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Implicit Bias in Behavioral Health

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Introduction

Implicit bias occurs in behavioral health care when professionals have attitudes toward people or associate stereotypes with them without conscious knowledge. Emerging research shows that it is prevalent among service providers. Although such bias occurs automatically and unintentionally, it adversely impacts judgments, decisions, and behaviors. The negative or stigmatizing attitudes toward population groups may be activated during practitioner-client encounters, and the disparities that occur must be addressed and mitigated. Understanding bias can help us address barriers and inequalities that exist in behavioral healthcare.

The ability to rapidly categorize every person or thing one encounters is believed to be an evolutionary development to ensure survival. Early humans needed to decide quickly whether a person, animal, or situation they encountered was likely to be friendly or dangerous. Centuries later, these innate tendencies to categorize everything one encounters is a shortcut that our brains still use (Marcelin et al., 2019).

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Explicit Bias

Explicit bias or conscious bias are biases, prejudices, stereotypes, or assumptions one is aware of having regarding a group of persons.

A stereotype is an exaggerated belief, image, or expectation about a person or group. The generalization does not allow for individual differences or social variations. Stereotypes are perpetuated by images in mass media and ideas passed on by parents, peers, and other members of society. While stereotypes can be "positive" or "negative," they are harmful in the limitations they place on a group of people or an individual from within that group. Examples of "positive" stereotypes are African Americans are good basketball players or mothers are naturally the more nurturing parent. Examples of "negative" stereotypes are French people are rude or elderly people are frail and forgetful (NCCC, 2022; Learning for Justice, 2022).

Prejudice is a known and conscious negative judgment or attitude toward a group of people or an individual from within that group. Prejudiced people are aware they hold these beliefs or attitudes about another group and can control their prejudiced thoughts to limit their impact on their behaviors. Prejudices are often accompanied by ignorance, fear, or hatred. Prejudices are built through a psychological process that begins with connections to a close circle of acquaintances or family to create an "in-group," and the

prejudice is aimed at "out-groups."

Examples of prejudice include a person not wanting to use the same bathroom as a transgendered person or believing that people over a certain age no longer have anything to contribute to the community (NCCC, 2022; Learning for Justice, 2022).

Discrimination can range from exclusionary behavior or unequal treatment to outright violent action toward another group or person based on prejudicial beliefs of the group the individual belongs to (race, gender, class, sex, ethnicity, age). Discriminatory behavior, from slights to hate crimes, often begins with negative stereotypes and prejudices. Examples of discrimination include not hiring someone based on age or physically attacking a transgendered person for entering a bathroom (NCCC, 2022; Learning for Justice, 2022).

Addressing Explicit Bias

It takes a clear understanding of one's beliefs, values, and feelings to be able to acknowledge and address the biases they hold. For behavioral health professionals, the following questions may assist in identifying and addressing explicit biases one holds toward race, ethnicity, age, gender, gender identity or expression, sexual orientation, English language proficiency, literacy, body size, or socioeconomic status.

Do my biases:

- Impact the amount of time I spend with clients and their families?
- Influence how I communicate with clients?
- Hinder my ability to feel and express empathy toward my clients?
- Affect my recommendations for treatment and medications?
- Interfere with my capacity to positively interact with my clients and their families?
- Make me less comfortable with clients of a different race?
- Give my colleagues whom I routinely work with the impression that my attitudes and behaviors show bias? Am I open to discussing these issues with them to elicit their point of view?
- Impact how my clients or their families, directly or through satisfaction surveys, raise concerns about my attitude or how I communicate with them? (NCCC, 2022)

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Implicit Bias

Implicit bias or unconscious bias is an unintentional prejudice or attitude, based on group stereotypes, that a person unconsciously holds that impacts the person's decision-making process. Unconscious bias can be expressed in non-verbal communication and negatively impacts the client's access to services. Implicit bias is often subtle and outside the person's conscious awareness (NCCC, 2022; Merino et al., 2018).

Implicit bias is prejudicial attitudes toward and stereotypical beliefs about a particular social group or members of the group. These prejudicial attitudes and stereotypical beliefs are activated spontaneously and effortlessly, often resulting in discriminatory behaviors (Hagiwara et al., 2020).

While professionals want to believe they are providing their clients with equitable care, research has found two-thirds of providers hold some form of implicit bias against a marginalized group. Implicit biases can negatively influence a provider who is working with diverse populations. Negative results have been seen in providers' ability to engage in client-centered care, offer referrals to specialized treatment, and adhere to evidence-based guidelines. Mental health organizations are particularly vulnerable to implicit bias's negative effects because diagnosing and treating mental health conditions are frequently at the provider's discretion. Due to this, a provider's unconscious attitudes about a group (ex. veterans, homeless persons, people of color, or incarcerated individuals) can have multiple negative consequences for the individual seeking mental health treatment (Merino et al., 2018).

DeHouwer (2019) has an alternative view of implicit bias, arguing against the idea of implicit bias being unconscious and uncontrollable, and making people perform inappropriate actions. One downside to be explored is when individuals are told they are implicitly biased, it can threaten their core beliefs about who they think they are and who they aspire to be. This can explain the defensiveness many people initially have when told they have implicit biases. However, it also hinders attempts to reduce implicit bias in society, first because of the controversy it instills and second because the idea that there is a hidden mental structure enables the idea that implicit bias is difficult to change and control.

Instead, DeHouwer (2019) views implicit bias as a behavioral phenomenon instead of a mental structure. Therefore, implicit bias is something people do rather than something people possess. Implicit bias can be defined as implicit group-based behavior; meaning behavior influenced implicitly by cues indicating the social group to which others belong.

For example, saying someone is racially biased means that part of what the person does (whether the person smiles at someone, shakes hands with someone, or hires someone for a job) is influenced by cues indicative of the racial group of others (skin color). The influence of these social cues can be labeled as implicit when it occurs quickly, effortlessly, unintentionally, unconsciously, or in a way that is difficult to control. For instance, people show implicit racial bias when they quickly and unintentionally respond fearfully to the presence of another person because of the skin color of that person. Implicit group-based behavior can be referred to as biased in that behavior is influenced by social cues systematically. Therefore the behavioral perspective is amoral in that it does not require a judgment about whether the impact of social cues on behavior is inappropriate according to some norm. It allows for moral debates but separates them from the behavioral phenomenon. It also does not assign blame for biased behavior but simply implies that the behavior is a function of social cues in the environment. When one is vigilant, implicitly biased behavior can be prevented or counteracted.

It is important to understand implicit bias as it can still inadvertently cause overt behaviors and impact decision-making in behavioral health care, and no one is immune to it. There is significant evidence that:

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- health care providers hold stereotypes based on client race, class, sex, and other characteristics
- these stereotypes influence their interpretations of behaviors and symptoms and their clinical decisions
- health care providers interact less effectively with minorities than with white clients.

It is important for behavioral healthcare providers to be aware of their conscious and unconscious biases and how they can impact their interactions with their clients.

One way to identify one's implicit biases is by completing the Implicit Association Test. The test can be completed online at one's discretion. The IAT measures attitudes and beliefs one may be unwilling or unable to report. The IAT may show that one has implicit biases they were unaware of holding. The Project Implicit program currently has 15 tests one can take to measure levels of bias in different areas (Project Implicit, 2022).

The IAT calculates how quickly people associate different terms with each other. The race IAT asks the subject to sort pictures (of white and black people) and words (good or bad) into pairs to determine unconscious race bias. For example, in one part of the Race

IAT, participants must associate good words with white people and bad words with black people. In another part of the Race IAT, they must associate good words with black people and bad words with white people. The software calculates a bias score based on the reaction times needed to perform these tasks. Category pairs that are unconsciously preferred are easier to sort (and therefore take less time) than those that are not. These unconscious associations can be identified even in individuals who outwardly express egalitarian beliefs. According to Project Implicit, the Race IAT has been taken over 4 million times between 2002 and 2017, and 75% of test takers demonstrate an automatic white preference, meaning that most people (including some black people) automatically associate white people with goodness and black people with badness. Proponents of the IAT state that automatic preference for one group over another can signal potential discriminatory behavior even when the individuals with the automatic preference outwardly express egalitarian beliefs. These preferences do not necessarily mean that an individual is prejudiced, which is associated with outward expressions of negative attitudes toward different social groups (Marcelin et al., 2019).

Areas of bias for behavioral healthcare providers can include:

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- Age
- Disability
- Education
- English language proficiency and fluency (including the capacity to speak Standard English for native-born English speakers)
- Ethnicity
- Health status
- Disease/diagnosis (HIV/AIDS)
- Insurance
- Obesity
- Race
- Socioeconomic status
- Sexual orientation, gender identity, or expression

- Skin tone
- Substance use (with more bias toward injection drug user)
- Social contact (amount of contact that practitioners have with client populations).

Implicit bias can conflict with the beliefs and values of the person. The danger is that implicit bias can seep into a person's behaviors without awareness and can impact decision-making, assessment of clients, and may even compromise the client's goals in treatment.

There are neuroscience explanations for how each person is "wired" for bias. A person's brain can differentiate between those who are similar (in-group) and those who are different (out-group). When the brain identifies someone as "not like us," the ventromedial prefrontal cortex is activated, and when the brain identifies someone as "like us," the dorsomedial prefrontal cortex is activated. When someone is identified as "not like us," implicit stereotypes can lead to the person being treated differently, often not as well treated if someone was instead coded as "like us." Further complicating things, the mirror neurons (the neurons that allow us to have experiential insight into others or have empathy) are not activated the greater the bias is. This causes the person with the implicit bias to have less interest in helping the other person or to experience less empathy toward that individual. The brain's purpose of labeling someone as "other" is a survival technique, meaning the person is labeled non-threatening or threatening. This happens in milliseconds but can activate the amygdala (the brain's flight or fight mechanism). The speed at which this happens and the automatic reactions cause it to happen so quickly that logical or rational thought can't interrupt it. Because this is linked to safety, it is harder to address. Another aspect that impacts implicit bias is stress. When a provider is multi-tasking several mental tasks, environmental factors, physical tasks, and psychological states, it is challenging to fully address each client's unique needs. Well-meaning practitioners may find it easier to stick to the stereotype than make the mental effort to separate the person from the stereotype and then make the mental corrections for the activated stereotype. It is more difficult to challenge stereotypes when operating under stress, even when people recognize the stereotyping thoughts or behavior (NCCC, 2022).

Impacts of Implicit Bias

Stereotypes have inadvertently played a role in both behavioral and physical healthcare

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education. Presentations of clients and case studies often start with the person's age, presumed gender, and presumed racial identity. When clinicians fail to see their clients as more than their perceived demographic characteristics, it can lead to premature closure and missed diagnoses. An extreme example of this can be seen at the beginning of the HIV epidemic. The high prevalence of HIV among gay men led to the early belief that the disease could not be transmitted beyond the gay community. This inhibited the recognition of the disease in women, children, heterosexual men, and blood donor recipients. Gay white men were also overrepresented in early data, leading to the lack of recognition of the epidemic in communities of color, which are still experiencing the impact (Marcelin et al., 2019).

One research study looked at medical school admission committees and found that members showed significantly unconscious white preference despite acknowledging almost zero explicit white preference. Unconscious bias also affects students' experience. In one study of African American residents' shared experiences of being only "one of a few" minority physicians, recurring themes of their encounters included discrimination, the presence of daily microaggressions, and the burden of being tasked as race or ethnic "ambassadors" expected to speak on behalf of their demographic group. Examples of gender bias in the medical community have been seen in letters of recommendation for residents, where letters for males have a more positive tone and more expressive evaluative descriptors. Women are less likely to be invited to speak during grand rounds and are less likely to have their formal titles used during introductions when compared to male medical colleagues. Sexual and gender minority groups are underrepresented in medicine and experience bias and microaggressions similar to those experienced by racial and ethnic minorities. LGBTQ healthcare professionals report challenges in lack of LGBTQ mentorship, poor recognition of scholarship opportunities, and non-inclusive or, at times, hostile institutional climates. Physicians with disabilities constitute another minority group that may experience bias in medicine. The degree to which they experience this may vary, depending on whether disabilities may be visible or invisible. Physicians with disabilities reported feeling compelled to work twice as hard as their able-bodied peers for acceptance, struggling with stigma and microaggressions, and encountering institutional climates where they generally felt like they did not belong (Marcelin et al., 2019).

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Healthcare providers' implicit prejudice is associated with lower-quality client-provider communication among clients from marginalized social groups. For example, black clients who interacted with providers with higher levels of implicit prejudice reported significantly lower levels of interpersonal care than clients who interacted with providers

with lower levels of implicit prejudice. Implicit bias is not a specific problem within the United States; everyone has biases worldwide. Research in other countries includes implicit racial bias in Italy, implicit racial and gender bias in the U.K., and implicit weight bias in Singapore. The type of implicit bias in any given country is determined by its cultural, historical, and economic contexts. In countries with relatively little racial variability, other forms of implicit bias, such as prejudice toward weight variations, immigrants, or religion, might play an important role in client care (Hagiwara et al., 2020).

Accessing Mental Health Care

Implicit bias can negatively impact certain groups from accessing mental health services. Mental health services are usually provided for on a one-on-one basis, with a single provider as the gatekeeper to obtaining care. There is a greater potential for implicit bias among mental health providers that limits certain groups from accessing the mental health services they need. For example, one study reviewed audio recordings of potential psychotherapy clients requesting services. The results showed middle-class white women are likelier than working-class black men to get a callback. When a marginalized group member can obtain an appointment, implicit biases may shape how a mental health provider interprets certain behaviors. For example, a black man was raised in a community where men and boys of color are disproportionately targeted by law enforcement. One provider might see his everyday hypervigilance as a natural consequence of racial profiling. In contrast, a different provider might see that same behavior as paranoia related to schizophrenia. The difference in how a behavioral healthcare provider interprets symptom presentation can significantly change future discussions regarding the client's psychiatric symptoms or screening for specific conditions. Even with the DSM-5 standardized diagnostic criteria, mental health service providers are more likely to over diagnose psychotic disorders and under diagnose affective disorders among clients from marginalized groups. When misdiagnosis happens, it increases the probability that the mental health professional will fail to refer clients to the appropriate healthcare professionals or inadvertently withhold treatment (Merino et al., 2018).

Treatment and Crisis Care

Clients with mental disorders often require long-term care to control symptoms, and a positive rapport between provider and client can support continuing treatment

adherence. Individuals with mental illness often report poor care experiences despite research supporting the power of a positive therapeutic alliance. Clients with mental illness commonly experience microaggressions from health professionals during their care process. After cumulative negative experiences with mental health providers, members of marginalized groups can begin to question the benefits of mental health services, which can decrease treatment adherence. Negative individual experiences can impact the broader community, perpetuating social norms that discourage treatment-seeking for psychiatric problems (Merino et al., 2018).

Emergency personnel and first responders must understand how implicit biases can affect crisis services. For example, a first responder's implicit biases can cause them to interpret a person in crisis behavior as dangerous or violent rather than seeing that person as experiencing frustration or fear during the crisis. Mental health disparities in emergency care settings are well documented, and more attention needs to be given to how implicit biases negatively affect clients in this setting. Some communities attempt to mitigate harmful interactions by training first responders in mental health crisis response techniques, creating formal collaboration between law enforcement and mental health clinicians, and establishing community-based crisis management programs (Merino et al., 2018).

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Criminal Justice

Most people with mental illness are non-violent. However, abnormal behavior attributed to mental disorders is often seen as deviant and dangerous, which creates a link between criminalization and mental illness diagnosis. When analyzing the role of bias in the mental health care system, the role of the prison industrial complex must also be acknowledged. Incarcerated people with mental illness make up almost 50% of the U.S. correctional population; hence the prison system is one of the biggest mental health providers in the country.

Implicit bias that assumes all abnormal behavior is dangerous can lead to disproportionate contact with the criminal justice system. Research has shown that confrontational interactions between first responders and people with mental health conditions can exacerbate symptoms due to the trauma of arrest and incarceration. In addition, more scrutiny of biases in law enforcement and the judicial system is needed to understand how prejudices against marginalized groups and individuals with mental disorders can lead to differential criminalization and disproportionate incarceration. Potential solutions include building partnerships between the criminal justice system

and mental health professionals to quickly identify and adequately treat people with mental illness without resorting to incarceration (Merino et al., 2018).

Interventions to Address Bias

Social psychology research has found that simply being aware of one's implicit bias is insufficient to produce change; people need to have an internal motivation for change to happen. Even working in behavioral healthcare, where biases are extremely condemned, is insufficient to stop implicit bias among providers. People with a high external motivation to avoid prejudice could not prevent their expression of implicit prejudice. In contrast, people with high internal motivation to avoid prejudice successfully reduced their implicit prejudice. Therefore, implicit bias training should address both providers' awareness and internal motivation (Hagiwara et al., 2020).

Implicit bias can be considered a habitual response; by definition, habits are default responses and hard to break. Learning specific strategies to interrupt habitual responses makes habit-breaking more effective. More harm than good may occur if steps are not taken to go beyond awareness and to include concrete strategies. Increased awareness of one's implicit biases without strategies to combat them could lead to:

- increased anxiety and, ultimately, avoidance of working with a specific group of marginalized people
- withdrawal by having shorter appointments
- overcompensating, such as being overly friendly, which then comes across as ungenuine and inauthentic.

Addressing implicit bias effectively should include exploring one's own biases to build awareness, increase internal motivation, and learn strategies to reduce bias (Hagiwara et al., 2020).

Personal motives to reduce bias might include:

- Create a more equitable society
- Eliminate prejudices against people or groups that people genuinely didn't realize they had
- Recognize one's biases to build a strong relationship and community

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- Acknowledge that implicit bias is often different from what people state they think, feel, or believe
- Know that biases almost always work to the detriment of the lower-status group
- Realize that implicit bias is a powerful determinant of behavior
- Eliminate biases to help remove the "in-group" and "out-group" stigma
- Reduce discrimination due to implicit bias
- Believe that Implicit biases are malleable, and therefore behaviors can be changed (LMU, 2022)

Accept Implicit Bias Exists

Behavioral healthcare providers must acknowledge that their implicit biases can affect their decision-making and client interactions. It is not easy for individuals to admit that they have biases that could impact their client care, as most people enter the behavioral health field wanting to help others and believing themselves to be fair and caring. It can be challenging to accept one has implicit biases and, even further, that those biases could be causing harm to one's clients.

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While most behavioral healthcare providers may dispute that they hold any bias toward others, some studies show over and over that every individual holds some bias and prejudice. Recognizing one's biases and beginning to struggle and dismantle those biases is the first step in addressing them. It is important to minimize guilt and blame during this step as it only slows one's effort to address implicit bias (NCCC, 2022).

Assume Individual Responsibility

As we have seen in the examples above, there is a correlation between implicit bias and healthcare disparities. It is, therefore, pertinent that all behavior healthcare providers take individual responsibility to identify and address their own biases. One may take individual responsibility by identifying beliefs leading to implicit bias and committing to combatting those so one can deliver the best care possible to clients. For example, this can be accomplished by participating in continuing education on implicit bias and advocating for one's worksite to provide training on implicit bias.

Implicit bias occurs because of automatic thinking; individual strategies to reduce

implicit bias through personal responsibility include recognizing the following:

- Conscious and deliberative thinking decreases and potentially disrupts the connection between implicit biases and overt behaviors. Take the time to process information and consider how implicit biases may be influencing decisions. Another suggestion is to learn the history of communities different from one's own.
- Perspective-taking builds empathy. Communication and interactions with other groups' members builds an inclusive culture. Engage in respectful discussions and actively listen to others' points of view.
- Positive interaction with other groups' members lowers the chance of biases being activated. Engage in activities that include people from diverse backgrounds. Interact with group members one does not usually come into contact with. One way to do this might be to attend an event or festival celebrating different ethnicities than one's own (LMU, 2022).

Institutions can reduce implicit bias through:

- Recognizing that conscious and deliberative thinking decreases and potentially disrupts the connection between implicit biases and overt behaviors. Provide time for important decision-making.
- Considering the organizational environment and subtle messages that could convey stereotypes via physical and social environments.
- Holding individuals, programs, and departments accountable for their decision-making to potentially stop the link between implicit biases and overt behavior.
- Documenting patterns and outcomes over time to uncover successful and unsuccessful strategies.
- Setting criteria ahead of time to help reduce the possibility of implicit bias impacting candidates. Set clear criteria to assess job skills required for successful job performance.
- Creating an inclusive environment. Open-dialogue environments encourage communication. Increasing bias literacy decreases bias effects. Create an open culture where people can acknowledge their biases and can respond to others' biases (LMU, 2022).

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Engage in Self-reflection and Self-assessment

Active self-reflection deepens our learning and understanding of ourselves, and self-assessment is a key component of providing culturally competent care. Taking the Implicit Association Test is one way a person can engage in self-assessment. The Implicit Association Test asks the test taker to look at pictures or word combinations and pick a concept associated with that picture or word. For example, it starts by categorizing people by labels of African American and European American and categorizing a list of emotions by bad or good. It then leads to categorizing people and emotions at the same time. How quickly and accurately one completes the sorting processes impacts the level of implicit bias the test identifies the test taker as having (NCCC, 2022).

Taking the Implicit Association Test can be unsettling or upsetting, depending on one's results. The test measures unconscious bias, and even those who are fair-minded and hate prejudice at a conscious level often have unconscious biases based on race, gender, age, and other demographic factors. Remember, being able to identify one's implicit biases now can lead to taking responsibility for them and addressing them (NCCC, 2022).

Important points that should be emphasized when using the IAT as part of diversity training include that people should be aware of their own biases and reflect on their behaviors individually. Although the IAT can generally suggest how groups of people with certain results may behave, rather than how each individual will behave on their own, the IAT is not a sufficient tool to mitigate the effects of bias. If there is to be any chance of success, an active cultural and behavioral change must be engaged in tandem with bias awareness and diversity training (Marcelin et al., 2019).

Providers are encouraged to evaluate how their experiences and identities influence their interactions. Including data on lapses in proper care due to provider bias also proves helpful in giving people real-life examples of the consequences of not being vigilant for bias. This motivated self-regulation based on reflections of individual biases has been shown to reduce stereotype activation and application. If one unintentionally behaves in a discriminatory manner, self-reflection and open discussion can help to repair relationships (Marcelin et al., 2019).

Use Neuroscience to Combat Implicit Bias

There are neurological aspects of implicit bias. Knowing this, we can use the same neuroscience to learn how to create solutions by overriding our hardwiring and overcoming our implicit biases. The amygdala plays an important role in our unconscious

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biases. fMRI neuroscience studies show that people use different brain areas when reasoning about familiar and unfamiliar situations. The neural zones that respond to stereotypes include the amygdala, the prefrontal cortex, the posterior cingulate, and the anterior temporal cortex, and all become activated when stereotype thoughts happen.

The following is an easily understood example of how our brains function. Walking down a dark, unfamiliar alleyway, we hear weird sounds and see a stranger walking toward us, causing our amygdala to activate. The amygdala helps us assess the threat level of the situation. We will likely feel a flood of emotions, our hearts will start beating faster, and our palms will become sweaty. On an evolutionary level, this kind of response is crucial. People are primed to respond to any potential threat to ensure survival. This response happens without any effort or conscious reasoning. Back in the alleyway, we realize the stranger is just our neighbor, and the sound is a cat rummaging behind the garbage can. Our prefrontal cortex then sends out a message to our amygdala that there is nothing to worry about. All is under control.

Our conscious brain does not have the time to process all the information we see, so our initial instincts interpret less processed information and frequently include biases of some kind. Our socialization, personal memories, and experiences produce unconscious biases. The amygdala labels and categorizes the incoming information efficiently and unconsciously, leading to people rapidly categorizing others as "like me" and "not like me" and, consequently, "in-group" or "out-group." This is the root of prejudice and discrimination.

Results from fMRI show amygdala activation when people are shown facial images of people with different ethnic backgrounds from their own and less activation when seeing people of the same ethnicity; similar results can be seen with exposure to different accents. Neuroplasticity is one of the breakthroughs in neuroscience that has allowed us to know that different experiences will change the brain's structure. This means our unconscious biases are not wired into us. Instead, they are learned through our experiences and, therefore can also be unlearned (Agarwal, 2020).

Collect Data and Self-Monitor

Being aware of what the data says about bias can be an effective way to combat both explicit and implicit bias. For example, learning what the data says about the disparities in healthcare with diagnosis, treatment, and outcomes may be beneficial.

Self-monitoring and mindfulness address increasing our recognition of our thoughts and

behaviors at the moment they happen. Allowing oneself to be curious, open, and accepting of one's reactions is essential to acknowledging and working on one's biases; any judgment or shame around bias is counterproductive to addressing it (NCCC, 2022).

Incorporate Cultural and Linguistic Competence

Cultural competence and linguistic competence are widely accepted by accreditation agencies, state professional licensing boards, quality care organizations, professional medical societies, researchers, educators, and policymakers as efficient ways to address disparities in healthcare.

There are five essential elements of cultural competence at the individual level that can have a preemptive or mitigating effect on implicit bias. They are:

- acknowledge cultural differences
- understand one's own culture
- engage in self-assessment
- acquire cultural knowledge and skills
- view behavior within a cultural context

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Implicit bias can not be addressed until it is brought into conscious awareness and acknowledged. This can be difficult for practitioners who may struggle to accept health disparities exist, or if they do, they attribute them to system disparities such as challenges with insurance rather than acknowledging disparities in the care given to different individuals. Implicit bias often manifests as stereotypes, simplified care, different treatment plans provided, and diminished quality of care. Culturally competent practices acknowledge cultural differences and view behaviors within a cultural context. This can limit one's implicit bias as it gathers highly specific information about clients' health beliefs and practices, values, and the environmental, social, and cultural contexts in which they live that impact their health and well-being.

Linguistic competency is the ability of behavioral health providers to communicate information in a way that diverse groups easily understand and to respond effectively to the mental health literacy needs of the populations they serve. This may include individuals with limited English proficiency, those with low literacy skills or who are not literate, persons with disabilities, and those who are hard of hearing or deaf (NCCC, 2022).

While cultural competence is important for healthcare providers, the label of culturally competent implies that one has achieved a static goal of championing inclusivity. This approach imparts false confidence in leaders and healthcare providers and fails to recognize that our understanding of cultural barriers is continually growing and evolving. Cultural humility has been proposed as an alternate approach, subsuming the teachings of cultural competency while steering participants toward a continuous path of discovery and respect during interactions with colleagues and clients of different cultural backgrounds. No one can be, nor need to be, the ultimate expert in all intersecting cultures they encounter but instead should focus on a readiness to learn about the people they are caring for. Cultural humility is important for recognizing and mitigating conscious and unconscious biases (Marcelin et al., 2019).

Counterstereotypical Interactions

Exposing individuals to counterstereotypical experiences can have a positive impact on unconscious bias. Individuals can intentionally diversify their circles, connecting with people from different backgrounds and experiences. This can include occasionally awkward and uncomfortable introductions at professional meetings or community events, making an effort to read books by diverse authors, or trying new foods with a colleague. These are small behavioral changes that, with time, can help to retrain our brain to classify people as "same" instead of "other." (Marcelin et al., 2019).

System Changes to Address Unconscious Bias

Creating change requires more than just a climate survey, a vision statement, or the creation of a diversity committee. Organizations must commit to a culture shift by building institutional capacity for change. This might include recruiting underrepresented individuals and promoting leaders with the power to create equitable environments. In one study, university admissions committee members took the IAT and responded to a survey afterward. When the researchers did a follow-up study after the new admission cycle, it was the most diverse class in the institution's history. A similar study targeting unconscious gender bias saw a decrease in the academic center's gender bias after participation in the study. Simply having one’s biases pointed out through the IAT and completing a self-reflection survey made an impact on future decision-making (Marcelin et al., 2019).

Another way organizations can implement changes is by implementing a person-centered care system. In person-centered care, the focus is shifted from a deficit or

disease model toward articulating and addressing a person's values, preferences, and goals, emphasizing co-produced rather than expert-driven care. Person-centered care shows promise in enhancing therapeutic alliances, incorporating stakeholder perspectives, addressing disparities, and improving engagement and outcomes. Organizations must also recognize that, at times, the culture of the mental health system itself may pose substantial barriers to client diversity and not the provider's lack of engagement with multicultural populations in person-centered care. These structural barriers and organizational biases persist despite emerging practices focused on empowering the client (Desai et al., 2021).

Conclusion

Implicit bias or unconscious bias is unintentional prejudice and attitudes based on group stereotypes that a person unconsciously holds and that impacts the person's decision-making process. While providers want to believe they are providing their clients with equitable care, research has found two-thirds of providers hold some form of implicit bias against a marginalized group. Healthcare providers' implicit prejudice is associated with lower-quality client-provider communication among clients from marginalized social groups. Negative impacts implicit bias can have include: limiting certain groups from accessing mental health care, misdiagnosing or over or underdiagnosing certain groups of people, mistreatment of people in mental health crises by first responders, and disproportionate incarceration of those with mental illness. Interventions to combat implicit bias include accepting that implicit bias exists, assuming individual responsibility, engaging in self-reflection and assessment, using neuroscience to one's advantage against implicit bias, incorporating cultural competence, exposure to counterstereotypical interactions, and creating system changes to address unconscious organizational bias. Everyone has some form of implicit bias, and through recognition of such prejudices and participating in interventions, individuals and organizations can reduce their biases and the impact they have on others.

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