(7), 831-846. doi:10.1007/s10964-012-9756-9

Jackson, V. (2002). In our own voice: African American stories of oppression, survival and recovery in mental health systems. *International Journal of Narrative Therapy and Community Work, 2002*(2), 11-31. Retrieved from https://search.informit.org/documentSummary;dn=126257994859584;res=IELIND

Jensen, A. (1969). *How much can we boost IQ and scholastic achievement*? Cambridge, Mass.: Harvard University, etc.]. doi:10.17763/haer.39.1. l3u15956627424k7

Johnson, A., & Jackson Williams, D. (2015). White racial identity, color-blind racial attitudes, and multicultural counseling competence. *Cultural Diversity and Ethnic Minority Psychology, 21*(3), 440-449. doi:10.1037/a0037533

Joyner, J. (2018). Why 'different spanks for different ranks' are often justified. *Defense One* Retrieved from https://www.defenseone.com/ideas/2018/03/officer-misconduct-military-justice/146423/

Kivlighan III, D. M., Swancy, A. G., Smith, E., & Brennaman, C. (2021). Examining racial microaggressions in group therapy and the buffering role of members' perceptions of their group's multicultural orientation. *Journal of Counseling Psychology, 68*(5), 621-628. doi:10.1037/cou0000531

Klein, H. S. (2010). *The Atlantic slave trade* (, New ed.). Cambridge; New York: Cambridge University Press.

Kuthy, D. (2017). Redlining and greenlining: Olivia Robinson investigates root causes of racial inequity. *Art Education, 70*(1), 50-57. doi:10.1080/00043125.2017.1247573

Lang, B. (2000). *Race and racism in theory and practice*. Lanham, Md.: Rowman & Littlefield Publishers.

Lee, M. Y. (2009). *Solution-focused treatment of domestic violence offenders accountability for change /*. Oxford: Oxford University Press. doi:10.1093/acprof:oso/9780195146776.001.0001

Leebaw, B. A. (2002). *Judging the past: Truth, justice, and reconciliation from Nuremberg to South Africa* (Ph.D.). Available from ProQuest Dissertations & Theses Global. (251693615). Retrieved from https://proxy.library.upenn.edu/login?url=https://www.proquest.com/dissertations-theses/judging-past-truth-justice-reconciliation/docview/251693615/se-2?accountid=14707

Lilienfeld, S. O. (2017). Microaggressions. *Perspectives on Psychological Science, 12*(1), 138-169. doi:10.1177/1745691616659391

Lindsey, M. A., Chambers, K., Pohle, C., Beall, P., & Lucksted, A. (2012). Understanding the behavioral determinants of mental health service use by urban, under-resourced black youth: Adolescent and caregiver perspectives. *Journal of Child and Family Studies, 22*(1), 107-121. doi:10.1007/s10826-012-9668-z

Mackenzie, C., Knox, V., Gekoski, W., & Macaulay, H. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. Journal of Applied Social Psychology, 34, 2410-2435.

Maclean A. (2008). The Privileges of Rank: The Peacetime Draft and Later-life Attainment. *Armed forces and society*, *34*(4), 682–713. Doi: 10.1177/0095327X07310336

Mallinckrodt, B. (2010). The psychotherapy relationship as attachment: Evidence and implications. *Journal of Social and Personal Relationships, 27*(2), 262-270. doi:10.1177/0265407509360905

Matsuda, M. J., Lawrence, C. R., Delgado, R., & Crenshaw, K. W. (1993). *Words that wound* (1st ed.). Boulder: Routledge. doi:10.4324/9780429502941 Retrieved from https://www.taylorfrancis.com/books/e/9780429502941

McGuire-Snieckus et al., 2007. Scale to Assess Therapeutic Relationship, new patient version.

McNeilly, M., Anderson, N., Armstead, C., et al. (1996). The Perceived Racism Scale: a multidimensional assessment of the experience of White racism among African Americans 6:154-166.

Mencke, B. K. B. (2010). *Education, racism, and the military: A critical race theory analysis of the GI bill and its implications for African Americans in higher education* (Ph.D.). Available from ProQuest Dissertations & Theses Global. (860945903). Retrieved from https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/860945903?accountid=14707

Mo, Y., Lee, J., Sebold, A., Uken, Mo, Y., Lee, J., . . . Uken. (2003). Developing useful goals . *Oxford Scholarship Online: January 2009,* Retrieved from DOI: 10.1093/acprof:oso/9780195146776.001.0001

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling and Development, 92*(1), 57-66. doi:10.1002/j.1556-6676.2014.00130.x

Nancy R. Kressin, Kristal L. Raymond, & Meredith Manze. (2008). Perceptions of race/ethnicity-based discrimination: A review of measures and evaluation of their usefulness for the health care setting. *Journal of Health Care for the Poor and Underserved, 19*(3), 697-730. doi:10.1353/hpu.0.0041

Nickerson, K. J., Helms, J. E., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and black students' attitudes toward seeking psychological help from white counselors. *Journal of Counseling Psychology, 41*(3), 378-385. doi:10.1037/0022-0167.41.3.378

Norman, L. R. *What is taking place in science classrooms? A case study analysis of teaching and learning in seventh-grade science of one Alabama school and its impact on African American student learning* Retrieved from http://hdl.handle.net/2097/16907

NW, 1. L. S., 800Washington, S., & Inquiries, DC 20036USA202-419-4300 | Main202-857-8562 | Fax202-419-4372 | Media. (a,). 6 facts about the U.S. military's changing demographics. Retrieved from https://www.pewresearch.org/fact-tank/2017/04/13/6-facts-about-the-u-s-military-and-its-changing-demographics/

Obegi, J. H. (2008). The development of the client-therapist bond through the lens of attachment theory. *Psychotherapy: Theory, Research, Practice, Training, 45*(4), 431-446. doi:10.1037/a0014330

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). *Clients' perceptions of their psychotherapists' multicultural orientation*. Washington, D.C.: American Psychological Association. doi:10.1037/a0022065

Owen, J., Tao, K. W., Drinane, J. M., Torino, G. C., Rivera, D. P., Capodilupo, C. M., . . . Sue, D. W. (2018). *Microaggressions: Clinical impact and psychological harm*. Hoboken, NJ: John Wiley & Sons, Inc. doi:10.1002/9781119466642.ch5

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., . . . Gee, G. (2015a). Racism as a determinant of health: A systematic review and meta-analysis. *PloS One, 10*(9), e0138511. doi: 10.1371/journal.pone.0138511

Pascoe, Elizabeth & Richman, Laura. (2009). Perceived Discrimination and Health: A Meta-Analytic Review. Psychological bulletin. 135. 531-54. 10.1037/a0016059.

Perry, B. L., Neltner, M., & Allen, T. (2013). A paradox of bias: Racial differences in forensic psychiatric diagnosis and determinations of criminal responsibility. *Race and Social Problems, 5*(4), 239-249. doi:http://dx.doi.org.proxy.library.upenn.edu/10.1007/s12552-013-9100-3

Phillips, D. (2019). Three Suicides in One Navy Ship's Crew Point to a Growing Problem. *The New York Times, p.19*. Retrieved from https://www.nytimes.com)2019/09/24)navy-suicides-USS-George-Bush

Pinderhughes, C. A. (1969). *The origins of racism*. New York, etc.: Science House, etc.

Pols, H., & Oak, S. (2007). WAR & military mental health. *American Journal of Public Health (1971), 97*(12), 2132-2142. doi:10.2105/ajph.2006.090910

Pressly, P. K., & Heesacker, M. (2001). The physical environment and counseling: A review of theory and research. *Journal of Counseling and Development, 79*(2), 148-160. doi:10.1002/j.1556-6676.2001.tb01954.x

Rawley, J. A. (2005). *The transatlantic slave trade: A history /*. Lincoln: University of Nebraska Press.

Razack, S. (1998). *Looking white people in the eye: Gender, race, and culture in courtrooms and classrooms*. Toronto: University of Toronto Press.

Redmond, M. L., Galea, S., & Delva, J. (2009). Examining racial/ethnic minority treatment experiences with specialty behavioral health service providers. *Community Mental Health Journal, 45*(2), 85-96. doi:10.1007/s10597-008-9164-5

Reid, L. D., & Radhakrishnan, P. (2003). Race matters: The relation between race and general campus climate. *Cultural Diversity and Ethnic Minority Psychology, 9*(3), 263-275. doi:10.1037/1099-9809.9.3.263

Robbie, A. & Babbie, E. (2017) Research methods for social work, 9th edition. (2017, Retrieved from https://link-gale-com.proxy.library.upenn.edu/apps/doc/A487964849/AONE?u=upenn_main&sid=AONE&xid=e770f372

Rogge, M., & Cox, M. (2002). The person-in-environment perspective in social work journals: A computer-assisted content analysis. *Journal of Social Service Research - J SOC SERV RES, 28*, 47-68. doi:10.1300/J079v28n02_03

Roos, J., & Werbart, A. (2013). Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review. *Null, 23*(4), 394-418. doi:10.1080/10503307.2013.775528

Salmon, T. W. (2019). *Care and treatment of mental diseases and war neuroses (shell shock) in the British army* Forgotten Books. Retrieved from http://www.vlebooks.com/vleweb/product/openreader?id=none&isbn=9780243794058

Satterfield, W. A., & Lyddon, W. J. (1998). Client attachment and the working alliance. *Counselling Psychology Quarterly, 11*(4), 407. doi:10.1080/09515079808254071

Schnurr, P. P., Lunney, C. A., & Sengupta, A. (2004). Risk factors for the development versus maintenance of posttraumatic stress disorder. *Journal of Traumatic Stress, 17*(2), 85-95. doi:10.1023/B:JOTS.0000022614.21794.f4

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

Schwartz, R. C., & Feisthamel, K. P. (2009). Disproportionate diagnosis of mental disorders among African American versus European American clients: Implications for counseling theory, research, and practice. *Journal of Counseling & Development, 87*(3), 295-301. doi:10.1002/j.1556-6678.2009.tb00110.x

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology, 84*(5), 1079-1092. doi:10.1037/0022-3514.84.5.1079

Shaver, P. R., & Mikulincer, M. (2016). *Attachment in adulthood: Structure, dynamics, and change* The Guilford Press. Retrieved from http://www.vlebooks.com/vleweb/product/openreader?id=none&isbn=9781462525553&uid=none

Solórzano, D. G., & Yosso, T. J. (2001). Critical race and LatCrit Theory and method: Counter-storytelling. *International Journal of Qualitative Studies in Education, 14*(4), 471-495. doi:10.1080/09518390110063365

Sue, D. W., Capodilupo, C. M., Nadal, K. L., & Torino, G. C. (2008). Racial microaggressions and the power to define reality. *American Psychologist, 63*(4), 277-279. doi:10.1037/0003-066X.63.4.277

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life. *The American Psychologist, 62*(4), 271-286. doi:10.1037/0003-066X.62.4.271

Sweet, J. H. (2003). *Recreating Africa: Culture, kinship, and religion in the African Portuguese world, 1441-1770*. Chapel Hill: University of North Carolina Press.

Swim, J. K., & Stangor, C. (1998). *Prejudice: The target's perspective*. San Diego: Academic Press.

Taber, B. J., Leibert, T. W., & Agaskar, V. R. (2011). Relationships among client-therapist personality congruence, working alliance, and therapeutic outcome. *Psychotherapy, 48*(4), 376-380. doi:10.1037/a0022066

Tannenbaum, A. S. (1982). J. C. Naylor, R. D. Pritchard, D. R. Ilgen: A theory of behavior in organizations. New York: Academic Press, 1980. *Behavioral Science, 27*(2), 194-195. doi:10.1002/bs.3830270212

Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among black clients. *Journal of Counseling Psychology, 31*(3), 371-375. doi:10.1037/0022-0167.31.3.371

Thomas, A., & Sillen, S. (1972). *Racism and psychiatry*. New York: Brunner/Mazel.

Thompson, C. E., & Jenal, S. T. (1994). Interracial and intraracial quasi-counseling interactions when counselors avoid discussing race. *Journal of Counseling Psychology, 41*(4), 484-491. doi:10.1037/0022-0167.41.4.484

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology, 41*(2), 155-161. doi:10.1037/0022-0167.41.2.155

Thompson, R., Dancy, B. L., Wiley, T. R. A., Najdowski, C. J., Perry, S. P., Wallis, J., . . . Knafl, K. A. (2012). African American families' expectations and intentions for mental health services. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(5), 371-383. doi:10.1007/s10488-012-0429-5

Tobe, E. H., Tobe, E. H., & Tobe, E. H. (2017). *EC PSYCHOLOGY AND PSYCHIATRY review article transgenerational sequela of slavery in the United States, a model of why atrocity psychological aspect of social problems view project EC PSYCHOLOGY AND*

PSYCHIATRY review article transgenerational sequela of slavery in the United States, a model of why atrocity

Torres-Harding, S. R., Andrade, A. L., & Romero Diaz, C. E. (2012). The racial microaggressions scale (RMAS). *Cultural Diversity and Ethnic Minority Psychology, 18*(2), 153-164. Doi:10.1037/a0027658

Tucker, W. H. (2005). The racist past of the American psychology establishment. *The Journal of Blacks in Higher Education,* (48), 108-112. Retrieved from https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/195540814?accountid=14707

Tucker, W. H. (2009). *The Cattell controversy: Race, science, and ideology*. Urbana: University of Illinois Press.

Utsey, S. O. (1998). Assessing the stressful effects of racism: A review of instrumentation. *Journal of Black Psychology, 24*(3), 269-288. doi:10.1177/00957984980243001

Utsey, S. O., & Ponterotto, J. G. (1996). Development and validation of the index of race-related stress (IRRS). *Journal of Counseling Psychology, 43*(4), 490. Retrieved from https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1683820136?accountid=14707

Varghese, R. (2016). Teaching to transform? addressing race and racism in the teaching of clinical social work practice. *Null, 52*, S134-S147. doi:10.1080/10437797.2016.1174646

Walker, M. (2020). *When getting along is not enough*. New York, NY; London: Teachers College Press.

Walls, M. L., Gonzalez, J., Gladney, T., & Onello, E. (2015). Unconscious biases: Racial microaggressions in American Indian health care. *Journal of the American Board of Family Medicine, 28*(2), 231-239. doi:10.3122/jabfm.2015.02.140194

Washington, H. A., & ProQuest eBook central. (2006). *Medical apartheid: The dark history of medical experimentation on black Americans from colonial times to the present* (pub ed.). New York: Harlem Moon. Retrieved from http://hdl.library.upenn.edu/1017.12/2547638

Wetzel, J. W. (1980). Operationalizing the person-environment conceptual framework for social work intervention with depressed clients. *Arete, 6*(2), 33-42. Retrieved from https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/scholarly-journals/operationalizing-person-environment-conceptual/docview/61632634/se-2?accountid=14707

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2008). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health, 98*(Suppl 1), S29. doi:10.2105/ajph.98.supplement_1.s29

Williams, D. R., Yu, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial Differences in Physical and Mental Health: Socioeconomic Status, Stress, and Discrimination. Journal of Health Psychology, 2(3), 335–351. https://doi.org/10.1177/135910539700200305

Williams, M. T. (2019). Microaggressions: Clarification, evidence, and impact - Monnica T. Williams, 2020. *Perspectives on Psychological Science,* Retrieved from https://journals-

sagepubcom.proxy.library.upenn.edu/doi/full/10.1177/1745691619827499?utm_source=summon&utm_medium=discovery-provider

Williams, M. T., Printz, D. M. B., & DeLapp, R. C. T. (2018). Assessing racial trauma with the trauma symptoms of discrimination scale. *Psychology of Violence, 8*(6), 735-747. doi:10.1037/vio0000212

Wiseman, H., & Tishby, O. (2014). Client attachment, attachment to the therapist, and client-therapist attachment match: How do they relate to change in psychodynamic psychotherapy? *Null, 24*(3), 392-406. doi:10.1080/10503307.2014.892646

Wright, B. (2014). Victory and defeat: World war I, the Harlem Hell fighters, and a lost battle for civil rights. *Afro - Americans in New York Life and History, 38*(1), 35-70. Retrieved from https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1514898108?accountid=14707

Yehuda, R., & McFarlane, A. C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry, 152*(12), 1705-1713. doi:10.1176/ajp.152.12.1705