Psychiatric Rehabilitation Journal



# Bridging the Humanities and Health Care With Theatre: Theory and Outcomes of a Theatre-Based Model for Enhancing Psychiatric Care via Stigma Reduction

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Funded by:

- American Occupational Therapy Foundation
- Indiana State Department of Health
- National Institutes of Health, National Center for Advancing Translational Sciences
- National Institutes of Health, National Center for Complementary and Integrative Health

**Title: Bridging the Humanities and Healthcare with Theatre: Theory and Outcomes of a Theatre-Based Model for Enhancing Psychiatric Care via Stigma Reduction**


Abstract

**Objective**. This paper describes the rational, methods, implementation, and effectiveness of Identity Development Evolution and Sharing (IDEAS), an evidence-supported, narrative theater-based training that reduces stigma among healthcare providers to increase healthcare equity in psychiatric rehabilitation.

**Methods**. The IDEAS model has been used to reduce provider bias toward patients. From May 2017 to January 2020, we interviewed people from three patient groups who have been harmed by stigma, including Black women, transgender and gender diverse people, and people with substance use disorders. These interviews informed the creation of three theatrical scripts that were performed by professional actors for audiences of healthcare providers from January 2020 to May 2022. The performances aimed to raise conscious awareness of implicit provider biases and to provide a reflective opportunity to ameliorate these biases. The purpose of IDEAS is to improve experiences in healthcare settings such as psychiatric rehabilitation of patients from groups who have been harmed by stigma. We used paired samples *t*-tests to compare pre/post provider stigma, measured via the Acceptance and Action Questionnaire -Stigma (AAQ-S).

**Results**. Sociodemographic factors for providers who viewed IDEAS were similar across all three performances. IDEAS significantly decreased AAQ-S scores ($t = 11.32$, $df = 50$, $M = 13.65$, 95% Confidence Limit: [11.32, 15.97], $p < .0001$.

**Conclusions and Implications for Practice.** IDEAS reduces provider stigma to support positive clinical encounters with diverse patient populations. These findings are relevant for psychiatric rehabilitation settings, which seek to establish positive rapport between providers and patients.


**Impact and Implications**

We found evidence that Identity Development Evolution and Sharing (IDEAS) significantly reduces provider stigma. Given the longstanding history and impact of stigma toward mental illness, substance use, and bias toward people with other intersecting minoritized identities, this paper is important for clinicians and policy makers wishing to engender stigma reduction and positive change.

## Introduction

Many studies have illustrated the significant role that stigma plays in health disparities (Dovidio et al., 2018; Morey et al., 2018; Valdiserri et al., 2109), especially for people with mental health diagnoses and substance use disorders (Link et al., 2018). Stigma can affect a person's ability to obtain or participate in housing, employment, education, and relationships, and can dissuade people with mental illness and/or substance use from seeking needed healthcare services (Corrigan et al., 2019; Dell et al., 2021). A recent study found that stigma was perceived by both providers and patients as a major concern for the majority of patients receiving psychiatric rehabilitation services (Paananen et al., 2020). Psychiatric rehabilitation patients with intersecting minoritized identities such as those related to age, race, gender, ability, and/or sexuality face even more troubling health disparities, largely due to implicit or explicit provider biases (Dell et al., 2021; Lee et al., 2021; Williams et al., 2019). Zescott and colleagues (2016) reviewed evidence on the role that implicit provider biases plays in health outcomes. They describe how implicit provider biases produce health disparities by influencing providers' judgment and decisions about care while also impacting communication and trust with patients which, in turn, affects patient engagement and adherence to treatment plans (Zescott et al., 2016).

Provider stigma plays an especially critical role in health outcomes for people with mental health conditions – whether stigma is directed toward mental health diagnoses or other aspects of a person's identity, it contributes to the onset and/or exacerbation of mental health distress, and can influence care decisions such as diagnosis and treatment plans (Merino et al., 2018). For example, Merino et al. (2018) describes that studies have found providers over-diagnose Black men with psychotic disorders compared to White patients, and that "middle-class white women are far more likely than working-class Black men to get a call back when requesting an appointment" (Merino eta l., 2018, para. 4). Fear of discrimination has been linked to higher rates of anxiety, depression, suicide attempts, social isolation, and marginalization (Parr et al., 2019). Moreover, fear of discrimination during healthcare encounters reduces health behaviors to prevent and manage chronic conditions related to both mental and physical health (James et al., 2016). Literature has also illustrated that for people with substance use disorders (SUD), despite numerous accessible, evidence-based practices, outcomes remain poor because people are less willing to be honest with their providers and/or may avoid services all

together because they have experienced negative attitudes from their providers and/or have been negatively impacted by societal stigma toward persons with SUD. (Adams et al., 2020).

Given the longstanding history of stigma that has harmed those with mental health conditions and intersecting minoritized identities, the need for alleviating harmful impacts of provider biases cannot be overstated (Carrara et al., 2019; Corrigan & Nieweglowski, 2019; Paananen et al., 2020). Education about mental illness alone, however, has limited impact in reducing stigma. Instead, literature suggests it is important that interventions require personal connection with people who experience mental illness – such approaches help to narratively communicate experiences of shared humanity (Corrigan et al., 2019). Many current interventions directed at cultural competence fail to ameliorate provider biases that detrimentally impact patients (Chae et al., 2020). Moreover, literature suggests that public stigma from providers and other members of society can produce and/or exacerbate self-stigma among people with mental illnesses (Yen et al., 2020). Resilience from and coping with this self-stigma becomes another critical factor to consider in psychiatric rehabilitation (Pescosolido & Martin, 2015). Reducing societal stigma and provider biases is therefore a critically important target for improving the lives and experiences of people with mental health conditions.

Identity Development Evolution and Sharing (IDEAS; Wasmuth et al., 2021) is a narrative theatre-based intervention that targets societal stigma and provider bias to support the wellbeing of people who have been harmed by systemic problems such as anti-Black racism, transphobia, and the marginalization and mistreatment of people with substance use disorders (Adams et al., 2020; James et al., 2016). IDEAS involves: 1) conducting narrative interviews with members of populations who have been harmed by societal stigma; 2) translating narratives into a theatrical script; 3) creating a professional, filmed, theatrical production rooted in lived experiences collected via interviews; 4) showing the film to an audience (typically of healthcare providers); 5) engaging audience members in a live, post-show panel conversation with members of the population of focus; and 6) measuring pre-post stigma of audience members using the Acceptance and Action Questionnaire – Stigma (AAQ-S; Levin et al., 2014). While there has not yet been an IDEAS program that focuses directly on the experiences of people with mental illness, the populations IDEAS *has* focused on include stories from people with comorbid mental health conditions. Likewise, reducing stigma that people experience based on

race, gender, and substance use is an important component of improving mental health care by reducing the likelihood that individuals receiving care will experience microaggressions and/or discrimination based on one of these factors. Moreover, IDEAS provides a methodology that can be followed to create future programs that center on stigma about mental illness by telling the stories of people with mental health diagnoses directly, thereby fostering the type of meaningful and deeply personal interventions described by Corrigan et al. (2019) that involve connection and that facilitate people's ability to perceive our shared humanity.

### Origination and Brief History of IDEAS

IDEAS originated as a live theatrical event in the mid-western United States with a single, audience post-survey (Wasmuth et al., 2020). During the COVID-19 pandemic when live theatre was not possible, IDEAS evolved to a filmed stigma-reduction training with a validated pre/post measure of enacted stigma (Wasmuth et al., 2021). Adapting IDEAS from live theatre to filmed monologues allowed for widespread dissemination and data collection, nationally and internationally. To date, we have created IDEAS films about healthcare experiences of: Black women, people with substance use disorders, and transgender and gender-diverse people (TGD; people whose gender identity does not match the sex they were assigned at birth). In June of 2022 over 2,000 individuals had participated in IDEAS trainings.

In this paper we 1) describe the theoretical and conceptual underpinnings of IDEAS to elucidate how/why IDEAS is an effective tool for reducing provider stigma; 2) review past findings regarding IDEAS implementation and effectiveness in reducing provider stigma; 3) present new findings from an ongoing study of IDEAS implementation and effectiveness as a tool for reducing bias among occupational therapy practitioners; and 4) discuss implications for psychiatric rehabilitation practice and future research directions.

## Background

### Theatre for Social Change

Social change promotion has been long supported by mechanisms of theatre tradition, colloquially known as applied theatre. These methods of applied theatre, often involving participatory action on the part of the audience and improvisation techniques, have been utilized to advocate for and direct supportive change for marginalized communities. One example of this is Augusto Boal's 'Theatre of the Oppressed' that incorporates

audience participation alongside performers, affecting not only the audience's analysis of but also the production of the theatrical performance itself, and allows opportunity for dialogue on issues of social justice (Howard, 2004). As an approach to social justice promotion, applied theatre has been utilized to reduce stigma surrounding HIV (Moyo & Sibanda, 2019; Quarcoo, 2012), youth depression and suicide (Sawyer & Earle, 2019), autism (Massa et al., 2020), and in health promotion for Indigenous communities (Baldwin, 2009).

In line with applied theatre methods, Solomon (2018) used Ideologically Challenging Entertainment (ICE) to support social justice-promoting goals. One main distinction between the approaches is that ICE, through the use of mainstream entertainment methods, reaches a broader audience than applied theatre's explicit exclusionary stance on mainstream methods. Due to this, Solomon asserts that ICE has the ability to "inspire audiences to re-think their own prejudices, biases, and preconceived notions about groups they may consider 'other.'" In one report on the impacts of ICE on audience members, 40% reported a willingness to reassess their views. Of those attendees, 85% reported a change in their views related to stereotypes and discrimination (Solomon, 2018, p. 179).

**Conceptual Underpinnings of IDEAS**

We conceptualize IDEAS as "narrative theatre," which can be understood as a form of theatre in which personal narratives are collected and translated for theatrical production. Narrative theatre can be understood under the larger umbrella term "ethnotheatre" (Saldaña, 2011), in which qualitative data is deliberately shared via live performance.

> An ethnodramatic play script and it's ethnotheatrical production are deliberately chosen as representational and presentational methods because the researcher or artist has determined that these art forms are the most appropriate and effective modalities for communicating observations of cultural social or personal life" (Saldaña, 2011, p. 15)

Ethnotheatre "create[s] space and time for marginalized voices to be heard [and] is a tool for social justice or social change agendas" (Saldaña, 2011, p. 31). Because IDEAS scripts are rooted solely in the narratives of peoples' live experiences, the performances do not ask that audiences members ascribe to any particular beliefs, attitudes, or ideas. They do not seek to persuade. The content of the play is only the telling of peoples' stories,

rather than a fictional creation of a playwright who wishes to convey a specific message. This telling of stories via narrative theatre allows audience members to encounter characters that may be unfamiliar to them. It may increase empathy for others, and it may produce strong reactions, negative or positive, which can be informational to viewers. For example, a person may notice themselves judging or disliking a character in the play, and this may reveal to them a bias that they didn't know they had. Every performance is followed by a post-show conversation with interviewees whose stories comprised the script. This conversation gives audience members time to reflect upon and share their experiences and feelings toward the characters of the play with others in the audience.

According to the Joint Commission's (2016) report, one critical method for reducing bias and improving overall health outcomes is through perspective taking. Theatre-based personal narrative is one such method of approaching this bias reduction and health outcome promotion. Despite applied theatre's potential to facilitate this perspective taking and shifting of beliefs and attitudes, few studies support direct behavioral changes resulting from this approach, citing cognitive resistance as a reason for inaction (Solomon, 2018). Attempts at promoting behavior are most often met with defensive denial (Costanza et al., 2017). Alliance-building, empathy, and reflective listening strategies are supported as alternative approaches over confrontational persuasion (Costanza et al., 2017). Through the use of narrative immersion, professional theatre envelops the audience into the stories being produced and allows safe connection with characters' emotional experiences without direct confrontation within the context of the audience's own lives. In doing so, audience members are encouraged to reflectively listen, increasing the potential for gaining insight about themselves, their biases, and others.

According to Levin et al. (2014), gaining awareness of one's own personal thoughts and beliefs is a first step toward the possibility of changing behavior. This is important because while healthcare professionals may hold strong convictions and personal values regarding healthcare equity, they may (and literature suggests they do) still contribute to healthcare inequities by acting on implicit biases of which they are unaware and which often contradict personal values (Burgess et al., 2017). Levin and colleagues, drawing on the work of Akrami, Ekehammar, and Bergh (2011), conceptualize stigma as "a more general tendency to evaluate and discriminate

against others based on their group membership, rather than being specific to attitudes towards any one group in particular" (Levin et al., 2014, p. 21). An underlying psychological process that contributes to this generalized prejudice is psychological flexibility, "the capacity to actively embrace one's private experiences in the present moment and engage or disengage in patterns of behavior in the service of chosen values" (p. 21). This ability to both recognize one's own biases and distance one's self from those biases is critical to providing equitable healthcare. The assertion that all people have implicit (or explicit) biases that arise from a series of life events, and that implicit biases often contradict personal values, lends insight as to how medical providers who value equitable healthcare provision can make inequitable decisions that cause harm to those seeking care. Levin et al. (2014) suggest that psychological flexibility with regard to stigma involves: 1) flexible awareness of one's private experiences in the present moment, including stigmatizing thoughts; 2) de-fusion from stigmatizing thoughts (seeing thoughts as just thoughts rather than something literally true); 3) willingness to have stigmatizing thoughts, rather than engaging in ineffective forms of avoidance (e.g., thought suppression, avoiding situations where stigmatizing thoughts occur); 4) relating to oneself and others as distinct from thoughts and feelings about them; 5) clarifying valued patterns of activity in social interactions; 6) committing to patterns of valued activity with others, even when stigmatizing thoughts and feelings seem to stand in the way (Levin et al., 2014, p. 22). Interventions can support patient care by aiming to increase psychological flexibility. This may be accomplished by enhancing providers' awareness of their own biases, supporting providers in examining and reflecting upon their biases, and providing educational opportunities for providers to learn alternative actions that counteract personal biases and align with values such as equity.

## Method

### Intervention Development

From May 2017 to January 2020, we conducted interviews with 3 groups – people with SUD (2017-2018), Black women who had experienced discrimination in healthcare (2018-2019), and TGD people (2020-2021). These populations were selected for IDEAS based on the literature emphasizing the healthcare disparities faced by these groups and the clinical expertise and research areas of focus of the IDEAS team. Participants were recruited via IRB-approved social media announcements and chain sampling. All interested

participants ≥18 years of age who identified as a member of one of the three populations of focus were invited to participate. Interviews were semi-structured, and were guided by three existing measures - the Indiana Psychiatric Illness Interview (IPII, Lysaker et al., 2002), the Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS, Forsyth et al., 2005), and the Experiences of Discrimination scale (EOD; Krieger et al., 2005). The IPII askes interviewees to describe the story of their lives, a challenge they are facing, the degree of control (or lack thereof) they feel to respond to that challenge, and what they see for themselves in the future. The interview is intentionally minimally structured to allow interviewees to share freely without being guided or influenced by responses from the interviewer. The OCAIRS askes interviewees to describe their roles, habits, routines, skills, goals, relationships, values, and identities. The EOD specifically asks people about experiences of discrimination in the contexts of their lives. These guides produced narratives containing descriptions of and reflections on experienced challenges, including discrimination, contextualized and embedded in personal life stories. All interviewees underwent the informed consent process verbally at the start of their interview.

Interviews were transcribed, deidentified, and given to a professional playwright who created a script. As described in Wasmuth et al., 2021:

> The playwright maintained the exact words in the transcripts, with the only exceptions being minor changes to clarify the meaning of words or phrases. The playwright's role was not to write the story of the play but rather to use her professional theater training to organize the content in a way that created theater that captivated and drew audience members into (rather than alienating them from) the inherent tension and conflict of the stories. After rearranging, aligning, and combining stories, the resulting script consisted of interwoven verbatim stories from each participant, emphasizing common themes (p. 5).

All interviewees were given the opportunity to review and approve or request changes to the script prior to performance. A professional theater company hired actors and a director to produce each performance. All interviewees were invited to attend – they were given the option to participate as panel speakers during a PI-moderated post-show conversation during which they would talk with the audience about the film and their own lived experiences.

The original production on Black women's experiences of discrimination, entitled *Stories of Inequity*, was performed live in a professional theatre for members of the local community. This initial performance was evaluated via a single post-survey that asked audience members to rate the degree to which the performance impacted their understanding of healthcare inequity within their community. Findings are reported in Wasmuth et al., 2020. The script was later edited to facilitate a filmed collection of monologues for widespread online implementation as part of a national hybrid study of IDEAS. This paper describes methods of the hybrid study and findings to date on the effectiveness of IDEAS to reduce provider stigma. *This Authentic Person*, which told the stories of TGD people, was originally written during the COVID-19 pandemic as a collection of filmed monologues, and was first performed on Zoom in March of 2020. AAQ-S pre/post data from this performance were analyzed and are reported in Wasmuth et al., 2021. This was the second film included in the national hybrid study described in this manuscript. The third IDEAS script included in the national hybrid study – *I'm going to do this for the rest of my life* – focused on experiences of people with substance use disorders and other addictive behaviors. It was originally written and performed in the community in 2019; no data were collected regarding audience impact, but in 2021 the script was revised and filmed as a collection of monologues to be included in the hybrid study. All study procedures were conducted in compliance with the principal investigator's (PI; first author's) university institutional review board.

**National Hybrid Study Methods**

The three films described above (*Stories of Inequity, This Authentic Person, and I'm going to do this for the rest of my life*) were offered as stigma reduction trainings for occupational therapy practitioners within the United States as part of a hybrid type 2 study of IDEAS implementation and effectiveness beginning in August of 2021. The IDEAS training was announced via social media and occupational therapy national conference venues. Occupational therapists wanting to implement an IDEAS training within their clinic contacted the PI (first author) who then provided a 30-60 minute training on how to facilitate an IDEAS training (Wasmuth et al., 2022). The PI provided a link to the film that the clinic wanted to use and/or felt was most relevant to their clinical site and priorities. The PI also connected the clinic with a list of panel speakers (interviewees who had volunteered to participate in this way) to join the training via Microsoft teams, and assisted with scheduling the

training and panel speakers. Participating occupational therapy practitioners completed pre/post AAQ-S surveys and answered demographic questions. All audience members watching the IDEAS films (or live performances) were eligible to provide written consent by reading an informed consent statement at the start of the pre-test (demographic questions paired with the AAQ-S) and checking a box to indicate consent. Implementation data were collected via stakeholder interviews – this study is ongoing and implementation data are reported elsewhere. This paper presents to-date effectiveness outcomes from the 3 IDEAS films being used to reduce stigma among occupational therapy practitioners.

**Measures**

The Acceptance and Action Questionnaire - Stigma (AAQ-S) has been translated to multiple languages, has a Cronbach's alpha = 0.84, is correlated to measures of psychological flexibility and stigma, ranges from 21 to 147, measures enacted stigma (stigma beliefs that result in discriminatory actions), and conceptualizes stigma as "a more general tendency to evaluate and discriminate against others based on their group membership, rather than being specific to attitudes towards any one group in particular." (Levin et al., 2014, p. 21). The AAQ-S is rooted in Acceptance and Commitment Therapy (ACT), and advocates that no person is exempt from stigmatizing thoughts. Rather, stigma is considered to emerge as a product of existing in shared cultural contexts of racism, misogyny, ableism, transphobia, heterosexism, ethnocentrism, and other forms of discrimination. Levin and colleagues (2014) suggest that all people are vulnerable to the effects of such contexts, whether they believe they have personal biases or not.

**Analysis**

Data analysis for the National Hybrid Study of IDEAS came from de-identified IDEAS participants during 2022. First, means and proportions were used to describe the audience's demographic characteristics. Second, Fisher's Exact test and an analysis of variance were used to test the null hypothesis that the distribution of key demographic factors and baseline AAQ-S scores did not differ across the type of performance video observed. Third, box and whisker plots were used to describe and visualize the overall AAQ-S pre-test and post-test scores for each video type. The box and whisker plots illustrated the medians, first and third quartiles, minimum and maximum scores, outliers, and represent the within and between group comparisons of the AAQ-

S scores. Finally, a paired samples *t*-test was used to test the null hypothesis that mean AAQ-S scores did not change from the pre-test baseline to the post-test follow-up. A priori power analysis for an effect size of 0.80, assuming $\alpha$=0.05 and 1-$\beta$=0.80, indicated a required sample size of N≥12. Normality of the pre-test and post-test AAQ-S scores for each performance were inspected visually and validated with Kolmogorov-Smirnov goodness-of-fit test ($p > 0.13$). Participants without AAQ-S baseline or follow-up data were excluded from analysis (Figure 1). One respondent had missing data for the race variable but was included in all AAQ-S outcome analyses. All analyses were two-sided with significance set at $P < 0.05$. Data management and analyses were conducted using SAS statistical software version 9.4 (SAS Institute, Cary, NC, USA).

## Results

The overall cohort demographics and mean pre/post AAQ-S scores can be seen in Table 1. The majority of participants observed *I'm going to do this for the rest of my life* or *This Authentic Person.* Overall, most participants were between 25-34 years of age, cisgender female, Non-Hispanic, White, and held a master's degree. There was no evidence for statistically significant differences in baseline characteristics across the type of video observed. Figure 2 demonstrates AAQ-S post-test scores tended to be lower than pre-test scores. Additionally, AAQ-S pre and post-test scores tended to be similar for all performance videos. Paired samples t-tests indicated that AAQ-S scores significantly decreased following observation of the performance videos. Overall, AAQ-S scores significantly decreased following the observation of any performance video ($t = 11.32$, $df = 50$, $M = 13.65$, 95% Confidence Limit: [11.32, 15.97], $p < .0001$. Similar decreases in AAQ-S score were observed after stratifying analyses by type of performance video (*Stories of Inequity*: $t = 5.62$, $df = 12$, $M = 12.46$, 95% Confidence Limit: [7.63, 17.29], $p = .0001$; *I'm going to do this for the rest of my life*: $t = 7.60$, $df = 18$, $M = 15.58$, 95% Confidence Limit: [11.27, 19.88], $p < .0001$; and *This Authentic Person*: $t = 7.00$, $df = 18$, $M = 12.53$, 95% Confidence Limit: [8.77, 16.29], $p < .0001$. Due to the increased risk of Type I error when conducting multiple hypothesis tests, a conservative interpretation of statistical significance could be set at $p = 0.0125$ using a post-hoc Bonferroni correction. Still, these findings indicate a statistically significant reduction in stigma following the observation of all performance types.

## Conclusions and Implications for Practice

While several studies within psychiatric rehabilitation literature have emphasized the importance of clinicians developing cultural competence to meet the needs of diverse patients, others have suggested a "culturally competent" clinician may over-estimate their competence in working with diverse people by failing to give attention to critically important aspects of patient-provider relationships such as power imbalances and implicit biases rooted in racism, ableism, transphobia, and other forms of discrimination (Hampton et al., 2017). Recent studies suggest a move toward the construct of cultural humility (Abe, 2020; Agner, 2020). Characteristics of cultural humility include openness, self-awareness, egolessness, supportive interactions, and self-reflection and critique (Foronda et al., 2016). Developing cultural humility within psychiatric rehabilitation providers can facilitate and advance their ability to partner with patients in deeper and more meaningful ways by reducing biases that may pose as barriers to this deep connection and trust (Hampton et al., 2017). IDEAS helps clinicians develop cultural humility by providing an opportunity to reflect upon and discuss their own biases. IDEAS is conceptually rooted in Acceptance and Commitment Therapy, which emphasizes the importance of examining and accepting aspects of ourselves that we wish to change, such as negative thoughts, beliefs, and/or actions toward others. ACT proclaims that it is only through this acceptance that we gain the ability to address undesirable behaviors/thoughts/beliefs and engender positive changes within ourselves. The ability to recognize and distance one's self from their own biases is a critical component of cultural humility, and is thus essential to providing equitable health care ~~and in service to the need for increased focus on cultural humility~~ within psychiatric rehabilitation (Abe, 2020).

**Limitations and Future Research**

Our findings should be interpreted with consideration for a few limitations. First, clinics have self-selected to enroll in IDEAS which may overestimate the effect of IDEAS on our AAQ-S measure of stigma because these viewers may be more self-aware or ready for change. Nonetheless, our estimates for the effect of IDEAS on AAQ-S were robust across video type and were conservative to type 1 error following Bonferroni correction. Second, ~~we cannot speak to how IDEAS compares to treatment as usual because, to our knowledge, there is no standard intervention used to reduce stigma and bias amongst healthcare providers. To address these~~

~~limitations,~~ IDEAS has not been the focus of a randomized controlled trial, and larger samples are needed to further generalize our findings.

While studies of IDEAS suggest it is an effective tool for reducing provider bias and enacted stigma, it remains unknown whether changes measured by the AAQ-S translate to better patient care. Pertinent items from the existing Agency for Healthcare Research and Quality (AHRQ) "Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence (CC) Item Set" (Weech-Maldonado et al., 2012) are available to measure patient experiences in the following domains: provider communication-positive behaviors; provider communication-negative behaviors; shared decision making; equitable treatment; and trust. Questions center on whether clinicians: listen carefully, explain things, show respect, spend enough time, cause the client to feel safe, respond to cultural needs, and involve clients as much as they want in treatment. While these items reflect important aspects of clients' experiences, they are insufficient for measuring population specific needs such as providing affirming care to transgender and gender-diverse clients. Moreover, while existing AHRQ items measure clients' experiences of healthcare, they do not measure how healthcare experiences might influence clients' utilization of psychiatric rehabilitation services. An absence of a robust, comprehensive measure of patients' healthcare experiences as they relate to provider stigma and healthcare utilization remains (Chae et al., 2020). Development of such a tool would bolster the ability to measure the impact of IDEAS not only on providers but also on their patients.

**Implications for Psychiatric Rehabilitation**

While IDEAS has significantly reduced provider biases, it has not been the subject of large-scale studies solely within psychiatric rehabilitation. Planned future work involves a large-scale study of IDEAS implementation to reduce bias among Veterans Affairs mental health providers. However, more research is needed to understand baseline individual- and facility-level characteristics of psychiatric rehabilitation providers related to stigma and implicit bias, and the impact of IDEAS on a well-defined cohort of psychiatric rehabilitation providers. Psychiatric rehabilitation clinicians have reported experiencing dynamic relationships with patients that can be concordant or discordant with the ideals of patient centeredness and equity (Dell et al., 2021). It is also well known that provider stigma continues to pose barriers to mental health recovery despite

providers' commitment to these ideals (Knaak et al., 2015). IDEAS provides a promising means of reducing stigma of psychiatric rehabilitation providers by acknowledging and confronting personal biases.

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*Table 1. Cohort Characteristics Across Type of Performance Video Observed for Hybrid Study*

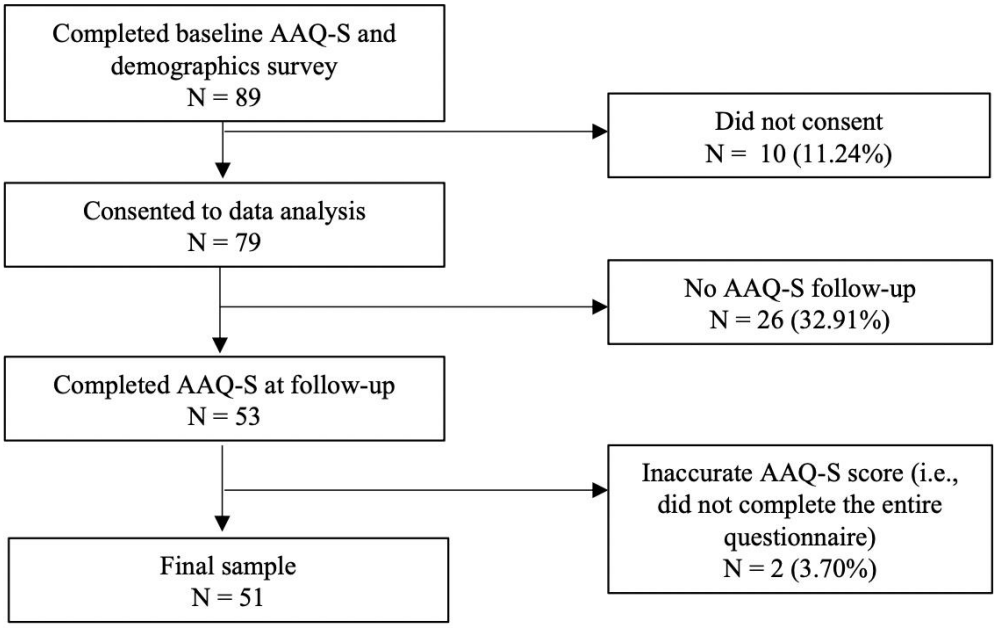
| | *Performance Video* | | | | |
|---|---|---|---|---|---|
| | ***I'm Doing This for the Rest of My Life: Stories of addiction and recovery (N = 19)*** | ***Stories of Inequality: Black women's experiences of discrimination (N = 13)*** | ***This Authentic Person: Journeys of people who are transgender and or non-binary (N = 19)*** | ***Total (N = 51)*** | ***P Value*** |
| **Age** | | | | | |
| 18-24 | 02 (010.53%) | 01 (007.69%) | 01 (005.26%) | 04 (07.84%) | 0.17 |
| 25-34 | 11 (057.89%) | 07 (053.85%) | 16 (084.21%) | 34 (66.67%) | |
| 35-44 | 01 (005.26%) | 04 (030.77%) | 01 (005.26%) | 06 (11.76%) | |
| 45-54 | 03 (015.79%) | 01 (007.69%) | 00 (000.00%) | 04 (07.84%) | |
| 55-64 | 02 (010.53%) | 00 (000.00%) | 01 (005.26%) | 03 (05.88%) | |
| **Gender Identity** | | | | | |
| Cisgender Female | 19 (100.00%) | 12 (092.31%) | 17 (089.47%) | 48 (94.12%) | 0.57 |
| Cisgender Male | 00 (000.00%) | 01 (007.69%) | 01 (005.26%) | 02 (03.92%) | |
| Other | 00 (000.00%) | 00 (000.00%) | 01 (005.26%) | 01 (01.96%) | |
| **Hispanic** | | | | | |
| Hispanic | 02 (010.53%) | 00 (000.00%) | 00 (000.00%) | 02 (03.92%) | 0.33 |
| Not Hispanic | 17 (089.47%) | 13 (100.00%) | 19 (100.00%) | 49 (96.08%) | |
| **Race** | | | | | |
| Asian | 02 (010.53%) | 00 (000.00%) | 00 (000.00%) | 02 (04.00%) | 0.48 |
| Black or African American | 00 (000.00%) | 01 (007.69%) | 01 (005.56%) | 02 (04.00%) | |
| Other | 01 (005.26%) | 00 (000.00%) | 00 (000.00%) | 01 (02.00%) | |
| White | 16 (084.21%) | 12 (092.31%) | 17 (094.44%) | 45 (90.00%) | |
| Missing | 00 (000.00%) | 00 (000.00%) | 01 (005.26%) | 01 (01.96%) | |
| **Highest Level of Education** | | | | | |
| Associate's Degree | 00 (000.00%) | 02 (015.38%) | 00 (000.00%) | 02 (03.92%) | 0.05 |
| Bachelor's Degree | 04 (021.05%) | 00 (000.00%) | 04 (021.05%) | 08 (15.69%) | |
| Doctorate Degree | 02 (010.53%) | 01 (007.69%) | 06 (031.58%) | 09 (17.65%) | |
| Master's Degree | 13 (068.42%) | 10 (076.92%) | 09 (047.37%) | 32 (62.75%) | |

| | *Performance Video* | | | | |
|---|---|---|---|---|---|
| | ***I'm Doing This for the Rest of My Life: Stories of addiction and recovery (N = 19)*** | ***Stories of Inequality: Black women's experiences of discrimination (N = 13)*** | ***This Authentic Person: Journeys of people who are transgender and or non-binary (N = 19)*** | ***Total (N = 51)*** | ***P Value*** |
| **AAQ-S Baseline Score** | | | | | |
| Mean (SD) | 79.16 (11.03) | 72.46 (9.27) | 73.95 (13.65) | 75.51 (11.83) | 0.23 |
| **AAQ-S Follow-up Score** | | | | | |
| Mean (SD) | 63.58 (10.97) | 60.00 (12.96) | 61.42 (10.75) | 61.86 (11.28) | 0.67 |

***Note:*** *Acceptance and Action Questionnaire (AAQ-S)*

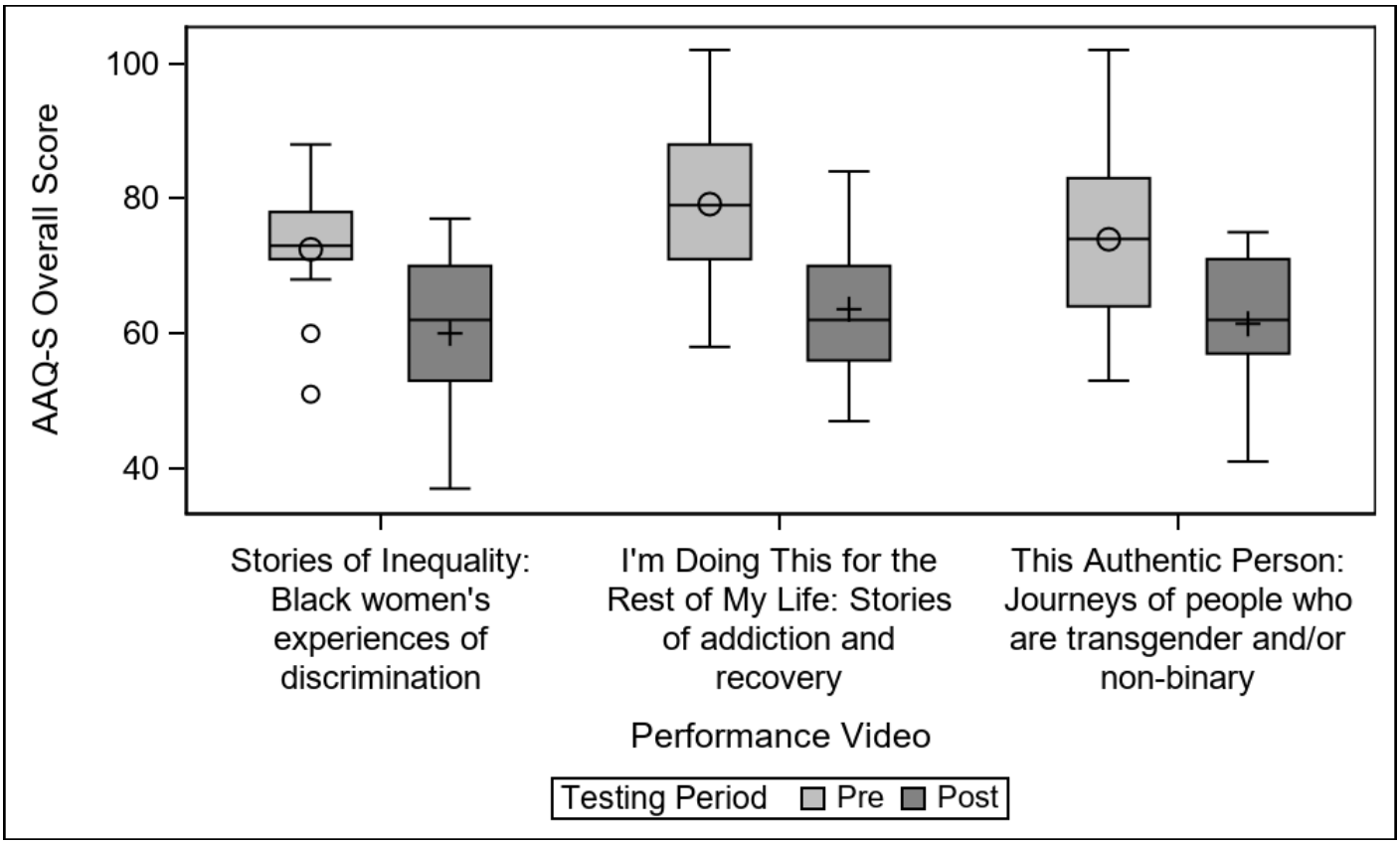
[*] *P value less than 0.05*

**Figure 1. IDEAS Hybrid Study Cohort Flow Diagram**




*Note. Acceptance and Action Questionnaire – Stigma (AAQ-S)*

**Figure 2. Box and Whisker Plots for AAQ-S Pre/Post-test Scores Across Type of Performance Video in Hybrid Study**




*Note: Acceptance and Action Questionnaire (AAQ-S)*