1-1-2023

The Efficacy of Mental Health Stigma and Discrimination Reduction Initiatives Among BIPOC: A Meta-analysis of Outcome Studies

Janita M. Springfield

Recommended Citation

Springfield, Janita M., "The Efficacy of Mental Health Stigma and Discrimination Reduction Initiatives Among BIPOC: A Meta-analysis of Outcome Studies" (2023). *Electronic Theses and Dissertations*. 2584.
https://egrove.olemiss.edu/etd/2584

THE EFFICACY OF MENTAL HEALTH STIGMA AND DISCRIMINATION REDUCTION INITIATIVES AMONG BIPOC: A META-ANALYSIS OF OUTCOME STUDIES

A Dissertation
presented in partial fulfillment of the requirements
for the degree of Doctorate of Philosophy
in the Department of Leadership and Counselor Education
The University of Mississippi

by

JANITA M. SPRINGFIELD

MAY 2023

ABSTRACT

Objective: An under-utilization of mental health care services among BIPOC exists, and one of the leading drivers of this barrier is stigma. Given a plethora of research on reducing the stigma associated with mental health issues, the present meta-analysis aimed to investigate the effectiveness, or lack thereof, of SDR interventions among BIPOC. **Method**: The present meta-analysis was performed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines to establish complete and accurate reporting of information. A systematic review yielded a total of seven articles meeting the predetermined inclusion criteria. Effect sizes were computed for all studies and for each treatment condition within the studies. **Results**: Sample sizes of the studies varied from 42 to 196 with a total of 609 participants across the selected studies. Collectively, studies investigated the effectiveness of SDR interventions among Black/African Americans, Korean (Asian) Americans, and Latinx. Overall outcomes of this meta-analysis suggest SDR interventions were not effective in reducing mental health stigma for BIPOC. **Conclusion:** Empirical conclusions and transparency on the current degree of effectiveness of mental health SDR interventions for BIPOC were provided through this study; however, the limited number of pooled studies suggests additional research is needed to identify positive SDR interventions for BIPOC.

DEDICATION

This dissertation is dedicated to my loving parents, Amy and Alfred Springfield, for your constant love and support. To my mom, thank you for modeling a beautiful example for me and for showing me the importance of family and faith. To my dad, thank you for your wise guidance and for teaching me to never give up on myself or my goals. Thank you both for always believing in me. I am forever thankful.

LIST OF ABBREVIATIONS AND SYMBOLS

AI/AN	American Indian/Alaska Native
AA/PI	Asian American/Pacific Islander
BIPOC	Black, Indigenous, and People of Color
CMA	Comprehensive Meta-Analysis
HSDF	Health Stigma and Discrimination Framework
ICC	Intergenerational cultural conflict
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCT	Randomized controlled trial
SDR	Stigma and discrimination reduction
USDHHS	U.S. Department of Health and Human Services

ACKNOWLEDGEMENTS

I would like to thank those who have helped me throughout my educational and professional journey of becoming a counselor educator. There were many individuals who have made a positive impact on my experience, but a particular group of individuals deserve special recognition. Thank you to Drs. Richard Balkin, Kenya Bledsoe, and Hannah Allen for serving as members of my dissertation committee. Dr. Balkin, I appreciate your willingness to meet with me and talk through my methodology. You were one person I could count on to share my excitement about research and statistics with, and your keen sense of humor made for some unforgettable laughs. Dr. Bledsoe, thank you for your support during this process. Your occasional well-being check-ins were truly appreciated. You helped me to take a step back and look at the bigger picture during such an all-consuming time. Dr. Allen, thank you for serving as an external committee member to my dissertation. Your outside perspective was just what I needed to make my dissertation a well-rounded document. I thank each of you for your time, commitment, and support.

Last but not least, I would like to express a special thanks to Dr. Stephanie Lusk Smith, one of the most selfless, giving, and supportive educators I have had the pleasure to know. Your continued support over the years has made all the difference in my academics. I am thankful to have had someone like you in my corner. You are truly appreciated.

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CHAPTER I: INTRODUCTION

Mental illness has become one of the most health conditions in the United States (National Alliance on Mental Illness [NAMI], 2022a). Millions of people are affected by mental health conditions each year, with 1 in 5 U.S. adults experiencing a mental illness, and 1 in 20 U.S. adults experiencing a serious mental illness (National Institute on Mental Health [NIMH], 2022b). The NAMI (2022b) reported that the rising cause of people with a disability is mental illness. Despite the growing societal awareness of the importance of mental health and the widespread prevalence of mental health issues in the U. S., over half of these adults do not receive treatment (NAMI, 2022b; Mental Health America [MHA], 2022), leaving many to unnecessarily suffer from symptoms. Unfortunately, this has been a long-standing problem as the number of Americans with unmet mental health needs has increased every year since 2011 (MHA, 2022). The vast impact of mental illness emphasizes that mental health conditions are not confined to a small number of predisposed individuals but are a major public health problem with considerably unfavorable outcomes for society. Untreated mental health conditions can negatively affect a person’s life and can increase one’s risk for unemployment, homelessness, substance use, disability, death by suicide, and poor quality of life (Brådvik, 2018; Elbogen et al., 2021; McKnight-Eily et al., 2021; NIMH, 2021a).

Although mental health challenges are experienced across the general public, certain racial/ethnic groups are disproportionately affected (McGuire et al., 2008; McKnight-Eily et al., 2021), as they encounter higher levels of bias (Hall et al., 2015; Rattan, 2022; Staats et al., 2017), and experience poorer mental health outcomes than their White counterparts (McGuire et al., 2008). In 2001, the landmark Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity*, declared the existence of significant disparities in mental health treatment engagement and mental health care among persons from racial-ethnic minority groups (U.S. Department of Health and Human Services [USDHHS], 2001). This report also noted that racial, ethnic, and cultural factors related to stigma are among the more commonly reported barriers that hinder help-seeking behaviors or the continuation of mental health treatment (USDHHS, 2001). Now, more than 20 years later, these disparities still exist for Black, Indigenous, and People of Color (BIPOC). Consequences related to these noted disparities have led to negative primary outcomes such as decreased engagement in high-quality care, including the use of evidence-based medications and therapy (Rattan, 2022), access to culturally sensitive mental health services, and poorer quality of care if and when treatment is available (USDHHS, 2001). The significant inequities in the utilization and quality of mental health care provided to people of color often leads them to end services prematurely, which impacts their overall quality of life (Adames et al., 2022; Alegria et al., 2002; McGuire et al., 2008).

A factor that has been commonly cited as a key contributor to these mental health disparities is the stigmatization of mental illness (Collins et al., 2014; Corrigan & Penn, 1999; Gray, 2002). Mental health stigma is a substantial problem all over the world, including the U.S. According to an early report on mental health from the office of the U.S. Surgeon General (USDHHS, 1999), mental illness stigma disrupts quality of life; erodes confidence that mental disorders are valid, treatable conditions; and leads people to avoid socializing, employing/working with, and renting to persons with a mental disorder. Due to these consequences of mental health stigma, the report also noted that the field of mental health is challenged by disparities in the availability of and access to its services. Further, in 2001, the

World Health Organization (WHO) declared that “the single most important barrier to overcome in the community is the stigma and associated discrimination toward persons suffering from mental and behavioral disorders” (World Health Organization, 2001, p. 98). Mental health stigma is related to several negative outcomes, such as those mentioned above, but also secondary outcomes, or problems that develop as a result of untreated or poor treatment of mental health disorders. Secondary outcomes influenced by stigma may include higher unemployment and underemployment rates, high work absenteeism and employee turnover, poor and unsafe housing, and increased economic cost (Knifton & Inglis, 2020; NAMI, 2021). While stigma is pervasive and impacts access to mental health care regardless of background, underrepresented groups often deal with more stigma and discrimination. Therefore, reducing the stigma associated with mental illness may be a significant step in addressing the disparities experienced by individuals of color and improving their overall quality of life.

Statement of the Problem

An under-utilization of mental health care services among BIPOC exists, and one of the leading drivers of this barrier is stigma (Corrigan et al., 2006; Henderson et al., 2013). Negative attitudes and beliefs toward people who live with mental health conditions are widespread in the U.S., and people of color face many adverse and unfavorable outcomes as a result (Williams, 2005). Black adults in the U.S. are more likely than White adults to report prolonged symptoms of emotional and psychological distress and are also more likely to experience their first contact with mental health services in emergency rooms and primary care as opposed to mental health specialists (Alegría et al., 2002; Snowden & Cheung, 1990; Williams, 2005), which suggests consistent mental health care is not being received. Despite the presence of increased mental health needs in this community, only one in three Black adults who need mental health care receive it (NAMI, 2022a). Additionally, Asian American/Pacific Islanders (AA/PIs) experience alarming disparities as well. According to the National Survey on Drug Use and Health, AA/PI adults are almost three times less likely than White adults to seek mental health services for unmet needs, and even more concerning, they are least likely to seek mental health services than any other racial/ethnic group (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Mental health service utilization rates are also low for American Indians and Alaska Natives (AI/ANs), and in 2014, suicide was the second leading cause of death for AI/ANs between the ages of 10 and 34 (SAMHSA, 2021). The American Psychiatric Association (2017) noted that the stigmatization of mental illness is a significant factor for disparities experienced by AI/ANs. Additionally, Latinx individuals experience cultural stigma associated with mental illness and are more likely to report poor communication with their mental health provider (NAMI, 2022a). They are also about half as likely to seek mental health care compared with White individuals (USDHHS, 2001).

Stigma is a key problem for BIPOC individuals with mental illness as stigma may prevent BIPOC individuals from seeking treatment, and even if they do, they are more likely to receive poor quality and culturally insensitive care. Therefore, working to reduce mental health stigma is of extreme importance. The WHO charged mental health professionals to develop programs that address stigma and psychiatric outcomes, which led to the development and continuation of a number of programs and initiatives in the U.S. known as stigma and discrimination reduction (SDR) programs (Collins et al., 2012). Components of SDR programs may include training, education, media campaigns, and contact with people with mental illness and are typically divided into two categories: 1) training interventions that involve in-person communication between a mental health advocate/professional and a small to moderate-sized group, and 2) mass media campaigns and broad multifaceted interventions (Gronholm, 2017). Although the existing literature on SDR programs has indicated promising outcomes towards mental health stigma, what remains unknown is to what degree SDR programs impact people of color and specifically, their initial help-seeking behavior. Collins et al. (2012) noted that a key limitation of existing research regarding stigma-reduction programs is the applicability to key subpopulations, such as racial and ethnic minorities, and the lack of studies that tested for differential effectiveness of an SDR intervention. Considerable methodological variability is evident among interventions that exist, therefore making it difficult for the public to determine what strategies are most effective. As such, this systematic meta-analysis will evaluate the effectiveness of various SDR interventions related to mental illnesses among BIPOC.

Purpose of the Study

The purpose of this research study is to conduct a comprehensive meta-analysis to investigate the efficacy of existing SDR programs. Of particular importance is identifying the degree to which SDR initiatives have increased or decreased treatment-seeking among BIPOC individuals with mental health symptoms. Conducting a meta-analysis of published outcomes from existing SDR programs can help identify the effectiveness, or lack thereof, of these programs among BIPOC communities. This analysis further delineates an empirical basis for applying evidence-based interventions that can potentially change attitudes toward BIPOC with mental illness, and it can establish clinical care standards that can be used to effectively end mental health stigma by continually decreasing its damaging consequences on marginalized communities with mental illness. Results from this study can provide valuable information for mental health professionals, local and national mental health organizations, and even the general public as they can be used to further develop new or enhance current SDR programs, particularly for individuals of color. Outcomes of this study can also increase mental health promotion and prevention efforts, increase awareness of the detriments of mental health stigma, and improve knowledge, attitudes, and willingness to address the specific mental health needs of this group.

Significance of the Study

Combating the stigma of mental health is a priority of the counseling profession. Specifically, an article published in *Counseling Today* reported that although stigma associated with mental health is a well-researched area, there exists a paucity of research that informs counselors on how to identify stigma and how to process and address stigma to decrease its impact on the client (Lott, 2022). For this reason, identifying effective SDR interventions can assist mental health professionals in targeting interventions that enhance help-seeking behavior, quality of care, and treatment engagement among their BIPOC clients. The identification of efficacious interventions is an essential step in providing much needed care in these communities. The current study can also increase awareness of the unique stigma experienced by BIPOC and improve people's attitudes toward people with mental illness. Furthermore, the results of this meta-analysis can advance the understanding of the clinical effectiveness of SDR initiatives in a variety of mental health disorders among BIPOC.

Research Questions

The following research questions will be addressed in this study:

Research Question 1: What is the degree of effectiveness of stigma and discrimination reduction programs on stigmatizing attitudes among Black, Indigenous, and People of Color with mental health symptoms?

Research Question 2: Which types of stigma and discrimination reduction programs are most effective among Black, Indigenous, and People of Color with mental health symptoms?

Research Question 3: What are the moderating effects of sample and study characteristics on the effectiveness of stigma and discrimination reduction initiatives for black, indigenous, and people of color?

Assumptions and Limitations of the Study

A considerable limitation of this meta-analysis will be the omission of qualitative and mixed-methods studies. Qualitative research is a reputable form of naturalistic inquiry that seeks an in-depth understanding of social phenomena by collecting and analyzing non-numerical data to better understand concepts, opinions, and experiences (Marshall et al., 2022). Qualitative inquiry can be used to generate rich information on a problem or develop new ideas for research. However, this approach can be greatly dependent on the individual skills of the researcher and can be more easily influenced by the researcher's personal biases. Additionally, the methodology used in this study will be a meta-analysis, which specifically analyzes quantitative data to develop a more conclusive estimate of effect (Siddaway et al., 2019), and this is unobtainable with qualitative data.

A second limitation of this study will be the restriction to English-language studies only. Determination of this exclusion criteria stems from barriers related to time and costs required to obtain and translate studies. However, systematic reviews and meta-analyses that exclude non-English articles may miss important empirical evidence. Morrison et al. (2012) reported that the selection of studies in a particular language is called a *language bias*, and this bias could lead to an over- or underestimation of an intervention's effectiveness. Although the researchers found no evidence of bias from the use of language in their investigation of the effect of English-language restriction on meta-analyses, this finding does not rule out the potential for language bias to occur when language restrictions are imposed. Neimann, Rasmussen, and Montgomery (2018) expanded on this research, and their findings indicated a connection between the limited inclusion of non-English studies and a lack of resources, which inadvertently forces researchers to depend on their limited language skills rather than the professional support of translators. Though the impact of this limitation varies across studies, efforts should be made to acknowledge and/or mitigate this limitation when possible.

Definitions and Terms

BIPOC: Black, Indigenous, and people of color. It is pronounced as “bye-pock” and is a term specific to the United States that is intended to center the experiences of groups who face racism and discrimination in a white-dominant culture (Adames et al., 2022).

Mental health: “A state of well-being in which the individual realizes their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community" (WHO, 2004, p. 10).

Mental health disorders: Identified by clinically significant disturbances in an individual’s cognition, emotion regulation, or behavior (American Psychiatric Association, 2013).

Mental health disparities: Disparities between the health of persons with mental illness as compared with those without mental illness and disparities between populations with respect to mental health and the quality, accessibility, and outcomes of mental health care (Marrast et al., 2016; Safran et al., 2009).

Mental health help-seeking behavior: The action of actively searching for help for mental health concerns (Aguirre Velasco et al., 2020).

Mental health stigma: The disgrace, social disapproval, or social discrediting of individuals with a mental health problem (Goffman, 1963; Kalichman, 2019).

Perceived/Internalized stigma: Occurs when individuals believe and apply the negative messages or stereotypes believed about mental illness to themselves (Gray, 2002).

Public stigma: A set of negative attitudes and beliefs that encourages individuals to fear, reject, avoid, and discriminate against people with mental health disorders (Corrigan & Penn, 1999).

Stigma: "Exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together where power must be exercised" (Link & Phelan, 2001, p. 377).

Structural stigma: Inequities that are manifested through laws, policies, and practices and result in the unfair treatment of people with mental health conditions (Hatzenbuehler, 2016).

Summary and Organization of Remaining Chapters

This chapter described the pervasiveness of mental illness in the U.S, the existence of mental health disparities among BIPOC, the role of stigmatization on mental illness, and the importance of investigating the effectiveness of SDR initiatives for vulnerable populations. A central goal of this research study is to concurrently bring awareness to the unique mental health challenges of BIPOC and to propose solutions that can mitigate these challenges moving forward. As such, current issues and barriers were addressed in the statement of the problem, and potential solutions to these problems were addressed in the purpose and significance of the study. Collectively, this chapter described the importance of the research topic, provided context to the specific research aims and objectives of the study, and provided a foundation to support the remaining chapters.

Chapter two provides an exhaustive review of the literature, including existing meta-analyses related to this topic, an in-depth overview of mental health stigma through a historical and modern lens, the role of intersectional stigma, vivid depictions of the role of mental health stigma on Black/African American, Asian American and Pacific Islander, Latinx/Hispanic, and American Indian and Alaska Native populations, and the relevance of this topic to counseling practice. Furthermore, chapter three expounds upon the research design and rationale of this study and provides a breakdown of the methodology of meta-analyses, including search procedures, methodological quality of included studies, statistical procedures and conventions, method of synthesis, and publication bias and selective reporting.

CHAPTER II: LITERATURE REVIEW

Considering the increasing attention given towards reducing health inequities in the U.S., particularly the existence of mental health disparities, understanding the impact of stigma and the effectiveness of stigma and discrimination reduction (SDR) programs for people of color is of particular importance. Stigma related to mental health exacerbates mental health disparities by creating barriers to help-seeking behavior and attitudes toward mental health treatment (Henderson et al., 2013). Well-Wilbon et al. (2022) noted that people with mental health disorders experience distress and poor access to healthcare due to the intersecting factors of fear, stigma, prejudice, and discrimination; this is especially true for communities of color.

The United States has experienced a rapid transition in demographics with about 4 out of 10 Americans, a 276% increase from 2010-2020, currently identifying with a race or ethnic group other than White (United States Census Bureau, 2021). As a result, additional efforts should be made to identify evidence-based techniques that support the reduction of stigma related to mental health and promote culturally sensitive client-centered care. Racial and ethnic groups have experienced marginalization for many years, and because of this, many have unique healthcare needs and are faced with challenges surrounding safety, security, and a sense of connection/integration to mental health services (Baah et al., 2018;2019). Therefore, this review of the literature will not only identify those groups often marginalized, but also focus primarily on one of the most common factors perpetuating the existence of mental health disparities among them: stigma.

Theoretical Framework

Mental health-related stigma is a distinctly complex construct that manifests in a number of ways and results in a variety of negative outcomes; therefore, approaching this area of research using a theoretical framework that equally identifies the complexities of stigma and also illustrates a roadmap for intervention and reduction of said stigma is pertinent. The Health Stigma and Discrimination Framework (HSDF), developed by Stangl and colleagues (2019), provided a foundation for both conceptualizing and responding to mental health-related stigma. This framework is based on theory, research, and practice, and it offers practical applications for program implementers, policymakers, and researchers alike. Many stigma-related theoretical frameworks have typically focused on one health condition in isolation, and consequently, encouraged a siloed approach to research efforts whereby professionals are working to answer similar research questions through different approaches and generating no comprehensive understanding. However, the HSDF demonstrates application to a range of health conditions, including mental health, and shows how a common framework can be used to enhance research and interventions.

As mental health stigma is an issue that affects the lives of millions, efforts towards its reduction and eventual eradication require multi-level intervention; the HSDF model supports this by identifying areas where clinicians, stakeholders, and policymakers can work to improve health outcomes among their clients, communities, and societies. The HSDF differs from many other stigma frameworks by not distinguishing the *stigmatized* from the *stigmatizer*. According to Kippax et al. (2013), there is danger in separating the two because it removes the power that vulnerable populations possess to resist the social contexts driving the stigma experiences. Attention is instead focused on the broader social, cultural, political, and economic forces that structure stigma by identifying the “interconnections between power and vulnerability and how they are fluid and complex” (Stangl et al., 2019, p. 4). Being that one of the cardinal goals of this research project is to inform best practices towards mental health stigma-reduction programs, and not simply identify the existence of stigma, this framework is particularly useful.

There are several components that make up the HSDF. This framework holds that stigma unfolds across the socio-ecological spectrum in the context of health, which varies across economic contexts in low-, middle-, and high-income countries (Stangl et al., 2019). The process of stigma is articulated through a series of constituent domains: drivers and facilitators, stigma ‘marking’, and stigma manifestations. These domains influence a range of outcomes among affected populations on the individual, interpersonal, organizational, community, and public levels that are believed to eventually impact health and society.

As described through this model, experiences of stigma stem from drivers and facilitators. Drivers of stigma, which can range from social judgment and fear of social/economic ramifications to lack of awareness and fear of infection, negatively influence the stigmatization process. These drivers are grounded in stereotypes, prejudice, and negative public attitudes, that are fueled and reinforced by the stigmatization process; they also contribute to the negative perceptions of people with mental illness (e.g., incompetent, dangerous, and violent; unable to work or live independently; and being responsible for their mental illness) (Stangl et al., 2019). As proposed through the HSDF model, these stigma manifestations subsequently influence a number of outcomes, including access to justice, advocacy, and a key construct of this current study: the acceptability of mental health services. Conversely, facilitators such as health policy, social equality, and cultural norms are factors that can influence the stigmatization process either positively or negatively, leading to variation in outcomes for affected populations. Drivers and facilitators determine whether stigma ‘marking’ occurs, which is when a stigma is applied to people or groups according to a specific health condition or other identified difference (Stangl et al., 2019). Stigma is still pervasive in the U.S. because these facilitators often manifest in more negative ways that hinder treatment-seeking than positive ways that facilitate treatment-seeking.

Race is also acknowledged as a key role in the manifestation of stigma through this framework. Stangl et al. (2019) described how all individuals can perceive, experience, and internalize stigma, but also recognizes the unique outcomes for affected populations. This framework works from and through an understanding of intersectional stigma, which identifies how race, occupation, gender, and class intersect with health-related stigmas. Cumulatively, the negative impacts of stigma are compounded by intersectional stigma and lead to poorer health outcomes for the most vulnerable populations (Stangl et al., 2019; Turan et al., 2019). Although there are no clear-cut boundaries for how stigma manifests and who perpetuates it, the HSDF highlights how stigma intersects with other axes of disempowerment and marginalization on multiple levels.

Systematic Review of Current Literature

A complete search of the literature was conducted to identify previously conducted meta-analyses or meta-analytic studies that have examined the efficacy of mental health stigma-reduction programs for Black, Indigenous, and People of Color (BIPOC). A complete search of the literature was conducted using the Cochrane Library, Google Scholar, EBSCO, ProQuest, PubMed, Science Direct, and Scopus. The following search terms were utilized: (“mental health” or “mental illness” or “mental health disorder” or “mental disorders”) AND (“stigma reduction” or “stigma reduction interventions” or “antistigma” or “stigma change”) AND (“meta-analysis” or “meta-analytic”). With the specific goal of identifying previously conducted meta-analyses, the search terms: meta-analysis or meta-analytic were required to appear within either the title, abstract, or keywords of the article/manuscript/dissertation/thesis.

This search yielded a total of four academic documents within the Cochrane Library, four academic documents in Google Scholar, five academic documents in EBSCO, two academic documents in ProQuest, eight academic documents in PubMed, three academic documents in Science Direct, five academic documents in SCOPUS, and two academic documents in ProQuest. All articles underwent multi-pass deduplication in a citation management software (EndNote), and a total of 13 meta-analyses or meta-analytic studies remained.

Through this systematic search of the literature, all articles were analyzed to identify the extent to which they addressed the intended scope of this dissertation. By and large, BIPOC mental health outcomes were not discussed in the meta-analyses. The lack of attention given to specific characteristics of participants (e.g., race, ethnicity, culture) was often described as limitations of the analyses and presented as areas for future research. For example, Lien et al. (2020;2021) noted that some factors known to influence attitude and stigma such as gender, previous experience with mental illness, and race/culture were not evaluated in their meta-analysis of mental illness stigma among healthcare professionals (HCPs) and students due to the limited research regarding anti-stigma interventions for mental illness among HCPs up to date. Thus, in order to generate foundational literature on this topic, critical factors that could have influenced the results of the meta-analysis were not examined.

Similarly, Corrigan et al. (2012) conducted a meta-analysis of outcome studies regarding public stigma of mental illness and acknowledged that one area not discussed in their review was the impact of multiple stigmas and the interaction of multiple prejudices. The authors highlighted the lack of focus on race and other characteristics as a considerable limitation of their study.

Conversely, Corrigan et al. (2012) provided context to this limitation by describing stigma as a local issue that requires the dissemination of future SDR programs and initiatives through a community-based participatory research approach between researchers and local advocates to better address the interaction of multiple prejudices. Additionally, Griffiths et al. (2014) evaluated the efficacy of different types of SDR interventions, including education, consumer contact, and cognitive behavior therapy in reducing various forms of stigma for mental health disorders. In this study, factors of race and ethnicity were also not discussed; however, rather than describing this as a limitation, similar to Lien et al. (2020;2021) and Corrigan et al. (2012), Griffiths et al. (2014) specifically excluded studies that addressed the stigma associated with factors other than mental illness, such as race.

Moreover, some meta-analyses referred to either race or culture in their results. Doley et al. (2017) extracted specific descriptions of participants (where available) including gender, country, age, SES, occupation/field of study, and ethnicity in their meta-analysis of interventions to reduce the stigma of eating disorders. Notably different from the previous studies, Doley et al. (2017) reported that in addition to investigating stigma outcomes directly, it was also important to assess secondary outcomes and study characteristics among the stigma interventions. The results indicated that study populations included low percentages of people who did not identify as White or Caucasian. Although outcomes related to race/ethnicity were included, they were brief and lacked data identifying the percentages of each demographic group and inferences on how the lack of diversity in population affected the results. Maunder and White (2019) also described some cultural factors in the results of their meta-analysis of intergroup contact SDR interventions on mental health stigma. The researchers noted that characteristics of the participants involved in the interventions, in addition to their cultural beliefs about mental illness, may also moderate its effectiveness. Results of this meta-analysis indicated that the effect of intergroup contact immediately after the intervention and in the short-term was significantly larger in non-Western (Asian and Middle Eastern) countries compared to Western countries. This finding also supports existing stigma reduction literature that Asian populations benefit more from contact interventions compared to Caucasians (Rao et al., 2007). However, no additional results related to culture were described.

Collectively, a total of 13 articles were reviewed in an attempt to identify previous meta-analyses that have evaluated the efficacy of mental health stigma and discrimination reduction programs and the extent to which BIPOC mental health outcomes were addressed in the analyses. Throughout this systematic search of the literature, BIPOC outcomes were largely absent and none of the reviewed studies addressed BIPOC outcomes comprehensively.

Mental Health Stigma and Discrimination Reduction Interventions

In recent years, advocacy groups and mental health charities have developed and implemented anti-stigma interventions across the world. The goal of these interventions is to reduce the stigma associated with mental illness and improve the overall well-being for individuals most affected. Stigma and discrimination reduction (SDR) interventions target various components of stigma, including self, structural, and public stigma, and therefore, vary widely in their design and implementation. According to the literature, there are three prominent types of mental health SDR interventions: (a) education; (b) contact; and (c) protest and advocacy (Corrigan & Gelb, 2006).

Educational anti-stigma interventions focus on factual information about the stigmatized mental illness with the goal of challenging inaccurate stereotypes or negative beliefs and attitudes (Corrigan et al., 2012). This strategy uses books, information sessions, videos, movies, announcements, and other audio-visual aids to counter myths about mental illness and replace them with facts (Finkelstein et al., 2016). Educational interventions generally target public stigma, but they have also shown effectiveness in reducing self-stigma and improving self-esteem (Cook et al., 2014). However, these reductions have mainly yielded short-term improvements in attitudes.

Contact-based interventions provide a more interpersonal approach to reducing stigma associated with mental illness. Face-to-face interactions between a person with a mental illness and the general public are employed to challenge prejudice (Pettigrew & Tropp, 2008). Contact interventions aim to reduce the discomfort, distrust, and fear that emerges from a lack of contact with individuals who have a mental illness and to facilitate positive interaction and connection (Brown et al., 2010). These strategies are aimed at reducing the effects of public stigma on a person-to-person level but have also been shown to reduce self-stigma by boosting self-esteem, similar to education-based interventions (Corrigan et al., 2013). As such, contact-based interventions are frequently combined with educational interventions to provide both factual and personalized information.

Protest and advocacy interventions are rooted in social justice and advancing civil rights agendas. The goal is to suppress negative attitudes at the grassroots level for those who have experienced stigma and discrimination by collaborating with advocates and community leaders (Corrigan, et al., 2001). Protest methods focus on dismantling stigmatizing advertisements, news stories, and media outlets through marches, press-releases, sit-ins, and boycotts, and they are generally targeted to politicians, journalists, and community officials (Arboleda-Florez & Stuart, 2012). Among all of the antistigma interventions, protests are the least common and least studied (Walsh & Foster, 2021).

Mental Illness Stigma through a Historical Lens

Ancient Greece

The term *stigma* originates from ancient Greek language. During this time, stigma symbolized burning or cutting marks into the skin of criminals, slaves, and traitors to identify them as immoral beings who should be avoided (Falk, 2001). In Greece, at the time of Homer (800 B.C.), many individuals believed that people became mentally ill because the gods had taken their minds. Evidence of trepanation, which is the practice of drilling circular holes with stone tools into a person's skull who was considered abnormal, has been found in prehistoric human remains (Arani et al., 2012). The goal of these primitive surgeries was to alleviate pressure on the brain following a cranial injury or, more commonly, to rid evil spirits from the heads of individuals who were deemed mentally ill (Woods, 2011). As described in Hinshaw (2006;2007), a limited number of temples also began to serve as places of refuge during this time. Individuals with symptoms of mental disturbance visited these temples to fast, receive purification through bathing and rest, and even be placed in dreamlike states through the use of psychedelics and analgesics (Tzeferakos & Douzenis, 2014). Although hundreds of temples were established in Greece, a majority of individuals with mental illness were unable to travel to these places of refuge or were denied entry and murdered (stoned to death) instead.

Middle Ages

During the Medieval period, mental illness was believed to be a punishment from God (Hajar, 2012; Rössler, 2016). The rise of Christianity encouraged a range of philosophical, religious, and occult beliefs about the manifestation of mental disturbance, and the spread of the Christian doctrine also permitted practices such as exorcisms to remove evil spirits from afflicted individuals because their religious faith was not strong enough to withstand possession by demonic forces (Hajar, 2012; Hinshaw, 2006;2007). Szasz (1961) described individuals with mental illness as weak beings who needed to be saved by God. Much of the abnormal behavior of people with mental illness during the Middle Ages became heavily affiliated with the pernicious efforts of witches. Religious authorities believed people with mental illness were responsible for altering the natural order of human existence by casting spells on unsuspecting people (Segal, 1978). In 1484, the German professors and Dominican friars, Jacobus Sprenger and Heinrich Kramer, obtained the power to investigate, torture, and murder witches (Kramer, & Sprenger, 1487) and developed three distinct levels to identify their offenses and subsequent punishment. The three levels were: 1) slight; 2) great; and 3) very great, with slight offenses representing something as simple as the meeting of small groups to secretly practice witchcraft, and very great offenses representing respecting and admiring heretics.

A "witchcraft craze" rippled through Europe, and according to Zilboorg's (1941) estimate, hundreds of thousands of witches were tortured and murdered in the 16th century alone. Burning the accused witch to death after being found guilty was mandatory. However, if a woman was suspected of engaging in witchcraft but was not prosecuted, she was thrown out into the streets by her family and forced to live in the stable with horses and cattle (Clausen & Yarrow, 1955; Kramer, & Sprenger, 1487). Extreme acts of violence shown through incidents like the "witchcraft craze" depicts the devastating treatment of individuals who were presumed to have an illness of the mind.

Enlightenment Period

With the Enlightenment period of the 18th century, individuals with a mental illness were less commonly viewed as possessed and evil but were still viewed as suffering from unknown diseases. A growing number of scholars and physicians expounded upon scientific and biological theories and classifications of mental afflictions; however, traditional, inhumane treatments were still being utilized. One of the more common treatments used was bloodletting. Scientists believed that excess blood was related to mood swings and shifts, so blood was extracted using a small blade or by attaching leeches to the skin (Kuriyama, 1995). Other treatments included abandoning individuals to the countryside, submerging them into water, twirling them to the point of unconsciousness, and chaining them in asylums (Hinshaw, 2006;2007). Extreme measures such as these were presumed to not affect the mentally ill in the same ways they affected normal people, so inhumane conditions were justified (Weinstein, 1983). A radical school of thought was born out of the crisis theory, which posited that physical crisis could lift the soul of the mentally ill and address the reasons for their afflicted states (Lindemann, 1994). Facilities designed specifically for those with mental disorders were still in development, so asylums for housing people with leprosy were used instead. Towards the end of the 18th century, social and political forces demanded human liberation and advocated for naturalistic, rather than demonologic, treatments for mental disorders (Hinshaw, 2006;2007).

Eugenics

The 20th century witnessed several major events related to mental illness. British scientist Sir Francis Galton argued that humanity was becoming infested with genetically inferior “stock”, such as individuals with a mental illness, a criminal history, or an ethnic minority background (Galton, 1909). Galton coined the term “eugenics”, which means “well born”, and theorized that the use of involuntary sterilization, segregation, and social exclusion would dimmish individuals deemed to be unfit, and thereby, encourage the fittest members of society to reproduce and save humanity from destruction.

Galton’s (1909) theory was characterized by both *positive eugenics*, the encouragement of breeding among parents with desirable traits, and by *negative eugenics*, the restriction of reproductive rights of persons deemed physically, mentally, or morally "undesirable." By 1907, the first state sterilization act was passed in the U.S., and by 1940, 30 states mandated the sterilization for those with insanity originating from mental illnesses, rape convictions and violence, and various forms of criminality, including “idiocy” and “imbecility” (Hinshaw, 2006; 2007). More than 36,000 people were sterilized in the U.S. from 1907 through the early 1940s; however, estimates of Black or African American individuals were almost double that number (Black, 2003). In addition to race, there was an over-representation of women from racial-ethnic minority groups who were sterilized, and according to reports from Colen (1990), this has resulted in ‘stratified reproduction’, which describes how some women have more opportunities to understand their reproductive health than other women due to structured social and cultural boundaries. Black women were especially discriminated against as they were one of the most targeted populations for forced sterilizations. These forms of stigmatization and discrimination peaked during the Nazi reign in Germany (Rössler, 2016). Within three years of the passage of the Eugenic Sterilization Law, over a quarter of a million Germans with a wide range of physical, mental, and intellectual disabilities had been sterilized under Adolf Hitler’s dictatorship. This also culminated in the near destruction of Jewish people. Ultimately, the theory of eugenics is linked to historical and present-day forms of ableism, discrimination, racism, and colonialism (National Human Genome Research Institute, 2022).

Mental Health Stigma Modern Conceptions

Modern conceptions of stigma have evolved into more widespread social disapproval. This concept has more recently been perceived as an overarching theory that captures a range of interlinking aspects from the individual to the structural. Although overt forms of moral and ethical judgments declined, the rise of scientific conceptualizations of abnormal behavior emerged.

Stigma was originally described in the U.S. by Goffman (1963) as any characteristic or attribute of a person that is devalued, discredited, or considered shameful. Goffman described a stigmatized individual as "reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 3). An example of a stigmatized attribute is one that is readily discernable, such as one's skin color or body size, or one that could be hidden but deemed discreditable if revealed, such as an individual with a mental illness or criminal record. Goffman's broad definition of stigma incorporates many present-day discredited attributes, including what he described as "tribal stigmas" (e.g., race, ethnicity, culture, and religion); "individual blemishes of character" (e.g., mental illness, addiction, homelessness, and homosexuality); and "physical deformities" (e.g., deafness, blindness, and leprosy); however, Goffman posited that the main elements of stigma are labeling, stereotyping, social isolation, rejection, prejudice, ignorance, status loss, marginalization, and discrimination. Through this worldview, stigma only exists in the relationship between the *attribute* and the *audience* (society), not solely in the attribute of the person being stigmatized or in the audience. This means that stigma does not reside in the person but rather in the social context.

Jones et al. (1984) elaborated on Goffman's conceptualization of stigma by focusing on the relationship between attributes and stereotypes. The authors described stigma as a mark or a deviation from a norm and reframed Goffman's three broad categories of stigmatized status into six dimensions of stigmatized attributes that documented the way stigma differs from one dimension to the next. The first dimension is *concealability*, which is characterized by hiding the stigmatized attribute from others to avoid negative consequences. The second dimension is *course,* which is the extent to which a stigma exists over time. If an individual is expected to live with their condition for a long period of time, then more negative attitudes are attributed; however, if the person is expected to recover from their condition, then more positive attitudes are attributed. For example, Hinshaw (2006;2007) suggested that chronic illnesses such as AIDS and paralysis tend to receive more stigmatization than acute conditions such as the flu or acute bronchitis.

The third dimension of Jones' et al. (1984) stigma conceptualization is *disruptiveness,* which is the extent to which a stigma disrupts social interactions and interpersonal relationships. The fourth dimension is *aesthetics*. This dimension of stigma is based on appearance and is attributed when an individual does not portray aesthetic qualities that fit into the norm. Appearing disheveled and exhibiting irrational behavior are considered noteworthy characteristics among individuals with a mental illness and can result in negative emotional reactions. The fifth dimension is *origin*, which describes the cause of the stigmatized condition (i.e., birth, accidental, deliberate); however, when a person is perceived to be responsible for their condition, enhanced stigma is experienced. The sixth dimension is *peril*, which is the extent to which a stigma poses a personal threat or potential of infection to others. As such, individuals with a mental illness are more likely to encounter hostile rather than empathetic experiences because they are perceived to be dangerous. For a group or individual to be stigmatized in one or more of these dimensions, a negative belief or reaction must be shared by a large group of people or a culture, which is similar to Goffman's ideals on the manifestation of stigma. Although these conceptualizations pioneered the theory of stigma, constructs of mental health or mental illness were not a specific focus.

Following these early conceptualizations of stigma, psychological and social-psychological research elaborated on the meaning of mental health stigma. Mental health stigma is described as the disgrace, social disapproval, or social discrediting of individuals with a mental health issue (Corrigan & Kleinlein, 2005; Corrigan & Watson, 2002; Link et al., 1989). Mental health stigma simultaneously occurs on multiple levels; it is operated in society (public stigma), internalized by individuals (self-stigma), manifested as barriers to individuals who may seek or engage in treatment services (structural stigma), and attributed by health professionals (health professional stigma).

Public stigma, also known as social stigma, refers to negative attitudes toward individuals with mental illness that are held by the general public (Corrigan et al., 2012). These negative attitudes are often based on misconceptions that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn, 1999). In this context, stigma is embedded in the social framework in which persons with the stigmatized condition are less equal or are part of an inferior group. Link and Phelan (2001) noted that the entire process of public stigma is accompanied by significant embarrassment by the stigmatized individuals and by those associated with them. Self-stigma occurs when people internalize these negative public attitudes. Crocker (1996) described that stigma is not only manifested in the public but can also be internalized by the person with the mental health condition. Thus, the continued effect of public/social stigma can lead to feelings of inadequacy and shame about their condition. In self-stigma, the awareness that stigma is present within society can have a deleterious effect on a person’s self-esteem and self-efficacy (Corrigan et al., 2006), even if the individual has not been directly stigmatized.

Another layer to this is structural stigma, which is increasingly recognized as one of the most significant barriers to the quality of life of people with mental illness (Hatzenbuehler, 2016;

Hatzenbuehler & Link, 2014). Structural stigma is the societal-level conditions, cultural norms, and institutional practices that restrict opportunities and means of freedom from people with mental illness (Hatzenbuehler, 2016). This form of stigma results in inequities that are manifested through rules, policies, and procedures within the society at large (Hatzenbuehler & Link, 2014). The manifestation of structural stigma, "sets the context in which individuals in the community respond to the onset of mental health problems, clinicians respond to individuals who come for treatment, and public policy is crafted" (Pescosolido et al., 2010, p. 1324). Furthermore, evidence suggests that healthcare professionals share similar attitudes to those of the general population that individuals with a mental illness are incompetent, violent, and dangerous (Kopera et al., 2014; 2015; Stone et al., 2019). Research has suggested that health professionals may not provide early detection, adequate intervention, and community referral options for individuals with mental or behavior disorders (Gassman et al., 2001; Kopera et al., 2014;2015). Health professionals such as nurses and hospital staff, in particular, may use unnecessary restraint and seclusion when patients are perceived as dangerous, and Acker and Lawrence (2009) suggested that social workers may develop their own biases from their social upbringing or from burnout in their professional roles and impose these biases on individuals with severe and persistent mental illnesses.

Intersectional Stigma: Mental Health and BIPOC Populations

Eylem et al. (2020) argued that stigma is integral to understanding mental health disparities among racial and ethnic minority groups in the U.S. as it can partially explain why these disparities persist. The stigma surrounding mental health and illness is often a barrier to treatment for BIPOC (Henderson et al., 2013), and a unique factor impacting the mental health outcomes for this group is the intersectional stigma that stems from their experience of living with multiple identities that are each stigmatized in society (Bauer, 2014). Turan et al. (2019) explained that intersectional stigma emphasizes how the consequences of stigma are worse for some racial and ethnic groups who are faced with other forms of minority stress and structural discrimination within policies, institutions, and organizations. Individuals with overlapping and intersecting stigmatized social identities often face excess stress and additional discrimination and harassment, including microaggressions (Turan et al., 2019). Therefore, the impact of experiencing multiple stigmas concurrently may further impede mental health outcomes. Nevertheless, there are differences in the impact of mental health stigma depending on the racial and/or ethnic background as every BIPOC brings with them different experiences with stigma. Though there are some similarities among BIPOC, patterns of stigma and discrimination vary between and within communities.

Black/African Americans

When considering the mental health of African Americans, it is important to view their experience through a cultural and historical lens as African Americans with mental illness have specific interactions with stigma which contribute to adverse outcomes. Existing literature documents a lack of trust within this community in the healthcare system as their mental health issues are often compounded by the psychological stress of systemic racism. For example, Matthews et al. (2006) conducted a qualitative exploration of African Americans' attitudes toward mental illness and its treatment and found that many participants believed that mental illness was used as a negative, limiting label to diminish their character. This study also found that participants identified feelings of disgrace, isolation, and embarrassment associated with mental illness. Similar findings emerged in a more recent exploratory, cross-sectional study that found African Americans were not open to acknowledging psychological problems due to concerns directly related to stigma associated with mental illness (Ward et al., 2013). Additionally, the effects of public stigma also influence African Americans' perceived stigma of mental illness. Lindsey et al. (2006) conducted a qualitative study on help-seeking behaviors among African American adolescents and found that adolescent boys were reluctant to seek mental health care due to a fear of mockery from peers and a social perception of weakness. This claim is further supported by a national survey conducted by the National Mental Health Association (1998) that found 63% of African American participants believed depression is a personal weakness. Collectively, these studies highlight the intersection between one's mental health and one's experience as a member of the Black community. However, the comparatively poor psychological outcomes among African Americans are complex and influenced by several historical, economic, and societal factors.

Slavery and Intergenerational Cultural Trauma. The concept of trauma or traumatic experiences is often associated with direct exposure to harmful stimuli such as exposure to war, combat, natural disasters, acts of terror, and physical or sexual abuse; however, an individual does not have to personally undergo a disturbing event to be significantly impacted by it (Grayson, 2020). Intergenerational trauma, or transgenerational trauma, is the cumulative emotional, psychological, and physiological wounding that is transmitted from one generation to the next (Dass-Brailsford, 2007). This means that family members who have not directly experienced trauma can feel the effects generations later. Halloran (2019) suggested that the experience of African Americans is historically characterized by trauma and violence, and the culmination of these effects impact their emotional and mental health. A particularly long-standing impact on African Americans is slavery.

The dehumanizing and inhumane treatment that African Americans experienced in this country can be traced to the Middle Passage (Jones, 2004) when Africans were kidnapped by the Portuguese, forcibly removed from ships on the shores of colonial Virginia, and bought by English colonists (DeGruy Leary, 2005). Enslaved Africans were involuntarily transported from the coasts of their fruitful homelands like modern-day Ghana, Togo, and Ivory Coast to North and South America through the trans-Atlantic slave trade (Eltis et al., 2010), where they were treated as property in the eyes of the law. They were subjected to mental and physical degradation, forced to perform grueling labor, denied their most basic needs and rights as humans, and forced to pick cotton and other agriculture (Myrdal, 1962). They were also beaten mercilessly, separated from loved ones, and forced to clean, cook, birth, and nurse for White plantation owners.

The abuse experienced by Africans was justified by the government's failure to pass laws protecting the physical and mental safety of slaves. White people believed Africans to be inferior, and this was shown even in how the word Negro was defined. The Encyclopedia Britannica (1884) defined the word Negro as referring to Africans who ''occupied the lowest position of the evolutionary scale…'' (p. 316).

The institution of slavery in North America lasted nearly 250 years, from 1619 to 1865 and resulted in the death of millions of Africans (DeGruy Leary, 2005). Thus, for 13 generations, enslaved Africans experienced daily traumas and abuse against the mind, body, and spirit. The aftermath of this historical abuse continues to impact the lives of African Americans, including their mental and emotional health. The belief that residual effects of slavery continue to shape societal dynamics is not new. Billingsley (1968) argued:

> It is often said that slavery was a long time ago; that surely the freedom and opportunity granted to the Negro people by emancipation has been sufficient…but the historical facts

> are otherwise. The Negro people have never been indemnified, either economically, or politically, or socially, or psychologically for two centuries of bondage (pp. 68–69).

Diagnosing Mental Illness among Black/African Americans. African Americans also experience historical and present-day problems with receiving accurate and culturally sensitive psychological diagnoses. Garretson (1993) strongly suggested that misdiagnosis was related to the pathologizing of African American culture. An early example was the 1840 U.S. Census Report that severely over-counted and falsified the number of Black people who were considered “insane” or “idiots” to show that the further north Black people lived, the higher their rates of mental illness (Grossi, 2021). This misreport was intended to provide basis for the argument that Black Americans were unable to handle freedom. Furthermore, in 1869, Dr. Benjamin Rush, often referenced as the “father of American psychiatry,” believed Black people had racial immunity. Rush published misleading material that stated Black people had a natural resistance to Yellow Fever and described "Negroes as suffering from an affliction called *Negritude*”, which was a mild form of leprosy in which the only cure was to become white. Rush’s apprentice, Dr. Samuel Cartwright, held similar ideals. Cartwright (1851) introduced two diseases of the mind to describe alleged mental illnesses of enslaved Black people: drapetomania and dysaethesia aethiopica. Drapetomania was defined as "sulky and dissatisfied" behaviors that usually resulted in slaves fleeing captivity, and dysaethesia aethiopica described slaves as lazy and exhibiting poor attention to their work. Although the claims from these doctors have been disproven over the years, scientific racism continues to affect the lives of African Americans.

In addition to issues surrounding inaccurate and implausible diagnoses, existing literature also documents issues of over-diagnosing mental health disorders among African Americans. Schwartz and Blankenship (2014) highlighted the disproportionately high rate of psychotic disorder diagnoses among consumers of color, specifically African Americans. Additional research shows that African Americans are almost five times more likely to be diagnosed with schizophrenia compared to White Americans admitted to state psychiatric hospitals (Barnes, 2003; 2004), and Kiselica et al. (2021) suggested there may be bias in mild cognitive impairments (MCIs), which leads to overdiagnosis among Black individuals and/or underdiagnosis of MCIs among White individuals.

Cultural Mistrust. Cultural mistrust also gives context to the reasons mental health care is stigmatized in Black communities. Cultural mistrust refers to Black Americans' distrust toward individuals from the mainstream culture (i.e., White Americans) due to experiences of racism and discrimination (Terrell & Terrell, 1981). Particularly, the most infamous public health ethics violation in U.S. history that has greatly contributed to the cultural mistrust experienced in the Black community is the Tuskegee Study of Untreated Syphilis in the Negro Male, also referred to as the Tuskegee Study. The scientific experiment was conducted in 1932 by the United States Public Health Service (USPHS), which is a federal uniformed service responsible for delivering public health promotion and disease prevention programs, conducting research, and providing appropriate medical care for patients in underserved communities (U.S. Department of Health and Human Services, 2019). Though the goal of this study was to observe the natural course of untreated syphilis in the human body, hundreds of Black male participants in Macon County, Alabama with low incomes and limited health care, were deprived of this information (Reverby, 2000). Instead, they were recruited under the guise of receiving free medical care for “bad blood”, in addition to free transportation, meals, and burial insurance (Thomas & Quinn, 1991). By 1947, penicillin became a viable treatment for syphilis; however, due to issues surrounding race and dehumanization, the participants received no treatment. In the end, 128 patients died from the disease or its complications, 40 of their wives contracted the disease, and 19 children acquired genital syphilis.

The Tuskegee Study exemplified scientific and medical racism towards Black Americans, and it negatively impacted their trust in the health care system. Recent research conducted by Chae & Hunter (2022) concluded that the health injustices for the predominantly Black community (Macon County) at the center of the 1932 Tuskegee Study remain prevalent. Members of the community reported structural and social issues, rather than individual-level attributes (e.g., diet, health knowledge) as their greatest health issue, and the most reported problem was healthcare access, including the lack of a hospital. The second most reported barrier was a deficiency in the service environment and having access to healthy food options. In addition to this, Chae's findings indicated that the majority of the Black residents in Macon County has more children in poverty than majority White surrounding counties.

Sussman et al. (1987) contributed the fear of treatment and the fear of being hospitalized as major reasons for Black people not seeking psychological help. This sense of fear may also be driven by mental health services being viewed by the Black community as a microcosm of the larger White society (Ridley, 1984). Many of the published studies investigating cultural mistrust have addressed the association between cultural mistrust and attitudes toward counseling among African Americans (Terrell & Terrell, 1984; Watkins et al., 1989; Whaley, 2001b). The results of these studies suggest a negative relationship between levels of cultural mistrust and attitudes/behaviors related to mental health services among African Americans.

Additionally, Ridley (1984) suggested that low self-disclosure, which has traditionally been interpreted as an indication of psychopathology, may be due to cultural mistrust. As such, African Americans fear their responses to a racist society may be misinterpreted by mental health professionals. Whaley (2001) examined negative attitudes toward White mental health clinicians in Black psychiatric hospitals and found that high cultural mistrust scores among recently admitted African Americans were associated with more negative attitudes toward White clinicians. Additionally, Ahluwalia (1990; 1991) compared cultural mistrust levels in relation to attitudes toward mental health services among African Americans, Native Americans, Hispanics, and Asian Americans, and a positive association between cultural mistrust and dissatisfaction with and unwillingness to seek mental health services was evident for Black and Native Americans but not for their Hispanic and Asian American counterparts. Ogbu (1988) suggested that differences among minorities can be attributed to African Americans and Native Americans being classified as involuntary or *castelike* minorities, whereas Latinx and Asian Americans are voluntary or immigrant minorities. These findings are consistent with the argument that therapeutic environments mimic the power relationships and cultural values of the larger society for African Americans (Maultsby, 1982), thereby eliciting cultural mistrust.

Asian Americans and Pacific Islanders

Asian Americans/Pacific Islanders (AA/PIs) are the fastest growing racial/ethnic group in the U.S., with a significant increase of 72% between 2000-2015, yet they have the lowest help-seeking rate of mental health services, prescription medication, and outpatient services of any racial/ethnic group (American Psychiatric Association [APA], 2017). A comparison breakdown provided by Augsberger et al. (2015) through an analysis of 5-year mixed method data, indicated that 69% of Asian Americans did not seek mental health treatment, compared to 64% of Latinx/Hispanics, 59% of African Americans, and 40% of White Americans. Some of the most common reasons given for not receiving mental health treatment include confidentiality concerns and fear of neighbors’ negative opinions (SAMSHA, 2015), which surround stigmatizing concerns related to mental illness.

For AA/PIs, stigma appears to affect their beliefs about the social status of individuals with mental health problems and how mental illness affects one’s level of functioning. For example, Wong et al. (2017) found that compared to White Americans, AA/PIs were less hopeful that individuals with mental health problems could be contributing members of society, and a staggering 95% of AA/PIs who reported experiencing a mental health problem reported they felt inferior to those who had not experienced a mental health problem compared to 29% of White Americans. Furthermore, Augsberger and colleagues (2015) found themes of public stigma negatively impacting attitudes toward help-seeking in Asian American interviewees and their families. After one participant disclosed some of her mental health concerns with her high school guidance counselor during the interview, one of her parents responded, "Why would you say something like that, why did you tell people about our personal lives, we should keep it in the family" (Augsberger et al., 2015, p. 6).

Similarly, this belief of keeping matters private is supported in other literature. Eng and TenElshof (2020) and Wong et al. (2017) found that Asian Americans tend to conceal mental health struggles and only seek help from their families, if they seek any help at all. Moreover, the belief that psychological problems are a sign of weakness was another theme found in the Augsberger et al. (2015) study, which is similar to perceived beliefs held by some African Americans. A participant told her mother that she was hospitalized during college for a suicide attempt, and her mother responded, “Oh, I don’t know how you can be so weak… You have to be strong” (p. 7). Together, these findings underscore the importance of understanding how mental health stigma affects AA/PIs in similar, yet different ways compared to other racial/ethnic groups. However, there are additional cultural factors to consider.

Intergenerational Cultural Conflict. Intergenerational cultural conflict (ICC) is particularly relevant as it helps to understand the interplay between Asian Americans' family relationships and acculturation as well as the psychological adjustment of Asian Americans and attitudes towards mental health. ICC pertains to the disagreements and arguments that stem from differences in acculturation orientations between parents and their offspring (Lui, 2015). Ahn (2008) suggested that Asian American parents and offspring typically disagree on traditional values that emphasize filial piety, academic achievement, parental authority, and a hierarchical structure within the family.

Parent-offspring acculturation mismatch can manifest in at least four profiles: the offspring may be more acculturated to the host society than the parent; the offspring may be less acculturated to the host society than the parent; the offspring may be more enculturated to the heritage society than the parent; and the offspring may be less enculturated to the heritage society than the parent (Telzer, 2010;2011). Pham and Lui (2020) indicated these four profiles may be differentially associated with offspring's psychological adjustment outcomes. Previous researchers who examined ICC within Asian American populations have found associations between ICC, well-being, and various mental health outcomes (Lui et al., 2019). Lui (2015) conducted a meta-analysis on ICC and Asian and Latinx adolescents and found that ICC was related to poorer mental health outcomes. However, there were distinctions among subgroups. Specifically, ICC and offspring mental health outcomes were found to be statistically significant for East Asians, Southeast Asians, mixed Asians, and mixed Latinx, but not for South Asians and Mexicans. Acculturation-based intergenerational family conflict has also been linked with depression and anxiety symptoms (Tummala-Narra et al., 2020). The main conclusions from these findings were that studies with more Asian Americans were more likely to detect a larger relationship between conflict and mental health outcomes.

Model Minority Myth. AA/PIs' mental health needs are also impacted by stereotypes and biases through the model minority myth. The model minority stereotype suggests ‘‘Asian Americans are more academically, economically, and socially successful than any other racial minority group associated with their supposedly stronger values emphasizing hard work, perseverance, and belief in the American meritocracy’’ (Yoo et al., 2010, p. 114). This widely perpetuated stereotype appears to shine a positive light on the Asian community; however, it implies false depictions of Asian Americans as a homogeneous ethnocultural group. The model minority stereotype overlooks mental and physical health issues within diverse Asian American communities (Chou & Feagin, 2008), and it insinuates that other ethnic minority groups are individually responsible for their shortcomings. As such, the status quo is maintained by denying the effects of historical and contemporary systemic issues that contribute to racial health disparities (Cheng et al., 2017). As suggested by Leong and colleagues (2001) negative misconceptions associated with the model minority myth may lead to misdiagnosis or underdiagnosis of Asian Americans, which contributes to the common belief that Asian Americans are not affected by mental health issues.

Latinx/Hispanic

The Latinx/Hispanic community is made up of diverse individuals and subgroups set apart by ancestral history or country of origin. However, there are some shared cultural factors that affect the mental health outcomes of this community. Turan and colleagues (2019) suggested that examining 'intersectional stigma' for groups living with multiple stigmatized identities, such as Latinx/Hispanic individuals, is essential to understanding how stigma is experienced by these groups. Research regarding the prevalence of mental illness among Latinx suggests that they experience mental health symptoms at similar or slightly lower rates compared to White populations (Alegría et al. 2002; Kessler et al. 2005); however, disparities exist in access and quality of mental health treatment for this population. According to the 2019 National Survey on Drug Use and Health, only about one-third of individuals in the Latinx/Hispanic community who had a mental illness receive some sort of mental health treatment, compared to 50% of non-Hispanic White Americans.

Existing empirical data, although limited, suggests that mental health stigma also negatively affects help-seeking attitudes among Latinx. Eghaneyan and Murphy (2020) found stigma to be negatively associated with the desire to engage in mental health care, management of depression symptoms, disclosure of mental illness to family and friends, and adherence to antidepressant medications among Hispanic individuals. Similar results were found in a study that examined the stigma of depression in Latino primary care patients. Patients were less likely to disclose their depression diagnosis to their family and friends, less likely to take depression medication, less likely to manage their depression symptoms, and more likely to have missed scheduled appointments with their primary care providers (Vega et al., 2010). Although these studies underscore the existence of stigma in Latinx communities, several cultural factors influence this process.

Cultural Influence. Research suggests that cultural factors related to Latinx mental health can contribute to mental health stigma (Escovar et al., 2018). According to Interian et al. (2007), individuals in the Latinx community have a fear of being labeled “loco” because it implies that the person is a dangerous, unstable threat to the community. Stigma and shame surrounding mental illness and the potential for being stereotyped often lead Latinx and Asian groups to resist mental health treatment-seeking (Hampton & Sharp, 2004) as this may reflect poorly on the individual and their family. In many Latinx communities, mental or emotional problems can be heavily attributed to factors outside of their control, such as *nervios*, which is a common idiom of distress among Latinx, and *susto*, which is a culture-bound syndrome characterized by psychological and somatic symptoms (APA, 2005). When compared to White and African American patients diagnosed with schizophrenia, higher rates of somatic symptoms were found among Latinx (Barrio et al., 2003). Comas-Diaz (2006) found that when somatic symptoms emerge, Latinx often seek out help from medical doctors or alternative healers instead of mental health professionals, and those who do seek professional psychological help tend to experience symptoms for prolonged periods before receiving treatment. However, researchers have proposed that somatization may be a culturally appropriate way of expressing emotional or social distress in an individual’s cultural context (Kirmayer & Young, 1998).

Moreover, the literature on Latinx cultural values and stigma reports that stigma resulting from cultural expectations discourages them from disclosing a need for mental help (Interian et al., 2007). Research has indicated that Latinx individuals who exhibit high levels of acculturation in the U.S. yield positive attitudes toward mental health services compared to those who are enculturated (Pomales & Williams, 1989). On the other hand, evidence suggests enculturation may lead to Latinx delaying mental health treatment when feeling distressed (Breslau et al., 2017).

Language Barriers. Cultural factors like language use also influence Latinx stigma and attitudes toward seeking professional psychological help. Language is an important factor associated with the utilization and adherence to mental health treatment; however, a lack of linguistic competency in the mental health field exists which prevents many Latinx with mental illness from seeking services (Kramer et al., 2009). Along with fear of stigma, the lack of available Spanish-speaking providers who are culturally and linguistically trained to meet Latinx mental health needs is among the more commonly reported barriers. Research has shown that Latinx with limited English proficiency tend to experience more dissatisfaction with their care, compared with English-speaking Latinx or White individuals in primary care settings (Escarce & Kapur, 2006). The number of Spanish-proficient providers, who can bridge both cultural and language barriers, remains insufficient to meet the needs of the Latinx community.

According to a recent study, the availability of Spanish-language mental health services is decreasing, even as the U.S. Latinx population continues to grow (Pro et al., 2022). Pro and colleagues reported that between 2014 and 2019, the national Hispanic population increased by 4.5% or 5.2 million people. However, during the same period, the number of facilities that offered treatment in Spanish declined by 17.8%, or a loss of 1,163 Spanish-speaking mental health facilities. This is concerning because establishing therapeutic rapport can be especially challenging if clear communication cannot be established. Even with the use of professional interpreters, language barriers can be difficult to overcome as loss of context or meaning may occur.

American Indians and Alaska Natives

Among American Indians and Alaska Natives (AI/ANs), there are 574 federally recognized Native tribes and more than 200 indigenous languages spoken in the U.S. (National Alliance on Mental Illness [NAMI], 2022b). AI/ANs live with a long legacy of colonial trauma, historical trauma, land and loss, and racism and discrimination, in addition to many enduring mental health disparities. The Urban Indian Health Institute (2012) reported that the psychological distress of AI/ANs, as evidenced by poor mental health and depression, is associated with historical and intergenerational trauma. This report also noted that shortcomings of the mental care system combined with systemic and cultural barriers impede mental health access and service utilization for AI/ANs. Further, AI/ANs appear to experience more widespread and unique mental health challenges, such as depression, substance abuse, and suicide, compared to non-Indigenous groups (Manson, 2000; Nelson et al., 1992). AI/ANs have the highest rates of lifetime major depressive episodes and highest self-reported depression rates than any other ethnic/racial group (APA, 2017), strikingly higher suicide rates compared to the overall U.S. population, and higher rates of co-occurring mental illness and substance use disorder at almost three times that of the general population (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).

Thompson et al. (1993) suggested that mental illness stigma differs among AI/ANs; some tribal groups attached stigma to most mental disorders, including alcohol and substance abuse, while others did not stigmatize mental illness at all. This study also posited that AI/ANs' experiences of annihilation or assimilation enforced by the U.S. government have led to the mistrust of the government, and this mistrust contributes to AI/AN's stigmatization of mental illness treatment by mental health professionals (Thompson et al., 1993). Similarly, Grandbois (2005) reported that mental health stigma could serve as a barrier to help-seeking and treatment compliance among AI/ANs, and that intersectional stigma and minority status greatly influence this.

Unresolved Historical and Intergenerational Trauma. The theory of historical trauma explains that AI/ANs are at greater risk of experiencing psychological distress and historical loss symptoms (e.g., depression, substance dependence, diabetes, and unemployment) (Brown-Rice, 2013). AI/ANs are more likely to have poorer overall mental and physical health and unmet medical and psychological needs (Barnes et al., 2010). For example, the social and economic consequences of unmet mental needs among AI/ANs are extensive and include comorbid substance use disorders, incarceration, suicide, increased healthcare expenditures, and loss of productivity (Shore et al., 2006; U.S. Department of Health and Human Services [USDHHS], 2021). Researchers argue the current problems facing this community may be the result of "a legacy of chronic trauma and unresolved grief across generations" enacted on them by the dominant culture through structural racism and structural stigma (Brave Heart & DeBruyn, et al., 1998, p. 56). Historical trauma is the cumulative emotional wounding transferred across generations through biological, psychological, environmental, and social means (Sotero, 2006). Sotero's (2006) conceptual framework describes three successive phases that explain challenges faced by AI/ANs: 1) mass traumas on a population, resulting in cultural, familial, societal, and economic devastation; 2) the original generation's response to the trauma through biological and psychological symptoms, and 3) initial responses to trauma transferred to successive generation through environmental factors, prejudice, and discrimination. This theory acknowledges the intergenerational trauma that has occurred within this population as a result of loss of land, forced relocation, separation of families, and loss of culture (Barnard, 2007; Sotero, 2006;).

Before colonization, AI/ANs maintained health and wellness for thousands of years through traditional healing and ceremonial practices, revering the land and all her inhabitants as relatives, and practicing "Population Health", where good health was promoted for all community members (Menzies & Lavallee, 2014). However, AI/ANs were subjected to many diseases that Europeans carried to North America, and as a result, a significant amount of the Native American population died due to a lack of resistance to diseases such as smallpox, measles, and cholera (Nunn & Qian, 2010). Decades of colonization, subsequent government policies, and resulting downstream negative impacts on health left a devastating impact on

Native/Indigenous communities.

Life on Reservations. The cultural and ecological location of U.S. American Indian reservations presents unique influences on mental health; however, many of these factors go unnoticed by the general public. LaDuke (2005) wrote: ‘‘Outside of those areas near reservations, the American people are almost completely ignorant of the present-day struggles of Native people. By and large, most discussions regarding Native people continue to be framed in the past" (p. 132). Many present-day concerns associated with AI/ANs' life on the reservation are not considered, including mental health outcomes.

Reservation lands are a result of root shock (and displacement), which is the repercussion of an event that uproots an individual or group from an environment that provides a sense of home (Fullilove, 2004). Many AI/AN tribes were removed from their ancestral homelands either permanently or partially, and these acts of displacement have deprived AI/ANs of much of their traditional culture (Manson, et al., 2005). However, Huyser et al. (2018) suggested that AI/AN reservation lands may be a source of both risk and resilience to psychological distress and mental health treatment seeking. Negative aspects of life on the reservation can include general feelings of depression and anxiety, whereas positive aspects can include social networks, social support, and tribal sovereignty, which promotes resiliency (Feinman, 1992; Snip 1989). In addition, Huyser et al. (2018) reported that the space in which individuals reside has an important influence on psychological distress. Researchers have found that physical, personal/social, and economic challenges affect AI/ANs’ access to mental health services at Indian Health Service and tribal facilities (USDHHS, 2011). Physical barriers such as travel conditions, personal and social barriers such as lack of childcare, and economic issues such as difficulty paying copayments were all found to affect clients’ access to services, in addition to staffing issues and shortages of highly skilled providers. Furthermore, the prevalence of substance use and mental health issues was linked with social determinants of health including poverty, lack of opportunity, and chronic stress and trauma.

High Incidences of Drug/Alcohol Abuse. Research has consistently found higher rates of substance use and mental health issues (e.g., posttraumatic stress, depression) among AI/ANs compared with the U.S. general population (Gone & Trimble, 2012), and higher drug-related deaths between 2013-2017 compared with other U.S. racial/ethnic groups (Shiels et al., 2020). Additionally, more recent data has revealed the alcohol-involved death rate among AI/ANs was five times higher than that in the general population (State Health Access Data Assistance Center, 2021). Contributors of these disparities have been associated with historical trauma as a direct link to poor health outcomes and increased substance use. However, there is significant variability within AI/AN populations.

A study investigating disparities of alcohol dependence in two American Indian populations found that AI/ANs members of Northern Plains tribes were at increased risk for both abuse (alcohol and drug) and dependence (alcohol only), and members of a Southwest tribe were at increased risk only for alcohol dependence (Spicer et al., 2003). Research also suggests higher rates of drug and alcohol use and earlier initiation among AI/AN adolescents compared with other U.S. adolescents, and even higher rates of drug, alcohol, and tobacco use among AI/AN adolescents living on reservations (Burnside et al., 2008). In another study, AI/AN adolescents reported similar rates of lifetime alcohol use, but higher rates of heavy drinking and drug use compared with adolescents from a sample of rural White adolescents. By and large, existing research indicates that a higher proportion of AI/AN adolescents residing on and off tribal lands use cigarettes, marijuana, alcohol, stimulants, and oxycodone compared with adolescents of other races/ethnicities (Chen et al., 2012; Plunkett & Mitchell, 2000; Stanley et al., 2014).

Relevance to Counseling Practice

Impact of Stigma on Help-Seeking and Service Utilization

Rickwood and Thomas (2012) defined mental health help-seeking as "an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns" (p. 180), and Cerully et al. (2018) defined treatment utilization as “efforts to seek, initiate, or utilize mental health treatment” (p. e428). The role of mental health help-seeking is important to receiving appropriate care and improving overall mental health outcomes; however, a treatment gap exists between those who need assistance and those who actually seek it. Stigma surrounding mental illness creates barriers that may impede individuals from receiving mental health services. Even more so, stigma has been shown to significantly influence whether someone will have a positive or negative attitude toward counseling (Komiya et al., 2000; Vogel et al., 2005). Knaak et al. (2017) suggested that consequences of stigma include delays in help-seeking, discontinuation of treatment, suboptimal therapeutic relationships, patient safety concerns, and poorer quality mental and physical care. Similarly, Vogel et al. (2007) investigated the relationship between stigma and the willingness to seek counseling for psychological and interpersonal concerns and found that perceived public stigma and willingness to seek counseling was substantially mediated by self-stigma and attitudes. Vogel et al. (2007) suggested that the anxiety and fear associated with negative, undesirable labels attributed to people with mental illness may be strong enough to deter them from accepting their mental health problems, seeking help, and remaining in treatment.

Likewise, stigma of mental health and counseling services is a major obstacle in many cultures. Research indicates that people in racial and ethnic groups in the U.S. are less likely than

White people to seek outpatient therapy services (Henry et al., 2020) and instead seek support from a broader network of pastors, physicians, spiritual resources, and traditional herbs and healers (Bolger & Prickett, 2021; Kramer et al., 2002; Mills, 2012) despite these sources having limitations in their ability to effectively influence or affect a wide range of conditions, including mental health.

Part of the reason BIPOC seek support from sources other than mental health professionals is due to issues surrounding health professional stigma and lack of cultural responsiveness. BIPOC have reported experiencing poorer quality of care when mental health providers did not acknowledge the reality of living in a racialized society in the counseling session (Bernal, 2003). These experiences impact the views of minoritized clients, and according to research from Thompson et al. (2004), if discussions of race were not initiated by the counselor, African American participants felt this was indicative of the counselor’s racism and discomfort. Moreover, other research has found that counselors who directly addressed racial/ethnic issues in the first two sessions of a 12-session counseling experience were more likely to report an environment conducive to building a strong therapeutic relationship (Fuertes et al., 2002). Collectively, this research emphasizes culturally relevant factors in mental health treatment that are salient to ethnic minority clients and how they perceive/respond to services.

CHAPTER III: METHODOLOGY

Research Design and Rationale

Due to the rising number of research studies being conducted on mental health stigma and discrimination reduction (SDR) initiatives, there is a pressing need to systematically synthesize extant findings. Therefore, a meta-analytic research design will be used to investigate the utility of SDR initiatives for BIPOC to address the gap in the literature. A meta-analysis combines the findings of multiple homogenous studies and provides conclusions about the strength and direction of a relationship between variables (Littell et al., 2008). According to Hunter et al. (1982), "A single study will not resolve a major issue. Thus, the foundation of science is the cumulation of knowledge from the results of many studies" (p. 10). In addition to offering a systematic method for examining existing literature on a specific topic, meta-analytic research designs provide a quantitative estimate for the effect of a treatment intervention, as opposed to statistical significance, which is closely linked to sample size and may overestimate or underestimate the true utility of the intervention (Ellis, 2010). When carefully conducted, meta-analyses can offer transparency about the effectiveness of an intervention, form treatment recommendations, and/or provide guidance for future clinical trials (Russo, 2007).

Meta-analyses are conducted through a structured and standardized approach for collecting, combining, and analyzing empirical research (Siddaway et al., 2019). As such, this meta-analysis will be performed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) guidelines. PRISMA 2020 is an evidence-based set of items for reporting in systematic reviews and meta-analyses. The PRISMA 2020 statement includes an exhaustive checklist of items that should be considered throughout the research process along with guidelines to develop a flow diagram. Obtaining familiarity with the PRISMA 2020 checklist is reportedly useful when organizing and conducting systematic reviews and meta-analyses to ensure that all recommended information is included. The checklist is comprised of 27 items that cover each section of a manuscript: title, abstract, introduction, methods, results, and discussion. However, the methods section covers 11 items: (a) eligibility criteria, (b) information sources, (c) search strategy, (d) selection process, (e) data collection process, (f) data items, (g) study risk of bias assessment, (h) effect measures, (i) synthesis methods, (j) reporting bias assessment, and (k) certainty assessment. Furthermore, the flow diagram depicts the flow of information through various parts of the meta-analysis, and it maps out the number of articles identified, included, and excluded in the study. Collectively, the PRISMA 2020 protocols will be used to establish complete and accurate reporting of information.

Search Procedures

Information Sources

The literature search for this study will include two levels of search terms: stigma and mental illness. Lipsey and Wilson (2001) recommended using a set of keywords that broadly cover the relevant domain to effectively identify a high proportion of potential studies for a meta-analysis. This process consists of: (1) identifying all descriptors that relate to the topic of interest, and (2) identifying the range of search terms different researchers might use in their titles or abstracts that indicates the study applies to the topic of interest. The identified search terms used in this meta-analysis were developed by conducting a preliminary search of terms on

PubMed and SCOPUS databases and identifying key terms used in a series of populated manuscripts. Stigma will incorporate the search terms “stigma” OR “antistigma” OR “discrimination” OR “stigma change” OR “stigma reduction”, and mental illness will incorporate the search terms “mental illness” OR “mental disorders” OR “mental health disorders” OR “mental health” OR “psychological distress” OR “mental health issues”. These identified search terms will guide the screening process. As noted by Lipsey and Wilson (2001) and Page et al. (2021), a comprehensive search generally requires a thorough investigation of multiple databases. Therefore, the following electronic databases will be used to identify articles that meet inclusion criteria: Cochrane Library, PubMed, Academic Search, Google Scholar, ProQuest, ProQuest Dissertations and Theses, and through EBSCO web searching of PsycARTICLES, PsychINFO, and MEDLINE.

Criteria for Inclusion and Exclusion of Studies

An important goal of inclusion and exclusion criteria is to develop a relatively homogenous study population (Russo, 2007). This process works to reduce extreme variability among studies to make it possible to identify differences between treatments. As such, articles that quantitatively investigate the effect of stigma reduction on mental illness and include members of BIPOC in their sample will be included in the study. To focus the analysis on the highest-quality evidence, eligible study designs will be restricted to randomized controlled trials (RCTs). Correlational, quasi-experimental, qualitative, and non-RCTs will be excluded. In the event there is a death of RCTs among the studies, quasi-experimental studies will be eligible. Inclusion of studies within this analysis will also depend on the following criteria: (a) interventions aimed at reducing stigma toward people with mental illness or mental health symptoms; (b) interventions including descriptive samples of BIPOC; (c) studies published in

English, and (d) studies conducted in U.S. geographic locations. Although articles are required to have samples of BIPOC, each study does not have to include samples of every BIPOC to be included. Additionally, articles will not be excluded based on participant age, ethnicity, race, gender, or occupation, and the search will not be limited by publication date to ensure the inclusion of as much relevant evidence as possible. Dissertations and/or theses may also be considered scholarly sources based on peer and/or expert reviews of the work. Studies will be excluded if: the reduction of stigma is not related to mental health problems; changes in stigma are not described; data reporting the changes in stigma are not reported; comorbid physical conditions (e.g., cancer) of participants are investigated as part of the intervention; and the study does not include a randomized control group as a comparison.

Search Strategy and Screening for Relevant Studies

When conducting a meta-analysis, Uman (2011) and Page et al. (2021) suggested that an optimal search strategy balances sensitivity, which is the collection of a high proportion of relevant studies, with specificity, which is the collection of a low proportion of irrelevant studies. Therefore, the eligibility of search results will be examined through a two-step process: first by title and abstract and second, by full text of articles. After conducting the initial database search, additional studies will be identified by employing a "backward snowballing' approach" (i.e., scanning references of retrieved articles or investigating "grey literature" (Greco et al., 2013). Manual searches of all reference lists of articles that meet inclusion criteria will be conducted in order to exhaust relevant article collection. Attempts will also be made to collect any unpublished articles. Authors who published two or more articles on the topic will be contacted via email to inquire about additional unpublished studies. All retrieved records will be uploaded in EndNote X9 software, and duplicate studies will be removed using multi-pass deduplication.

For the remaining studies, titles and abstracts will be screened and studies that do not reference the search terms and meet the inclusion criteria will be removed at this stage. Reasons for exclusion will be recorded for each document. Potential articles deemed suitable will undergo further examination during the second stage. Articles will be reviewed to identify that pertinent information needed to compute effect sizes (e.g., mean, standard deviation, and sample) are included. If the required information is reported or can be obtained from the article, the article will remain in the selected pool of articles.

Data Collection and Coding

Pigott and Polanin (2020) explained that one of the final steps prior to conducting a meta-analysis is to code each included study. The systematic coding and analysis of included studies serves two purposes: (a) highlights the contexts, participants, and methods used to extract relevant data in selected studies so the reviewer understands the limits of external validity, and (b) examines how effect size varies as a function of the methods, contexts, and participants of studies (Wood & Eagly, 2009). For this meta-analysis, the independent reviewer will develop a coding guide that will be used to include all variables of interest from studies using principles of PRISMA 2020 (Page, et al., 2021). Characteristics of data extracted from each article will be: study and author descriptors (e.g., year, geographic location, setting, publication type); sample descriptors (e.g., total sample size, race and/or ethnicity, age, gender); research design descriptors (e.g., study design, control or comparison intervention, type of outcome measures); main outcomes and effect sizes of the interventions (e.g., univariate and multivariate effect sizes, descriptive statistics, and inferential test statistics). In addition, unique information about the study will also be included.

Methodological Quality of Included Studies

Method for Assessing Reliability and Inter-rater Reliability

Krippendorff (2004) identified three aspects of coding as it relates to reliability: (1) *stability* (which refers to whether the process of coder behavior remains the same over time), (2) *accuracy* (whether coding is conducted by a previously agreed upon codebook), and (3) reproducibility (when multiple coders code with similar results). Furthermore, Kolbe and Burnett (1991) suggested that measuring reliability of coding is important to establish the quality of research. For example, low agreement between coders (or with the coding book) suggests weakness in the research methods or weakness in the explanation and execution of the inclusion/exclusion criteria. To ensure reliability of coding procedures, all studies will be coded by the author of this study, and a random sample of 20% of studies will be coded by a secondary coder (i.e., a different counselor education doctoral candidate) to establish an estimate of inter-rater reliability. Discrepancies will be resolved by subsequent discussion.

Additionally, when different observers are observing the same constructs, some variation in outcome is likely. Therefore, Cohen's k will be used to test interrater reliability. Cohen's k is frequently used to determine whether the degree of agreement between two raters is higher than would be expected by chance (Cohen, 1960). It also represents the extent to which the data collected in a meta-analysis are correct representations of the variables measured. Cohen's k ranges from -1.00 to +1.00, with the upper limit of k falling between 0 and +1.00 and occurring when two raters have exactly the same marginal distribution, and the lower limit of k falling between 0 and -1.00 when two raters have different distributions. An intercoder reliability of .80 or greater is considered acceptable internal consistency. However, .90 or greater is considered highly reliable. If more than a 10% discrepancy exists between the two coders in the random sample, discrepancies will be resolved by consulting a third reviewer. The formula for computing Cohen’s k is as follows: $k = \frac{p0-pc}{1-pc}$, where $p0$ is percent agreement (the proportion of subjects on which raters agree), and pc, is chance agreement (the proportion of agreement that would be expected by chance.

Method for Assessing Risk to Internal and External Validity

Harrison (2011) reported that the conclusion of a meta-analysis strongly depends on the quality of the studies selected to estimate the pooled effect. Additionally, Greco et al. (2013) explained that the quality of RCTs should be evaluated based on issues relating to randomization and adequate blinding and explanation for dropouts and withdrawals, which both address matters of internal validity (minimization of bias) and external validity (ability to generalize results). The Effective Public Health Practice Project’s Quality Assessment Tool (EPHPP) will be used to assess the quality of evidence for all outcomes (Thomas et al., 2004). This tool has been judged suitable to be used in meta-analyses and with a variety of study designs such as RCTs. It has also demonstrated fair reliability and validity content and construct validity (Armijo-Olivo, 2010). The EPHPP assesses six domains: (1) selection bias; (2) study design; (3) confounders; (4) blinding; (5) data collection method; and (6) withdrawals/dropouts. Each of these domains will be rated for each of the selected studies as: strong quality (3 points), moderate quality (2 points) or weak quality (1 point). After the total score is identified, studies will be assigned a global rating of methodological quality of strong, moderate, or weak.

Statistical Procedures and Conventions

Software

The Comprehensive Meta-Analysis (CMA) 3.0 software will be used to synthesize and analyze data. The CMA 3.0 was developed by Borenstein and colleagues (2021) and funded by the U.S. National Institutes of Health. CMA is considered the most preferred software for conducting meta-analyses (Rand & Paul, 2022). A considerable strength of this software is its ability to support over 100 different data formats, which means that the CMA 3.0 can be used to systematically analyze studies with heterogeneous data sets. Additional operations of this software include estimating effect sizes, comparing effect sizes of different subgroups, running meta-regressions, running moderator analyses, constructing forest plots, and detecting the presence of bias in research.

Effect Size Computations

For this meta-analysis, Hedges' g measure of effect size was selected as the appropriate unit of analysis. Hedges' g (1981) is a measure of standardized mean difference that allows for the comparisons of outcomes using different measurement scales. This computation is similar to Cohen's d; however, a considerable strength of Hedges' g is its ability to statistically correct for variance that may form when sample sizes are small, thereby reducing the impact for bias related to sample size. Hedges' g will be computed for each study using the following formula: $g = \frac{\overline{X_1} - \overline{X_2}}{S\, pooled}$, where $\overline{X_1}$ and $\overline{X_2}$ are the means for groups 1 and 2 respectively, and $S\, pooled$ is the pooled estimate of the standard deviation of the two groups (Hedges & Olkin, 1985). Hedges' g was a correction added to Cohen's d metric, so one must first calculate Cohen's d using the following formula: $d = \frac{\overline{X_1} - \overline{X_2}}{SD\, pooled}$ (Watson et al., 2016). $SD\, pooled$ is properly calculated using the formula: $S\, pooled = \frac{(n_1 - 1)S_1^2 + (n_2 - 1)S_2^2}{n_1 + n_{2-2}}$, where SD_1 and $\mathrm{S}D_2$ are the standard deviations Group $\overline{X_1}$ and Group $\overline{X_2}$ and $n1$ and $n2$ are the sample sizes in Group $\overline{X_1}$ and Group $\overline{X_2}$, respectively. Being that Cohen's d and Hedges' g are computed in similar ways, the magnitude of effect sizes will be classified according to Cohen's benchmarks, which provides an estimate of an observed effect. An effect of 0.2 indicated a small degree of practical significance, 0.5 indicated a medium degree of practical significance, and 0.8 indicated a large degree of practical significance

(Cohen, 1988).

Variance and Standard Error

Jackson and Bowden (2016) reported that confidence intervals for between study variance is important in random effects meta-analyses because it measures the uncertainty in the corresponding point estimates. Variance of Hedges' g effect size (v_g) is given by: $v_g = J^2\ x\ v_d$, where v_d represents the variance of Cohen's d (Borenstein et al., 2010). Therefore, the variance of Cohen's d must be computed in order to compute the variance of Hedges' g. Cohen's d variance is calculated using the formula $v_d = \frac{n^1+n^2}{n^1n^2} + \frac{g^2}{2(n^1+n^2)}$. Afterwards, the variance of Hedges' g is then used to calculate the standard error of g through the formula: $SE_{gi} = \sqrt{V_{gi}}$ (Borenstein et al., 2009). The term SE_{gi} will be used to calculate a 95% confidence interval (CI), which is a range of numbers around a point estimate that provides an estimated population parameter. Watson et al. (2016) suggest the following formula for computing confidence intervals for Hedges' g: $CI = gi \pm z * SE_{es}$, where SE_{es} is equivalent to SE_{gi} and z reflects the value of 1.96 as the normal distribution cumulative density value for the confidence coefficient 95%.

Grand Effect Size Estimate and Grand Confidence Intervals

The grand effect sizes derived from the meta-analysis will be calculated by combining the standardized effect sizes of the included studies. Factors associated with sample size, variance, and reliability of the outcome measures can influence the magnitude and direction of the effect size (Sullivan & Feinn, 2012). Larger sample studies may provide more precise estimates of the effect size, whereas smaller studies are less precise, unless little variance exists. Because the precision of estimates differs, Hedges and Olkin (1985) described that a weighted mean of the observed effect sizes should be calculated. Weight of the standard error based on sample size allows for the best precision of the effect size estimates. Erford et al. (2010) provided a process for weighting effect sizes. The formula for this is the inverse of variance associated with the g estimate: $G_{ES} = \frac{\Sigma(V_d g_i)}{\Sigma V_d}$. Following this, the standard error of the grand effect size will be calculated using: $SE_{GES} = \sqrt{\frac{1}{\Sigma V_d}}$. The grand effect size estimate will then be used to calculate the lower and upper limits of the confidence intervals: $G_{ESL} = G_{ES} - 1.96(SE_{GES})$ and $G_{ESU} = G_{ES} + 1.96(SE_{GES})$, where G_{ESL} is the lower limit and G_{ESU} is the upper limit.

Method of Synthesis

Analysis of Homogeneity

The Q test will be used to assess the homogeneity of studies in this meta-analysis. Kulinskaya et al. (2011) reported that it is common to test for homogeneity to identify if the method and results of several studies are adequately similar to warrant the combination of an overall result. A measure frequently used to test homogeneity is Cochran's Q statistic (Cochran, 1937). This statistic calculates a weighted sum of the square distances of the observed effects. Homogeneity tests for Hedges' g are calculated using the Qt statistic: $Qt = \sum_1^k w_i g_{2i} - \frac{(\sum k_i = 1\, w_i g_{2i})2}{\sum k_i = 1 w_i}$, which is proposed by Hedges and Olkin (1985). The generated values for Qt is assessed for significance using chi-square values, with k-1 degrees of freedom (k is the number of effect sizes). Variance attributed to study characteristics may be evident if the value of Qt is greater than the critical value of the upper tail value of chi-square. Furthermore, the I_2 statistic is used in addition to the Qt statistic to identify the amount of within-study variance. I_2 is calculated as follows: $I_2 = \sum \frac{Q-df}{Q} \text{x}\ 100\%$. According to Cochrane Collaboration, an I_2 value above 75% may be indicative of considerable heterogeneity (Deeks et al., 2008).

Moderator Analysis

The Campbell Collaboration (2001) recommended that the appropriateness of subgroup and moderator analysis be considered when conducting meta-analyses. Kemery et al. (1989) explained that a moderator analysis is conducted to determine whether the relationship between two variables affects the value of a third variable. In other words, a moderator variable alters the strength of the relationship between variables. Under certain conditions, a meta-analytic research design without a moderator analysis may be unable to explain why results vary across studies, even when conducted in accordance to proposed guidelines. One possible method of conducting a moderator analysis is using a meta-regression. A meta-regression analysis accounts for the deviation of observed studies due to issues surrounding sampling error and between-study heterogeneity that impacts true overall effects. Thompson and Higgins (2002) reported that ‘random effects’ rather than ‘fixed effect’ meta regression is the appropriate analysis. A fixed effect analysis identifies the assumed common effect, whereas a random effects analysis estimates the mean distribution of effects across studies. Thompson and Higgins justified this reasoning by explaining, “If residual heterogeneity exists, a random effects analysis appropriately yields wider confidence intervals for the regression coefficients than a fixed effect analysis” (p.1562). The CMA 3.0 software will be used to undertake random effects meta-regression using available summary statistics. This will provide restricted maximum likelihood (REML) estimates of regression parameters and the residual heterogeneity variance.

Publication Bias and Selective Reporting

Greco et al. (2013) reported that the most common source of type I error in meta-analyses is publication bias. This form of bias occurs when studies that are statistically significant are: more likely to be published, published more quickly than studies without statistically significant results, published in journals with higher impact factors, and more likely to be cited by others (Dubben & Beck-Bornholdt, 2005). As such, this emphasizes the importance of including both published and unpublished studies in meta-analyses as results that are gathered exclusively from published studies can be misleading. Although including unpublished literature is one approach to limit the risk of publication bias, additional considerations should be made. To address the potential for publication bias in this meta-analysis, several methods will be utilized.

Funnel Plot Analysis

The funnel plot analysis is commonly used in systematic reviews and meta-analyses. This test of publication bias provides a visual tool that depicts whether or not publication bias had any effect on the observed effect (Borenstein et al., 2010). The estimated treatment effects from individual studies will be displayed on the horizontal axis of the funnel plot, and the measures of study size will be displayed on the vertical axis (Sterne & Harbord, 2004). If publication bias exists, studies will portray an asymmetrical appearance of the funnel plot with effect estimates evenly distributed on either side of the funnel plot. However, if publication bias is not present, the studies will be distributed symmetrically because sampling error is random. If publication is detected in the graph, a closer examination of the study’s characteristics will be examined.

Additionally, the *Trim and Fill* can be employed as an iterative method that re-computes the effect size at each point until the funnel plot is symmetric (Duval and Tweedie, 2000a & 2000b). This helps to yield an unbiased estimate of the effect size and reduce the variance of the effects. Borenstein et al. (2010) acknowledged that a major advantage of using *Trim and Fill* to remove publication bias is that most statistical software programs are able to create a funnel plot that includes both the observed studies and the imputed studies, thereby, providing a visual of effect size shifts when the imputed studies are included.

Rosenthal's Fail-safe N

An additional method for identifying publication bias in meta-analyses is Rosenthal's *Fail-safe N* (Rosenthal, 1979). This test describes the robustness of a significant result by identifying the number of missing studies with an effect size zero that should be added to make the combined effect size statistically significant. Rosenthal's concern was that some statistically nonsignificant studies may be missing from studies, and the exclusion of these studies nullifies the observed effect. Rosenthal referred to the location of missing studies as the *file drawer effect*. According to Borenstein et al. (2010), the goal is to classify each meta-analysis into one of three broad groups using Rosenthal's *Fail-safe N*. If all relevant studies were included and the effect size would remain largely unchanged then the impact of bias is considered *trivial*. If all relevant studies were included and the effect size might shift then the impact of bias is considered *modest*. Lastly, if all relevant studies were included and the effect size would change, then the impact of bias is considered *substantial*.

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The Efficacy of Mental Health Stigma and Discrimination Reduction Initiatives Among BIPOC: A Meta-analysis of Outcome Studies

Janita M. Springfield

Author Note

Janita M. Springfield https://orcid.org/0000-0002-6815-6429.

I have no conflicts of interest to disclose.

Correspondence concerning this article should be addressed to Janita M. Springfield, University of Mississippi, 49 Guyton Drive, University, MS 38677. Email: jmspring@go.olemiss.edu

The Efficacy of Mental Health Stigma and Discrimination Reduction Initiatives Among BIPOC: A Meta-analysis of Outcome Studies

Mental illness has become one of the most health conditions in the United States (National Alliance on Mental Illness [NAMI], 2022a). Millions of people are affected by mental health conditions each year, with 1 in 5 U.S. adults experiencing a mental illness, and 1 in 20 U.S. adults experiencing a serious mental illness (National Institute on Mental Health [NIMH], 2022b). The NAMI (2022b) reported that the rising cause of people with a disability is mental illness. Despite the growing societal awareness of the importance of mental health and the widespread prevalence of mental health issues in the U. S., over half of these adults do not receive treatment (NAMI, 2022b; Mental Health America [MHA], 2022), leaving many to unnecessarily suffer from symptoms. Unfortunately, this has been a long-standing problem as the number of Americans with unmet mental health needs has increased every year since 2011 (MHA, 2022). The vast impact of mental illness emphasizes that mental health conditions are not confined to a small number of predisposed individuals but are a major public health problem with considerably unfavorable outcomes for society. Untreated mental health conditions can negatively affect a person’s life and can increase one’s risk for unemployment, homelessness, substance use, disability, death by suicide, and poor quality of life (Brådvik, 2018; Elbogen et al., 2021; McKnight-Eily et al., 2021; NIMH, 2021a). The outcomes for minoritized communities are even more bleak.

Although mental health challenges are experienced across the general public, certain racial/ethnic groups are disproportionately affected (McGuire et al., 2008; McKnight-Eily et al., 2021) as they encounter higher levels of bias (Hall et al., 2015; Rattan, 2022; Staats et al., 2017) and experience poorer mental health outcomes than their White counterparts (McGuire et al., 2008). In 2001, the landmark Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity*, declared the existence of significant disparities in mental health treatment engagement and mental health care among persons from racial-ethnic minority groups (U.S. Department of Health and Human Services [USDHHS], 2001). The report also noted that racial, ethnic, and cultural factors related to stigma are among the more commonly reported barriers that hinder help-seeking behaviors or the continuation of mental health treatment (USDHHS, 2001). Now, more than 20 years later, these disparities still exist for Black, Indigenous, and People of Color (BIPOC). Consequences related to these noted disparities have led to negative primary outcomes such as decreased engagement in high-quality care, including the use of evidence-based medications and therapy (Rattan, 2022), access to culturally sensitive mental health services, and poorer quality of care if and when treatment is available (USDHHS, 2001). The significant inequities in the utilization and quality of mental health care provided to people of color often leads them to end services prematurely, which impacts their overall quality of life (Adames et al., 2022; Alegria et al., 2002; McGuire et al., 2008).

A factor that has been commonly cited as a key contributor to these mental health disparities is the stigmatization of mental illness (Collins et al., 2014; Corrigan & Penn, 1999; Gray, 2002). According to an early report on mental health from the office of the U.S. Surgeon General (USDHHS, 1999), mental illness stigma disrupts quality of life; erodes confidence that mental disorders are valid, treatable conditions; and leads people to avoid socializing, employing/working with, and renting to persons with a mental disorder. Further, in 2001, the World Health Organization (WHO) declared that "the single most important barrier to overcome in the community is the stigma and associated discrimination toward persons suffering from mental and behavioral disorders" (World Health Organization, 2001, p. 98). Mental health stigma is related to several negative outcomes, such as those mentioned above, but also secondary outcomes, or problems that develop as a result of untreated or poor treatment of mental health disorders. Secondary outcomes influenced by stigma may include higher unemployment and underemployment rates, high work absenteeism and employee turnover, poor and unsafe housing, and increased economic cost (Knifton & Inglis, 2020; NAMI, 2021). While stigma is pervasive and impacts access to mental health care regardless of background, underrepresented groups often deal with more stigma and discrimination. Therefore, reducing the stigma associated with mental illness may be a significant step in addressing the disparities experienced by individuals of color and improving their overall quality of life.

Mental Health Stigma

Mental health stigma is described as the disgrace, social disapproval, or social discrediting of individuals with a mental health issue (Corrigan & Kleinlein, 2005; Corrigan & Watson, 2002; Link et al., 1989). Mental health stigma simultaneously occurs on multiple levels; it is operated in society (public stigma), internalized by individuals (self-stigma), and manifested as barriers to individuals who may seek or engage in treatment services (structural stigma).

Public stigma, also known as social stigma, refers to negative attitudes toward individuals with mental illness that are held by the general public (Corrigan et al., 2012). These negative attitudes are often based on misconceptions that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn, 1999). In this context, stigma is embedded in the social framework in which persons with the stigmatized condition are less equal or are part of an inferior group. Link and Phelan (2001) noted that the entire process of public stigma is accompanied by significant embarrassment by the stigmatized individuals and by those associated with them. Self-stigma occurs when people internalize negative public attitudes; thus, the continued effect of public/social stigma can lead to feelings of inadequacy and shame about their condition. In self-stigma, the awareness that stigma is present within society can have deleterious effects on a person's self-esteem and self-efficacy (Corrigan et al., 2006), even if the individual has not been directly stigmatized.

In addition, structural stigma is increasingly recognized as one of the most significant barriers to the quality of life of people with mental illness (Hatzenbuehler, 2016; Hatzenbuehler & Link, 2014). Structural stigma represents the societal-level conditions, cultural norms, and institutional practices that restrict opportunities and means of freedom from people with mental illness (Hatzenbuehler, 2016), and it results in inequities that are manifested through rules, policies, and procedures within the society at large (Hatzenbuehler & Link, 2014). The manifestation of structural stigma "sets the context in which individuals in the community respond to the onset of mental health problems, clinicians respond to individuals who come for treatment, and public policy is crafted" (Pescosolido et al., 2010, p. 1324).

Mental Health Stigma and Discrimination Reduction Interventions

In recent years, advocacy groups and mental health charities have developed and implemented anti-stigma interventions across the world. The goal of these interventions is to reduce the stigma associated with mental illness and improve the overall well-being for individuals most affected. Stigma and discrimination reduction (SDR) interventions target various components of stigma, including self, structural, and public stigma, and therefore, vary widely in their design and implementation. According to the literature, there are three prominent types of mental health SDR interventions: (a) education; (b) contact; and (c) protest and advocacy (Corrigan & Gelb, 2006).

Educational anti-stigma interventions focus on factual information about the stigmatized mental illness with the goal of challenging inaccurate stereotypes or negative beliefs and attitudes (Corrigan et al., 2012). Books, information sessions, videos, movies, announcements, and other audio-visual aids are used to counter myths about mental illness and replace them with facts (Finkelstein et al., 2016). Educational interventions generally target public stigma, but they have also shown effectiveness in reducing self-stigma and improving self-esteem (Cook et al., 2014). However, these reductions have mainly yielded short-term improvements in attitudes.

Contact-based interventions provide a more interpersonal approach to reducing stigma associated with mental illness. Face-to-face interactions between a person with a mental illness and the general public are employed to challenge prejudice (Pettigrew & Tropp, 2008). Contact interventions aim to reduce the discomfort, distrust, and fear that emerges from a lack of contact with individuals who have a mental illness and to facilitate positive interaction and connection (Brown et al., 2010). These strategies are aimed at reducing the effects of public stigma on a person-to-person level but have also been shown to reduce self-stigma by boosting self-esteem, similar to education-based interventions (Corrigan et al., 2013). As such, contact-based interventions are frequently combined with educational interventions to provide both factual and personalized information.

Protest and advocacy interventions are rooted in social justice and advancing civil rights agendas. The goal is to suppress negative attitudes at the grassroots level for those who have experienced stigma and discrimination by collaborating with advocates and community leaders (Corrigan, et al., 2001). Protest methods focus on dismantling stigmatizing advertisements, news stories, and media outlets through marches, press-releases, sit-ins, and boycotts, and they are generally targeted to politicians, journalists, and community officials (Arboleda-Florez & Stuart, 2012). Among all of the antistigma interventions, protests are the least common and least studied

(Walsh & Foster, 2021). Although existing literature on SDR programs have indicated promising outcomes towards mental health stigma, what remains unknown is to what degree SDR programs are effective for BIPOC.

Purpose of the Study

The purpose of this research study was to conduct a comprehensive meta-analysis to investigate the efficacy of existing SDR programs. Of particular importance was identifying the degree to which SDR interventions have increased or decreased stigma among BIPOC individuals. Conducting a meta-analysis of published outcomes from existing SDR programs can help identify the effectiveness, or lack thereof, of these programs among BIPOC communities. The current analysis further delineates an empirical basis for applying evidence-based interventions that can potentially change attitudes toward BIPOC with mental illness, and it can establish clinical care standards that can be used to effectively end mental health stigma by continually decreasing its damaging consequences on marginalized communities with mental illness. Results from this study can provide valuable information for mental health professionals, local and national mental health organizations, and even the general public as they can be used to further develop new or enhance current SDR programs, particularly for individuals of color. Outcomes of this study can also increase mental health promotion and prevention efforts, increase awareness of the detriments of mental health stigma, and improve knowledge, attitudes, and willingness to address the specific mental health needs of these groups.

To investigate the utility of SDR interventions, the following research questions were addressed: (a) What is the degree of effectiveness of stigma and discrimination reduction programs on stigmatizing attitudes among Black, Indigenous, and People of Color with mental health symptoms?; (b) Which types of stigma and discrimination reduction programs are most effective among Black, Indigenous, and People of Color with mental health symptoms?; and (c) What are the moderating effects of sample and study characteristics on the effectiveness of stigma and discrimination reduction initiatives for black, indigenous, and people of color?

Systematic Review of the Literature

A systematic search of the literature was conducted to identify previously conducted meta-analyses or meta-analytic studies that have examined the efficacy of mental health stigma-reduction programs for BIPOC. By and large, BIPOC mental health outcomes were not discussed in the meta-analyses. The lack of attention given to specific characteristics of participants (e.g., race, ethnicity, culture) was often described as limitations of the analyses and presented as areas for future research. For example, Lien et al. (2020;2021) noted that some factors known to influence attitude and stigma such as gender, previous experience with mental illness, and race/culture were not evaluated in their meta-analysis of mental illness stigma among healthcare professionals (HCPs) and students due to the limited research regarding anti-stigma interventions for mental illness among HCPs up to date. Thus, in order to generate foundational literature on this topic, critical factors that could have influenced the results of the meta-analysis were not examined.

Similarly, Corrigan et al. (2012) conducted a meta-analysis of outcome studies regarding public stigma of mental illness and acknowledged that one area not discussed in their review was the impact of multiple stigmas and the interaction of multiple prejudices. The authors highlighted the lack of focus on race and other characteristics as a considerable limitation of their study. Additionally, Griffiths et al. (2014) evaluated the efficacy of different types of SDR interventions, including education, consumer contact, and cognitive behavior therapy in reducing various forms of stigma for mental health disorders. In this study, factors of race and ethnicity were also not discussed; however, rather than describing this as a limitation, Griffiths et al. specifically excluded studies that addressed the stigma associated with factors other than mental illness, such as race.

Moreover, some meta-analyses referred to either race or culture in their results. Doley et al. (2017) extracted specific descriptions of participants (where available) including gender, country, age, socioeconomic status, occupation/field of study, and ethnicity in their meta-analysis of interventions to reduce the stigma of eating disorders. The results indicated that study populations included low percentages of people who did not identify as White or Caucasian. Although outcomes related to race/ethnicity were included, they were brief and lacked data identifying the percentages of each demographic group and inferences on how the lack of diversity in population affected the results. Maunder and White (2019) also described some cultural factors in the results of their meta-analysis of intergroup contact SDR interventions on mental health stigma. The researchers noted that characteristics of the participants involved in the interventions, in addition to their cultural beliefs about mental illness, may also moderate its effectiveness. Results of this meta-analysis indicated that the effect of intergroup contact immediately after the intervention and in the short-term was significantly larger in non-Western (Asian and Middle Eastern) countries compared to Western countries. However, no additional results related to culture were described. Throughout this systematic search of the literature, BIPOC outcomes were largely absent and none of the reviewed studies addressed BIPOC outcomes comprehensively.

Method

Research Design and Rationale

Due to the rising number of research studies being conducted on mental health SDR interventions, there is a pressing need to systematically synthesize extant findings. Therefore, a meta-analytic research design was used to investigate the utility of SDR initiatives for BIPOC to address the gap in the literature. The present meta-analysis was performed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) guidelines to establish complete and accurate reporting of information.

Search Procedures

Information Sources

The literature search for this study included two levels of search terms: stigma and mental illness. Lipsey and Wilson (2001) recommended using a set of keywords that broadly cover the relevant domain to effectively identify a high proportion of potential studies for a meta-analysis. The process consisted of: (a) identifying all descriptors that relate to the topic of interest, and (b) identifying the range of search terms different researchers might use in their titles or abstracts that indicates the study applies to the topic of interest. The identified search terms used in this meta-analysis were developed by conducting a preliminary search of terms on PubMed and SCOPUS databases and identifying key terms used in a series of populated manuscripts. Stigma included the search terms “stigma” OR “antistigma” OR “discrimination” OR “stigma change” OR “stigma reduction”, and mental illness included the search terms “mental illness” OR “mental disorders” OR “mental health disorders” OR “mental health” OR “psychological distress” OR “mental health issues”. The identified search terms guided the screening process. As noted by Lipsey and Wilson (2001) and Page et al. (2021), a comprehensive search generally requires a thorough investigation of multiple databases. Therefore, the following electronic databases were used to identify articles that meet inclusion criteria: Cochrane Library, PubMed, Academic Search, Google Scholar, ProQuest, ProQuest Dissertations and Theses, and through

EBSCO web searching of PsycARTICLES, PsychINFO, and MEDLINE. Searches were conducted from inception of the databases to February 2023.

Criteria for Inclusion and Exclusion of Studies

Specific inclusion and exclusion criteria were identified to reduce extreme variability among studies to make it possible to identify differences between treatments. As such, articles that quantitatively investigated the effect of stigma reduction on mental illness and included members of BIPOC in their sample were included in the study. To focus the analysis on the highest-quality evidence, eligible study designs were restricted to randomized controlled trials (RCTs). Correlational, quasi-experimental, qualitative, and non-RCTs were excluded. Inclusion of studies within this analysis also depended on the following criteria: (a) interventions aimed at reducing stigma toward people with mental illness or mental health symptoms; (b) interventions including descriptive samples of BIPOC; (c) studies published in English; and (d) studies conducted in U.S. geographic locations. Although articles were required to have samples of BIPOC, each study did not have to include samples of every BIPOC to be included.

Additionally, articles were not excluded based on participant age, ethnicity, race, gender, or occupation, and the search was not limited by publication date to ensure the inclusion of as much relevant evidence as possible. Dissertations and/or theses were also considered scholarly sources based on peer and/or expert reviews of the work. Studies were excluded if: the reduction of stigma was not related to mental health problems; changes in stigma were not described; data reporting the changes in stigma were not reported; comorbid physical conditions (e.g., cancer) of participants were investigated as part of the intervention; and the study did not include a randomized control group as a comparison.

Search Strategy and Screening for Relevant Studies

The eligibility of search results was examined through a two-step process: first by title and abstract and second, by full text of articles. After conducting the initial database search, additional studies were identified by employing a "backward snowballing' approach" (i.e., scanning references of retrieved articles or investigating "grey literature" (Greco et al., 2013). Manual searches of all reference lists of articles that meet inclusion criteria were conducted in order to exhaust relevant article collection. Attempts were also made to collect any unpublished articles. Authors who published two or more articles on the topic were contacted via email to inquire about additional unpublished studies. A total of two principal authors were contacted via email addresses provided in their publications; however, no responses were received.

All retrieved records were uploaded in EndNote X9 software, and duplicate studies were removed using multi-pass deduplication. For the remaining studies, titles and abstracts were screened and studies that did not reference the search terms and meet the inclusion criteria were removed at this stage. Potential articles deemed suitable underwent further examination during the second stage. Articles were reviewed to identify that pertinent information needed to compute effect sizes (e.g., mean, standard deviation, and sample size) were included. If the required information was reported, the article remained in the selected pool of articles. Reasons for exclusion were recorded for each document.

Data Collection and Coding

For this meta-analysis, the independent reviewer developed a coding guide that was used to extract all variables of interest from studies using principles of PRISMA 2020 (Page, et al., 2021). Characteristics of data extracted from each article were: study and author descriptors (e.g., year, geographic location, setting, publication type); sample descriptors (e.g., total sample size, race and/or ethnicity, age, gender); research design descriptors (e.g., study design, control or comparison intervention, type of outcome measures); main outcomes and effect sizes of the interventions (e.g., univariate and multivariate effect sizes, descriptive statistics, and inferential test statistics).

Methodological Quality of Included Studies

Method for Assessing Reliability and Inter-rater Reliability

Krippendorff (2004) identified three aspects of coding as it relates to reliability: (1) *stability* (which refers to whether the process of coder behavior remains the same over time), (2) *accuracy* (whether coding is conducted by a previously agreed upon codebook), and (3) reproducibility (when multiple coders code with similar results). Low agreement between coders (or with the coding book) suggests weakness in the research methods or weakness in the explanation and execution of the inclusion/exclusion criteria. To ensure reliability of coding procedures, all studies were coded by the author of this study, and a random sample of 20% of studies were coded by an independent analyst to establish an estimate of inter-rater reliability. Discrepancies were resolved by subsequent discussion. The coding process continued until there was an agreement rate of 95% or higher to control risks to internal validity.

Method for Assessing Risk to Internal and External Validity

The Effective Public Health Practice Project’s Quality Assessment Tool (EPHPP) was used to assess the quality of evidence for all outcomes (Thomas et al., 2004). Greco et al. (2013) explained that the quality of RCTs should be evaluated based on issues relating to randomization and adequate blinding and explanation for dropouts and withdrawals, which both address matters of internal validity (minimization of bias) and external validity (ability to generalize results). The EPHPP has been judged suitable to be used in meta-analyses and with a variety of study designs such as RCTs, and it has demonstrated fair reliability and validity content and construct validity

(Armijo-Olivo, 2010). The EPHPP assesses six domains: (a) selection bias; (b) study design; (c) confounders; (d) blinding; (e) data collection method; and (f) withdrawals/dropouts. Each of these domains were rated for each of the selected studies as: strong quality (1 point), moderate quality (2 points) or weak quality (3 points), and the scores for all domains were used to provide a global rating score. Studies with no weak ratings received a global rating of strong. Studies with one weak rating received a global rating of moderate, and studies with two or more weak ratings received a global rating of weak.

Statistical Procedures and Conventions

Effect Size Computations

The Comprehensive Meta-Analysis (CMA) 4.0 software was used to synthesize and analyze data (Borenstein et al., 2021). Hedges' g measure of effect size was selected as the appropriate unit of analysis. Hedges' g (1981) is a measure of standardized mean difference that allows for the comparisons of outcomes using different measurement scales. This computation is similar to Cohen's *d*; however, a considerable strength of Hedges' g is its ability to statistically correct for variance that may form when sample sizes are small, thereby reducing the impact for bias related to sample size. Hedges' g was computed for each study using the following formula: $g = \frac{\overline{X_1} - \overline{X_2}}{S\,pooled}$, where $\overline{X_1}$ and $\overline{X_2}$ are the means for groups 1 and 2 respectively, and $S\ pooled$ is the pooled estimate of the standard deviation of the two groups (Hedges & Olkin, 1985). Being that Cohen's *d* and Hedges' g are computed in similar ways, the magnitude of effect sizes was classified according to Cohen's benchmarks, which provides an estimate of an observed effect. An effect of 0.2 indicated a small degree of practical significance, 0.5 indicated a medium degree of practical significance, and 0.8 indicated a large degree of practical significance (Cohen, 1988).

Grand Effect Size Estimate and Grand Confidence Intervals

The grand effect sizes derived from the meta-analysis were calculated by combining the standardized effect sizes of the included studies. Factors associated with sample size, variance, and reliability of the outcome measures can influence the magnitude and direction of the effect size (Sullivan & Feinn, 2012). Larger sample studies may provide more precise estimates of the effect size, whereas smaller studies are less precise, unless little variance exists. Because the precision of estimates differs, Hedges and Olkin (1985) described that a weighted mean of the observed effect sizes should be calculated. Weight of the standard error based on sample size allows for the best precision of the effect size estimates. Erford et al. (2010) provided a process for weighing effect sizes. The formula for this is the inverse of variance associated with the g estimate: $G_{ES} = \frac{\Sigma(V_d g_i)}{\Sigma V_d}$. Following this, the standard error of the grand effect size is calculated using: $SE_{GES} = \sqrt{\frac{1}{\Sigma V_d}}$. The grand effect size estimate is used to calculate the lower and upper limits of the confidence intervals: $G_{ESL} = G_{ES} - 1.96(SE_{GES})$ and $G_{ESU} = G_{ES} + 1.96(SE_{GES})$, where G_{ESL} is the lower limit and G_{ESU} is the upper limit.

Method of Synthesis

Analysis of Homogeneity

The Q test was used to assess the homogeneity of studies in this meta-analysis. Kulinskaya et al. (2011) reported that it is common to test homogeneity to identify if the method and results of several studies are adequately similar to warrant the combination of an overall result. A measure frequently used to test homogeneity is Cochran's Q statistic (Cochran, 1937), which calculates a weighted sum of the square distances of the observed effects. Homogeneity tests for Hedges' g are calculated using the Qt statistic: $Qt = \sum_1^k w_i g_{2i} - \frac{(\sum k_i = 1\ w_i g_{2i})2}{\sum k_i = 1 w_i}$, which is proposed by Hedges and Olkin (1985). The generated values for Qt is assessed for significance using chi-square values, with k-1 degrees of freedom (k is the number of effect sizes). Variance attributed to study characteristics may be evident if the value of Qt is greater than the critical value of the upper tail value of chi-square. Furthermore, the I^2 statistic is used in addition to the Qt statistic to identify the amount of within-study variance. I^2 is calculated as follows: $I^2 \ = \sum \frac{Q-df}{Q} \text{ x } 100\%$.

Moderator Analysis

The Campbell Collaboration (2001) recommended that the appropriateness of subgroup and moderator analysis be considered when conducting meta-analyses. Under certain conditions, a meta-analytic research design without a moderator analysis may be unable to explain why results vary across studies, even when conducted in accordance to proposed guidelines. The CMA 4.0 software was used to undertake random effects meta-regression using available summary statistics. The computation provides restricted maximum likelihood (REML) estimates of regression parameters and the residual heterogeneity variance.

Publication Bias and Selective Reporting

The most common source of type I error in meta-analyses is publication bias (Greco et al., 2013). Type I error occurs when studies that are statistically significant are: more likely to be published, published more quickly than studies without statistically significant results, published in journals with higher impact factors, and more likely to be cited by others (Dubben & Beck-Bornholdt, 2005). As such, efforts were made to include both published and unpublished studies in the meta-analysis. Although including unpublished literature is one approach to limit the risk of publication bias, additional considerations should be made. To address the potential for publication bias in this meta-analysis, several methods were utilized.

Funnel Plot Analysis

A funnel plot was created to identify the impact of publication bias. The estimated treatment effects from individual studies were displayed on the horizontal axis of the funnel plot, and the measures of study size were displayed on the vertical axis (Sterne & Harbord, 2004). If publication bias exists, studies portray an asymmetrical appearance of the funnel plot with effect estimates evenly distributed on either side of the funnel plot. However, if publication bias is not present, studies are distributed symmetrically because sampling error is random. If publication is detected in the graph, a closer examination of the study's characteristics was examined.

Additionally, the *Trim and Fill* method was employed as an iterative method to yield an unbiased estimate of the effect size and reduce the variance of the effects by re-computing the effect size at each point until the funnel plot was symmetric (Duval and Tweedie, 2000a & 2000b). The *Trim and Fill* computation was completed using CMA 4.0 software. Borenstein et al. (2010) acknowledged that a major advantage of using *Trim and Fill* to remove publication bias is that most statistical software programs are able to create a funnel plot that includes both the observed studies and the imputed studies, thereby, providing a visual of effect size shifts when the imputed studies are included.

Rosenthal's Fail-safe N

An additional method for identifying publication bias in meta-analyses is Rosenthal's *Fail-safe N* (Rosenthal, 1979). *Fail-safe N* addressed the concern of statistically nonsignificant studies being missing from pooled studies, and the exclusion of these studies nullifying the observed effect. Therefore, the *Fail-safe N* test was conducted to describe the robustness of a significant result by identifying the number of missing studies with an effect size zero that should be added to make the combined effect size statistically significant.

Results

Study Selection

Of the 5141 studies retrieved from the selected databases, 1357 duplicates were removed using EndNote X9 multi-pass deduplication, and 3784 were screened. Upon screening of the title and abstracts, 3655 were removed. For the remaining 129 studies, 123 articles were successfully retrieved and assessed for full-text eligibility. A total of 116 articles were excluded at the full-text screening stage: 36 articles did not investigate BIPOC stigma changes, 26 included non-U.S. study samples, 23 were not aimed at reducing stigma, 19 were qualitative reports, 8 included comorbid physical conditions (e.g., HIV) as part of the intervention results; and 4 were not published in English (see Figure 1 for PRISMA flow diagram). After screening, seven studies with eight total effect sizes were included in the meta-analysis.

Study Characteristics

Data pertaining to sample characteristics of the studies by study design, target population, sample size, age, sample description, type of stigma targeted, measure of stigma, and type of stigma and discrimination reduction (SDR) intervention are reported in Table 1. The selected articles were published between 2002 and 2022. All studies were conducted in the U.S. and used randomized controlled trial study designs. Sample sizes of the studies varied from 42 to 196 with a total of 609 participants across the selected studies. Race and ethnicity of participants included Black/African American (43.67%), Latinx (43.66%), Korean American (7.88%), White (2.79%), and Other (1.97%), and study participants tended to be female (67.14%). The type of stigma varied across studies, with three studies targeting self-stigma, two studies targeting depression-related stigma, one study targeting suicide-related stigma, and one study targeting general mental health stigma. The type of SDR intervention mostly consisted of psychoeducational interventions on stigma (*k* = 5), followed by contact-based interventions (*k* = 1) and an educational intervention in the form of entertainment (*k* = 1).

Effectiveness of SDR interventions for Decreasing Stigma among BIPOC

Primary Outcomes

The analysis was based on eight effect sizes. The effect size index was the standardized difference in means (*g)*, and the random-effects model was employed for the analysis. The overall effect of the meta-analysis yielded a mean effect size of .59 (95% CI [–0.04, 1.21]), *p* = .07, τ^2 = 0.71, indicating an unstable, negligible to large effect size and suggesting that the null hypothesis related to the SDR intervention effectiveness cannot be rejected. Sub-group analyses were conducted to identify the effect on race and ethnicity. The mean effect size of the sub-group analysis was .21 (95% CI [0.00, 0.41]), $p < 0.05$, indicating a small effect size. The analysis for studies with Black/African American participants (*k* = 2) yielded a mean effect size of .01 (95% CI [–.26, .27]), *p* = .96, indicating a negligible effect. For studies with Latinx participants (*k* = 3), the mean effect size was –.02 (95% CI [–.43, .38]), *p* = .91, indicating a negligible effect. The analysis for Korean Americans (*k* = 1) yielded a mean effect size of 7.74 (95% CI [6.09, 9.38]), $p > .001$, indicating an effect size larger than seven standard deviations, and the analysis for one study including Black (*n* = 49.1%), White (*n* = 29.8%), and Other (*n* = 21.1%) participants (*k* = 1) yielded a mean effect size of .61 (95% CI [0.08, 1.13]), $p < .05$, indicating a moderate effect size but suggesting that the SDR intervention may yield unstable findings based on confidence intervals. The effect size distribution within the sample of studies was heterogeneous *Q*(7) = 94.26, $p < .001$, I^2 = 93%, resulting in a large amount of heterogeneity wherein approximately 93% of the observed differences in effect sizes reflected non-systematic differences; thus, exploration of outlier studies was warranted.

Sensitivity Analysis. To identify sources contributing to the high heterogeneity of the meta-analysis, a one-study removed computation was conducted as a sensitivity analysis to determine whether the overall estimates were influenced by outlier studies. The Shin & Lukens (2002) article had substantially higher effects (*g* = 7.74) than the other studies. Removing Shin & Lukens from the meta-analysis yielded a nonsignificant mean effect size of .06 (95% CI [–0.17 to 0.29], *p* = .61, τ^2= .05, indicating a negligible effect size and suggesting that the SDR interventions were not effective. Removing this study reduced the mean effect size and statistical significance, thereby keeping the original evaluation of retaining the null hypothesis.

After computing the one-study removed, the mean effect size of the sub-group analysis decreased to .09 (95% CI [–0.11, 0.29]), *p* = .39, indicating a negligible effect. Individual differences regarding stigma reduction by race/ethnicity remained the same for the remaining groups because no other studies included a similar sample with Korean Americans. The effect size distribution within the sample of studies decreased heterogeneity to $Q(6) = 11.76$, *p* = .07, I^2 = 49%, which suggested that the Shin & Lukens (2002) article accounted for more than 40% of the variance in the meta-analysis.

Secondary Outcomes

A meta-analysis was conducted on the included studies according to the type of mental health SDR intervention. Five studies (Alvidrez et al., 2009; Collado et al., 2019; Drapalski et al., 2021; Dueweke & Bridges, 2017; Shin & Lukens, 2002) examined the impact of psychoeducational interventions on stigma. One study, (Martin et al., 2022), examined the impact of a contact-based intervention, and one study (Hernandez & Organista, 2013) examined the impact of an educational intervention with an entertainment component. The overall effect of the analysis with the type of SDR interventions as a moderator was *k* = 8, *g* = .12 [95% CI –0.08

to 0.33], *p* = .24), indicating a negligible effect size. The analysis of the pooled result for psychoeducation SDR interventions across other levels of intervention was *k* = 5, *g* = 1.24 [95% CI –0.08 to 2.56], *p* = .07), indicating an unstable, negligible to large effect size. The analysis for the contact-based SDR intervention across other levels of intervention was (*k* = 2, *g* = .09 [95% CI –0.17 to 0.36], *p* = .49), indicating a negligible effect, and the analysis for the one entertainment-education SDR intervention across other levels of intervention was (*k* = 1, *g* = .10 [95% CI –0.23 to 0.43], *p* = .55), also indicating a negligible effect.

One-study Removed. A one-study removed analysis was also conducted on the type of mental health SDR intervention. Removal of Shin & Lukens (2002) resulted in four studies that examined the impact psychoeducational interventions on stigma, one study (with two effect sizes) that examined the impact of a contact-based intervention, and one study that examined the impact of an educational intervention with an entertainment component. The overall effect of the analysis with SDR interventions as a moderator resulted in a lower mean effect size and higher *p* value, (*k* = 7, *g* = .08 [95% CI –0.11 to 0.27], *p* = .40), indicating a negligible effect size. The analysis of the pooled result for psychoeducation SDR interventions across other levels of intervention also resulted in a lower mean effect size and higher *p* value, (*k* = 4, *g* = –.01 [95% CI –0.53 to 0.5], *p* = .98), yielding a negligible effect. The analysis for the one contact-based SDR intervention and the one entertainment-education SDR intervention across other levels of intervention remained unchanged because the removed article examined a psychoeducation intervention, and therefore, did not impact the pooled effect of the other interventions.

Study Quality and Risk of Bias

Each of the seven articles were assessed for risk of bias and overall study quality using the EPHPP. A detailed quality rating report of the included studies is provided in Table 2.

Overall study quality using the EPHPP tool ranged from weak to strong. The *selection bias* domain resulted in a rating of one (1 = strong quality) for six of the seven studies, indicating that individuals selected to participate in the studies were representative of the target population and 80-100% of selected individuals agreed to participate in the studies. A rating of two (2 = moderate quality) was attributed to one study (Collado et al., 2019) because data pertaining to the number of selected individuals who agreed to participate in the study was not provided. The *study design* domain resulted in a rating of one (1) for all seven studies, indicating all studies were considered randomized controlled trials. Regarding *confounders*, six of the seven studies received a rating of one (1), suggesting there were no important differences between groups prior to the intervention and most of the relevant confounders were controlled. One study (Martin et al., 2022) received a rating of two (2) in this domain due to some, but not most, of the confounders being controlled.

Ratings for *blinding* procedures resulted in the lowest ratings among all the domains. Researchers were blinded to participant exposure in only one study (Drapalski et al., 2021) and received a rating of one (1). The remaining six studies received a rating of two (2) because it was unknown whether the researchers were aware of the intervention or exposure status of participants and whether the study participants were aware of the research question. Ratings for the *data collection* domain demonstrated that four studies used valid and reliable measures and received a rating of one (1), and the remaining three studies (Alvidrez et al., 2009; Collado et al., 2019; Shin & Lukens, 2002) used reliable measures but did not describe the validity of the measures and received a rating of two (2). For the rating on *withdrawals and drop-outs*, most of the studies yielded strong quality. Six of the seven studies received a rating of one (1), indicating that withdrawals and drop-outs were reported in terms of numbers and/or reasons per group and most of the participants completed the study. One study (Shin & Lukens, 2002) received a rating of three (3 = weak), due to a lack of report on withdrawals and drop-outs in the study. Overall, only three studies (Drapalski et al., 2021; Dueweke & Bridges, 2017; Hernandez & Organista, 2013) received a global rating of one (1 = strong). The remaining studies (Alvidrez et al., 2009; Collado et al., 2019; Martin et al., 2022; Shin & Lukens, 2002) received a global rating of three (3 = weak).

Publication Bias

Inspection of the funnel plot of standard error by Hedges's *g* depicted a symmetrical pattern. The symmetrical visual inspection suggested publication bias was not present. Despite the forest plot suggesting no evidence of publication bias, further analyses were conducted to confirm the findings. Duval and Tweedie's *Trim and Fill* test supported the findings of the funnel plot. Under the random effects model, the point estimate and 95% confidence interval for the combined studies was 0.58513 (-0.03860, 1.20885). Using *Trim and Fill*, these values were unchanged, and no studies were missing.

Publication bias was also examined through the Fail-safe *N*. The meta-analysis incorporated data from 8 studies, which yielded a z-value of 3.88240 and corresponding 2-tailed p-value of 0.00010. The Fail-safe *N* was 24, which means that 24 'null' studies would need to be located and included in order for the combined 2-tailed *p*-value to exceed 0.050. Hence, there would need to be 3.0 missing studies for every observed study for the effect to be nullified.

Discussion

The purpose of this research was to identify the degree to which mental health stigma and discrimination reduction interventions were effective among BIPOC. A systematic review of the literature identified seven randomized control trials with eight total effect sizes. Collectively, the studies investigated the effectiveness of SDR interventions among Black/African Americans, Korean (Asian) Americans, and Latinx. The results of the meta-analysis yielded a negligible to large mean effect size, indicating unstable findings of SDR interventions among BIPOC. The effects of six studies were negligible, with the exception of Drapalski et al. (2021), Dueweke & Bridges (2017), and Shin & Lukens (2002). Due to high heterogeneity, a sensitivity analysis was conducted. Results indicated that Shin & Lukens (2002) accounted for more than 40% of the variance in the meta-analysis, and therefore, warranted removal. After removing the outlier study, the mean effect size was negligible. Overall outcomes of this meta-analysis suggest SDR interventions were not effective in reducing mental health stigma for BIPOC. These findings contrast from those of Corrigan et al. (2012) and Griffiths et al. (2014) who investigated the effectiveness of SDR interventions but without examining applicability to key subpopulations, such as racial and ethnic minorities.

Sub-group analyses on race and ethnicity yielded negligible effect sizes for Black/African Americans and Latinx. This suggested that SDR interventions were not effective in reducing stigma among these groups. One study (Drapalski et al., 2021) with a combined effect for SDR interventions with Black, White, and Other participants yielded a moderate effect size; however, the findings suggested instability based on the confidence intervals. Although the sample was combined in this study, Black participants made up majority of the sample size (*n* = 49.1%), and participants who identified as Other (*n* = 21.1%) than White or Black made up slightly less than the White (*n* = 29.8%) sample size.

A moderator analysis was conducted according to the type of mental health SDR intervention. SDR interventions were mostly education-based, with the inclusion of one contact based. Consistent with the literature (Walsh & Foster, 2021), no studies examined the impact of protest and advocacy SDR interventions. Before removal of the outlier study, the overall effect of the analysis yielded a negligible effect size. Psychoeducation SDR interventions yielded an unstable, negligible to large effect size, and the contact-based and entertainment-education SDR interventions yielded negligible effects. After removal of the outlier study, the overall effect of the analysis and the various types of SDR interventions yielded negligible effects.

Limitations and Suggestions for Further Research

An important limitation of the present meta-analysis was the paucity of studies that investigated the effects of mental health SDR interventions among BIPOC. Due to the lack of randomized controlled trials on this topic, the meta-analysis was underpowered and conclusions that could be drawn about the relative effects of the interventions were limited. The year of publication of the selected articles ranged from 2002 to 2022, and within that 20-year period, researchers only published seven articles that evaluated the effects of SDR interventions among BIPOC with an RCT study design. Similarly, a second limitation of this study was the lack of diversity with respect to race and ethnicity in the selected studies. None of the studies in the meta-analysis examined the effects of SDR interventions with American Indians and Alaska Natives (AI/ANs). This is a considerable limitation as AI/ANs tend to experience more widespread and unique mental health challenges, such as depression, substance abuse, and suicide, compared to non-Indigenous groups (Manson, 2000; Nelson et al., 1992). Additionally, only one study (Shin & Lukens, 2002) in the meta-analysis examined the effects of SDR interventions with Asian Americans and Pacific Islanders, particularly Korean Americans, but due to issues concerning heterogeneity, the study was removed from additional analyses. Nevertheless, one study alone would be insufficient to determine meaningful conclusions of an intervention for Korean Americans.

An additional limitation of the study relates to the methodological quality of the studies. As per the EPHPP tool, only three of the studies received a strong overall rating, while the remaining four received a weak overall rating. Harrison (2011) reported that the conclusion of a meta-analysis strongly depends on the quality of the studies selected to estimate the pooled effect. This limitation suggests there is a need to improve the quality of studies in this area of research, particularly with respect to blinding procedures and data collection methods.

Finally, the present meta-analysis was confined to published studies in the English language. Determination of this exclusion criteria stems from barriers related to time and costs required to obtain and translate studies. However, systematic reviews and meta-analyses that exclude non-English articles may miss important empirical evidence. Morrison et al. (2012) reported that the selection of studies in a particular language is called a *language bias*, and this bias could lead to an over- or underestimation of an intervention's effectiveness. Although the researchers found no evidence of bias from the use of language in their investigation of the effect of English-language restriction on meta-analyses, this finding does not rule out the potential for language bias to occur when language restrictions are imposed.

Despite the limitations of this study, certain implications are clear. Additional research is needed to identify SDR interventions that positively impact BIPOC with mental health challenges. Existing literature on SDR programs has indicated promising outcomes towards mental health stigma (Corrigan et al., 2012; Griffiths et al., 2014; Maunder and White, 2019); however, results of this meta-analysis suggest these outcomes cannot be generalized to individuals from minoritized backgrounds. The consequences of stigma are worse for some racial and ethnic groups who are faced with other forms of minority stress and structural discrimination within policies, institutions, and organizations (Turan et al., 2019), and therefore, research is warranted within these groups to determine its overall effectiveness. Studies involving various racial and ethnic minority groups in the U.S. with sizeable samples could be beneficial. Also, researchers are encouraged to take additional steps to enhance the methodological quality of studies investigating the impact of SDR interventions to make for more robust findings.

Conclusion

Due to the rising number of studies being conducted on mental health SDR initiatives, there was a pressing need to systematically synthesize extant findings for historically marginalized populations. Overall, SDR interventions did not yield meaningful effects among BIPOC. Nonetheless, a major strength of the study was its focus on widely underserved U.S. populations who experience unique challenges related to mental health stigma. The present meta-analysis offers empirical conclusions and transparency on the current effectiveness of mental health SDR interventions for BIPOC; however, the limited number of studies in this meta-analysis suggests additional studies are needed to identify positive SDR interventions for BIPOC. The U.S. has experienced a rapid transition in demographics with about 4 out of 10 Americans, a 276% increase from 2010-2020, currently identifying with a race or ethnic group other than White (United States Census Bureau, 2021). Therefore, more attention should be placed on the applicability of SDR interventions to diverse populations and to recognize the multicultural identity of participants included in studies. Further development of stigma interventions and higher quality studies are needed to improve mental health outcomes among BIPOC.

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Figure 1

PRISMA flow diagram

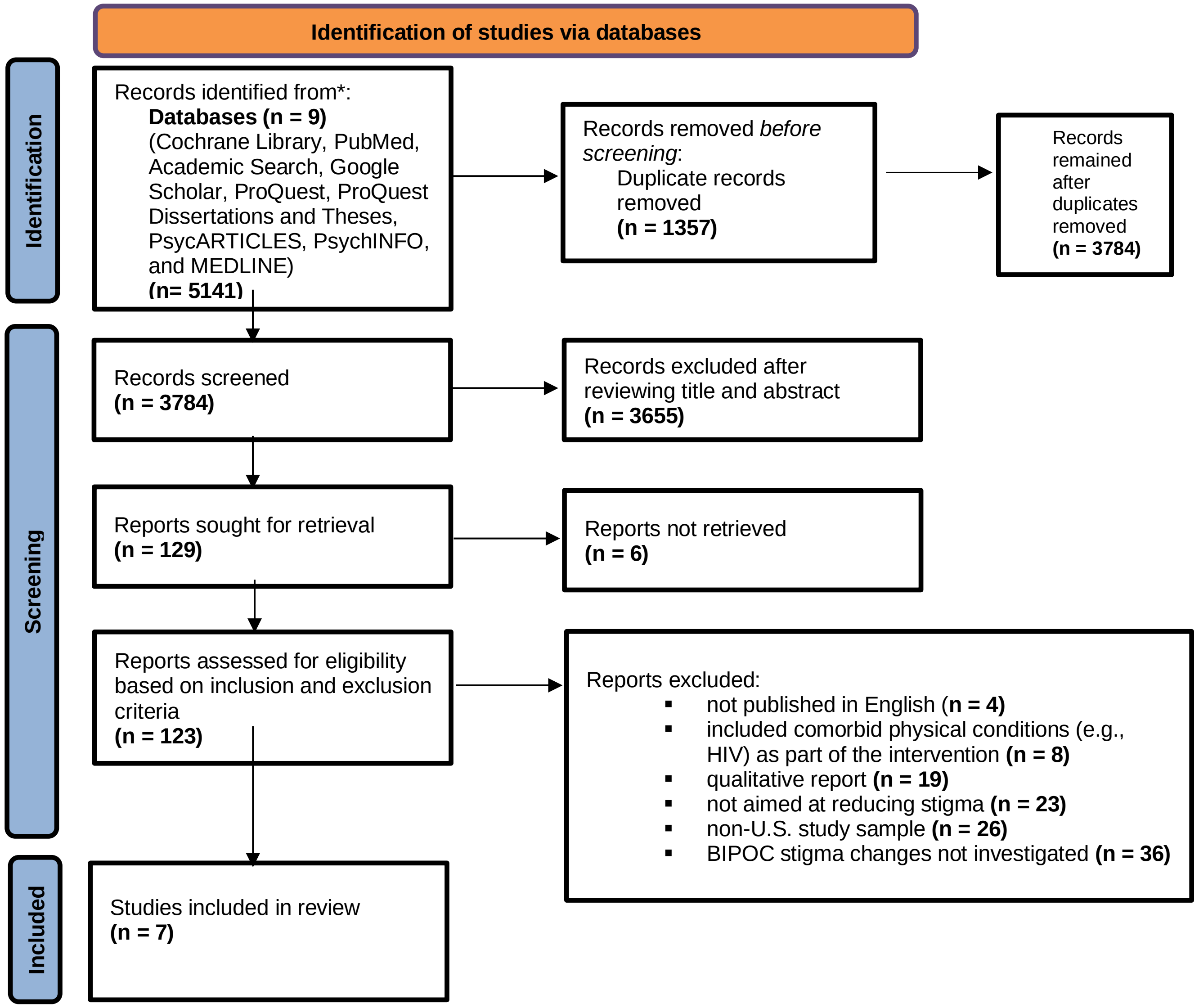
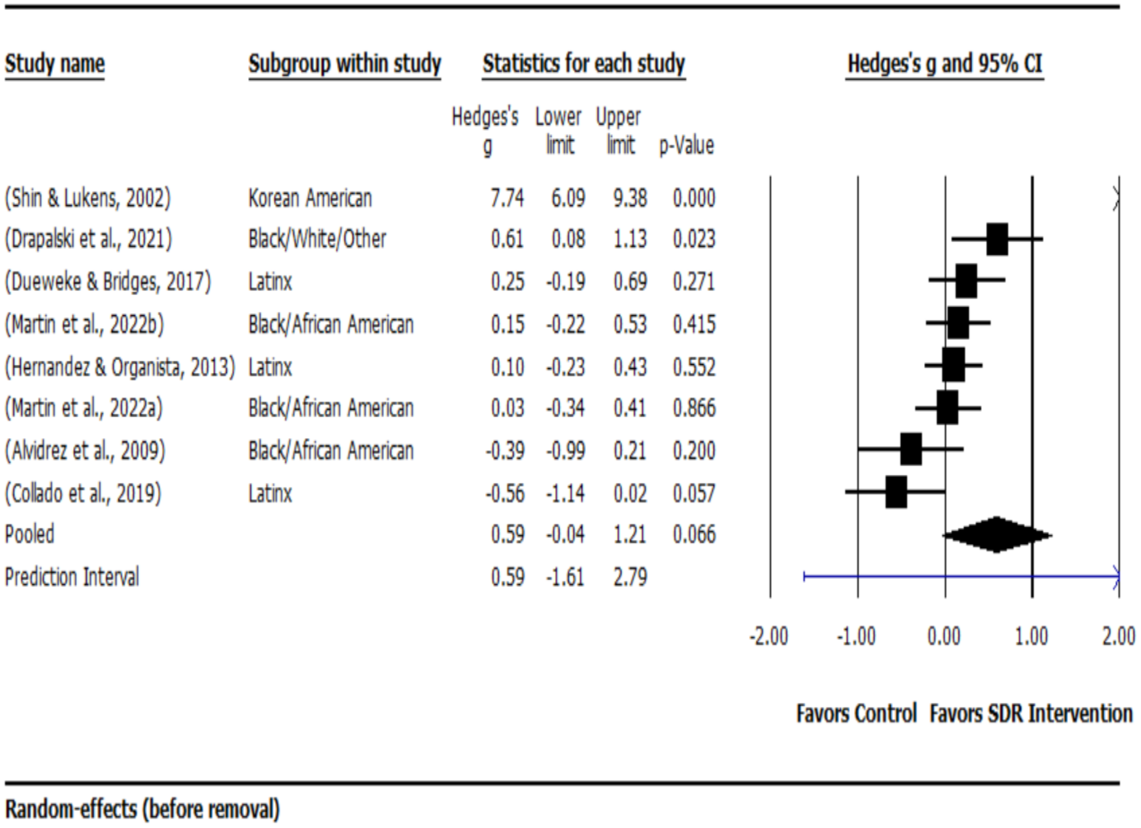


Figure 2

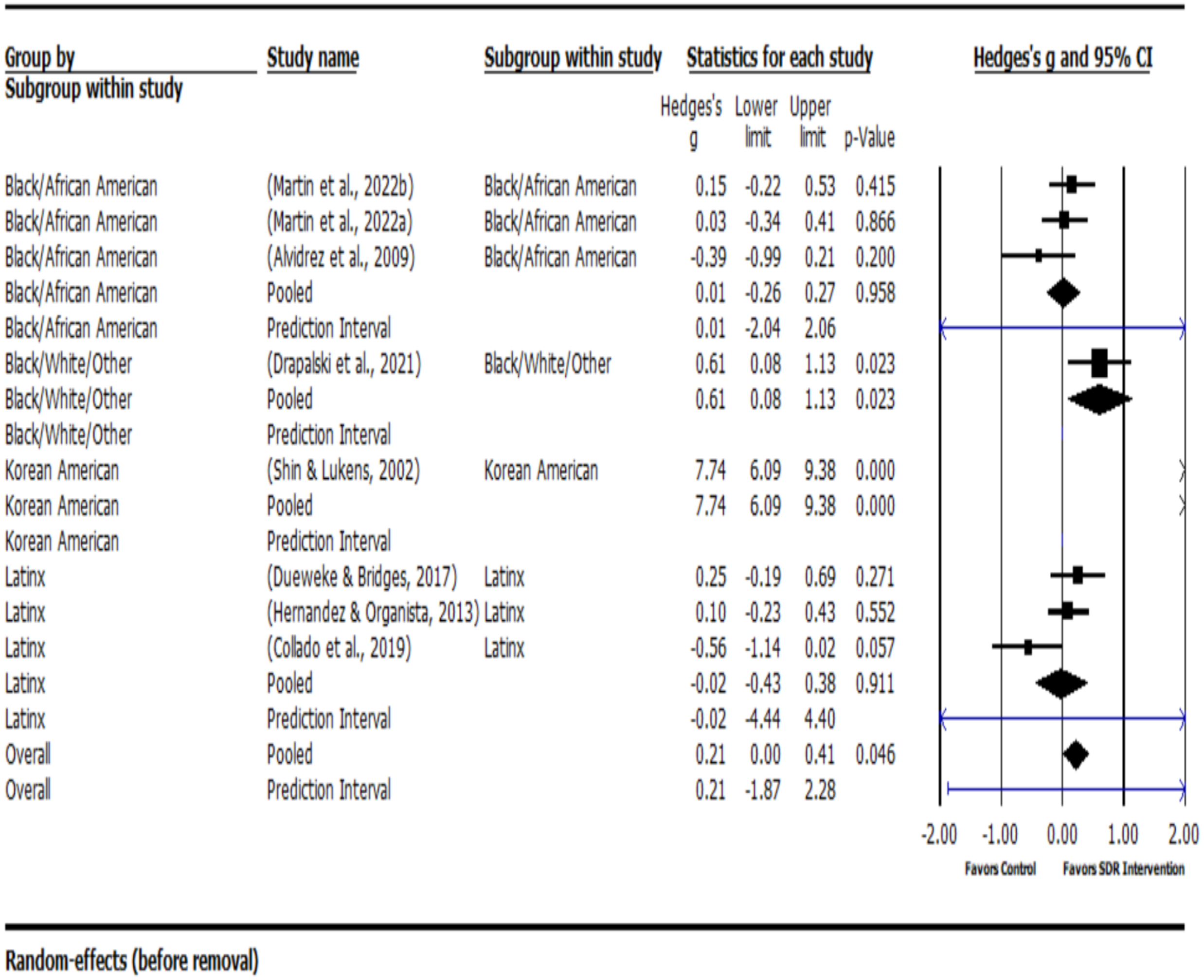
Effect sizes, 95% confidence intervals, and p-values for Studies Evaluating Stigma and Discrimination Reduction Interventions versus Control Groups for Decreasing Mental Health Stigma among BIPOC – Primary Analysis (before removal)



Study name	Subgroup within study	Hedges's g	Lower limit	Upper limit	p-Value
(Shin & Lukens, 2002)	Korean American	7.74	6.09	9.38	0.000
(Drapalski et al., 2021)	Black/White/Other	0.61	0.08	1.13	0.023
(Dueweke & Bridges, 2017)	Latinx	0.25	-0.19	0.69	0.271
(Martin et al., 2022b)	Black/African American	0.15	-0.22	0.53	0.415
(Hernandez & Organista, 2013)	Latinx	0.10	-0.23	0.43	0.552
(Martin et al., 2022a)	Black/African American	0.03	-0.34	0.41	0.866
(Alvidrez et al., 2009)	Black/African American	-0.39	-0.99	0.21	0.200
(Collado et al., 2019)	Latinx	-0.56	-1.14	0.02	0.057
Pooled		0.59	-0.04	1.21	0.066
Prediction Interval		0.59	-1.61	2.79	

Figure 3

Effect sizes, 95% confidence intervals, and p-values for Studies Evaluating Stigma and Discrimination Reduction Interventions versus Control Groups for Decreasing Mental Health Stigma among BIPOC – by Subgroup (before removal)

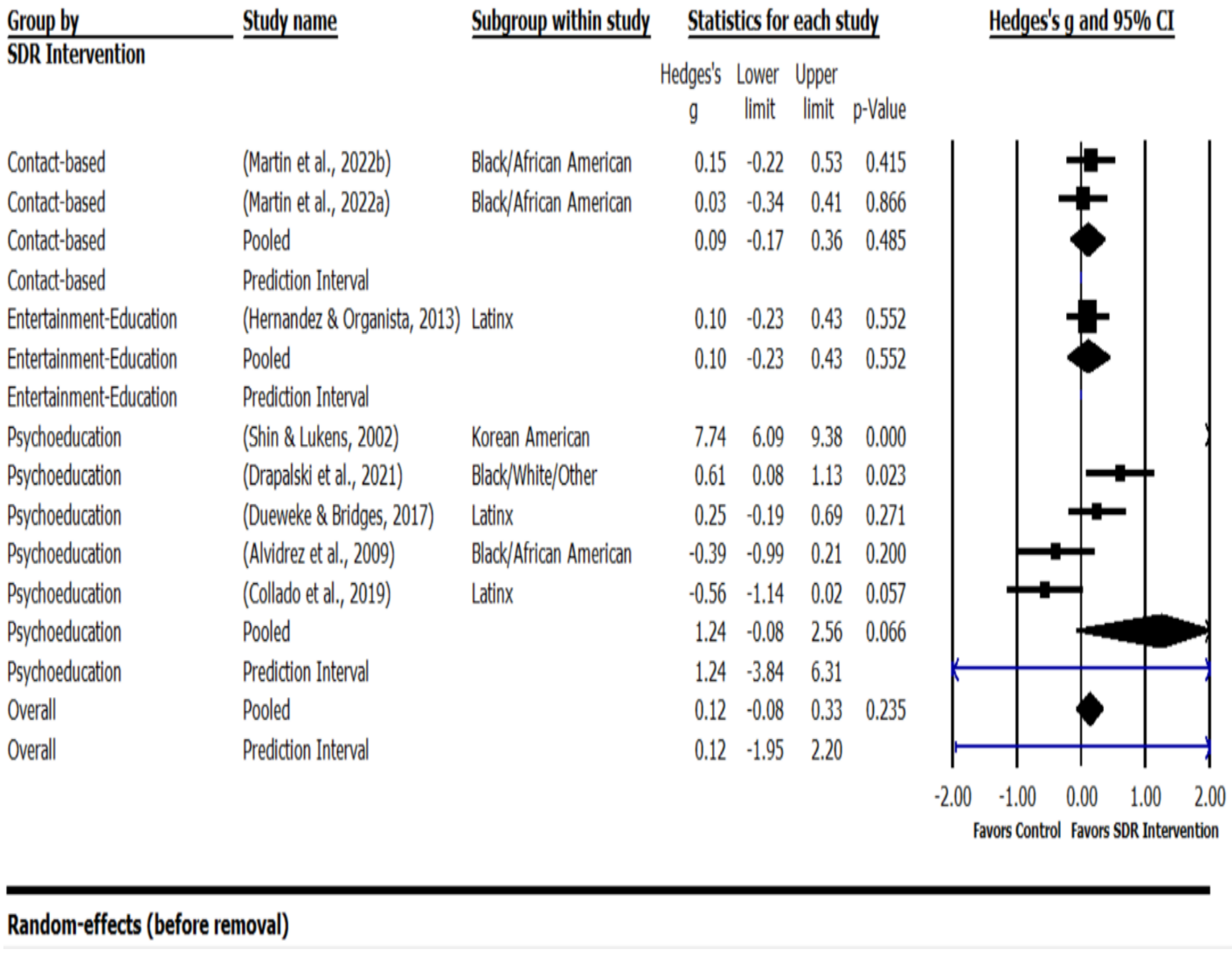


Group by Subgroup within study	Study name	Subgroup within study	Statistics for each study Hedges's g	Lower limit	Upper limit	p-Value
Black/African American	(Martin et al., 2022b)	Black/African American	0.15	-0.22	0.53	0.415
Black/African American	(Martin et al., 2022a)	Black/African American	0.03	-0.34	0.41	0.866
Black/African American	(Alvidrez et al., 2009)	Black/African American	-0.39	-0.99	0.21	0.200
Black/African American	Pooled		0.01	-0.26	0.27	0.958
Black/African American	Prediction Interval		0.01	-2.04	2.06	
Black/White/Other	(Drapalski et al., 2021)	Black/White/Other	0.61	0.08	1.13	0.023
Black/White/Other	Pooled		0.61	0.08	1.13	0.023
Black/White/Other	Prediction Interval					
Korean American	(Shin & Lukens, 2002)	Korean American	7.74	6.09	9.38	0.000
Korean American	Pooled		7.74	6.09	9.38	0.000
Korean American	Prediction Interval					
Latinx	(Dueweke & Bridges, 2017)	Latinx	0.25	-0.19	0.69	0.271
Latinx	(Hernandez & Organista, 2013)	Latinx	0.10	-0.23	0.43	0.552
Latinx	(Collado et al., 2019)	Latinx	-0.56	-1.14	0.02	0.057
Latinx	Pooled		-0.02	-0.43	0.38	0.911
Latinx	Prediction Interval		-0.02	-4.44	4.40	
Overall	Pooled		0.21	0.00	0.41	0.046
Overall	Prediction Interval		0.21	-1.87	2.28	

Random-effects (before removal)

Figure 4

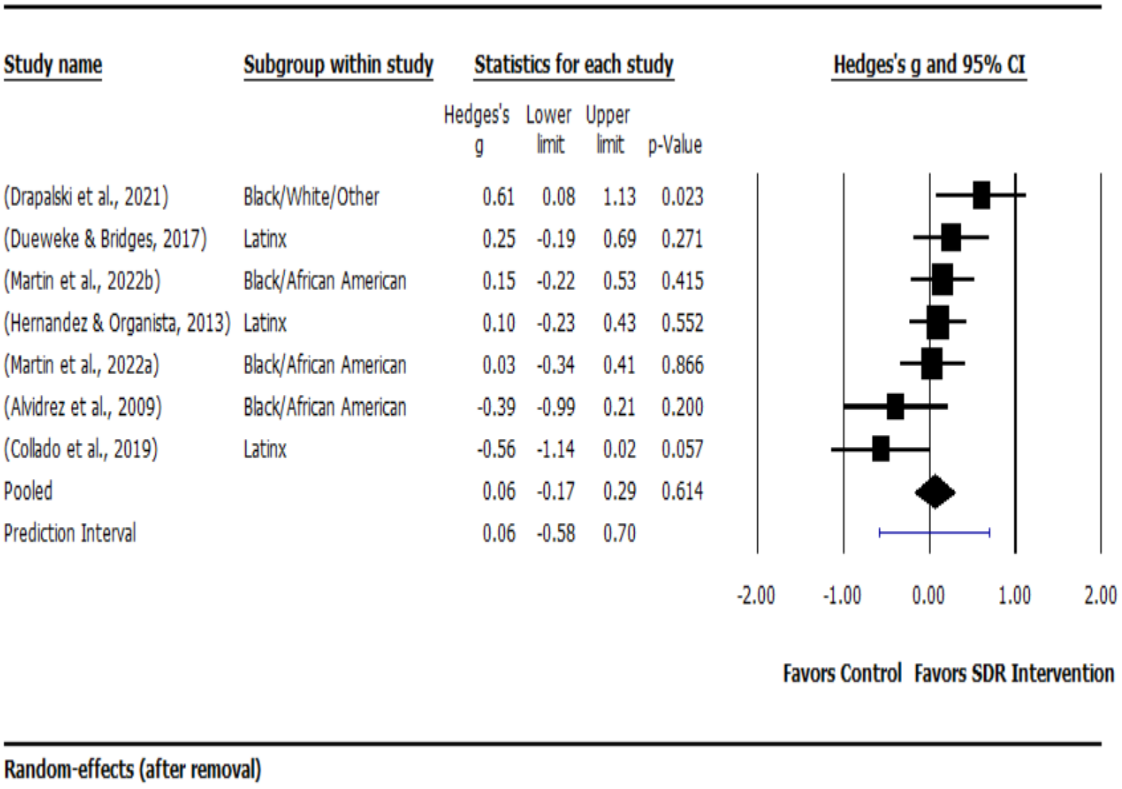
Effect sizes, 95% confidence intervals, and p-values for Studies Evaluating Stigma and Discrimination Reduction Interventions versus Control Groups for Decreasing Mental Health Stigma among BIPOC – by Intervention Type (before removal)



Group by SDR Intervention	Study name	Subgroup within study	Hedges's g	Lower limit	Upper limit	p-Value
Contact-based	(Martin et al., 2022b)	Black/African American	0.15	-0.22	0.53	0.415
Contact-based	(Martin et al., 2022a)	Black/African American	0.03	-0.34	0.41	0.866
Contact-based	Pooled		0.09	-0.17	0.36	0.485
Contact-based	Prediction Interval					
Entertainment-Education	(Hernandez & Organista, 2013)	Latinx	0.10	-0.23	0.43	0.552
Entertainment-Education	Pooled		0.10	-0.23	0.43	0.552
Entertainment-Education	Prediction Interval					
Psychoeducation	(Shin & Lukens, 2002)	Korean American	7.74	6.09	9.38	0.000
Psychoeducation	(Drapalski et al., 2021)	Black/White/Other	0.61	0.08	1.13	0.023
Psychoeducation	(Dueweke & Bridges, 2017)	Latinx	0.25	-0.19	0.69	0.271
Psychoeducation	(Alvidrez et al., 2009)	Black/African American	-0.39	-0.99	0.21	0.200
Psychoeducation	(Collado et al., 2019)	Latinx	-0.56	-1.14	0.02	0.057
Psychoeducation	Pooled		1.24	-0.08	2.56	0.066
Psychoeducation	Prediction Interval		1.24	-3.84	6.31	
Overall	Pooled		0.12	-0.08	0.33	0.235
Overall	Prediction Interval		0.12	-1.95	2.20	

Figure 5

Effect sizes, 95% confidence intervals, and p-values for Studies Evaluating Stigma and Discrimination Reduction Interventions versus Control Groups for Decreasing Mental Health Stigma among BIPOC – Primary Analysis (after removal)

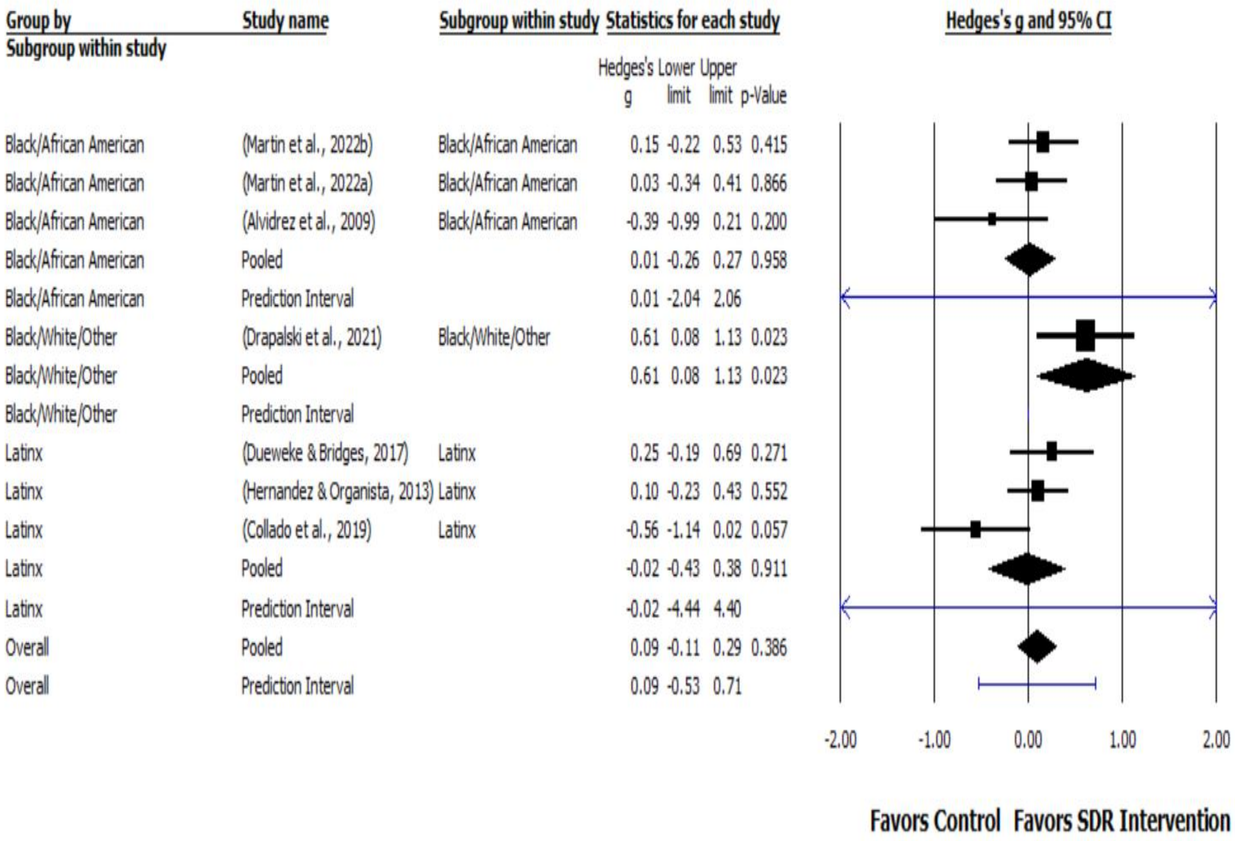


Study name	Subgroup within study	Statistics for each study			
		Hedges's g	Lower limit	Upper limit	p-Value
(Drapalski et al., 2021)	Black/White/Other	0.61	0.08	1.13	0.023
(Dueweke & Bridges, 2017)	Latinx	0.25	-0.19	0.69	0.271
(Martin et al., 2022b)	Black/African American	0.15	-0.22	0.53	0.415
(Hernandez & Organista, 2013)	Latinx	0.10	-0.23	0.43	0.552
(Martin et al., 2022a)	Black/African American	0.03	-0.34	0.41	0.866
(Alvidrez et al., 2009)	Black/African American	-0.39	-0.99	0.21	0.200
(Collado et al., 2019)	Latinx	-0.56	-1.14	0.02	0.057
Pooled		0.06	-0.17	0.29	0.614
Prediction Interval		0.06	-0.58	0.70	

Random-effects (after removal)

Figure 6

Effect sizes, 95% confidence intervals, and p-values for Studies Evaluating Stigma and Discrimination Reduction Interventions versus Control Groups for Decreasing Mental Health Stigma among BIPOC – by Subgroup (after removal)

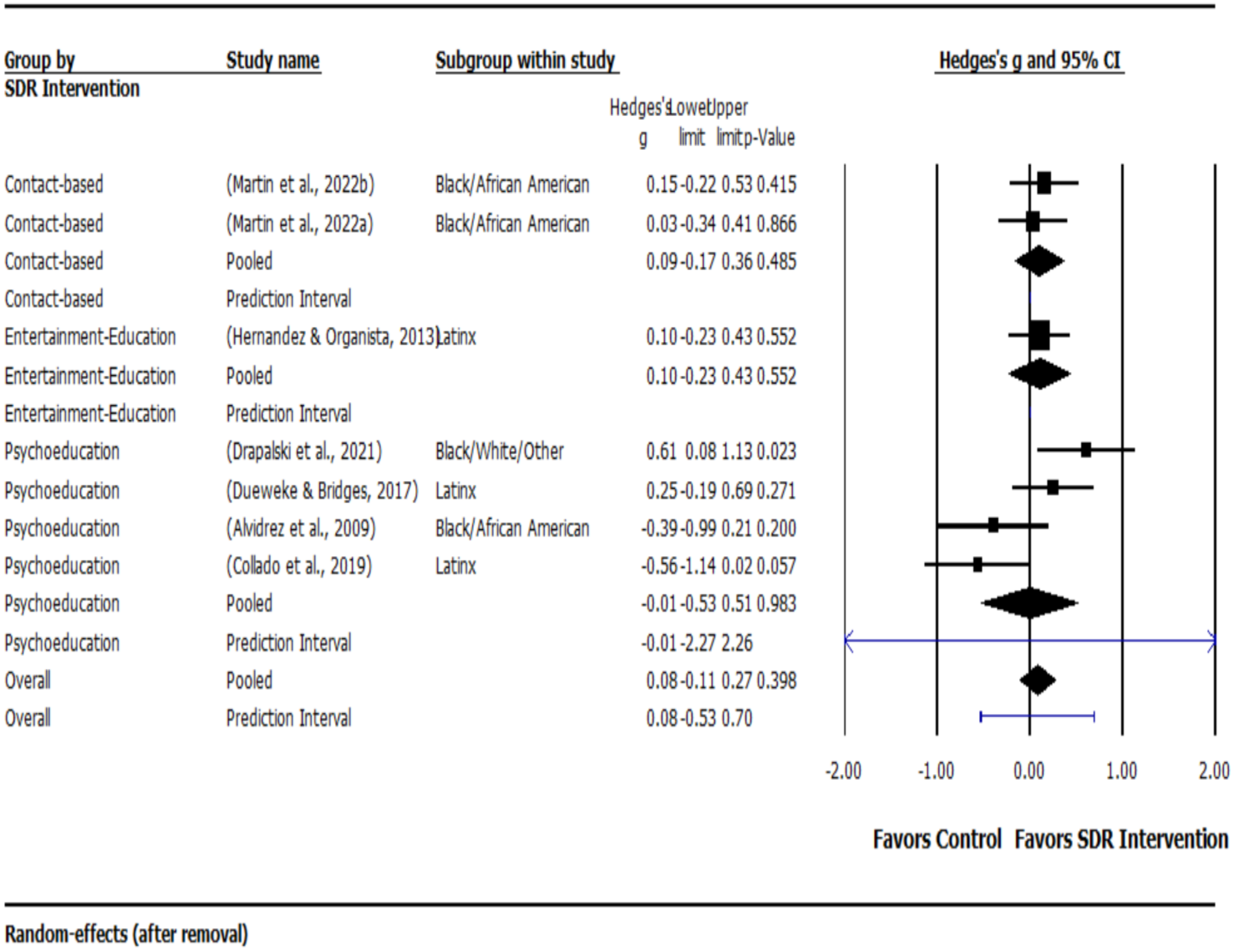


Group by Subgroup within study	Study name	Subgroup within study	Hedges's g	Lower limit	Upper limit	p-Value
Black/African American	(Martin et al., 2022b)	Black/African American	0.15	-0.22	0.53	0.415
Black/African American	(Martin et al., 2022a)	Black/African American	0.03	-0.34	0.41	0.866
Black/African American	(Alvidrez et al., 2009)	Black/African American	-0.39	-0.99	0.21	0.200
Black/African American	Pooled		0.01	-0.26	0.27	0.958
Black/African American	Prediction Interval		0.01	-2.04	2.06	
Black/White/Other	(Drapalski et al., 2021)	Black/White/Other	0.61	0.08	1.13	0.023
Black/White/Other	Pooled		0.61	0.08	1.13	0.023
Black/White/Other	Prediction Interval					
Latinx	(Dueweke & Bridges, 2017)	Latinx	0.25	-0.19	0.69	0.271
Latinx	(Hernandez & Organista, 2013)	Latinx	0.10	-0.23	0.43	0.552
Latinx	(Collado et al., 2019)	Latinx	-0.56	-1.14	0.02	0.057
Latinx	Pooled		-0.02	-0.43	0.38	0.911
Latinx	Prediction Interval		-0.02	-4.44	4.40	
Overall	Pooled		0.09	-0.11	0.29	0.386
Overall	Prediction Interval		0.09	-0.53	0.71	

Random-effects (after removal)

Figure 7

Effect sizes, 95% confidence intervals, and p-values for Studies Evaluating Stigma and Discrimination Reduction Interventions versus Control Groups for Decreasing Mental Health Stigma among BIPOC – by Intervention Type (after removal)



Group by SDR Intervention	Study name	Subgroup within study	Hedges's g	Lower limit	Upper limit	p-Value
Contact-based	(Martin et al., 2022b)	Black/African American	0.15	-0.22	0.53	0.415
Contact-based	(Martin et al., 2022a)	Black/African American	0.03	-0.34	0.41	0.866
Contact-based	Pooled		0.09	-0.17	0.36	0.485
Contact-based	Prediction Interval					
Entertainment-Education	(Hernandez & Organista, 2013)	Latinx	0.10	-0.23	0.43	0.552
Entertainment-Education	Pooled		0.10	-0.23	0.43	0.552
Entertainment-Education	Prediction Interval					
Psychoeducation	(Drapalski et al., 2021)	Black/White/Other	0.61	0.08	1.13	0.023
Psychoeducation	(Dueweke & Bridges, 2017)	Latinx	0.25	-0.19	0.69	0.271
Psychoeducation	(Alvidrez et al., 2009)	Black/African American	-0.39	-0.99	0.21	0.200
Psychoeducation	(Collado et al., 2019)	Latinx	-0.56	-1.14	0.02	0.057
Psychoeducation	Pooled		-0.01	-0.53	0.51	0.983
Psychoeducation	Prediction Interval		-0.01	-2.27	2.26	
Overall	Pooled		0.08	-0.11	0.27	0.398
Overall	Prediction Interval		0.08	-0.53	0.70	

Random-effects (after removal)

Table 1

Study Characteristics of Individual Studies

Study (Authors, Year)	Country/ Geographical Area	Study Design	Target Population	Sample Size	Age (mean/SD or range)	Sample Description	Type of Stigma Targeted	Measure of Stigma	Intervention Type
(Alvidrez et al., 2009)	USA/California	RCT	Black/African American adults in outpatient mental health	*N* = 42	44.8 (11.2)	Female: 69% Ethnicity: Black (100%)	Self-Stigma	Devaluation Discrimination Scale	Psycho-education
(Collado et al., 2019)	USA/Washington, D.C. Metro Area	RCT	Latino/a individuals 18+ or older w/criteria for Major Depressive Disorder	*N* = 46	35.91 (13.80)	Female: 39 Male: 7 Ethnicity: 100% Latinx	Mental health stigma	Stigma Checklist Questionnaire	Psycho-education
(Drapalski et al., 2021)	USA/Maryland	RCT	Veterans with a diagnosis of PTSD	*N* = 57	53.6 (11.1)	Male: 94.7% Race/Ethnicity: Black (49.1%) White (29.8%)	Self-stigma	Internalized Stigma of Mental Illness	Psycho-Education
(Dueweke & Bridges, 2017)	USA/mid-southern region	RCT	Participants who self-identified as a first-generation Latino immigrant	*N* = 78	36.2 (9.9)	Female: 70.5% Mexican origin (85%); From another country in Central America (8%); Puerto Rican (6%); South American (1%)	Suicide Stigma	Revised version of the Social Distance Scale	Psycho-education

(Table 1 continues)

Table 1

Study Characteristics of Individual Studies

Study (Authors, Year)	Country/ Geographical Area	Study Design	Target Population	Sample Size	Age (mean/SD or range)	Sample Description	Type of Stigma Targeted	Measure of Stigma	Intervention Type
(Hernandez & Organista, 2013)	USA/San Francisco	RCT	Spanish-speaking Latina immigrants not receiving mental health treatment	$N = 142$	26–35 (39.7%) 36–45 (36.1%)	Mexican origin: (79%) Central American: (21%)	Depression-related stigma	Spanish version of the Stigma Concerns About Mental Health Care Scale	Entertainment-Education
(Martin et al., 2022)	USA/ crowdsourcing platform	RCT	Only English-speaking youth, 14-18 years of age, and living in the U.S.	$N = 196$	16.8 (1.1)	Female: 45% Male: 45% Black: 100%	Depression-related stigma	Depression Stigma Scale; Racethermometer” to gauge racial attitudes	Contact-based
(Shin & Lukens, 2002)	USA/New York	RCT	Individuals who identified as Korean American with chronic mental illness	$N = 48$	37.1 (8.62)	Female: 28 Male: 20 Korean American: 100%	Self-stigma	Stigma-Devaluation Scale	Psycho-Education

Table 2

Effective Public Health Practice Project (EPHPP) Quantitative Quality Assessment Tool for Quantitative Studies

Authors	**Rating for Selection Bias**	**Rating for Study Design**	**Rating for confounders**	**Rating of studies on blinding**	**Rating of studies on data collection**	**Rating of studies on withdrawals and drop-outs**	**Global rating**
(Alvidrez et al., 2009)	1	1	1	2	2	1	3
(Collado et al., 2019)	2	1	1	2	2	1	3
(Drapalski et al., 2021)	1	1	1	1	1	1	1
(Dueweke & Bridges, 2017)	1	1	1	2	1	1	1
(Hernandez & Organista, 2013)	1	1	1	2	1	1	1
(Martin et al., 2022)	1	1	2	2	1	1	3
(Shin & Lukens, 2002)	1	1	1	2	2	3	3

Note. 1 = strong; 2 = moderate; 3 = weak

JS

CURRICULUM VITA

JANITA M. SPRINGFIELD

EDUCATION

Doctor of Philosophy, *Counselor Education and Supervision* **2020 - 2023**
University of Mississippi, Oxford, Mississippi
Cumulative GPA: 4.0

Master of Science, *Rehabilitation Counseling* **2017 - 2019**
University of Arkansas, Fayetteville, Arkansas
Degree Conferred: 05/11/2019
Cumulative GPA: 4.0

Bachelor of Science, *Psychology* **2013 - 2017**
University of Arkansas, Pine Bluff, Arkansas
Degree Conferred: 05/13/2017
Cumulative GPA: 3.93

RESEARCH INTERESTS

- Substance misuse and mental health factors; mental health, health, and racial/ethnic disparities; research identity development in counselor education; career counseling services with underserved populations

RESEARCH EXPERIENCE

Research Manuscript Collaborator **06/2022 – Present**
Research Area: *Assessing the Social Determinants of Mental Health in Counseling Practice*

- Participation in research team meetings; manuscript development, completion, and submission to the *Journal of Counseling & Development*

Graduate Research Assistant **01/2022 – Present**

Research Area: *The Development of the Anti-Racist School Counseling Competencies Scale: A Tool for School Counselors' Self-Evaluation*

- To bring awareness to the systemic inequities inherent within education systems and provide school counselors with a self-evaluation tool to engage in anti-racist practices
- Participation in research team meetings, participant recruitment, data collection, data analysis, and manuscript development (compensated on an hourly basis through the Association for Assessment and Research in Counseling grant)

Graduate Research Assistant **07/2021 – Present**

Supervisor: Dr. Hannah Allen, University of Mississippi
Substance Use & Mental Health Research Lab
Research Area: Daily exposure to bias/discrimination and health and academic outcomes of undergraduate and graduate Black, Indigenous and People of Color students enrolled in STEM

- Assisted principal investigator with review of Institutional Review Board application materials
- Research team meetings, weekly research participant recruitment, and weekly research laboratory data collection

Research Manuscript Collaborator **09/2021 – 01/2022**

Department of Leadership & Counselor Education
Research Area: *Brief Report on Counseling Clients at a Distance: Implications for Mississippi Counselors*

- Worked in collaboration with a core faculty member and fellow doctoral students to develop an article discussing best practices for distance counseling, including rationale, research, and practice
- Direct involvement in data analysis, manuscript development, completion, and submission to the *Journal of Counseling Research and Practice*

Research Assistant **01/2021 – 08/2021**

Department of Leadership & Counselor Education
Research Area: *Addiction, Medical Marijuana, and Rehabilitation Counseling: Emerging Practices and Implications*

- Participation in meetings regarding manuscript organization; direct involvement in manuscript development and writing; revisions, editions, and formatting

Research Assistant **08/2015 – 05/2017**

Advisor: Dr. Anthony Austin, University of Arkansas Pine Bluff
Department of Social and Behavioral Sciences
Research Area: Promoting psychological research and training on health disparities at ethnic minority serving institutions and educational attainment disparities in health and cardiovascular reactivity

- Assisted principal investigator in day-to-day procedures in the student-centered research learning laboratory

- Administered surveys, assessed participant's blood pressure, heart rate, brain waves, and muscle contractions, recorded data and made corresponding notes

TEACHING EXPERIENCE

CPCE Research, Assessment, and Program Evaluation Trainer **12/03/2022**
Master of Education in Counselor Education CPCE Preparation
Research and Program Evaluation Core Content Area

- Assisted master's level students prepare for the CPCE by providing lecture content on research and program evaluation core areas via synchronous online learning
- Facilitated training/learning on research, assessment, and program evaluation content

Co-Instructor **05/2022 - 07/2022**
COUN 615 Addictions Counseling

- Introduced master's students to the field of addictions by defining clinical models of addiction; key concepts of pharmacology, pharmacokinetics, and pharmacodynamics for the major classes of drugs; methods of prevention, intervention, and treatment
- Provided in-person and virtual course instruction in accordance with CACREP standards
- Co-created course evaluation and assessment; including construction of course, quizzes and exams, and class activities

CPCE Research, Assessment, and Program Evaluation Trainer **12/04/2021**
Master of Education in Counselor Education CPCE Preparation
Research and Program Evaluation Core Content Area

- Assisted master's level students prepare for the CPCE by providing lecture content on research and program evaluation core areas via synchronous online learning
- Facilitated training/learning on research, assessment, and program evaluation content

Teaching Assistant **08/2021 - 12/2021**
COUN 601 Lifespan Development

- Engaged in and facilitated group discussions via online communications
- Enhanced teaching skills and efficient use of online technology and resources
- Facilitated students' knowledge and understanding of lifespan development and assisted with course grading

Teaching Assistant **05/2021 - 07/2021**
COUN 615 Addictions Counseling

- Developed and planned assignments with corresponding chapter/discussion content
- Organized and led group discussions both in-class and via Blackboard communications
- Assisted in the development of course evaluation and assessment; including construction of course quizzes and exams, class activities, and course grading

SUPERVISION EXPERIENCE

Ph.D. Student Supervisor **08/2021 - 12/2021**

- Provided weekly individual supervision to two second-year school counseling master's students
- Communications through supervisee self-report, audio and videotapes, case consultation, and clinical skill development
- Engaged in weekly supervision of supervision with faculty member and fellow counselor education doctoral students

Ph.D. Student Supervisor **08/2020 - 12/2020**

- Provided weekly individual supervision to two second-year clinical mental health master's students
- Communications through supervisee self-report, case consultation, and clinical skill development
- Engaged in weekly supervision of supervision with faculty member and fellow counselor education doctoral students

LEADERSHIP & SERVICE

- *Nominated Student Representative,* NAMRC Finance/Economic Committee **2021-2023**
- *Appointed Committee Member*, Doctoral Education Network (DEN) **2021-2022**
- *Student Volunteer*, ACES 2021 Conference **Oct. 2021**
- *Committee Member,* Student Disability Services Pilot Program **2020-2021**
- *Student Volunteer*, NAMRC 2018 Conference **July 2018**
- *Student Volunteer*, Arkansas Rehabilitation Association 2018 Conference **May 2018**
- *Committee Member,* U.S. Dept. of Veterans Affairs Career Dev. Service **2018 - 2019**
- *Committee Member,* U.S. Dept. of Veterans Affairs Psychosocial Rehabilitation and Recovery Services **2018 - 2019**
- *Nominated Vice President*, Rehabilitation Counseling Student Association **2018 - 2019**
- *Summer Volunteer,* Our House - Social services organization empowering homeless near-homeless children in central Arkansas **May - Aug 2016**
- *Summer Volunteer*, St. Francis Hospital-Bartlett, TN Mental & Behavioral Health **May - Aug 2015**

COUNSELING EXPERIENCE

- Student Disability Services, *Graduate Assistant* **08/2020 – Present**
  Oxford, Mississippi

- EmployU, Incorporated, *Rehabilitation Counselor* **07/2019 – 07/2020**
  Lakeland, Florida

- Elizabeth Richardson Center, *Supported Employment Aide* **12/2017 – 06/2019**
  Fayetteville, Arkansas

- U.S. Department of Veterans Affairs, *Counseling Intern* **08/2018 – 05/2019**
  Fayetteville, Arkansas

- Elizabeth Richardson Center, *Practicum Clinical Experience* **05/2018 – 08/2018**
  Fayetteville, Arkansas

PRESENTATIONS

Stickl Haugen, J., Bledsoe, K., & **Springfield, J**. (2022, September). *The Development of the Anti-Racist School Counseling Inventory: A Self-Evaluation Tool for School Counselors.* 2022 Association for Assessment and Research in Counseling (AARC) Conference. Atlanta, GA. Content Session.

Springfield, J. & Sobrino, M. (2021, October). *The Scarcity of Minority Counselor Educators: An Exploration of the Challenges Contributing to Mentorship, Clinical Supervision, and Tenure".* 2021 Association for Counselor Education and Supervision (ACES) Conference. Atlanta, GA. Poster Presentation.

Springfield, J. (2019, August). Panel Member, *Navigating College Life and Strategies for Maintaining Mental Wellness*. University of Arkansas Pine Bluff. Invited Presentation.

Springfield, J. (2019, May). *Importance of Well-being, Self-Care, and Mental and Emotional Wellness for Undergraduate and Graduate Students in Helping Professions.* University of Arkansas Pine Bluff. Invited Presentation.

Springfield, J. (2018, July). *Innovations in Multicultural Rehabilitation and the Impact on Consumer Outcomes.* National Association for Multicultural Rehabilitation Concerns (NAMRC) Conference, Las Vegas, NV. Invited Presentation.

Springfield, J. & Bates, T. (2018, May). *Psychosocial Aspects of Disability and Implications for Future Research.* Arkansas Rehabilitation Association Conference, Hot Springs, AR. Poster Presentation.

Springfield, J. & Bates, T. (2018, April). *Psychosocial Aspects of Disability and Implications for Future Research.* University of Arkansas Fayetteville. Poster Exhibit.

GRANTS

Coleman, M., **Springfield, J**., & Watson, C. (2021). *Improving Continuity of Care for Addiction Services of Rural Communities through Education (iCARE)*. Agency for Healthcare Research and Quality (AHRQ) Small Research Grant Program.

Blount, C., **Springfield, J**., & Watson, C. (2020). *Diversity and Inclusion Disability Grant*. Funding provided by the University of Mississippi.

HONORS & AWARDS

University of Mississippi SREB Dissertation Scholar	**2022 – 2023**
University of Mississippi Outstanding Doctoral Student in CES Research	**2021 – 2022**
Phi Kappa Phi National Honors Society	**Sept 2021**
Honorable Mention in Dept. of Leadership & Counselor Education Newsletter	**Aug 2021**
University of Mississippi Graduate School's Cole-Eftink Fellowship Recipient	**Aug 2021**
Chi Sigma Iota International Honor Society	**Mar 2021**
Most Distinguished Graduate Student Award (Univ. of Arkansas Fayetteville)	**April 2019**
2018 NAMRC Scholarship Award Recipient at 24th Annual Conference	**July 2018**
ARA State Conference Graduate Student Award	**May 2018**
Vincent H. Bond Scholarship Recipient/Distinguished Scholar	**April 2018**
Rehabilitation Services Administration (RSA) Grant Recipient	**2017-2019**
Summa Cum Laude, University of Arkansas Pine Bluff)	**May 2017**
Top 5% Distinguished Student Award - University of Arkansas Pine Bluff	**May 2017**
Chancellor's List **-** University of Arkansas Pine Bluff	**2013 – 2017**
Salutatorian (Fayette Ware Comprehensive High School)	**May 2013**

ACTIVE PROFESSIONAL MEMBERSHIPS

American Counseling Association (ACA)
Association for Counselor Education and Supervision (ACES)
  - Southern Association for Counselor Education and Supervision (SACES)
American Rehabilitation Counseling Association (ARCA)
Chi Sigma Iota International Honor Society
Cole-Eftink Scholars
Doctoral Education Network (DEN)
Phi Kappa Phi National Honors Society
National Rehabilitation Association (NRA)
National Association of Multicultural Rehabilitation Concerns (NAMRC)
  - National Student Representative (2021-2023)