

Unconscious Bias: An Obstacle to Cultural Competence

Our latest supplemental issue covers a range of topics related to diversity and cultural competence, including student academic success, career choice, global learning experiences, and working with diverse populations including older adults and the poor. Given the continuing challenges we face in our profession, in our communities, and in the larger society, it is perhaps fitting and timely that there was a critical mass of accepted manuscripts focused on diversity-related topics to create this supplement. These articles also affirm that fostering student diversity and producing culturally competent graduates remain important priorities for nurse educators and a focus for their scholarly work.

During the past few decades, we have made substantial progress in assuring that nursing education curricula are aligned with our profession's commitment to "practice with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (American Nurses Association, 2001). Nursing has long been a leader among the health professions in espousing compassionate and respectful caregiving that conveys dignity and respect for the inherent worth of individuals and communities regardless of their backgrounds and status. Our nursing programs, curricula, student learning experiences, and expected student learning outcomes have reflected this commitment for years. We have devoted attention and resources to teaching and research that address important

issues of workforce diversity, cultural competence, health disparities, and social justice.

And yet, recent events have dramatically heightened awareness that more than 50 years after the historic passage of the Civil Rights Act of 1964, equality and freedom—cherished ideals of democracy—remain elusive dreams for many. Persistent and in many cases growing disparities in health, wealth, education, work, and justice continue to plague society.

As nurse educators, we profess to graduate students who are culturally competent and prepared to respond appropriately and effectively in caring for a diverse society. Yet, we also know that our learning places and work environments continue to be places in which microaggressions occur with unfortunate frequency. Microaggressions are hurtful, demeaning, and dismissive words and actions committed by one individual or group against another whose characteristics and backgrounds are different.

Microaggressions are often the result of unconscious biases that lead to unintended discrimination against or degradation of those who are socially marginalized in a society, whether for skin color, gender, sexual orientation, age, language, origin, religion, disability, or any other characteristic. Sue (2003) described these acts toward others as not only the extreme racist acts of hatred such as that which apparently led to the recent murders in Charleston, South Carolina, but also the more subtle attitudes, actions, institutional structures, or social policies that subordinate a person or group because of their difference(s).

I wonder to what extent our nursing curricula address unconscious bias and microaggressions as they pertain to caregiving, to the learning and work climates in our schools of nursing, and to the clinical practice environment. Doing so seems at least as important as addressing cultural differences, health disparities, and social justice. In fact, unconscious biases are more often than not the root contributors to unintentional, insensitive attitudes and behaviors that reflect innate prejudices or biases. Such biases can be for or against, positive or negative, advantaging some and disadvantaging others, and are held by all of us whether we are aware of them or are willing to admit to having them.

Banaji and Greenwald (2013) likened unconscious bias to the blind spot in the retina. The difference is that we are able to "see" our blind spot by looking at a specially marked piece of paper and covering one eye. Unfortunately, our unconscious biases operate as hidden blind spots, ones that are difficult to see and of which we are unaware yet influence our beliefs about and behavior toward others. Banaji and Greenwald defined unconscious biases as acquired "bits of knowledge about social groups" (p. xii) that implicitly and automatically shape our thoughts and responses to others in both positive and negative ways. They note that most of us are "good people" who are generally well intentioned and try to behave in ways consistent with our good intentions, and who usually resist the very idea that we hold such biases. Even more so, we especially resist the notion that our unconscious biases influence our behavior toward others.

Although historically adaptive and protective when humans needed to distinguish danger from real predators in the environment, in our modern environment, unconscious biases serve as “social mindbugs” (Banaji & Greenwald, 2013, p. 13). These are contextual cues that lead us to form unconscious social inferences that influence how we perceive and behave toward people from social groups that are alike or different from our own. Noting that “the mind forms strong alliances with things and people that are familiar while developing subtle biases against those that aren’t,” Ives Erickson (2015) pointed out “these biases exist in our minds without our knowledge or consent” (p. 2).

Banaji and Greenwald (2013) and their colleagues have developed a scientifically grounded assessment tool, the Implicit Association Test (IAT), that is designed to reveal an individual’s unconscious biases on a variety of dimensions (e.g., gender, race, age, and political leaning). They note that a person’s typical response to taking the IAT is that there is something wrong with the test itself because people find it difficult to believe they have preferences—or biases—of which they are unaware.

There are a number of versions of the IAT available at no cost online (IAT Corporation, 2011); there are versions on race, gender, sexual orientation, age, and other topics, including tests of pref-

erence for certain political or celebrity figures. Having taken two of these tests myself (one on gender—science and the other on feminism—“good or bad”), I can attest to my surprise, and dismay, after a few of my own unconscious biases were revealed, even when I hold a strong conscious belief, for example, that women are as capable of becoming scientists as are men.

The point of the IAT is to raise awareness of our personal biases, and once aware, use conscious strategies or evidence-based guidelines to modify our thoughts and behaviors and better align our behaviors with our good intentions. Ives Erickson (2015) suggested that we need to surface the idea of unconscious bias in our conversations with ourselves and with each other if we are to become culturally competent and fulfill our moral and professional commitment to embrace diversity and assure that everyone—the students, colleagues, patients, and communities we serve, as well as those we encounter socially—is treated with dignity and respect regardless of how unfamiliar they are to us or how different they are from us.

The IAT is a welcome, easily accessible, and free tool that offers us as nurse educators the opportunity to gain awareness of both the idea of unconscious bias as it exists in society and our personal unconscious biases that influence our daily interactions with each other and

with those we serve. Equally important, it can be a powerful addition to our toolbox of teaching–learning strategies as we strive to help our students develop into sensitive, caring, and culturally competent practitioners who are self-aware, who strive to avoid unintended social hurts or discriminatory actions, and who learn to consciously align their behaviors with their good intentions to mitigate the negative effects of unconscious bias.

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