2024

TESTING THE EFFICACY OF PSYCHOEDUCATIONAL BOOKLET ABOUT THE MENTAL HEALTH EFFECTS OF DISCRIMINATION

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A thesis submitted in partial fulfillment
of the requirements for the degree of

MASTER OF ARTS

to the faculty of the

DEPARTMENT OF PSYCHOLOGY

of

ST. JOHN'S COLLEGE OF LIBERAL ARTS AND SCIENCES

at

ST. JOHN'S UNIVERSITY
New York
by
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Date Submitted 3/25/2024 Date Approved 4/17/2024

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ABSTRACT

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There is a significant relationship between discrimination and mental health (Assari et al., 2017; Brondolo et al., 2009; Paradies et al., 2015). Although there are a high number of individuals who experience discrimination, there are limited data reported on effective ways to lessen the effect that discrimination and racism can have on overall cultural competency is crucial in psychotherapy and helps create an understanding between the mental health provider and client (Sue et al., 1992), previous research has shown that there is still a need for mental health providers to learn more about cultural competency and to understand how to successfully apply it during visits. Psychoeducational tools may facilitate these conversations (Mollen & Ridley, 2021; Chan et al., 2018). We created a psychoeducational booklet that facilitates communication about mental health and discrimination for providers and clients. This study examines the efficacy of this psychoeducational booklet with undergraduate students. The outcomes evaluated include an analysis of self-efficacy managing depression that showed a significant increase from pre-test to post-test, $p < .001$; a repeated measures regression analysis examining self-efficacy and discrimination that indicated self-efficacy discussing

discrimination improving from pre-test to post-test, $p<.001$; and significant reductions in distress discussing discrimination-related issues, $p<.001$.

Keywords: *Discrimination, Racism, Psychoeducation, Inter-racial anxiety, Depression, Mental health stigmatization, Education, Stigmas, Ethnic groups.*

ACKNOWLEDGEMENTS

Funded by a Faculty Research Consortium grant to E. Brondolo.

Margarita Manzano – First author, literature review, recruitment, consenting, conducted zoom interviews with subjects, data curation, data analysis, writing.

Elizabeth Brondolo – Principal Investigator.

Ellalandra Arakelow – literature review, recruitment, consenting, conducted zoom interviews with subjects, data analysis, editing.

Aldona Chorzepa – literature review, recruitment, consenting, conducted zoom interviews with subjects, data analysis, editing.

Leigha Clarke – literature review, recruitment, consenting, conducted zoom interviews with subjects, data analysis, editing.

Kyara Archie – recruitment, consenting, conducted zoom interviews with subjects, data analysis, editing.

Amaya Iverson –recruitment, consenting, conducted zoom interviews with subjects, data analysis, editing.

Dawson Hughes – literature review, recruitment, consenting, conducted zoom interviews with subjects, data analysis, editing.

Theodore MacGowan, Skylor Louiseau, Alexandra Spinelli, and Jessica Korins – assisted with the subject zoom interviews.

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INTRODUCTION

There is a significant relationship between discrimination and mental health (Assari et al., 2017; Brondolo et al., 2009; Paradies et al., 2015). Although many individuals experience discrimination throughout their everyday life, there are limited data on ways to lessen the effect that discrimination and racism can have on overall mental health (Brondolo et al., 2009).

Previous research has also found that racial discrimination is not being addressed as often as needed by mental health professionals, therefore negatively affecting those receiving therapy (Chang & Berk, 2009; Meyer & Zane, 2013) Because of this, many scholars have called for mental health professionals to become more culturally competent (Sue et al., 1992). To achieve cultural competency, mental health professionals will need to develop an awareness of diverse cultures, as well as gather the necessary knowledge and skills to effectively address this topic with their clients (Cardemil & Battle, 2003; Mollen & Ridley, 2021; Sue et al., 1992).

Cultural competency is essential in psychotherapy as it brings forth a sense of communal understanding between the mental health provider and the client (Sue et al.,1992). In fact, while many mental health providers learn about cultural competency within psychotherapy, clinicians report hesitation in applying the skills that they learned into the therapy session (Mollen & Ridley, 2021). The research conducted by Sue et al. (1992) identified inadequacies in the instruction of cultural competency, indicating that there are still gaps in the education of this topic. From a teaching perspective, they

recognize that these issues lie within its integration into curriculums, the cultural perspectives that are discussed, and the level of commitment that the teaching staff have regarding this topic (Sue et al., 1992). By integrating cultural competency into the curriculum, future mental health providers will better understand the need to effectively serve the diverse populations. By providing knowledge on how to respect different cultural backgrounds, mental health professionals will be able to build trust and rapport with their clients, therefore providing a more culturally responsive treatment plan.

According to Chan et al. (2018), multiculturalism and social justice have become major topics in counseling, leading to a shift in the interpretation of social identity, cultural identity, and diversity. The multicultural orientation expresses the idea that mental health professionals receive trainings that provide an overall understanding of multicultural knowledge through insights into their clients' cultures, therefore allowing them to share this understanding with their clients. Training in multicultural competency assumes that this knowledge will therefore enable the mental health professional to maintain open discussions about different social factors while learning and adapting at the same time (Owen 2013). Although there is a substantial body of research that addresses the significance of culturally competent psychotherapy and the importance of openly holding conversations related to the topic, there is still a need for strategies that can help mental health providers better facilitate these conversations with ease (Chan et al., 2018; Mollen & Ridley, 2021).

Mollen & Ridley (2021) argues that multicultural counseling competence, as a construct, has stalled. Clinicians generally must determine for themselves how to engage in this process and tend to struggle with the gaps between their multicultural beliefs and

practices. They argue that because there is a lack of understanding in the foundation of multicultural counseling competence and how it works, that there is an impasse that prevents the advancement of new skills that will aide mental health professionals to address multicultural competency in therapeutic settings. Therefore, due to not having a thorough understanding of this foundation, educators struggle to develop a consistent standard of training and a universal meaning of multicultural counseling competence (Mollen & Ridley, 2021).

Because of this, there is a need to develop materials that will help ease these forms of communication between mental health professionals and clients. Creating and establishing an effective form of communication is not only necessary between the mental health professionals and their clients, but also between the professionals from different fields who all play a role in the treatment of the client. Because there is very limited research on this, there is a gap in existing multicultural counseling approaches on the importance of ensuring that all acting parties share the same vocabulary and ideas about their client's treatment.

Teachings and training techniques that have been valuable and effective in other clinical areas may be appropriate to guide the development of methods to improve the quality of therapeutic discussions about race-related issues. Studies of end-of-life communication training may be instructive because end-of-life communication presents significant challenges and is often emotionally activating for both patient and provider.

The significance of interdisciplinary communication skills among healthcare professionals has been emphasized in various studies; most notably in studies relating to end-of-life care. These studies focused on experimental interdisciplinary communication

training among participants from different disciplines and professions to see the effects that has occurred with their patients. While with end-of-life care, communication between the treatment team and the patients can be emotionally demanding and difficult; persistent training may permit participants to reach consensus about the types of material and approaches that are likely to be effective.

In 2005, Fineberg published a study that looked at the effectiveness of creating workshops using an interdisciplinary approach and how it helped in improving the communication between all healthcare providers, patients, and their families about the patient's treatment. Ferrell et al. (2019) have focused their research on the benefits of creating an interdisciplinary communication program within healthcare settings that focuses on end-of-life care. They found that it was very effective in helping healthcare professionals learn more about the ways they can communicate with patients, resulting in significant positive outcomes (scoring 4.8 out of 5 in their evaluations) in meeting expectations and objectives after a 6 and 9 month follow up evaluation (Ferrell et al., 2019). Having done similar research, Pan et al. (2022) have focused their attention in creating a multifaceted training program that is centered around inter-professional communication of advance care planning. After administering this one-day workshop to the participants on a hospital-wide scale with different physicians, house staff, nurses, therapists, and other disciplines, they have found that this structured program met the goal of helping these participants to become better communicators with their patients (Pan et al., 2022). Smith et al. (2018) have looked towards a simulation-based learning experience to help with palliative care and end-of-life communication skills. They have found that this form of learning lacked in structure for the participants and they

recommend for others to focus more on the delivery of the educational information by providing clear specifying goals and evaluation methods to teach the material in a more effective manner (Smith et al., 2018). Grey et al. (2017) have focused on a more straight-forward delivery method on the education of advanced care planning. They used role-playing with the participating physicians and have found that role-playing produced positive results not only in the delivery of the information from the program to the physicians, but also in the way that the physicians were able to communicate with their patients with more ease. They also found that this method really helped in having the participants recognize the importance of having high-quality conversations with their patients regarding their treatment plan (Grey et al., 2017). Although these articles are based on research surrounding end-of-life care, they all emphasize the importance of creating a solid educational foundation for interdisciplinary communication between healthcare professionals across different fields. They all demonstrate that the healthcare professionals involved have benefited from this type of education, which in turn, has helped them establish an effective form of communication between all parties involved in a patient's care. An improvement may also be seen if the methods from end-of-life communication training is applied to race-related issues.

Given the success of the educational programs and materials found in end-of-life planning, there is a need to create similar materials that can help with understanding the need to facilitate conversations about emotionally demanding topics within a mental healthcare setting. While these previous educational programs offered a lot of exposure and discussion of emotionally distressing topics, they used actors to simulate patients, whereas we use characters in our illustrated book to help engage the participants.

The term *psychoeducation* was first coined in 1980 by Anderson et al. in a research article that emphasized the importance of educating the relatives of patients diagnosed with schizophrenia about the mental illness and methods for at-home intervention. This led to researchers looking into the effectiveness of psychoeducation on the families of patients who are diagnosed with mental illness. In an article written in 2020, Sarkhel et al. have explored the different areas that psychoeducation has have identified the goals for psychoeducation as well as different models of psychoeducation which can be used to teach others about mental health.

These four main goals of psychoeducation are as follows (Sarkhel et al., 2020):

- To ensure that patients and family relatives develop a basic understanding and competence about the mental illness.
- To provide comprehension and discernment of the mental illness.
- To help in lessening and preventing future relapses.
- To promote engagement in crisis interventions.

In accordance with these goals for psychoeducation, Sarkhel et al. found that certain models of psychoeducation have proven to be effective in achieving each of these goals.

These models of psychoeducation are as follows (Sarkhel et al., 2020):

- The information model, which focuses on providing knowledge of mental illnesses to care takers.
- The skill training model, which focuses on having care takers develop skills to manage these mental illnesses.
- The supportive model, which focuses on creating a community of support for the care takers.
- The comprehensive model, which is a combination of all three.

A meta-analytic review done by Lean et al. (2019), has evaluated the effectiveness of self-management interventions for adults with severe mental illnesses. This meta-analysis included a review of 37 studies from a total of 45 full-text articles. Lean et al. (2019) mentioned that although there is no universally accepted classification

of self-management, there is a common understanding that providing information and education to patients regarding their treatment will yield a positive outcome in overall high-quality care for long-term conditions. The areas of self-management of severe mental illnesses included in their meta-analysis which were found to be effective include: providing psychoeducation about mental illness and its treatment, behavioral tailoring to facilitate medication adherence, developing a relapse prevention plan and teaching coping strategies for persistent symptoms (Lean et al., 2019).

By looking at passive interventions, such as educational leaflets, Donker et al. (2009) have found that they are beneficial in reducing symptoms which are related to mental illness and stress. By looking at two different time points (immediately after the self-management intervention and a 1 year follow up) in their meta-analysis, they have found that when including self-management interventions within routine standard-of-care visits for clients, it would produce positive outcomes in the client's ability to manage their own mental illness over a long period of time. Different forms of self-management interventions have demonstrated a positive impact on symptom severity. After these interventions were implemented, there was a decrease in symptom severity, as seen by a pooled effect size of -0.33. They have also reported self-efficacy favoring self-management, overall improved functioning, and quality of life from after intervention to post 1 year follow up. Given these findings, this meta-analysis provides crucial evidence that self-management interventions lead to significant outcome improvements for individuals with severe mental illnesses (Lean et al., 2019).

Given the previous research that has been done on psychoeducation, it is clear that this method of teaching can be beneficial for clients and their families because it

produces an overall sense of understanding of the mental illness that the client is experiencing, as well as providing familial support, which in turn, helps with the management of the mental illness overall (Sarkhel et al., 2020). The beneficial outcome from psychoeducation makes it an ideal tool for many situations.

To develop psychoeducational materials, one needs to incorporate theoretical models and empirical evidence that explain how the condition develops or why the treatment is valuable. Theoretical models help by providing a baseline structure that one can build on. Adding empirical evidence in support of the theory increases the validity of the psychoeducational materials.

The psychoeducational materials tested in this research focused on a social cognitive model of depression and the effects of racism on depression. Social cognition refers to the processes and structures involved in the perception and response to the social environment (Fiske & Taylor, 2013). Brondolo et al. (2018) explored how social cognition not only encompasses certain processes (such as schemas and appraisal processes) that deal with how individuals perceive themselves and the world around them, but also how cognitive control processes help with the regulation and processing of attention and information within an individual. They sought to create a visual representation in the form of a biopsychosocial model that can be used to illustrate how the social cognitive process occurs when discrimination is. Because social cognition is rooted in how an individual perceives themselves and the world around them, Brondolo et al. have focused on how schemas and appraisal processes, as well as cognitive control processes can all be altered according to the frequency of the occurrence of discrimination to the individual. In their biopsychosocial model, they acknowledge that

discrimination can occur in different levels (cultural discrimination, institutional discrimination, and interpersonal discrimination), all of which plays a role in the individual's social cognitive processes, which they separated into schemas and appraisal processes (Path A) and cognitive control processes (Path B). In Path A, Brondolo et al. recognized that discrimination can alter schemas and appraisal processes in such a way that affects an individual's ability to perceive discrimination-related threats and stress. In Path B, Brondolo et al. recognized that an individual's cognitive control processes can be modified by an increase in discrimination-related threats, therefore affecting their ability to recover from these threats. When taking into consideration the social cognitive processes in both Path A and Path B, having an increase in discrimination-related changes can influence an individual's motivational goals, their approach and engagement with others, as well as their persistence, therefore creating Path C. This all highlights the negative impact that the social world can have on an individual's motivation, engagement, and persistence (Brondolo et al., 2018).

We see similar findings to that of depressed individuals where their interpersonal stressors can develop into negative relational schemas (Mikrut et al., 2022; Rudolph et al., 2000). Therefore, negative relational schemas can trigger or further accentuate depressive-type symptoms when being discriminated against. Mikrut et al. tested several hypotheses in a cross-sectional study to examine how lifetime discrimination was associated with depression via social cognition. An ethnically diverse sample of 256 participants completed measures of exposure to interpersonal discrimination, depressive symptoms, and relational schemas. They found that discrimination was related to several relational schemas such as rejection and invalidation, social vigilance, and mistrust. This

is consistent with other research which has demonstrated relations of discrimination to schemas about rejection and invalidation (Brondolo et al., 2016). The findings from this research article suggests that negative relational schemas found in both depression and in discrimination raises concerns about the effects that it can have on the mental health of those who are afflicted; therefore, it is suggested that future research should be conducted where interventions could focus on how understanding more about these social cognitive effects could improve treatment for depression in those who have been exposed to discrimination (Mikrut et al., 2022; Botha & Dozois, 2015).

In an article written in 2014, Weightman et al. performed an extensive literature review on individuals with Major Depressive Disorder (now being referred to as MDD). They identified the ways in which social cognition can be negatively impaired from the way individuals interpret emotions. By interpreting through a mood-congruent bias, they interpret social cognitive stimuli differently than healthy individuals. This included facial affect recognition where they included a study from Csukly et al. 2011, where they found that individuals with MDD have an impaired ability to correctly recognize facial expressions as compared to healthy controls (Csukly et al., 2011, Weightman et al., 2014). This also includes both affective and cognitive theory of mind for people with MDD (Weightman et al., 2014). In terms of affective theory of mind, they look at studies that conducted the *reading the eyes of the mind* task where individuals with MDD were asked to recognize the emotions being portrayed from images of people's eyes; they performed less accurately overall when compared to healthy controls but were surprisingly more accurate in recognizing negative emotions when compared to healthy controls, (Weightman et al., 2014; Cao et al., 2013; Wolkenstein et al., 2011). In terms of

cognitive theory of mind, Weightman et al looked at studies where emotional awareness was being observed and they reported that individuals with MDD are poorer in emotional awareness when compared to the healthy controls (Weightman et al., 2014; Donges et al., 2005). When considering these social cognitive models of depression, we see that individuals who are developing negative schemas as they engage with the social world may be worsening their depressive symptoms due to how they process the environment around them (Weightman et al., 2014, Botha & Dozois, 2015).

A study has been conducted in 2015 where Botha and Dozois test how negative attitudes, such as stigma and fear, towards individuals who are depressed can be reduced by providing a contextual explanation on this matter to people who have this negative pre-disposition. They have found that by providing a contextual explanation for depression, it is significantly more effective in reducing perceptions of dangerousness and fear of people with depression vs. a biomedical explanation. They also found that providing a cognitive distortion explanation for depression is significantly more effective in reducing anger vs. a cognitive schema explanation. Therefore, by providing a form of education with the aim of changing the perception of dangerousness and anger towards individuals with depression has been proven to be effective in reducing these negative attitudes among those who receive this type of education (Botha & Dozois, 2015).

We hypothesize that psychoeducational materials can be helpful in facilitating conversations about race, discrimination, and mental health. They can be used as an educational tool to help clients learn about the potential mental health impacts of discrimination and can help provide opportunities to guide self-reflection and communication with their therapist. However, to the best of our knowledge, there are

limited psychoeducational tools to support more explicit discussions of the mental health effects of racial and ethnic discrimination; as well as limited information available about the best messages for communication and the best strategies for communicating these messages.

We developed a psychoeducational booklet that is comprised of six state-of-science messages relating to depression and the relationship between racial discrimination and depression, and we included accompanying illustrations that supports our psychoeducational approach in a previous version of our study (Manzano et al., 2022). The aim of this current study is to evaluate the effectiveness of our psychoeducational booklet that is geared towards improving knowledge about and attitudes towards depression and depression treatment, as well as decreasing mental health stigmatization and inter-racial anxiety within college-aged individuals.

OVERVIEW

Given how discrimination has significant effects on mental health, there has been a need to address the topic of how discrimination is consistently associated with depressive symptoms in an educational manner. There is still limited data on effective strategies that will help mitigate the effects of discrimination on depression.

After reviewing previous research, we have found that one potential approach is psychoeducation, however there is very little information on what the best messages to communicate would be, as well as what the best strategies would be to help communicate these messages. Because of this, we have taken the initiative to find potential messages and strategies to communicate to others. This masters describes both the methods used to identify the messages to communicate and the outcomes of delivering these messages in an illustrated psychoeducational booklet. The first part was done in a previous study to develop psychoeducational messages about discrimination and depression (Manzano et al., 2022). This current study was done to test their efficacy on outcomes related to both depression and discrimination.

Background

In our preliminary work, we described the strategy for creating our psychoeducational materials (Manzano et al., 2022). When conducting the literature review for our psychoeducational materials, we were able to identify what messages were appropriate for use in the booklet. We identified 6 messages to include in the materials.

The six major points that these messages reflected on are as follows:

1. Information on the nature of depression. It is important to know what depression is and the effects it can have on people. This message explains

how common depression is, how it can be harmful to someone in many aspects of their life, and the symptoms of depression (Paradies et al., 2015, Brondolo et al. 2009, Manzano et al., 2022).

2. How stress relates to depression. It is important to know the effects that stress can have on depression. This message conveys to the readers that stress involving relationships with other people is one of the biggest stressors that leads to depression. Because of this existing link between stress to depression, a cycle has been identified where stress leads to depression, and depression leads to an increase in social stress (Rudolph et al., 2000, Manzano et al., 2022).
3. The social cognitive pathways that elaborate on how stress can lead to depression. It is important to note the many ways that stress and trauma can lead to depression through a social cognitive view. Having a history of stress and trauma can alter the way one thinks of themselves and others in a negative way and it can trigger depressive symptoms. This leads to an overall negative mindset about oneself and any relationships they have with others (Brondolo et al., 2016, Manzano et al., 2022).
4. Information on the nature of discrimination. It is important to know what discrimination is and how it can occur in day-to-day life. Racial and ethnic discrimination are social stressors where people are treated unfairly. This message conveys how racial and ethnic discrimination are social stressors where people are treated unfairly. It also conveys that this type of discrimination is associated to depressive symptoms, and well as

the common occurrence and experience in everyday life to those who experience racial and ethnic discrimination (Paradies et al., 2015, Manzano et al., 2022).

5. Social cognitive pathways that elaborate on how discrimination is linked to depression. Discrimination is a stressor that affects the way one thinks of themselves and the people around them, leading to an increased risk for depressive symptoms. This message highlights how racial discrimination can lead to race-related rejection or threat from others by including experiences that mention how a relationship with others is affected due to of lack of connection because of race (Mikrut et al., 2022, Manzano et al., 2022).
6. Information on supportive ways to address discrimination and depression. This message highlights how building connections and maintaining positive and meaningful relationships can build resilience and help decrease depressive symptoms. (Botha & Dozois, 2015, Manzano et al., 2022).

These six points were then reviewed and validated by four experts in the field whose work revolves around issues relating to discrimination and how it affects mental health. These four experts were accumulated from different universities and healthcare settings. Once finalized, these 6 statements were used as the main talking points in our psychoeducational materials, which eventually developed into a booklet. These 6 state-of-science statements were then used to create several illustrations for each statement by an illustrator from St. John's University. These illustrations served to visually

communicate these messages. These illustrations were created to help better communicate each statement through a visual representation of the accompanying topic and to provide an easier understanding of the topic to the individuals who utilize the psychoeducational booklet. We worked closely with the illustrator, Jashton Gieser, to develop these illustrations.

Next, we recruited a Community Advisory Board to figure out the best way to communicate these messages. These individuals were recruited by members of the CHIRP lab via networking and finding individuals who are well versed and have experience in the field of mental health and racial discrimination. Our Community Advisory Board were made up of eight adults who self-identify as Black, since our target audience for our psychoeducational booklet is more geared towards individuals who self-identify as Black. The messages we communicate reflect the state-of-science concerning six major topics related to depression and the relationship between racial discrimination and depression.

This booklet was written in laypeople's terms as to ensure that it could be easily understood by the general population. There are 6 major sections in the booklet. Each 2-page section is accompanied by illustrations that were hand selected and evaluated by our community advisory board. Within each section of the book, there are the state-of-science statements on the leftmost page and then statements and illustrations reflecting real life experiences that the community advisory board shared on the right-hand page. The right-hand page also includes questions that help foster introspection and communication on the topic on the rightmost page.

To promote open discussion about topics related to discrimination and depression, we have structured the psychoeducational booklet in a way that would be helpful for teaching when used by both laypeople and mental health providers. This was done by formatting the booklet in such a way that when it's open, two pages are used to explain each topic/state-of-science statement. The page on the left showcases the topic, the main illustration and the scientific information which is meant to be used by the mental health providers and the individuals who are educating others through the booklet. The page on the right showcases quotes from real-lived experiences that our Community Advisory Board shared for use in our booklet, along with supporting theme illustrations and questions that can be to facilitate communication between both parties. Before creating the final version of the booklet, we conducted individual zoom interviews with each member of the community advisory board to ensure that the messages being portrayed were done so effectively and in a manner that serves to educate the public.

Although this version of the booklet is specifically focused on the experiences of discrimination and depression amongst Black individuals, these experiences and attitudes towards mental health can be experienced by anyone and may also vary by race/ethnicity. The current booklet is intended to be used by both black and non-black individuals to help foster discussion of issues related to discrimination and mental health and to humanize the experiences of depression and discrimination. Given the work that we have done on this booklet, we sought to test the efficacy of the psychoeducational materials in this next part. We are currently developing booklets for individuals from other groups.

Purpose

For this study, we gathered participants from St. John's University in Queens, New York, to help us evaluate the efficacy of how well these state-of-science messages are communicated through the booklet as a tool for mental health professionals. We examined the effects of the booklet on changes in self-efficacy in handling depression and racism. We reviewed the materials with our participants and conducted pre-test and post-test evaluations to see if there were any changes in outcome measures. The primary outcomes include changes in self-efficacy in managing depression, stigmatization of mental health conditions, and inter-racial anxiety. We hypothesize that reviewing the psychoeducational materials (booklet) will improve self-efficacy towards depression and its treatment, and will decrease mental health stigmatization and inter-racial anxiety.

METHODOLOGY

Participants

We recruited all participants both in-person and virtually. Please refer to table 2 for the number of participants that were involved the total number of individuals approached regarding interest in our study was not recorded, however, the final sample included 68 adults who completed all steps of our study. The number of people approached during the recruitment phase of our study is not available. Of those 68 participants who completed the study, 27 participants self-identified as Black individuals and 41 participants self-identified as non-Black individuals. Of those 68 participants who completed our study, there were 17 participants who self-identified as male, 49 participants who self-identified as female, and 2 participants who self-identified as other in the gender category. The age range of our participants varied from 18 years old to 32 years old. Our participants were all current students or alumni of St. John's University.

Materials

The materials that were used in this study were recruiting posters, our psychoeducational booklet, Zoom, a pre-test survey, a post-test survey, and a series of different measures. All measures can be found in the Appendix. The following measures were used to help with our findings in this study:

Depression: To assess depression we used the CESD, also known as the Center for Epidemiological Studies Depression Scale, created by Radloff (1977). This measure is used to help individuals rate how often they experience symptoms related to depression, usually within a two-week timespan. This measure is used as an aid in identifying people who may be at risk for clinically diagnosable depression. To test for reliability, Radloff

looked at the time intervals from test to retest, where he found that the shorter the time intervals between test and retest produced higher correlations than longer time intervals; r = 0.67 (Radloff 1977).

Self-efficacy in addressing depression. To evaluate this construct, we adapted a version of the Patient Activation Measure (PAM) (Hibbard et al., 2004). We modified the questions to focus on self-efficacy regarding depression. This measure is used to assess an individual's knowledge about depression and their ability to be confident in managing depression. In Hibbard's version of the PAM, they tested for reliability by calculating Cronbach's alpha; $\alpha = 0.91$, therefore demonstrating that there is a strong internal consistency reliability (Hibbard et al., 2004).

Self-Efficacy in discussing racial discrimination. We used a measure for Self-Efficacy in race, which we have adapted from the Racial Socialization Competencies Scale, created by Anderson et al., 2019. This measure is used to address the knowledge and confidence in an individual's self-efficacy in discussing racial discrimination. In Anderson's of the Racial Socialization Competencies Scale, they tested for reliability by calculating Cronbach's alpha; $\alpha = 0.94$ (Anderson et al., 2020).

Mental Health Stigmatization. We used a measure for Mental Health Stigmatization, which was adapted from Day et al., 2007. This is used measure stigmatization towards mental illness in relationships and anxiety, which demonstrate one's willingness or unwillingness to express stigmatizing attitudes towards others who have mental illnesses (Day et al., 2007).

Interracial Anxiety. We used a measure for Interracial Anxiety, which was adapted from Plant et al., 2003. This was used to measure anxiety that individuals can experience with other individuals of different races.

Finally, we created a consumer satisfaction survey to quantify how effective our psychoeducational booklet was within our sample, which is not included in this masters.

Methods

We presented the psychoeducation materials and surveys during a Zoom call. During the Zoom call, we had two team members present on the call with the participant: one graduate student and one undergraduate student. All team members have been trained in how to communicate and present the psychoeducational materials to the participants. We also had the Principal Investigator (P.I.), a licensed clinical psychologist, available if any participants experienced distress. During the zoom call, one of the two students would serve as the interviewer, whereas the other student would serve as the administrator, checking the fidelity of the procedures. The interviewer would follow a script and present the psychoeducational materials to the participant. They would ask the questions associated with each section, as well as addressing any questions that the participant may have throughout the zoom call as they went through the psychoeducational materials and completed the post survey. The administrator followed the protocol to make sure the first person followed the script correctly, sent the links to the surveys via the Zoom chat, and administered a backup of the psychoeducational materials should any technical or other difficulties arise at any point.

The psychoeducational materials were presented via Power Point. The interviewer would explain to the participant what pertained to each section and then would play the

audio recording that is associated with each page. The participant would then be prompted to answer the questions that were associated with each topic before moving on to the next section. The questions that correlate to each topic are meant to be thought provoking and to encourage talk and communication of experiences that the participant may have witnessed or experienced themselves with the individual who is presenting the booklet to them. The full set of questions from the booklet can be found in the appendix.

Once the participant reviewed the entirety of the psychoeducational materials, they were sent the link to the post-test survey. The post test survey was identical to the pre-test survey. This was done to track any changes that may have occurred across time from when they completed the pre-test survey to when they completed reviewing the psychoeducational materials. Along with the post-test survey, participants also completed a consumer satisfaction survey where they shared their thoughts on the booklet itself. All participants where then compensated with $30 for their time spent on the study.

Analytic Plan

The research design was a within-subjects pre-test to post-test design. Therefore, we used repeated measures regression for our outcomes in this study. This was done using PROC GLM from the statistical software SAS 9.4. Time is the predictor in the analyses.

RESULTS

The goal of the present study was to examine the impact that the psychoeducational materials had on self-efficacy discussing depression and discrimination. The assumptions that we took into consideration were normality, outliers, and sphericity.

Table 3 shows the results of a repeated measures regression analysis comparing scores prior to viewing the booklet to scores obtained after viewing the booklet. Analysis indicated that self-efficacy managing depression showed a significant increase from pre-test to post-test, $p < .001$. A repeated measures regression analysis examining self-efficacy and discrimination indicated that self-efficacy discussing discrimination improved from pre-test to post-test, $p < .001$. There were also significant reductions in distress discussing discrimination-related issues, $p < .001$.

DISCUSSION

Studies have suggested that clinicians might benefit from psychoeducational materials to facilitate conversations about discrimination and depression. We designed a booklet based on social cognitive models of depression to discrimination, which focused on the following six major points: information on the nature of depression, how stress relates to depression, social cognitive pathways that elaborate on how stress can lead to depression, information on the nature of discrimination, social cognitive pathways that elaborates on how discrimination is linked to depression, and information on supportive ways to address discrimination and depression (Manzano et al., 2022). Results of the tests on the efficacy of the materials indicated that the booklet was associated with significant improvements from pre-test to post-test in self-efficacy in managing depression and depression treatment, self-efficacy in managing discrimination, and improvements in reducing distress when discussing discrimination-related issues such as stigma and racial discrimination.

The significant improvements seen with self-efficacy in managing depression and depression treatment means that our participants felt more confident and capable in managing and coping with depressive symptoms after reviewing the booklet. The significant improvements seen with self-efficacy in managing discrimination means that our participants felt more confident and capable in addressing and coping with instances of discrimination after reviewing the booklet. The improvements in reducing distress when discussing discrimination-related issues such as stigma and racial discrimination means that our participants experienced less emotional distress when engaging in these kinds of conversations after reviewing the booklet.

The variables which proved to not be significant are stigma and depression, confident communication with others about discrimination, and confident communication with others about depression. The reason these variables are not significant could be due to having a moderately small sample group where a significant p-value could not be detected, the scores that were gathered for each variable were not reliable, or there is very little to no correlation between what we were looking for and the variable that was chosen.

All in all, we see that this booklet has performed well throughout our study and has a strong potential to aid in the flow of conversation regarding these topics between individuals and mental health providers.

Psychoeducation serves the purpose of informing patients and family members with a basic understanding and knowledge of the mental illness. It provides individuals with knowledge of treatment options and coping strategies to help them manage their symptoms effectively, while also promoting engagement in crisis intervention (Anderson et al., 1980, Sarkhel et al., 2020). In Botha's study from 2015, they found that individuals who experience negative attitudes towards those who are depressed can have these attitudes reduced by providing a contextual explanation of depression. They found that offering a contextual explanation aimed at changing the perceptions of dangerousness and anger towards depressed individuals was more effective in reducing the perceptions of dangerous and fear to a biomedical explanation (Botha & Dozois., 2015). Social cognitive models are rooted in how an individual perceives themselves and the world around them. This plays an important role in the onset and maintenance of depressive symptoms. Therefore, a contextual explanation acknowledges these factors and

emphasizes the interaction between the individual and their environment in understanding depression. Because of this, our booklet has included six main points regarding the social cognitive model of depression to discrimination by providing a contextual explanation with each main point. The findings from this paper support the idea that basic research on social cognition has implications for clinical practice.

Limitations

We encountered a few limitations throughout the duration of our study. Due to technical difficulties, we had some missing data. We had a moderately small sample which limited our ability to test moderating variables, including history of experiences of discrimination. The study was not a randomized controlled trial, limiting our ability to make causal inferences. The sample was limited to University students. By having a limited sample of participants, our data may not fully represent the population that our psychoeducational booklet was geared towards, therefore producing results that may not generalize if this study were to be replicated with a larger sample of participants.

CONCLUSION

Previous research has shown that there is a need for guided communication on topics such as depression and discrimination in the mental health field regarding race. While there has been some research regarding the impact that psychoeducational materials can have on this matter, we took the initiative to create a booklet that contains psychoeducational materials on topics such as information on the nature of depression, how stress relates to depression, the social cognitive pathways that elaborate on how stress can lead to depression, information on the nature of discrimination, the social cognitive pathways that elaborates on how discrimination is linked to depression, and finally, information on supportive ways to address discrimination and depression.

Using this booklet, we have conducted a study where we have obtained preliminary evidence that psychoeducational materials can improve one's self efficacy in discussing difficult topics such as depression and discrimination, mental health stigmatization, and inter-racial anxiety.

We plan on integrating this booklet within local hospitals to get a better gauge on how the psychoeducational materials will perform on a larger scale. For future studies, we plan on creating similar booklets that will be based on individuals of different races and ethnic groups, in order to better facilitate communication of these topics with a variety of populations.

APPENDIX A – BOOKLET AND INTERVIEW QUESTIONS

Booklet Questions

Each of the 6 pages in the booklet contains a set of questions. Participants were asked to elaborate on these questions as they complete the page of the booklet.

1. Have you ever felt depressed or known someone who was depressed? What did depression feel like on the inside? How was depression expressed on the outside?

2. Think about a conflict you might have had with family, friends, or coworkers. What happened? How did you think and feel? Did the thoughts and feelings stick with you?

3. Do experiences of stress change the way you act and feel around others? Do symptoms of depression affect your relationships?

4. Have you had experiences in which you were treated badly because of your race or ethnicity? Have you ever seen someone else treated this way? What happened? How did you feel?

5. How do experiences of discrimination affect your relationships? How do these experiences change the way you think and feel about others?

6. Who helps you stay strong? How does the relationship help both of you? How can these relationships help you fight against discrimination?

Interview Questions

Participants were asked to provide opinions about the experience of reading this booklet.

1. Think about the booklet that you just looked at; do you have any comments about the booklet?

2. Could you relate to anything? Do you have any experiences you would like to share?

3. Is there anything else you would like to share?

APPENDIX B - MEASURES

CESD (Center for Epidemiological Studies Depression Scale, by Radloff (1977))

How often has this occurred recently: 1 = zero or less than one day last week; 2 = one or two days last week; 3 = three or four days last week; 4 = five to seven days last week; 5 = nearly every day for two weeks.

1. My appetite was poor.
2. I could not shale off the blues.
3. I had trouble keeping my mind on what I was doing.
4. I felt depressed.
5. My sleep was restless.
6. I felt sad.
7. I could not get going.
8. Nothing made me happy.
9. I felt like a bad person.
10. I lost interest in my usual activities.
11. I slept much more than usual.
12. I felt like I was moving too slowly.
13. I felt fidgety.
14. I was tired all the time.
15. I did not like myself.
16. I lost a lot of weight without trying to.
17. I had a lot of trouble getting to sleep.
18. I could not focus on the important things.

Self-Efficacy regarding depression (Adapted from the Patient Activation Measure, Hibbard et al., 2004)

Please indicate how much you agree or disagree with each statement as it applies to you personally: 1 = disagree strongly; 4 = agree strongly; 5 = N/A.

1. When all is said and done, I am the person who is responsible for managing my own mood and health.
2. Taking an active role in my own mental health care is the most important factor in determining my health and ability to function.
3. I am confident that I can take actions that will prevent or minimize some symptoms or problems associated with my mental health.
4. I am confident I can recognize symptoms of depression.
5. I am confident that I can tell when I need to go get medical care and when I can handle a mental health problem myself.
6. I am confident that I can tell a doctor about concerns I have even when he or she does not ask.
7. I am confident that I can follow through on mental health treatments I need to do at home.
8. I understand the ways stress can affect my mental health.
9. I am confident that I can work through stressful relationships to help protect my health.

Self-Efficacy in discussing racial discrimination (Adapted from the Racial Socialization Competencies Scale, Anderson et al., 2019)

How much do you agree with the following statements: 1 = do not agree at all; 5 = agree very much.

1. I can share my emotions about negative racial encounters.
2. I can share my emotions about positive racial encounters.
3. I can speak up if I am racially mistreated by someone in authority.
4. I can speak up if I am racially mistreated by a peer or someone who is not in authority over me.
5. I can speak up if I see someone racially mistreated by someone else.
6. I can communicate my concerns about racial mistreatment to others.
7. I notice other people's stressful reactions during a negative racial encounter.
8. I notice how racial encounters affect me and the way I feel about others.
9. I notice how positive racial encounters affect me and the way I feel about others.

Mental Health Stigmatization (adapted from Day et al., 2007)

How much do you agree with each of these statements: 0 = do not agree; 5 = agree much.

1. I don't think it is possible to have a normal relationship with someone with depression.
2. I would find it difficult to trust someone with depression.
3. It would be difficult to have a close relationship with someone with depression.
4. I feel anxious and uncomfortable when I am around someone with depression.
5. I would feel unsure about what to say or do if I were around someone with depression.
6. I don't think I can relax and be myself around someone with depression.
7. I feel anxious and uncomfortable when I am talking about discrimination.
8. I would feel unsure about what to say or do if I were talking about discrimination.
9. I don't think I can relax and be myself when talking about discrimination.
10. I am interested in talking to others about experiences of discrimination.
11. I am confident I can talk to others about their experiences of depression.
12. I am confident I can talk to others about their experiences of depression.
13. I feel comfortable talking about my mental health concerns.

Interracial Anxiety (adapted from Plant et al., 2003)

For participants who are not Black:

In this booklet, we discuss experiences of discrimination for Black Americans. How much do you agree with these statements: 0 = not at all; 5 = very much.

1. I would feel awkward when interacting with a person who is Black or African American.
2. I would feel uncomfortable interacting with a person who is Black or African American.
3. When interacting with a person who is Black or African American, I would feel nervous.

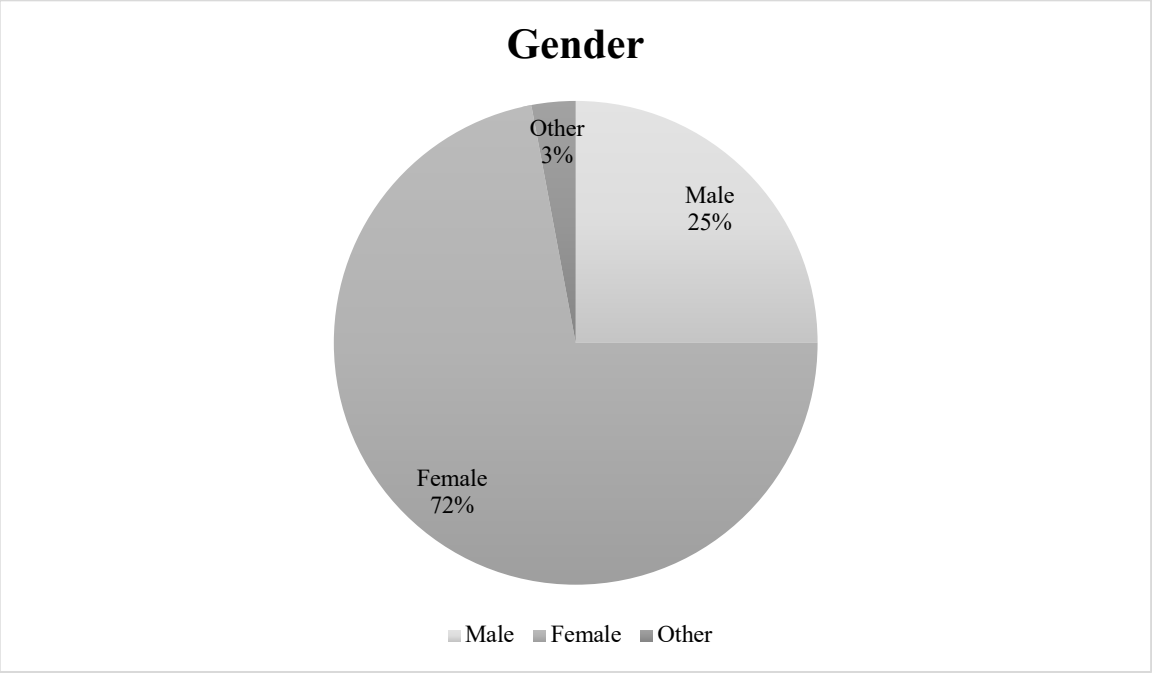
For participants who are Black:

How much do you agree with these statements: 0 = not at all; 5 = very much.

1. I would feel awkward when interacting with a person of another race.
2. I would feel uncomfortable interacting with a person of another race.
3. When interacting with a person who is of another race, I would feel nervous.

Table B1

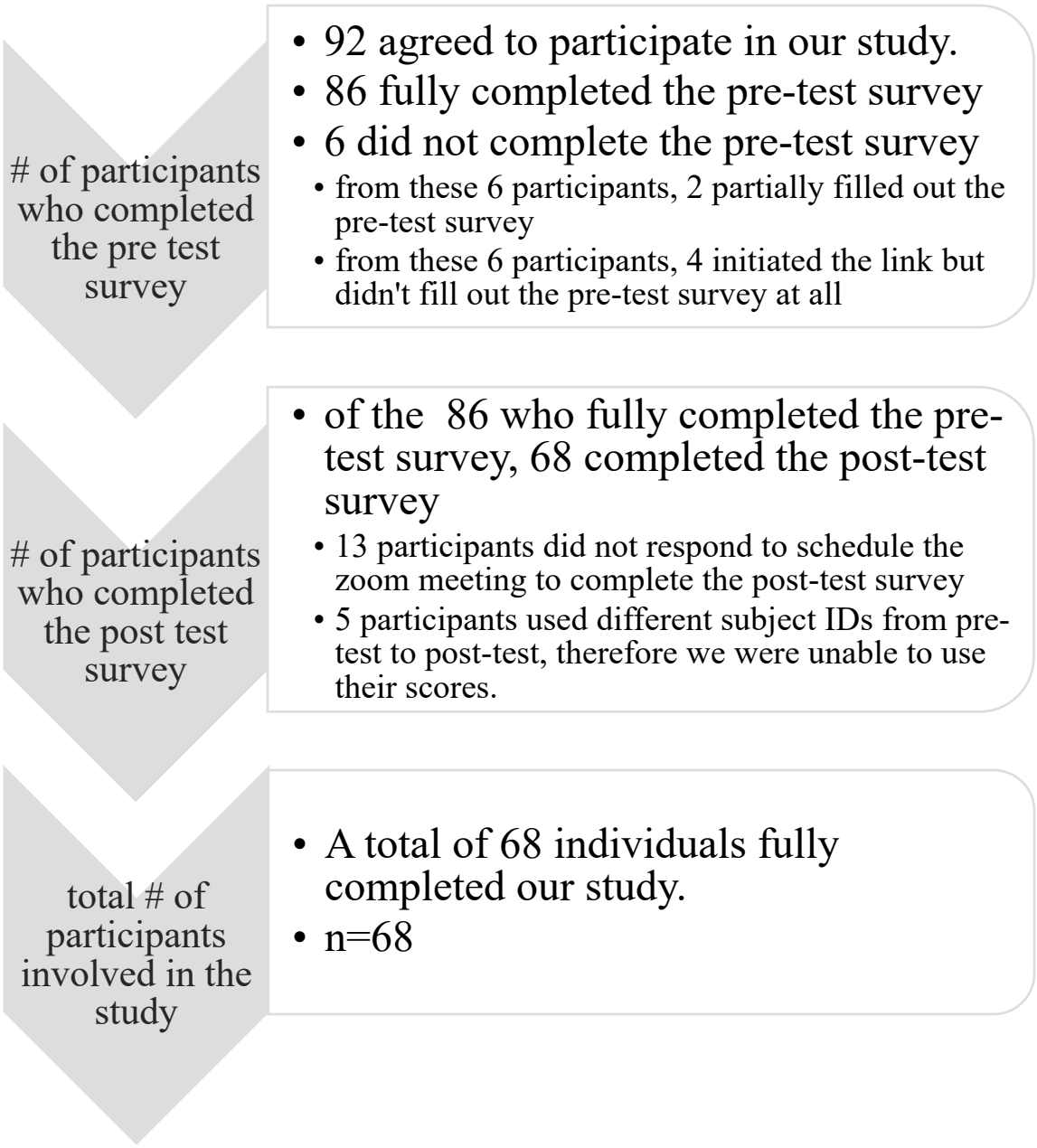
Gender Demographics (n=68)



Note: This pie chart demonstrates the percentage of our participants who have completed the study in its entirety who self-identified as either male (17 out of 68), female (49 out of 68), or other (2 out of 68).

Table B2

Participant Flowchart



Note: This flowchart illustrates the process we went through with our participants as we conducted the study.

Table B3

Repeated Measures Regression (n=68)

Variable	Pre Test Mean (SD)	Post Test Mean (SD)	F Statistics
Self-efficacy and Depression	***3.26 (0.51)***	**3.5 (0.45)**	**F(1, 67)=13.22, *p*<.001**
Self-efficacy and Discrimination	***4.14 (0.6)***	***4.38 (0.57)***	***F(1,67)=19.38, p<.001***
Reductions in Distress Discussing Discrimination-Related Issues (Stigma and Racial Discrimination)	**2.15 (0.98)**	**1.87 (0.91)**	**F(1,67)=7.61, *p*<.001**
Stigma and Depression	1.96 (0.84)	1.88 (0.76)	F(1,67)=1.39, *p<.2428*
Confident communication with others about discrimination (mhpositive - Discrimination)	3.91 (0.77)	3.96 (1.01)	F(1,67)=0.15, *p<.7027*
Confident communication with others about depression (mhpositive – Depression)	3.98 (0.9)	4.01 (1.03)	F(1,67)=0.15, *p<.7035*

Note: This table demonstrates the results from the repeated measures regression from pre test to post test after participants have gone through the psychoeducational booklet. The F statistics in bold are significant and has been referenced in the paper.

Table B4

Alphas and stats from Self-Efficacy in race, Mental Health Stigmatization, and Self-Efficacy regarding Depression

Scales	**Raw Alphas**	**Variables**	**Variable definition**	**Pre Test Mean (SD)**	**Post Test Mean (SD)**
Self Efficacy in Race *(n=68)*	0.9				
		SEnegirace	Sharing emotions about negative racial encounters	4.01 (0.91)	4.24 (0.81)
		SEposrace	Sharing emotions about positive racial encounters	4.03 (0.90)	4.37 (0.81)
		SEauthorit	Speaking up if racially mistreated by authority	3.81 (1.00)	4.15 (0.93)
		SEnotauth	Speaking up if racially mistreated by non-authority	4.12 (0.94)	4.53 (0.72)
		SEseemistreat	Speak up if they see someone being racially mistreated	4.28 (0.81)	4.50 (0.72)
		SEconcern	Communicate concerns about racial mistreatment	4.27 (0.79)	4.41 (0.74)
		SEotherstr	Noticing other's stressful reactions during negative racial encounter	4.28 (0.75)	4.40 (0.67)
		SEnegaffect	Notice how negative racial encounters affect them	4.31 (0.78)	4.43 (0.72)

		SEpostaffect	Notice how positive racial encounters affect them	4.13 (0.84)	4.40 (0.72)
Mental Health Stigma --- Depression *(n=68)*	0.8				
		MHnormdep	Thinks its not possible to have normal relationship with a depressed person	2.03 (1.10)	1.86 (1.12)
		MHdiffdep	Difficulty in trusting a depressed person	1.88 (1.03)	1.56 (0.85)
		MHdiffclose	Difficulty in having a close relationship with depressed person	2.35 (1.35)	1.84 (1.09)
		MHanxdep	Feels anxious when around a depressed person	1.81 (1.10)	1.69 (0.93)
		MHnotrelax	Cannot relax and be themselves around a depressed person	1.81 (1.01)	2.44 (1.30)
Mental Health Stigma --- Discrimination *(n=68)*	0.77				
		MHanxdisc	Feeling anxious / uncomfortable when talking about discrimination	2.24 (1.24)	1.93 (1.02)

		MHunsuredisc	Feeling unsure about what to say or do when tallking about discrimination	2.16 (1.22)	1.90 (0.99)
		MHnotreldisc	Can't relax and be themselves when talking about discrimination	2.04 (1.13)	1.79 (1.03)
Mental Health Stigma --- Confidence *(n=68)*	0.72				
		MHconfdep	Confident they can talk to others about their experiences of depression	4.00 (0.96)	4.12 (0.99)
		MHconfmh	Comfortable talking about their mental health concerns	3.96 (1.10)	3.91 (1.18)
Self-Efficacy regarding Depression *(n=68)*	0.9				
		PAMmood	"When all is said and done, I am the person who is responsible for managing my own mood and health"	3.51 (0.63)	3.54 (0.63)

		PAMfunct	“Taking an active role in my own mental health care is the most important factor in determining my health and ability to function”	3.44 (0.61)	3.65 (0.51)
		PAMprevent	“I am confident that I can take actions that will prevent or minimize some symptoms or problems associated with my mental health”	3.33 (0.70)	3.41 (0.72)
		PAMrecdep	“I am confident I can recognize symptoms of depression”	3.30 (0.77)	3.53 (0.61)
		PAMmedical	“I am confident that I can tell when I need to go to get medical care and when I can handle a mental health problem myself”	3.06 (0.81)	3.34 (0.82)
		PAMtelldoc	“I am confident that I can tell a doctor about concerns I have even when he or she does not ask”	3.01 (0.92)	3.31 (0.89)

		PAMmhhome	"I am confident that I can follow through on mental health treatments I need to do at home"	3.13 (0.79)	3.41 (0.78)
		PAMstress	"I understand the way stress can affect my mental health"	3.50 (0.66)	3.84 (0.48)
		PAMrelation	"I am confident that I can work through stressful relationships to help protect my health"	3.04 (0.84)	3.44 (0.68)

Note: The scoring used in the measure for Self-Efficacy in Race ranges from 1-5 where 1 = does not agree at all, 5 = agree very much. The scoring used in the Measure for Mental Health Stigma ranges from 1-5 where 1 = strongly disagree, 5 = strongly agree. The scoring used in the measure for Self-Efficacy regarding Depression ranges from 1-5 where 1 = disagree strongly, 4 = agree strongly, and 5 = N/A.

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