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MEASURING CONSUMER SATISFACTION AND EFFICACY OF A PSYCHOEDUCATIONAL MATERIAL

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MEASURING CONSUMER SATISFACTION AND EFFICACY OF A PSYCHOEDUCATIONAL MATERIAL

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ABSTRACT

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Discrimination has been shown to have negative effects on mental health (Vargas et al., 2020). Studies have shown that experiencing and perceiving racism can lead to symptoms of depression in Black individuals (Gayman & Barragan, 2013). Though this problem exists, there are limited methods and solutions presented that address the effects of racism on depression (Brondolo et al., 2009). Empirical research has not yielded clear findings on the best strategies for addressing discrimination. This limits the guidance that can be provided to people as they attempt to alleviate the concern associated with discrimination. Further, individuals may experience distress and discomfort when attempting to vocalize their feelings about these concerns, and healthcare providers have been shown to experience the same discomfort (Livingston, 2018). While diversity and cultural awareness training have been implemented in healthcare settings, healthcare providers may still feel that it does not adequately prepare them to have to address racism related concerns with patients (Sempertegui et al., 2018).

Despite the minimal resources available to help providers feel sufficiently informed about best practices for having conversations about racism and depression, psychoeducational materials can potentially serve as a means to facilitate conversations. Psychoeducation can be beneficial for both patients and providers because it prepares

both with a framework and language for discussing difficult subjects. Psychoeducation can also assist in structuring a conversation about race and depression that is thought provoking and helpful. In this study, we developed a psychoeducational material that targets depression and the effects that discrimination may have on depression. This psychoeducational material is intended to help support conversations about these topics.

In this thesis, we examine the consumer satisfaction of participants when using and viewing the booklet. Consumer satisfaction is measured quantitatively among university students, and measured qualitatively among mental health care providers.

DEDICATION

I would like to dedicate this thesis to my family, whose unconditional love and support provided me with the determination to continue in my academic career.

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BACKGROUND

Depression is characterized as a mood disorder that causes individuals to experience a persistent feeling of sadness, loss of interest in activities, and a feeling of lethargy. Individuals with depressive disorders may find it difficult to participate in everyday tasks, and have difficulties enjoying things that they once did. Depressive disorders are a risk factor for suicide and can also significantly influence the outcome and potential mortality associated with other comorbid illnesses such as cancer, cardiac diseases, and diabetes (NIMH, n.d).

An estimated 8.4 percent of adults in the United States have experienced or are experiencing symptoms of depression (SAMHSA, 2020). The prevalence in 18 to 29 year old individuals is almost 3 times higher than adults in their sixties. Women also experience higher rates of depression than males in both adolescence and adulthood (Essau et al., 2010). The prevalence may be underreported because of negative stigmas associated with reporting symptoms or receiving mental health care (Ward & Besson, 2013).

Depression can be seen in episodes for some, while for others it can become a chronic illness (Cassano & Fava, 2002). Stress is a risk factor for depression (Hammen, 2015). Certain life events and struggles may operate as triggers for the onset and development of depressive symptoms. Traumatic events such as the death or loss of a loved one, lack of social support, financial problems, and numerous interpersonal difficulties can cause people to experience depression (Hammen, 2015). One of the social stressors that increases the risk for developing depression is experiencing racism (Woody et al., 2022).

Definitions of racism. Racism is defined as prejudice against racial groups that have been deemed inferior, and includes negative reactions, stereotype acceptance, discrimination, and sometimes violence against individuals of those groups (APA, n.d). This kind of discrimination can have an effect on many aspects of an individual's social life, including difficulty finding employment, difficulty gaining access to proper care, and alienation from social groups or settings (Williams & Rucker, 2000). Racism can also affect individuals' personal lives due to the internalization of stigmas and stereotypes that are imposed upon members of minority groups (James, 2017). Stigma can be defined as a negative attitude that is shared socially that has been attached to an attribute of an individual that is often treated as a mental, physical, or social deficiency (APA, n.d).

There are many kinds of racism/discrimination including cultural racism, institutional racism, interpersonal racism, and internalized racism. Cultural racism can be defined as derogatory messaging that advances the assumption that the practices and ideologies of non-white minorities are inferior to those of white individuals (Cogburn, 2019). This can include damaging images and representations of minority groups in media, news, and literature to uphold the inferiority complex attached to these groups as a result of white supremacy (Harrell, 2000).

Institutional racism includes structural implications involving various organizations, including governmental institutions that sustain and utilize both implicit and explicit practices of racial discrimination and inequities (Elias & Paradies, 2021). Institutional racism can also be reflected in an institutions' norms, policies, and practices.

For example, these can include discriminatory hiring processes, discriminatory disciplinary processes, discriminatory practices, among others (Walter et al., 2017; Wun, 2014).

Social and interpersonal racism can be defined as directly perceived unequal treatment that is experienced by members of minority groups (Krieger 1999). Experienced racism can include negative comments, unfair treatment, and violence that minority individuals encounter or have encountered. Around 71% of African Americans state that they have experienced racism, while 11% of African Americans state that they experience racism regularly (Pew Research Center, 2016).

Individuals who experience racism may begin identifying with misrepresentations of their race and racist tropes associated with their race. They may be concerned that others will see them only in terms of negative attributes associated with their race. This can generate a cycle of mental oppression. In gaining insight into what racism entails, it can cause negative feelings about their race and cause Black individuals to feel like they are at a much lower and less deserving place in society. When these feelings begin to progress, these individuals may begin to link themselves to the negative beliefs and believe that their race is what defines them and their behaviors.

Racism and depressive symptoms. Each level of racism has been associated with depressive symptoms or other forms of mental distress. Exposure to media, and potentially to cultural racism is something that is seemingly unavoidable, therefore individuals may involuntarily consume racially harmful content that can be detrimental to their well-being. Cultural racism has been associated with depression (Gibson et al., 2022). In a cross sectional study of 604 Black adolescents between the ages of 13-17, Gibson et al (2022) measured the participants' exposure to cultural racism with 10 items that illustrated different race-centered scenarios that they may or may not have experienced. The items were derived from the Inventory of Race-Related Stress and included items like "You have observed the police treat White/non-blacks with more respect and dignity than they do Blacks" and measured the frequency of these experiences. Depression was measured through 7 items about depressive symptoms and how they experienced these symptoms within the past two weeks derived from the Depression, Anxiety, and Stress Scale. Their findings indicated that Black adolescents who had reported that they experienced more cultural racism also reported more depressive symptoms.

It is often believed that for institutions to be racist, that they must state and support racist policies; however by simply adhering to discriminatory practices these institutions are further perpetuating institutional racism (Elias & Paradies, 2021). Discriminatory practices have been found and maintained in housing procedures and policies. Housing discrimination can include differential treatment, discriminatory terms and conditions on leases and other arrangements, and housing segregation (Roscigno et al., 2009). Individuals who reside in segregated neighborhoods with scarce resources may internalize the lack of support that their community has as a personal shortcoming, which may contribute to feelings of depression (Sadler et al., 2022). Perceived housing discrimination has also been linked to symptoms of depression as well. Yang et al., (2016) measured if perceived housing discrimination has an effect on individuals' self reported health, including depression. Housing discrimination was measured with items about if participants had experienced discrimination, were hassled, or made to feel inferior when attempting to obtain housing because of their race. They found that the rates of depression were higher among participants who had experienced housing discrimination than those that did not. Their findings also suggested that individuals who perceived discrimination reported higher levels of distrust in the healthcare system as well.

Institutional discrimination also affects healthcare organizations and institutions as well, as racism in healthcare settings towards minority individuals has been well documented (Peek et al., 2010). African American patients in the United States have long received less than satisfactory care in comparison to white patients when seeking medical treatment (Williams and Wyatt, 2015). In addition to inadequacies in care, Black patients are also viewed as "difficult", and also state that they are often dismissed during their healthcare interactions. These kinds of experiences of racism in healthcare have been associated with a lack of trust of providers and a delay in individuals seeking services (Hamed et al., 2022).

Some evidence suggested that Black individuals do not seek out mental health care services due to racism and mistrust of healthcare providers. In a study conducted on 343 patients with lupus, they aimed to find if perceived racism in healthcare settings or experiences had an effect on the severity of their symptoms and the likelihood of having depressive symptoms. The study included 163 Black patients and 180 White patients who were over 18 years old. African American patients reported higher levels of perceived racism in their healthcare experiences, as well as higher levels of medical mistrust than their White counterparts. They also found that Black patients' levels of perceived racism were significantly associated with depressive symptoms even after adjusting for variables like marital status and income (Vina et al., 2015).

Interpersonal racism has been recognized as a chronic stressor that can have a negative effect on mental health (Vines, et al., 2017). Studies have shown that discrimination has been associated with depressive symptoms and chronic depressive disorders (Becares and Zhang, 2018; Quist, et al., 2022). Many studies have found that interpersonal discrimination can be a significant predictor for experiencing depressive symptoms (Hunte et al., 2013, Huebner et al., 2005). This topic has been well studied, and a meta-analysis conducted on discrimination and depression shared similar findings. Britt-Spells et al., (2018) conducted a meta analysis using 12 studies on discrimination and its association with depressive symptoms among Black men. As a result of their analyses, they found that among the studies there was a significant positive relationship between discrimination and depression and suggested that greater perceived discrimination was associated with greater depressive symptoms in Black men.

In the health care context, individuals may lack trust in providers due to potential medical racism, and do not want to be associated with negative stereotypes about their race as well as stigma associated with mental health disorders. This is problematic as once Black individuals become depressed, they are more likely to be chronically or depressed, have more severe symptoms, and are less likely to seek out or receive treatment (Williams, 2018).

Internalized racism has been described as being able to lead to feelings of hopelessness, increased feelings of self doubt, and diminished self esteem and self worth (Molina & James, 2016).

Discrimination and social cognition. Experiences and observations of racism can have effects on the development of certain socially cognitive processes that can shape how they interact in social settings. Social cognition encompasses the numerous psychological processes that allow individuals to understand and respond to different social signals that aid in our learning about the world and society around us (Frith, 2008). When interacting with others, this can involve taking in certain social cues that individuals then associate with an expectation of a specific emotion and or reaction from the other.

Experiencing or being aware of everyday racism can cause individuals to utilize internal scripts as a way to interpret the behaviors of others which includes racist notions, and in turn these scripts also direct individuals on how to behave and make those kind of ideas and situations feel controllable (Bourabain & Verhaeghe, 2021). Racism against minorities can seemingly occur in any social situation, including interactions that many would deem ordinary, which can cause minority individuals to become more observant of their social situations. (Lewis et al., 2023). When in social settings, a person may become aware that their stigmatized social status is relevant, so they might pay attention to cues that they view as related to possible discrimination (Casad & Bryant, 2016).

As a result of repeated communication about their social status, individuals may develop certain social cognitions. When Black individuals experience or are aware of the experiences of others involving racism, they can develop anticipatory sensitization because of the perceived need to be more aware of and responsive to race-related threats and potential stress that may be a result of having to experience discrimination (Hope et al., 2022). In an attempt to cope with racism-related stress, the social cognitions that

Black individuals may develop can include anticipating or expecting discrimination, rejection sensitivity, vigilance, and stereotype confirmation concern (Himmelstein et al., 2014; Mendoza-Denton et al., 2002; Thomas, 2020).

Relational schemas are developed as a result of experiences in social events or through social stressors that individuals use to formulate a general attitude about others and their potential feelings and actions. Exposure to racial discrimination can cause individuals to expect negative treatment from others in interpersonal relationships or situations and contribute to a negative view of relationships (Guyll et al., 2010). Racial disadvantages and race-related stressful events can also cause minority individuals to develop cynical and distrusting relational schemas that may lead to issues with developing connections. Expectations like these can cause minority individuals to fear rejection from others that they may attempt to build relationships with which can make forming healthy, communicative relationships difficult. The pathways that link experiences of discrimination and difficulties in interpersonal relationships can possibly be explained by dysfunctional behaviors that occur as a response to external stressors that confirm negative relational schemas (Wofford et al., 2019).

Negative relational schemas are associated with depressive symptoms (Bishop et al., 2022), potentially because of a fear or inability to properly communicate their feelings. Some individuals fear that they will be dismissed or overlooked if they do decide to express themselves, and in turn can activate schemas of rejection. The long term activation of these types of schemas can become a stressor for individuals and be damaging for their mental health.

Discrimination has been associated with several different types of negative relational schemas. In a study from our group conducted on 256 participants, an association emerged between discrimination and negative relational schemas. The negative schemas observed were concerns about rejection and invalidation, mistrust, and social vigilance. In addition to those findings, they were able to conclude that schemas related to discrimination served as a mediator between the relationship of discrimination and depression (Mikrut et al., 2022). Results like these provide evidence of mechanisms which can explain the effects of racism on the onset or exacerbation of depressive symptoms.

When there is a perceived social threat, individuals may have an increased need to avoid negative evaluations from others and enhanced social vigilance which has been shown to increase negative mood and risk for depression. Other negative relational schemas like stereotype confirmation concern, can cause individuals to increase their self-focused attention, in an attempt to determine the potential risk of their behaviors confirming negative stereotypes (Beatty Moody et al., 2016). When these schemas are activated, individuals may fear rejection and have increased distrust in others, which can negatively impact their social interactions.

For African Americans, perceived racism can be an anticipatory stressor, which is a stressor that can lead to the activation of the biological stress response system in anticipation of a potentially stressful situation, even if it does not occur (Waugh et al., 2010) . Studies have shown that the recurrence of a stressor like racism can lead to health disparities as a result of the over-activation of the biological stress system. In order to cope with these kinds of stressors, individuals may heighten their vigilance in an attempt to deter themselves from having those experiences. Discrimination-related vigilance is described as a social-cognitive coping mechanism in which one attempts to protect themself from anticipated discrimination by constantly and actively monitoring and modifying their behavior and surroundings (Hicken et al., 2013). Though it may be an attempt at protection, the overutilization of vigilance as a coping mechanism against racism and prejudice can lead to negative psychological and cardiovascular stress responses (Sawyer et al., 2012). In a study conducted on 1240 Black respondents, they attempted to find a connection between vigilance against discrimination and health disparities both physically and mentally. They found that their participants who reported that they sometimes engaged in vigilant behaviors reported a greater level of depressive symptoms, in comparison to participants who reported that they had never engaged in vigilant behavior. It was also found that participants who frequently engaged in vigilant behaviors reported greater levels of depressive symptoms as well as lower levels of self reported health (Lee & Hicken, 2016).

Accepting the anti-Black sentiments associated with race can be harmful to minority individuals' mental health because it is considered to be a reinforcement of Black inferiority and maintains the cycle of oppression on an individual and group level (Harper, 2007). It is believed that the internalization or acceptance of racism and negative tropes can be linked to minority individuals experiencing symptoms of depression. Internalized racism can lead to the development and onset of negative schemas about oneself and their race which can potentially exacerbate or bring on symptoms of depression. Research has suggested that the understanding and onset of racist experiences increase during early adolescence among Black adolescents, and comes with an increase in depression rates (English, et al., 2014). Though this connection may have only been studied more recently, there have been studies linking these concepts.

Internalized racism has been described as being able to lead to feelings of hopelessness, increased feelings of self doubt, and diminished self esteem and self worth (Molina & James, 2016). Minority individuals may begin identifying with misrepresentations of their race and racist tropes associated with their race, and start to feel like that is all that they will be seen as by others and fall into a cycle of mental oppression. Molina and James (2016) sought to examine the correlation among discrimination, internalized racism, and major depressive disorder. Their cross-sectional study utilized 4,988 African American and Afro-Caribbean adults. They measured internalized racism by providing participants with a series of questions such as “How true do you think it is, that most [Black people/Black Americans/Afro-Caribbean] people are: intelligent, lazy, hardworking, give up easily, proud of themselves, and violent?”, and asked them to rate their agreement with each statement on a scale from 1 (very true) to 4 (not true at all). They found that African Americans reported higher levels of internalized racism than Afro-Caribbeans. They also found that everyday discrimination was positively associated with internalized racism, and past-year Major Depressive Disorder; and that internalized racism was positively associated with meeting past-year MDD criteria. These results suggest that experiencing discrimination can lead to individuals’ internalizing racism, and also potentially lead to them exhibiting symptoms of depression or developing a depressive disorder.

Interventions to address depression. In order to combat symptoms of depression, there are a myriad of interventions that are often suggested by providers. For high risk cases, some patients require medication and intensive therapy, however there are other measures that can be used in certain cases. There are also low intensity interventions that have been effectively used to help lessen symptoms of depression, and provide individuals with information about disorders.

One approach can include psychoeducation about depression and its treatment. Psychoeducation is defined as an intervention with didactic and structured knowledge given on an illness and its treatment. Psychoeducational interventions integrate informational, emotional and motivational components to help patients cope and improve their adherence to the treatment and increase its efficacy (Ekhtari et al., 2017). Psychoeducation typically includes scientific information, that is usually written in a way that will be easily digestible for patients who may not have medical knowledge or even background information in regards to a specific disorder. The literature provided may be modified to better fit the needs of the patients, or accommodate skill or education level. When utilizing psychoeducation, this resource is often easily accessible for people who may decide to use it and can be accessed privately if necessary. This can be useful for individuals who have apprehensions towards receiving treatments like counseling, and allows them to be able to become knowledgeable about why they are experiencing certain symptoms and assist them in considering professional assistance or continue to mediate their symptoms with low intensity interventions.

Psychoeducation can be used in many different ways and as a possible solution for a number of health concerns. Psychoeducation can be provided for patients who prefer to work individually, to inform families about disorders and treatments, and also in group settings as well (Lyman et al., 2014). When utilized individually, patients are able to educate themselves on a disorder at their leisure and does not require much intervention from their healthcare provider. Psychoeducation has the potential to improve patients' satisfaction with mental health services, support a better quality of life, and promote better social and global functioning (Xia et al., 2011). Psychoeducation can help reduce stigma and increase treatment adherence. Many patients feel stigmatized by their disorder which causes denial and increases the likelihood of non-compliance with the plan provided by their healthcare provider. Increasing their knowledge about their disorder can make patients more comfortable with accepting their disorder which decreases stigma, and also has the potential to set them on the path to feeling empowered instead of hopeless (Strkalj Ivezic et al., 2017). In order to ensure the effectiveness of the material for patients, the proper material can either be found or created.

There are a few models that are used when creating psychoeducational material, they include the informational model, skill training model, supportive model, and the comprehensive model. The informational model focuses on providing individuals with knowledge about psychiatric illnesses and how to manage them. The skill training model focuses on the development of certain skills for self care so that the individual can understand how to manage the illness effectively and to the best of their ability. The supportive model involves the use of support groups to engage individuals to share their feelings and engage in a community that shares similar issues. The comprehensive model uses a combination of the aforementioned three models (Sarkhel et al., 2020). Though there have not been studies comparing the effectiveness of the use of each model, there have been studies completed on the effectiveness of psychoeducational material in alleviating depressive symptoms.

Morokuma and other researchers (2013) conducted a study on the effectiveness of psychoeducation for treating major depressive disorders. Their study included 32 participants that had been diagnosed with major depressive disorder and were between the ages of 20 and 70. Participants engaged in group psychoeducation weekly for 6 hour and a half sessions.They found that participants who received psychoeducation had a relapse rate of 6% in comparison to the participants that did not receive psychoeducation who had a relapse rate of 36% which was determined by an independent psychiatrist utilizing the DSM-IV threshold for major depressive disorder. They also found that participants who received psychoeducation had significantly lower depression severity on the Beck Depression Inventory nine months after they had participated in the study.

Similarly to psychoeducation, bibliotherapy is also able to reduce the stigma associated with receiving mental health care, in addition to being able to reduce the stigma associated with depression and other mental health disorders as well (Chen et al., 2021). Bibliotherapy is used to refer to literature intended to help people cope with mental illnesses, emotional problems, and changes in their lives or to produce and promote positive personality growth and development (Yontz-Orlando, 2017). The aim of bibliotherapy is to teach through the comprehension of certain educational material that provides both information on disorders and a number of strategies to help control negative emotions and also explain how to practice and incorporate them into their everyday lives (Jorm et al., 2002). Bibliotherapy is typically a low maintenance care option, as it allows patients to see providers less often than required when receiving talk therapy and other in-patient care methods.

Bibliotherapy reduces both the impact of stigma towards mental health disorders and the burdens that are often associated with visiting a mental health provider (Yuan, 2018). It offers individuals the opportunity to feel like the driving force of their therapeutic experience as they are the ones that are required to read and digest the material that is presented to them. Since bibliotherapy is a method of self directed treatment, it is important that providers ensure that their patient is actively involved in choosing it as a viable option that they will reliably use for their care and or treatment. (Usher, 2013). This method of treatment has been shown to be helpful for reducing symptoms of depression.

In an attempt to measure the effectiveness of bibliotherapy in reducing symptoms of depression, Taleban and other researchers conducted a randomized clinical trial with 198 participants that were 18 and older. Participants were placed into groups in which one group received bibliotherapy and text messages that included positive affirmations and things of that nature, and the other group only received bibliotherapy. They found that their participants responded well to both methods of treatment and saw less severity in their depressive symptoms. However, participants who received only bibliotherapy seemed to show quicker progress in the alleviation of their depressive symptoms that remained continuous throughout the 3 month period that the study was conducted (Taleban et al., 2016). The effectiveness of bibliotherapy to treat depression has been shown in this study and several other studies (Gualano et al., 2017; Gregory et al., 2004), which suggests that it is a useful intervention for treating depressive symptoms in individuals who are self-sufficient and able to persist in using the reading materials.

In addition to reducing symptoms of mental disorders, psychoeducation can also be used as an aid for learning. Psychoeducation can be seen as more approachable than a typical medical pamphlet, because the language used in psychoeducation is often simplified to increase comprehension among users. Patients who receive psychoeducation have been shown to be more knowledgeable about their disorder than those who do not receive psychoeducation. This knowledge may be advantageous when it comes to managing themselves and potential care that they or others may need (Devins, 2000). Psychoeducation has also been shown to result in patients reporting more knowledge about their conditions both immediately and long-term after receiving it and can contribute to better coping skills (Bossema et al., 2011). An increase in knowledge can also provide patients with better language to subjectively explain how they are feeling with a medical provider or others around them.

Gaining knowledge about relatable issues and being able to have a tool to help understand those issues can be useful for individuals. Psychoeducation can be beneficial especially in regard to learning new information and then applying it to their own situation. People may notice that they are not alone in their problems. (Aho-Mustonen, 2009). They may begin to make changes in an attempt to improve their lives.

Psychoeducation has been shown to be able to help patients make sense of their major problems and acknowledge their feelings about these problems and support personal growth (Inan & Ustun, 2019). This can provide people with the opportunity to have a resource that gives them stronger language to express what they may be going through and can help improve their well being that they can access at any time.

After consuming a form of psychoeducational material, patients may want to discuss some of their thoughts and feelings about what they viewed with their provider. In order for a patient to feel comfortable enough to share their thoughts, a proper rapport should be established between the patient and their provider. The ability to have open conversations and the level of trust between a patient and provider are the building blocks to establishing a connection that can positively enhance a patient's outcomes (Mucci et al., 2020). Some patients may have difficulty vocalizing their experiences in a way that they deem proper, and psychoeducation can provide them with a framework for describing and processing those experiences (Reynolds, 2019). Utilizing psychoeducational materials as a conversational tool can be useful for not only the patients, but the providers as well. These materials can support the provider in creating an opportunity to have a discussion with their patient about their thoughts on depression.

Psychoeducation can also be used as a support for conversations that may be difficult to address among individuals. When clients feel like they are misunderstood by their provider or feel disconnected from them, they are more likely to be dissatisfied by their care or treatment (Chang & Berk, 2009). Discussions of racism and race-related issues are important to have in psychotherapy, and these discussions can have positive effects on the quality of care provided (Knox et al., 2003). Providing minority patients with a space where they are able to speak about their feelings on race has been shown to be beneficial to the outcome of their therapy and improve the therapeutic alliance between the patient and their provider (Cardemil et al., 2003).

Though these conversations may appear to be necessary to enhance patient-provider communication and the experience of the patient, providers may be unaware of how to approach conversations of that nature. Studies have shown that White individuals may have more apprehension and unwillingness to have or ask about race related conversations when speaking to Black individuals in comparison to other White individuals (Trawalter & Richeson, 2008). Using psychoeducational materials that provide structure for discussing racism can help bridge the seemingly awkward disconnect between a patient and provider by providing a material that can be utilized as a conversation starter.

Psychoeducation that addresses uncomfortable topics like race can serve as a tool to open up a conversation about those issues. There is a need for interventions that can help navigate these issues. These materials may also help reduce mental health stigma. As stated previously, Black individuals are more likely to have maintained stigmas about receiving mental health care and psychoeducation can prove to be helpful in reducing that stigma. A study of Black individuals who were provided with psychoeducational material that was based on the experiences of other mental health clients found that individuals who reported higher perceived need for treatment or uncertainty about treatment showed greater stigma reduction after the use of psychoeducation (Alvidrez et al., 2009).

Psychoeducation has been suggested, in addition to other interventions, to be a strategy to help mental health professionals address racism in their practice that includes difficulties initiating discussions about race and racism (Miller et al., 2018). Though there are few psychoeducational materials on racism for minorities, it has been suggested that bibliotherapy has the potential to help minority individuals gain insight about personal dilemmas that they may have and provoke constructive discourse that can increase both awareness of structural challenges that they may face and self-awareness (Byrd et al., 2021). Developing psychoeducational material that addresses the mental health effects of racism could possibly prove to be beneficial in supporting and evoking conversations that may be difficult during treatment and can enhance the therapeutic process for minority clients**.**

Outcomes: Consumer Satisfaction. Ensuring that clients are pleased with the quality of care that they are receiving should be a priority in any medical setting. The expectations that a patient has about their quality of care has been linked to their perceptions of their care. When a patient's perception of their care is positive, then their experience and outcomes are more likely to be reported as positive (Srinivasan & Saravanan, 2015). Patients that are satisfied with their care are more likely to report better health outcomes and have better retention with services. Patients may require specialized healthcare services and demand care that satisfies their basic rights and respects their individuality. Minority patients who perceive their healthcare as culturally sensitive are also more likely to be satisfied by their care and also have higher levels of adherence to treatment (Roncoroni et al., 2014).

Patients are now viewed as healthcare consumers, which means they make decisions to use services and see providers that they feel satisfied with and those that best meet their needs (Wadhwa, 2002). Standards and expectations of care may vary among individuals, which is why it is important to ensure that clients are comfortable expressing themselves and their needs. In order for methods of care and treatments to be used and popularized among patients, it is important to measure their satisfaction with what they are receiving. Measuring consumer satisfaction can provide insight into the perceived effectiveness of the method and provide an outlet for necessary feedback on potential practices for improvement (Abboodi, 2010).

Healthcare approaches are constantly being improved, not only for cost benefits, but for the benefits of patients and providers as well. Consumer satisfaction is a substantial outcome when implementing a new approach in healthcare, to decide if it is ready for public use or if it needs to be improved. An intervention is more likely to be effective if potential consumers are satisfied by the intervention (Fernandez et al., 2006). Consumer satisfaction can also be used to determine whether or not an intervention will be effective for wide-scale usage.

Interventions like diversity training have been studied in order to establish its effectiveness and satisfaction among healthcare providers in an attempt to show the necessity for implementations like such to be introduced into institutional practices. Difficulties may arise between providers and patients who do not share a similar background. Therefore, it is valuable to ensure health care providers are educated about and familiar with potential cultural differences that providers may encounter. Providing resources and training for individuals in the healthcare field could better prepare them for caring for patients from different backgrounds and allow them to feel more comfortable during those interactions. In a cross-sectional survey that was conducted on a sample of pediatric residents, Frintner et al., (2013) examined the relationship of cross-cultural training with satisfaction with training, perceived readiness for providing culturally effective care, and attitudes surrounding care for underserved populations. They found that residents who received training reported being better prepared to care for families from different backgrounds and those with limited English proficiency. They also found that ninety-three percent of their participants were satisfied with their residency training, however that number decreased in terms of satisfaction with knowledge on global health issues and the amount of training received on culturally appropriate care.

In a study aimed to measure the effectiveness of a diversity-oriented competence training directed at the treatment of depression for minority patients, they provided training in an attempt to determine if it had the potential to increase diversity competence and measure satisfaction. They found that after the training, in comparison to the control group, participants who received training had higher scores on self-reported attitude-awareness, diversity competence, and received higher total knowledge test scores. They also found that the therapists' satisfaction with the training resulted in positive outcomes. Though most were satisfied with the training that they received, others stated that the training helped them realize that there is still a lot to learn about diversity competence for daily clinical practice (Sempertegui, 2018). Studies have shown that healthcare providers and administrators have reported that after receiving satisfactory cross-cultural training that they feel like they have an increase in their skills working in cross-cultural situations as well as improved understanding of the health care experiences of their patients from diverse backgrounds (Khanna et al., 2009).

Providers are not the only ones that benefit from these kinds of training. The training can be beneficial for their patients as well. Interventions intended to increase cultural sensitivity for healthcare professionals such as cultural competence training and racial sensitivity training have been shown to lead to improvements in patient satisfaction (Williams, 2011). Patients who are able to experience care from a provider that is educated on cultural issues may feel like they are receiving care that is tailored to their needs, especially those from minority backgrounds. Healthcare professionals that have empathy and understanding of the culture of their patient will be better able to have conversations and propose plans of care for their patients that they agree with (Dubey, 2020). They are more likely to be satisfied by their care which can lead to better outcomes in their experiences during treatment and outcomes of care as well.

Consumer satisfaction can be measured in numerous ways. The most common two approaches for evaluating and measuring satisfaction are qualitative and quantitative methods (Al-Abri & Al-Balushi, 2014). In order to obtain consumer satisfaction data, individuals are often given a survey or they are given an open interview in which they are able to share their thoughts about what they are presented with. Quantitative methods like surveys are the most utilized method of measuring satisfaction and can be useful for obtaining and analyzing information (Ilioudi, 2013). The data is collected using a numeric scale typically from 1 to 5 in which the ratings for satisfied and not satisfied are on opposite ends of the scale. Open-ended interviews have been utilized to measure consumer satisfaction qualitatively because it provides an opportunity to use professional observations, and it has the potential to produce higher response rates (Shirley et al., 2016). Qualitative methods and interviewing have also been shown to allow surveyors to get an in-depth analysis of the satisfaction level of the participant (Merkouris et al., 2004).

The most commonly used methods of measuring consumer satisfaction typically considers the quality of different aspects of the proposed idea, are comprehensive, yet contain few items. To determine satisfaction with a tool, dimensions of usability, acceptance, and perceived quality are often examined (Hajesmaeel-Gohari, 2022). This is especially important in healthcare, where introducing methods that most practitioners are unfamiliar with can be difficult to navigate without expert help, therefore if the method is not easily usable it will affect satisfaction and acceptance among consumers (Holden, 2020). Measures like the Usefulness, Satisfaction, and Ease of Use Questionnaire and The Client Satisfaction Questionnaire assesses dimensions like such on a Likert scale and have been shown to be effective. They include items like “How satisfied are you with the help that you received?” and “It helps me be more effective”. Utilizing effective items to measure consumer satisfaction is vital to the implementation of a product to ensure long term and successful interventions.

The current study utilizes a psychoeducational material intended to address depression in Black individuals and the pathways between discrimination and depression. The pathway from discrimination to depression is examined from a socially cognitive perspective, and explains the effects of both depression and discrimination on social cognition, relational schemas, and relationships. Having conversations about discrimination and depression can be difficult and using psychoeducational materials can potentially be a solution to help building the language and connection needed to be able to openly discuss these issues without distress. Healthcare providers and patients may have reservations about having those kinds of discussions initially, and psychoeducation may help navigate and alleviate tensions surrounding these concerns. A psychoeducational booklet was created that consisted of scientific information and quotes developed from a community advisory board of Black individuals. In order to evaluate the usefulness of this material, the booklet was presented to participants and data was collected both quantitatively and qualitatively on consumer satisfaction. Consumer satisfaction was measured among two different kinds of consumers in this study. Initially, consumer satisfaction was measured among students at a university quantitatively. In the next phase, consumer satisfaction was measured among physicians qualitatively.

METHODS

Booklet Development. To develop the booklet, six sets of statements that utilized the current literature on social cognitive processes and their role in discrimination and depression. Three sets of statements provided information about depression, the relation of stress and depression, and social cognitive pathways and processes that can lead from stress to depression. The second set of statements reviewed information about discrimination, the social cognitive pathways that link discrimination to depression, and support for addressing discrimination and depression.

The validity of the scientific statements was evaluated by four experts from universities and medical organizations that have focused on issues related to discrimination and mental health. These statements are the basis of the scientific and educational information provided in the booklet. In addition to the statements, the booklet included illustrations. The illustrations are intended to show the impact that the issues discussed can have on individuals and their relationships. Observing the illustrations was believed to be useful as a method of introducing thoughtful conversations about racism and depression between viewers.

In order to further the development of and assess the booklet, a Community Advisory Board was formed. Eight Black participants aged from 20 to 65 that were recruited by members of the research team formed the Community Advisory Board and participated in individual interviews over Zoom. They were presented with the psychoeducational material and were asked to provide their reactions, critiques, and relatable anecdotes that could be examples of the ideas presented in the booklet. Two weeks after the initial interview, the Community Advisory Board participated in a Zoom interview to provide additional thoughts on the material. All interviews were recorded and transcribed.

After their feedback was incorporated into a complete version of the booklet, members of the Community Advisory Board participated in a follow up meeting where they offered thoughts and opinions on the proposed final product. Their feedback was then used to make changes and produce the final version of the booklet. The psychoeducational booklet consists of 8 illustrated pages. On the left hand side, there is scientific information and illustrations about the page's topic which include depression, pathways from stress to depression, discrimination and depression, and others. On the right hand side, there are illustrations, and quotes from our community advisory board about their personal experiences. At the end of each section there are questions designed to facilitate conversations based on the topic of each section. The questions were open ended and intended to drive introspective thoughts that individuals may then potentially share with a provider.

Participants in Study 1: The booklet was shown to 68 students from a university from 18 to 32. The sample included 41 participants who identified as non-Black and 27 participants who identified as Black. Forty nine participants identified as female, 17 participants identified as male, and 2 participants identified themselves as other. Participants were recruited using posters, flyers, and face to face recruitment. During the recruitment process, the study was explained to participants and an informed consent and pre-test survey was completed.

Procedures: A post test survey was given to measure their feelings and satisfaction with the booklet. After participants had viewed the entire booklet, they were asked to share their overall thoughts about the booklet and any changes that could possibly be made. They then completed the post test survey which included questions that evaluated consumer satisfaction. Data was collected and then assessed on a scale from 1 to 5; 1 being “not at all” and 5 being “very much”.

Measures: The survey on Consumer Satisfaction aimed to evaluate the opinions of the participants on the psychoeducational material that they viewed and their level of comfort with the material and discussing topics that were included in the booklet. We included questions like “After reviewing this booklet, how much better prepared do you feel to discuss racial discrimination with others?” and “How much did this booklet give you information that would be useful in your everyday life?” in our measure to determine its usability among consumers. Determining acceptance with our booklet was measured using items about comfort while using the booklet like “How comfortable did you feel answering the questions in the booklet?” and “Did you feel uncomfortable or distressed at any point throughout the booklet experience?”. Satisfaction was directly measured using the questions, “How likely would you recommend this booklet to other people?” and “Overall, how much did you find this booklet helpful?”. The full consumer satisfaction battery can be found in Appendix A.

Participants in Study 2: In the next phase, the booklet was presented to 4 physicians. 3 were psychiatrists and one was a psychotherapist. Participants were recruited from New York Hospitals and other medical organizations.

Procedures: Participants were interviewed individually as they were read the booklet and answered questions presented by the interviewer designed to measure consumer satisfaction. Individual pages from the booklet were shown, then they were read the discussion questions and were asked to provide feedback on what they were shown. They were asked questions about their satisfaction of what they viewed, potential implementation settings, and changes that they believed should be made.

Measures: We developed questions for the interviews to elicit perceptions of satisfaction and utility and to provide clinical perspectives on the use of the booklet. To determine usability in a healthcare setting questions like “Do you think that this would not also be useful for patients, but also psychiatrists as well?” and “Do you see yourself using this booklet during sessions with your patients?” were asked. Acceptance was measured using questions like “Do you have any concerns about implementation and how your patients would react to this booklet?” and “What in particular do you like about this setup, as opposed to the regular sitting down with psychiatrists and interview questions that you would go through?” Provider satisfaction was measured using the questions “On a scale from 1 to 10, how likely would you be to use this material and “What are the benefits you anticipate if you were to use this?”.

RESULTS

The booklet received positive levels of satisfaction from the participants in Study 1 who viewed the booklet virtually. 92.96% of participants rated that working through the booklet was helpful or very helpful, with a mean score of 4.45. 88.73% of participants stated that they would be likely to recommend this booklet to others (M=4.39). 76.05% stated that they felt like the booklet gave them information that they would deem useful in their everyday lives. 66.19% of participants felt much or very much better prepared to discuss depression with others (M=4.03). 67.61% of participants rated that they felt much or very much better prepared to discuss racial discrimination with others, (M=4.04). 95.77% of participants stated that they were comfortable answering the discussion questions provided in the booklet (M=4.73).

Several themes emerged in the participants' comments. 42 out of 68 participants made verbal comments related to their satisfaction with the booklet and expressed how much they liked and enjoyed the experience associated with reviewing the booklet. 49 out of 68 participants said that they could relate to themes discussed in the booklet. 32 out of 68 participants spoke about the composition of the booklet and their perceived effectiveness of the structure and material presented in the booklet. 3 out of 68 participants made comments of dissatisfaction due to the booklet centering the experiences of African Americans instead of addressing racism faced by other ethnic groups as well.

In terms of the qualitative interviews in Study 2, the physicians overall believed that the use of this booklet could be helpful for the facilitation of race-related conversations. They felt that the booklet's questions could potentially provide physicians with a framework to have appropriate conversations with their patients. There was also a general satisfaction with how the booklet was presented as the interviews were in person in a private setting similar to sessions with patients, and the structure of the components. Comments were also made on the questions provided at the end of each page, all physicians stated that the questions would most likely be accepted and answered by patients that choose to participate. They all enjoyed the simplicity of the language when describing depression and other topics in the booklet and stated that it makes it more approachable for individuals from different backgrounds. Most individuals also said that they appreciated the explanation of the pathways between stress and depression and racism and depression. All physicians stated that they enjoyed the booklet and would recommend its usage to others as well.

Though there were many positive responses to the booklet, we also received a few suggestions about promotion in medical settings. A few physicians suggested that the booklet would be helpful if it was targeted towards a younger demographic because they may be more willing to utilize it due to the illustrations. Some physicians also made the suggestion that the booklet be provided not directly during therapy sessions, but placed in waiting room areas for patients to read and discuss with their practitioner on their own accord; in order to lessen the possibility of a patient feeling targeted.

DISCUSSION

In the current study, we aimed to assess the satisfaction of participants viewing the psychoeducational booklet that we created to address themes of discrimination, stress, and depression. General consumer satisfaction data was provided in Study 1, as well as qualitative responses offered by participants. The quantitative results from Study 1 were overall quite positive, as many were comfortable using the booklet and found it to be helpful. The booklet is intended to help facilitate conversations about race and depression, and we received positive results from participants about their increased willingness to have conversations about race and depression. However, we saw that the percentage of participants who felt like they were prepared to have discussions like such after booklet use was lower than the percentage who enjoyed the overall booklet experience. This is expected as previous studies (Trawalter & Richeson, 2008) have shown that non-Black individuals display more unease having race-related conversations, and all races and ethnicities were included in this study. These findings help to confirm that this booklet can potentially be used as a talking point between individuals who may be of different races to have conversations about issues that may be difficult to initiate.

The qualitative results received during Study 1 were relatively positive as well. Participants were able to offer comments about the booklet after they completed the full booklet experience, and many stated that they enjoyed the booklet and felt like they could relate to the themes presented in it. Several participants mentioned that they liked that the imagery contained Black individuals because it made it more relatable for them since Black people are not often seen in education materials. Previous literature has shown that racial minorities are often underrepresented in imagery shown in educational medical information, and the number of individuals with dark skin tones are shown at an even smaller proportion (Louie & Wilkes, 2018). When creating this booklet, we ensured that the booklet featured individuals of all skin tones in order to make it relatable for individuals who do not often see others that look like them when they have viewed medical or scientific literature in the past. This aspect is important for our measure of consumer satisfaction because it has been shown that healthcare products and services that can be effectively marketed address needs and services that patients have not yet requested or realized that they needed (Purcarea, 2019). Due to a lack of literature and psychoeducation that displays diversity like the current booklet, we decided that there was a need to create a booklet like ours. Qualitative information like such provides the confirmation that the composition of the booklet was proper and that it has the potential to be successfully used and well received across diverse populations.

Study 2 intended to probe further into changes that could be made in order to improve its potential usage in medical settings. Gathering and examining responses from physicians allowed us to gain insight into what aspects of our booklet are effective, any foreseen difficulties with using the booklet, and if they believe it could be useful if implemented into healthcare settings. Overall, all of the physicians stated that they could see themselves using the booklet with their patients. However, there was a difference in opinion on how the booklet would be used during sessions. There was overall agreement between the physicians about allowing participants to view the booklet on their own and then discussing it with their provider on their own accord, however there were mixed feelings about using the booklet with patients who utilize telehealth. Some providers believed that it would be effective using telehealth, while others had concerns about patients ruminating at home over themes presented in the booklet since it must be provided to them before the session. In addition to the booklet not being the best option for patients with a history of ruminating thinking patterns, half of the physicians stated that they would not give it to an individual with a diagnosis of paranoid schizophrenia. Obtaining this information allows us to understand what populations would be best served by this booklet, as well as determine if there is a way that the booklet can be altered to serve the populations that would not be suggested for original usage.

All physicians believed that having the booklet available in waiting rooms to pick up and discuss at their leisure would be the best method of initial implementation, though their reasoning differed. All believed that this method would provide wide-spread accessibility, but one physician mentioned that it should be accessible to physical healthcare settings as well as mental health clinics. There was also the point raised that giving the booklet to patients directly may make some people feel targeted and apprehensive towards utilizing the booklet because of how it was provided. Having uncomfortable conversations can be difficult for individuals to initially embrace and this stands true even for medical and mental health providers just as it does for patients. This led a provider to suggest that it may be used over multiple sessions so that all of the topics can be discussed in full because the topics addressed can possibly spark conversations that patients feel need more time.

Many comments were made on the language used to describe and discuss not only scientific information but the quotes and questions provided as well. All believed that the dialogue could be easily understood by anyone that decided to use it and one of the physicians even suggested that we modify one of the words in order to make it easier to understand for individuals who may be unfamiliar with the word. The ease of comprehension ensures that the booklet will be able to reach a wide-range of individuals, all-ages included. One physician stated that they believed that the language could be comprehensible to elementary school level readers who may also find great usage and realizations while consuming the booklet. All agreed that younger individuals may benefit the most from the booklet, and would probably be the most likely demographic to use it. However, most stated that they would recommend and use the booklet for all ages.

A limitation of this study was that the booklet was only presented to college-aged individuals which prevents us from examining how older individuals may receive the booklet. We received feedback from the physicians of the possibility of use among an older cohort, however it is difficult to determine if the perceived potential acceptance will prove to be true until we are able to gauge their satisfaction. Another limitation of this study was that not every participant from Study 1 was able to benefit from the booklet. In the interest of understanding why this occurred, future data should be collected on other aspects and additional support that could be extended to participants that could be added to enhance their satisfaction with the overall experience.

As a result of these findings, there are currently projects underway that are looking to implement the booklet into medical and psychological facilities. In addition to implementation efforts, there is also the potential of the creation of a similar psychoeducational booklet directed towards another minority population.

APPENDIX A

CONSUMER SATISFACTION:

1. Overall, how much did you find this booklet helpful?
   ☐ not at all. ☐ a little. ☐ somewhat. ☐ much ☐ very much

Commented [MDM6]: BOOKHELPFUL
Not at all = 1
A little = 2
Somewhat = 3
Much = 4
Very much = 5

2. How much did this booklet give you information that would be useful in your everyday life?
   ☐ not at all. ☐ a little. ☐ somewhat. ☐ much ☐ very much

Commented [MDM7]: BOOKUSEFUL
Not at all = 1
A little = 2
Somewhat = 3
Much = 4
Very much = 5

3. After reviewing this booklet, how much better prepared do you feel to discuss depression with others?
   ☐ not at all. ☐ a little. ☐ somewhat. ☐ much ☐ very much

Commented [MDM8]: BOOKPREPDEP
Not at all = 1
A little = 2
Somewhat = 3
Much = 4
Very much = 5

4. After reviewing this booklet, how much better prepared do you feel to discuss racial discrimination with others?
   ☐ not at all. ☐ a little. ☐ somewhat. ☐ much ☐ very much

Commented [MDM9]: BOOKPREPDISCRIM
Not at all = 1
A little = 2
Somewhat = 3
Much = 4
Very much = 5

5. How likely would you recommend this booklet to other people?
   ☐ not at all. ☐ a little. ☐ somewhat. ☐ much ☐ very much

Commented [MDM10]: BOOKREC
Not at all = 1
A little = 2
Somewhat = 3
Much = 4
Very much = 5

6. How comfortable did you feel answering the questions in the booklet?
   ☐ not at all. ☐ a little. ☐ somewhat. ☐ much ☐ very much

Commented [MDM11]: BOOKCOMFQU
Not at all = 1
A little = 2
Somewhat = 3
Much = 4
Very much = 5

7. Did you feel uncomfortable or distressed at any point throughout the booklet experience?
   ☐ not at all. ☐ a little. ☐ somewhat. ☐ much ☐ very much

Commented [MDM12]: BOOKUNCOMFDIS
Not at all = 1
A little = 2
Somewhat = 3
Much = 4
Very much = 5

Table A1

Quantitative Data from 68 Participants

Consumer Satisfaction Questions	**Mean**	**SD**	**Min.**	**Max.**	**% Scoring between 4/5**
Overall, how much did you find working through this booklet helpful?	4.45	0.67	2	5	92.96%
How much did this booklet give you information that would be useful in your everyday life?	4.13	0.90	2	5	76.05%
After reviewing this booklet, how much better prepared do you feel to discuss depression with others?	4.03	0.96	2	5	66.19%
After reviewing this booklet, how much better prepared do you feel to discuss racial discrimination with others?	4.04	1.01	2	5	67.61%
How likely would you be to recommend this booklet to other people?	4.39	0.72	2	5	88.73%
How comfortable did you feel answering the questions in the book?	4.73	0.36	2	5	95.77%
Did you feel uncomfortable or distressed at any point throughout the booklet experience?	1.44	0.93	1	5	4.23%

Table A2
Qualitative Responses Offered by Participants

Positive Responses	Frequency
Overall Satisfaction: “I like it”	42
Relatability to Themes: “I can relate to..”	49
Effectiveness of Composition and Structure: “The booklet is well put-together”	32
Negative Responses	
Dissatisfaction with target audience: “...only includes racism faced by African Americans”	3

Table A3
Qualitative Responses from Physicians

Themes Mentioned	Positive Responses	Constructive Criticisms
Validity of Scientific Information	P1: “Yeah, I mean, just in the sense that almost all people, even doctors, everybody, they don't understand what depression feels like. So I don't think that this is specifically to help an African American person, but it would help any person to think a little about examining themselves.” P2: “Any type of resource such as this that provides psychoeducation and, and just basic understanding about things that we may take for granted as Americans would be useful.” P3: “I thought they were valid. I also liked that they weren't, like, heavy on the medical jargon.”	P1: "You might want to include something that explains a little bit, just depressive symptoms, it can make it hard to look at yourself and see that those negative thoughts are depression”

Evaluation of Constructs	P1: It's done a good job of saying if there's a racial difference between, say, a doctor and a patient. Even then the doctor has to reach out in a different way, even after, you know” P2: “I think this is good. I think that that's true. There is the elephant in the room where people may not connect, because there's no opportunity for people to connect.” P3: “So, I mean, my initial thought was that, like this is really necessary, even for communities of color. Sometimes I think that we don't make the connection. Like we are, in some way, shape, or form being traumatized by discrimination even without knowing it. So I think having it in a booklet where people can say okay, yeah, maybe maybe that's what this was about. Or maybe that's why I responded that way, without even knowing that's what it was. So I do really think this is super helpful and connecting it to depression because it is super connected, but people blame it on other things, right? Because no one wants to admit that they've been the subject of discrimination or racism. So that was my first initial reaction, putting it on paper so that they can say okay, this is a legitimate connection to me.” P4: “I think you can use this with all races and ethnicities. Because it's very general. So it can help prompt a discussion about depression, and related to race or ethnicity with practically any race.”	
Preferred Age Cohort	P1: “I suspect it would benefit younger people most. But that	P4: “Probably younger. Older, older patients have their ways

wouldn't make me stop or not want to give it to different groups. I want to give it to everybody."

P2: "I could also see it for maybe an older African American who is in depression, but never thought, you know, anything's wrong with me, I just go to the doctor when I have high blood pressure, or my arthritis, but may say what I don't know, I don't think I'm depressed. And so I could see using that as well, using this booklet for an older African American person who needs some psychoeducation…I would also consider using this booklet, in that sense for my Asian American community would be maybe recent new immigrants. First generation born not here, but in their home country, who may be bringing their child or son or you know to therapy, or for treatment, and doesn't understand that my daughter is depressed, my daughter is not just lazy. Okay, and so it's a whole process of providing education, the child born here, likely will understand because they may be 13 years old, or you know, 15. And so they know they've been depressed for many years, but never taken seriously by the parents. So this booklet I could use when I talk with the parents, say, Hey, here's a copy of this book. And like can we go through it during one of my sessions because I do speak with the parents as part of my work for the minor patients who don't understand treatment, I do have to provide education. So I'm educating the whole family, in a sense, I would say, probably across the board, probably for my older patients who said that they've developed the coping mechanisms that they have developed. So most of them would be able to talk about these issues without having to use this. But then again, if somebody's very depressed, it's very good to bring this up. So they can see it."

	are not familiar with mental health” P3: I don't know what age group you're targeting with the booklet. But I feel like even for middle school, elementary school range, they could understand that, which is probably an age group where we want them to start to recognize the symptoms of what depression looks like. You know, and it's kind of around the same time that they start to recognize that they look a little bit different than other people, and how does that change the way that you interact with the world. So having it in words that all age groups can kind of understand is preferable.	
Digestible Dialogue	P1: “Yeah. I think it's very useful for everybody. Because even though, you know, it's not like I think the fact that it's not jargon, it's incredibly helpful. Well, very thought provoking, healing provoking questions.” P2: “I like that it's not very long. And you have bullet points, which makes it readable? And the questions sets it apart so I think that it feels good, it looks right., “Any type of resource such as this that provides psychoeducation and, and just basic understanding about things that we may take for granted as Americans would be useful.” P3: “I like the questions. Because sometimes like, I like that they're not assuming, like, I'm not assuming that you've had this type of trauma, or that you're depressed, but you have to address it within yourself. So it's like, you ask them, hey, like, has this ever happened to you? Giving them	P2: “The first thing that kind of came to me was the use of the word pathways. You know, it's not a common word, I would say. I mean, it is to us right as people who are you know in academics… I'm even thinking breaking up pathways like ways that stress can lead to depression. I'm wondering just for a more clear connection between stress and depression. And if you're gonna give this to a layperson, just to someone who doesn't have any background in this type of language, you also have to kind of consider the educational level of the folks you're giving this material to.” P3: “I think, just because the words are so like, like, it's so simplified, I can see how some people would feel like maybe you're almost trying to

	the space to say, no, that's not happened to me, rather than saying you have depression, you've had these experiences. You don't really know. All right. So I like that they're kind of open ended and let them evaluate themselves.” P4: “It's a very quick description, and it makes it very simple.”	like, infantilize them like, make it seem like they couldn't understand something a little bit more complex. But then the flip side of that is not everyone has the same level of education. So if you make it too wordy, or too heavy on medical jargon, then you like, lose out on a group of people”
Use in Medical Settings	P1: “I think it's good for the patient to pick it up on their own. But in certain specific cases, where you thought that the person themselves will be open? Yeah, because the act of handling somebody is everything that a doctor does, is evaluated differently than somebody else in the world coming towards you… But I believe there are so many feelings and things that go on in people they're not aware of when they're being addressed by a doctor. So, you know, I think you'd have to be very thoughtful about applying for thoughtful discussion. I think it would be a great tool in certain cases to have. P2: “I think the idea might be that this booklet is something that could be used in several sessions, especially in African American communities, because, you know, I know very few African American friends or people in my networks who have not experienced racism, and discrimination. So I think this is a very, like a poignant topic that may lead to other conversations, that it's not, I think the other two are more informational, the two other stress and depression, but this is personal. And so just, I would say, be prepared as a therapist, if I do bring this up, I	P1: “So only that I wouldn't hand this to somebody who's terribly paranoid because they would read something into it in that moment.” P3: Yeah, I think my first thought was, let them read it themselves. Just because, you know, people, you've introduced it to me, like some of this could be like, bring up some negative emotions. So letting them process that when someone else is not waiting for a response from them is probably easiest. And then I would also say, when you when I came in, you were saying the importance of having someone that looks like you as your physician when you talk about this, because if I've read this, and now I have these negative emotions, and now someone from a different race is now asking me all these questions about whether or not I've been discriminated against. I'm -my response is negative like, whether or not I intend for it to be that's going to be the response. So let them process this alone, at least once and

would be prepared to spend some time on this particular section.
And because really, patients come to Flushing and Jamaica for the vast number of different mental health conditions So I would say yes, a provider can provide this, doctors, pediatricians, should have copies. So I'd say whoever sees patients should have a copy to give when needed, when necessary. I get a lot of referrals from pediatricians that come by way to Flushing because the child is depressed. Also, postpartum patients. So OBGYN should have copies as well. I really don't see that anyone should not have a copy. Right? I don't think it's inappropriate for any provider to have one and to give, if they can why not? Because you may be a cardiologist, but you have patients who will complain of chest pains, but it's not related to anything physical, right, maybe it's mental. So I'm always wanting to say providing as many different formats as possible PDF, hardcopy, you know, in waiting rooms, wherever is needed, even community based organizations CBOs go, you know, there are studios in every borough of New York City and, and say this free booklet is being offered by Jamaica hospital."

P3: "If there was like some magazines or pamphlets or something that people can walk by and grab on the way in because it is kind of suggestive if you're like, Hi, here's this booklet on racism and depression, you look like both of those things. So here, yeah, here you go."

then you know.
Personally, I would probably refrain from using it for people who are suspicious or paranoid already. Just because like it's almost like confirming what they already believe about the healthcare system. So I would probably refrain from that.
The only thing I would say about Telehealth is if they have this with them and they, like I was saying earlier like to allow them to process it alone, but also in a controlled space like in the waiting room or an area where they can read it. But they're at home on telehealth, reading through it. And then you know that this is over now they're just at home processing the information alone. And not all - not all people will be triggered by it. But I don't. We don't know. Like it might bring up something in someone, and now they're just at home. You know? Yeah, that's just my fear."

P4: "The one thing I would add is something about not wanting to live or thoughts of ending your life. So that people who are suicidal can see that in print, and they might bring that up or they might not"

	P4: “So if you have this booklet available for patients to pick up in the waiting room, or wherever they are, they can pick it up, and then they can discuss it. If it's something that's meaningful to them when they come to see me. It seems like it'd be most useful to leave it for somebody to pick up to read and then just have a general discussion about something they found was meaningful to them inside the booklet rather than go through every page.”	
Imagery Presented	P1: “ I think it's a very good use of time. It's just short enough, succinct enough. I think it's great. It doesn't put you off. The writing isn't too small, you know, the pictures, I like it, it's inviting.” P2: “I do like the graphics. Because, you know, people don't tend to read. You know, you find even clinicians like we just don't have a lot of time. So I think where you can make it user friendly, where you've done it with the pictures and the graphics, I think that's good.” P3: “Yeah. Which I think is helpful, because even the caricatures I've been looking at, I'm super visual. There are African Americans that have the word depression on the same page of someone who is African American. We don't really get to see that that often. So helpful, for sure.”	P1: “The cartoon version would be well, you wouldn't give it to a paranoid schizophrenic.”

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