Impact of a Psychoeducation Intervention on Stigma and Help seeking among African Americans: A Pretest and Posttest Study

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Abstract

Stigma is considered the most significant barrier to African Americans psychological treatment. Literature addressing stigma among African Americans is understudied and needed. Previous researchers have attempted to address stigma among African Americans via anti-stigma interventions, such as education-based programs aimed to educate and improve understanding and information about psychological health. The purpose of the pretest-posttest study aimed to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and increase their willingness to seek treatment. The results showed the psychoeducational based intervention reduced public stigma, self-stigma, and improved help-seeking attitudes. The mean scores for public stigma before the seminar (M = 14.71 SD = 7.95) and after the seminar (M =13.28, SD = 7.77);t(41)= -8.360, p = <.001 showed significant difference. The mean scores of self-stigma scale showed there was a significant difference in mean scores before the seminar on the aware scale (M = 23.57, SD = 10.41) and after the seminar (M=18.92, SD = 9.48); t(41)= -9.48, p = <.001, agree scale before the seminar (M=18.92, SD=11.78) and after the seminar (M=14.66, SD=9.46); t(41)=-7.280, p=<.001, apply scale before the seminar (M=18.50, SD=10.99) and after the seminar, and hurt scale scores before the seminar (M=18.39, SD=13.17) and after the seminar (M=13.59, SD=10.44); t(41)=-8.477, p=<.001. There was significant difference in mean scores for help-seeking before the seminar (M = 4.86, SD = 1.09) and after the seminar (M=5.13, SD = 1.02);t(41)= 5.296, p = <.001. Future research should focus on using a control group and post follow up group, examining help-seeking behaviors and self-stigma, and continuing to create and explore psychoeducational interventions that address mental health stigma among Black diasporas.

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Chapter 1: Introduction

Over 16% of African Americans or Black individuals living in the U.S. report experiencing mental illness (Mental Health America, MHA, n.d). Mental illness is a clinically significant disturbance in an individual's thinking, emotions, and behaviors (World Health Organization, WHO, 2022). Despite the need, only one in three African Americans receive mental health treatment (National Alliance on Mental Illness, 2023). Substance Abuse and Mental Health Services Administration (SAMHSA, 2021) reports that only 8.9% of Black Americans received psychological services in the past year compared to 18.3% of White adults and 14.4% of American Indians. Black Americans are less likely to receive psychological treatment than White adults (Cadaret et al., 2018; Harris et al., 2020). African Americans suggest that insurance costs and structural barriers contribute to not using mental health services (Alang, 2019).

In 2020, 10.4% of Black Americans had no health insurance coverage compared to 7% of White Americans. Among Black adults with serious mental illness, 40.8% did not receive treatment due to cost or insurance, while 39.6 % reported not receiving treatment due to stigma (SAMHSA, 2021). When controlling for socioeconomic factors, Black Americans are twice as likely to live in poverty, and only 12% of them receive services compared to 24.5% of White adults, 16.8% of American Indian or Alaskan Native, and 12.1% of Native Hawaiian or Pacific Islander (SAMHSA, 2021). African Americans living below poverty are twice as likely to report clinical emotional issues as those above poverty (U.S. Department of Health and Human Services Office of Minority Health, DHHS-OMH, 2023).

Black American culture in the U.S. is diverse, consisting of different subcultures, which include African Americans, Caribbean Americans, Jamaican Americans, Nigerian Americans,

Kenyan Americans, and many more. However, within the African American community, individuals with mental illness are perceived as “crazy” or “bad” due to misinformation or lack of education about mental health (Friedman & Paradis, 2019). One study showed that within Black communities, those who experience severe levels of depression reported stigmatizing behaviors such as distancing themselves from others with mental health disorders than those with mild or no depression (Pederson et al., 2022). In the past seven years, African American depression rates increased from 9 % to 10.3% in youth ages 12-17, 6.1 % to 9.4 % in young adults ages 18-25, and 5.7 % to 6.3 % in the 26-49 age group (DHHS-OMH, 2023).

In more alarming rates, suicide was the third leading cause of death among Black adults ages 18-24, with Black American men dying by suicide four times more often than Black women (DHHS-OMH, 2023). Black adolescent females were 60% more likely to attempt suicide than White adolescent females (DHHS-OMH, 2023). Overall, depression rates in African Americans are lower at 24.4% compared to 34.7% of White adults; however, 56% of African Americans are more likely to develop chronic depressive symptoms of sadness, hopelessness, and worthlessness than their White counterparts (Bailey et al., 2019; MHA, n.d). Furthermore, 62% of Black males have experienced a traumatic event in their lifetime, and Black women are twice as likely to experience physical or sexual violence than White women (Motley et al., 2018; MHA, n.d). Nine percent of Black individuals experience lifetime post-traumatic stress disorder (PTSD) (Gran-Ruaz et al., 2022).

The history of racism in the U.S. may play an influential role in the cultural mistrust among African Americans toward the healthcare system (Pew Research Center, 2022; Taylor et al., 2019). For instance, experiments such as the Tuskegee experiment or the case of Henrietta Lacks demonstrate the disregard for Black life by withholding treatment, coercion, and

capitalizing off them without informed consent in the name of advancing science. The inhuman treatment of Black Americans has caused deeply rooted and generational mistrust in the healthcare system that 63% of Black adults believe they will not receive adequate care and will be mistreated in social and medical services (Pew Research Center, 2022; Taylor et al., 2019). At least 55% of Black adults reported negative experiences with their providers, such as feeling rushed or not being treated with respect compared to other patients (Pew Research Center, 2022). Thus, some African Americans may believe coping independently or using other informal supports is better than seeking services from the dominant culture (Campbell et al., 2020). Researchers have explored treatment barriers among African Americans, including accessibility issues, lack of transportation, affordability, lack of providers, and religion (Campbell et al., 2020). In most Black cultures, religion is essential and used as a coping skill to cope with mental health symptoms; at the same time, it acts as a barrier to pursuing treatment. Fanegan et al. (2022) and Neely-Fairbanks et al. (2018) found that Black adults who frequently practice religious coping often did not pursue psychological services compared to those with lower religious coping.

Stigma is considered the most significant barrier due to its impact on individual attitudes toward seeking psychological treatment. Within the Black American community, 29.8% report stigma as the most prominent factor that impedes psychological treatment (Misra et al., 2021). African Americans often fear being judged or labeled by others, which hinders them from seeking professional help (Crumb et al., 2021). African Americans are 2.5 times more likely to fear psychological treatment than their White counterparts (National Child Traumatic Stress Network, 2016). As a result, Black Americans are at risk of not being treated for their psychological illness, and an urgent response is needed to overcome stigma.

Previous researchers have aimed to reduce mental health stigma via anti-stigma interventions(Chakawa, 2023; Diouf et al., 2022). Anti-stigma interventions are based on protest, education, and contact. Protest-based interventions increase awareness of biases and poor conditions for individuals experiencing psychological illness(Carrara et al., 2021). Education-based interventions focus on increasing knowledge about mental health using media, psychoeducational classes, or training (Carrara et al., 2021). Contact interventions consist of interacting with individuals with mental illness via videos or in person (Carrara et al., 2021). Education and contact-based interventions have effectively reduced stigma compared to protest interventions (Chakawa, 2023; Diouf et al., 2022).

Anti-stigma interventions explicitly targeting African Americans have yielded mixed results. For instance, Rivera et al. (2021) found that studies attempted to address stigma among African Americans, such as using a twelve-minute contact intervention, a psychoeducational booklet, a 10-hour training curriculum, and a four-month participatory research study, had little to no effect in reducing stigma. In contrast, Chakawa (2023) found that Bridge the Gap Program, an anti-stigma program, significantly decreased stigma and remained low across a three-month follow-up among African Americans. Anti-stigma interventions among African Americans need further exploration as the high prevalence of untreated psychological distress in African Americans can lead to severe mental health disorders, legal issues, homelessness, substance use disorders, and impairment in emotional, social, and work functioning (Snowden et al., 2022).

Statement of the Problem

The problem addressed in this study was the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. The general problem is that 37% of African Americans experience mental illness; however, less than 9% receive mental health treatment (Alcarez et al., 2019; Reinert et al., 2021). Stigma is often reported as a significant barrier to African Americans not seeking mental health treatment despite rising mental health needs(Connell et al., 2019; Saykeo et al., 2018). African Americans seeking psychological treatment are perceived as weak, evoking external and internal feelings of being judged, shamed, and rejected (Goodcase et al., 2022; Misra et al., 2021). African Americans' stigma was positively correlated with worsening psychological health and reduced help-seeking behaviors (Shannon, 2023; Cadaret et al., 2018). Furthermore, African Americans anticipate negative experiences with treatment, such as not receiving good quality care, being ineffective, and being mistreated by providers (Misra et al., 2021).

Consequently, African Americans' psychological needs go untreated, leading to a greater risk of experiencing adverse outcomes such as increased symptomology, poor standard of living, jail, unemployment, medical and physical illness, poverty, and substance abuse(Alvarez et al., 2019; Snowden et al., 2022). Literature addressing stigma among African Americans is understudied and needed. Previous researchers have attempted to address stigma among African Americans via anti-stigma interventions, such as education-based programs aimed to educate and improve understanding and information about psychological health, which appears to be effective in decreasing stigma(Chakawa, 2023; Diouf et al.,2022).The rising psychological illness rates, underutilization of services, stigma and negative attitudes about mental illness and treatment, and the adverse outcomes emphasize the necessity for psychoeducation interventions

to inform African Americans about psychological conditions and services to reduce stigma and improve therapy-seeking attitudes.

Purpose of the Study

The purpose of this study was to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and improve their willingness to seek treatment. The psychoeducational intervention was adopted from the National Alliance on Mental Illness (NAMI) Family and Friends seminar. The 90-minute seminar informed individuals with family or friends about mental health conditions. The seminar covers diagnoses, treatment and recovery, effective communication strategies, self-care, crisis preparation strategies, and community resources. The researcher modified the seminar to include the unique needs of African Americans, such as stigma beliefs of feeling weak or that mental illness is terrible and cultural mistrust.

The target population was African American adults. The study focused on African Americans born in the United States between the ages of 18 and 60 who have experienced mental illness, have a family or friend with a mental illness, and or unaffected by mental illness. Based on Cohen's D (1988), the study aimed to recruit no less than 45 and no more than 176 participants. Assuming a small effect size and t-test for matched pairs within Ss pre-posttest design with alpha set to .05 and 95% power, a priori G power analysis suggested N= 45 to detect with 95% power a small effect if it exists. Participants were recruited via convenience sampling from various entities, such as universities and local organizations across Northwest Arkansas. The participants completed the Stigma-9 Questionnaire (STIG-9) developed by (Gierk et al., 2018), the Self-Stigma of Mental Illness Short Form (SSMIS-SF) developed by Corrigan et al. (2012), and Mental Health Seeking Attitude Scale (MHSAS; Hammer et al., 2018), and a

demographic survey regarding participants' age, gender, education level, and income level and mental health status or association with a person with mental health 10 minutes before the NAMI Family and Friends Seminar then the STIG-9 (Gierk et al., 2018), SSMIS-SF(Corrigan et al. (2012), and MHSAS(Hammer et al., 2018) was given 10 minutes after the intervention. Since this study used one group or within subjects and two-time points, a paired t-test was used to determine if the scores change from the baseline or across the time points. For the paired t-test, the independent variable was the NAMI seminar, and the dependent variables were the mean scores from STIG-9(Gierk et al., 2018), SSMIS-SF(Corrigan et al., 2012), and MHSAS(Hammer et al., 2018). SPSS 29 software was used to run the paired t-test analysis.

Theoretical Framework

Current literature uses social cognitive theory to conceptualize stigma (Do et al.,2020; Sawaf, 2022; Yu et al., 2022). Social cognitive theory suggests that we gain knowledge and behavior through observation and contact with one another. This social interaction and learning help shape individual identities, attitudes, and beliefs. Social cognitive theory conceptualizes stigma as stereotypes, prejudice, and discriminatory attitudes learned from social networks (Sawaf, 2022). For instance, social learning theory suggests that when individuals are exposed to negative views about mental illness from the public (e.g., media), it gets reinforced via their social network (e.g., parents, families, peers, and media), creating prejudice towards individuals with mental illness (Sawaf, 2022). In addition, the theory explains that if individuals join cultures or social networks that have either heightened or less stigmatizing views, it can increase or decrease stigma (Sawaf, 2022).

Exploring stigma through the lens of social cognitive theory helps identify two types of stigmas, public and self-stigma, for understanding stigma. The review of literature concerning

social learning theory and mental health stigma among African Americans published over the last decade suggested that African Americans often perceive mentally ill individuals as bad, dangerous, or crazy due to society or their family and peers' unfavorable attitudes toward them (Abdullah et al.,2020; Brown et al., 2019; Pederson et al., 2022).Consequently, African Americans who seek psychological treatment are perceived as weak, evoking external and internal feelings of being judged, shamed, and rejected (Goodcase et al., 2022; Misra et al., 2021).

The lens of social cognitive theory enabled the link between mental health stigma and help-seeking to the foundation of the study and point of investigation. Furthermore, understanding that individuals learn through observation led to examining the literature for interventions that help reduce stigma. Previous researchers found that psychoeducational interventions effectively reduce stigma, which guided the development of the research questions and research design, with public-stigma, self-stigma, help-seeking, and psychoeducational interventions providing the main channels of inquiry. Since the foundation of social cognitive theory is learning through observation, the pretest and posttest design was selected to determine if an intervention is effective or what has been learned. Components of social learning theory were used to conceptualize stigma and identify the three measurements, STIG-9 (Gierk et al., 2018), SSMIS-SF (Corrigan et al., 2012), which provided well-structured questions about stigma and attitudes toward help-seeking.

Introduction to Research Methodology and Design

A pretest and posttest design study was used to address the research questions. The pretest and posttest designs are a form of quasi-experimental methods and quantitative studies. Since this study had no control group, randomization, and manipulation, it is a quasi-

experimental design (Cook & Campbell, 1979). Pretest and Posttest design measure subjects against themselves, so these subjects serve as their own control (Cook & Campell, 1979).

The current study used a within-subjects design since the same participants were measured at different time points. In a within-group design, each individual participant participates in the same conditions; then, measured for changes and outcomes over time (Montoya, 2023). In other words, a within-subjects design usually has one group that is placed in multiple conditions, followed by comparing the dependent variables between the conditions (Montoya, 2023).Within-subjects design is an experimental method comparing related measures from the same participants between same or different conditions (Privitera, 2020). Within-subjects' design only need small size sizes since the same participants are observed group. Within-subjects design can remove effects of individual differences between groups (Privitera, 2020). Within- subjects design has greater test statistics that detect significant differences between groups.

Convenience sampling is a nonprobability sampling method where participants are easy to access (Mertens, 2015). Convenience sampling is cost-efficient and given the historical nature of African Americans' reluctance to participate in scientific research, it may be easier to recruit from places African Americans visit. Participants completed the STIG-9 (Gierk et al., 2018), SSMIS-SF(Corrigan et al., 2012), and MHSAS(Hammer et al., 2018) and demographics ten minutes before and after the intervention. Therefore, with the components of the study, such as a lack of control group, randomization, same participants in both time points, and analysis of the differences in scores before and after the intervention, the proposed pretest and posttest design was suitable to answer and meet the purpose and research goals of determining if a

psychoeducational-based intervention addressing African Americans' stigma towards mental health helps reduce stigma and improve their willingness to seek treatment.

The effect of the interventions is determined by measuring or comparing the scores between the two groups pretest and post-intervention. First, using G power, a t-test with one sample was used to determine the sample size. Using the significance level of $\alpha = .05$. power, $1 - \beta = .95$, medium effect size .5 we need a sample size of $n = 45$ to achieve power. The alpha level of .05 was chosen based on previous research on stigma and it is a common level used in research (Serder et al., 2021). Cohen's D (1988) medium effect size of .5 was chosen as it is big enough to determine meaningful differences. For power analysis, .95 was chosen. With 95%, there is a 5% probability of being unable to detect an actual difference. However, Cohen (1988) suggests that 95% is a reasonable balance between alpha levels and beta risk. The study aimed to recruit no less than 45 participants and more than 176 based on previous stigma research sample sizes and to control dropout between pretest and posttests. A paired t-test was used to determine if measurement scores changed from pretest to post-intervention. For this study, the independent variable is the intervention (e.g., NAMI Family and Friend seminar) and dependent variables were public- stigma (e.g., STIG-9; Gierk et al., 2018), self-stigma (e.g., SSMIS-SF; Corrigan et al., 2012), and help-seeking (e.g., MHSAS; Hammer et al., 2018).

Research Questions

Research Question (1): What impact does a 90-minute psychoeducational live seminar have on reducing public stigma among African Americans from pretest to posttest ?

H0: The psychoeducational-based intervention has no effect on reducing stigma in participants from pretest to post-test intervention.

H1: The mean scores from a STIG-9 (Gierk et al., 2018) will be significantly reduced after a 90-minute psychoeducation informational live seminar post-intervention comparative to pre-intervention mean scores.

Research Question (2) What impact does a 90-minute psychoeducational live seminar have on reducing self-stigma among African Americans from pretest to posttest ?

H0: The psychoeducational-based intervention has no effect on reducing stigma in participants from pretest to post-test intervention.

H2: The mean scores from a scale SSMIS-SF(Corrigan et al.,2012) will be significantly reduced after a 90- minute psychoeducation informational live seminar post-intervention comparative to pre-intervention means scores.

Research Question (3) What impact does 90-minute psychoeducational live seminar have on improving attitudes towards seeking therapy among African Americans from pretest to posttest?

H0: The psychoeducational-based intervention has no effect on improving attitudes toward seeking therapy in participants from pre- to post-intervention.

H3: The mean scores from the MHSAS(Hammer et al., 2018) will significantly increase post-intervention comparative to pre-intervention mean scores.

Significance of the study

Mental health stigma has caused adverse outcomes and poor quality of life among African Americans experiencing psychological distress. Stigma is positively associated with African Americans not pursuing mental health treatment when needed (Ferrie et al., 2020; Harris et al., 2020; Saykeo et al., 2018). Currently, peer-reviewed literature that addresses African Americans' mental health stigma via psychoeducation is limited. Thus, the current study results

can encourage more researchers, clinical providers, and health providers to utilize psychoeducation when working with African Americans. In addition, the results will aid in reducing stigma and improving treatment-seeking attitudes among African Americans, which can break the cycle of African Americans not pursuing professional health and lead to more engagement in treatment. Furthermore, it would aid with increasing mental health awareness among African Americans and support that the National Alliance on Mental Illness (NAMI) Family and Friends seminar is an effective psychoeducation intervention for African American communities.

Definitions of Key Terms

Anti-stigma interventions encompass protest, educational, and contact programs to educate the public about mental health by sharing up-to-date research, stories, lived experiences, and professional perspectives (Ponte, 2022).

Protest-based Interventions

Protest based interventions increase awareness of biases and poor conditions for individuals experiencing psychological illness (Carrara et al., 2021).

Educational or Psychoeducational based Interventions

Educational or psychoeducational based interventions focus on increasing knowledge about mental health using media, psychoeducational classes, or training (Carrara et al., 2021).

Contact -based Interventions

Contant based interventions consist of interaction with individuals with mental illness via videos or in person (Carrara et al., 2021).

Black or African American

Black Americans are U.S. citizens having origins in any of the Black racial groups of Africa. African Americans are U.S. citizens whose ancestors were enslaved Africans brought to the U.S. via the transatlantic slave trade (U.S. Census Bureau, 2022). Black and African American will be used interchangeable throughout the proposal.

Help -Seeking

Help-seeking is the decision to seek professional help to resolve emotional, behavioral, or health issues (Neighbors,1985;Unrau et al., 2005).

Mental Illness

Mental illness is defined as a clinically significant disturbance in an individual thinking, emotions, and behaviors (World Health Organization, WHO, 2022).

Public stigma

Public stigma is defined as unfavorable views the public has about mental illness (Corrigan &Watson, 2002). Society uses signals and labels to define mental illness, which forms and perpetuates stereotypes and hostile ideation of mental illness (Abdullah & Brown, 2020). These views may perpetuate beliefs that individuals with mental illness are dangerous or crazy.

Self-stigma

Self-stigma or internal stigma is the negative views individuals with mental illness internalize about themselves (Corrigan &Watson, 2001). The internalized feelings may evoke shame, isolation, and embarrassment. Both public and self-stigma have been associated with positive and negative attitudes toward help-seeking (Harris et al., 2020; Ferrie et al., 2020; Tsang et al., 2020).

Summary

Despite increased mental illness, less than 9% of African Americans receive mental health treatment (National Alliance on Mental Illness, 2023). Even when addressing financial and structural barriers to treatment, Black Americans still do not seek treatment (Connell et al., 2019; Ferrie et al., 2020). One salient barrier is stigma; research shows that stigma and mental health treatment are significantly correlated and hinder African Americans from seeking professional help (Crumb et al., 2019). Therefore, research focusing on effective interventions to reduce stigma and improve help-seeking attitudes is needed. The current study aimed to determine the effectiveness of a psychoeducational-based intervention on African Americans' stigma. Effectiveness is based on the reduction of stigma and improved help-seeking attitudes. Past literature has shown the effectiveness of psychoeducational-based interventions than other interventions (Chakawa, 2023).

Chapter 2: Literature Review

Previous investigators found a significant correlation between mental health stigma and help-seeking among African Americans (Crumb et al., 2021). The problem addressed in this study was the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. Thirty-seven percent of African Americans experience mental illness; however, less than 9% receive mental health treatment (Alcarez et al., 2019; Reinert et al., 2021). Stigma is often reported as a significant barrier to African Americans not seeking mental health treatment despite rising mental health needs(Connell et al., 2019; Saykeo et al., 2018). In attempts to address mental health stigma, researchers have used educational interventions to reduce stigma; however, there is a gap in the literature involving psychoeducational interventions that reduce stigma among African Americans (Diouf et al., 2022). Stigma-reducing interventions among African Americans is of a particular interest because of the rising mental health issues of the group (MHA, n.d). The purpose of the study was to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and increase their willingness to seek treatment.

The literature review will provide a comprehensive view of mental health stigma among African Americans by exploring social cognitive theory, barriers to African Americans' mental health services use, African Americans mental health stigma and help seeking, the racial and ethnic differences between stigma and mental health services use, intergroup gender and age differences in stigma and mental health service use, and lastly, the different types of anti-stigma interventions and the effectiveness of each. Several databases were used to identify scholarly articles written in the last five years for literature review. The databases APA Psyc Articles,

Academic Search Complete, MEDLINE Complete, APA PsycInfo, Google scholar, and EBSCOhost were all used to find articles relating to mental health stigma, help-seeking behaviors, service use among African Americans, and anti-stigma interventions. Other helpful resources include the World Health Organization, WHO, the Center for Disease Control Prevention, COC, the National Institute of Health, NIH, the Substance Abuse and Mental Health Services Administration, SAMHSA, National Alliance of Mental Illness, National Library of Medicine, U.S Department of Human Services, U.S Department of Education, and the Pew Research Center were used to locate statistics and other information relating to barriers to treatment and utilization of mental health services among African Americans.

Search terms used to locate relevant and recent articles are*: barriers to mental health care, mental health stigma, impact mental health stigma have on seeking help, mental health stigma among Black Americans, mental health stigma among African Americans, African Americans perceptions towards mental health services, racial differences in mental health stigma, Black Americans mental health service use, Black men mental health stigma and help-seeking behaviors, Black women mental health stigma, mental health statistics in the U.S, African Americans mental health stats, Older Black adults stigma and help-seeking, Black youth mental health statistics, Black youth perceptions on stigma and help seeking, African Americans attitudes towards health care, Black counselors or psychologists in U.S, graduation rates for African Americans high school students, Income levels by race, Prevalence and distribution of major depressive disorder in African Americans, and non-Hispanic Whites 2022, African Americans help-seeking behaviors, social cognitive theory, social cognitive theory and stigma, group differences among African Americans stigma and help-seeking, gender schema impacting treatment, Black women gender schema impact on treatment seeking, Black Men gender schema*

on treatment seeking, age differences among African Americans towards stigma and help-seeking, anti-stigma interventions, anti-sigma intervention to reduce mental health stigma, anti-stigma intervention among African Americans, effectiveness of psychoeducational intervention to reduce stigma, protest basted intervention, contact based interventions, and social cognitive theory and help-seeking behaviors. The published articles used for the literature review and theoretical framework ranged from 1969-2023.

Theoretical or Conceptual Framework

Social cognitive theory or social learning theory made up the theoretical framework for this study. In 1989, Albert Bandura developed the social cognitive theory (Bandura, 2012). Bandura suggested that behaviors, environment, and internal personal factors like beliefs, preferences, and self-perceptions are influenced by one another (Ewen, 2009). Bandura further suggests that we learn by observing one another. For this study, social cognitive theory was used to define stigma. The social cognitive perspective of stigma is that individuals construct cognitive classifications and associate them with stereotyped beliefs (Link & Phelan, 2001). Goffman's (1966) seminal essay was one of the first to conceptualize stigma definition from a social cognitive perspective. Goffman (1963) defines stigma as unappealing attributes and stereotypes that lead to societal rejection or discrimination. Since Goffman (1963), researchers have continued to expand on stigma. The primary conceptualization and definition of stigma using social cognitive theory was created by Corrigan and Watson (2002). There are two types of stigma, public or social and self-stigma, which can be understood in three components: stereotypes, prejudice, and discrimination.

Public or social stigma is defined as society's unfavorable and stereotypical views of psychological illness and services (Corrigan &Watson, 2002). Public stigma is formed through

stereotypes or negative beliefs about the group. For instance, individuals believe mentally ill individuals are dangerous. Then, individuals develop prejudiced views that agree with their beliefs. Then, they have an adverse emotional reaction like anger or fear towards the person, followed by discrimination, which is the behavior response to prejudice (e.g., avoidance). Corrigan, Druss, and Perlick (2014) suggest that public stigma impacts help-seeking behaviors when they lead to avoidance. Individuals try to avoid mental health treatment or clinics due to loss of opportunities due to stigmatizing labels. Self-stigma is the pessimistic belief that individuals with psychological issues internalize (Corrigan &Watson, 2002). Self-stigma occurs when individuals have negative beliefs, such as perceiving themselves as weak or crazy (e.g., stereotypes), which leads to adverse emotional reactions like low self-efficacy, followed by a behavioral response, such as failure to seek therapy. Further expanding on self-stigma, Corrigan, Druss, and Perlick (2014) explain the regressive model of self-stigma with four stages: agreement, self-application, self-esteem, and self-efficacy. The first stage is awareness. Individuals are aware of the stigma of mental illness. The second stage is an agreement with stigma. For instance, “people with mental illness are dangerous,” followed by self-application, “ I have a mental illness, so I am dangerous,” which impacts individual self-esteem, “I am a useless person because of my mental illness” and self-efficacy, “I cannot accomplish my goals because I have a mental illness” leading to shame.

One limitation of social cognitive theory is that it does not integrate historical and societal factors' influences on mental health stigma (Swarf, 2022). Another limitation is that the Corrigan and Watson four stages of stigma model is highly cited; however, there has not been substantial empirical support when working with individuals with serious mental illness (Catalano et al., 2011). Corrigan and Watson (2011) conducted a longitudinal study on 85

individuals with schizophrenia and other mental health disorders, testing the relationship between the four stigma stages and adverse outcomes. Results yield mixed responses. Participants endorsed awareness of stereotypes more than an agreement to stereotypes and self-application to stereotypes. However, with further analysis, later stages, such as self-application, self-esteem, and self-efficacy, were correlated with poor outcomes. Consistent with Corrigan and Watson's (2011) findings, Catalano et al. (2021) found that the internalization of stigma is formed by a single pathway from stereotype awareness to stereotype agreement, to application to self, to decrease in self-esteem then adverse recovery outcomes and attitudes.

Expanding on Goffman's (1963) stigma theory, Link and Phelan (2001) used labeling theory to define stigma. Stigma develops from labeling, stereotyping, separation, status loss, and discrimination. According to Links and Phelans (2001), labeling occurs when society differentiates and labels individuals' attributes, and then cultural norms or beliefs declare the attributes negative or unfavorable, leading to stereotyping. Next, society creates a division or separation between individuals with psychological illness and healthy individuals. Finally, individuals with psychological illness encounter status loss and discrimination via rejection, exclusion, and avoidance. Furthermore, stigma is reinforced by other infrastructures of power.

For this study, Corrigan and Watson's (2002) definition of public and self-stigma via social cognitive theory was measured and used to define stigma. The definition of public stigma led to the identification of the Stigma-9 Questionnaire (STIG-9) developed by Gierk et al.(2018) to conceptualize public stigma, it is based on Link and Phelan's (2001), however, closely correlated with social cognitive theory. The Self-Stigma of Mental Illness Short Form (SSMIS-SF) developed by Corrigan et al.(2012) was identified to conceptualize self-stigma based on Corrigan's four-stage stigma model: awareness, agreement, application, and self-efficacy.

Components of stigma play a role in individual help-seeking behaviors, with several studies supporting the correlation (Catalano et al.,2021; Corrigan & Watson, 2011; Wu et al., 2023). The Mental Health Seeking Attitude Scale (MHSAS; Hammer et al., 2018) was used to measure help-seeking and based on theory of planned behaviors. The theory of planned behaviors is frequently used in stigma research. The MHSAS (Hammer et al., 2018) has shown convergent evidence of validity was demonstrated when the MHSAS(Hammer et al., 2018) score was correlated with subjective norms, perceived behavioral control, intention, public stigma, self-stigma, anticipated risks, and benefits (Hammer et al., 2018).

The theoretical framework of this study helped identify stigmatizing views among African Americans in literature, which is an integral part of understanding how African Americans conceptualize and internalize stigma, which is addressed in the literature review. Social cognitive theory suggests we learn from watching others or interactions with others; therefore, what is learned can be unlearned and replaced. The framework led to literature focusing on interventions that address stigma; however, research on anti-stigma interventions among African Americans needs to be more extensive, which led to this study's current problem and purpose. The theoretical framework for this study supports Corrigan's model of stigma while highlighting that future researchers can focus more on interventions addressing stigma within a social cognitive approach and social systems.

Barriers to African Americans Mental Health Service Use

Disparities in mental health treatment among African Americans continue to persist despite national efforts to improve mental health services (Mongelli et al., 2020). One in three Black Americans receive mental health treatment despite an alarming increase in mental health needs occurring among the population (NAMI, n.d). Many barriers impede the utilization of

mental health services among African Americans, including individual barriers such as income, insurance, cultural mistrust and stigma, systemic and structural behaviors of accessibility, and provider availability and bias.

Individual Barriers

Socioeconomic Status. The median income for Black or African American households is 52,860 compared to 81,060 for White Americans, with 21.7% of African Americans living below the poverty level compared to non-Hispanic White Americans at 9.5% (Guzman & Kollar, 2023). The disparities have narrowed down; however, Black Americans remain twice as likely to be unemployed than White workers, with a 5.4% unemployment rate for Black workers compared to 3.1% for White workers (United States Joint Economic Committee, 2023). Family structure and educational attainment may explain the disparities in income and unemployment (Rostain et al., 2015). Family structures may influence poverty levels because two adults typically make more money than single-parent families. The average income of a two-parent Black household is 92,180 compared to 121,2550 of White families (Sullivan, 2020). Black single parents' average income is 46,950 compared to 79,374 of White single parents' income (Sullivan, 2020). Since income and employment correlate with educational attainment, high school and college graduate rates can impact the potential earnings among African Americans. In 2019-2020, high school graduate rates for African Americans were 81% compared to 93% of Asian/Pacific Islanders, 90% of White, and 83% of Hispanic students (National Center for Education Statistics, 2023). Although in recent years, African Americans graduating with college degrees has increased, with 1 out of 4 Black Americans receiving a degree, White Americans are 50% more likely to have a four-year college degree compared to Black Americans (United States Joint Economic Committee, 2023).

One reason the disparity continues to persist is due to early difficulties in accessing quality education for Black children (United States Joint Economic Committee, 2023). Individuals living below the poverty level face numerous structural barriers, such as a lack of adequate services, fewer services and resources, and no insurance (Haynes et al., 2017). Haynes et al. (2017) further found that African Americans with low income reported limited knowledge about mental health, stigma, and access to services as barriers to mental health treatment. In a study, Pulsifer et al. (2019) found that families with low SES lack access to treatment and often were diagnosed with psychological disorders yet did not seek any form of treatment.

No insurance. No health insurance plays an influential role in unmet mental health needs. In 2020, 10.4% of Black Americans had no health insurance coverage compared to 7% of White Americans. Among Black adults with serious mental illness, 40.8% did not receive treatment due to cost or insurance (SAMSHA, 2021). The disparities in insurance coverage affect mental health treatment among African Americans of all ages. For instance, 37.5% of uninsured Black adults received mental health treatment compared to 47.2% of White adults (SAMSHA, 2021). In terms of private insurance, 6.5% of Black adults received mental health care services compared to 9.1% of Hispanic adults. (SAMSHA, 2021). Nine-point one percent of Black adolescents with no insurance received mental health treatment compared to 13.1 White adolescents (SAMSHA, 2021).

Nationally, 1 in 10 youth who had private insurance do not have coverage for mental health (Reinert et al., 2021). Nine-point five percent of Black youth received mental health services compared to 16.2% of White and 14.3% of Hispanic counterparts (SAMSHA, 2021). Despite experiencing depression episodes within the past year, 68% of Black adolescents did not have mental health care (Reinert et al., 2021). Reinert et al. (2021) note that minority youth with

major depression receive more mental health care through non-specialty services from school social workers, school psychologists, and school counselors. In 2021, 61.20% of Black youth with major depression did not receive any non-specialty services in the past year (Reinert et al., 2021). Although income and insurance contribute to barriers to mental health care, other barriers, such as cultural mistrust, stigma accessibility, and provider bias, play an influential role in the underutilization of services.

Cultural Mistrust. Throughout history, systemic racism and discrimination in the healthcare system have bred mistrust in the African American community. The most famous experiment that resonated with African Americans and fueled mistrust was the Tuskegee syphilis study. Sixty one percent of Black Americans believe that research misconduct is likely to occur in today's time despite laws and guidelines to stop such misconduct (Pew Center Research, 2022). Black Americans tend to report negative experiences with their health provider as they believe advanced medical care is withheld from them and they will have less access to quality medical care (Pew Center Research, 2022). In a survey of 3,546 Black adults, 47% reported hospitals and medical centers giving lower priority to their well-being and medical care (Pew Center Research, 2022). In the same study, 34% of women reported that their doctor did not take their health concerns seriously. Attitudes about healthcare have improved over the years among African Americans; however, there are still ways to go to decrease the disparities and mistrust.

Stigma. Stigma is considered one of the most influential barriers among African Americans. Stigma is associated with mental health knowledge, which is understanding the disorder, including the ability to recognize symptoms of mental health disorders. Negative attitudes and beliefs towards mental health are widely held in African American communities. In African American communities, mental health stigma is associated with shame and

rejection(Goodcase et al., 2022; Misra et al., 2021). For example, in a study consisting of 638 African Americans, participants reported feeling fear of being judged and shamed due to mental illness (Harris et al., 2020). African Americans view having mental illness as a personal weakness and are not open to admitting they have psychological issues (NAMI, n.d; Ward et al., 2013). African Americans may believe coping independently or using other informal supports like church is better than seeking services (Campbell et al., 2020). In a mixed method study with 163 African American mothers, stigma was the most cited barrier to seeking treatment. The mothers reported fearing that people will blame them for their child problems which hindered them from seeking services (Murry et al., 2011). Pederson et al. (2023) suggest that stigma is the root cause of health inequities, which increases negative experiences and disparities in mental health among African Americans.

Systemic or Structural Barriers

Accessibility. The availability of services is correlated with the number of mental health providers and locations of resources or places (MHA, n.d). There is currently a mental health provider shortage, which is predicted to worsen by 2025 (University of Michigan Behavioral Health Workforce Research Center, 2018). Only 2% of psychiatrists are Black, and 5.08% of psychologists are Black (American Psychological Association, 2022). From 2015-2019, serious mental illness (SMI) rates increased among African Americans, yet only 55.3% received some form of mental health treatment compared to 69.2 White adults (SAMSHA, 2021). Furthermore, when examining depression rates, 19.9% of African Americans, 15.2% of Hispanics, and 11.9% of Caucasians did not receive treatment. However, McGregor et al. (2020) suggest African Americans were still less likely to receive treatment. The disparities may be explained by the limited access to quality care for mental health (Alegría et al., 2008). Similarly, Bailey et al.

(2019) explains that disparities in treatment are caused by misdiagnosing, counseling referral, and medication management in primary care and psychiatry visits.

Provider Bias. Historically, African Americans have received less quality care and often report that providers are biased and indifferent, leading to African Americans often being misdiagnosed (Pew Research Center, 2022). In one survey, 56% of African Americans had to speak up to get the proper care and felt they were treated with less respect than other patients (Pew Research Center, 2022). African Americans are more likely to be misdiagnosed compared to White Americans (Bailey et al., 2009). On the other hand, African Americans are over diagnosed with some disorders, such as schizophrenia in adults and behavioral or conduct disorders in children. For instance, Black children are more likely to be diagnosed with oppositional defiant disorder when presenting with disruptive behavior symptoms.

In contrast, White children presenting with the same symptoms are diagnosed with adjustment disorder. Grimmett et al. (2016) explain that counselors tend to perceive conduct and attention deficit, and oppositional behaviors as symptoms related to minority children. Another reason they may explain disparities in diagnosis is that African Americans usually describe physical symptoms of mental illness, such as pain in the heart when describing depression. However, less culturally competent therapists may fail to recognize the symptoms as mental illness (NAMI, n.d). The misdiagnosis or overdiagnosis may influence Black American's perceptions that treatment is ineffective. Thirteen-point nine percent of African Americans with SMI who did not receive mental health services reported they did not think treatment would help as a reason for not receiving therapy (SAMSHA, 2021). Many Africans Americans believe that providers of different race cannot understand them or dismissive of their experiences(Planey et al., 2019). APA (2017) states that 90% of clinician's biases, stereotypes, and prejudice contribute

to the differences in services and quality care in minority populations. Many barriers hinder the utilization of mental health services among African Americans; however, stigma is the most significant barrier (Misra et al., 2021). The following topic will explore the literature regarding the correlation between mental health stigma and help seeking among African Americans.

African American Stigma and Help-Seeking Behaviors

African Americans consistently endorse self and public stigma such as a fear of being judged, isolated, rejected, feelings of shame and embarrassment, and stereotypical and stigmatizing views of perceiving psychologically ill individuals as dangerous (Goodcase et al., 2022; Misra et al., 2021). Abdullah et al. (2020) conducted an experimental study that explored 152 African Americans' stigma, views, and reactions toward mild and severe mental health disorders by using vignettes. Results showed that participants had stigmatizing and unfavorable views towards psychotic and addictive disorders, while mood disorders were positively associated with social isolation and disconnection. Historically, African Americans have a higher tendency to disapprove of alcohol use. Results can further be explained by communalism. Black Americans tend to isolate themselves from individuals whose behaviors may make the group look bad. This concept could have impacted results as participants were recruited from an organization that may hold communalism views. The study has limitations, including sample size and fatigue effects due to participants completing questionaries at four time points. The subject of the vignettes was Black men, which could have influenced results when considering the stigmatization of Black men expressing emotions which is rooted in masculinity, gender stereotypes, and stigma. For instance, Black men are not supposed to express cry or express their emotions. The researcher called for more extensive research on mental health stigma in the Black community in hopes that interventions can be identified that help reduce stigma. One major

strength is that the study was experimental, which is limited when exploring stigma among African Americans.

In a qualitative study, 201 African Americans shared their perceptions and experiences toward mental health and psychological services (Harris et al., 2020). Participants feared feeling shame and being judged by others within the community due to mental illness. Participants viewed mentally ill individuals as violent or crazy, equating mental illness to intellectual disability and inferiority. Participants stated that mental health behaviors within African American communities tend to be viewed as exaggerated and easily manageable. Participants noted religion and spirituality as coping mechanisms for mental illness. One limitation to the study is the lack of male representation in the sample.

A study using stratified sampling and multiple regression analysis investigated the relationship between public stigma, self-stigma, race, and professional treatment-related attitudes among 449 African Americans and White adults found a significant relationship between self-stigma and mental health treatment (Brown et al., 2010). African Americans who reported self-stigma were more likely to report negative attitudes toward seeking professional help. African Americans reported more negative attitudes toward mental health treatment compared to White participants. However, there were no differences in the participants' current mental health treatment or intention to seek treatment. Further analysis showed no relationship between public stigma and treatment-related behaviors. The study's results must be viewed with caution as they may only be generalized to the study participants due to location and data collection methods.

In a later study, Masuda et al. (2012) found that public stigma and self-concealment predicted help-seeking attitudes after controlling for age, gender, and past mental health treatment among 221 African American college students. African Americans may try to hide or

conceal mental illness due to fear of being judged or other responses to their illness (Masuda et al., 2021; Misra et al., 2021). Within the same study, older students had more positive attitudes toward counseling services if they sought counseling services in the past compared to those who did not have past services (Masuda et al., 2021).

In a more diverse sample, Benuto et al. (2020) explored demographic and socioeconomic differences in mental health literacy, stigma, psychological distress, and help-seeking attitudes among 286 Latino and African Americans. Interestingly, gender and ethnicity did not predict help-seeking attitudes, which is contrary to past findings in the literature that found women have more favorable attitudes towards seeking professional help than men and Black adults endorse more stigmatized views than Latino adults (DeFreitas et al.,2018; Terlizzi & Norris, 2021). The sample in the study may explain the discrepancy, as participants were primarily Latino and recruited from primary care clinics. African Americans have a higher tendency to seek help from primary care providers for mental health concerns rather than professional counseling (Avent-Harris et al., 2021). In further analysis, mental health literacy, stigma, psychological distress predicted help-seeking attitudes, Benuto et al. (2020) found that individuals' attitudes or beliefs about mental illness influence them to seek help rather than how others perceive them. To address stigma, the researchers recommended examining interventions that reduce stigma and improve attitudes toward therapy.

African Americans' stigmatized beliefs or attitudes contribute to not seeking services (Brown et al., 2019; Ferrie et al.,2020; Villatoro et al., 2018). Among a sample of 152 African American and Latino adults, Fripp and Carlson (2017) found that participants reported that stigma influenced them not to seek mental health treatment. African Americans perceive clinical treatment as ineffective or mental illness as not serious (Planey et al., 2019). African Americans

conceptualize mental illness as a concept that does not impact them or as something they can handle independently (Planey et al., 2019; Samuel, 2015). Ngyugen et al. (2020) found that older African Americans had a positive attitude toward professional helping; however, they did not seek help as they thought they would get better without help. This attitude can be tied to stigma since African Americans often view mental illness as a weakness that can be controlled without professional assistance (Harris et al., 2020). Also, it shows that having positive attitudes about help-seeking does not translate to receiving services. African Americans may seek informal support for mental health concerns from church, friends, family, and mentors (Avent Harris et al., 2021).

Some studies show that the severity of the illness and how knowledgeable African Americans are about specific mental health disorders increase their chances of attending therapy (Pederson et al., 2023;Willams et al., 2023). For instance, Pederson et al. (2023) observed that Black Americans more often pursued mental health treatment when they had more knowledge of disorders like schizophrenia than depression and suicidal ideation. Similarly, Neely-Fairbanks et al. (2018) discovered that higher mental health knowledge positively correlated with increased openness to seeking professional help among 409 African American churchgoers. One observation from this study is that most participants had bachelor's and graduate degrees and higher socioeconomic status. There is a link between SES, educational attainment, stigma, and utilization of services (Haynes et al., 2017). Typically, individuals with SES have more access to services and resources than those with lower SES (Pulsifer et al., 2019). Other factors, such as religion or spirituality, could have influenced the results. Religion is an integral part of African American culture. Many African Americans use it as a form of coping with life stressors and mental health concerns. For the study, it is possible that participants provided socially acceptable

answers that align with their religious beliefs. In the same study, 1 out of 3 participants could not recognize mental health symptoms accurately. The finding indicated a positive association between knowledge and help-seeking and a negative relationship with stigma (Neely-Fairbanks et al., 2018).

Black youth tend to endorse stigma towards mental illness and mental health services. In a qualitative study, Kranke et al. (2012) explored stigmatizing attitudes toward mental health treatment and medication use among 17 African American adolescents. Adolescents reported negative attitudes and reactions from parents, culture, peers, and media about mental health treatment and medication use (Kranke et al., 2012). Adolescents describe being mistrustful towards mental health professionals, and people who experience mental illness and take medications are crazy (Harris et al., 2020). One contradictory result is that youth religious beliefs did not influence negative stigmatization attitudes about mental illness like in the adult population. One study limitation is that researchers used secondary analysis to gather data. Researchers suggest that results imply that psychoeducational programs and models that address issues identified by Black families may be essential in reducing stigma in Black families. Therefore, researchers recommend that future research focus on the impact of psychoeducation interventions on reducing stigma and increasing the utilization of services.

Some contradictory findings suggest that stigma is a positive predictor of help-seeking behaviors. Shannon et al. (2022) found that self and public stigma positively influenced help-seeking behaviors among African American male college students. Contradictory to previous findings, Black males tend to have higher stigmatizing views than women (Powell et al., 2016). Similarly, Williams et al. (2023) suggest stigma increases the likelihood of utilizing services among Black male youth. Tsang et al. (2020) found that when children's behaviors significantly

impair the daily functioning of their lives, African American parents seek help regardless of holding stigmatized views. Some of the differences in other findings could be explained by the population of focus, which is parents and males. Parents are influential in deciding if youth will receive treatment, so if parents endorse stigma, it increases or hinders the chances of the youth receiving help. For Shannon et al. (2022) study on African American males, the difference may lie within the theoretical framework used to explore stigma and help-seeking behaviors, as the study used the theory of planned behaviors. In addition, the study did not explore gender differences, as males were the only participants. Given the contradictory results, within-group differences among Black males may need further exploration. There is a correlation between stigma and utilization of services among African Americans. There are some mixed results when factoring in intergroup differences. Researchers have indicated that there are racial, ethnic, and other demographic differences in mental health stigma that may play a role in service utilization. Next, we will discuss research surrounding racial, gender, and age differences among African Americans.

Racial and Ethnic Differences in Stigma and Mental Health Service Use

African Americans seek mental health treatment less often than other groups(SAMHSA, 2021), which stigma may explain some of the disparities in care. Previous research suggests that African Americans have higher stigmatized beliefs about psychological illness and are unlikely to pursue therapy services than White, Hispanic, and Asian Americans (Brown et al., 2020; DeFreitas et al., 2018; Fripp et al., 2017). DeFreitas et al. (2018), conducting a study on the stigma between African American and Latino adults, showed that African Americans expressed more stigmatized beliefs than Latino adults. Both groups reported personal and perceived stigma when interacting with individuals with mental illness. There were no significant differences

between groups on therapist efficacy and treatability of mental illness. Interestingly, African Americans believed that only people with severe mental illness need professional treatment and reported less stigma when they believed the disorder did not strain or disrupt their relationship with others. One critique of this study is that the sample was primarily female and recruited from a psychology course. Women tend to have less stigmatization views than men, and participants could have less biases due to their understanding of psychology.

In an earlier study, Conner et al. (2010) explored the impact public stigma and self-stigma has on help seeking attitudes and behaviors among 449 African Americans and White older adults diagnosed with depression, African American participants reported more unfavorable attitudes toward mental health services. Both groups endorsed self-stigma, African Americans endorsed self-stigma at greater levels and had more impact on seeking professional treatment. There were no differences in intention to seek treatment between the two groups. Similarly, Nguygen et al. (2020) observed that older African Americans and Black Caribbean adults were less likely to seek services compared to White adults among sample of 862 older adults(Nguyen et al., 2020). In the same study, African Americans and White participants were more likely to use family doctors compared to traditional mental health providers or clergy which was inconsistent with past finding that African Americans tend to seek help from out more informal support such as pastor or church family (Avent Harris et al., 2021). Nguyen et al. (2020) explains inconsistent may be explained by African Americans tend to seek help from clergy through church for serious problems.

Turner et al. (2015) showed that African American participants displayed more negative and stigmatizing beliefs about psychological services than White and Latino participants. Although White participants had more positive attitudes toward seeking mental health treatment,

there were no differences between the groups when examining the likelihood of them seeking mental health services. Similarly, Misra et al. (2021) conducted a systematic review examining cultural influences on mental health stigma among minorities and observed that Latinos and African Americans endorsed stigma more than White Americans. African Americans described feeling fearful of being perceived as weak or crazy and facing more discrimination due to having a mental illness.

In contradictory findings, Saykeo et al. (2018) and Sigal et al. (2023) found that Asian Americans have more stigmatizing views and are less likely to pursue services than Black and other racial groups. Culture and racial identity may explain the differences. Culture shapes our beliefs and values. It is an integral part of our identity and how we view the world. Culture is an intricate and influential part of how individuals experience, perceive, and view mental health (Misra et al., 2021). For instance, one culture may label an individual who sees things as delusional or crazy, whereas another may view them as spiritual gifts from God. Even more so, if one's culture has negative views about mental health, it can significantly affect whether an individual will seek help or services (Misra et al., 2021). In a study by Wallace et al. (2005), higher levels of Afrocentrism positively correlated with increased perceived stigma about seeking professional help and self-concealment among 251 African American college students. Asian culture tends to be more collectivistic, or community based. Asian Americans may endorse more public stigma and want to save face or fear they will burden their families, which would influence them not to pursue services. In a broader context, African Americans reported structural and public stigma due to experiences of discrimination and racism against them, resulting in mistrust in mental health care providers and the dismissiveness of their psychological and emotional worries (Misra et al.,2021). The literature lacks studies examining differences

between other cultures within the Black culture, such as Caribbean, Haitians, or Nigerian Americans.

In stigma literature among youth, stigma hinders Black youth from pursuing psychological treatment (Brown et al., 2019; Ferrie et al., 2020; Turner et al., 2015; Villatoro et al., 2018). Black adolescents reported shame and sigma contributed to them not seeking services in a qualitative study by Samuel (2015). The participants talked about how mental illness is a result of discrimination and racism; therefore, addressing those issues is beneficial and needed more than counseling services. In circumstances where Black Americans have access to services, they still do not pursue them due to stigma. Ijadi-Maghsoodi et al. (2018) conducted a study investigating barriers to seeking help among 76 diverse school students with access to School-Based Health Centers (SBHCs). Black students expressed stigmatized beliefs of being judged, ashamed, and embarrassed as factors that hinder them from seeking help from SBHCs. Fitts and Allen (2019) conducted the study on 3607 White, Latino, and Black Americans enrolled Children of Mental Health Initiative (CMHI). Results showed that 63% of African Americans received less therapy than 74.3% of White and 79.9% of Latino youth. Despite the structural and logistic barriers being addressed such as insurance, access, transportation, Black adolescents continue to receive less therapy. In contradictory findings, Villagrana (2017) and Turner et al. (2015) state that Latino youth are unlikely to go to therapy compared to Black, White, and Asian youth. Villagrana (2017) explains that the likely reason for the finding is that the Latino culture may have more stigmatizing views about psychological illness. Villagrana's study focused on youths in foster care.

In a similar study to Ijadi-Maghsoodi et al. (2018), Wang et al.(2019) investigated factors related to high school students' help-seeking behaviors for SBMHS consisted of 369 Black,

Caucasian, Latino, Asian/Pacific Islander, and Multiracial high school students. Asian students were less likely to seek help compared to other students. This finding is similar to adult literature, Asian Americans seek therapy less than other races (Saykeo et al., 2018). Maihotra et al. (2015) examined the racial and ethnic differences of mental health service utilization among youth with externalizing behaviors among 20,970 White, Black, and Hispanic adolescents ages ranging from 12-17. White youth used more outpatient services compared to 95% of Black and Hispanics. In comparison, Black and Hispanics used more inpatient services, with Black using twice as much as the other two groups. Results show that African Americans parents are willing to use other services rather than traditional mental health services (Tsang et al., 2020). Some researchers have explored whether the types of services offered influence mental health treatment among youths. Villagrana (2017) reported that African Americans and Latinos are more likely to use individual and group service. In contradictory findings, Tsang et al. (2020) suggest Black caregivers are more likely to utilize other forms of services such as mentoring programs instead of counseling services for their children. Villagrana (2017) and Vázquez et al. (2019) recommended using individualized and evidence-based approaches to increase engagement and counseling services in minority populations.

Most stigma studies focus on Black youth perceptions but not specifically on Black parents' attitudes toward seeking treatment. Other studies examining Black parents' stigma and therapy yield different results than those of Tsang et al. (2020) and Williams et al. (2023). For example, Dempster et al. (2015) suggested that the probability of parents seeking therapy services decreased when they endorsed public stigma and felt stigmatized due to child behaviors. Self and public stigma influence whether parents and youth used services. Overall, there are mixed findings on whether African Americans seek treatment less often than other minority

populations (Saykeo et al., 2018; Sigal et al., 2023). However, differences have been noted in African Americans reporting higher levels of stigma compared to White and Latino adults. Next, we will explore the intergroup gender differences to gain insight into the inner workings of mental health stigma among the group.

Intergroup Gender Differences in Sigma and Mental Health Service Use

In 2020, suicide was the third leading cause of death for Black men ages 25-32. Black men's suicide rates are four times greater than Black women's (NAMI, n.d). Women have more positive views about therapy and often engage and receive treatment more than men (Terlizzi & Norris, 2021). Black men are less likely to receive therapy for anxiety and depression than racial groups (Blumberg et al., 2015). Black men are less likely to pursue services and report higher stigmatized views than women (Cet al., 2023; Powell et al., 2016).

In general, Black men's reported barriers to treatment such as accessibility, no insurance and provider availability, racism, and cultural mistrust overlap with the African American community barriers (Lindsey et al., 2013; Planey et al., 2019). We can examine the gap in services through the lens of intersectionality and gender identity. Intersectionality theory suggests that intersecting identities cannot be viewed as separate since they transpire within infrastructures of power and constitutions. Yu et al. (2022), utilizing an intersectionality lens, explains that race and psychological illness have a mutual and contingent partnership that fosters stigma. Similarly, gender identity or norms dictate male and female behaviors. Masculinity is a part of gender identity and norms and plays a significant role in men not seeking treatment (Powell et al., 2016).

Masculinity encourages stereotypes that men do not cry or show emotions; they must always be in control of emotions and cope with life stressors. African American men endorse

high masculinity norms, which further contribute to stigmatizing beliefs that they can handle their issues on their own or they feel less of a man; therefore, they do not need therapy (Planey et al., 2019; Powell et al., 2016). In a qualitative study, Ward et al. (2013) found that African American men endorsed stigma related to individuals with mental illness as dangerous; however, no stigma associated with seeking treatment. The participants had a favorable view of seeking mental help treatment and believed it was one of the best ways to control mental illness (Ward et al., 2013). Results are not consistent with current findings of Black men reporting stigma as a significant barrier to seeking treatment (Coleman-Kirumba et al., 2023; Watson et al.,2015). In a qualitative study investigating the lived experiences of 17 Black men diagnosed with depression, the men reported public stigma as a barrier for them seeking services (Allen et al., 2023). The men expressed trouble verbalizing their feelings due to fearing others would judge them, and they felt compelled to adjust to their environment so they would not appear different and weak. Although the participants reported public stigma, most of them received mental health treatment in the past or are currently receiving treatment.

Historically, society places masculinity expectations and behaviors on Black women. In the media and society, troupes, or stereotypes of the “strong Black women or superwoman” consistently suggest that Black women are independent and can cope independently, which enforces the idea that they cannot be vulnerable and express their emotions. Within the African Americans community, woman are the pillars of support, expected to fill many roles often time at the expense of their own wellbeing. In a qualitative study among 48 African American women exploring barriers to therapy through superwomen schema conceptual framework, the women expressed pressure to suppress their emotions, wanting to present a strong image, resistance to showing their emotions and depending on others which hinder them from wanting

to pursue help (Woods-Giscombe et al., 2016). Watson et al. (2015) explain that the stigma associated with receiving mental health services may cause African Americans additional problems for them, leading to them not seeking services. McCleary and James (2024) found that when Black women endorsed strong Black women schema, they had increased mental health symptoms. However, no correlation was found between strong Black women schema and help-seeking behaviors. Findings may be explained by the measures used in the study; help-seeking was measured by the Attitudes Toward Seeking Professional Psychological Help–Short Form (ATSPPH-SF; Fischer & Farina, 1995), which is unidimensional and has not been validated among African American populations.

Literature exploring the intersectionality of racial and gender identity among African Americans and its influence on stigma and help-seeking behaviors is understudied. Even more so, research examining African American men's mental health and help-seeking is understudied (Powell et al., 2016; Watson et al., 2015). Although Black women seek help more often than men, there are still disparities in treatment (SAMHSA, 2021; Watson et al., 2015). Overall, both Black men and women uphold gender schemas that correlate with stigma and help-seeking. The following section focuses on age differences in mental health stigma and help-seeking among African Americans.

Age Differences in Stigma and Mental Health Service Use

Studies indicate no significant difference between ages, as African Americans across age groups have stigmatizing views; however, older adults may seek more informal support than other age groups (Nguyen et al., 2020). Among African Americans religious coping is a culturally accepted coping style. African Americans use prayer as way to give all their problems to God. Within the African American community, older adults tend to rely more on religion than

younger populations. Older adults may believe they are too old to get help for mental illness which can be associated with stigma of aging(Conner et al., 2010). Some older adults believe depression or mental health issues are a part of getting older which can prevent them from seeking help.

Cadaret and Speight (2018) investigated the association between social and self-stigma, coping styles, and views toward therapy services among 120 African American men ages 18-73. A preliminary analysis path-analytic strategy and one-way between-group analysis were performed to analyze the data. The finding showed that when the men held high internalized stigma, it decreased their likelihood of seeking help. Intergroup differences were noted, as older African American men were more likely to seek therapy if they had less self-stigmatizing views than younger men; however, if self-stigma increased, older men were less likely to pursue psychological help than younger men. Social and self-stigma were correlated, but there was no direct relationship between social stigma and help-seeking. A study of 1,559 Black young adults ages 18-25 reported fear and stigmatizing beliefs as barriers to service use even when experiencing severe psychological stress (Busby et al., 2021).

One significant difference in Black youth stigma is that it positively correlates with social identity (Ferrie et al., 2020). During these times, social identity has developed. Youths are extremely concerned about their peers' perception of them, evoking a variety of positive and negative feelings of being judged, embarrassed, and rejected, which are prominent factors in youth hiding and not disclosing psychological issues and refusing therapy services (Ferrie et al., 2020). In an earlier mixed methods study, Lindsey et al. (2010) explored the influence stigma and social support have on depression symptoms among 18 African American teen boys and found that teens felt peers would think they were " weak" if they showed any depressive

symptoms which influenced them to hide their feelings. The teens associated "shame" for seeking professional mental health treatment and a level of mistrust towards mental health professionals. The teens preferred to rely on family support to help address depressive symptoms. The finding is consistent with the literature that African Americans prefer informal support such as mentors, family, and religious coping rather than seeking professional health (Avent Harris et al., 2021; Harris et al., 2020). Although youth have stigmatizing views, parents are gatekeepers to their receiving treatment. Parental stigma is an important topic to address as Black youth mental health is rising at alarming rates, and treatment is needed to decrease poor outcomes. Across age groups, stigma impacts help-seeking among African Americans. Thus, researchers have recommended that more studies focus on interventions to address stigma.

Anti-Stigma Interventions

Some researchers have aimed to address mental health stigma and increase psychological service use (Chakawa, 2023; Diouf et al., 2022; Tablot et al., 2019). Anti-sigma interventions are based on protest, education, and contact. Protest-based interventions increase awareness of biases and poor conditions for individuals experiencing psychological illness (Carrara et al., 2021). Education-based interventions focus on increasing knowledge about mental health using media, psychoeducational classes, or training. Contact based interventions consist of interaction with individuals with mental illness via videos or in person. Anti-stigma interventions have been shown to reduce stigma. In a systematic review of anti-stigma interventions in educational settings, most of the anti-stigma studies showed significant results in reducing stigma and improving attitudes, help-seeking, and knowledge regarding mental health (Naveed et al., 2020). The focus of the following few topics will examine the effectiveness of protest, contact, and educational interventions in reducing stigma and willingness to seek treatment.

Protest Based Interventions

Protest-based intervention's goal is to block media and advertisements that display harmful and inaccurate information about individuals with mental illness (Walsh and Foster et al., 2021). Protest intervention is rooted in advocacy through campaigning, boycotts, protests, writing letters, and marches. Their target audience is usually politicians, journalists, or community leaders. There is little to no research on the effectiveness of protest-based interventions. Griffiths et al. (2014) studied protest, education, and contact interventions targeting various forms of stigma. Some protest interventions were able to reduce stigma. However, most studies had small sample sizes. In an earlier study by Corrigan et al. (2001), protest interventions had no significant changes in stigmatizing attitudes among 153 adults. Protest can lead to an increase in negative views towards mental illness, depending on the type of strategy. In another meta-analysis, Clement et al. (2013) found that protest interventions reduce prejudice regarding mental illness but yield a weak response to reducing discrimination towards mental illness. Since there is little research on protest-based intervention, researchers focus on contact-based and education-based interventions targeting stigma.

Contact Based Intervention

Contact based interventions consist of interaction with individuals with mental illness via videos or in person (Carrara et al., 2021). The assumption of contact-based intervention is that by exposing individuals to people who experience and or work with mental illness will help reduce stigma or negative perceptions towards mental illness. A pretest-posttest study was conducted to examine the impact of three stigma interventions: curriculum, contact, and printed materials on mental health knowledge, attitudes towards mental illness, and help-seeking among 751 sixth graders (Painter et al., 2017). Findings indicated that the curriculum intervention was

more effective than contact and printed materials. Contact intervention did improve mental health knowledge among sixth graders, with no significant effect on other variables. This finding is inconsistent with previous contact-based studies with adults, indicating that contact-based intervention effectively reduces stigma (Kosyluk et al., 2016).

There are limited studies available that explore contact-based interventions targeted at adolescents. Many contact-based interventions target adults in professional settings, such as nurses, students, teachers, and professionals. In those studies, contact-based interventions effectively reduce stigma and improve attitudes towards mental illness (Kolb et al., 2023; Mohammad et al., 2020). For instance, Stuart et al. (2011) conducted a pretest and posttest study evaluating the impact a contact-based educational presentation had on reducing mental health stigma in 89 journalism students. The presentation consisted of three individuals with mental illness sharing their experiences and the impact stigma had on them. Then, two media experts discussed the role media has in creating and perpetuating mental illness stigma or stereotypes. Before and after the presentation, students complete a Stigma Evaluation survey. To create the Stigma Evaluation Survey, the researchers adapted items from other measures to evaluate anti-stigma programs. The Stigma Evaluation survey is a 20-item self-report survey to explore the changes in attitudes, expressions of social acceptance, and feelings of social responsibility. The survey has a Cronbach Alpha of .74, which is reliable. Post-test results were weighted to pretest results for gender and age groups.

The scores decreased from 43.6 to 39.5 from the pretest to the posttest, indicating a 5% reduction in stigmatizing attitudes after the presentations. There was a 26% improvement in reducing stereotypes of individuals with mental illness being dangerous or unpredictable. An interesting result was that 14% of posttest students reported a willingness to go to a doctor if they

were experiencing a mental illness. Findings may be explained by students learning about the stigma that individuals with mental illness face. One major limitation of the study was that the researchers did not provide adequate data analysis statistics. Furthermore, researchers noted that they used statistical tests that showed the dependence of the sample, which resulted in wider confidence intervals, making it difficult to detect significant differences. The study used a one-group design, which makes it difficult to rule out external influences; however, since the pretest and posttest were completed on the same day, it decreases the chances of external influences on the findings. Due to the uncontrolled design, it is hard to generalize the results to broader populations. However, contact-based intervention had some impact on reducing stigma.

In a randomized controlled study, Amsalem and Martin (2022) evaluated the effectiveness of a brief social contact-based video on reducing stigma and improving help-seeking behaviors. The videos lasted 30 minutes consisting of individuals describing how they are coping with depression, false assumptions about mental illness, and how they decided to seek professional help. Then researchers used two control videos of the same individuals discussing general things unrelated to mental illness. The sample consisted of 1,183 White, African American, Asian, Native American, and Hispanic 14- to 18-year-olds who were divided into four study groups. The Depression Stigma Scale and General Help Seeking Questionnaire were used to measure stigma toward depression and help-seeking behavior with reliability ranging from .83 to .86. Various statistical analyses were conducted, including Pearson's chi-square and one-way ANOVA, to compare demographic variables among groups. Univariate ANOVA compared DSS total scores and GHSQ mean scores across the groups and time points; post hoc tests were used to compare each group pair when between-group differences were found, and paired t-tests were

used to compare changes between the baseline and post intervention across study groups. Independent sample t-tests were used to compare gender and race within the intervention.

The brief video intervention decreased stigma and increased willingness to seek treatment. In post hoc analysis, the protagonist's race had a more significant impact on White participants. The authors noted that when personalizing video interventions, the content should be racially congruent to the viewers to help them connect and increase emotional engagement. In addition, interventions that address the viewer's cultural background align with stigma intervention research targeted at African Americans. Some researchers recommended that interventions addressing stigma among African Americans should be culturally informed and address specific stigma rather than general stigma if a significant impact is desired (Codjoe et al., 2021; Powell et al., 2016). Another consistent finding from the study is that the females showed more willingness to seek treatment than males. Typically, women have more positive views about therapy and often engage and receive treatment more than men (Terlizzi & Norris, 2021). The authors used appropriate and robust statistical testing to analyze the data, which helped them draw firm interpretations or conclusions. One limitation of the study is that 52% of the participants were White. Therefore, results may be limited to the sample rather than the general population. Since the group does not have a follow-up, it is hard to determine whether the effects last longer. However, the study demonstrates that brief video intervention can effectively decrease stigma and improve help-seeking behaviors, as shown in other studies (Tablot et al., 2019).

Education Based Interventions

Psychoeducational-based intervention appears more effective in reducing stigma across settings (Chakawa, 2023; Diouf et al., 2022; Tablot et al., 2019; Ciydem et al., 2023). The basis

of educational interventions is that educating and providing accurate mental health or information will help reduce stigma or stereotypes towards individuals with mental illness. Educating a client or patient is a vital part of the treatment process. Patients are more compliant and willing to continue treatment when they understand their diagnosis and treatment plan. A thematic analysis was conducted from 1,255 White, Black, Asian, Hispanic, and Native American college students' responses to the question how we can end stigma associated with mental illness? Twenty percent of the participants reported education, 17.1% awareness, and 11.2% positive atmosphere which were the top responses (Elbulok-Charcap et al., 2021).

Anti-stigma intervention literature consists of a significant amount of educational based intervention focused on individuals in the medical and teaching field. For instance, Ciydem and Ayci (2022) conducted a single group pretest and post-test experimental study exploring the effects of a psychiatric nursing class on 80 students' beliefs toward mental illness from September 2017 to January 2018. Data was collected using surveys such as the Personal Information Form, Beliefs toward Mental Illness Scale (BMI), Psychiatric Nursing Perception Scale(PNPS), and Student Evaluation Form. The BMI and PNPS scale's reliability were .87 and .84. A t-test with significance level set at $p < 0.05$ was used to analyze data. From pretest to posttests, the nursing students' unfavorable attitudes about psychological illness significantly decreased after a psychiatric nursing lesson. Overall, the quality of the study is fair. Some limitations to the study, including results that may not be generalized to all nursing students and no control group. The study was conducted and focused on Türkiye students mostly women, so it may be difficult to draw firm conclusions for Americans even more so for African Americans. The study design can have threats to history which can all in question the actual effectiveness of the class. For instance, the nursing students could have experienced another type of intervention

or exposure to mental illness (e.g., another class, media, clinical practice), resulting in a change of beliefs scores.

Education-based intervention with one group sample effectively reduces stigma despite not having a control group (Curren et al., 2023; İnan et al., 2019). For example, İnan et al. (2019) conducted a one group pretest and posttest quasi-experimental design on 64 nursing students assessing the impact of a mental health nursing module, clinical practice, and anti-stigma program on nursing students' attitudes toward mental illness. The students had to complete clinical practice in an adult psychiatric clinic and participate in the anti-stigma program afterward. The data were collected before the module (pretest), three weeks after the module (posttest 1), five weeks after the clinical practice (posttest 2), and two weeks after the anti-stigma program (posttest 3). The Socio-demographic Information Form, the Beliefs Toward Mental Illness Scale (BMI), and the Social Distance Scale were used to measure stigma and attitudes. There was a significant decrease in attitudes toward mentally ill individuals after the mental health nursing module, clinical practice, and anti-stigma program. Also, the finding showed significant positive differences in the mean scores of the social distance scale after the module, clinical practice, and anti-stigma program. Since researchers tested the participants at three different time frames, it helped the study determine the effectiveness of the interventions. However, the results may be called into question due to the repeated measure influencing students' scores (e.g., they can remember questions/answers). Another limitation is that statistical testing could not be attained for the study.

In another one-group sample study, Curren et al. (2023) investigated the efficacy of the What’s Up Everyone digital mental health education and awareness campaign impact on mental health knowledge, stigma, and help-seeking behavior among high school and college students

age ranging from 17-22 years of age. The campaign consists of short animations discussing mental health education and awareness. Participants watched the animations and then completed the sub-scales of the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form Depression Stigma Scale used to measure willingness to seek help, reluctance to seek help, and stigma. Four questions created by the authors measured knowledge, attitudes, and willingness. The scales had good internal reliability scores ranging from .82-.86 from the pretest to the posttest. Three paired samples t-tests were used to measure differences in willingness, help-seeking reluctance, and stigma from the pretest to the posttest. Four one-sample t-tests were conducted to measure knowledge, attitudes, willingness, and confidence. After the intervention, participants reported improved attitudes toward seeking professional help for mental health issues and increased knowledge of mental health. Participants reported decreased stigma towards depression and less reluctance to seek help. Results further support literature on the efficacy of brief videos in mental health education (Livingston et al., 2014; Sampogna et al., 2017; Tablot et al., 2017).

One major critique of education-based stigma reduction interventions is that many need better statistical power and methodology approach. For example, Song et al. (2022) conducted a systematic review evaluating the effectiveness of interventions reducing stigma among 10-19-year-olds. Twenty-two articles focusing on education only, contact, and a combination of education and contact interventions were selected. Researchers noted that out of the 22 articles, 11 did not report adequate statistics and were excluded from the meta-analysis. Most of the studies had pretest, posttest, and follow-up interventions. In the meta-analysis, education-based intervention had the most positive effects on reducing stigma compared to other interventions despite mixed effects or no effects. The most effective intervention components were

educationally based, including lessons and curriculums explaining stigma-related information. The review could not examine ethnicity and cultural differences among 10-19-year-olds because studies within the review need more details. The researchers noted that the quality of the studies could have been better; therefore, the result may not be generalized to larger populations.

In a pretest and posttest design exploring the effectiveness of the Ending the Silence (ETS) intervention in reducing the stigma, 206 African, White, Asian, and Latino American youth were stratified into the control vs. intervention group. Students completed questionnaires relating to stigma before, after, 4, and 8 weeks after the intervention and qualitative assessment of the presentations(DeLuca et al., 2021). The intervention group received 35-40 presentations of ETS, and the control group received a presentation unrelated to stigma. Descriptive analysis, mixed effects multilevel modeling, power analysis, intent-to-treat analysis, and consensual qualitative framework were used to analyze the data. Results showed that the stigma decreased, and mental health knowledge and help-seeking behaviors increased in the ETS group. The primary limitation is that presentation times differ across groups, which could impact the results. Some of the questionnaires had unacceptable and weak reliability (e.g., .25), which can limit the interpretation of the results. The study finding is consistent with stigma reduction literature among youth (Painter et al., 2017). Despite its limitations, the study helps show the need for and the effectiveness of stigma reduction intervention to combat stigma and improve mental health knowledge and help-seeking behaviors.

The above studies focus on in-person curriculum and lessons, Talbot and Malas (2019) used educational videos to determine if they can reduce stigma and improve help-seeking attitudes. The study was pretest and posttest design. Participants were parents of children who stayed at the hospital with medical and mental health issues. The video focused on introducing

the staff and services, addressing common stigma about mental health, and patients' testimonials. Participants completed surveys to gather information about mental health history (e.g., services, diagnosis, medications), children's and caregivers' attitudes toward pediatric psychiatry, and stigma about mental health care. Researchers used IBM SPP Statistics 24 and a series of t-tests to analyze the data. Caregivers improved attitudes toward the effectiveness of hospital treatment. However, there is no significant decrease in parents' mental health stigma. This may be explained by most of the participants who reported their child received psychiatric services in the past; therefore, parents may have a lower stigma from the beginning. Caregivers showed significant improvement in sigma relating to psychotropic medications. The researchers suggested that using a short educational video may be a potential intervention in reducing stigma towards mental health services in high-risk youth populations.

Similarly, Diouf et al. (2022) conducted a pretest and posttest study to evaluate the impact of a digital mental health campaign on decreasing stigma in midwestern cities among 466 18-65-year-old adults using an action-minded or collective impact model. The campaign used psychoeducational information on mental health paired with images of pets and individual testimonies on mental health and resources across social media. Researchers administered two cross-sectional surveys to measure knowledge, attitudes, and behaviors relating to campaign content. The psychometric properties of the surveys were not provided. Data was collected from the beginning of the campaign from June to July 2020 and 10 months after. A two-sided Person Chi-square test was used to analyze the data. Results showed that participants' stigma and mental health views improved over time. Participants reported more willingness to live and work with someone with mental health illness and take the initiative to address their mental health. The study could improve by having a better data collection process as the baseline and follow-up

participants differed. The surveys were cross-sectional, so results must be interpreted as directional trends. The panels used to administer the surveys differed across data collection times. Findings are consistent with past research suggesting psychoeducational interventions effectively reduce mental health stigma (Chakawa, 2023; Ciydem et al., 2023;Diouf et al., 2022; Tablot et al., 2019). However, it demonstrates how education-based intervention tends to have weak methodology designs and data collection. On the other hand, the article shows the potential of using more digital campaigns to address stigma.

Wei et al. (2020) conducted a pretest and posttest study with a control group exploring the impact professional development sessions (PD) had on mental health literacy outcomes and whether results differ when the PD is presented face-to-face or online. One hundred seventy-six preservice teachers at a large Canadian postsecondary institution participated in the study. Participants were divided into three groups: in-person, online, and control group. The three groups completed surveys that measured mental health knowledge, attitudes toward mental health and illness, and help-seeking. The measurements were completed before and three months after the posttest. Analysis of Covariance (ANCOVA) analyzed all the variables. The results showed statistically significant improvements in knowledge, stigma reduction, and enhancement of help-seeking intentions in the in-person and online group post intervention compared to the control group. Knowledge and stigma outcomes persisted at a 3-month follow-up. There was no statistical difference between in-person or online groups. The study design was appropriate and implemented well compared to previously discussed studies. In addition, the study used adequate analysis and statistical power.

Psychoeducational-based intervention appears effective in reducing stigma (Diouf et al., 2022; Tablot et al., 2019; Ciydem et al., 2023). However, willingness to seek treatment has

yielded weak results. Most mental health stigma interventions have proven to be effective among White adults and children but have mixed results among African Americans.

Anti- Stigma Interventions targeting African Americans

Anti-stigma interventions specifically targeting African Americans are limited and have yielded mixed results. For instance, in a systematic review, only six out of 120 articles were found to have African Americans or Blacks as the majority sample, focused on at least one stigma reduction intervention among the population, and reported outcomes of the intervention (Rivera et al., 2021). In the systematic review, the six studies addressed stigma using a twelve-minute contact intervention, a psychoeducational booklet, a 10-hour training curriculum, and a four-month participatory research study. The studies had little to no effect on reducing stigma. All the studies had small sample sizes, at most 50 participants, no control groups, and lacked robust statistical analysis. The researchers suggest that stigma interventions should be culturally informed and specific to African Americans. In addition, studies should focus on effective delivery methods and settings.

In an earlier study, Alvidrez et al. (2009) explored a psychoeducational booklet about stigma or brochures explaining general information about services impacting the perceived helpfulness of the information provided, treatment entry, treatment attendance, and perceived stigma among 42 African Americans. Twenty-two participants were randomly assigned to receive the psychoeducation booklet, and 20 were assigned to the brochure lasting 15-30 minutes. Participants had to complete a demographic survey, The Global Severity Score of the Brief Symptom Inventory (Derogatis, 1983), An adaptation of the Patient's Experience of Hospitalization Scale PEH (Carsky et al., 1992), and The Devaluation-Discrimination Scale (Link et al., 1989). The surveys were completed before the intervention, after, and at 3- month

follow up. A general linear model was used to analyze the data. Findings showed no differences in treatment outcomes between the two interventions. The study setting can explain the findings. The participants were recruited from a primary care clinic; therefore, participants may have more positive attitudes toward treatment and be more willing to seek treatment. Forty percent of participants had previous mental health treatment. In a three-month follow-up, participants who reported greater treatment needs and uncertainty showed reduced stigma from the psychoeducation booklet. The general information brochure was more effective in reducing stigma if participants had fewer treatment needs after three months of follow-up. This study has significant limitations due to the small sample size, which limited the statistical power to detect interaction effects between variables.

Although limited, educational based intervention appears to be effective in reducing stigma in African Americans. In another single-group pretest, posttest, and follow-up study, Chakawa (2023) assessed the effectiveness of the Bridge the Gap Program, a psychoeducational workshop on reducing mental health stigma in 65 Black American parents while increasing their likelihood of seeking mental health treatment for their children using the lay health worker model. Participants completed a demographic survey, subscales Parental Attitudes Toward Psychological Services Inventory (PATPSI; Turner, 2012) to measure mental health stigma and help-seeking, the Vanderbilt Assessment Scale—Parent Report ("Vanderbilt"; American Academy of Pediatrics and National Initiative for Children's Healthcare Quality, 2002) to measure mental health symptoms, and evaluation program form before and after the 2.5-hour psychoeducational workshop. The subscales for the Parental Attitudes Toward Psychological Services Inventory (PATPSI; Turner, 2012) had an acceptable reliability of .68 for the study. The data was collected five times, including a double pretest two weeks apart and a double

follow-up 1 and 3 months after the posttest from Fall of 2016 to Summer of 2017. Significance tests, linear mixed models, Cohen's d, descriptive statistics, one-way chi-square analysis, and thematic analysis were used to analyze the data. A p-value of ≤.05 was used to assess the significance of all analyses.

Results showed that the Bridge the Gap Program effectively reduced mental health sigma across three months. However, seeking therapy services yielded positive yet weak results, with no notable change. One limitation of the study is the small sample size; therefore, results cannot be generalized to larger populations. Another limitation is the possibility of attrition. Lastly, the study has no control group, so readers may not make substantial implications from the data. The research finding is consistent with current research that educational-based interventions are effective in reducing stigma (Song et al., 2020; Diouf et al., 2022). It further provides evidence that educational-based intervention can be effective in reducing stigma among African Americans. More research should explore effective interventions that increase seeking behaviors or intentions and reduce stigma, especially targeting African Americans while incorporating cultural backgrounds and specific stigma rather than general stigma if a significant impact is desired (Codjoe et al., 2021; Powell et al., 2016).

Summary

Based on research, factors and barriers such as socioeconomic status, accessibility, no insurance, cultural mistrust, provider bias, and stigma continue to African Americans not seeking psychological help (Goodcase et al., 2022; Misra et al., 2021; Planey et al., 2019; Radez et al., 2021). African Americans have highly stigmatized views towards psychological services and illness (Brown et al., 2019; Goodcase et al., 2022; Misra et al., 2021). Despite some inconsistent findings, the studies demonstrated a solid relationship between stigma and psychological services

use among African Americans across ages, ethnicities, and genders (DeFreitas et al., 2018; Saykeo et al., 2018; Turner et al., 2015; Villagrana et al., 2018). African Americans still do not seek services when systemic and structural barriers are addressed (Bulanda et al., 2014; Fitts et al., 2019; Ijadi-Maghsoodi et al., 2018). When African Americans endorsed self and public stigma, it decreased their probability of seeking treatment (Dempster et al., 2015; Lindsey et al., 2013; Fripp & Carlson, 2017). Contact-based and education-based interventions are more effective in reducing stigma (Chakawa, 2023; Kosyluk et al., 2016),however, has shown mixed results in willing to seek treatment. Pretest and posttest designs with no control group appear to be appropriate designs for measuring effectiveness of interventions when statistical power and data collection procedures are robust and carried out efficiently. Anti stigma interventions targeting African Americans are needed (Codjoe et al., 2021). This study investigated the effectiveness of the NAMI Family and Friends seminar, an anti-stigma psychoeducational seminar among African Americans.

Chapter 3: Research Method

The problem this study addressed is the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. The proposed pretest-posttest quasi-experimental study aimed to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and improve their willingness to seek treatment. Chapter 3 discusses the pretest-posttest study design, population and sample, instrumentation, operational definitions of variables, study procedures, data analysis, assumptions, limitations, delimitations, and ethical assurances.

Research Methodology and Design

This study design was a pretest-posttest quasi-experimental design. The researcher used a pretest-posttest design to explore if African Americans' stigma towards mental health reduces and improves their willingness to seek treatment after attending a modified seminar based on NAMI Family and Friends 90-minute psychoeducational seminar. A quasi-experimental design was appropriate as the study lacks randomization and a control group, measures cause-and-effect relationships, and hypothesis testing(Privitera, 2020). The pretest-posttest design helped measure outcomes or differences before and after a specific intervention or treatment. The study used a within-the-subject design since there will be no control group, and participants will be observed at two time points. In this study, quasi-experimental design and pretest and post-test helped results and outcomes remain unbiased and subjective by examining the changes in attitudes toward help-seeking and mental health and using survey results that cannot be manipulated.

A paired t-test was used to analyze the relationship between the independent variable of NAMI Friends and Family Seminar and the dependent variables of STIG-9 (Gierk et al., 2018), SSMIS-SF(Corrigan et al., 2012) and MHSAS(Hammer et al., 2018) questionnaires. A

demographic survey regarding participants' age, gender, education level, income level, and mental health status or association with a person with mental health was administered to help narrow down participants. Descriptive statistics of the demographic survey summarized the participants' basic features.

Other research designs, such as phenomenological qualitative design and correlational study, were considered but were not selected for the study. Phenomenological studies explore individuals lived experiences to gain deeper insights into how people understand those experiences (Privitera, 2020). The design was excluded because there is substantial literature on African Americans' perceptions and experiences towards mental health, and the literature lacks studies examining interventions or strategies to help reduce stigma. Phenomenological design does not align with the purpose of this study. The correlational design investigates relationships between variables and can assess causal relationships. However, this study design has excluded the purpose of the study not to determine the association between mental health stigma and help-seeking, which has already been proven by previous researchers (Brown et al., 2019; Ferrie et al., 2020; Villatoro et al., 2018) but whether the effectiveness of the intervention.

Population and Sample

The target population was African American adults. The focus on African American adults was appropriate as this population is understudied. Secondly, African American adults have higher rates of stigmatizing attitudes compared to other races (DeFreitas et al., 2018). The study focused on African Americans born in the United States ages 18 and older who have experienced mental illness, have a family or friend with a mental illness, and are unaffected by mental illness. Since the focus was on African Americans born in the U.S., this specific criterion helped exclude other subgroups of Black and African Americans, such as Africans not born in

the U.S., Caribbean Americans, Jamaican Americans, Nigerian Americans, and Kenyan Americans. The other criteria were not used for exclusion purposes but to gather more participant information. Convenience sampling was used to recruit participants. Convenience sampling is a nonprobability sampling method where participants are easy to access (Mertens,2015). Convenience sampling is cost-efficient and given the historical nature of African Americans' reluctance to participate in scientific research, it was easier to recruit from places African Americans visit. Furthermore, it was affordable and easy to use. The researcher gained permission to post a recruitment flyer (see Appendix A) across the University of Arkansas Fayetteville campus and the researcher posted the flyer via social media page which local Black organizations in Northwest Arkansas shared the post via their social media pages with contact information if interested in participating to help meet the minimum sample requirement and ensure the sample is representative of African American community.

For this study, the researcher aimed to recruit no less than 45 participants and no more than 176 based on previous stigma research sample sizes and to control dropout or refusal between pretest and posttests (Mohammad et al., 2022; Kolb et al., 2022). Assuming a small effect size and t test for matched pairs within pre-posttest design with alpha set to .05 and 95% power, a priori G power analysis suggests N= 45 to detect with 95% power a small effect if it exists. After eliminating five participants due to extreme outliners, 42 participants were included in the study. A paired test was used to analyze the data since the study is within-subject design and only uses one group. The paired test evaluated the differences in scores on STIG-9 (Gierk et al., 2018), SSMIS-SF(Corrigan et al., 2012), and MHSAS(Hammer et al., 2018) (e.g., dependent variables) before and after the NAMI Family and Friends Seminar(e.g., independent variable).

Instrumentation

For this pretest and posttest study, the principal researcher used the NAMI Family and Friends Seminar as the psychoeducational intervention, a demographic survey to gather basic information from the participants, the Stigma-9 Questionnaire (STIG-9 Gierk et al., 2018) Self-Stigma of Mental Illness Short Form (SSMIS-SF; Corrigan et al., 2012), and Mental Health Seeking Attitude Scale (MHSAS; Hammer et al., 2018) which measured public stigma, self-stigma, and help-seeking.

NAMI Family and Friends Seminar. NAMI Family and Friends seminar is 90 minute or four-hour seminar lead by individuals who have experiences with family members of friends with mental illness. The seminar was held after participants completed the questionnaires. The seminar covers five topics: diagnoses, treatment and recovery, effective communication strategies, self-care, crisis preparation strategies, and community resources. The diagnosis section provides mental health facts and information on several types of mental health disorders. The treatment and recovery section focuses on current psychotherapies, communication-based interventions, and medications used to treat various mental health conditions. The communication strategies focus on healthy communication skills. The self-care sections provide tips on self-care and coping strategies. The crisis preparation strategies provide tips on how to create safety and relapse plans for family or friends with mental health conditions. Lastly, community resources discuss the list of NAMI resources. NAMI provides a supplemental eBook for the NAMI Family and Friends seminar that covers the five components. The researcher used the eBook to create a PowerPoint for the seminar and included information directly related to African American culture, mental health stigma, and mental health statistics. Currently, no published research can be found on the effectiveness of the seminar. NAMI provide some

testimonials of individuals who participant in the seminar which indicates some impact on reducing stigma about mental illness. Approval to use was granted (See Appendix B).

Demographics Survey. The demographic survey was developed by the researcher. The survey included questions about participants' age, gender, marital status, education level, income level, and mental health status or association with a person with mental health (See Appendix C). The demographic survey was administered 10 minutes before and after the NAMI seminar. Age was categorized by 18-24 years old, 25-34 years old, 32-44 years old, 45-54 years old, 55 -64 years old, 66-74 years old and 78 and older. Gender was categorized as man or woman, transgender man, transgender woman, non-binary, gender not listed or prefer not to answer. Marital status was categorized single, married, divorced, separated, cohabiting with a significant other or in a domestic partnership, and preferred not to answer. Educational attainment was categorized by did not attend school, some high school, high school graduate, some college but no agree, associate degree ,bachelor's degree, and graduate or professional degree. Income level was categorized by 0-$24,999, 25,000- 49,999,50,000-$74,999, 75,000-$99,999, and over 100,000. Mental health status was categorized by individuals having a mental illness, knowing a family member with a mental illness, or having no experience with mental illness.

Stigma-9 Questionnaire (STIG-9). The Stigma-9 Questionnaire (STIG-9) developed by Gierk et al. (2018) was administered 10 minutes before and after the intervention. STIG-9 is based on modeling theory by Link and Phelan (2001). The STIG-9 consists of nine items measuring public stigma's cognitive, behavioral, and affective features (Giek et al., 2018). Individuals must rate questions (e.g., I think most people avoid contact with someone who has been treated for a mental illness) on a four-point Likert scale (0 disagree to 3 agree). Higher scores indicate more substantial expectations of negative societal beliefs, feelings, and behaviors

toward individuals with mental illness. For item and scale, corrected item-scale correlations were high between 0.57 and 0.69. Item means were between 0.87 and 1.69 and standard deviations were equivalent among the items. Standardized item difficulty ranged from 0.29 to 0.56 and most scores were between 0.40 and 0.60, indicating an acceptable range of item difficulty. STIG-9 had high internal consistency with $\alpha = .88$. Under the factor structure the average variance extracted was 53% and the composite reliability was 0.91. The global model fit parameters Tucker-Lewis Index was 0.96 and Composite Fit Index 0.97 while the Root Mean Square Error of Approximation acceptable was at 0.10. Internal consistency, convergent and discriminant validity was supported in the study with 1042 German patients at a= .91 and 95 and a=.86 with Irian patients (Gierk et al., 2018; Gohari et al., 2023). Approval to use measure was granted (see Appendix D).

Self-Stigma of Mental Illness Short Form (SSMIS-SF). The SSMIS-SF-was developed by Corrigan et al. (2012). The SSMIS was administered 10 minutes before and after the intervention. SSMIS consists of twenty items rated on a nine-point Likert scale ranging from 1 strongly disagree to 9 strongly agree that measure four components of self-stigma: awareness, agreement, application, and self-efficacy. Each subscale consists of five questions. Examples of items are "I think the public believes… most persons with mental illness are unpredictable (e.g., awareness), I think most persons with mental illness are to blame for their problems(e.g., agreement), because I have a mental illness I will not recover or get better (e.g., application), and I currently respect myself less because I am dangerous" (e.g., self-application). Scores are calculated by summing the five items for each subscale: scores range between 5 and 45 between the scales. Higher scores indicate high self-stigma. Across three studies, internal consistency ranged from fair to good reliability (Corrigan et al., 2012). In one study, Corrigan et al. (2006)

reported alphas ranging from 0.72 to 0.89 and the second study by Rüsch et al. (2006) reported alphas ranging from 0.82 to 0.92. The last study, Corrigan et al. (2006) found the alphas ranged from 0.65 to 0.87. In cross scale correlations between the subscales, correlations are high for apply/harm 0.78, 0.78, 0.76 for the three studies compared to relationships between aware and harm at 0.27 for the three studies. The SSMIS-SF has high reliability in various populations (Bär et al., 2021; Li et al., 2022). Approval of use was granted (see Appendix E).

The Mental Health Seeking Attitude Scale. The Mental Health Seeking Attitude Scale (MHSAS) was developed by Hammer et al., (2018). The MHSAS was administered 10 minutes before and after the intervention. The MHSAS (Hammer et al., 2018) is based on the theory of planned behavior. The MHSAS(Hammer et al., 2018) consists of nine items measuring favorable vs unfavorable attitudes towards seeking help from a mental health professional if they found themselves dealing with a mental health concern(Hammer et al., 2018). The items are rated on a 7-point semantic differential scale with differing adjectives at either end. For example, useful to useless. All the nine items are summed up, and a higher score indicates a more positive attitude toward seeking help. The internal consistency for MHSAS (Hammer et al., 2018) is .92. Test-retest reliability scores had acceptable ranges with bivariate correlation between two time points was .76 and the intraclass correlation coefficient was .86. The unidimensional solution demonstrated acceptable ranges including RMSEA .065; 90% CI [.042, .087], CFI .959, TLI .945, SRMR .032 Items showed high correlation with help-seeking attitudes factors ranging from .61 to .79. The MHSAS (Hammer et al., 2018) scores FD (.96) and H index (.93) are above recommended levels. The scale has high validity and reliability, ranging from .82 to .93 across numerous studies and populations. Approval was granted to use (see Appendix F).

Operational Definitions of Variables

This section will focus on how the variables will be measured and operationalized. The independent variable for the study is the NAMI Family and Friends Seminar. The seminar covers five topics: diagnoses, treatment and recovery, effective communication strategies, self-care, crisis preparation strategies, and community resource. The dependent variables are public stigma which is operationalized by the Stigma-9 Questionnaire (STIG-9; Gierk et al., 2018), self-stigma which is operationalized by the Self-Stigma of Mental Illness Short Form (SSMIS-SF; Corrigan et al., 2012), and help-seeking attitudes which is operationalized by The Mental Health Seeking Attitude Scale (MHSAS; Hammer et al., 2018).

Public Stigma

Public stigma is defined by society's unfavorable and stereotypical views of psychological illness and services (Corrigan &Watson, 2002). Public stigma was operationalized by the Stigma-9 Questionnaire (STIG-9; Gierk et al., 2018). STIG-9 (Gierk et al., 2018) consists of nine questions, and participants must rate questions on a four-point Likert scale (0 disagree to 3 agree). The highest score possible is 27. All items are totaled to determine the mean score. Higher scores indicate negative societal beliefs, feelings, and behaviors toward individuals with mental illness (Gierk et al., 2018). The scale is ordinal. STIG-9(Gierk et al., 2018) had high internal consistency with $\alpha = .88$. Under the factor structure the average variance extracted was 53% and the composite reliability was 0.91. The global model fit parameters Tucker-Lewis Index was 0.96 and Composite Fit Index 0.97.

Self-Stigma

Self-stigma is the pessimistic belief that individuals with psychological issues internalize (Corrigan &Watson, 2002). Its development involves four stages: agreement, self-application,

self-esteem, and self-efficacy. Self-stigma will be operationalized by the Self-Stigma of Mental Illness Short Form (SSMIS-SF; Corrigan et al., 2012). SSMIS-SF(Corrigan et al., 2012) has twenty items rated on a nine-point Likert scale ranging from 1 strongly disagree to 9 strongly agree. The SSMIS-SF (Corrigan et al., 2012) consists of four subscales that measure agreement, self-application, self-esteem, and self-efficacy. Each subscale consists of five questions. Scale scores are determined by summing only the five items for each subscale, generating a range of scores between 5 and 45 for each of the four subscales. The higher score indicates self-stigma. The scale is acceptable with high validity and reliability, across numerous studies and populations. In three samples, reliability ranges from 0.72 to 0.89, 0.82 to 0.92, and 0.65 to 0.87. The SSMIS measures self-stigma on an ordinal scale.

Help-Seeking

Help-seeking seeks professional help to resolve emotional, behavioral, or health issues (Neighbors,1985; Unrau et al., 2005). Help-seeking will be operationalized by The Mental Health Seeking Attitude Scale (MHSAS; Hammer et al., 2018). The MHSAS(Hammer et al., 2018) consists of nine items rated on a 7-point differential scale measuring individuals' attitudes toward seeking professional help when dealing with mental health concerns(Hammer et al., 2018). Participants must rate if they believe seeking professional help is useful, important, unhealthy, ineffective, good, healing, disempowering, satisfying, and desirable. Before calculating the measure score, items must be reverse coded. The mean score is calculated by summing all the items' scores and dividing them by the total number of items answered. The mean score ranges from 1 to 7. A score of 1 indicates unfavorable attitudes, a score of 4 indicates a neutral attitude, and a score of 7 indicates favorable attitudes toward seeking help. The internal consistency for MHSAS(Hammer et al., 2018) is .92. Test-retest reliability scores had acceptable

ranges of .76 and the intraclass correlation coefficient was .86. Items showed high correlation with help-seeking attitudes factors ranging from .61 to .79. The MHSAS(Hammer et al., 2018) measures help-seeking on an ordinal scale.

Study Procedures

The National University Institutional Review Board approved the study. The researcher recruited and conducted the study from November 2024-March 2025. The principal researcher used a modified NAMI Family and Friends Seminar for the study (NAMI, n.d; Robinson, 2017) The NAMI website recommends finding local NAMI affiliates to request permission and determine if they offer the seminar. The seminar was not offered locally but the researcher reached out to the local NAMI liaison who helped the researcher find the seminar materials, decide location, and with recruitment strategies. The researcher used information from the NAMI Family and Friends supplemental eBook to create a PowerPoint for the seminar. For recruitment, the researcher posted a flyer via Facebook with a QR code that directs participants to a contact form asking for their first name, email address, and if they meet following criteria: you are 18 or older, you identify as African American, you were born in the United States, and you live in Northwest Arkansas (Washington or Benton County). In addition, the researcher reached out to local Black organizations groups in Northwest Arkansas. who shared researcher post on their social media pages. The NAMI liaison shared the researcher flyers on their social media pages. The researcher posted the flyer across University of Arkansas Fayetteville campus.

Due to lack of participants signing up, the researcher had to modify the study to include offering the seminar over zoom to help with recruitment which was approved by National University IRB. The participants were emailed instructions including the study's date, time, and location. If the participant chose to attend via zoom, the STIG-9 (Gierk et al., 2018), SSMIS-SF

(Corrigan et al., 2012), and MHSAS (Hammer et al., 2018) were emailed to them and they were instructed to complete it 10 minutes before joining the zoom (see Appendix F). Participants who had questions or concerns about the study were able to contact the researcher by using information on the flyer.

The principal researcher conducted the study in person at a Blue Cross Blue Shield community event center in Northwest Arkansas. The goal was to recruit at least 45 and, at most, 176 participants. Forty-seven participated in the study with seven attending in person and forty attended online. In person or via zoom, the researcher reviewed the informed consent which described the purpose of the study, duration of the study, and informed participants they can stop their participants at any time during the study and have no obligation to complete the study. The researchers explained that after participants completed the surveys and attended the NAMI Family Friends Seminar, they could enter their name or email address in a drawing for a chance to receive a $10 Walmart gift card in person before they leave the study site or emailed to them after the zoom seminar. After reviewing the consent, when on zoom the researcher placed links to the following questionnaires demographics questions, 10-items (see Appendix B), STIG-9 (Gierk et al., 2018) 9 items, SSMIS-SF(Corrigan et al., 2012) 20 items, and MHSAS(Hammer et al., 2018) 9-items in the chat and instructed participants to complete. The total number of questions was 48 and took 10-15 minutes to complete. For the participants who chose to attend in person, they too worked on the questionnaires 10 minutes before researchers started the NAMI seminar and completed 10 after the intervention. The total number of questions between pretest and posttest time is 96. The researchers allowed the participants to ask questions or comments before, during, and after the intervention.

Data Analysis

Once the data was collected, the researcher transcribed the surveys answers from the online copies to physical copies then individually calculated the STIG-9(Gierk et al., 2018) SSMIS-SF(Corrigan et al., 2012) and MHSAS(Hammer et al., 2018) scores. The researcher eliminated any questionnaires that were not fully completed or missing data. The researcher assigned an ID number to each participant demographic survey answers and scores on STIG-9 (Gierk et al., 2018) SSMIS-SF(Corrigan et al., 2012) and MHSAS(Hammer et al., 2018) before and after the NAMI intervention. The scores were documented in the statistical package for the social sciences software (SPSS, version 29.0). A descriptive analysis was conducted on demographic information to determine the means and averages of data. In SPSS, a participant column, pretests, and posttest column were created for the mean scores from the three questionaries. The paired t-test was used to test the hypothesis and determine the mean scores from STIG-9(Gierk et al., 2018) SSMIS-SF(Corrigan et al., 2012) and MHSAS (Hammer et al., 2018) changed from the pretest to the posttest. The paired t-test is appropriate for this study since the two samples are the same subjects(Privera, 2020). To test hypothesis 1, a paired test was used to examine the pretest and post test scores from STIG-9(Gierk et al., 2018). To test hypothesis 2, another paired t-test was conducted using the pretest and post test scores from SSMIS-SF (Corrigan et al., 2012) then Bonferroni correction calculated to adjust significance levels. To test hypothesis 3, the paired t-test was used to analyze the pretest and post test scores from MHSAS(Hammer et al., 2018). A Mann-Whitney analysis was conducted to examine any differences in mean scores between in person and zoom. The Mann-Whitney was appropriate for this study due to the small sample size of the two groups, and the data was not normally distributed. For hypothesis 1, a Mann-Whitney analysis was used to examine differences between in person

group and zoom group pretest and post test scores from STIG-9(Gierk et al., 2018). For hypothesis 2, another Mann-Whitney analysis was used to examine differences between in person group and zoom group using the pretest and post test scores from SSMIS-SF (Corrigan et al., 2012) . For hypothesis 3, a Mann-Whitney analysis was used to examine differences between in person group and zoom group using the pretest and post test scores from MHSAS(Hammer et al., 2018).

Assumptions

The primary assumption is that stigma will be reduced from pretest-posttest due to a 90-minute psychoeducational intervention. Previous studies using pretest and posttest design with single exposure have shown positive results in reducing stigma (Alvidrez et al., 2009;Tablot et al., 2019; Wei et al., 2020). Another assumption is that participants will be willing to seek therapy after the intervention. Studies have yielded mixed results on anti-stigma intervention impact on help seeking, the researchers assuming since the intervention covering a range of topics such as diagnoses, treatment and recovery, effective communication strategies, self-care, crisis preparation strategies, and community resources that will be culturally relevant to the population it would improve attitudes towards help seeking. Before researchers run the paired t-test, several assumptions must be met. First, each observation is independent from one another. The assumption can be checked by using a random sampling method. The researcher used convenience sample method to recruit participants; however, the sample population was recruited from various places and once used a random generator wheel to randomly assign the participants to different presentation dates. Another assumption is that the differences between the pairs are normally distributed. To check for this assumption, the researcher reviewed histogram of paired differences and check to see if it makes a bell shape (Kim & Park, 2019).

The third assumption is that there are no extreme outliners. To check this assumption, the researcher used q-q plots of the paired differences to see if there are any outliers which were removed from the data.

Limitations

One major limitation of the study is that there is no control group. It may be difficult to confirm if a change in results is due to intervention or outside factors. The second limitation is the sampling method. Since the study uses convenience sampling, it has an elevated risk of observer bias, and the sample may not represent the general population of African Americans. Another limitation is the small sample size. Due to the small sample size, the result may not be generalized to a larger or general population (Priverta, 2020). Another limitation is the pretest and post-test design. Pretest and posttest design can threaten the internal validity including selection differences, history, and regression to means(Priverta, 2020). One limitation is that the two modes of delivery were not accounted for in the original research study. The two modes of delivery in person and zoom are a potential confounding variable. Confounding variables can be associated with observed changes in the data (Priverta, 2020). Although no statistical differences between the two modes of delivery were found, this may be due to the sample size. The data between the two groups were not normally distributed as the in-person group consisted of seven participants compared to thirty-five zoom participants. Another limitation to pretest and posttest design is attrition if the participants leave before completing the post questionnaires. Missing data on the measurements can impact results. Maturation affects psychological or biological factors such as stress may be present from between pretest and posttest which can impact results. Another limitation is instrumentation. The use of self-reported surveys can be a limitation as the

risk of participants responding in a socially desirable way and which can impact results. The questionnaires use Likert scale which has some limitations such as
participants may avoid answering in extremes manners (Theofanidis& Fountouki,2018). The measures including NAMI Family and Friends Seminar, STIG-9(Gierk et al., 2018) SSMIS-SF(Corrigan et al., 2012) and MHSAS(Hammer et al., 2018) have not been tested or validated exclusively on African Americans. There may be limitations in the statistical testing used such as carryover effects. Another limitation is the use of single researchers which can lead to researcher bias.

Delimitations

The study is delimited to the location of the study. The participants were recruited from Northwest Arkansas; therefore, the results may only be generalized to this population and no other Africans Americans in different part of Arkansas and other states. Another delimitation is that the population of focus is African Americans men and women 18 years old and older. In addition, the study is delimitated to exploring mental health stigma and help seeking rather than other factors that may contribute to African Americans not seeking therapy. Another delimitation is the socioeconomic status, given the location of the study, most participants reported higher income. The study is delimited to African Americans born in the United States and does not include other Black diaspora such as Caribbean, Nigerians, Haitians, African, and many more. Theofanidis and Fountouki (2018) suggest that delimiting studies to one ethnicity will help avoid uneven distribution in participants parameters when having smaller population sizes.

Ethical Assurances

The study was approved by the National University Institutional Review Board (IRB) before collecting data. The researchers adhere to rules and regulations set by IRB. Informed

consents were reviewed with participants for the study to allow participants to ask questions if needed. The informed consent included their rights to privacy, protection from harm, and minimum risk. The research provided a list of resources and support systems they can use if they experience any discomfort or want to pursue mental health treatment after the study. There was minimum risk to physical, social, economic factors for the study. The researchers explained to participants they can be given the results of the study if they wish by emailing the researcher.

Informed Consent. All participants were given written informed consent. Before the intervention, the researcher reviewed the informed consent with participants(see Appendix H) The researcher informed participants that participation is voluntary and that they can stop participating during the study. Participants were informed of the purpose of the study, duration of the study, the risks of the study, potential harm, and risks of the study(National Institute of Health, NIH, 2016). Participants were given National University IRB contact information and researcher contact information if they have any questions regarding the study. The researcher explained to participants the study's data will be stored to ensure confidentiality and privacy.

Confidentiality and Privacy. To protect participants' privacy, the participants' names were not used in the study but assigned a number (e.g., P1) (Ethicist et al.,2015) when computing the data on a computer and when the participants filled out the measures. Physical copies of information like informed consent and contact information were limited to the researcher's access and stored in a filing cabinet in the office of the secure building at Arisa Health. The surveys and data will be shredded at the exact location when allowed by law to be destroyed. The researcher is the only one who has the key and access to the filing cabinet. To add another level of protection, the researchers used password-protected laptop with Endpoint encryption to protect data stored in SPSS.

Summary

The problem this study addressed the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. This pretest-posttest quasi-experimental study aimed to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and improve their willingness to seek treatment. Convenience sampling was used to recruit African Americans participants. The participants completed the informed consent, demographic survey, STIG-9(Gierk et al., 2018) SSMIS-SF(Corrigan et al., 2012) and MHSAS(Hammer et al., 2018) ten minutes before the NAMI Family and Friends Seminar, then ten minutes after the seminar, complete STIG-9(Gierk et al., 2018) SSMIS-SF(Corrigan et al., 2012) and MHSAS(Hammer et al., 2018). SPSS was used to run a paired t-test analysis to determine if the mean scores from STIG-9(Gierk et al., 2018) SSMIS-SF(Corrigan et al.,2012) and MHSAS(Hammer et al., 2018) changed from the pretest to the posttest. One major limitation of the study is that there is no placebo control group, and the study is delimited to the location of the study, age group, and African Americans. The study was approved by the National University Institutional Review Board (IRB) before collecting data and following all regulations and guidelines. Informed consent detailing their rights to privacy, protection from harm, and minimum risk were reviewed and signed by participants. To protect participants' privacy and confidentiality the participants' names were not used in the study but assigned a number when computing raw data to computer and when participants fill out the measures. Physical copies of information like informed consent and contact information is limited to the researcher's access and stored in a filing cabinet in the office of the secure building.

Chapter 4: Findings

The problem this study addressed the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. Approximately, 37% of African Americans experience mental illness; however, less than 9% receive mental health treatment (Alcarez et al., 2019; Reinert et al., 2021). Stigma is often reported a significant barrier to African Americans not seeking mental health treatment despite rising mental health (Connell et al., 2019; Saykeo et al., 2018). Previous researchers have attempted to address stigma among African Americans via anti-stigma interventions, such as education-based programs aimed to educate and improve understanding and information about psychological health, which appears to be effective in decreasing stigma (Chakawa, 2023; Diouf et al.,2022).The purpose of this pretest-posttest study was to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and improve their attitudes towards seeking treatment.

The researcher chose pretest and posttest quasi experimental using paired t-test. Data was analyzed to explore whether African Americans' stigma towards mental health reduces and improves their attitudes towards seeking treatment after attending a NAMI Family and Friends 90-minute psychoeducational seminar. From November 2024 -March 2025, data was obtained from anonymous surveys completed by 47 participants with seven participants who attended in person and 40 who attended via zoom. Five participants were eliminated due to extreme outline leading to 42 participants with seven participants in person and thirty-five attending via zoom. The purpose of using surveys was to gather data on African Americans attitudes toward mental health stigma and mental health treatment and if the intervention helped change or improve their attitudes. Chapter 4 discusses the assumptions of paired t-test, the reliability and validity of the

study, the results from the statistical analysis data for the research questions and hypothesis, and the evaluation of the findings.

Assumptions of Paired T-test

The paired t-test is appropriate for this study since the two samples are the same subjects(Privera, 2020).There are four assumptions that must be considered for a paired t-test. First, each observation is independent from one another. The assumption can be checked by using a random sampling method. The researcher used convenience sampling to recruit, however, once the participants signed up, the researcher used a random generator wheel to randomly assign the participants to different presentation dates. The second assumption is that the differences between the pairs are normally distributed. To test for normality the differences between pretest and posttest scores were calculated for the STIG-9 (Gierk et al., 2018), SSMIS-SF(Corrigan et al., 2012), and MHSAS(Hammer et al., 2018). then a Shapiro-Wilk was performed which departed from absolute normality on Stigma-9 (W = .916, p = .002) see table 1, SSMIS -SF (W = .948, p=.036, W=.904, p=<.001, W=.898,p=<.001, W=.913,p=.002) see table 2, 3, 4, and 5, and MHSAS (W=.741, p=<.001) see in table 6. The critical values of the Shapiro-Wilk test were examined. A df (47) of the Shapiro Wilk Test is W=.946. These values indicate that acceptable amounts of normality were present, and parametric tests are appropriate (White, personal communication, April 2025). To further examine, normality the skewness and kurtosis values were reviewed. Skew and kurtosis ratio values for STIG-9 (Gierk et al., 2018), (-.083 for skew, and -.429 for kurtosis) see table 7, SSMIS-SF (Corrigan et al., 2012) (533-.1018 for skew and .711-2.821 for Kurtosis) see table 9, and MHSAS (Hammer et al., 2018) (.559- .-459 for skew and .595 and -.641 for Kurtosis) see table 6 were within the appropriate ranges reflecting a normal distribution of the data. The third assumption is that there are no extreme outliners. To

check this assumption, the researcher observed the q-q plots of the measures represented in figures 1 , 2,3,4,5, 6 and 7. Five outliers were removed from the data resulting in 42 participants.

Table 1

Shapiro Wilk Test Statistics Values differences between pretest and posttest Stigma-9

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
difference	.186	47	<.001	.916	47	.002

a. Lilliefors Significance Correction

Table 2

Shapiro Wilk Test Statistics Values for differences between pretest and posttest SSMIS-SF Aware subscale

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
difference	.094	47	.200*	.948	47	.036

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Table 3

Shapiro Wilk Test Statistics Values for differences between pretest and posttest SSMIS-SF Agree subscale

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
agreedifference	.135	47	.032	.904	47	<.001

a. Lilliefors Significance Correction

Table 4

Shapiro Wilk Test Statistics Values for for differences between pretest and posttest SSMIS-SF apply subscale

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
applydifference	.118	47	.104	.898	47	<.001

a. Lilliefors Significance Correction

Table 5

Shapiro Wilk Test Statistics Values for differences between pretest and posttest SSMIS-SF hurt subscale

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
hurtdifference	.157	47	.005	.913	47	.002

a. Lilliefors Significance Correction

Table 6

Shapiro Wilk Test Statistics Values for differences between pretest and posttest of MHSAS.

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
difference	.252	47	<.001	.741	47	<.001

a. Lilliefors Significance Correction

Table 7

Skewness and Kurtosis Statistic Values differences between pretest and posttest of Stigma-9.

Descriptives

			Statistic	Std. Error
difference	Mean		1.4043	.19154
	95% Confidence Interval for Mean	Lower Bound	1.0187	
		Upper Bound	1.7898	
	5% Trimmed Mean		1.3936	
	Median		2.0000	
	Variance		1.724	
	Std. Deviation		1.31314	
	Minimum		-2.00	
	Maximum		4.00	
	Range		6.00	
	Interquartile Range		2.00	
	Skewness		-.083	.347
	Kurtosis		-.429	.681

Table 8

Skewness and Kurtosis Statistic Values differences between pretest and posttest of SSMIS-SF subscales of aware, agree, apply, and hurt subs

Descriptives

			Statistic	Std. Error
difference	Mean		4.9362	.48607
	95% Confidence Interval for Mean	Lower Bound	3.9578	
		Upper Bound	5.9146	
	5% Trimmed Mean		4.7553	
	Median		5.0000	
	Variance		11.105	
	Std. Deviation		3.33235	
	Minimum		.00	
	Maximum		15.00	
	Range		15.00	
	Interquartile Range		5.00	
	Skewness		.533	.347
	Kurtosis		.711	.681
agreedifference	Mean		4.5532	.56396
	95% Confidence Interval for Mean	Lower Bound	3.4180	
		Upper Bound	5.6884	
	5% Trimmed Mean		4.3144	
	Median		4.0000	
	Variance		14.948	
	Std. Deviation		3.86629	
	Minimum		.00	
	Maximum		18.00	
	Range		18.00	
	Interquartile Range		7.00	
	Skewness		.924	.347
	Kurtosis		1.495	.681
applydifference	Mean		4.5319	.52226
	95% Confidence Interval for Mean	Lower Bound	3.4807	
		Upper Bound	5.5832	
	5% Trimmed Mean		4.2908	
	Median		5.0000	
	Variance		12.820	
	Std. Deviation		3.58045	
	Minimum		.00	
	Maximum		18.00	
	Range		18.00	
	Interquartile Range		5.00	
	Skewness		1.018	.347
	Kurtosis		2.821	.681
hurtdifference	Mean		4.6596	.52705
	95% Confidence Interval for Mean	Lower Bound	3.5987	
		Upper Bound	5.7205	
	5% Trimmed Mean		4.5745	
	Median		5.0000	
	Variance		13.056	
	Std. Deviation		3.61324	
	Minimum		.00	
	Maximum		11.00	
	Range		11.00	
	Interquartile Range		8.00	
	Skewness		.086	.347
	Kurtosis		-1.204	.681

Table 9

Skewness and Kurtosis Statistic Values pretest and posttest of MHSAS.

Descriptives

			Statistic	Std. Error
MHSASpre	Mean		4.9189	.16594
	95% Confidence Interval for Mean	Lower Bound	4.5849	
		Upper Bound	5.2530	
	5% Trimmed Mean		4.9072	
	Median		4.6600	
	Variance		1.294	
	Std. Deviation		1.13761	
	Minimum		3.00	
	Maximum		7.00	
	Range		4.00	
	Interquartile Range		1.55	
	Skewness		.559	.347
	Kurtosis		-.459	.681
MHSASpost	Mean		5.1570	.15628
	95% Confidence Interval for Mean	Lower Bound	4.8424	
		Upper Bound	5.4716	
	5% Trimmed Mean		5.1482	
	Median		4.8800	
	Variance		1.148	
	Std. Deviation		1.07142	
	Minimum		3.33	
	Maximum		7.00	
	Range		3.67	
	Interquartile Range		1.33	
	Skewness		.595	.347
	Kurtosis		-.641	.681

Figure 1

Q – Q plot results from differences between pretest and posttest of Stigma-9

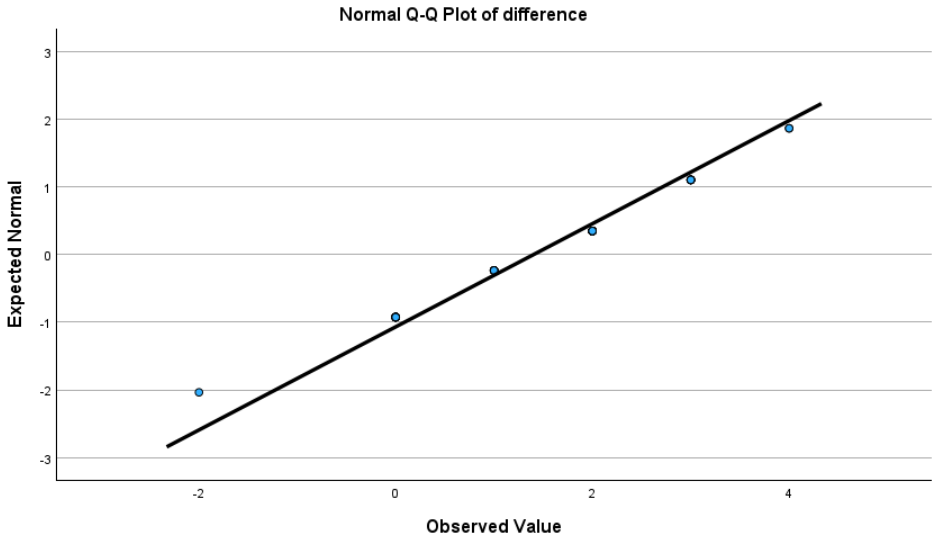


Figure 2

Q -Q plot results from differences between pretest and posttest of SSMIS-SF aware subscale

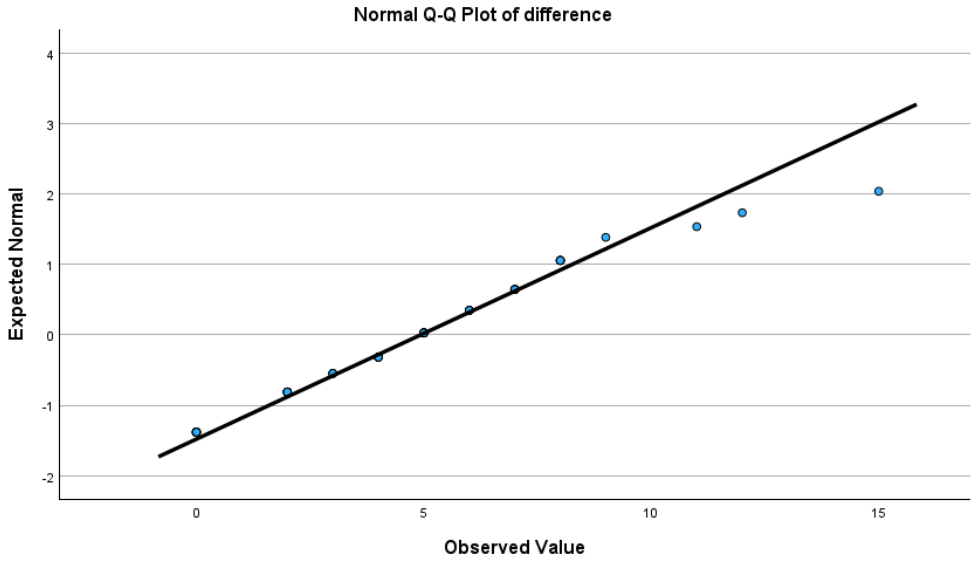


Figure 3

Q-Q plot from differences between pretest and posttest score of SSMIS-SF agree subscale

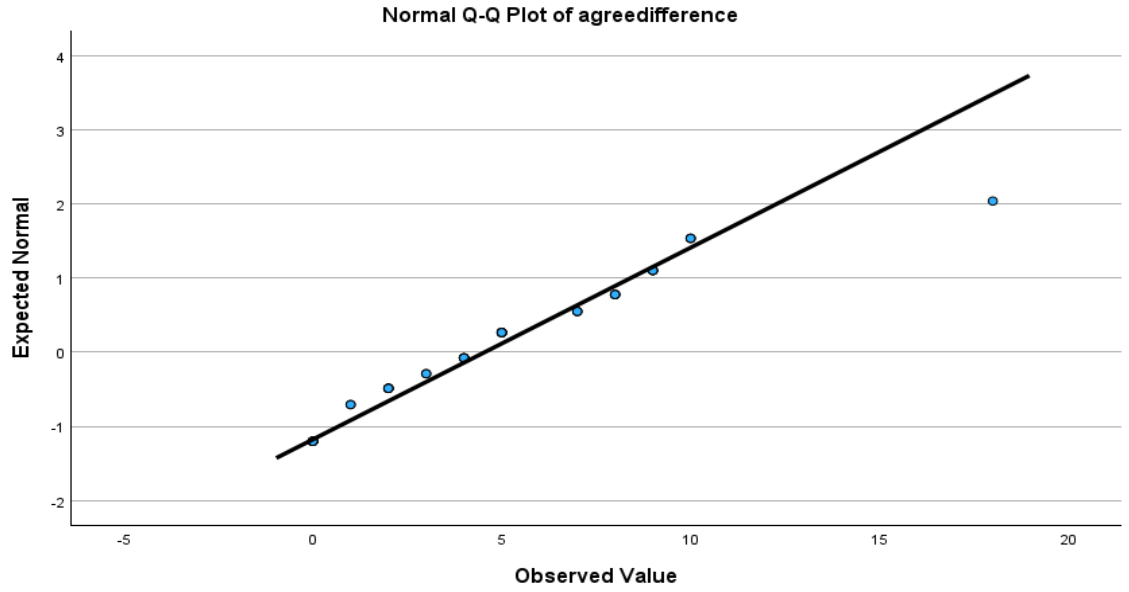


Figure 4

Q-Q plot from differences between pretest and posttest score of SSMIS-SF apply subscale

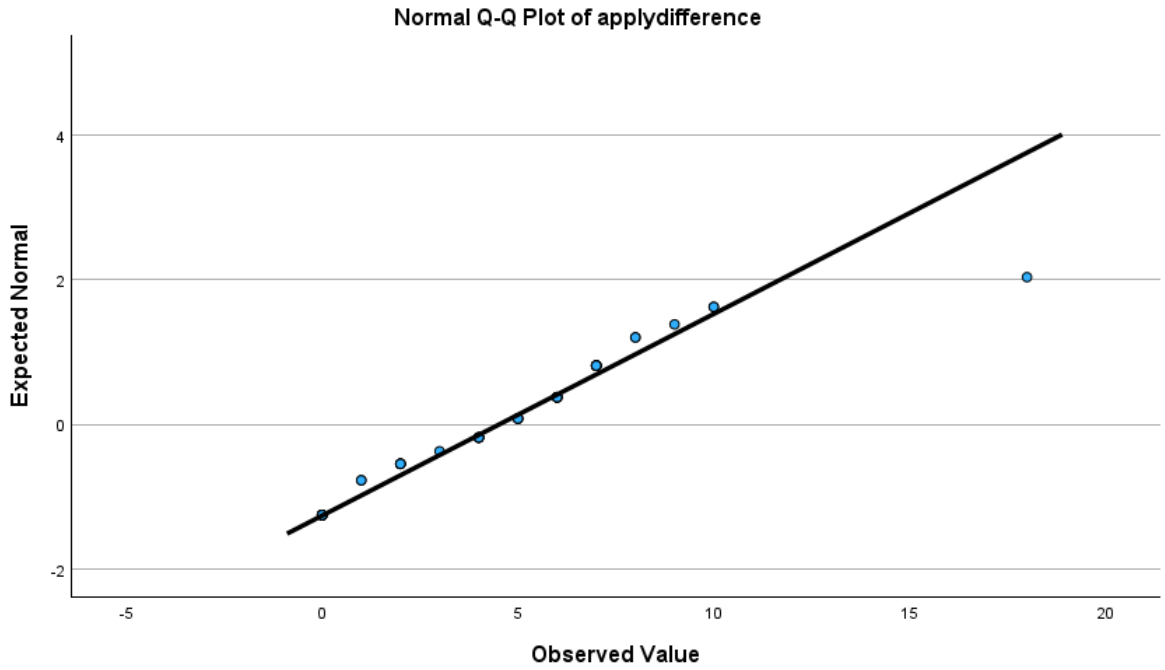


Figure 5

Q-Q plot from differences between pretest and posttest score of SSMIS-SF hurt subscale

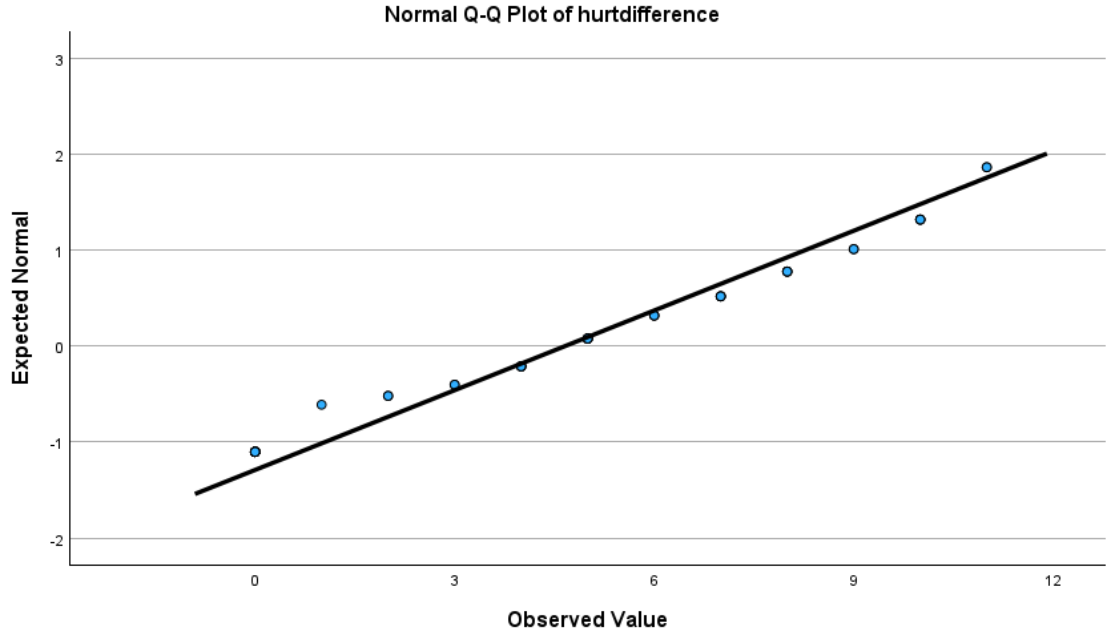


Figure 6

Q- Q plots of MHSAS pretest scores

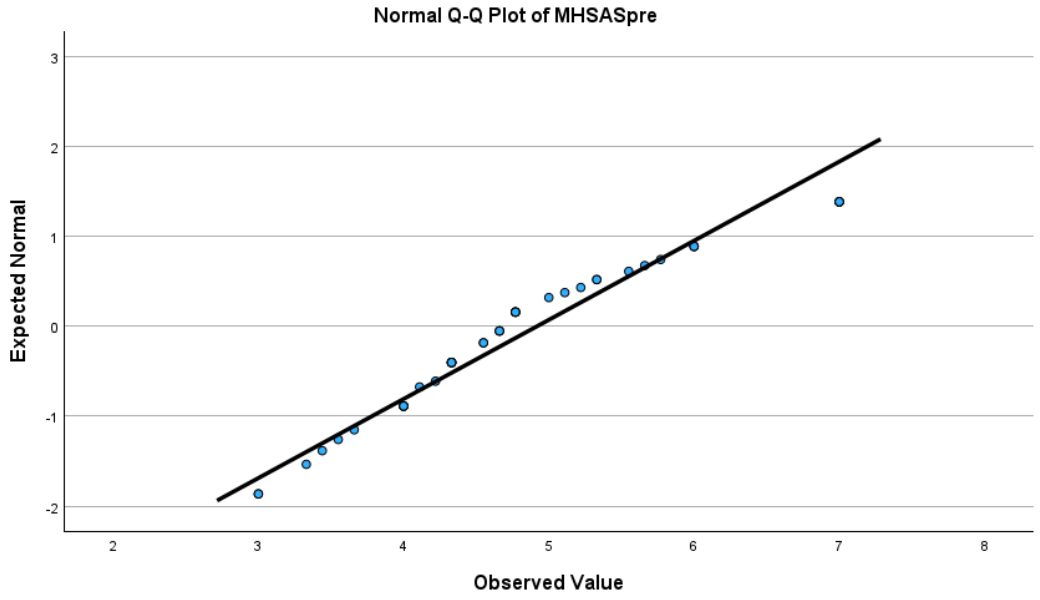
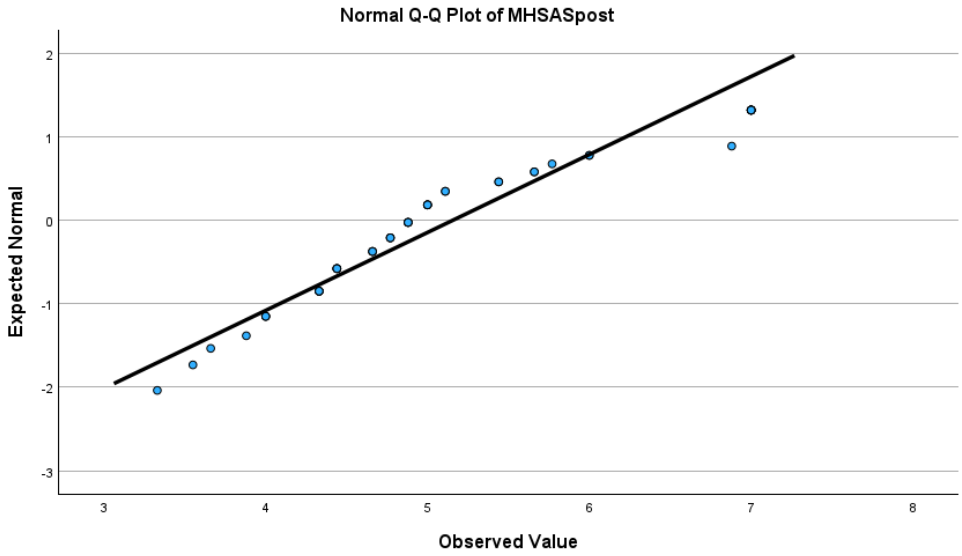


Figure 7

Q-Q plots of MHSAS posttest scores



Reliability and Validity

The surveys used to collect the data consisted of recognized instruments, the Stigma-9 Questionnaire(STIG-9;Gierk et al., 2018) to test public sigma, Self- Stigma of Mental Illness Short Form to measure self-stigma (SSMIS-SF; Corrigan et al., 2012), Mental Health Seeking Attitude Scale(MHSAS; Hammer et al., 2018) to test help seeking attitudes towards mental health treatment. The Stigma-9 Questionnaire (Gierk et al., 2018) has a high internal consistency with $\alpha = .88$. Furthermore, positive validity was indicated with Cronbach alphas scores ranging from .91 to 95 with a group of German adults and .86 with Irian adults (Gierk et al., 2018; Gohari et al., 2023). For this study, the population showed high reliability with Cronbach alpha of .995. The Self Stigma of Mental Illness Short Form (Corrigan et al.,2012) has fair to good reliability across three studies with alphas ranging from 0.72 to 0.89 in one study (Corrigan et al. (2006), 0.82 to 0.92. in the second study (Rüsch et al.,2006), and 0.65 to 0.87 in a third study (Corrigan et al.,2006). The Cronbach alpha scores ranged from .967 to .976 with the African

Americans of this study showing high reliability. Mental Health Seeking Attitude Scale (Hammer et al., 2018) indicates positive internal consistency of .92. Test-retest reliability scores have acceptable ranges with bivariate correlation between two times was .76 and the intraclass correlation coefficient was .86.(Hammer et al., 2018). In addition, items showed high correlation with help-seeking attitudes, factors ranging from .61 to .79 .The scale has high validity and reliability, ranging from .82 to .93 across numerous studies and populations (Hammer et al., 2018). There is a potential for the reliability and validity scores of the surveys to change due to the population of this study as the surveys have not previously been tested with them. For this sample study, the Cronbach alpha was .976 indicating high reliability.

Results

Descriptive statistics were used to examine participants' demographics. A total of 42 participants in the study. The majority of the sample consisted of woman at 74.5%, men at 9%, transgender men at 8.5%, and transgender woman at 2.1% (see figure 8) The largest group in the sample (34%) were between 25–34-year-old and 35-44 years old (see figure 9). The majority (48.9%) of the participants were single as presented in figure 10. Most of the participants had some college but no degree (27.7%) see figure 11. The highest income ranged from 25,000-49,000(44.7%) and second highest income was 50,000-74,000 at 31.9% see figure 12. 61.7% of participants reported yes on whether you have ever received a mental health diagnosis, and do you have a history of experiencing mental health issues as shown in figure 13 and 14. The majority of participants(80.9%) answered yes to do you know someone experiencing mental illness? (see figure 15).

Figure 8

Simple bar graph of percentage by gender

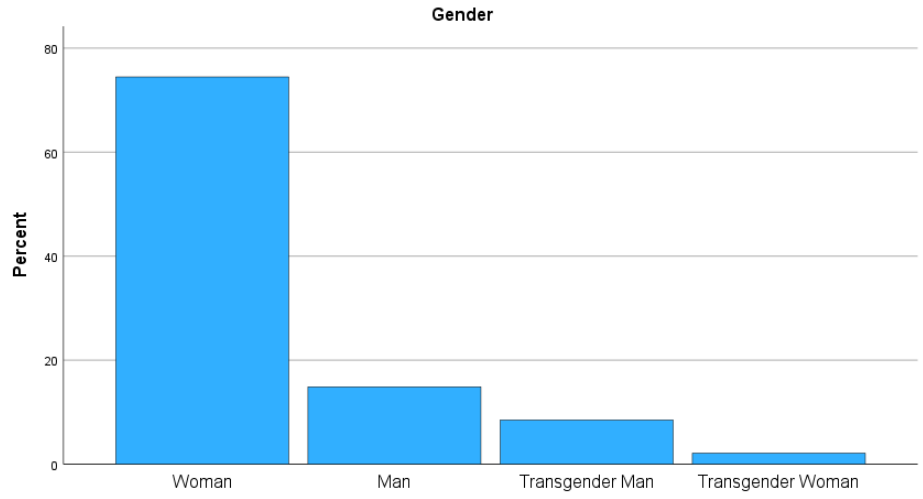


Figure 9

Simple bar graph of percentage by age

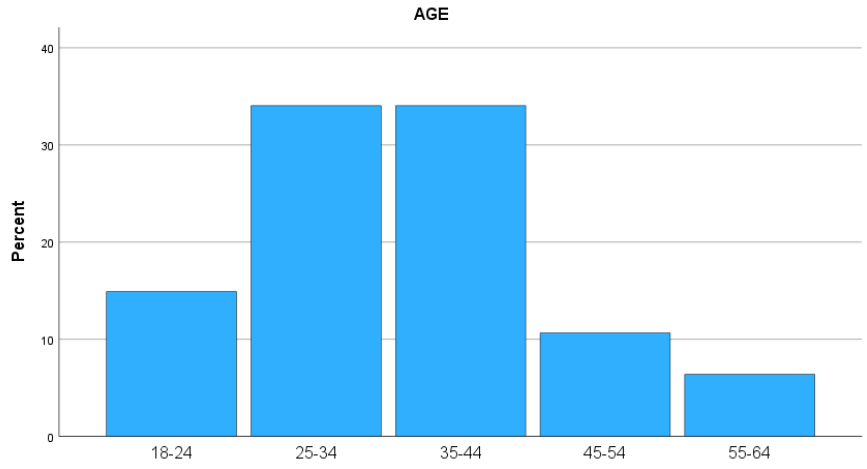


Figure 10

Simple bar graph of percentages by relationship status

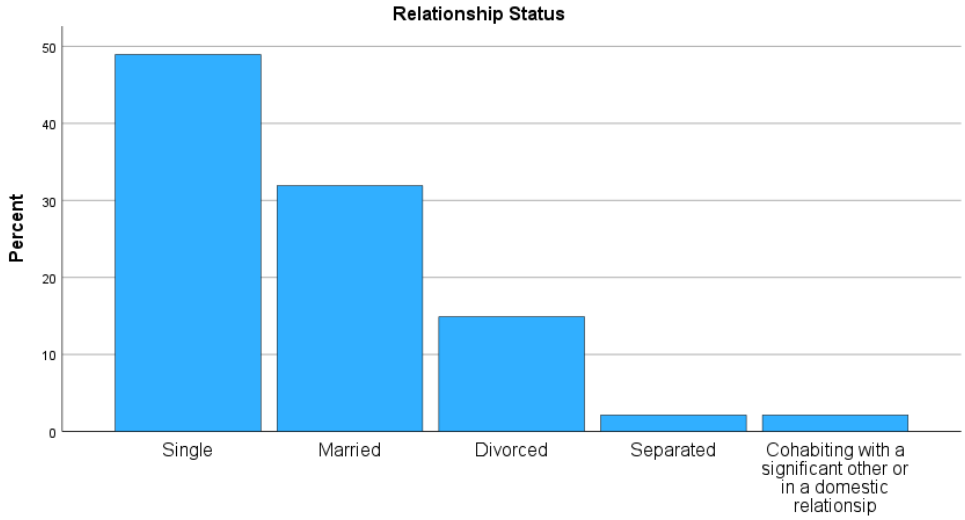


Figure 11

Bar graph of percentage by education level

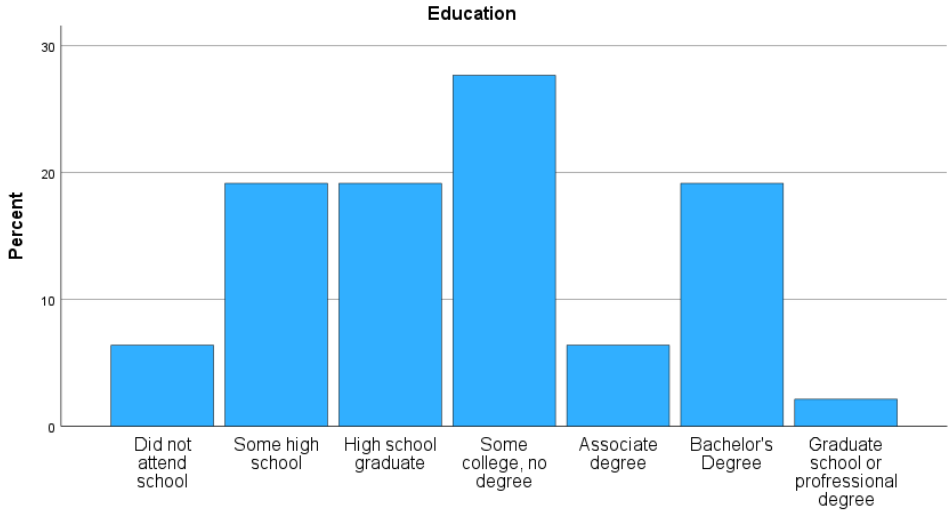


Figure 12

Bar graph of percentages by income level

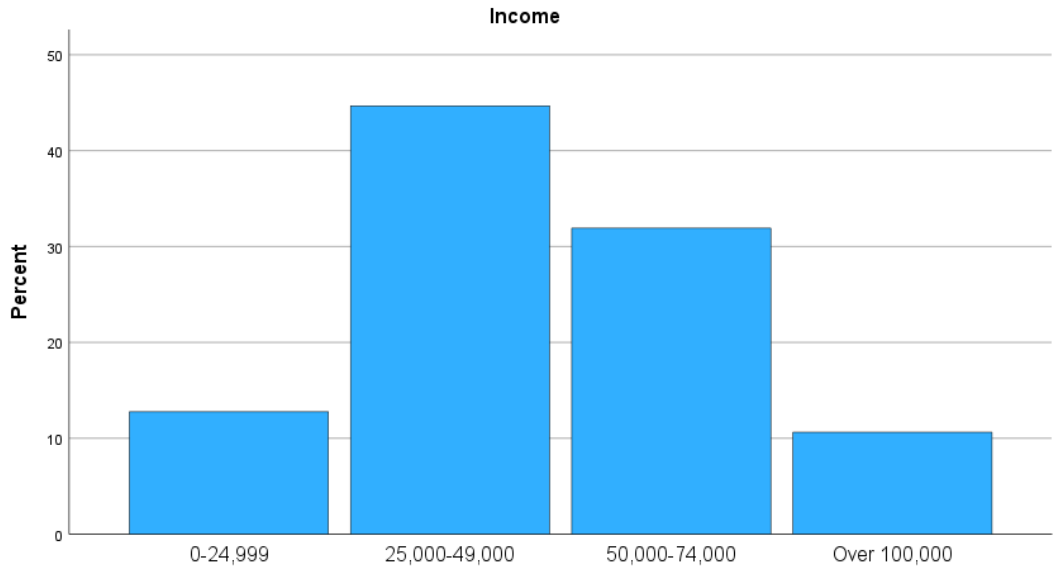


Figure 13

Bar graph of percentages by answered for have you ever received a mental health diagnosis?

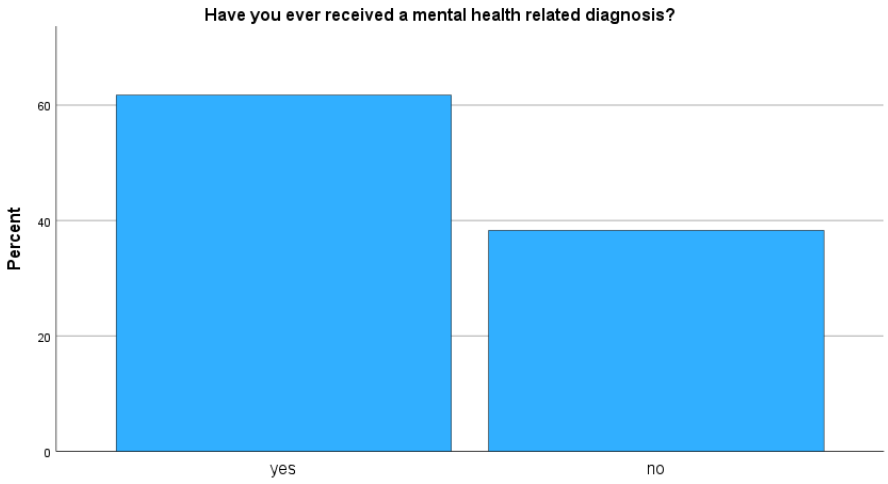


Figure 14

Bar graph of percentages by answered for so you have a history of experiencing mental health issues?

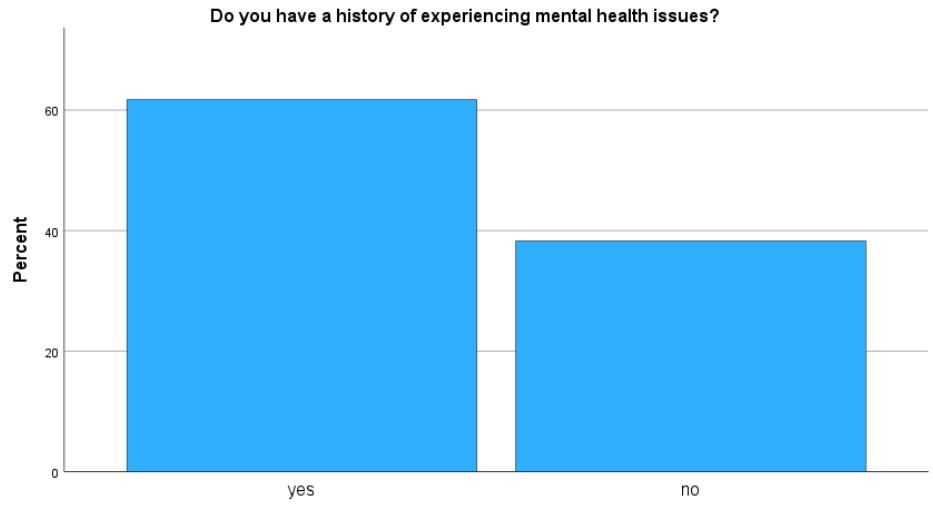
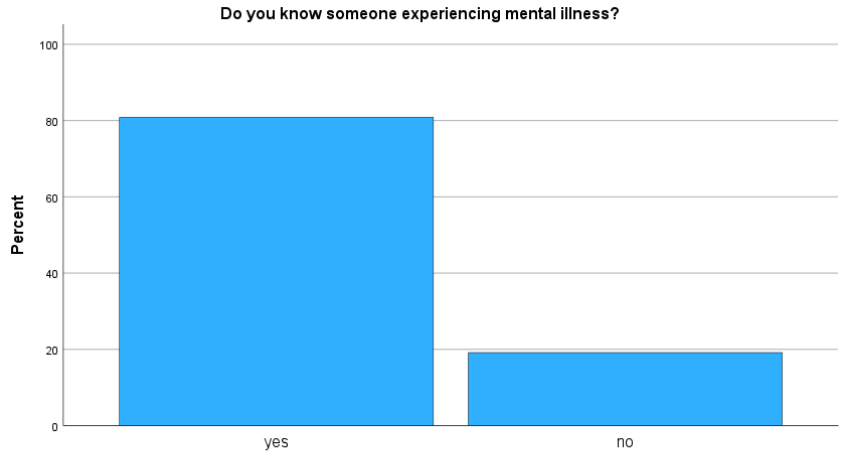


Figure 15

Bar graph of percentages by answered for do you know someone experiencing mental illness?



Research Question 1/Hypothesis

In this study, the researcher used paired t-tests to investigate the following research question:

Q1: What impact does a 90-minute psychoeducational live seminar have on reducing public stigma among African Americans from pretest to posttest ?

Hypothesis

$\mathbf{H_0}$ The psychoeducational-based intervention has no effect on reducing stigma in participants from pretest to post-test intervention.

$\mathbf{H_1}$: The mean scores from a Stigma-9 scale (Gierk et al., 2018) will be significantly reduced after a 90-minute psychoeducational live seminar post-intervention comparative to pre-intervention mean scores.

A paired samples t-test was performed to compare mean scores between the Stigma 9 (Gierk et al., 2018) before the NAMI seminar after the seminar. Results showed a significant difference between the mean scores before the seminar (M = 14.71 SD = 7.95) and after the seminar (M =13.28, SD = 7.77); t(41) = -8.360, p = <.001 indicating scores decreased between the two time points (see table 10 and 11).

Table 10

Paired t-test mean and standard deviations scores of STIG-9

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Stigma9post	13.2857	42	7.77515	1.19973
	Stigma9pre	14.7143	42	7.95195	1.22701

Table 11

Paired t-test means, standard deviations, and p values of STIG- 9

Paired Samples Test

		Paired Differences					t	df	Significance	
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			One-Sided p	Two-Sided p
Pair 1	Stigma9post - Stigma9pre	-1.42857	1.10747	.17089	-1.77368	-1.08346	-8.360	41	<.001	<.001

A Mann-Whitney U test was performed to compare the differences in mean scores between in person and zoom groups on the Stigma-9(Gierk et al., 2018) before the NAMI seminar after the seminar. There was not a significant difference in mean scores between participants that attended the seminar in person or zoom; z = -1.122, p = .262 (see table 12 and 13).

Table 12

Mann-Whitney U test differences of mean rank for in person and zoom group on STIG-9.

Ranks

	Group	N	Mean Rank	Sum of Ranks
DIFFSTIG	In Person	7	26.07	182.50
	Zoom	35	20.59	720.50
	Total	42		

Table 13

Mann-Whitney U z scores, and p values for in person and zoom groups of STIG-9.

Test Statistics[a]

	DIFFSTIG
Mann-Whitney U	90.500
Wilcoxon W	720.500
Z	-1.122
Asymp. Sig. (2-tailed)	.262
Exact Sig. [2*(1-tailed Sig.)]	.287[b]

a. Grouping Variable: Group

b. Not corrected for ties.

Research Question 2/Hypothesis.

A paired t-test was used to explore the following question:

Q2. What impact does a 90-minute psychoeducational live seminar have on reducing self-stigma among African Americans from pretest to posttest ?

H_0: The psychoeducational-based intervention has no effect on reducing stigma in participants from pretest to post-test intervention.

H_2: The mean scores from a scale SSMIS-SF(Corrigan et al., 2012) will be significantly reduced after a 90- minute psychoeducational live seminar post-intervention comparative to pre-intervention means scores.

A paired samples t-test was performed to compare mean scores between the SSMIS-SF (Corrigan et al., 2012) four subscales before the NAMI seminar after the seminar. There was a significant difference in mean scores before the seminar on the aware scale (M = 23.57, SD = 10.41) and after the seminar (M =18.92, SD = 9.48); t(41) = -9.48, p = <.001 as shown in table 14 and 15. There was a significant difference on the agree scale before the seminar (M=18.92, SD=11.78) and after the seminar (M=14.66, SD=9.46); t(41)=-7.280,p=<.001 (see table 16 and 17).

Table 14

Paired t-test mean and standard deviations scores of SSMIS-SF aware subscales

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	awarepost	18.9286	42	9.48527	1.46361
	aware1	23.5714	42	10.47446	1.61624

Table 15

Paired t-test means, standard deviations, and p values of SSMIS -SF aware subscale

Paired Samples Test

		Paired Differences					t	df	Significance	
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			One-Sided p	Two-Sided p
Pair 1	awarepost - aware1	-4.64286	3.37727	.52112	-5.69529	-3.59043	-8.909	41	<.001	<.001

Table 16

Paired t-test mean and standard deviations scores of SSMIS-SF agree subscale

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	agreepost	14.6667	42	9.46023	1.45975
	agreepre	18.9286	42	11.78547	1.81854

Table 17

Paired t-test means, standard deviations, and p values of SSMIS-SF agree subscale

Paired Samples Test

		Paired Differences					t	df	Significance	
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			One-Sided p	Two-Sided p
Pair 1	agreepost - agreepre	-4.26190	3.79383	.58540	-5.44415	-3.07966	-7.280	41	<.001	<.001

A Mann-Whitney U test was performed to compare the differences in mean scores between in person and zoom groups on the SSMIS-SF (Corrigan et al., 2012) four subscales before the NAMI seminar after the seminar. There was not a significant difference in mean scores on the aware scale between participants that attended the seminar in person or zoom; z = -1.224, p = .221 (see table 18 and 19). There was not a significant difference in mean scores on the agree scale between participants that attended the seminar in person or zoom; z = -1.023, p = .306 (see table 19 and 20).

Table 18

Mann-Whitney U test differences of mean rank for in person and zoom group the SSMIS-SF aware scale

Ranks

	Group	N	Mean Rank	Sum of Ranks
DIFFAware	In Person	7	16.36	114.50
	Zoom	35	22.53	788.50
	Total	42		

Table 19

Mann-Whitney U z scores, and p values for in person and zoom groups of SSMIS-SF aware scale

Test Statistics[a]

	DIFFAware
Mann-Whitney U	86.500
Wilcoxon W	114.500
Z	-1.224
Asymp. Sig. (2-tailed)	.221
Exact Sig. [2*(1-tailed Sig.)]	.230[b]

a. Grouping Variable: Group

b. Not corrected for ties.

Table 20

Mann-Whitney U test differences of mean rank for in person and zoom group the SSMIS-SF agree scale

Ranks

	Group	N	Mean Rank	Sum of Ranks
DIFFAgree	In Person	7	25.79	180.50
	Zoom	35	20.64	722.50
	Total	42		

Table 21

Mann-Whitney U z scores, and p values for in person and zoom groups of SSMIS-SF aware scale

Test Statistics[a]

	DIFFAgree
Mann-Whitney U	92.500
Wilcoxon W	722.500
Z	-1.023
Asymp. Sig. (2-tailed)	.306
Exact Sig. [2*(1-tailed Sig.)]	.319[b]

a. Grouping Variable: Group

b. Not corrected for ties.

Results show a significant difference between mean score before the seminar on apply scale (M=18.50,SD=10.99) and after the seminar(M=13.90,SD=8.72); t(41)=-8.282, p= <.001(see table 22 and 23). The hurt scale scores significantly differed from before the seminar (M= 18.39,SD=13.17) and after the seminar(M=13.59,SD=10.44); t(41)=-8.477, p=<.001 as shown in table 24 and 25. Results indicate scores decreased between before and after the seminar. Since the scale requires multiple testing, to control for probability of committing type 1 error α=.05, Bonferroni adjustment 0.0125 was applied.

Table 22

Paired t-test means, standard deviations, and p values of SSMIS-SF apply subscale

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	applypost	13.9048	42	8.72845	1.34683
	applypre	18.5000	42	10.99945	1.69725

Table 23

Paired t-test means, standard deviations, and p values of SSMIS-SF apply subscale

Paired Samples Test

		Paired Differences					t	df	Significance	
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			One-Sided p	Two-Sided p
Pair 1	applypost - applypre	-4.59524	3.59579	.55484	-5.71577	-3.47471	-8.282	41	<.001	<.001

Table 24

Paired t-test means, standard deviations, and p values of SSMIS -SF hurt subscale

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	hurtpost	13.5952	42	10.44395	1.61154
	hurtpre	18.3095	42	13.17145	2.03240

Table 25

Paired t-test means, standard deviations, and p values of SSMIS-SF hurt subscale

Paired Samples Test

		Paired Differences					t	df	Significance	
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			One-Sided p	Two-Sided p
Pair 1	hurtpost - hurtpre	-4.71429	3.60410	.55612	-5.83740	-3.59117	-8.477	41	<.001	<.001

A Mann-Whitney U test was performed to compare the differences in mean scores between in person and zoom groups on the SSMIS-SF (Corrigan et al., 2012) four subscales before the NAMI seminar after the seminar. There was not a significant difference in mean scores on the apply scale between participants that attended the seminar in person or zoom, z = -1.668, p =.095 (see table 26 and 27). There was not a significant difference in mean scores on the hurt scale between participants that attended the seminar in person or zoom; z = -1.380, p = .168 (see table 28 and 29).

Table 26

Mann-Whitney U test differences of mean rank for in person and zoom group the SSMIS-SF apply scale

Ranks

	Group	N	Mean Rank	Sum of Ranks
DIFFApply	In Person	7	14.50	101.50
	Zoom	35	22.90	801.50
	Total	42		

Table 27

Mann-Whitney U z scores, and p values for in person and zoom groups of SSMIS-SF apply scale

Test Statistics[a]

	DIFFApply
Mann-Whitney U	73.500
Wilcoxon W	101.500
Z	-1.668
Asymp. Sig. (2-tailed)	.095
Exact Sig. [2*(1-tailed Sig.)]	.099[b]

a. Grouping Variable: Group

b. Not corrected for ties.

Table 28

Mann-Whitney U test differences of mean rank for in person and zoom group the SSMIS-SF hurt scale

Ranks

	Group	N	Mean Rank	Sum of Ranks
DIFFHurt	In Person	7	15.71	110.00
	Zoom	35	22.66	793.00
	Total	42		

Table 29

Mann-Whitney U z scores, and p values for in person and zoom groups of SSMIS-SF hurt scale

Test Statistics[a]

	DIFFHurt
Mann-Whitney U	82.000
Wilcoxon W	110.000
Z	-1.380
Asymp. Sig. (2-tailed)	.168
Exact Sig. [2*(1-tailed Sig.)]	.181[b]

a. Grouping Variable: Group

b. Not corrected for ties.

Research Question 3/Hypothesis

A paired t-test was used to answer the following question:

Q3. What impact does a 90-minute psychoeducational live seminar have on improving attitudes towards seeking therapy among African Americans from pretest to posttest?

H_0 The psychoeducational-based seminar has no effect on improving attitudes toward seeking therapy in participants from pre- to post-intervention.

H_3: The mean scores from MHSAS (Hammer et al., 2018) will significantly increase post-intervention comparative to pre-intervention mean scores.

A paired samples t-test was performed to compare mean scores between the MHSAS(Hammer et al., 2018) before the NAMI seminar after the seminar. There was a significant difference in mean scores before the seminar (M = 4.86, SD = 1.09) and after the seminar (M =5.13, SD = 1.02); t(41) = 5.296, p = <.001 (see table 30 and 31).

Table 30

Paired t-test means, standard deviations, and p values of MHSAS.

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	MHSASpost	5.1338	42	1.02309	.15787
	MHSASpre	4.8674	42	1.09103	.16835

Table 31

Paired t-test means, standard deviations, and p values MHSAS.

Paired Samples Test

		Paired Differences					t	df	Significance	
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			One-Sided p	Two-Sided p
Pair 1	MHSASpost - MHSASpre	.26643	.32601	.05030	.16484	.36802	5.296	41	<.001	<.001

A Mann-Whitney U test was performed to compare the differences in mean scores between in person and zoom groups on the MHSAS (Hammer et al., 2018)**.** There was not a significant difference in mean scores on MHSAS (Hammer et al., 2018) between participants that attended the seminar in person or zoom, z = -.305, p =.760 (see table 32 and 33).

Table 32

Mann-Whitney U z scores, and p values for in person and zoom groups of MHSAS

Ranks

	Group	N	Mean Rank	Sum of Ranks
DIFFMHSAS	In Person	7	20.29	142.00
	Zoom	35	21.74	761.00
	Total	42		

Table 33

Mann-Whitney U z scores, and p values for in person and zoom groups of MHSAS

Test Statistics[a]

	DIFFMHSAS
Mann-Whitney U	114.000
Wilcoxon W	142.000
Z	-.305
Asymp. Sig. (2-tailed)	.760
Exact Sig. [2*(1-tailed Sig.)]	.792[b]

a. Grouping Variable: Group

b. Not corrected for ties.

Evaluation of the Findings

Stigmatized beliefs or attitudes have contributed to not seeking services (Brown et al., 2019; Ferrie et al., 2020; Villatoro et al., 2018). Previous research suggests that African Americans have higher stigmatized beliefs about psychological illness and are unlikely to pursue therapy services than White, Hispanic, and Asian Americans (Brown et al., 2020; DeFreitas et al., 2018; Fripp et al., 2017). Literature addressing stigma among African Americans is understudied and needed. Previous researchers have attempted to address stigma among African Americans via anti-stigma interventions, such as education-based programs aimed to educate and improve understanding and information about psychological health, which appears to be effective in decreasing stigma (Chakawa, 2023; Diouf et al., 2022). This study aimed to answer the following research question:

Q1: What impact does a 90-minute psychoeducational live seminar have on reducing public stigma among African Americans from pretest to posttest ?

Hypothesis

H_0 Psychoeducational-based intervention has no effect on reducing stigma in participants from pretest to post-test intervention.

$\mathbf{H_1}$: The mean scores from a Stigma-9(Gierk et al., 2018) scale will be significantly reduced after a 90-minute psychoeducational live seminar post-intervention comparative to pre-intervention mean scores.

The null hypothesis was rejected and hypothesis 1 is accepted as findings of the research question suggest that the psychoeducational intervention (e.g., NAMI family and friend's seminar) did have an impact in reducing public stigma from pretest to post test. These results support previous studies findings reporting that educational based interventions reduced stigma towards mental illness (Deluca et al., 2021; İnan et al., 2019). In a study, examining the efficacy of digital mental health education and awareness campaign impact on mental health knowledge, stigma, and help-seeking behavior, it was observed that stigma decreased towards mental illness (Curren et al., 2023). Similarly in a systemic review, it was reported that education-based intervention had the most positive effects on reducing stigma compared to other interventions (Song et al., 2022). In a comparison study between a control and treatment group examining the effectiveness of a 30–45-minute presentation of Ending the Silence (ETS) intervention on mental health stigma, it was found that stigma decreased in the ETS treatment group. In another single-group pretest, posttest, and follow-up study assessing the effectiveness a psychoeducational workshop on reducing mental health stigma Black American parents, it was concluded that workshop effectively reduced mental health sigma across three months (Chawka, 2023; Rivera et al., 2021).

Research Question 2/Hypothesis.

This section includes the answer for the following research question:

Q2. What impact does a 90-minute psychoeducational live seminar have on reducing self-stigma among African Americans from pretest to posttest ?

$\mathbf{H_0}$: The psychoeducational-based intervention has no effect on reducing stigma in participants from pretest to post-test intervention.

$\mathbf{H_2:}$ The mean scores from a scale SSMIS-SF(Corrigan et al., 2012) will be significantly reduced after a 90- minute psychoeducational live seminar post-intervention comparative to pre-intervention means scores.

The null hypothesis was rejected and hypothesis 2 was accepted as findings of the research question suggest that the psychoeducational intervention (e.g., NAMI family and friend's seminar) did have an impact in reducing self-stigma from pretest to post test. The findings are supported by previous studies indicating that education-based interventions help decrease self-stigma (Ciydem and Ayci et al., 2022). In a study assessing the effectiveness of video-based mental health de-stigmatization intervention on mental health stigma and mental health care concerns, it was observed that scores on three stigma scales including a self-stigma scale significantly decreased in the treatment group (Gonçalves et al., 2015). In a systematic review, it was determined that educational interventions helped reduce both public and self-stigma as well as improve mental health literacy, attitude, and beliefs towards mental health issues (Waqas et al., 2020).

Research Question 3/Hypothesis.

A paired t-test was used to answer the following question:

Q3. What impact does a 90-minute psychoeducational live seminar have on improving attitudes towards seeking therapy among African Americans from pretest to posttest?

$\mathbf{H_0}$ The psychoeducational-based live seminar has no effect on improving attitudes toward seeking therapy in participants from pre- to post-intervention.

H_3: The mean scores from MHSAS(Hammer et al., 2018) will significantly increase post-intervention comparative to pre-intervention mean scores.

The results indicate that psychoeducational intervention improved attitudes towards help seeking. The null hypothesis was rejected and hypothesis 3 accepted. The findings are supported by previous literature that indicates psychoeducational intervention helps improve attitudes toward seeking treatment (Curren et al., 2023). Previous findings have yielded positive but small effect sizes. In a study, comparing in person or online professional development sessions (PD) impact on mental health literacy outcomes, it was observed that help-seeking intentions improved in the in-person and online post intervention compared to the control group ($p = .000$, 95% CI [2.66, -.78]) (Wei et al.,2020).

In another study, evaluating a psychoeducational intervention on stigma showed that participants' stigma and mental health views improved over time and more willingness to address their mental health($p= 0.002$) (Diouf et al., 2022). In a study evaluating online biological intervention and physical education intervention on stigma and help-seeking intentions for depression, it ascertained that stigma was not reduced, however, a minor increase in help seeking intentions ($d=0.24$) were found (Howard et al., 2018). The results of this research study slightly differ from previous literature indicating that help-seeking attitudes significantly increased with a moderate to large effect size of .814. This may be explained by the location of the study and socioeconomic status of the sample population. The location of the study was held in Northwest Arkansas which consists of the four largest cities in Arkansas which have more resources and access to mental health treatment compared to smaller and rural towns in Arkansas. The median income for Northwest Arkansas is 73,364 compared to the 58,773 of the median income of overall Arkansas residents (United Stated Census Bureau, n.d). For this study, 44.7% reported

income between 25,000-49,000 and 31.9% between 50,000-74,000 at 31.9% which had a cumulative percent of 89.4%. Studies have indicated a link between location, income, and mental health treatment (Haynes et al., 2017; Pulsifer et al., 2019). Haynes et al. (2017) found that African Americans with low income reported limited knowledge about mental health, stigma, and access to services as barriers to mental health treatment.

The differences in means scores on the STIG-9(Gierk et al., 2018) SSMIS-SF(Corrigan et al., 2012) and MHSAS(Hammer et al., 2018) between participants attending in person and zoom were examined. There was not sufficient number of participants in-person group which had seven participants compared to 35 participants who attended via zoom. Based on the data, there was not a significant difference between the two groups.

Summary

The purpose of this pretest-posttest study was to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and improve attitudes towards seeking treatment. This chapter presented the findings of the data collection and analysis. There was a final sample size of 42 after removing five outliers. Descriptive statistics were used to examine frequencies and percentages of demographic data. A paired t-test was used to measure the differences between mean scores of the Stigma-9 Questionnaire (Gierk et al., 2018) to test public sigma, the Self-Stigma of Mental Illness Short Form (Corrigan et al., 2012) to measure self-stigma, and the Mental Health Seeking Attitude Scale (Hammer et al., 2018) to test help-seeking attitudes towards mental health treatment. Also, the paired test was used to answer the following research question: What impact does a 90-minute psychoeducational live seminar have on reducing public stigma among African Americans from pretest to posttest ? The results indicated that the

psychoeducational intervention (e.g., NAMI family and friend's seminar) did have an impact in reducing public stigma. These findings support previous studies reporting that educational based interventions reduced stigma towards mental illness (Deluca et al., 2021; İnan et al., 2019). The second research question examined: What impact does a 90-minute psychoeducational live seminar have on reducing self-stigma among African Americans from pretest to posttest ? Findings show that the psychoeducational intervention (e.g., NAMI family and friend's seminar) did have an impact in reducing self-stigma. The findings are supported by previous studies indicating that education-based interventions help decrease self-stigma (Gonçalves et al., 2015). The last research question sought to answer: What impact does a 90-minute psychoeducational live seminar have on improving attitudes towards seeking therapy among African Americans from pretest to posttest? Results indicated that psychoeducational intervention improved attitudes towards help seeking. Findings of the study corroborate with previous literature that educational interventions improve help-seeking, however, adds a stronger effect size .814 compared to previous literature (Diouf et al., 2022; Wei et al., 2020). The difference may be explained due to the location and socioeconomic status of the study population. There were no statistically significant differences between participants attending in person or via zoom.

Chapter 5: Implications, Recommendations, and Conclusions

Over 16% of African Americans or Black individuals living in the U.S. report experiencing mental illness (Mental Health America, MHA, n.d). Mental illness is a clinically significant disturbance in an individual's thinking, emotions, and behaviors (World Health Organization, WHO, 2022). Despite the need, only one in three African Americans receive mental health treatment (National Alliance on Mental Illness, 2023). The problem this study addressed was the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. Stigma is considered the most significant barrier due to its impact on individual attitudes toward seeking psychological treatment. Approximately, 37% of African Americans experience mental illness; however, less than 9% receive mental health treatment (Alcarez et al., 2019; Reinert et al., 2021). Consequently, African Americans' psychological needs go untreated, leading to a greater risk of experiencing adverse outcomes such as increased symptomology, poor standard of living, jail, unemployment, medical and physical illness, poverty, and substance abuse (Alvarez et al., 2019; Snowden et al., 2022). Literature addressing stigma among African Americans is understudied and needed. Previous researchers have attempted to address stigma among African Americans via anti-stigma interventions, such as education-based programs aimed to educate and improve understanding and information about psychological health, which appears to be effective in decreasing stigma (Chakawa, 2023; Diouf et al.,2022).

The purpose of this pretest-posttest study was to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and improve their attitudes towards seeking treatment. A paired t-test was used to measure the differences between mean scores of Stigma-9 Questionnaire (Gierk

et al., 2018) to test public sigma, the Self-Stigma of Mental Illness Short Form (Corrigan et al., 2012) to measure self-stigma, and the Mental Health Seeking Attitude Scale (Hammer et al., 2018) to test help-seeking attitudes towards mental health treatment. Results indicated a significant impact in reducing public stigma, self-stigma, and improving help-seeking attitudes. The study had some limitations that may have influenced the results. One limitation of the study is the sample size. The sample size did not meet the number of participants required by G power analysis, as it was reduced by removing extreme outliers from the data. However, the study did achieve a post hoc analysis of 0.99. The study's results must be viewed with caution, as they may only be generalized to the study participants due to the location and data collection methods used. Another limitation of the study is the possibility that participants may respond in a socially desirable manner, such as overreporting or underreporting symptoms, based on their belief that they will receive positive benefits or negative consequences (Theofanidis & Fountouki, 2018). Another limitation is the possibility of maturation from pretest to posttest, although the researcher tried to minimize this by having participants complete a questionnaire 10 minutes before and after. Additionally, the researcher emphasized that participants could stop studying at any time. Another limitation is possible carryover effects due to questionnaires being the same in the pretest and posttest; participants may have remembered the questions. The researcher examined the differences between the methods of delivery of in person and online participation via zoom and the data showed no difference, however, results must be viewed with caution due to possible confounding variable. To migrate risk, the same procedures were conducted online and in person. Both methods were presentation only and there were no questions or conversation from the participants. Over half of the participants reported yes on whether they have ever received a mental health diagnosis, which indicates at some point, they had contact with a mental

health provider (e.g., primary care physician, therapist, psychiatrist) to receive a diagnosis, which can impact results. Chapter 5 discusses implications, practice recommendations, and future research recommendations.

Implications

The problem this study addressed is the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. Around 37% of African Americans experience mental illness; however, less than 9% receive mental health treatment (Alcarez et al., 2019; Reinert et al., 2021). Stigma is often cited as significant barrier to African Americans not seeking mental health treatment despite rising mental health needs (Connell et al., 2019; Saykeo et al., 2018). The purpose of this pretest-posttest study was to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma and improve their attitudes towards seeking treatment. Finding interventions to address the mental health stigma of African Americans can help reduce stigma and improve therapy-seeking attitudes. Kranke et al. (2012) and Harris et al. (2020) suggest that psychoeducational programs and models addressing issues identified by Black individuals may be essential in reducing stigma within the Black community. The study results revealed that the psychoeducation intervention had a statistically significant impact on public stigma, self-stigma, and help-seeking attitudes. The findings contribute to the literature on mental health stigma among African Americans and interventions addressing stigma. There are several other implications based on the study findings.

Research Q1: What impact does a 90-minute psychoeducational live seminar have on reducing public stigma among African Americans from pretest to posttest?

The findings of the study show that psychoeducational intervention can reduce public stigma among African Americans. The findings align with those of several researchers, including Deluca et al. (2021), İnan et al. (2019), Curren et al. (2023), and Song et al. (2022), who have indicated that psychoeducation-based interventions reduce public stigma. The key implication of the research question findings is that it adds supportive evidence to the literature indicating that psychoeducation interventions help reduce stigma in African Americans. Current literature on anti-stigma interventions specifically targeting African Americans is limited and has yielded mixed results (Alvidrez et al., 2009; Rivera et al., 2021). The findings align with research suggesting that African Americans report high levels of public stigma (Abdullah et al.,2020, Goodcase et al., 2022; Misra et al., 2021). The data reflects the current state of mental health illness, with 80.9% of the participants reporting knowing someone with mental illness. Another implication of this research question finding is that including specific stigma and statistics relating to African Americans is beneficial in reducing public stigma. Codjoe et al. (2021) and Powell et al. (2016) suggested that to achieve a significant impact on African American stigma, research should incorporate cultural backgrounds and specific stigmas rather than general stigma.

Research Q2. What impact does a 90-minute psychoeducational live seminar have on reducing self-stigma among African Americans from pretest to post-test?

The findings of the study show that psychoeducational intervention can reduce self-stigma among African Americans. The findings align with those of several researchers, including Ciydem and Ayci et al. (2022) and Gonçalves et al. (2015), who have indicated that psychoeducation-based interventions reduce self-stigma. One implication is that African Americans report highly stigmatized beliefs towards themselves. In the current findings, 61.7% of participants reported having been diagnosed with mental health illness or experienced mental

health issues. Brown et al. (2020), Conner et al. (2010), and DeFreitas et al. (2018) found African Americans endorsed self-stigma at greater levels and are unlikely to pursue therapy services. Another implication is that the findings provide support for Corrigan and Watson's four stages of stigma model, which is a theoretical framework used to define self-stigma (e.g., the Self-Stigma of Mental Illness Short Form). Similar to Corrigan's (2011) and Catalano et al. (2021) study, which tested the relationship between the four stigma stages and adverse outcomes, the participants endorsed awareness of stereotypes more than agreement, endorsed application to self, experienced a decrease in self-esteem, and then reported adverse recovery outcomes and negative attitudes. The Cronbach alpha scores ranged from 0.967 to 0.976 in this study, demonstrating high reliability. Therefore, this measurement is reliable to use for future studies examining African Americans and self-stigma.

Research Q3. What impact does a 90-minute psychoeducational live seminar have on improving attitudes towards seeking therapy among African Americans from pretest to posttest?

The finding indicated that psychoeducational seminar improved attitudes toward seeking therapy among African Americans. The results of this research study differ slightly from those in previous literature, suggesting that help-seeking attitudes increased significantly, with a moderate to large effect size, compared to studies with positive but weak effect sizes (Chawka, 2023). The study findings showed that an increase in mental health knowledge helps improve attitudes towards therapy. Pederson et al. (2023) and Williams et al. (2023) suggest that the severity of the illness and how knowledgeable African Americans are about specific mental health disorders increase their chances of attending therapy. Neely-Fairbanks et al. (2018) discovered that higher mental health knowledge positively correlated with increased openness to seeking professional help. Although, a positive or improved attitude does not mean it translates

to actually seeking mental health services. Another implication is that the research question's findings indicated a link between SES, stigma, educational attainment, and the use of services. Pulsifer et al. (2019) explained that individuals with higher socioeconomic status (SES) have greater access to services and resources than those with lower SES.

Recommendations for Practice

Based on the study findings that psychoeducational interventions help reduce stigma and improve helping-seeking attitudes, there are three recommendations for practice. The first recommendation is that stakeholders should implement education and mental health awareness campaigns at the local, state, and national levels in culturally relevant or community-based settings that African Americans attend, such as churches, mentor programs, Juneteenth celebrations, or festivals. Campbell et al. (2020) stated that African Americans may believe coping independently or using other informal supports like church is better than seeking services. Similarly, Tsang et al. (2020) suggest that Black caregivers are more likely to utilize other forms of services, such as mentoring programs instead of counseling services for their children. Song et al. (2022) suggest that effective intervention components are educationally based, including lessons and curriculum explaining stigma-related issues. If mental health awareness and educational campaigns focus on informal places, then more African Americans will be educated on mental health, and it can help reduce stigma towards mental health.

The second recommendation is that primary care doctors, mental health professionals, and other behavioral health professionals should incorporate psychoeducation about mental health and therapy in their practice and educate themselves on African American culture, especially primary care physicians. APA (2017) states that 90% of clinician's biases, stereotypes, and prejudice contribute to the differences in services and quality care in minority

populations. Black Americans tend to report negative experiences with their health provider as they believe advanced medical care is withheld from them and they will have less access to quality medical care (Pew Center Research, 2022). In the study findings, over half of the participants reported they had been diagnosed with a mental health disorder. Results suggest that at some point, they would have contact with a doctor or mental health professional, yet they still endorsed high levels of stigma. Bailey et al. (2019) explains that disparities in treatment are caused by misdiagnosis, counseling referral, and medication management in primary care and psychiatric visits. Since primary care physicians are usually the first line of contact for mental health and medical issues, it is important they educate themselves about African-American culture but also use the time to educate them about mental health, which could reduce cultural mistrust and stigma which can help them seek therapy more often. Pederson et al. (2023) stated that Black Americans more often pursued mental health treatment when they had more knowledge of disorders.

The third recommendation is that stigma-related interventions should incorporate cultural background and information specific to African Americans. For this study, the researcher modified the intervention to include information related to African Americans, including mental health statistics, shared beliefs and misconceptions African Americans report relating to mental health stigma and therapy, barriers, and history of cultural mistrust. Harris et al.(2020) implied that psychoeducational programs and models that address issues identified by Black families may be essential in reducing stigma in Black families. Similarly, Rivera et al. (2021) recommend that stigma interventions should be culturally informed and specific to African Americans. Additionally, when possible, the presenters of educational interventions or mental health awareness campaigns should match the target culture. Amsalem and Martin (2022) suggest that

when personalizing interventions, the content should be racially congruent with the viewers to help them connect and increase emotional engagement. Likewise, Chen et al. (2016) recommend that the presenter's demographics, such as age, race, and/or ethnicity, should match those of the targeted audience when possible.

Recommendations for Future Research

Based on the study's results and limitations, the following recommendations are proposed for future research. One recommendation is for future researchers to include a control group and post-follow-up. The control group will provide more evidence that the intervention is effective (Priverta, 2020). Additionally, the post-follow-up can examine whether the intervention has a lasting impact on stigma and help-seeking attitudes. Another recommendation is that future research should have a larger, sample size. Based on an alpha level of 0.05 and 95% power, a priori G power analysis suggests that 45 participants are needed to detect an effect size. However, a larger, more diverse sample size would help generalize the results. Researchers may encounter difficulties with recruitment, making it challenging to attain a larger sample size. Researchers may need to offer incentives to facilitate recruitment. The current study presented intervention options, both online and in person, to facilitate recruitment. The researcher did not include a question on whether the participants received mental health treatment in the past; it is an important question as participants reported high levels of stigma. Therefore, future researchers should include questions regarding past mental health treatment and barriers or attitudes that prevented them from continuing therapy. Since the intervention was offered online and in person, future research can further examine the differences between the two methods to see which is more effective with a larger and normally distributed sample size. Although attitudes towards help-seeking improved, it does not necessarily mean that participants will seek therapy.

Future research should focus on helping-seeking behaviors, such as creating interventions that specifically address these behaviors and therapy. Participants in the study endorsed high levels of self-stigma, more research should focus on self-stigma. The current literature that specifically focuses on self-stigma is limited (Waqas et al., 2020). The current study focused on a subculture of the Black diaspora; future research should continue to create psychoeducational interventions to address mental health stigma in African American communities across the diaspora.

Conclusions

Despite the need, only one in three African Americans receive mental health treatment (National Alliance on Mental Illness, 2023). The problem this study addressed is the lack of adequate data for stigma-reducing interventions among African Americans seeking mental health care. Thirty seven percent of African Americans experience mental illness; however, less than 9% receive mental health treatment (Alcarez et al., 2019; Reinert et al., 2021). Stigma is considered the most significant barrier due to its impact on individual attitudes toward seeking psychological treatment. Consequently, African Americans' psychological needs go untreated, leading to a greater risk of experiencing adverse outcomes such as increased symptomology, poor standard of living, jail, unemployment, medical and physical illness, poverty, and substance abuse (Alvarez et al., 2019; Snowden et al., 2022). Literature addressing stigma among African Americans is understudied and needed. Previous researchers have attempted to address stigma among African Americans via anti-stigma interventions, such as education-based programs aimed to educate and improve understanding and information about psychological health, which appears to be effective in decreasing stigma (Chakawa, 2023; Diouf et al., 2022).The purpose of this pretest-posttest study was to determine the effectiveness of a psychoeducational-based intervention addressing African Americans' stigma towards mental health to help reduce stigma

and improve their attitudes towards seeking treatment. The study results revealed that the psychoeducation intervention had a statistically significant impact on public stigma, self-stigma, and help-seeking attitudes. The findings align with those of several researchers, including Deluca et al. (2021), İnan et al. (2019) and Song et al. (2022), who have indicated that psychoeducation-based interventions reduce public stigma and Ciydem and Ayci et al. (2022) and Gonçalves et al. (2015), who have indicated that psychoeducation-based interventions reduce self-stigma. The results of this research study differ slightly from those in previous literature, suggesting that help-seeking attitudes increased significantly, with a moderate to large effect size, compared to studies with positive but weak effect sizes (Chawka, 2023). The findings contributed to Corrigan's (2011) ,Watson (2011), and Catalano et al. (2021) four stages of stigma model including participants endorsed awareness of stereotypes more than agreement, endorsed application to self, experienced a decrease in self-esteem, and then reported adverse recovery outcomes and negative attitudes. The findings contribute to the literature on mental health stigma among African Americans and interventions addressing stigma. Results may have to be viewed with caution due to possible impact of confounding variable and not being able to generalize to larger population.

The recommendations for practice included 1) stakeholders should implement education and mental health awareness campaigns at the local, state, and national levels in culturally relevant or community-based settings that African Americans attend, 2)primary care doctors, mental health professionals, and other behavioral health professionals should incorporate psychoeducation about mental health and therapy in their practice and educate themselves on African American culture,3) stigma-related interventions should incorporate cultural background and information specific to African Americans. Recommendations for future research include

using a control group and post follow up group, focusing on help -seeking behaviors and self - stigma, and continuing to create and explore psychoeducational intervention that address mental health stigma among Black diasporas, and explore the differences and effectiveness in methods of delivery with larger sample size. The researchers hope that the study findings can aid with reducing the disparities in African American mental health treatment and shows the continue potential of utilizing psychoeducational intervention to reduce stigma among African Americans.

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Appendix A

Would you like to know more about mental health?

Consider participating in a research study about the effectiveness of NAMI Family and Friends Seminar on mental health stigma and help seeking behaviors.

You may participate in this study if you meet all of the following criteria:

- You are 18 year old or older
- You identify as African American
- You were born in the United States
- You live in Northwest Arkansas (Benton or Washington county)

Participants will:

- Complete four paper-based surveys demographic survey, Stigma-9 Questionnaire, Self-Stigma of Mental Ilness Short Form, and Mental Health Seeking Attitude Scale in person or online 15 minutes before seminar.
- Participate NAMI Family and Friends Seminar in person or via zoom for 90 minutes.
- Complete three paper-based surveys the Stigma-9 Questionnaire, Self- Stigma of Mental Illness Short Form, and Mental Health Seeking Attitude Scale in person or online 15 minutes after the seminar.

After you complete the surveys and attend the NAMI Family Friends Seminar, you can enter your name or email address in a drawing for a chance to receive a $10 Walmart gift card in person before you leave the study site or emailed to your after the zoom session.

Scan QR code to sign up

or

Contact Tanesha Eabron
Doctoral student at National University at
t.eabron2335@o365.ncu.edu

Appendix B

Demographic Survey

Subject ID: _____ Date: _____

1. What is your age? (Please circle one)

1- 18 to 24
2- 25 to 34
3- 35 to 44
4- 5 to 54
5- 55 to 64
6- 65 to 74
7- 75 or older

2. Which of the following options most closely aligns with your gender?

1- Woman
2- Man
3- Transgender Man
4- Transgender Woman
5- Non-binary
6- A gender not listed here
7- Prefer not to answer

3. Were born in the United States?

1- Yes
2- No

4. Are you African American?

1- Yes
-No

5. Which of the following best describes your current relationship status? (Please circle one)

1- Single
2- Married
3- Divorced
4- Separated
5- Cohabiting with a significant other or in a domestic partnership
6- Prefer not to answer

6. What is the highest level of education you have completed? (Please circle one)

1- Did not attend school
2- Some high school
3- High school graduate
4- Some college, no degree
5- Assoicate degree
6- Bachelor's degree
7- Graduate or professional degree

7. What is your approximate average household income? (Please circle one)

$0-$24,999
$25,000-$49,999
$50,000-$74,999
$75,000-$99,999
$ Over 100,000

8. Have you ever received a mental health related diagnosis? (Please circle one)

1- Yes
2- No

9.Have you had a history of experiencing a mental illness? (Please circle one)

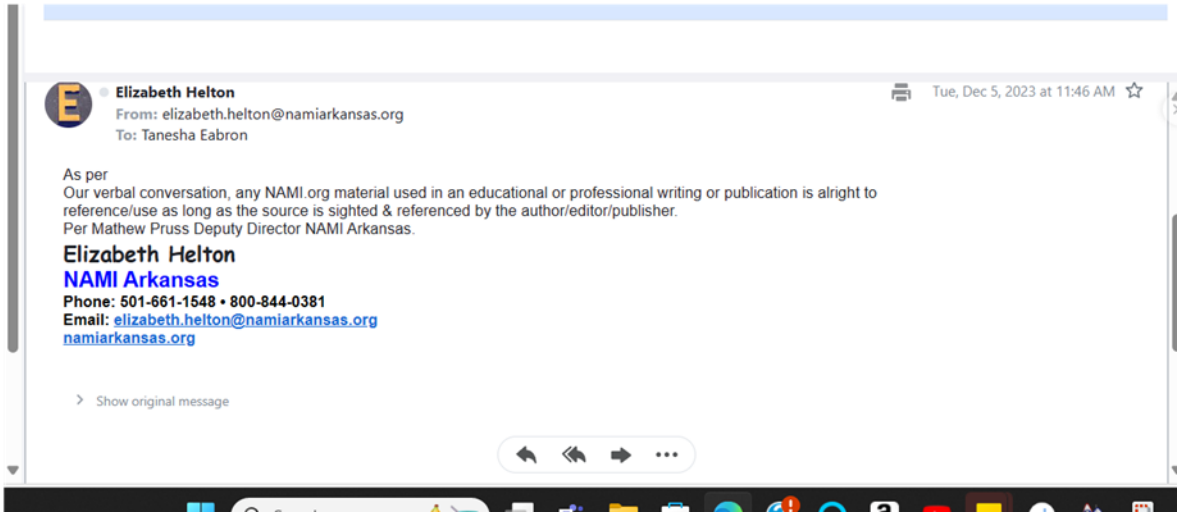
1- Yes
2- No

10. Do you know someone with experiencing mental illness? (Please circle one)

1- Yes
2- No

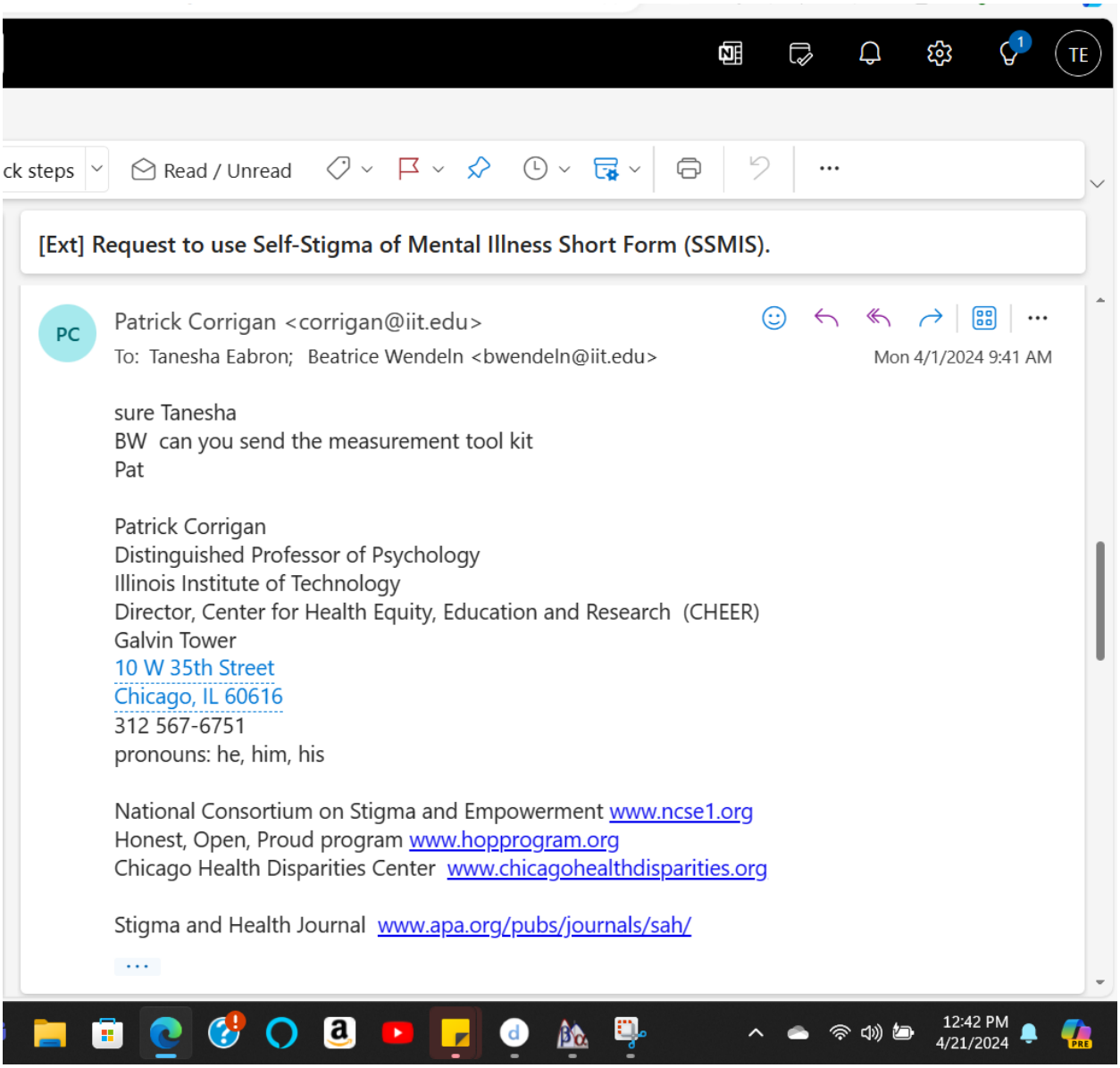
Appendix C

NAMI Family and Friends Seminar Permission to Use



Appendix D

Self-Stigma of Mental Illness Short Form (SSMIS) Permission to Use



ck steps Read / Unread

[Ext] Request to use Self-Stigma of Mental Illness Short Form (SSMIS).

PC

Patrick Corrigan <corrigan@iit.edu>

To: Tanesha Eabron; Beatrice Wendeln <bwendeln@iit.edu> Mon 4/1/2024 9:41 AM

sure Tanesha
BW can you send the measurement tool kit
Pat

Patrick Corrigan
Distinguished Professor of Psychology
Illinois Institute of Technology
Director, Center for Health Equity, Education and Research (CHEER)
Galvin Tower
10 W 35th Street
Chicago, IL 60616
312 567-6751
pronouns: he, him, his

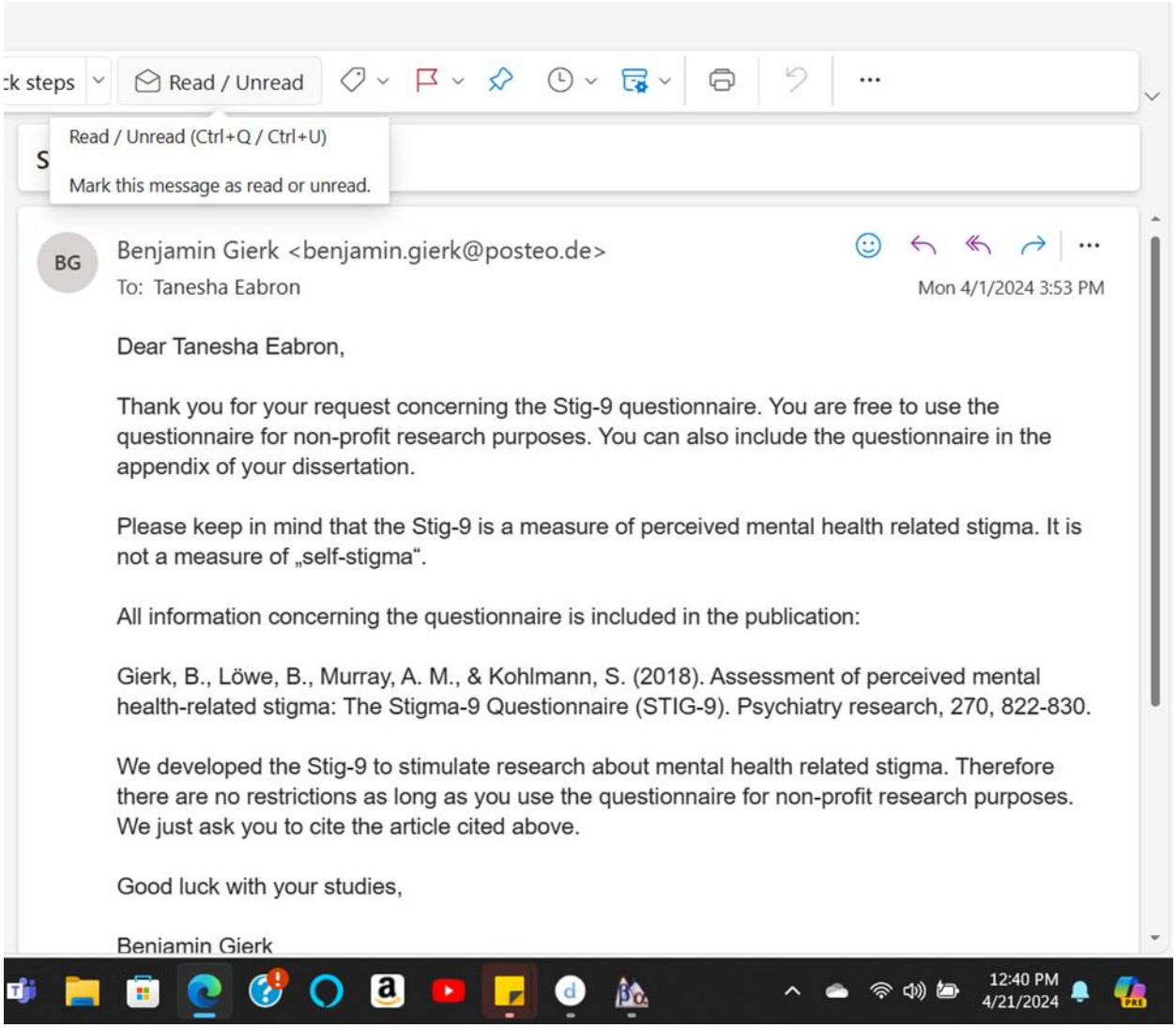
National Consortium on Stigma and Empowerment www.ncse1.org
Honest, Open, Proud program www.hopprogram.org
Chicago Health Disparities Center www.chicagohealthdisparities.org

Stigma and Health Journal www.apa.org/pubs/journals/sah/

12:42 PM
4/21/2024

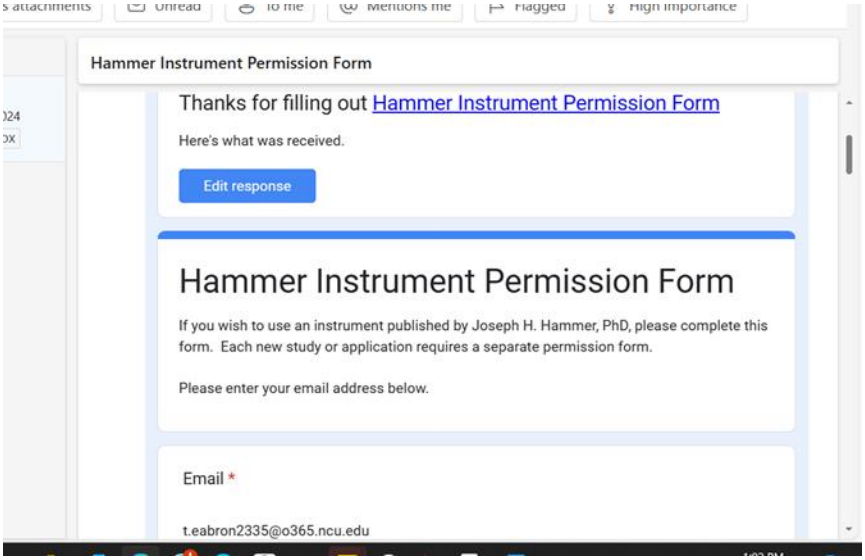
Appendix E

STIG 9 Questionnaire Permission to Use



Appendix F

The Mental Health Seeking Attitude Scale (MHSAS)



Appendix G

Email Instructions

Hello,
Thank you for your interest in participating in my research study about the effectiveness of NAMI Family and Friends Seminar on mental health stigma and help seeking behavior.
I am looking forward to seeing you on Saturday. Also, I am attaching the consent form so you can understand what the study entails.
Here are the details you will need:
Date: Saturday, March 1,2025
Time: 1:00-3:00pm
Here is the zoom :
https://us06web.zoom.us/j/85775565680?pwd=BTVKqUaU1NitERyXjwSZyKM9jjLezt.1

Please take 10-15 minutes to complete the 4 surveys below before attending the seminar.
https://forms.gle/iSDTBL59KSrPyizR8
https://forms.gle/GNFojWaCWov8gYvq8
https://forms.gle/KFGz6TCS9MpVPALBA
https://forms.gle/XJxVvNX9fzTQQJ2F6
Recommendations:

- Please join about 10 minutes early in case there are any technical issues, so we can start on time.
- I recommend using Google Chrome or a laptop/computer to open the Zoom link as it may not work well with other internet platforms.
- If possible, find a quiet place that is free of distractions and noise. This will help you and other participants have a better experience.

Please email me if you have any issues or concerns about logging on that day!

Thanks,
Tanesha Eabron

Appendix H

UNIVERSITY | irb@nu.edu

Consent Form

My name is Tanesha Eabron, and I am a doctoral student at National University (NU).

I'm asking you to take part in a research study about the effectiveness of psychoeducational intervention on mental health stigma and help -seeking. The name of this research is "[Impact of Psychoeducation Intervention on Stigma and Help Seeking among African Americans.
You may participate in this research if you meet all of the following criteria:

1. You are 18 or older
2. You identify as African American
3. You were born in the United States
4. You live in Northwest Arkansas (Washington or Benton County)

I hope to include 45 people in this research.

Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What you will be asked to do: If you agree to be in this study, you will be asked to do the following activities:

1. Complete a set of 48 questions from four paper-based surveys (demographic survey, Stigma-9 Questionnaire, Self- Stigma of Mental Illness Short Form, and Mental Health Seeking Attitude Scale) in person or online for 15 minutes before seminar in Blue Cross Blue Shield community room or via zoom.
2. Participate in the NAMI Family and Friends Seminar in person for 90 minutes in the Blue Cross Blue Shield community room or via zoom.
3. Complete a set of 38 questions from three paper-based surveys the Stigma-9 Questionnaire, Self- Stigma of Mental Illness Short Form, and Mental Health Seeking Attitude Scale in person or via online for 15 minutes after the seminar in the Blue Cross Blue Shield community room.

During these activities, you will be asked questions about:

- Your age, gender, relationship status, level of education, household income, mental health status, and if you know someone who experience mental illness.
- Your beliefs about individuals with mental illness.
- Your beliefs on seeking help from a mental health professional.

Risks: There are minimal foreseeable risks, however, you may experience some discomfort with the questions asked on the questionnaires about stigma and by the information provided during the seminar about mental illness. To decrease the impact of these risks, you can skip any question you do not wish to answer or stop participation at any time. At the end of the study or at any time you wish to stop participating in the study, you will be given a list of resources including coping skills sheet and places you can seek additional support in the community.

Benefits: If you participate, there are no direct benefits to you.This research may increase the body of knowledge in the subject area of this study.

Compensation: After you complete the surveys and attend the NAMI Family Friends Seminar, you can enter your name or email address in a drawing for a chance to receive a $10 Walmart gift card in person before you leave the study site or emailed to you after the zoom seminar.

National University IRB
9338 Lightwave Ave., San Diego, CA 92123
irb@nu.edu

Mandated Reporting: My professional role outside of NU requires me to report suspicion of child or elderly abuse, suspicion of possible harm to self or others, and committed crimes to the appropriate authorities.

Confidentiality: I will keep the records of this study private and take reasonable measures to protect the security of all your personal information. In any report I make public, I will not include any information that will make it possible to identify you. I will not include any information that will make it possible to identify you. I will securely store your data for 3 years. Then, I will delete electronic data and destroy paper data.

Taking part is voluntary: Participation in this study is completely voluntary. You may quit at any time.

If you have questions: Please ask any questions you have now. If you have questions later, you may contact me at t.eabron2335@o365.ncu.edu.

If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) via email at irb@nu.edu