Implicit Bias: The Michigan Requirement

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners

John M. Leonard, MD
James Trent, PhD
Jane C. Norman, RN, MSN, CNE, PhD
Randall L. Allen, PharmD

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for the interprofessional healthcare team and professions working in all practice settings in Michigan.

Accreditations & Approvals

JOINTLY ACCREDITED PROVIDER™ INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the

A complete Works Cited list begins on page 36.

Mention of commercial products does not indicate endorsement.

boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

This course is considered self-study by the New York State Board of Mental Health Counseling.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed marriage and family therapists. #MFT-0015.

This course is considered self-study by the New York State Board of Marriage and Family Therapy.

Designations of Credit

NetCE designates this enduring material for a maximum of 2 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 2 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. Completion of this course constitutes permission to share the completion data with ACCME.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to earn credit toward the CME and Self-Assessment requirements of the American Board of Surgery's Continuous Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABS credit.

This activity has been approved for the American Board of Anesthesiology's® (ABA) requirements for Part II: Lifelong Learning and Self-Assessment of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program® (MOCA®), known as MOCA 2.0®. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements. Maintenance of Certification in Anesthesiology Program® and MOCA® are registered certification marks of the American Board of Anesthesiology®. MOCA 2.0® is a trademark of the American Board of Anesthesiology®.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 2 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

This activity has been designated for 2 Lifelong Learning (Part II) credits for the American Board of Pathology Continuing Certification Program.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

NetCE designates this continuing education activity for 2 ANCC contact hours.

IPCE CREDIT™

This activity was planned by and for the healthcare team, and learners will receive 2 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 2.4 hours for Alabama nurses.

AACN Synergy CERP Category B.

NetCE designates this activity for 2 hours ACPE credit(s). ACPE Universal Activity Numbers: JA4008164-0000-23-013-H04-P and JA4008164-0000-23-013-H04-T.

Social workers completing this intermediate-to-advanced course receive 2 Clinical continuing education credits.

NetCE designates this continuing education activity for 2 NBCC clock hours.

Individual State Nursing Approvals

In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 07/29/2025); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2023); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

Special Approvals
This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency, and California Assembly Bill 241, Implicit Bias.

This course meets the Michigan requirement for implicit bias training.

About the Sponsor
The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective
The purpose of this course is to provide healthcare professionals with an overview of the impact of implicit biases on clinical interactions and decision making.

Learning Objectives
Upon completion of this course, you should be able to:

1. Define implicit and explicit biases and related terminology.
2. Evaluate the strengths and limitations of the Implicit Association Test.
3. Describe how different theories explain the nature of implicit biases, and outline the consequences of implicit biases.
4. Discuss best practices for providing culturally competent care to various patient populations.
5. Discuss strategies to raise awareness of and mitigate or eliminate one's implicit biases.

Pharmacy Technician Learning Objectives
Upon completion of this course, you should be able to:

1. Identify implicit bias, its consequences, and possible mitigating interventions.
2. Describe components of culturally responsive care.

INTRODUCTION

In the 1990s, social psychologists Dr. Mahzarin Banaji and Dr. Tony Greenwald introduced the concept of implicit bias and developed the Implicit Association Test (or IAT) as a measure. In 2003, the Institute of Medicine published the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* highlighting the role of health professionals' implicit biases in the development of health disparities [1]. The phenomenon of implicit bias is premised on the assumption that while well-meaning individuals may deny prejudicial beliefs, these implicit biases negatively affect their clinical communications, interactions, and diagnostic and treatment decision-making [2; 3].

One explanation is that implicit biases are a heuristic, or a cognitive or mental shortcut. Heuristics offer individuals general rules to apply to situations in which there is limited, conflicting, or unclear information. Use of a heuristic results in a quick judgment based on fragments of memory and knowledge, and therefore, the decisions made may be erroneous. If the thinking patterns are flawed, negative attitudes can reinforce stereotypes [4]. In health contexts, this is problematic because clinical judgments can be biased and adversely affect health outcomes. The Joint Commission provides the following example [3]: A group of physicians congregate to examine a child's chest x-rays but has not been able to reach a diagnostic consensus. Another physician with no knowledge of the case is passing by, sees the x-rays, and says "Cystic fibrosis." The group of physicians was aware that the child was African American and had failed to consider cystic fibrosis because it is less common among Black children than White children.

The purpose of this course is to provide health professionals an overview of implicit bias. This includes an exploration of definitions of implicit and explicit bias. The nature and dynamics of implicit biases and how they can affect health outcomes will be discussed. Finally, because implicit biases are unconscious, strategies will be reviewed to assist in raising professionals' awareness of and interventions to reduce them.

interactive activity

Consider the following statements and rank your level of agreement using the following scale:

Strongly Agree: 6 points; Agree: 5 points; Somewhat Agree: 4 points; Somewhat Disagree: 3 points; Disagree: 2 points; Strongly Disagree: 1 point

1. Everyone has implicit bias.
2. Bias is a part of my subconscious.
3. Bias is pervasive in the health care system.
4. Implicit bias is deeply rooted to positive and negative stereotypes that affect our understanding, actions, motives, and decisions we make on a daily basis.
5. I have a specific plan to overcome biases that show up when interacting with patients.

Make a note of your total score.

Adapted from an assessment developed by the Center for Black Educator Development

DEFINITIONS OF IMPLICIT BIAS AND OTHER TERMINOLOGIES

IMPLICIT VS. EXPLICIT BIAS

In a sociocultural context, biases are generally defined as negative evaluations of a particular social group relative to another group. Explicit biases are conscious, whereby an individual is fully aware of his/her attitudes and there may be intentional behaviors related to these attitudes [5]. For example, an individual may openly endorse a belief that women are weak and men are strong. This bias is fully conscious and is made explicitly known. The individual's ideas may then be reflected in his/her work as a manager.

FitzGerald and Hurst assert that there are cases in which implicit cognitive processes are involved in biases and conscious availability, controllability, and mental resources are not [6]. The term "implicit bias" refers to the unconscious attitudes and evaluations held by individuals. These individuals do not necessarily endorse the bias, but the embedded beliefs/attitudes can negatively affect their behaviors [2; 7; 8; 9]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [9].

Implicit biases can start as early as 3 years of age. As children age, they may begin to become more egalitarian in what they explicitly endorse, but their implicit biases may not necessarily change in accordance to these outward expressions [10]. Because implicit biases occur on the subconscious or unconscious level, particular social attributes (such as skin color) can quietly and insidiously affect perceptions and behaviors [11]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [12]:

- Age
- Disability
- Education
- English language proficiency and fluency
- Ethnicity
- Health status
- Disease/diagnosis
- Insurance
- Obesity
- Race
- Socioeconomic status
- Sexual orientation, gender identity, or gender expression
- Skin tone
- Substance use

An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities [6; 13]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can fur-

ther exacerbate these existing disadvantages [13]. Examples of vulnerable populations in health care include chronically ill and disabled individuals; rural populations; low-income and/or unhoused individuals; and LGBTQ+ populations.

When the concept of implicit bias was introduced in the 1990s, it was thought that implicit biases could be directly linked to behavior. Despite the decades of empirical research, many questions, controversies, and debates remain about the dynamics and pathways of implicit biases [2].

OTHER COMMON TERMINOLOGIES

In addition to understanding implicit and explicit bias, there is additional terminology related to these concepts that requires specific definition.

Cultural Competence

Cultural competence is broadly defined as practitioners' knowledge of and ability to apply cultural information and appreciation of a different group's cultural and belief systems to their work [14]. It is a dynamic process, meaning that there is no endpoint to the journey to becoming culturally aware, sensitive, and competent. Some have argued that cultural curiosity is a vital aspect of this approach.

Cultural Humility

Cultural humility refers to an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups. Practitioners who apply cultural humility readily concede that they are not experts in others' cultures and that there are aspects of culture and social experiences that they do not know. From this perspective, patients are considered teachers of the cultural norms, beliefs, and value systems of their group, while practitioners are the learners [15]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [16].

Discrimination

Discrimination has traditionally been viewed as the outcome of prejudice [17]. It encompasses overt or hidden actions, behaviors, or practices of members in a dominant group against members of a subordinate group [18]. Discrimination has also been further categorized as lifetime discrimination, which consists of major discreet discriminatory events, or everyday discrimination, which is subtle, continual, and part of day-to-day life and can have a cumulative effect on individuals [19].

Diversity

Diversity "encompasses differences in and among societal groups based on race, ethnicity, gender, age, physical/mental abilities, religion, sexual orientation, and other distinguishing characteristics" [20]. Diversity is often conceptualized into singular dimensions as opposed to multiple and intersecting diversity factors [21].

Intersectionality

Intersectionality is a term to describe the multiple facets of identity, including race, gender, sexual orientation, religion, sex, and age. These facets are not mutually exclusive, and the meanings that are ascribed to these identities are inter-related and interact to create a whole [22]. This term also encompasses the ways that different types and systems of oppression intersect and affect individuals.

Prejudice

Prejudice is a generally negative feeling, attitude, or stereotype against members of a group [23]. It is important not to equate prejudice and racism, although the two concepts are related. All humans have prejudices, but not all individuals are racist. The popular definition is that "prejudice plus power equals racism" [23]. Prejudice stems from the process of ascribing every member of a group with the same attribute [24].

Race

Race is linked to biology. Race is partially defined by physical markers (such as skin or hair color) and is generally used as a mechanism for classification [25]. It does not refer to cultural institutions or patterns. In modern history, skin color has been used to classify people and to imply that there are distinct biologic differences within human populations [26]. Historically, the U.S. Census has defined race according to ancestry and blood quantum; today, it is based on self-classification [26].

There are scholars who assert that race is socially constructed without any biological component [27]. For example, racial characteristics are also assigned based on differential power and privilege, lending to different statuses among groups [28].

Racism

Racism is the "systematic subordination of members of targeted racial groups who have relatively little social power...by members of the agent racial group who have relatively more social power" [29]. Racism is perpetuated and reinforced by social values, norms, and institutions.

There is some controversy regarding whether unconscious (or implicit) racism exists. Experts assert that images embedded in our unconscious are the result of socialization and personal observations, and negative attributes may be unconsciously applied to racial minority groups [30]. These implicit attributes affect individuals' thoughts and behaviors without a conscious awareness.

Structural racism refers to the laws, policies, and institutional norms and ideologies that systematically reinforce inequities resulting in differential access to services such as health care, education, employment, and housing for racial and ethnic minorities [31; 32].

MEASUREMENT OF IMPLICIT BIAS

Project Implicit is a research project sponsored by Harvard University and devoted to the study and monitoring of implicit biases. It houses the Implicit Association Test (or IAT), which is one of the most widely utilized standardized instruments to measure implicit biases. The IAT is based on the premise that implicit bias is an objective and discreet phenomenon that can be measured in a quantitative manner. Developed and first introduced in 1998, it is an online test that assesses implicit bias by measuring how quickly people make associations between targeted categories with a list of adjectives [33]. For example, research participants might be assessed for their implicit biases by seeing how rapidly they make evaluations among the two groups/categories career/family and male/female. Participants tend to more easily affiliate terms for which they hold implicit or explicit biases. So, unconscious biases are measured by how quickly research participants respond to stereotypical pairings (for example, career/male and family/female). The larger the difference between the individual's performance between the two groups, the stronger the degree of bias [34; 35]. Since 2006, more than 4.6 million individuals have taken the IAT, and results indicate that the general population holds implicit biases [3].

interactive activity

Visit the Project Implicit website (https://implicit.harvard.edu/implicit) and complete an assessment. Does it reflect your perception of your own biases? Did you learn anything about yourself?

Measuring implicit bias is complex, because it requires an instrument that is able to access underlying unconscious processes. While many of the studies on implicit biases have employed the IAT, there are other measures available. They fall into three general categories: the IAT and its variants, priming methods, and miscellaneous measures, such as self-report, role-playing, and computer mouse movements [36]. This webinar will focus on the IAT, as it is the most commonly employed instrument.

The IAT is not without controversy. One of the debates involves whether IAT scores focus on a cognitive state or if they reflect a personality trait. If it is the latter, the IAT's value as a diagnostic screening tool is diminished [37]. There is also concern with its validity in specific arenas, including jury selection and hiring [37]. Some also maintain that the IAT is sensitive to social context and may not accurately predict behavior [37]. Essentially, a high IAT score reflecting implicit biases does not necessarily link to discriminating behaviors, and correlation should not imply causation. A meta-analysis involving 87,418 research participants found no evidence that changes in implicit biases affected explicit behaviors [38].

EXTENT OF IMPLICIT BIASES AND RISK FACTORS

Among the more than 4 million participants who have completed the IAT, individuals generally exhibited implicit preference for White faces over Black or Asian faces. They also held biases for light skin over dark skin, heterosexual over gender and sexual minorities (LGBTQ+), and young over old [39]. The Pew Research Center also conducted an exploratory study on implicit biases, focusing on the extent to which individuals adhered to implicit racial biases [40]. A total of 2,517 IATs were completed and used for the analysis. Almost 75% of the respondents exhibited some level of implicit racial biases. Only 20% to 30% did not exhibit or showed very little implicit bias against the minority racial groups tested. Approximately half of all single-race White individuals displayed an implicit preference for White faces over Black faces. For single-race Black individuals, 45% had implicit preference for their own group. For biracial White/Black adults, 23% were neutral. In addition, 22% of biracial White/Asian participants had no or minimal implicit racial biases. However, 42% of the White/Black biracial adults leaned toward a pro-White bias.

In another interesting field experiment, although not specifically examining implicit bias, resumes with names commonly associated with African American or White candidates were submitted to hiring officers [41]. Researchers found that resumes with White-sounding names were 50% more likely to receive callbacks than resumes with African American-sounding names [41]. The underlying causes of this gap were not explored.

Implicit bias related to sex and gender is also significant. A survey of emergency medicine and obstetrics/gynecology residency programs in the United States sought to examine the relationship between biases related to perceptions of leadership and gender [42]. In general, residents in both programs (regardless of gender) tended to favor men as leaders. Male residents had greater implicit biases compared with their female counterparts.

Other forms of implicit bias can affect the provision of health and mental health care. One online survey examining anti-fat biases was provided to 4,732 first-year medical students [43]. Respondents completed the IAT, two measures of explicit bias, and an anti-fat attitudes instrument. Nearly 75% of the respondents were found to hold implicit anti-fat biases. Interestingly, these biases were comparable to the scope of implicit racial biases. Male sex, non-Black race, and lower body mass index predicted holding these implicit biases.

Certain conditions or environmental risk factors are associated with an increased risk for certain implicit biases, including [44; 45]:

- Stressful emotional states (like anger and frustration)
- Uncertainty
- Low-effort cognitive processing
- Time pressure
- Lack of feedback
- Feeling behind with work
- Lack of guidance
- Long hours
- Overcrowding
- High-crises environments
- Mentally taxing tasks
- Juggling competing tasks

THEORETIC EXPLANATIONS AND CONTROVERSIES

A variety of theoretical frameworks have been used to explore the causes, nature, and dynamics of implicit biases. Each of the theories is described in depth, with space given to explore controversies and debates about the etiology of implicit bias.

SOCIAL PSYCHOLOGICAL AND COGNITIVE THEORETICAL FRAMEWORKS

One of the main goals of social psychology is to understand how attitudes and belief structures influence behaviors. Based on frameworks from both social and cognitive psychology, many theoretical frameworks used to explain implicit bias revolve around the concept of social cognition. One branch of cognitive theory focuses on the role of implicit or nondeclarative memory. Experts believe that this type of memory allows certain behaviors to be performed with very little conscious awareness or active thought. Examples include tooth brushing, tying shoelaces, and even driving. To take this concept one step farther, implicit memories may also underlie social attitudes and stereotype attributions [46]. This is referred to as implicit social cognition. From this perspective, implicit biases are automatic expressions based on belonging to certain social groups [47]. The IAT is premised on the role of implicit memory and past experiences in predicting behavior without explicit memory triggering [48].

Another branch of cognitive theory used to describe implicit biases involves heuristics. As discussed earlier, heuristics are essentially mental short cuts that facilitate (usually unconscious) rules that promote automatic processing. These rules can be influenced by socialization factors. Family, friends, media, school, religion, and other social institutions all play a role in developing and perpetuating implicit and explicit stereotypes, and cognitive evaluations can be primed or triggered by an environmental cue or experience. When a heuristic is activated, an implicit memory or bias may be triggered simultaneously. This is also known as the dual-process model of information processing [47; 49; 50; 51].

BEHAVIORAL OR FUNCTIONAL PERSPECTIVES

Behavioral or functional theorists argue that implicit bias is not necessarily a latent or unconscious cognitive structure. Instead, this perspective recognizes implicit bias as a group-based behavior [52]. Behavior is biased if it is influenced by social cues indicating the social group to which someone belongs [52]. Social cues can occur rapidly and unintentionally, which ultimately leads to automatic or implicit effects on behavior. The appeal of a behavioral or functional approach to implicit bias is that it is amoral; that is, it is value- and judgment-free [52]. According to this perspective, rather than viewing implicit bias as an invisible force (or an unconscious cognitive structure), it is considered a normal behavior [53].

NEUROSCIENTIFIC PERSPECTIVES

Implicit bias has neuroscientific roots as well and has been linked to functions of the amygdala [2; 54]. The amygdala is located in the temporal lobe of the brain, and it communicates with the hypothalamus and plays a large role in memory. When situations are emotionally charged, the amygdala is activated and connects the event to memory, which is why individuals tend to have better recall of emotional events. This area of the brain is also implicated in processing fear. Neuroscientific studies on implicit biases typically use functional magnetic resonance imaging to visualize amygdala activation during specific behaviors or events. In experimental studies, when White research subjects were shown photos of Black faces, their amygdala appeared to be more activated compared to when they viewed White faces [55]. This trend toward greater activation when exposed to view the faces of persons whose race differs from the viewer starts in adolescence and appears to increase with age [54]. This speaks to the role of socialization in the developmental process [54].

It may be that the activation of the amygdala is an evolutionary threat response to an outgroup [56]. Another potential explanation is that the activation of the amygdala is due to the fear of appearing prejudiced to others who will disapprove of the bias [56]. The neuroscientific perspective of implicit bias is controversial. While initial empirical studies appear to link implicit bias to amygdala activation, many researchers argue this explanation is too simplistic [2].

STRUCTURAL OR CRITICAL THEORY

Many scholars and policymakers are concerned about the narrow theoretical views that researchers of implicit bias have taken. By focusing on unconscious cognitive structures, social cognition and neuroscientific theories, it's possible to miss the opportunity to also address the role of macro or systemic factors in contributing to health inequities [9; 57]. By focusing on the neurobiology of implicit bias, for example, racism and bias is attributed to central nervous system function, releasing the individual from any control or responsibility. However, the historical legacy of prejudice and bias has roots in economic and structural issues that produce inequities [58]. Larger organizational, institutional, societal, and cultural forces contribute, perpetuate, and reinforce implicit and explicit biases, racism, and discrimination. Psychological and neuroscientific approaches ultimately decontextualize racism [9; 57].

In response to this conflict, a systems-based practice has been proposed [59]. This type of practice emphasizes the role of sociocultural determinants of health outcome and the fact that health inequities stem from larger systemic forces. As a result, medical and health education and training should focus on how patients' health and well-being may reflect structural vulnerabilities driven in large part by social, cultural, economic, and institutional forces. Health and mental health professionals also require social change and advocacy skills to ensure that they can effect change at the organizational and institutional levels [59].

Implicit bias is not a new topic; it has been discussed and studied for decades in the empirical literature. Because implicit bias is a complex and multifaceted phenomenon, it is important to recognize that there may be no one single theory that can fully explain its etiology.

CONSEQUENCES OF IMPLICIT BIASES

HEALTH DISPARITIES

Implicit bias has been linked to a variety of health disparities [1]. Health disparities are differences in health status or disease that systematically and adversely affect less advantaged groups [60]. These inequities are often linked to historical and current unequal distribution of resources due to poverty, structural inequities, insufficient access to health care, and/or environmental barriers and threats [61]. Healthy People 2030 defines a health disparity as [62]:

> ...a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

As noted, in 2003, the Institute of Medicine implicated implicit bias in the development and continued health disparities in the United States [1]. Despite progress made to lessen the gaps among different groups, health disparities continue to exist. One example is racial disparities in life expectancy among Black and White individuals in the United States. Life expectancy for Black men is 4.4 years lower than White men; for Black women, it is 2.9 years lower compared with White women [63]. Hypertension is 25% more prevalent in non-Hispanic Black populations than White populations, while diabetes and obesity are 49% and 59% more prevalent, respectively [64]. In one study, African American and Latinx patients were more likely to experience cesarean deliveries than their White counterparts, even after controlling for medically necessary procedures [65]. This places African American and Latinx patients at greater risk of infection and maternal mortality.

Gender health disparities have also been demonstrated. Generally, self-rated physical health (considered one of the best proxies to health) is poorer among women than men. Depression is also more common among women than men [66]. Lesbian and bisexual women report higher rates of depression and are more likely than non-gay women to engage risky behaviors such as smoking and binge drinking, perhaps as a result of LGBTQ+-related stressors. They are also less likely to access healthcare services [67].

Socioeconomic status also affects health care engagement and quality. In a study of patients seeking treatment for thoracic trauma, those without insurance were 1.9 times more likely to die compared with those with private insurance [68].

CLINICAL DECISIONS AND PROVIDER-PATIENT INTERACTIONS

In an ideal situation, health professionals would be explicitly and implicitly objective and clinical decisions would be completely free of bias. However, healthcare providers have implicit (and explicit) biases at a rate comparable to that of the general population [6; 69]. It is possible that these implicit biases shape healthcare professionals' behaviors, communications, and interactions, which may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions [69]. They may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up [7].

In a landmark 2007 study, a total of 287 internal medicine physicians and medical residents were randomized to receive a case vignette of an either Black or White patient with coronary artery disease [70]. All participants were also administered the IAT. When asked about perceived level of cooperativeness of the White or Black patient from the vignette, there were no differences in their explicit statements regarding cooperativeness. Yet, the IAT scores did show differences, with scores showing that physicians and residents had implicit preferences for the White patients. Participants with greater implicit preference for White patients (as reflected by IAT score) were more likely to select thrombolysis to treat the White patient than the Black patient [70]. This led to the possible conclusion that implicit racial bias can influence clinical decisions regarding treatment and may contribute to racial health disparities. However, some argue that using vignettes depicting hypothetical situations does not accurately reflect real-life conditions that require rapid decision-making under stress and uncertainty.

interactive activity

Over her many years in health care, Shelley has worked with a diverse group of patients. Based on her experiences, she has seen many Black patients who are reluctant to breastfeed their infants. She has not seen the same reluctance in Latinx patients. While Shelley knows that patients of all cultures breastfeed their infants, she holds a subconscious belief that Black mothers are less likely to breastfeed their infants and assumes that Latinx mothers are more likely to breastfeed their infants. This is an example of implicit bias.

How might Shelley's implicit bias manifest in her actions in her practice? How could she evaluate her bias? If she recognizes she has this bias, what could she do to make sure it does not affect her actions?

Highlighting pregnancy and birth disparities, statistics show that, in the United States, Black patients have lower rates of breastfeeding compared to other racial groups. However, despite the statistics, in order to deliver optimal health care and avoid perpetuating health disparities, we must not assume Black patients are not breastfeeding or interested in breastfeeding.

PATIENTS' PERCEPTIONS OF CARE

It has been hypothesized that providers' levels of bias affect the ratings of patient-centered care [34]. Patient-centered care has been defined as patients' positive ratings in the areas of perception of provider concern, provider answering patients' questions, provider integrity, and provider knowledge of the patient. Using data from 134 health providers who completed the IAT, a total of 2,908 diverse racial and ethnic minority patients participated in a telephone survey. Researchers found that for providers who scored high on levels of implicit bias, African American patients' ratings for all dimensions of patient-centered care were low compared with their White patient counterparts. Latinx patient ratings were low regardless of level of implicit bias.

A 2013 study recorded clinical interactions between 112 low-income African American patients and their 14 non-African American physicians for approximately two years [71]. Providers' implicit biases were also assessed using the IAT. In general, the physicians talked more than the patients; however, physicians with higher implicit bias scores also had a higher ratio of physician-to-patient talk time. Patients with higher levels of perceived discrimination had a lower ratio of physician-to-patient talk time, meaning they spoke more than those with lower reported perceived discrimination. A lower ratio of physician-patient talk time correlated to decreased likelihood of adherence to prescribed treatments.

Another study assessed 40 primary care physicians and 269 patients [72]. The IAT was administered to both groups, and their interactions were recorded and observed for verbal dominance (defined as the time of physician participation relative to patient participation). When physicians scored higher on measures of implicit bias, there was 9% more verbal dominance on the part of the physicians in the visits with Black patients and 11% greater in interactions with White patients. Physicians with higher implicit bias scores and lower verbal dominance also received lower scores on patient ratings on interpersonal care, particularly from Black patients [72].

In focus groups with racially and ethnically diverse patients who sought medical care for themselves or their children in New York City, participants reported perceptions of discrimination in health care [73]. They reported that healthcare professionals often made them feel less than human, with varying amounts of respect and courtesy. Some observed differences in treatment compared with White patients. One Black woman reported [73]:

> When the doctor came in [after a surgery], she proceeded to show me how I had to get up because I'm being released that day "whether I like it or not"...She yanked the first snap on the left leg...So I'm thinking, 'I'm human!' And she was courteous to the White lady [in the next bed], and I've got just as much age as her. I qualify on the level and scale of human being as her, but I didn't feel that from the doctor.

Another participant was a Latino physician who presented to the emergency department. He described the following [73]:

> They put me sort of in the corner [in the emergency department] and I can't talk very well because I can't breathe so well. The nurse comes over to me and actually says, "Tu tiene tu Medicaid?" I whispered out, "I'm a doctor…and I have insurance." I said it in perfect English. Literally, the color on her face went completely white…Within two minutes there was an orthopedic team around me…I kept wondering about what if I hadn't been a doctor, you know? Pretty eye opening and very sad.

These reports are illustrative of many minority patients' experiences with implicit and explicit racial/ethnic biases. Not surprisingly, these biases adversely affect patients' views of their clinical interactions with providers and ultimately contribute to their mistrust of the healthcare system.

THE INTERSECTION OF IMPLICIT BIAS AND SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Further, at clinician and systems levels, implicit biases contribute to the maintenance of these disparities. Healthy People 2030 groups social determinants of health into five categories [101]:

- Economic stability
- Education access and quality
- Health care access and quality
- Social and community context
- Neighborhood and built environment

These factors have a major impact on people's health, well-being, and quality of life. Examples of social determinants of health include [101]:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Social determinants of health also contribute to wide health disparities and inequities. For example, people who lack access to grocery stores with healthy foods are less likely to have good nutrition, which raises the risk of heart disease, diabetes, and obesity and lowers life expectancy compared with those who have easier access to healthy foods [101].

Promoting healthy choices will not eliminate these and other health disparities. There is often a false sense that all of these inequities are the result of factors outside of health care. Clinicians have a responsibility to consider how implicit biases might be contributing to the perpetuation of health disparities; conversely, one should also consider how social determinants of health may have informed biases regarding certain patient groups. Public health organizations and their partners must take action to improve the conditions in people's environments. Healthcare providers play a role by identifying factors affecting the health of their patients, providing resources (when appropriate), and advocating for healthy environments.

DEVELOPMENTAL MODEL OF RECOGNIZING AND REDUCING IMPLICIT BIAS

There are no easy answers to raising awareness and reducing health providers' implicit bias. Each provider may be in a different developmental stage in terms of awareness, understanding, acceptance, and application of implicit bias to their practice. A developmental model for intercultural sensitivity training has been established to help identify where individuals may be in this developmental journey [74; 75]. It is important to recognize that the process of becoming more self-aware is fluid; reaching one stage does not necessarily mean that it is "conquered" or that there will not be additional work to do in that stage. As a dynamic process, it is possible to move back and forth as stress and uncertainty triggers implicit biases [74]. This developmental model includes six stages:

- Denial: In this stage, the individual has no awareness of the existence of cultural differences between oneself and members of other cultural groups and subgroups. Individuals in this stage have no awareness of implicit bias and cannot distinguish between explicit and implicit biases.
- Defense: In this stage, the person may accept that implicit biases exist but does not acknowledge that implicit biases exist within themselves.
- Minimization: An individual in this stage acknowledges that implicit biases may exist in their colleagues and possibly themselves. However, he or she is uncertain of their consequences and adverse effects. Furthermore, the person believes he or she is able to treat patients in an objective manner.
- Acceptance: In the acceptance stage, the individual recognizes and acknowledges the role of implicit biases and how implicit biases influence interactions with patients.
- Adaptation: Those in the adaptation stage self-reflect and acknowledge that they have unrecognized implicit biases. Not only is there an acknowledgement of the existence of implicit bias, these people begin to actively work to reduce the potential impact of implicit biases on interactions with patients.
- Integration: At this stage, the health professional works to incorporate change in their day-to-day practice in order to mitigate the effects of their implicit biases on various levels—from the patient level to the organization level.

APPROACH TO EXPLORING IMPLICIT BIASES

Creating a safe environment is the essential first step to exploring issues related to implicit bias. Discussions of race, stereotypes, privilege, and implicit bias, all of which are very complex, can be volatile or produce heightened emotions. When individuals do not feel their voices are heard and/or valued, negative emotions or a "fight-or-flight" response can be triggered [76]. This may manifest as yelling, demonstrations of anger, or crying or leaving the room or withdrawing and remaining silent [76].

Creating and fostering a sense of psychological safety in the learning environment is crucial. Psychological safety results when individuals feel that their opinions, views, thoughts, and contributions are valued despite tension, conflict, and discomfort. This allows the individual to feel that their identity is intact [76]. When psychological safety is threatened, individuals' energies are primarily expended on coping rather than learning [76]. As such, interventions should not seek to confront individuals or make them feel guilty and/or responsible [77].

When implicit bias interventions or assessments are planned, facilitators should be open, approachable, non-threatening, and knowledgeable; this will help create a safe and inclusive learning environment [77]. The principles of respect, integrity, and confidentiality should be communicated [77]. Facilitators who demonstrate attunement, authenticity, and power-sharing foster positive and productive dialogues about subjects such as race and identity [76]. Attunement is the capacity of an individual to tacitly comprehend the lived experiences of others, using their perspectives to provide an alternative viewpoint for others. Attunement does not involve requiring others to talk about their experiences if they are not emotionally ready [76]. Authenticity involves being honest and transparent with one's own position in a racialized social structure and sharing one's own experiences, feelings, and views. Being authentic also means being vulnerable [76]. Finally, power-sharing entails redistributing power in the learning environment. The education environment is typically hierarchical, with an expert holding more power than students or participants. Furthermore, other students may hold more power by virtue of being more comfortable speaking/interacting [76]. Ultimately, promoting a safe space lays a foundation for safely and effectively implementing implicit bias awareness and reduction interventions.

STRATEGIES TO PROMOTE AWARENESS OF IMPLICIT BIAS

As discussed, the IAT can be used as a metric to assess professionals' level of implicit bias on a variety of subjects, and this presupposes that implicit bias is a discrete phenomenon that can be measured quantitatively [79]. When providers are aware that implicit biases exist, discussion and education can be implemented to help reduce them and/or their impact.

Another way of facilitating awareness of providers' implicit bias is to ask self-reflective questions about each interaction with patients. Some have suggested using SOAP (or subjective, objective, assessment, and plan) notes to assist practitioners in identifying implicit biases in day-to-day interactions with patients [80]. Integrating the following questions into charts and notes can stimulate reflection about implicit bias globally and for each specific patient interaction:

- Did I think about any socioeconomic and/or environmental factors that may contribute to the health and access of this patient?
- How was my communication and interaction with this patient? Did it change from my customary pattern?
- How could my implicit biases influence care for this patient?

When reviewing the SOAP notes, providers can look for recurring themes of stereotypical perceptions, biased communication patterns, and/or types of treatment/interventions proposed and assess whether these themes could be influenced by biases related to race, ethnicity, age, gender, sexuality, or other social characteristics.

A review of empirical studies conducted on the effectiveness of interventions promoting implicit bias awareness found mixed results. At times, after a peer discussion of IAT scores, participants appeared less interested in learning and employing implicit bias reduction interventions. However, other studies have found that receiving feedback along with IAT scores resulted in a reduction in implicit bias [81]. Any feedback, education, and discussions should be structured to minimize participant defensiveness [81].

INTERVENTIONS TO REDUCE IMPLICIT BIASES

Interventions or strategies designed to reduce implicit bias may be further categorized as change-based or control-based [58]. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors [58]. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

interactive activity

Consuming media that presents a viewpoint and life experience different from your own can help minimize implicit biases. Visit the following sites and consider how they might challenge or expand your perception of each group. Internet searches can help identify many more options for various social groups.

Think Out Loud Podcast
Young Black people share their experiences growing up in Portland, Oregon.

https://www.opb.org/article/2020/10/30/young-black-people-share-their-experiences-growing-up-in-portland

George Takei: Growing Up Asian-American
This PBS clip is a brief introduction, and the subject can be further explored in Takei's book They Called Us Enemy.

https://www.pbs.org/wnet/pioneers-of-television/video/george-takei-growing-up-asian-american

Seattle Public Library LGBTQ Staff Picks
A reading list including books and films focusing on LGBTQ+ life, culture, history, and politics.

https://www.spl.org/programs-and-services/social-justice/lgbtq/lgbt-staff-picks

PERSPECTIVE TAKING

Perspective taking is a strategy of taking on a first-person perspective of a person in order to control one's automatic response toward individuals with certain social characteristics that might trigger implicit biases [82]. The goal is to increase psychological closeness, empathy, and connection with members of the group [4]. Engaging with media that presents a perspective can help promote better understanding of the specific group's lives, experiences, and viewpoints. This can include watching documentaries or reading autobiographies. In one study, participants who adopted the first-person perspectives of African Americans had more positive automatic evaluations of the targeted group [83].

EMPATHY INTERVENTIONS

Promoting positive emotions such as empathy and compassion can help reduce implicit biases. This can involve strategies like perspective taking and role playing [77]. In a study examining analgesic prescription disparities, nurses were shown photos of White or African American patients exhibiting pain and were asked to recommend how much pain medication was needed; a control group was not shown photos. Those who were shown images of patients in pain displayed no differences in recommended dosage along racial lines; however, those who did not see the images averaged higher recommended dosages for White patients compared with Black patients [84]. This suggests that professionals' level of empathy (enhanced by seeing the patient in pain) affected prescription recommendations.

In a study of healthcare professionals randomly assigned to an empathy-inducing group or a control group, participants were given the IAT to measure implicit bias prior to and following the intervention. Level of implicit bias among participants in the empathy-inducing group decreased significantly compared with their control group counterparts [85].

INDIVIDUATION

Individuation is an implicit bias reduction intervention that involves obtaining specific information about the individual and relying on personal characteristics instead of stereotypes of the group to which he or she belongs [4; 82]. The key is to concentrate on the person's specific experiences, achievements, personality traits, qualifications, and other personal attributes rather than focusing on gender, race, ethnicity, age, ability, and other social attributes, all of which can activate implicit biases. When providers lack relevant information, they are more likely to fill in data with stereotypes, in some cases unconsciously. Time constraints and job stress increase the likelihood of this occurring [69].

MINDFULNESS

Mindfulness requires stopping oneself and deliberately emptying one's mind of distractions or allowing distractions to drift through one's mind unimpeded, focusing only on the moment; judgment and assumptions are set aside. This approach involves regulating one's emotions, responses, and attention to return to the present moment, which can reduce stress and anxiety [86]. There is evidence that mindfulness can help regulate biological and emotional responses and can have a positive effect on attention and habit formation [4]. A mindfulness activity assists individuals to be more aware of their thoughts and sensations. This focus on deliberation moves the practitioner away from a reliance on instincts, which is the foundation of implicit bias-affected practice [4; 87].

Mindfulness approaches include yoga, meditation, and guided imagery. Additional resources to encourage a mindfulness practice are provided later in this webinar.

An approach to mindfulness using the acronym STOPP has been developed as a practical exercise to engage in mindfulness in any moment. STOPP is an acronym for [88]:

- Stop
- Take a breath
- Observe
- Pull Back
- Practice

interactive activity

Visit the following website to view a short, animated video on the STOPP technique. After viewing the video, consider how you can incorporate the technique into your work.

https://www.youtube.com/watch?v=tStXi7f7Vgk

Mindfulness practice has been explored as a technique to reduce activation or triggering of implicit bias, enhance awareness of and ability to control implicit biases that arise, and increase capacity for compassion and empathy toward patients by reducing stress, exhaustion, and compassion fatigue [89]. One study examined the effectiveness of a loving-kindness meditation practice training in improving implicit bias toward African Americans and unhoused persons. One hundred one non-Black adults were randomized to one of three groups: a six-week loving-kindness mindfulness practice, a six-week loving-kindness discussion, or the waitlist control. The IAT was used to measure implicit biases, and the results showed that the loving-kindness meditation practice decreased levels of implicit biases toward both groups [90].

There is also some novel evidence that mindfulness may have neurologic implications. For example, one study showed decreased amygdala activation after a mindfulness meditation [91]. However, additional studies are required in this area before conclusions can be reached.

COUNTER-STEREOTYPICAL IMAGING

Counter-stereotypical imaging approaches involve presenting an image, idea, or construct that is counter to the oversimplified stereotypes typically held regarding members of a specific group. In one study, participants were asked to imagine either a strong woman (the experimental condition) or a gender-neutral event (the control condition) [92].

Researchers found that participants in the experimental condition exhibited lower levels of implicit gender bias. Similarly, exposure to female leaders was found to reduce implicit gender bias [93]. Whether via increased contact with stigmatized groups to contradict prevailing stereotypes or simply exposure to counter-stereotypical imaging, it is possible to unlearn associations underlying various implicit biases. If the social environment is important in priming positive evaluations, having more positive visual images of members in stigmatized groups can help reduce implicit biases [94]. Some have suggested that even just hanging photos and having computer screensavers reflecting positive images of various social groups could help to reduce negative associations [94].

EFFECTIVENESS OF IMPLICIT BIAS INTERVENTIONS

The effectiveness of implicit bias trainings and interventions has been scrutinized. In a 2019 systematic review, different types of implicit bias reduction interventions were evaluated. A meta-analysis of empirical studies published between May 2005 and April 2015 identified eight different classifications of interventions [13]:

- Engaging with others' perspectives, consciousness-raising, or imagining contact with outgroup: Participants either imagine how the outgroup thinks and feels, imagine having contact with the outgroup, or are made aware of the way the outgroup is marginalized or given new information about the outgroup.
- Identifying the self with the outgroup: Participants perform tasks that lessen barriers between themselves and the outgroup.
- Exposure to counter-stereotypical exemplars: Participants are exposed to exemplars that contradict negative stereotypes of the outgroup.
- Appeal to egalitarian values: Participants are encouraged to activate egalitarian goals or think about multiculturalism, cooperation, or tolerance.
- Evaluative conditioning: Participants perform tasks to strengthen counter-stereotypical associations.
- Inducing emotion: Emotions or moods are induced in participants.
- Intentional strategies to overcome biases: Participants are instructed to implement strategies to over-ride or suppress their biases.
- Pharmacotherapy

Interventions found to be the most effective were, in order from most to least, [13]:

- Intentional strategies to overcome biases
- Exposure to counter-stereotypical exemplars
- Identifying self with the outgroup
- Evaluative conditioning
- Inducing emotions

In general, the sample sizes were small. It is also unclear how generalizable the findings are, given many of the research participants were college psychology students. The 30 studies included in the meta-analysis were cross-sectional (not longitudinal) and only measured short-term outcomes, and there is some concern about "one shot" interventions, given the fact that implicit biases are deeply embedded. Would simply acknowledging the existence of implicit biases be sufficient to eliminate them [95; 96]? Or would such a confession act as an illusion to having self-actualized and moved beyond the bias [95]?

Optimally, implicit bias interventions involve continual practice to address deeply habitual implicit biases or interventions that target structural factors [95; 96].

BEST PRACTICES FOR CULTURALLY RESPONSIVE CARE

One of the most important steps to mitigating the impact of implicit biases in health care is the focus on providing culturally responsive care. For the next section, we will shift gears a bit and dive into the basics of culturally responsive care for a variety of patient groups.

Culture plays a huge role in how patients define health and how they interact with the health care system. The National Institutes of Health defines culture as "the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements including personal identification, language, thoughts, communications, actions, customs, beliefs, values and institutions that are often specific to ethnic, racial, religious, geographic or cultural groups." In order to provide culturally responsive care, providers and systems must understand the importance of culture and consider culture when providing resources, education, and services. This means being open to new ideas that may conflict with the ideas, beliefs and values of your own culture, and being able to see these differences as equal.

Examples of culturally responsive care include, but are not limited to, being responsive to diverse beliefs and values related to health and well-being, delivering services in preferred languages, and being mindful of health literacy and numeracy.

The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [102].

The first step is to engage patients. In nonemergent situations, it is important to establish rapport before asking a series of assessment questions or delving deeply into history taking. Providers should use simple gestures as culturally appropriate to help establish a first impression. The intent is that all patients feel understood and seen following each interaction. Culturally responsive interview behaviors and paperwork should be used at all times [102].

When engaging in any patient teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Patients should be encouraged to collaborate in every step of their care. This consists of seeking the patient's input and interpretation and establishing ways they can seek clarification. Patient feedback can then be used to help identify cultural issues and specific needs. If appropriate, collaboration should extend to include family and community members.

Assessment should incorporate culturally relevant themes in order to more fully understand patients and identify their cultural strengths and challenges. Themes include [102]:

- Immigration history
- Cultural identity and acculturation
- Membership in a subculture
- Beliefs about health, healing, and help-seeking
- Trauma and loss

In some cases, it may be appropriate and beneficial to obtain culturally relevant collateral information, with the patient's permission, from sources other than the patient (such as family or community members) to better understand beliefs and practices that shape the patient's cultural identity and understanding of the world.

Practitioners should work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group or groups. An instrument's cultural applicability to the population being served should be assessed, keeping in mind that research is limited on the cross-cultural applicability of specific test items or questions, diagnostic criteria, and concepts in evaluative and diagnostic processes [102].

Typically, culturally responsive care establishes holistic treatment goals that include objectives to improve physical health and spiritual strength; utilizes strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognizes that treatment planning is a dynamic process that evolves along with an understanding of patient history and treatment needs.

In addition to these general approaches, specific considerations may be appropriate for specific populations. While discussion of every possible patient subgroup is outside of the scope of this webinar, some of the most common factors are outlined in the following sections [102].

RACIAL BACKGROUNDS

Race and color impact the ways in which individuals interact with their environments and are perceived and treated by others. Race is defined as groups of humans divided on the basis of inherited physical and behavioral differences. As part of the cultural competence process and as a reflection of cultural humility, practitioners should strive to learn as much as possible about the specific racial/ethnic populations they serve [129]. However, considerable diversity exists within any specific culture, race, or ethnicity [129]. Cultural beliefs, traditions, and practices change over time, both through generations and within an individual's lifetime. It is also possible for the differences between two members of the same racial/ethnic group to be greater than the differences between two people from different racial/ethnic groups. Within-group variations in how persons interact with their environments and specific social contexts are also often present.

As with all patients, it is vital to actively listen and critically evaluate patient relationships. All practitioners should seek to educate themselves regarding the experiences of patients who are members of a community that differs from their own. Resources and opportunities to collaborate may be available from community organizations and leaders.

Finally, preferred language and immigration/migration status should be considered. Interpreters should be used when appropriate, with adherence to best practices for the use of interpretation services. Stressing confidentiality and privacy is particularly important for undocumented workers or recent immigrants, who may be fearful of deportation.

Black Patients

"Black" or "African American" is a classification that serves as a descriptor; it has sociopolitical and self-identification ramifications. The U.S. Census Bureau defines African Americans or Black Americans as persons "having origins in any of the Black racial groups of Africa" [130].

According to the U.S. Census, there were 46.9 million African or Black Americans in the United States in 2020 [131]. By 2060, it is projected they will comprise 17.9% of the U.S. population [132]. This group tends to be young; 30% of the African American population in the United States is younger than 18 years of age. In 2019, the median age for this group was 35 years [133]. In terms of educational attainment, 89.4% of African Americans 25 years of age or older had a high school diploma or completed college in 2020 [131]. Texas has the largest African American population, at 3.9 million [133].

Historical adversity and institutional racism contribute to health disparities in this group. For the Black population, patient assessment and treatment planning should be framed in a context that recognizes the totality of life experiences faced by patients. In many cases, particularly in the provision of mental health care, equality is sought in the provider-patient relationship, with less distance and more disclosing. Practitioners should assess whether their practices connect with core values of Black culture, such as family, kinship, community, and spirituality. Generalized or Eurocentric treatment approaches may not easily align with these components of the Black community [134]. Providers should also consider the impact of racial discrimination on health and mental health among Black patients. Reports indicate that expressions of emotion by Black patients tend to be negatively misunderstood or dismissed; this reflects implicit or explicit biases.

Asian Patients

As of 2019, 22.9 million Americans identified as Asian [135]. Between 2000 and 2019, Asians experienced the greatest growth compared with any other racial group at 81% [136; 137]. The Chinese group represents the largest Asian subgroup in the United States, and it is projected that this population will grow to 35.7 million between 2015 and 2040 [138; 139]. In 2019, Chinese Americans (excluding Taiwanese Americans) numbered at 5.2 million [135]. They also have the highest educational attainment; 54.6% of Asians 25 years of age or older had a bachelor's degree or higher in 2019 [135].

"Asian" is a single term widely used to describe individuals who have kinship and identity ties to Asia, including the Far East, Southeast Asia, and the Indian subcontinent [140]. This encompasses countries such as China, Japan, Korea, Vietnam, Cambodia, Thailand, India, Pakistan, and the Philippines. Pacific Islander is often combined with Asian American in census data. The Pacific Islands include Hawaii, Guam, Samoa, Fiji, and many others [140]. There are more than 25 Asian/Pacific Islander groups, each with a different migration history and widely varying sociopolitical environments in their homelands [141].

Asian American groups have differing levels of acculturation, lengths of residency in the United States, languages, English-speaking proficiency, education attainment, socioeconomic statuses, and religions. For example, there are approximately 32 different languages spoken among Asian Americans, and within each Asian subgroup, multiple dialects may be present [141; 142]. In 2019, California had the largest Asian American population, totaling 5.9 million [136].

The following best practices have been established hen caring for Asian American patients, but these tips can be used for any racial/ethnic minority group:

- Create an advisory committee using representatives from the community.
- Incorporate cultural knowledge and maintain flexible attitudes.
- Provide services in the patients' primary language.
- Develop culturally specific questionnaires for intake to capture information that may be missed by standard questionnaires.
- Emphasize traditional values and incorporate traditional practices into treatment plans, when appropriate and desired.
- Explore patient coping mechanisms that draw upon cultural strengths.

Latino/a/x or Hispanic Patients

In 2020, the Hispanic population in the United States numbered 60.6 million [143]. The majority of the Hispanic population in the United States (63.3%) identify themselves as being of Mexican descent [144]. Approximately 27% of the U.S. Hispanic population identify as Puerto Rican, Cuban, Salvadoran, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, or Peruvian [145].

In 2020, the Hispanic population comprised 18.7% of the U.S. population [143]. As such, they are the largest ethnic minority group in the United States. By 2060, Hispanic individuals are expected to represent 31% of the U.S. population [146]. They are also a young group, with a median age of 29.8 years [143]. In 2019, the three states with the largest Hispanic population growth were Texas (with 2 million in population growth), California (with 1.5 million in population growth), and Florida (with 1.4 million in population growth); these three states have the largest Hispanic populations overall [147].

When involved in the care of Latinx/Hispanic individuals, practitioners should strive to employ *personalismo* (warm, genuine communication) and recognize the importance of *familismo* (the centrality of the family). More flexible scheduling strategies may be more successful with this group, if possible, and some patients may benefit from culturally specific treatment and ethnic and gender matching with providers. Aspects of Latino culture can be assets in treatment: strength, perseverance, flexibility, and an ability to survive.

Native American Patients

The Native American population is extremely diverse. According to the U.S. Census, the terms "Native American," "American Indian," or "Alaskan Native" refer to individuals who identify themselves with tribal attachment to indigenous groups of North and South America [148]. In the United States, there are 574 federally recognized tribal governments and 324 federally recognized reservations [149].

In 2020, it was reported that there were 7.1 million Native Americans in the United States, which is approximately 2% of the U.S. population [149]. By 2060, this number is projected to increase to 10.1 million, or 2.5% of the total population [149].

In general, this group is young, with a median age of 31 years, compared with the general median age of 37.9 years [150]. As of 2018, the states with the greatest number of residents identifying as Native American are Alaska, Oklahoma, New Mexico, South Dakota, and Montana [151]. In 2016, this group had the highest poverty rate (at 26.2%) of any racial/ethnic group [150].

Listening is an important aspect of rapport building with Native American patients, and practitioners should use active listening and reflective responses. Assessments and histories may include information regarding patients' stories, experiences, dreams, and rituals and their relevance. Interruptions and excessive questioning should be avoided if at all possible. Extended periods of silence may occur, and time should be allowed for patients to adjust and process information. Practitioners should avoid asking about family or personal matters unrelated to presenting issues without first asking permission to inquire about these areas. Native American patients often respond best when they are given suggestions and options rather than directions.

White American Patients

In 2021, 76.3% of the U.S. population identified as White alone [152]. The U.S. Census Bureau defines White race as persons having origins in any of the original peoples of Europe, the Middle East, or North Africa [130]. While the proportion of population identifying as White only has decreased between 2010 and 2020, the numbers of persons identifying as White and another race/ethnicity increased significantly. The White population in the United States is diverse in its religious, cultural, and social composition. The greatest proportion of this group reports a German ancestry, followed by Irish, English, and Italian [128].

Providers can assume that most well-accepted treatment approaches and interventions have been tested and evaluated with White American individuals, particularly men. However, approaches may need modification to suit class, ethnic, religious, and other factors.

Providers should establish not only the patient's ethnic background, but also how strongly the person identifies with that background. It is also important to be sensitive to a person's multiracial/multiethnic heritage, if present, and how this might affect their family relationships and social experiences. Assumption of White race should be avoided, as White-passing persons of color have their own unique needs.

RELIGIOUS, CULTURAL, AND ETHNIC BACKGROUNDS

Religion, culture, beliefs, and ethnic customs can influence how patients understand health concepts, how they take care of their health, and how they make decisions related to their health. Without proper training, clinicians may deliver medical advice without understanding how health beliefs and cultural practices influence the way that advice is received. Asking about patients' religions, cultures, and ethnic customs can help clinicians engage patients so that, together, they can devise treatment plans that are consistent with the patients' values [103].

Respectfully ask patients about their health beliefs and customs and note their responses in their medical records. Address patients' cultural values specifically in the context of their health care. For example, one may ask [103]:

- "Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?"
- "Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight?"
- "Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to share about your condition?"
- "What do you call your illness and what do you think caused it?"
- "Do any traditional healers advise you about your health?"

Practitioners should avoid stereotyping based on religious or cultural background. Each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Asking patients about their beliefs and way of life is the best way to be sure you know how their values may impact their care [103].

GENDER

Gender identity is a vital aspect of a person's experience of the world and of themselves. It also impacts the ways in which the world perceives and treats individuals, with a clear effect on the provision of health and mental health care. This section will focus on persons presenting as cisgender male or female; special considerations for those who are transgender, non-binary, or gender nonconforming will be explored in the next section.

An increasing amount of research is supporting a relationship between men's risk for disease and death and male gender identity, and the traditional male role has been shown to conflict with the fostering of healthy behaviors [155; 156]. Male gender identity is related to a tendency to take risks, and the predilection for risky behavior begins in boyhood [156; 157; 158]. In addition, boys are taught that they should be self-reliant and independent and should control their emotions, and societal norms for both boys and men dictate that they maintain a strong image by denying pain and weakness [155; 157; 158].

Issues related to male gender identity have several important implications for health. First, risky behavior is associated with increased morbidity and mortality. Second, the concept of masculinity leads to inadequate help- and information-seeking behavior and a reduced likelihood to engage in behavior to promote health [155; 157; 158]. These behaviors appear to be rooted in a decreased likelihood for men to perceive themselves as being ill or at risk for illness, injury, or death [155]. Third, male gender identity, coupled with lower rates of health literacy, creates special challenges for effectively communicating health messages to men [159; 160; 161]. Gender differences in health-related behaviors are consistent across racial/ethnic populations, although specific behaviors vary according to race/ethnicity [156].

Men's beliefs about masculinity and traditional male roles affect health communication, and healthcare practitioners should consider male-specific beliefs and perceptions when communicating with male patients. For example, because men tend to focus on present rather than future health, concepts of fear, wellness, and longevity often do not work well in health messages [162]. Instead, healthcare practitioners should focus more on "masculine" concepts, such as strength, safety, and performance, all of which tie into men's perceptions of their roles as providers and protectors.

Although men are more likely than women to lack a regular healthcare provider and to avoid seeking help or information, women are more likely to have a chronic condition requiring regular monitoring and are more likely to have forgone necessary health care due to the cost [163]. In general, women are disproportionately affected by stresses related to caregiving, and this can be a barrier to help-seeking. Caregiving has been socialized as a feminine role, and two out of every three caregivers in the United States are women, meaning they provide daily or regular support to children, adults, or people with chronic illnesses or disabilities [199]. Women who are caregivers have a greater risk for poor physical and mental health, including depression and anxiety.

Women are more likely than men to be diagnosed with a mental health disorder, and more than 20% of women in the United States experienced a mental health condition in the past year [200]. In addition to being disproportionately affected, mental health conditions, such as depression and bipolar disorder, can manifest differently in or have different impacts on women than men. Much of the research into women's health has focused on the perinatal period, which limits our knowledge of how mental illness affects women's lives.

Providing gender-sensitive care to women involves overcoming the limitations imposed by the dominant medical model in women's health. This requires theoretical frameworks that do not reduce women's health and illness experience into a disease. This philosophy incorporates explanations of health and empowers women to effectively and adequately deal with their situations. The major components incorporated into the development of sensitive care include:

- Gender is a central feature.
- Women's own voices and experiences are reflected.
- Diversities and complexities are incorporated into women's experiences.
- Theorists reflect about underlying androcentric and ethnocentric assumptions.
- Sociopolitical contexts and constraints of women's experiences are considered.
- Guidelines for practice with specific groups of women are provided.

GENDER AND SEXUAL MINORITIES

The gender and sexual minority (or GSM) population, also referred to as the LGBTQ+ community, is a diverse group that can be defined as a subculture. It includes gay men, lesbian women, bisexual persons, transgender individuals, and those questioning their sexual identity, among others. The GSM population is diverse, representing all ages and all socioeconomic, ethnic, educational, and religious backgrounds. The population has been described as "hidden and invisible," "marginalized," and "stigmatized." As a result, the unique health and safety needs of the population have often been overlooked or ignored. Clear definitions of the concepts related to sexual identity will be helpful. The following is a glossary of terms used in discussions of this group [164; 165; 166; 167; 168; 169]:

Asexual/aromantic: An individual who does not experience sexual attraction. There is considerable diversity in individuals' desire (or lack thereof) for romantic or other relationships.

Bisexual: An adjective that refers to people who relate sexually and affectionately to both women and men.

Coming-out process: A process by which an individual, in the face of societal stigma, moves from denial to acknowledging their sexual or gender identity. Successful resolution leads to self-acceptance. Coming out is a lifelong process for lesbian, gay, bisexual, and transgender persons and their families and friends as they begin to tell others at work, in school, at church, and in their communities.

Gay: The umbrella term for GSM persons, although it most specifically refers to men who are attracted to and love men. It is equally acceptable and more accurate to refer to gay women as "lesbians."

Gender and sexual minorities (or GSM): A term meant to encompass lesbian, gay, bisexual, trans, queer/questioning, intersex/intergender, asexual/ally (LGBTQIA) people as well as less well-recognized groups, including aromantic, two-spirited, and gender-fluid persons.

Heterosexism: An institutional and societal reinforcement of heterosexuality as the privileged and powerful norm.

Heterosexuality: Erotic feelings, attitudes, values, attraction, arousal, and/or physical contact with partners of the opposite gender.

Homophobia: A negative attitude or fear of nonstraight sexuality or GSM individuals. This may be internalized in the form of negative feelings toward oneself and self-hatred. Called "internalized homophobia," it may be manifested by fear of discovery, denial, or discomfort with being LGBTQIA, low self-esteem, or aggression against other lesbians and gay men.

Homosexuality: The "persistent sexual and emotional attraction to members of one's own gender" as part of the continuum of sexual expression. This is an outdated term that is now considered derogatory and offensive.

LGBTQIA: An acronym used to refer to the lesbian, gay, bisexual, transgender, queer/questioning, intersex/intergender, asexual/ally community. In some cases, the acronym may be shortened for ease of use or lengthened for inclusivity. Members of this group may also be referred to as gender and sexual minorities.

Queer: An umbrella term to describe persons with a spectrum of identities and orientations that are outside of the heteronormative standard.

Sexual identity: The inner sense of oneself as a sexual being, including how one identifies in terms of gender and sexual orientation.

Sexual orientation: An enduring emotional, romantic, sexual, and/or affectionate attraction to another person. Individuals may experience this attraction to someone of the same gender, the opposite gender, both genders, or gender nonconforming.

Transgender: Generally, an umbrella term for those whose gender identity or expression is different than that typically associated with their assigned sex at birth, including transsexual individuals, androgynous people, crossdressers, genderqueers, and other gender nonconforming people who identify as transgender. Some, but not all, of these individuals desire to transition; some, but not all, desire medical changes to their bodies as part of this process. Sometimes abbreviated as trans or trans*.

Transgender man (transman): A transgender individual who, assigned female at birth, currently identifies as a man. It is important to note that these patients are men and do not require additional description unless medically necessary. Older terminology, including female-to-male transsexual or FTM, is generally considered insensitive.

Transgender woman (transwoman): A transgender individual who, assigned male at birth, currently identifies as a woman. It is important to note that these patients are women and do not require additional description unless medically necessary. Older terminology, including male-to-female transsexual or MTF, is generally considered insensitive.

One's intrapersonal acceptance or rejection of societal stereotypes and prejudices, the acceptance of one's self-identity as a sexual minority, and how much one affiliates with other members of the GSM community varies greatly among individuals [170]. It is important to acknowledge diversity within the GSM community by discussing "GSM populations" [171]. For example, it is understandable that a GSM population living in rural areas of the United States

would have little in common with a GSM population living in urban areas or or areas considered to be "gay-friendly." Additionally, mental health experts have suggested that "GSM community" symbolizes a single group of individuals who express their sexuality differently than the majority of heterosexual individuals. However, many distinct communities have been identified, including lesbian, gay, bisexual, and transgender [172]. Each community is different from the other as well as different from the heterosexual community. A culturally competent healthcare provider should keep this diversity in mind so that vital differences among these smaller groups are not lost when thinking of the GSM population in general.

Commonalities exist among the GSM communities as well. For example, many adolescents, whether gay, lesbian, bisexual, transgender, or questioning their sexual identity, lack sexual minority role models to assist with successful psychosocial development [172].

The subtle and pervasive ways that discomfort with GSM individuals may be manifested have been examined and, in some instances, categorized as "cultural heterosexism," which is characterized by the stigmatization in thinking and actions found in our nation's cultural institutions, such as the educational and legal systems [173]. "Cultural heterosexism fosters individual antigay attitudes by providing a ready-made system of values and stereotypical beliefs that justify such prejudice as natural" [174]. Perhaps the paucity of information about the GSM community in basic professional education has been a reflection of cultural heterosexism. Writers, funding sources, and publishers have been exposed to the same cultural institutions for many years.

Individuals generally begin to absorb these institutional attitudes as children and may consequently develop "psychological heterosexism," which may also manifest as antigay prejudice. Many individuals, as children, have little contact with someone who is openly gay and, as a result, may not be able to associate homosexuality with an actual person. Instead, they may associate it with concepts such as "sin," "sickness," "predator," "outsider," or some other negative characteristic from which the individual wants to maintain distance [174]. Psychological heterosexism involves (among other factors) considering sexual identity and determining that one does not want to think further about it. The direction of this thinking is undeniably negative, resulting in an environment that allows antigay hostility [174]. The impact of antigay prejudice on the physical and mental health of members of the LGBTQIA community and their families should not be underestimated [175; 176].

Sexual minority individuals are not immune to societal attitudes and may internalize negative aspects of the antigay prejudice experience. Anxiety, depression, social withdrawal, and other reactions may result [177; 178]. While the study of psychological heterosexism, both blatant and subtle, is in the early stages of research, it has had a measurable impact on the mental health of the GSM community [179; 180; 181; 182].

Examples of the range of manifestations of heterosexism and/or homophobia in our society are readily available. Without difficulty, each example presented here may be conceptualized as related to the emotional or physical health of a GSM individual or family member:

- A kindergarten student calls another child an LGBTQ+ slur but does not really know what he is saying.
- A teenage girl allows herself to become pregnant, "proving" her heterosexuality to herself, her family, and her friends.
- A parent worries that her 12-year-old daughter is still a "tomboy."
- An office employee decides to place a photo of an old boyfriend in her office rather than a photo of her gender-nonconforming partner of five years.
- A college student buries himself in his studies in an effort to ignore his same-sex feelings and replace feelings of isolation.

- Two teenage girls, thought by peers to be transgender individuals, are assaulted and killed while sitting together in an automobile.
- A female patient is told by a healthcare provider that her haircut makes her look like a lesbian and is examined roughly.
- A gay man chooses not to reveal his sexual identity to his healthcare provider out of fear of a reduction or withdrawal of healthcare services.

The manifestations of heterosexism have inhibited our learning about the LGBTQIA population and its needs [171]. LGBTQ+ patients have feared open discussion about their health needs because of potential negative reactions to their self-disclosure. Prejudice has impacted research efforts by limiting available funding [170]. All of these factors emphasize that the healthcare education system has failed to educate providers and researchers about the unique aspects of LGBTQIA health [176; 183].

AGE

Older patients should be routinely screened for health and mental health conditions using tools specifically developed for this population, in spite of some practitioners' discomfort with asking questions about sensitive topics. These population-appropriate assessments may be included in other health screening tools [184].

Wellness and purpose have become important emphases when working with older adults [185]. In the past, aging was associated with disability, loss, decline, and a separation from occupational productivity. Although patient growth and positive change and development are values that practitioners embrace, the unconscious acceptance of societal myths and stereotypes of aging may prevent practitioners from promoting these values in elderly individuals [186].

Common Myths of Aging

Society holds several myths about older adults. Many of these myths may be easily disputed based on data from the U.S. Census and other studies.

Myth: Most older adults live alone and are isolated.

Fact: In 2021, 60% of adults 65 years of age and older were married. An estimated 27% lived alone and 24% are considered socially isolated. In 2016, an estimated 20% of the U.S. population lived in a household comprised of two adult generations or a grandparent or at least one other generation, compared with 12% in 1980. This multigenerational household trend particularly affects those 65 years and older, with 21% of these individuals living in multigenerational households in 2016. This group was second only to individuals 25 to 29 years of age, 33% of whom live in multigenerational households. Several factors have contributed to this trend, including growing racial and ethnic diversity and adults getting married later [188; 189].

Myth: Most older adults engage in very minimal productive activity.

Fact: In 2021, 10.6 million persons 65 years and older were employed or actively looking for work, and this population represents approximately 8% of the total labor force in the United States. Older adults are more engaged in self-employed activities than younger persons. In 2016, 16.4% of those 65 years of age and older were self-employed, compared with an average of 5.5% of those 16 years to 64 years of age [190; 191].

Myth: Life satisfaction is low among the elderly.

Fact: Data from the Berkeley Older Generation Study indicate that many elders are quite satisfied with their life. More than one-third of persons older than 59 years of age and 15% of those older than 79 years of age stated they were currently experiencing the best time in their lives. A 2022 survey study found that older adults had the highest levels of reported happiness of all the adults surveyed. Most of the factors that predict happiness for the young, such as good health and financial stability, also apply to the elderly. Older adults tend to report higher levels of well-being in part due to the quality of their social relationships [192; 193; 201].

PERSONS WITH MENTAL OR PHYSICAL DISABILITY

Americans with disabilities represent a large and heterogeneous segment of the population. The prevalence of disability varies by age group and definition. Based on the U.S. Census Bureau's 2013 American Community Survey, which describes disability in terms of functional limitations, 12.6% of the civilian U.S. noninstitutionalized population has a disability, defined as difficulty in hearing or vision, cognitive function, ambulation, self-care, or independent living [130]. The U.S. Department of Education, which uses categorical disability labels, estimates that 13% of children and youth 3 to 21 years of age have a disability (defined as specific learning disabilities, speech or language impairments, intellectual disability, emotional disturbance, hearing impairments, orthopedic impairments, other health impairments, visual impairments, multiple disabilities, deaf-blindness, autism, traumatic brain injury, or developmental delay) [130].

People with disabilities experience many health disparities. Some documented disparities include poorer self-rated health; higher rates of obesity, smoking, and inactivity; fewer cancer screenings (particularly mammography and Pap tests); fewer breast-conserving surgeries when breast cancer is diagnosed; and higher rates of death from breast or lung cancer [130].

Disability cultural competence requires appreciation of social model precepts, which recognize patients' rights to seek care that meets their expectations and values. The social model of disability has been characterized as centering disability as a social creation rather than an attribute of the patient [131]. As such, disability requires a social/political response in order to improve environmental factors affecting access and acceptance [131]. This involves adoption of person-first language, acknowledgement of social and environmental factors impacting persons abilities, and confronting disability-associated stigma.

VETERANS

The effects of military service and deployment to military combat on the individual and the family system are wide-reaching. According to the U.S. Department of Defense, there were 2.1 million current military personnel and 19 million veterans in 2021 [194; 195]. The Army has the largest number of active-duty members, followed by the Navy, the Air Force, the Marine Corps, and the Space Force [194]. Military service presents its own set of risk and protective factors for a variety of mental health issues, including post-traumatic stress disorder (or PTSD), traumatic brain injury (or TBI), depression and suicide, substance abuse, and interpersonal violence. In particular, transitioning from combat back to home life can be particularly trying for veterans and their families.

As the number of military conflicts and deployments has increased since 2001, the need to identify and provide better treatment to veterans and their families has become a greater priority. The first step in providing optimal care is the identification of veterans and veteran families during initial assessments, with an acknowledgement that veterans may be any sex/gender and are present in all adult age groups [195].

Unfortunately, veterans and military families often do not voluntarily report their military service in healthcare appointments. In 2015, the American Medical Association updated its recommendations for social history taking to include military history and veteran status [196]. In addition, the American Academy of Nursing has designed the Have You Ever Served? Initiative to encourage health and mental health professionals to ask their patients about military service and related areas of concern [197]. This program provides pocket cards, posters, and resource links for professionals working with veterans and their families. Recommended questions for intake include [197]:

- Have you or has someone close to you ever served in the military?
- When did you serve?

- Which branch?
- What did you do while you were in the military?
- Were you assigned to a hostile or combative area?
- Did you experience enemy fire, see combat, or witness casualties?
- Were you wounded, injured, or hospitalized?
- Did you participate in any experimental projects or tests?
- Were you exposed to noise, chemicals, gases, demolition of munitions, pesticides, or other hazardous substances?

CULTURALLY SENSITIVE PRACTICE

Communication and assessment are cornerstones of culturally sensitive practice. Efforts to ensure that patient communication and assessment is culturally responsive are essential to counteract implicit biases in health care.

CREATE A WELCOMING AND SAFE ENVIRONMENT

Improving access to care can be facilitated, in part, by providing a welcoming environment. The basis of establishing a safe and welcoming environment for all patients is security, which begins with inclusive practice and good clinician-patient rapport. Shared respect is critical to a patient's feeling of psychological well-being. Security can also be fostered by a positive and safe physical setting. For patients who are acutely ill, both the illness experience and treatment process can produce trauma. This is particularly true if involuntary detainment or hospitalization is necessary, but exposure to other individuals' narratives of experienced trauma or observing atypical behaviors from individuals presenting as violent, disorganized, or harmful to themselves can also be traumatic. As such, care environments should be controlled in a way to minimize traumatic stress responses. Providers should keep this in mind when structuring the environment (such as lighting and the arrangement of space), creating processes (including forms and the layout of appointments or care systems), and providing staff guidance. During each encounter, the patient's perception of safety is impacted by caretakers and ancillary staff.

Experts recommend the adoption and posting of a nondiscrimination policy that signals to both healthcare providers and patients that all persons will be treated with dignity and respect [153]. Also, checklists and records should include options for the patient defining their race/ethnicity, preferred language, gender expression, military service, and pronouns; this can help to better capture information about patients and be a sign of acceptance to that person. If appropriate, providers should admit their lack of experience with patient subgroups and seek guidance from patients regarding their expectations of the visit.

Front office staff should avoid discriminatory language and behaviors. For example, staff should avoid using gender-based pronouns, both on the phone and in person. Instead of asking, "How may I help you, sir?" the staff person could simply ask, "How may I help you?" Offices that utilize electronic health records should have a system to track and record the gender, name, and pronoun of all patients. This can be accomplished by standardizing the notes field to document a preferred name and pronoun for all patients [154]. Some persons who identify as nonbinary or gender-nonconforming may prefer that plural pronouns be used.

Part of ensuring that the healthcare environment is welcoming and safe is how an intake or assessment is conducted. Questions should be framed in ways that do not make assumptions about a patient's culture, gender identity, sexual orientation, or behavior. Language should be inclusive, allowing the patient to decide when and what to disclose. Assurance of confidentiality should be stressed to the patient to allow for a more open discussion, and confidentiality should be ensured if a patient is being referred to a different healthcare provider.

Asking open-ended questions can be helpful during a history and physical.

The FACT acronym may be helpful for healthcare providers. Providers should:

- **F**ocus on those health issues for which the individual seeks care.
- **A**void intrusive behavior.
- **C**onsider people as individuals.
- **T**reat individuals according to their gender.

Training office staff to increase their knowledge and sensitivity toward persons will also help facilitate a positive experience for patients.

CULTURALLY SENSITIVE COMMUNICATION

More generally, culturally sensitive communication is an essential aspect of providing any type of culturally responsive care. Let's look more closely at how culture can affect approaches to communication. Communication, the process of sending a message from one party to another, consists of both verbal and nonverbal components. Verbal and nonverbal communications are embedded within the culture of the parties disseminating the information and within the culture of the parties receiving the information. Communication is complex and multilayered because it involves unstated, implicit rules about a variety of factors, including physical distance between parties, tone of voice, acceptable topics of discussion, physical contact, and amount of eye contact [132]. Each of these variables is influenced by the perception of the level of formality/informality of the situation. Frequently, misunderstandings occur because the decoding and interpretation of these nonverbal cues are not accurate.

The verbal component of communication is just as complicated. Certainly, similarity in language shared by both parties enhances communication, but assuming that both parties in a conversation speak the same language, how the information is interpreted is still influenced by a host of factors. Linguists have posited that approximately 14,000 different meanings and interpretations can be extracted from the 500 most common English words [133]. Consequently, practitioners must be aware of the different communication styles held by diverse patients, as the clinical communication process is the primary vehicle by which problems and solutions are identified and conveyed [134].

Styles of communication can be classified from high- to low-context [135]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [133; 136]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [132; 135]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in the conversation [133]. Consequently, low-context communicators listen with their ears and focus on what is being said [132; 135; 136]. Western culture, including the United States, can be classified as a low-context culture. On the other hand, groups from collectivistic cultures, such as Asian/Pacific Islanders, Hispanic individuals, Native Americans, and African Americans, are from high-context cultures [135].

Communicators from high-context cultures generally display the following characteristics [132; 133; 136; 137]:

- Use of indirect modes of communication
- Use of vague descriptions
- Less talk and less eye contact
- Interpersonal sensitivity
- Use of feelings to facilitate behavior
- Assumed recollection of shared experiences
- Reliance on nonverbal cues such as gestures, tone of voice, posture, voice level, rhythm of speaking, emotions, and pace and timing of speech
- Assimilation of the "whole" picture, including visual and auditory cues
- Emotional speech
- Use of silence
- Use of more formal language, emphasizing hierarchy between parties

On the other hand, low-context communicators can typically be described as [132; 133; 136]:

- Employing direct patterns of communication
- Using explicit descriptions and terms
- Assuming meanings are described explicitly
- Utilizing and relying minimally on nonverbal cues
- Speaking more and often raising their voices—more animated, dramatic
- Often being impatient to get to the point of the discussion
- Using more informal language; less emphasis on hierarchy, more equality between parties (more friendly)
- Being more comfortable with fluidness and change
- Uncomfortable using long pauses and storytelling as a means of communicating

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. For example, a Chinese American man may not necessarily be a high-context communicator because he is Asian. A host of factors, such as level of acculturation, upbringing and socialization, education, and family immigration history, will all play a role in how one learns to communicate. Third, a major criticism of the discussion of low-/high-context cultures is that it reinforces dualism and ultimately oversimplifies the complexities and nuances of communication [138].

Learning to communicate effectively also requires an understanding of how different conversational traits influence the communication process, or how information is conveyed and interpreted. Again, the goal of this section is not to simply dichotomize individuals' conversational styles into categories, but rather to understand the factors that play a role in how someone makes a decision on how to communicate [132].

As long as there are two parties involved in a conversation, nonverbal communication is inevitable, and it becomes salient particularly when it is processed from one culture to another. Nonverbal communication is any behavior (including gestures, posture, eye contact, facial expressions, and body positions) that transcends verbal or written forms of communication [139]. Nonverbal communication can enhance or reinforce what is said verbally, and conversely, it can completely contradict the message communicated verbally. It can also end up replacing what was verbally communicated if both parties do not share a native language [140].

As discussed, in Western culture, communication is more direct and eye contact is highly valued. When eye contact is not maintained, many from Western cultures assume that the party is hiding pertinent information. However, in some cultures, reducing eye contact is a sign of respect [134]. Conversely, patients may interpret direct and indirect gazes differently. For example, in one study, Japanese individuals tended to rate faces with a direct gaze as angry and less pleasant compared with Finnish participants [141].

The amount of social space or distance between two communicating parties is culturally charged as well. Depending upon the social context, those from low-context cultures tend to maintain a distance of about three feet, or an arm's length, in conversations [133]. In a public setting, where both parties are engaged in a neutral, nonpersonal topic, those from low-context cultures will feel encroached upon and uncomfortable if an individual maintains a closer conversational distance. However, in other cultures, such as Latino and Middle Eastern, a closer distance would be the norm [133]. In a clinical setting, practitioners should allow patients to set the tone and social distance [142]. For example, the practitioner can sit first and permit the patient to select where they want to sit.

In the United States, about one out of five people speaks a language other than English at home [198]. Identifying a patient's preferred language is clearly important for providing culturally competent care. If you speak a language that is different from your patient, you may not be able to accurately identify the patient's problem or concern, make sure the patient understands explanations, or help the patient with their healthcare needs. However, note that cultural competence and language fluency are not the same thing.

Consider the following points to assess how you interact with patients who are not proficient in English:

- A limited proficiency in English does not reflect a patient's level of intellectual functioning.
- A limited ability to speak the language of the dominant culture has no bearing on a patient's ability to communicate effectively in their language of origin.
- A patient may or may not be literate in their language of origin or English.
- There are many different dialects or language variations that may alter a patient's interpretation of a prescription or instructions.

Start by identifying the patient's preferred language. Patients may be bilingual but prefer, and have a higher health literacy, in one language over the other when discussing their health care. To avoid confusion, simply ask the patient, "In what language do you prefer to discuss your health care?" Some state departments of health or social services provide language identification cards (also referred to as "I Speak" cards) that help identify what language an individual speaks and identify what language an interpreter will need to speak to communicate effectively with that individual.

Cross-cultural communication is by no means simple, and there is no set of rules to merely abide by. Instead, promoting culturally sensitive communication is an art that requires practitioners to self-reflect, be self-aware, and be willing to learn. As practitioners become skilled in noticing nonverbal behaviors and how they relate to their own behaviors and emotions, they will be more able to understand their own level of discomfort and comprehend behavior from a cultural perspective [132].

CULTURALLY SENSITIVE ASSESSMENT GUIDELINES

Practitioners should seek to understand the sociopolitical context of the origin country [151]. A migration narrative is also recommended, whereby an individual provides a story of their migration history. Asking about how long the family has been in the United States, who immigrated first, who was left behind, and what support networks are lacking gives the practitioner an overview of the individual's present situation [152]. The theme of loss is very important to explore. Types of losses may include family and friends left behind, social status, social identity, financial resources, and familiarity [152]. For refugees and newly immigrated individuals and families, assessment of basic needs (like food, housing, and transportation) is necessary [151].

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. Practitioners should work to recognize that there are a host of factors that contribute to patients' multiple identities, including race, gender, socioeconomic status, ability, and religion [130].

Practitioners may be categorized as either disease-centric or patient-centric [143]. Disease-centered practitioners are concerned with sign/symptom observation and, ultimately, diagnosis. On the other hand, patient-centered practitioners focus more on the patient's experience of the illness, subjective descriptions, and personal beliefs [143]. Patient-centered practice involves culturally sensitive assessment. It allows practitioners to move assessment and practice away from a pathology-oriented model

and instead acknowledge the complex transactions of the individual's movement within, among, and between various systems [144].

Practitioners who engage in culturally sensitive assessment nonjudgmentally obtain information related to the patient's cultural beliefs, overall perspective, and specific health beliefs [145]. They also allow the patient to control the timing [146].

The goal is to avoid the tendency to misinterpret health concerns of minority patients. Panos and Panos have developed a qualitative culturally sensitive assessment process that focuses on several domains [145]. Each domain includes several questions a practitioner may address in order to ensure that he or she is providing culturally responsive care.

Alternatively, Kleinman suggests that the practitioner ask the patient what he or she thinks is the nature of the problem [147]. He highlights the following types of questions that may be posed to the patient [147]:

- Why has the illness/problem affected you?
- Why has the illness had its onset now?
- What course do you think the illness will follow?
- How does the illness affect you?
- What do you think is the best or appropriate treatment? What treatment do you want?
- What do you fear most about the illness and its treatment?

Similar to Kleinman's culturally sensitive assessment questions, Galanti has proposed the 4 Cs of Culture [148]:

- What do you call the problem?
- What do you think caused it?
- How do you cope with the problem?
- What questions or concerns do you have about the problem or treatment?

Pachter proposed a dynamic model that involves several tiers and transactions, similar to Panos and Panos' model [149]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional must be willing to acknowledge that they do not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups they come in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [149]. Pachter advocates the notion that there is tremendous diversity within groups. Often, there are many intersecting variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the patient and the professional [149]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. The professional might recommend a combination of alternative and Western treatments.

Persons who have recently immigrated to the United States will have unique assessment needs. Beckerman and Corbett further recommend that recently immigrated families be assessed for [150]:

- Coping and adaptation strengths
- Issues of loss and adaptation
- The structure of the family in terms of boundaries and hierarchies after immigration
- Specific emotional needs
- Acculturative stress and conflict for each family member

Effective communication is the cornerstone of optimum medical and mental health care, and this is true for all patients, regardless of culture, language, age, ability, and identity. By taking steps to ensure that all patients are engaged in their care and have been able to provide information about their condition, you are on the road to providing culturally responsive care.

ROLE OF INTERPROFESSIONAL COLLABORATION AND PRACTICE AND IMPLICIT BIASES

All healthcare providers work in systems and with other providers. Working effectively and collaboratively with your colleagues will allow for more diverse perspectives, strengths, and resources.

The study of implicit bias is appropriately interdisciplinary, representing social psychology, medicine, health psychology, neuroscience, counseling, mental health, gerontology, LGBTQ+ studies, religious studies, and disability studies [13]. Therefore, implicit bias empirical research and curricula training development lends itself well to interprofessional collaboration and practice (or ICP).

One of the core features of ICP is sharing—professionals from different disciplines share their philosophies, values, perspectives, data, and strategies for planning of interventions [97]. ICP also involves the sharing of roles, responsibilities, decision making, and power [98]. Everyone on the team employs their expertise, knowledge, and skills, working collectively on a shared, patient-centered goal or outcome [98; 99].

Another feature of ICP is interdependency. Instead of working in an autonomous manner, each team member's contributions are valued and maximized, which ultimately leads to synergy [97]. At the heart of this are two other key features: mutual trust/respect and communication [99]. In order to share responsibilities, the differing roles and expertise are respected.

Experts have recommended that a structural or critical theoretical perspective be integrated into core competencies in healthcare education to teach providers about implicit bias, racism, and health disparities [100]. This includes [100]:

- Values/ethics: The ethical duty for health professionals to partner and collaborate to advocate for the elimination of policies that promote the perpetuation of implicit bias, racism, and health disparities among marginalized populations.
- Roles/responsibilities: One of the primary roles and responsibilities of health professionals is to analyze how institutional and organizational factors promote racism and implicit bias and how these factors contribute to health disparities. This analysis should extend to include one's own position in this structure.
- Interprofessional communication: Ongoing discussions of implicit bias, perspective taking, and counter-stereotypical dialogues should be woven into day-to-day practice with colleagues from diverse disciplines.
- Teams/teamwork: Health professionals should develop meaningful contacts with marginalized communities in order to better understand whom they are serving.

Adopting approaches from the fields of education, gender studies, sociology, psychology, and race/ethnic studies can help build curricula that represent a variety of disciplines [78]. Providers can learn about and discuss implicit bias and its impact, not simply from a health outcomes perspective but holistically. Skills in problem-solving, communication, leadership, and teamwork should be included, so providers can effect positive social change [78].

CONCLUSION

In the more than three decades since the introduction of the IAT, the implicit bias knowledge base has grown significantly. It is clear that most people in the general population hold implicit biases, and health professionals are no different. While there continue to be controversies regarding the nature, dynamics, and etiology of implicit biases, it should not be ignored as a contributor to health disparities, patient dissatisfaction, and suboptimal care. Given the complex and multifaceted nature of this phenomenon, the solutions to raise individuals' awareness and reduce implicit bias are diverse and evolving.

This webinar has introduced and discussed not only implicit bias but also the ways in which healthcare professionals can work to minimize the effects of bias on health care and outcomes. We are excited to hear how you incorporate this knowledge into your practice.

interactive activity

Now that you've finished reading through this webinar, reflect on your own experiences or observations with barriers and disparities in access to and delivery of healthcare services.

Also, we ask that you take the time now to complete the same IAT that you completed earlier (https://implicit.harvard.edu/implicit). Compare your test results. Did your results change? How do you think differently about implicit bias now compared to before you took this course?

RESOURCES

Implicit bias and culturally responsive health care are complex subjects. The following resources are provided in the event that you are interested in further exploring the topic, or even trying some of the approaches discussed in this webinar.

American Bar Association
Diversity and Inclusion Center
Toolkits and Projects
https://www.americanbar.org/groups/diversity/resources/toolkits

National Implicit Bias Network
https://implicitbias.net/resources/resources-by-category

The Ohio State University
The Women's Place: Implicit Bias Resources
https://womensplace.osu.edu/resources/implicit-bias-resources

The Ohio State University
Kirwan Institute for the
Study of Race and Ethnicity
http://kirwaninstitute.osu.edu

University of California, Los Angeles
Equity, Diversity, and Inclusion: Implicit Bias
https://equity.ucla.edu/know/implicit-bias

University of California, San Francisco,
Office of Diversity and Outreach
Unconscious Bias Resources
https://diversity.ucsf.edu/resources/unconscious-bias-resources

Unconscious Bias Project
https://unconsciousbiasproject.org

MINDFULNESS RESOURCES

University of California,
San Diego Center for Mindfulness
https://medschool.ucsd.edu/som/fmph/research/mindfulness

University of California, Los Angeles Guided Meditations
https://www.uclahealth.org/marc/mindful-meditations

Mindful: Mindfulness for Healthcare Professionals
https://www.mindful.org/mindfulhome-mindfulness-for-healthcare-workers-during-covid

interactive activity

At the beginning of this course, you rated your agreement with the following statements. Consider these statements once again and compare your scores.

Strongly Agree: 6 points; Agree: 5 points; Somewhat Agree: 4 points; Somewhat Disagree: 3 points; Disagree: 2 points; Strongly Disagree: 1 point

1. Everyone has implicit bias.
2. Bias is a part of my subconscious.
3. Bias is pervasive in the health care system.
4. Implicit bias is deeply rooted to positive and negative stereotypes that affect our understanding, actions, motives, and decisions we make on a daily basis.
5. I have a specific plan to overcome biases that show up when interacting with patients.

Has your understanding, feelings, and/or appreciation changed?

Adapted from an assessment developed by the Center for Black Educator Development

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

Works Cited

1. Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. Washington, DC: National Academies Press; 2003.
2. Amodio DM. The social neuroscience of intergroup relations. *Eur Rev Soc Psychol.* 2008;19(1):1-54.
3. The Joint Commission, Division of Health Care Improvement. Quick Safety 23: Implicit Bias in Health Care. Available at https://www.jointcommission.org/-/media/tjc/documents/newsletters/quick-safety-issue-23-apr-2016-final-rev.pdf. Last accessed May 23, 2023.
4. Edgoose J, Quiogue M, Sidhar K. How to identify, understand, and unlearn implicit bias in patient care. *Fam Pract Manag.* 2019;26(4):29-33.
5. Georgetown University National Center for Cultural Competence. Conscious and Unconscious Biases in Health Care. Available at https://nccc.georgetown.edu/bias. Last accessed May 23, 2023.
6. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics.* 2017;18(1):19.
7. Blair IV, Steiner JF, Havranek EP. Unconscious (implicit) bias and health disparities: where do we go from here? *Perm J.* 2011;15(2):71-78.
8. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health.* 2015;105(12):e60-e76.
9. Matthew DB. Toward a structural theory of implicit racial and ethnic bias in health care. *Health Matrix.* 2015;5(1):61-85.
10. Baron AS, Banaji MR. The development of implicit attitudes: evidence of race evaluations from ages 6 and 10 and adulthood. *Psychol Sci.* 2006;17(1):53-58.
11. Ogungbe O, Mitra AK, Roberts JK. A systematic review of implicit bias in health care: a call for intersectionality. *IMC Journal of Medical Science.* 2019;13(1):1-16.
12. Georgetown University National Center for Cultural Competence. What the Literature Is Telling Us. Available at https://nccc.georgetown.edu/bias/module-2/2.php. Last accessed May 23, 2023.
13. FitzGerald C, Martin A, Berner D, Hurst S. Interventions designed to reduce implicit prejudices and implicit stereotypes in real world contexts: a systematic review. *BMC Psychol.* 2019;7(1):29.
14. DeAngeles T. In Search of Cultural Competence. Available at https://www.apa.org/monitor/2015/03/cultural-competence. Last accessed May 23, 2023.
15. Lekas H-M, Pahl K, Lewis CF. Rethinking cultural competence: shifting to cultural humility. *Health Services Insights.* 2020;13:1178632920970580.
16. Velott D, Sprow FK. Toward health equity: mindfulness and cultural humility as adult education. *New Directions for Adult & Continuing Education.* 2019;161:57-66.
17. Allport GW. *The Nature of Prejudice.* New York, NY: Bacon Press; 1954.
18. Feagin J, Feagin CBR. *Racial and Ethnic Relations.* 9th ed. Boston, MA: Pearson; 2011.
19. Essed P. *Everyday Racism: Reports for Women of Two Cultures.* Dutch ed. Claremont, CA: Hunter House; 1990.
20. Lum D. *Culturally Competent Practice: A Framework for Understanding Diverse Groups and Justice Issues.* 4th ed. Belmont, CA: Cengage; 2010.
21. Baker DL, Schmaling K, Fountain KC, Blume AW, Boose R. Defining diversity: a mixed-method analysis of terminology in faculty applications. *The Social Science Journal.* 2016;53(1):60-66.
22. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev.* 1991;43(6):1241-1299.
23. Diller JV. *Cultural Diversity: A Primer for the Human Services.* 5th ed. Stamford, CT: Cenage Learning; 2014.
24. Gasner B, McGuigan W. Racial prejudice in college students: a cross-sectional examination. *College Student Journal.* 2014;48(2):249-256.
25. Kitano HHL. *Race Relations.* 5th ed. Upper Saddle River, NJ: Prentice Hall; 2007.
26. Harawa NT, Ford CL. The foundation of modern racial categories and implications for research on Black/White disparities in health. *Ethn Dis.* 2009;19(2):209-217.
27. Ross JP. The indeterminacy of race: the dilemma of difference in medicine and health care. *Soc Theory Health.* 2016;15(1):1-24.
28. Okazaki S, Saw A. Culture in Asian American community psychology: beyond the East-West binary. *Am J Community Psychol.* 2011;47(1-2):144-156.
29. Wijeyesinghe CL, Griffin P, Love B. Racism-curriculum design. In: Adams M, Bell LA, Griffin P (eds). *Teaching for Diversity and Social Justice.* 2nd ed. New York, NY: Routlege; 2007: 123-144.
30. Quillian L. Does unconscious racism exist? *Soc Psychol* Q. 2008;71(1):6-11.
31. Gee G, Ford C. Structural racism and health inequities: old issues, new directions. *Du Bois Review: Social Science Research on Race.* 2011;8(1):115-132.

32. Johnson TJ. Intersection of bias, structural racism, and social determinants with health care inequities. *Pediatrics*. 2020;146(2):e2020003657.
33. Greenwald AG, McGhee DE, Schwartz JLK. Measuring individual differences in implicit cognition: the Implicit Association Test. *Journal of Personality and Social Psychology*. 1998;74(6):1464-1480.
34. Blair IV, Steiner FJ, Fairclough DL, et. al. Clinicians implicit ethnic/racial bias and perceptions of care among Black and Latino patients. *Ann Fam Med*. 2013;11(1):43-52.
35. Dehon E, Weiss N, Jones J, Faulconer W, Hinton E, Sterling S. A systematic review of the impact of physician implicit racial bias on clinical decision making. *Acad Emerg Med*. 2017;24(8):895-904.
36. Lai CK, Wilson ME. Measuring implicit intergroup biases. *Soc Personal Psychol Compass*. 2020;15(1).
37. Tinkler JE. Controversies in implicit race bias research. *Sociol Compass*. 2012;6(12):987-997.
38. Forscher PS, Lai CK, Axt JR, et al. A meta-analysis of procedures to change implicit measures. *J Per Soc Psychol*. 2019;117(3):522-559.
39. Nosek BA, Smyth FL, Hansen JJ, Devos T, Lindner NM, Ranganath KA. Pervasiveness and correlates of implicit attitudes and stereotypes. *Eur Rev Soc Psychol*. 2007;18:36-88.
40. Morin R. Exploring Racial Bias Among Biracial and Single-Race Adults: The IAT. Available at https://www.pewresearch.org/social-trends/2015/08/19/exploring-racial-bias-among-biracial-and-single-race-adults-the-iat. Last accessed May 23, 2023.
41. Bertrand M, Mullainathan S. Are Emily and Greg more employable than Lakisha and Jamal? A field experiment on labor market discrimination. *Am Econ Rev*. 2004;94:991-1013.
42. Hansen M, Schoonover A, Skarica B, Harrod T, Bahr N, Guise J-M. Implicit gender bias among U.S. resident physicians. *BMC Med Educ*. 2019;19(1):396.
43. Phelan SM, Dovidio JF, Puhl RM, et al. Implicit and explicit weight bias in a national sample of 4,732 medical students: the medical student changes study. *Obesity (Silver Spring)*. 2014;22(4):1201-1208.
44. Johnson TJ, Hickey RW, Switzer GE, et al. The impact of cognitive stressors in the emergency department on physician implicit racial bias. *Acad Emerg Med*. 2016;23(3):297-305.
45. National Center for States Courts. Strategies to Reduce the Influence of Implicit Bias. Available at https://horsley.yale.edu/sites/default/files/files/IB_Strategies_033012.pdf. Last accessed May 23, 2023.
46. Greenwald AG, Banaji MR. Implicit social cognition: attitudes, self-esteem, and stereotypes. *Psychological Review*. 1995;102(1):4-27.
47. Lucas HD, Creery JD, Hu X, Paller KA. Grappling with implicit social bias: a perspective from memory research. *Neuroscience*. 2019;406:684-697.
48. Gawronski B. Six lessons for a cogent science of implicit bias and its criticism. *Perspect Psychol Sci*. 2019;14(4):574-595.
49. Aronson E. Social cognition. In: Aronson E (ed). *Social Animal*. New York, NY: Worth Publishers; 2008: 117-180.
50. Roche JM, Arnold HS, Ferguson AM. Social judgments of digitally manipulated stuttered speech: cognitive heuristics drive implicit and explicit bias. *J Speech, Lang Hear Res*. 2020;63(10):3443-3452.
51. Kempf A. If we are going to talk about implicit race bias, we need to talk about structural racism: moving beyond ubiquity inevitability in teaching and learning about race. *The Journal of Culture and Education*. 2020;19(2):50.
52. De Houwer J. Implicit bias is behavior: a functional-cognitive perspective on implicit bias. *Perspect Psychol Sci*. 2019;14(5):835-840.
53. De Houwer J. What is Implicit Bias? Available at https://www.psychologytoday.com/us/blog/spontaneous-thoughts/201910/what-is-implicit-bias. Last accessed May 23, 2023.
54. Staats C. State of the Science: Implicit Bias Review, 2014. Available at https://kirwaninstitute.osu.edu/research/2014-state-science-implicit-bias-review. Last accessed May 23, 2023.
55. Reihl KM, Hurley RA, Taber KH. Neurobiology of implicit and explicit bias: implications for clinicians. *J Neuropsychiatry Clin Neurosci*. 2015;27(4):248-253.
56. Amodio DM. The neuroscience of prejudice and stereotyping. *Nat Rev Neurosci*. 2014;15:670-682.
57. Penner LA, Hagiwara N, Eggly S, Gaertner SL, Albrecht TL, Dovidio JF. Racial healthcare disparities: a social psychological analysis. *Eur Rev Soc Psychol*. 2013;24(1):70-122.
58. Wong Y-LR, Vinsky J. Beyond implicit bias: embodied cognition, mindfulness, and critical reflective practice in social work. *Australian Social Work*. 2021;74(2):186-197.
59. Castillo EG, Isom J, DeBonis KL, Jordan A, Braslow JT, Rohrbaugh R. Reconsidering systems-based practice: advancing structural competency, health equity, and social responsibility in graduate medical education. *Acad Med*. 2020;95(12):1817-1822.
60. Dehlendorf C, Bryant AS, Huddleston HG, Jacoby VL, Fujimoto VY. Health disparities: definitions and measurements. *Am J Obstet Gynecol*. 2010;202(3):212-213.
61. Centers for Disease Control and Prevention. Health Disparities Among Youth. Available at https://www.cdc.gov/healthyyouth/disparities/index.htm. Last accessed May 23, 2023.
62. Healthy People 2030. Questions and Answers. Available at https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9. Last accessed May 23, 2023.

63. National Center for Health Statistics. Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Available at https://www.cdc.gov/nchs/data/hus/hus15.pdf. Last accessed May 23, 2023.
64. National Center for Health Statistics. Life Expectancy. Available at https://www.cdc.gov/nchs/fastats/life-expectancy.htm. Last accessed May 23, 2023.
65. Roth LM, Henley MM. Unequal motherhood: racial-ethnic and socioeconomic disparities in cesarean sections in the United States. *Social Problems*. 2012;59(2):207-227.
66. Sagynbekov K. Gender-Based Health Disparities: A State-Level Study of the American Adult Population. Available at https://milkeninstitute.org/sites/default/files/reports-pdf/103017-Gender-BasedHealthDisparities.pdf. Last accessed May 23, 2023 .
67. Pharr JR, Kachen A, Cross C. Health disparities among sexual gender minority women in the United States: a population-based study. *Journal of Community Health.* 2019;44(4):721-728.
68. Haines KL, Zens T, Beems M, Rauh R, Jung HS, Agarwal S. Socioeconomic disparities in the thoracic trauma population. *J Surg Res.* 2018;224:160-165.
69. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities.*J Gen Intern Med*. 2013;28(11):1504-1510.
70. Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for Black and White patients. *J Gen Intern Med*. 2007;22(9):1231-1238.
71. Hagiwara N, Penner LA, Gonzalez R, et. al. Racial attitudes, physician-patient talk time ratio, and adherence in racially discordant medical interactions. *Soc Sci Med.* 2013;87:123-131.
72. Cooper LA, Roter DL, Carson KA, et al. The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health*. 2012;102(5):979-987.
73. Gonzalez CM, Deno ML, Kintzer E, Marantz PR, Lypson ML, McKee MD. Patient perspectives on racial and ethnic implicit bias in clinical encounters: implications for curriculum development. *Patient Education & Counseling*. 2018;101(9):1669-1675.
74. Teal CR, Gill AC, Green AR, Crandall S. Helping medical learners recognize and manage unconscious bias toward certain patient groups. *Med Educ*. 2012;46(1):80-88.
75. Bennett MJ. A developmental approach to training for intercultural sensitivity. *Int J Intercult Relat*. 1986;10(2):179-196.
76. Lain EC. Racialized interactions in the law school classroom: pedagogical approaches to creating a safe learning environment. *J Legal Educ*. 2018;67(3):780-801.
77. Sukhera J, Watling CA. A framework for integrating implicit bias recognition into health professions education. *Acad Med*. 2018;93(1):35-40.
78. Bennett CJ, Dielmann KM. Weaving the threat of implicit bias through health administration curricula to overcome gender disparities in the workforce. *J Health Adm Educ*. 2017:34(2): 277-294.
79. Sukhera J, Wodzinski M, Rehman M, Gonzalez CM. The Implicit Association Test in health professions education: a meta-narrative review.*Perspect Med Educ*. 2019;8(5):267-275.
80. Johnson R, Richard-Eaglin A. Combining SOAP notes with guided reflection to address implicit bias in health care. *J Nurs Educ*. 2020;59(1):59-59.
81. Zestcott CA, Blair IV, Stone J. Examining the presence, consequences, and reduction of implicit bias in health care: a narrative review. *Group Process Intergroup Relat*. 2016;19(4):528-542.
82. Devine PG, Forscher PS, Austin AJ, Cox WT. Long-term reduction in implicit race bias: a prejudice habit-breaking intervention. *J Exp Soc Psychol*. 2012;48(6):267-1278.
83. Todd AR, Bodenhausen GV, Richeson JA, Galinsky AD. Perspective taking combats automatic expressions of racial bias. *J Pers Soc Psychol*. 2011;100(6):1027-1042.
84. Drwecki BB, Moore CF, Ward SE, Prkachin KM. Reducing racial disparities in pain treatment: the role of empathy and perspective-taking. *Pain*. 2011;152(5):1001-1006.
85. Whitford DK, Emerson AM. Empathy intervention to reduce implicit bias in pre-service teachers. *Psychol Rep*. 2019;122(2):670-688.
86. Mayo Clinic. Consumer Health: Mindfulness Exercises. Available at https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/mindfulness-exercises/art-20046356. Last accessed May 23, 2023.
87. Narayan MC. Addressing implicit bias in nursing: a review. *American Journal of Nursing*. 2019;119(7):36-43.
88. Goldstein E. The STOP Practice for Stress. Available at https://www.mindful.org/the-s-t-o-p-practice-for-stress. Last accessed May 23, 2023.
89. Burgess DJ, Beach MC, Saha S. Mindfulness practice: a promising approach to reducing the effects of clinician implicit bias on patients. *Patient Educ Couns*. 2017;100(2):372-376.
90. Kang Y, Gray JR, Dovidio JF. The nondiscriminating heart: lovingkindness meditation training decreases implicit intergroup bias. *J Exp Psychol Gen*. 2014;143(3):1306-1313.
91. Tang Y-Y, Hölzel BK, Posner MI. The neuroscience of mindfulness meditation. *Nat Rev Neurosci*. 2015;16(4):213-225.

92. Blair IV, Ma JE, Lenton AP. Imagining stereotypes away: the moderation of implicit stereotypes through mental imagery. *J Pers Soc Psychol*. 2001;81(5):828-841.
93. Dasgupta N, Asgari, S. Seeing is Believing: exposure to counterstereotypic women leaders and its effect on the malleability of automatic gender stereotyping. *J Exp Soc Psychol*. 2004;40(5):642–658.
94. National Center for States Courts. Addressing Implicit Bias in the Courts. Available at https://www.nccourts.gov/assets/inline-files/public-trust-12-15-15-IB_Summary_033012.pdf?q_DMMIVv0v_eDJUa1ADxtw59Zt_svPgl. Last accessed May 23, 2023.
95. Applebaum B. Remediating campus climate: implicit bias training is not enough. *Studies in Philosophy & Education*. 2019;38(2): 129-141.
96. Byrne A, Tanesini A. Instilling new habits: addressing implicit bias in healthcare professionals. *Adv Health Sci Educ Theory Pract*. 2015;20(5):1255-1262.
97. D'Amour D, Oandasan I. Interprofessionality as the field of interprofessional practice and interprofessional education: an emerging concept. *J Interprof Care*. 2005;(Suppl 1):8-20.
98. Petri L. Concept analysis of interdisciplinary collaboration. *Nursing Forum*. 2010;45(2):73-82.
99. Lam AHY, Wong JTL, Ho ECM, Choi RYY, Fung MST. A concept analysis of interdisciplinary collaboration in mental healthcare. *COJ Nurse Healthcare*. 2017;1(2).
100. Cahn PS. How interprofessional collaborative practice can help dismantle systemic racism. *J Interprof Care*. 2020;34(4):431-434.
101. Healthy People 2030. Social Determinants of Health. Available at https://health.gov/healthypeople/priority-areas/social-determinants-health. Last accessed May 23, 2023.
102. Substance Abuse and Mental Health Services Administration. Improving Cultural Competence: Quick Guide for Clinicians. Available at https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf. Last accessed May 23, 2023.
103. Agency for Healthcare Quality and Research. Health Literacy Universal Precautions Toolkit, 2nd Edition. Available at https://www.ahrq.gov/health-literacy/improve/precautions/index.html. Last accessed May 23, 2023.
104. U.S. Census Bureau. About the Topic of Race Available at https://www.census.gov/topics/population/race/about.html. Last accessed at May 23, 2023.
105. U.S. Census Bureau. National Black (African American) History Month: February 2023. Available at https://www.census.gov/newsroom/facts-for-features/2023/black-history-month.html. Last accessed May 23, 2023.
106. U.S. Census Bureau. National African-American (Black) History Month: February 2018. Available at https://www.census.gov/newsroom/facts-for-features/2018/black-history-month.html. Last accessed May 23, 2023.
107. Tamir C. The Growing Diversity of Black America: 46.8 Million People in the U.S. Identify as Black. Available at https://www.pewresearch.org/social-trends/2021/03/25/the-growing-diversity-of-black-america. Last accessed May 23, 2023.
108. American Psychiatric Association. Working with African American/Black Patients. Available at https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights/best-practice-highlights-for-working-with-african-american-patients. Last accessed May 23, 2023.
109. U.S. Census Bureau. Asian American, Native Hawaiian and Pacific Islander Heritage Month: May 2023. Available at https://www.census.gov/newsroom/facts-for-features/2021/asian-american-pacific-islander.html. Last accessed May 23, 2023.
110. Budiman A, Ruiz NG. Asian Americans are the Fastest-Growing Racial or Ethnic Group in the U.S. Available at https://www.pewresearch.org/fact-tank/2021/04/09/asian-americans-are-the-fastest-growing-racial-or-ethnic-group-in-the-u-s. Last accessed May 23, 2023.
111. Pew Research Center. U.S. Hispanic Population Growth has Leveled Off. Available at https://www.pewresearch.org/fact-tank/2017/08/03/u-s-hispanic-population-growth-has-leveled-off. Last accessed May 23, 2023.
112. Pew Research Center. Demographics of Asian Americans. Available at https://www.pewresearch.org/social-trends/2013/04/04/asian-groups-in-the-u-s. Last accessed May 23, 2023.
113. Ong P, Ong E. The Future of Asian America in 2040 Asian American Electorate to Double. Available at https://luskin.ucla.edu/sites/default/files/AA2040_report.pdf. Last accessed May 23, 2023.
114. Lee E. Asian American families: an overview. In: McGoldrick M, Giordano J, Pearce JK (eds). *Ethnicity and Family Therapy*. 2nd ed. New York, NY: The Guilford Press; 1996: 227-248.
115. U.S. Census Bureau. We the People: Asians in the United States: Census 2000 Special Reports. Available at http://www.u.arizona.edu/~jag/Census-Asians-2000Rpt.pdf. Last accessed May 23, 2023.
116. Lee E. *Working with Asian Americans: A Guide for Clinicians*. New York, NY: The Guilford Press; 1997.
117. U.S. Census Bureau. Hispanic Heritage Month 2022. Available at https://www.census.gov/newsroom/facts-for-features/2022/hispanic-heritage-month.html. Last accessed May 23, 2023.
118. Pew Research Center. 2015, Hispanic Population in the United States Statistical Portrait. Available at https://www.pewresearch.org/hispanic/2017/09/18/2015-statistical-information-on-hispanics-in-united-states-trend-data. Last accessed May 23, 2023.
119. Pew Hispanic Center. Hispanic Origin Profiles, 2010. Available at https://www.pewresearch.org/hispanic/2012/06/27/country-of-origin-profiles. Last accessed May 23, 2023.

120. Kagawa Singer M, Dressler W, George S. Culture: the missing link in health research. *Soc Sci Med*. 2016;170:237-246.

121. Krogstad JM. Hispanics Have Accounted for More than Half of Total U.S. Population Growth Since 2010. Available at https://www.pewresearch.org/fact-tank/2020/07/10/hispanics-have-accounted-for-more-than-half-of-total-u-s-population-growth-since-2010. Last accessed May 23, 2023.

122. U.S. Census Bureau. We the People: American Indians and Alaska Natives in the United States. Available at https://www.census.gov/library/publications/2006/dec/censr-28.html. Last accessed May 23, 2023.

123. U.S. Census Bureau. Facts for Features: American Indian and Alaska Native Heritage Month: November 2022. Available at https://www.census.gov/newsroom/facts-for-features/2022/aian-month.html. Last accessed May 23, 2023.

124. U.S. Census Bureau. American Indian and Alaska Native Heritage Month: November 2017. Available at https://www.census.gov/newsroom/facts-for-features/2017/aian-month.html. Last accessed May 23, 2023.

125. Center for Disease Control and Prevention. Health of American Indian or Alaska Native Population. Available at https://www.cdc.gov/nchs/fastats/american-indian-health.htm. Last accessed May 23, 2023.

126. U.S. Census Bureau. QuickFacts: United States. Available at https://www.census.gov/quickfacts/fact/table/US/PST045221. Last accessed May 23, 2023.

127. Butler M, McCreedy E, Schwer N, et al. *Improving Cultural Competence to Reduce Health Disparities*. Rockville, MD: Agency for Healthcare Research and Quality; 2016.

128. U.S. Census Bureau. American Community Survey: B04006 People Reporting Ancestry. Available at https://data.census.gov/cedsci/table?q=ancestry&tid=ACSDT1Y2019.B04006. Last accessed May 23, 2023.

129. Bruine de Bruin W, Parker AM, Strough J. Age differences in reported social networks and well-being. *Psychology Aging*. 2020;35(2):159-168.

130. Braun FK, Fine ES, Greif DC, Devenny JM. Guidelines for multicultural assessment: an Asian Indian American case study. *J Multicult Couns Devel*. 2010;38(3):130-141.

131. Agaronnik N, Campbell EG, Ressalam J, Iezzoni LI. Exploring issues relating to disability cultural competence among practicing physicians. *Disabil Health J*. 2019;12(3):403-410.

132. Okun BF, Fried J, Okun ML. *Understanding Diversity: A Learning-As-Practice Primer*. Pacific Grove, CA: Brooks/Cole Publishing Co.; 1999.

133. Lynch EW, Hanson MJ (eds). *Developing Cross-Cultural Competence: A Guide for Working with Children and Their Families*. 4th ed. Baltimore, MD: Paul H. Brookes Publishing, Co.; 2011.

134. Ayonrinde O. Importance of cultural sensitivity in therapeutic transactions: considerations for healthcare providers. *Disease Management & Health Outcomes*. 2003;11(4):233-248.

135. Singh NN, Mckay JD, Singh AN. Culture and mental health: nonverbal communication. *J Child Fam Stud*. 1998;7(4):403-409.

136. Manrai LA, Manrai AK, Lascu D, Friedeborn S. Determinants and effects of cultural context: a review, conceptual model, and propositions. *Journal of Global Marketing*. 2019;32(2):67-82.

137. Gudykunst WB. *Asian American Ethnicity and Communication*. Thousand Oaks, CA: Sage; 2001.

138. Chang H, Chen L. Commonalities as an alternative approach to analyzing Asian Pacific communication. *Journal of Asian Pacific Communication*. 2015;25(1):1-21.

139. Herring RD. Nonverbal communication: a necessary component of cross-cultural counseling. *J Multicult Couns Devel*. 1990;18(4):172-179.

140. le Roux J. Effective educators are culturally competent communicators. *Intercultural Education*. 2002;13(1):37-48.

141. Akechi H, Senju A, Uibo H, et al. Attention to eye contact in the West and East: autonomic responses and evaluative ratings. *PLoS One*. 2013;8(3):e59312.

142. Chung DK. Asian cultural commonalities: a comparison with mainstream culture. In: Furuto S, Biswas R, Chung DK, Murase K, Ross-Sheriff F (eds). *Social Work Practice with Asian Americans*. Newbury Park, CA: Sage Publications; 1992: 27-44.

143. Castillo RJ. *Culture and Mental Illness: A Client-Centered Approach*. Pacific Groves, CA: Brooks/Cole Publishing Company; 1997.

144. Fong R, Furuto S (eds). *Culturally Competent Practice: Skills, Interventions, and Evaluations*. Needham Heights, MA: Allyn & Bacon; 2001.

145. Panos PT, Panos AJ. A model for a culture-sensitive assessment of patients in health care settings. *Soc Work Health Care*. 2000;31(1):49-62.

146. Fondacaro KM, Harder VS. Connecting cultures: a training model promoting evidence-based psychological services for refugees. *Training & Education in Professional Psychology*. 2014;8(4):320-327.

147. Kleinman A. *The Illness Narratives: Suffering, Healing and the Human Condition*. New York, NY: Basic Books; 1988.

148. Galanti GA. *Caring for Patients from Different Cultures*. 5th ed. Philadelphia, PA: University of Pennsylvania Press; 2015.

149. Pachter LM. Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. *JAMA*. 1994;271(9):690-695.

150. Beckerman NL, Corbett L. Immigration and families: treating acculturative stress from a systemic framework. *Fam Ther*. 2008;35(2):63-81.

151. Ellis BH, Abdi SM, Winer JP. Psychosocial assessment with refugee and immigrant youth and families. In: *Mental Health Practice with Immigrant and Refugee Youth: A Socioecological Framework*. Washington, DC: American Psychological Association; 2020: 53-76.

152. Weisman A, Feldman G, Gruman C, et al. Improving mental health services for Latino and Asian immigrant elders. *Prof Psychol Res Pr*. 2005;36(6):642-648.

153. Committee on Health Care for Underserved Women. Committee Opinion #512: health care for transgender individuals. *Obstet Gynecol*. 2011;118(6):1454-1458.

154. National LGBT Health Education Center. Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff. Available at https://www.lgbtagingcenter.org/resources/pdfs/13-017_TransBestPracticesforFrontlineStaff_v9_04-30-13.pdf. Last accessed May 23, 2023.

155. Addis M, Mahalik JR. Men, masculinity, and the contexts of help seeking. *Am Psychol*. 2003;58(1):5-14.

156. Courtenay WH. Key determinants of the health and well-being of men and boys. *Internat J Mens Health*. 2003;2(1):1-30.

157. Mahalik JR, Lagan HD, Morrison JA. Health behaviors and masculinity in Kenyan and US male college students. *Psychol Men Masculin*. 2006;7(4):191-202.

158. Mahalik JR, Burns SM, Syzdek M. Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Soc Sci Med*. 2007;64(11):2201-2209.

159. Galdas PM, Cheater F, Marshall P. Men and health help-seeking behaviour: literature review. *J Adv Nurs*. 2005;49(6):616-623.

160. Peerson A, Saunders M. Men's health literacy: advancing evidence and priorities. *Crit Pub Health*. 2009;19(3&4):441-456.

161. Kutner M, Greenberg E, Jin Y, Paulsen C. *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy*. Washington, DC: National Center for Education Statistics; 2006.

162. Peak T, Gast J, Ahlstrom D. A needs assessment of Latino men's health concerns. *Am J Mens Health*. 2010;4(1):22-32.

163. U.S. Department of Veterans Affairs. Spotlight: Gender Differences in Healthcare. Available at https://www.hsrd.research.va.gov/news/feature/gender_differences.cfm. Last accessed May 23, 2023.

164. Sears JT, Williams WL (eds). *Overcoming Heterosexism and Homophobia: Strategies That Work*. 1st ed. New York, NY: Columbia University Press; 1997.

165. Centers for Disease Control and Prevention. *The State of Aging and Health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services; 2013.

166. Williamson IR. Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research*. 2000;15(1):97-107.

167. Greenberg JS, Bruess CE, Conklin SC. Sexual orientation. In: Greenberg JS, Bruess CE, Conklin SC. *Exploring the Dimensions of Human Sexuality*. 4th ed. Sudberry, MA: Jones and Bartlett Publishers; 2011:352-356.

168. Centers for Disease Control and Prevention. Health Considerations for LGBTQ Youth. Available at https://www.cdc.gov/healthyyouth/disparities/health-considerations-lgbtq-youth.htm. Last accessed May 23, 2023.

169. National Center for Transgender Equality. Understanding Transgender People: The Basics. Available at https://transequality.org/issues/resources/understanding-transgender-people-the-basics. Last accessed May 23, 2023.

170. Dean L, Meyer IH, Robinson K, et al. Lesbian, gay, bisexual, and transgender health: findings and concerns. *J Gay Lesbian Med Assoc*. 2000;4(3):102-151.

171. Meyer IH. Why lesbian, gay, bisexual, and transgender public health? *Am J Public Health*. 2001;91(6):856-859.

172. Jones BE, Hill MJ. *Mental Health Issues in Lesbian, Gay, Bisexual, and Transgender Communities*. 1st ed. Washington, DC: American Psychiatric Publishing: 2002.

173. Perry B. The sociology of hate: theoretical approaches. In: Levin B, Iganski P, Blazak R, Lawrence FM. *Hate Crimes*. Volumes 1-5. Westport, CT: Greenwood Publishing Group, Inc.; 2009: 56-57.

174. Herek GM. The context of anti-gay violence: notes on cultural and psychological heterosexism. *J Interpersonal Violence*. 1990;5(3):316-333.

175. American Psychological Association Committee on Lesbian and Gay Concerns. Avoiding Heterosexual Bias in Language. Available at https://www.apa.org/pi/lgbt/resources/language. Last accessed May 23, 2023.

176. Like RC, Steiner RP, Rubel AJ. Society of Teachers of Family Medicine (STFM) Core Curriculum Guidelines: recommended core curriculum guidelines on culturally sensitive and competent health care. *Fam Med*. 1996;28(4):291-297.

177. Baker K, Beagan B. Making assumptions, making space: an anthropological critique of cultural competency and its relevance to queer patients. *Med Anthropol Q*. 2014;28(4):578-598.

178. O'Hanlan KA, Cabaj RP, Schatz B, Lock J, Nemrow P. A review of the medical consequences of homophobia with suggestions for resolution. *J Gay Lesbian Med Assoc*. 1997;1(1):25-39.

179. Kitzinger C. Speaking of oppression: psychology, politics, and the language of power. In: Rothblum ED, Bond LA (eds). *Preventing Heterosexism and Homophobia*. Thousand Oaks, CA: Sage Publications; 1996.

180. Matthews CR, Adams EM. Using a social justice approach to prevent the mental health consequences of heterosexism. *J Prim Prev*. 2009;30(1):11-26.

181. Hong JS, Woodford MR, Long LD, Renn KA. Ecological covariates of subtle and blatant heterosexist discrimination among LGBQ college students. *J Youth Adolesc*. 2016;45(1):117-131.

182. Woodford MR, Kulick A, Sinco BR, Hong JS. Contemporary heterosexism on campus and psychological distress among LGBQ students: the mediating role of self-acceptance. *Am J Orthopsychiatry*. 2014;84(5):519-529.

183. Misener TR, Sowell RL, Phillips KD, Harris C. Sexual orientation: a cultural diversity issue for nursing. *Nurs Outlook*. 1997;45(4):178-181.

184. Willenbring M, Spring WD Jr. Evaluating alcohol use in elders. *Aging*. 1990;361:22-27.

185. Greene RR, Cohen HL. Social work with older adults and their families: changing practice paradigms. *Fam Soc*. 2005;86(3):367-374.

186. Koenig T, Spano R. Professional hope in working with older adults. *J Sociol Soc Welf*. 2006;33(2):25-44.

187. Administration for Community Living. 2021 Profile of Older Americans. Available at https://acl.gov/sites/default/files/Profile%20of%20OA/2021%20Profile%20of%20OA/2021ProfileOlderAmericans_508.pdf. Last accessed May 17, 2023.

188. Pew Research Center. The Return of the Multi-Generational Family Household. Available at https://www.pewresearch.org/social-trends/2010/03/18/the-return-of-the-multi-generational-family-household. Last accessed May 22, 2023.

189. Pew Research Center. A Record 64 Million Americans Live in Multigenerational Households. Available at https://www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households. Last accessed May 22, 2023.

190. U.S. Senate. America's Aging Workforce: Opportunities and Challenges. Available at https://www.aging.senate.gov/imo/media/doc/Aging%20Workforce%20Report%20FINAL.pdf. Last accessed May 23, 2023.

191. Toossi M, Torpey E. Older Workers: Labor Force Trends and Career Options. Available at https://www.bls.gov/careeroutlook/2017/article/older-workers.htm. Last accessed May 23, 2023.

192. Denmark FL. Myths of aging. *Eye on Psi Chi*. 2002;7(1):14-21.

193. Harrar S. It's Time to Throw Out Stereotypes on Aging. Available at https://www.aarp.org/health/healthy-living/info-2022/aging-survey.html. Last accessed May 17, 2023.

194. U.S. Department of Defense. 2021 Demographics Report: Profile of the Military Community. Available at https://download.militaryonesource.mil/12038/MOS/Reports/2021-demographics-report.pdf. Last accessed May 23, 2023.

195. U.S. Department of Veterans Affairs. National Center for Veterans Analysis and Statistics: Veteran Population, Fiscal Year 2020. Available at https://www.va.gov/vetdata/veteran_population.asp. Last accessed May 23, 2023.

196. Kime P. Experts: Docs Should Ask about Patients' Military History. Available at https://www.militarytimes.com/pay-benefits/military-benefits/health-care/2015/02/16/experts-docs-should-ask-about-patients-military-history. Last accessed May 23, 2023.

197. American Academy of Nursing. Have You Ever Served? Available at http://www.haveyoueverserved.com. Last accessed May 23, 2023.

198. National Institutes of Health. Cultural Respect. Available at https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect. Last accessed May 23, 2023.

199. Centers for Disease Control and Prevention. Women, Caregiving, and COVID-19. Available at https://www.cdc.gov/women/caregivers-covid-19/index.html. Last accessed May 23, 2023.

200. U.S. Department of Health and Human Services. Office on Women's Health. Mental Health. Available at https://www.womenshealth.gov/mental-health. Last accessed May 23, 2023.

201. Bruine de Bruin W, Parker AM, Strough J. Age differences in reported social networks and well-being. *Psychology Aging*. 2020;35(2):159-168.

SELF-ASSESSMENT QUESTIONS
#97440 IMPLICIT BIAS: THE MICHIGAN REQUIREMENT

After reviewing the course, complete the following Self-Assessment Questions. Receive immediate feedback by reviewing the Study Guide provided on page 45. Please record the number of questions you correctly answered on the Evaluation. The Evaluation must be completed in order to receive credit for this course.

This 2 contact hour/credit activity must be completed by May 31, 2026.

1. Dr. X, a physician, acknowledges that she still has a lot to learn about different racial and ethnic minority groups. She is willing to learn from her patients and assume the role of learner. Dr. X is demonstrating
- A) *diversity.*
- B) *reflexivity.*
- C) *explicit bias.*
- D) *cultural humility.*

2. What tool is used to quantitatively measure implicit bias?
- A) *IAT*
- B) *SOAP*
- C) *STOPP*
- D) *fMRI*

3. Which of the following is NOT a risk factor in triggering implicit biases for health professionals?
- A) *Uncertainty*
- B) *Cognitive dissonance*
- C) *Time pressure to make a rapid decision*
- D) *Heavy workload and feeling behind schedule*

4. An implicit bias training is offered at a hospital, and a total of 50 health professionals attend. During the breakout session, training participants are assigned to discussion groups. One nurse agrees that implicit bias is prevalent, but she is quite sure she does not hold any implicit biases. Which developmental stage might this nurse be in?
- A) *Defense*
- B) *Minimization*
- C) *Structural competence*
- D) *Counter-stereotype acceptance*

5. As part of an implicit bias training, participants watch a film about an African American man's experiences navigating the health system and are asked to enter the protagonist's lived reality. What type of intervention is this?
- A) *Priming*
- B) *Attunement*
- C) *Control strategies*
- D) *Perspective taking*

6. Mr. A, a social worker, attempts to record personal information about his patients and not simply social characteristics. For example, he writes, "Patient is an elderly Hispanic woman, age 79 years. She lives with her daughter and is an avid pianist." What is this an example of?
- A) *STOPP*
- B) *Priming*
- C) *Power-sharing*
- D) *Individuation*

7. Cultural heterosexism is characterized by
- A) *negative feelings toward oneself and self-hatred.*
- B) *A negative attitude or fear of non-straight sexuality or GSM individuals.*
- C) *considering sexual identity and determining that one does not want to think further about it.*
- D) *the stigmatization in thinking and actions found in cultural institutions, such as educational and legal systems.*

8. The basis of establishing a safe and welcoming environment for all patients is
- A) *security.*
- B) *autonomy.*
- C) *beneficence.*
- D) *maintaining distance.*

Self-Assessment questions continue on next page ➞

9. **Which of the following is a typical characteristic of communication in high-context cultures?**
   A) *Use of more informal language*
   B) *Speaking more and often raising one's voice*
   C) *Assumption that meanings are described explicitly*
   D) *Reliance on interpreting eye contact, gestures, and tone of voice*

10. **Which of the following is an attribute of patient-centered practice?**
   A) *The practitioner focuses on observed signs and symptoms.*
   B) *The practitioner is concerned with identifying the disease pathology.*
   C) *The practitioner focuses on the subjective description of the illness.*
   D) *The practitioner is not influenced by how the client/patient defines the illness.*

Study Guide

COURSE #97440 IMPLICIT BIAS: THE MICHIGAN REQUIREMENT

This Study Guide has been included to provide immediate feedback about your achievement for the course learning objectives. The correct answers for the Self-Assessment Questions and their locations within the text are indicated below.

1. **Dr. X, a physician, acknowledges that she still has a lot to learn about different racial and ethnic minority groups. She is willing to learn from her patients and assume the role of learner. Dr. X is demonstrating**
   D) cultural humility. (Definitions of Implicit Bias and Other Terminologies; Other Common Terminologies; Cultural Humility)

2. **What tool is used to quantitatively measure implicit bias?**
   A) IAT (Measurement of Implicit Bias)

3. **Which of the following is NOT a risk factor in triggering implicit biases for health professionals?**
   B) Cognitive dissonance (Measurement of Implicit Bias; Extent of Implicit Biases and Risk Factors)

4. **An implicit bias training is offered at a hospital, and a total of 50 health professionals attend. During the breakout session, training participants are assigned to discussion groups. One nurse agrees that implicit bias is prevalent, but she is quite sure she does not hold any implicit biases. Which developmental stage might this nurse be in?**
   A) Defense (Developmental Model of Recognizing and Reducing Implicit Bias)

5. **As part of an implicit bias training, participants watch a film about an African American man's experiences navigating the health system and are asked to enter the protagonist's lived reality. What type of intervention is this?**
   D) Perspective taking (Interventions to Reduce Implicit Biases; Perspective Taking)

6. **Mr. A, a social worker, attempts to record personal information about his patients and not simply social characteristics. For example, he writes, "Patient is an elderly Hispanic woman, age 79 years. She lives with her daughter and is an avid pianist." What is this an example of?**
   D) Individuation (Interventions to Reduce Implicit Biases; Individuation)

7. **Cultural heterosexism is characterized by**
   D) the stigmatization in thinking and actions found in cultural institutions, such as educational and legal systems. (Best Practices for Culturally Responsive Care; Gender and Sexual Minorities)

8. **The basis of establishing a safe and welcoming environment for all patients is**
   C) beneficence. (Culturally Sensitive Practice; Create a Welcoming and Safe Environment)

9. **Which of the following is a typical characteristic of communication in high-context cultures?**
   D) Reliance on interpreting eye contact, gestures, and tone of voice (Culturally Sensitive Practice; Culturally Sensitive Communication)

10. **Which of the following is an attribute of patient-centered practice?**
    C) The practitioner focuses on the subjective (Culturally Sensitive Practice; Culturally Sensitive Assessment Guidelines)