Mindful
Continuing Education

Implicit Bias for Social Workers

Section 1: Introduction

As you opened this training module, what were you thinking about? Were you nervous about addressing bias? Confident that you have mastered your biases? Your brain was busily trying to make sense of what you were about to learn and has engendered a feeling about the topic of bias and health care disparities.

Our brains do the same thing with bias. Our brains are always trying to make sense of the world we live in by creating categories of characterizations of people and objects. Bias occurs when our brains create categories that ultimately lead to emotions and behaviors that are harmful either overtly or covertly to those who are marginalized and those who are experiencing health disparities.

In this lesson, we will learn about our biases and how biases impact health care disparities. We will also address how to change our biases and be better equipped to recognize and mitigate health disparities.

Section 2: Defining Implicit Bias and Behaviors that Support Implicit Bias

Introduction to Implicit Bias

Implicit bias is a “bias or prejudice that is present but not consciously held or recognized.” (Merriam-Webster Dictionary, n.d.). Biases are comprised of thoughts, actions, or norms that are rooted in historical marginalization, microaggressions, racism, discrimination, prejudice, and disempowerment. While some of the earliest forms of these are rooted in slavery in the 1860s, research during the years post slavery was mainly focused on the concepts of prejudice, discrimination, racism (Payne, Vuletich & Brown-Iannuzzi, 2019). These concepts

are heavily focused on the explicit, conscious actions of an individual. It wasn't until 1995 that social psychologists like Mahzarin Banaji and Anthony Greenwald, and Fazio et. al. focused on the automation of unconscious thought processes, or the implicit side of social cognition. (Stanford Encyclopedia of Philosophy). From their research, implicit bias is thought to be created by both a person's internalized experiences and a dominant cultural narrative as these factors can influence one's perceptions of and actions towards others (Banaji & Greenwald 1995, Fazio, Dunton, and Williams, 1995). Implicit bias then leads to both individually created disparities and systemic disparities like health disparities (Shah & Bohlen, 2023). In the next section, we will explore what creates bias and how bias influences our thoughts and actions.

Foundations of Implicit Bias

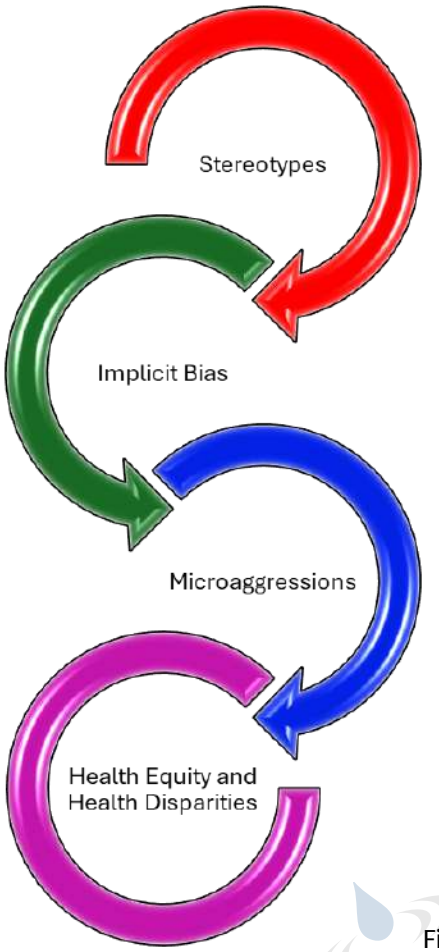
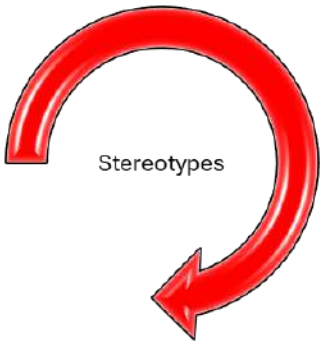


Figure 1.

To start the discussion about implicit bias, let's first take a look at Figure 1. Implicit bias is not the starting point, as implicit bias needs to be created. Your brain needs inputs (stereotypes) to create the characterizations and categories that influence behavior (microaggressions). In the next sections, we will break this pathway down into each individual step and show how bias influences our participation in health care disparities.

Defining Stereotypes and Stereotyping



Stereotypes are generalized and biased beliefs about an individual or group of individuals that are curated from personal experience, familial influence, and societal influences (Zhang, et. al. 2022). Stereotypes can ascribe either positive or negative beliefs towards an individual or group (Cheryan & Bodenhausen, 2011, Czopp, 2008). **Stereotyping** is when a belief or belief system is applied to all persons perceived to be in the same group, thus discounting that individuals, even when belonging to the same group, have their own unique experiences and needs (Battle, 2012).

At the neurological level, stereotypes and stereotyping is our brain's way of categorizing both positive and negative characteristics of persons within social groups to both simplify decision making and differentiate groups of people (Zhang et. al. 2023).

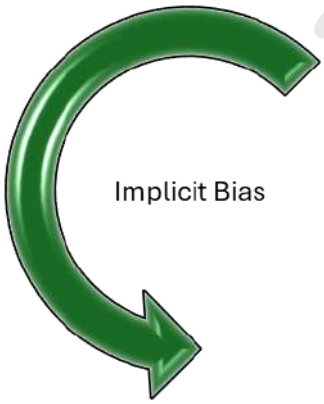
Examples of stereotypes in health care service delivery include but are not limited to:

Stereotype	Dismantling the Stereotype
Persons of size are lazy, eat unhealthy diets, and don't want to lose weight. Conversely, persons who are thin are healthy, have no medical problems, and are generally better than persons of size.	Weight management is very heavily influenced by genetics, medications, and medical diagnoses in addition to lifestyle choices. Similarly, medical diagnoses can impact all individuals. For example, diabetes can affect both persons who are slender or thin and persons of size. Only focusing on lifestyle choices or appearances dismisses any other conditions that can affect a person's weight (Nicholas, 2023).
African Americans do not feel pain the same as their White counterparts and therefore do not need as much pain management.	This stereotype has been medically refuted as false. African American persons feel pain and have the right to receive equitable pain management to any other patient (Sabin, 2020).
Older adults do not experience substance abuse and do not need to be screened for this type of care.	There are an alarming number of older adults who are chemically dependent on opioids and other addictive medicines. Addiction does not disappear with age (National Institute on Drug Abuse, 2020).

A person diagnosed with HIV must be gay and must have had risky unprotected sex to get the disease.	A person can contract HIV from sex, but they can also contract HIV from tainted blood products/infusions or contact with infected bodily fluids. While HIV is more prevalent in the LGBTQ+ community, it is medically untrue to assume HIV is contracted only from sexual intercourse (Human Rights Campaign, 2023, Centers for Disease Control, 2024).

These examples highlight how stereotypes can have a significant impact on developing implicit biases, which can then impact how we interact with diverse clients.

Defining Implicit Bias



To best understand how implicit bias is formed, it is best to start with a definition of what makes a thought, action, or behavior an implicit bias versus an explicit bias.

Implicit bias is a thought or **"mental association"** that "(a) manifests (and can be measured) indirectly and (b) can operate without those who perpetrate **discrimination** needing to be aware of their biased associations or role those associations play in guiding their judgment and action." (Greenwald & Krieger, 2006) This means that both positive and negative stereotypes turn into mental associations that **subconsciously** or **unconsciously** influence our thinking and our engagement with clients.

Conversely, with **explicit bias**, a person is aware of their thoughts and can make a decision as to whether or not to act on those thoughts (Gopal et. al., 2021, Vela et. al. 2022). Explicit biases have declined over time (Vela et. al. 2022), likely because a person is readily aware that they are engaging in a biased practice (Shah & Bohlen, 2023, Charlesworth & Banaji, 2019).

Section 2 Case Example 1

A social worker sees an Asian family sitting in the waiting room for their visit. The social worker feels positive about the upcoming encounter as they think it will be easy because they know that Asian persons are intelligent and hardworking with lots of family support. They also know that this may be wrong to think, but, based on their experiences, they believe Asian persons are better to work with.

Is this an example of implicit bias or explicit bias?

Answer: Explicit Bias because the social worker is knowingly engaging in a stereotype. Because the family is Asian, they are assuming this family will have little to no health or social work concerns and it will be an easy encounter.

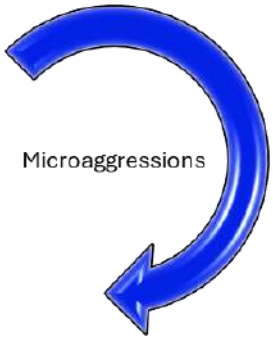
Section 2 Case Example 2

A social worker sees a patient who identifies as female who is wearing a wedding ring. While assessing the patient for their social support for medical follow up, the social worker asks, “What is your husband’s name?” The patient states that their partner died two years ago, and their name was Sarah.

Is this an example of explicit bias or implicit bias?

Answer: Implicit Bias because the social worker engaged in a stereotype (wedding ring indicating a male-female union with a living spouse), but did so subconsciously rather than intentionally.

Microaggressions



The idea of **microaggressions** was first penned by Dr. Chester Pierce in 1970 to describe both the conscious explicit acts of racism and the unconscious implicit acts of racism towards African Americans during the Jim Crow era (Turner, Higgins, & Childs, 2021, Williams et. al. 2021). More recently, research has been primarily focused on the explicit acts of racism or discrimination towards African American persons and other persons of color.

Building upon Dr. Pierce's work, in 2007 Sue et. al. provided a more distinct definition and taxonomy of racial microaggressions. Microaggressions are now defined as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color. Perpetrators of microaggressions are often unaware that they engage in such communications when they interact with racial/ethnic minorities." (Sue et. al. 2007) The taxonomy of microaggressions included three types or categories:

1. **Microassault** - "an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions." An example of a microassault is using words like "colored" or "Oriental" or when attending to a White client before a client of color in a waiting room or office.

2. **Microinsult** - "communications that convey rudeness and insensitivity and demean a person's racial heritage or identity. Microinsults represent subtle snubs, frequently unknown to the perpetrator, but clearly convey a hidden insulting message to the recipient of color." And example of this at the organizational level is during the hiring process telling candidates of color that you only hire qualified candidates because race should not be a deciding factor, or asking a person of color, "How did you get your job?"

3. **Microinvalidation** - "communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color." An example of this is saying "I don't see color" or "I am color blind, a human is a human."

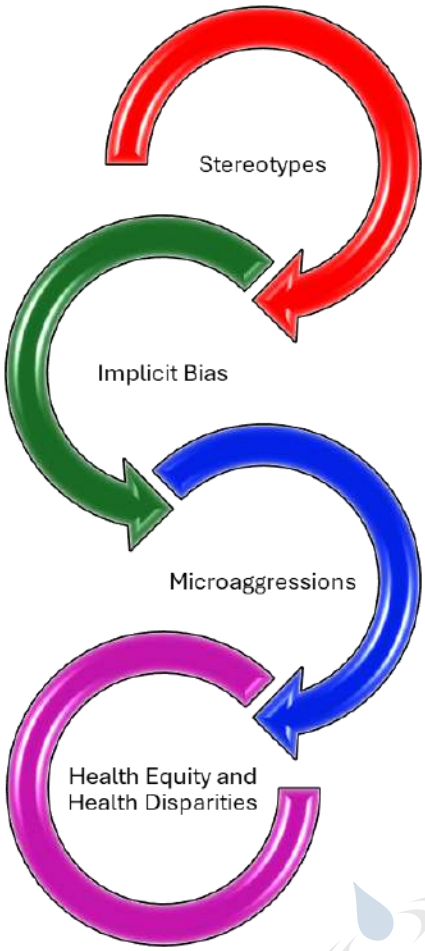
Each of the microaggressions listed above are ways for providers to negate their responsibility to understand and address the racial discriminations experienced by communities of color, and other marginalized communities on a daily basis.

While microaggressions have historical roots in understanding the lived experiences of communities of color, microaggression research continues to expand to include the lived experiences of persons living in other marginalized groups (Williams, et. al. 2021, Sue, 2010). These groups include but are not limited to:

- Gender, sexual orientation, and gender identity
- Ability and Disability status
- Social class or socioeconomic status
- Religion
- National origin
- Immigration status
- Limited English proficiency
- Physical characteristics or health conditions (NIH Minority Health)
- Mental health and chemical health

When we allow for microaggressions to live in ourselves and in our health care systems, we are engaging in the creation of and perpetuation of health disparities.

Section 2 Conclusion



Before we move on to health equity and health disparities, let's recap what we've learned thus far.

We learned that stereotypes are mental associations that carry both positive and negative characteristics. These characteristics in turn create an implicit bias, or a bias that is unconcious or subconscious that automatically influences our interactions with clients. The influence of bias thus create behaviors that are called microaggressions. Engaging in all three of these processes contributes to the inequitable and disparate delivery of healthcare to marginalized populations.

Section 2 Key Words

Discrimination - the unfair and unethical/unjust treatment of people based on their race, age, gender, sexual orientation, ability or disability.

Explicit bias - when a person is aware of their thoughts and can make a decision as to whether or not to act on those thoughts (Gopal et. al. 2021)

Implicit bias - a thought or "mental association" that "(a) manifests (and can be measured) indirectly and (b) can operate without those who perpetrate discrimination needing to be aware of their biased associations or role those associations play in guiding their judgment and action." (Greenwald & Krieger, 2006)

Mental association - a set of thoughts grouped together by a shared characteristic. The brain can use these associations for memory recall.

Microaggressions - brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color.

Stereotypes - a belief or set of beliefs about an individual or group of individuals that are curated from personal experience, familial influence, and societal influences.

Stereotyping - when a belief or belief system is applied to all persons perceived to be in the same group, thus discounting that individuals, even when belonging to the same group, have their own unique experiences and needs.

Subconscious thoughts - thoughts that are outside of our awareness, but are still readily recalled when a mental association is triggered. One can be made aware of subconscious thoughts as these are nearer to the surface of consciousness.

Unconscious thoughts - the thoughts that are stored in memories and are automatically retrieved when necessary. These thoughts are not readily available to one's awareness or conscious level of thinking.

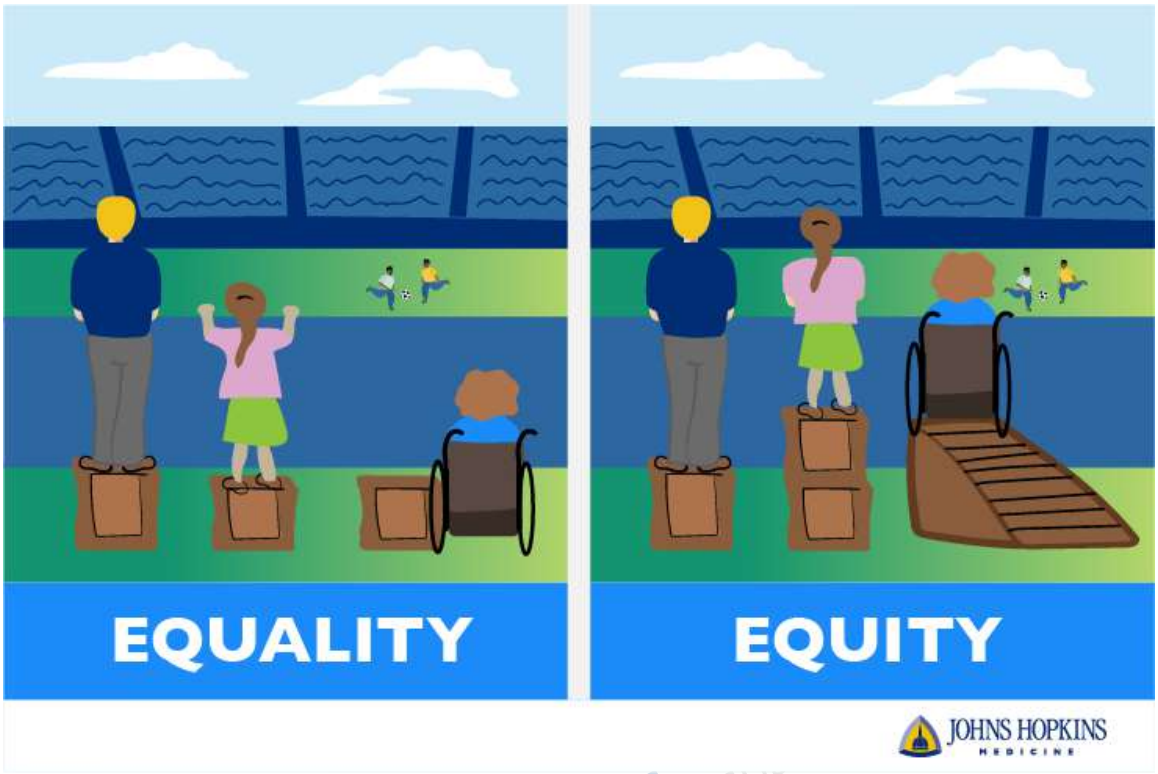
Section 3: Understanding Health Equity and Disparities

Definition of Health Equity and Health Disparities

When starting to define health equity and health disparities, it is important to understand that, while they are two distinct ideas, they overlap in many ways.

Health equity is defined as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." (Office of Disease Prevention and Health Promotion, n.d.) Notice how this definition does not include the word equality. This is purposeful and an important distinction to make.

For example, see the figure below from John's Hopkins University (2022):



The figure shows that each person may have the same goal of being able to watch the game, but they each need different types of support to achieve that goal.

Similarly in healthcare, while a client's goal may resemble the goals of other clients, how each client achieves that goal will be influenced not only by the client's individual needs, but also by the systems in place that either support or hinder the client's ability to achieve their goals.

When a client experiences either individual or systemic barriers to addressing their healthcare, these barriers lead to health disparities. **Health disparities** are defined as "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." (Office of Disease Prevention and Health Promotion, n.d.)

Social Determinants of Health

To better capture and organize health disparities, Healthy People 2030 has created the following categories called **The Social Determinants of Health** (SDOH) Office of Disease Prevention and Health Promotion, n.d.).

Social Determinants Of Health (SDOH) are grouped by the following categories:

1. Economic stability
2. Education Access and Quality
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

(Office of Disease Prevention and Health Promotion, n.d.)

How do each of the social determinants of health impact health equity and health disparities? Let's take a look.

1. Economic Stability focuses on the rate of poverty and access to gainful employment.

    a. Insurance or lack thereof - If a person does not have access to an employer that provides insurance and they are above the federal or state poverty line (ineligible for Medicaid), they may be unable to afford a health insurance plan or the co-pays needed for a plan to cover their care.

    b. Sick Leave – A person may not have an adequate sick leave policy as part of their employment opportunities. They may be forced to choose between losing pay or losing their job and taking care of their health.

2. Education Access and Quality focuses on improving education delivery systems in schools to support children, adolescents, and returning adults so that they can receive the education they need to access higher paying jobs.

    a. Health literacy, or the ability to read and understand health care literature, is an insidious assumption. Individuals in the healthcare industry, including front line workers like social workers, may assume that clients have had access to equitable reading comprehension supports in English or in their first language to allow them to understand even basic reading materials. Many clients will not admit to being unable to read due to the discrimination and shame experienced when asking for help.

3. Health Access and Quality focuses on how clients are able to access healthcare systems.

    a. If a client does not have insurance coverage, they are unlikely to pay privately for a primary care physician. Primary care physicians are

often the gatekeepers to specialists because they control who gets a referral for a higher level of care and when. Without access to a primary care physician, many health conditions go untreated.

   b. Transportation - A person may not be able to afford a car, have access to a car, be able to pay for gas, or even be able to pay for mass transit systems to get to clinic appointments. Costs of parking or nearby parking can also be a barrier to accessing care.

   c. Clinics are not located near bus stops, train terminals, or other mass transit stations and require the use of a car, taxi, or rideshare to access the appointment.

4. Neighborhood and Built Environment focuses on environmental justice for marginalized communities.

   a. Redlined communities are communities that have been outlined by lending institutions like banks as suboptimal areas of land. For example, there are communities that have been built in flood zones, on top of landfills, or near chemical waste sites. While these homes and rental buildings are less expensive, it is because there are major health risks associated with living there.

   b. Violence can be a result of historical trauma or oppression, or it can be used as a means to survive from day-to-day. If violence were reduced, or stressors that lead to violence were reduced, then communities could potentially live healthier and longer.

5. Social and Community Context involves the health of the support system of an individual.

a. Social support systems that are stressed or absent make it difficult for a person, by themselves, to achieve the health that they want or to recover from health-related injuries.

(Office of Disease Prevention and Health Promotion, n.d.)

Section 3 Reflection Questions

1. Which of the 5 social determinants of health (Economic Stability, Educational Access, Health Access and Quality, Neighborhood and Built Environment, Social and Community Support) affect me either positively or negatively?
2. Which of the 5 social determinants of health most commonly affects the clients with whom I work?
3. How does reflecting on my social determinants of health and the social determinants of health of the clients with whom I work highlight disparities, privilege, or gaps in care?
4. What additional education do I want or need to start to address this power differential?

Section 3 Conclusion

To recap this section, health equity and health disparities are inextricably linked, but they are also two separate concepts that seek to dismantle individual and systemic barriers to improved health outcomes.

Section 3 Key Words

Health equity - the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Health Disparities - 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.

Social Determinants Of Health - Categories created by the Healthy People initiative to categorize and focus health care equity into 5 distinct categories: Economic stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context.

Section 4: Strategies to Remedy the Negative Impact of Implicit Bias on Health Care Equity and Health Care Disparities

Negative Impact of Implicit Bias on Health Equity and Health Disparities

Now that we've discussed implicit bias, how implicit bias can manifest, health equity, and health disparities, let's see how all these concepts fit together.

Remember, implicit biases are created by stereotypes that influence what we say and do in our relationships with clients. This can be seen both in the patient-provider relationship and in the systems in which we as providers work. (Payne & Hannay. 2021).

In the next section, we will explore how implicit biases impact health care access and service delivery at the micro, mezzo, and macro levels.

Implicit Biases at the Micro Level

At the **micro level** of care, we are focusing on the day-to-day interactions of providers, including social workers, with clients. At this level, implicit bias can manifest in the ways that we understand how clients access healthcare, interpret healthcare needs, and ultimately make decisions on what they need for healthcare services (Gopal et. al., 2021).

Examples of implicit biases at the micro level include but are not limited to:

- Making uninformed or ill-informed judgements about a patient's health based on stereotypes (Gopal, et. al. 2021, Office of Disease Prevention and Human Services 2023, Shah & Bohlen, 2023).
- Using a family member as a medical interpreter because they are there and present rather than waiting for a medical interpreter to arrive.
- Misdiagnosis based on race (Gopal et. al. 2021, Office of Disease Prevention and Human Services 2023, Shah & Bohlen, 2023, The Joint Commission, 2024).
- Asking a provider, client, family member, staff person, or interpreter to be a cultural broker to educate you about your client's race, ethnicity, cultural practices, beliefs systems, sexuality, and or gender identity (DiAngelo, 2016).

- Not acknowledging that having a person of color tell you about oppression is reopening trauma for them (DiAngelo, 2016).

Implicit Bias at the Mezzo Level

At the **mezzo level** of care, we are focusing on the systems and policies that govern the organizations within which we work and the organizations our clients interact with to meet their health care needs. Implicit bias manifests here in the assumption that clients have access to healthcare, can navigate health care systems independently, and are comfortable with Western Medicine practices. It can also manifest when clients are continuously working with staff who are White or are from a different cultural group.

Examples of implicit biases at the mezzo level include but are not limited to:

- Bathrooms in a facility that are gender specific.
- Inaccessible doorways, hallways, entrances, rooms, etc. for those with mobility needs (Marcelin et. al., 2019).
- Organizational policies that limit the ability of any person to fully achieve their health goals. Examples of this include:
    - A client is given “two strikes” and dropped from a clinic for missing an appointment rather than investigating what the client needs to successfully get to their clinic appointment.
    - Not allowing a partner who is not legally married to the client to be a healthcare decision maker if there is an emergency.
- Organizational practices that prevent the hiring and promotion of providers and staff of color (Marcelin et. al., 2019).

- Paintings, wall decor, signs, etc. within the organization that connote systems of historical oppression, historical trauma, or cultural appropriation.
- Only offering Western Medicine and denying or preventing other forms of cultural, spiritual, or holistic healing from being used. This can also include the exclusion of spiritual and cultural healers from being a part of the treatment team (Ganotta, et. al., 2018).

Implicit Bias at the Macro Level

At the **macro level** of care, we are focusing on the state and federal systems, policies, laws, programs, etc. that govern who is allowed to receive care and financial support. Implicit bias manifests here in how we assume what clients need and how we make assumptions about who is most in need of assistance mainly through financial needs assessments.

Examples of implicit biases at the macro level include but are not limited to:

- Financially accessible insurance plans for lower income persons offering suboptimal care, coverage, or a very limited provider network.
- State and Federal programs that require clients to wait on hold for hours to talk to a representative about their financial needs, social needs, Medicaid status, etc.
- Continuing to uphold laws that were written during eras of discrimination, have not evolved to meet the healthcare needs of the constituents they govern, and may only have been written from a white, affluent perspective (Braveman et. al, 2022).

- Continuing to elect public officials who maintain the “status quo”, thus allowing bias to continue in our government systems. (Braveman et. al, 2022)

After learning about some of the implicit biases that exist within ourselves and within the systems where we work, the next step is working on individual, organizational, and systemic strategies that dismantle implicit bias.

Professional Strategies (Micro Level)

In this section, we will focus on strategies to help remedy implicit bias within ourselves, within our client relationships, and within the systems and organizations in which we work and provide healthcare services.

Awareness

The first step in recognizing implicit bias is to look within ourselves and find a level of awareness of how we may be intentionally or unintentionally engaging in implicit biases and microaggressions. Atkins (2023) recommends taking the following steps to find your own inner awareness:

The first step in recognizing implicit bias is to look within ourselves and find a level of awareness of how we may be intentionally or unintentionally engaging in implicit biases and microaggressions. Atkins (2023) recommends taking the following steps to find your own inner awareness:

1. **Recognition that “implicit biases and microaggressions exist”:** By deciding for yourself that “these phenomena are problematic”, you can start to work towards improving your care delivery as a provider.
2. **Acknowledge your bias:** While this is a hard and often scary step, it is important to know yourself inside and out. What you have learned, have

been told, and have lived through has formed experiences and mental associations that may knowingly or unknowingly hurt another person.

3. **Learn more about you:** If you have someone you trust, ask them if they notice any implicit biases that you hold. It is not recommended to ask a person from a marginalized community to be your "litmus test" for implicit bias. This will cause more harm to them than help to you.

4. **Extend your comfort zone:** Get to know your clients individually. What is unique about them, their circumstances, and their needs? While we may have assumptions or ideas about groups of clients, it is best practice to always ask questions to create truly client-centered care.

5. **Take responsibility for mitigating bias:** Now that you have thoroughly examined yourself, it is time to monitor your day-to-day interactions. Where do you see yourself continuing to need education, improvement, or support? By being open to learning, we don't fall into the trap of "cultural competency" or being "free of bias" based our own personal assessment.

6. **Admit mistakes:** When you make a mistake with a client, repair the relationship as best as you can. Some tips to repair a relationship include:

    a. Being intentional in your apology by ensuring that you take responsibility for the harm caused to the client.

    b. Set aside any defensiveness or desire to explain yourself. Trying to explain yourself may give the impression you think that it was okay to say what you said or did what you did. Know that you caused harm. You will likely not feel good about it, but it is not up to the client to comfort you or tell you it is okay.

    c. Do not dwell, but instead move forward. Once you've apologized, if your client has accepted your apology, then continue with your work

and learn from this experience to try to prevent it from happening again. (Kothari, 2017).

The Power of Words

Have you ever taken the time to think about the words you use in everyday life? For example, saying “you look good for your age” or “you haven’t aged a day” perpetuates the idea that aging is bad and that the younger we appear, the more able we are.

Words hold power, and when used inappropriately, words can create and perpetuate systemic and historical traumas faced by many groups of people. Knowing the “right thing to say” every time is not an achievable standard as you will never know everything about every person. Also, this idea assumes that individuals within groups have the same lived experiences, which is untrue. It is recommended to engage in open conversations with your clients. (Ro, 2021, McClure, 2020).

Am I Providing Equitable Care Every Time?

When working with diverse clients, ask yourself, am I doing the same level of work for each client? For example, you may find yourself wanting to “go the extra mile” for a client because you “really like them”. Ask yourself, what makes this client more likeable than another client? What makes this client deserving of the extra mile? Does the extra mile take away time in your day that could be devoted to another client? If a less likeable client had the same need, would you go the extra mile for them as well?

Asking these questions requires us to critically examine our biases and if we are upholding the NASW Code of Ethics. It helps us understand who we work harder for, who we advocate more for, and, conversely, those who we work less for and

advocate less for. It is recommended to examine where and why this is happening so that you can strive for ethically equitable care practices.

Am I Practicing Ethically?

Take time to review the NASW code of ethics to determine if your actions are addressing social injustice and social problems, upholding the dignity and worth of your client, including their cultural needs, and prioritizing respect in the human relationship. Each of these values culminate in practicing with integrity and respect for each client we serve (NASW, 2021).

It is recommended to review the NASW Code of Ethics regularly to determine if your actions are ethically sound. Even though you may have practiced for many years, it is still important to seek ongoing supervision or consultation if you are unsure if your practices are meeting ethical standards.

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Never strive to be culturally competent. No one person is truly ever competent, and this idea perpetuates the idea that cultural groups share the same characteristics and does not leave room for individuality. You should instead strive to be culturally aware and recognize that each individual person has their own voice, their own unique lived experiences, and requires individualized attention and care (Lekas, Pahl, & Fuller Lewis, 2020).

In developing your cultural awareness, it is recommended to attend trainings and read peer reviewed / evidence-based literature to start to inform yourself of the possibilities that exist with your clients. Never use a colleague or a client to provide your education. You are responsible for educating yourself.

Transference and Countertransference and Implicit Bias

Implicit bias can appear in the therapeutic relationship as transference and countertransference. So far, we have been strongly focused on the provider's potential bias towards their clients, but what happens if a client has a bias towards us as the provider? That is where transference and countertransference can play a role. For example, many historical and present day traumas between marginalized groups and social workers continue to exist today. These traumas create an immediate barrier of mistrust from the client towards the provider (transference). This can then elicit a negative response from the provider (countertransference), which can turn into an implicit bias about groups of traumatized persons. It is important that we, as providers, understand why our clients come guarded and protective of themselves. We should work to provide a restorative experience through the therapeutic alliance. (The Joint Commission, 2013).

Organizational Level Strategies (Mezzo and Macro Levels)

At the organizational level, we should engage in strategies that look within the organization, be it the culture, the diversity and availability of staff, the policies that govern our work, the immediate surroundings, or something else. The goal of looking into the organization is to continuously improve service delivery and to create an intentionally safe space for our clients. It is important for us as social workers to notice when our organization needs to engage in change.

Recommendations for organizational change include but are not limited to:

1. **Review policies and procedures.** While healthcare institutions are governed by state and federal laws, it is important to create a space to have open and healthy discussions about how to operate both legally and equitably. If a policy is at least a year old, it should be reviewed to determine if it

continues to support diverse clientele or if it is biased towards diverse clientele (The Joint Commission, 2022).

2. **Review the culture of an institution.** Who does the institution mainly serve? If the answer is that it serves predominantly affluent white clients, you should have honest and thorough discussions about why this is and why other communities of people do not come to your institution or do not have access to your institution.

3. **Create norms** that do not allow for bias, discrimination, cultural appropriation, or other harmful and unsafe practices.

4. **Examine the diversity of your staff beyond just race.** While race is important, remember that individuals may also have preferences to see providers that are LGBTQ+, have mobility needs, are a person of size, etc. It is also important to ensure that this diversity is seen in all levels of management of the organization (de Silva de Alwis, Heberlig, & Holcomb, 2020).

5. **Normalize the conversation around bias** (Atkins, 2023). The more that bias is collectively worked on, the faster that cultural norms will improve.

6. **Request and require yearly DEI trainings** that highlight various cultural groups, cultural norms, and cultural practices as they relate to healthcare service delivery (The Joint Commission, 2022).

7. **Review organizational practices** for adherence to improving social determinants of health (Office of Disease Prevention and Health Promotion, n.d., The Joint Commission, 2022).

8. **Be the change you want to see in your organization.** We cannot expect a group to change if we aren't changing ourselves.

Section 4 Additional Activities

If you want to learn more about implicit associations and implicit biases, it is recommended to try a few of the Implicit Associations Tests (IATs) from Harvard. After taking these tests, reflect on these questions:

1. What did I learn about me that was new?
2. After receiving this training, what can I start to do that can help change my biases that were shown in the IAT tests that I took.
3. After receiving this training, what do I notice about my organization's biases, and what is one way that I can start to make a difference in my workplace.

Section 4 Conclusion

To recap this section, implicit biases are embedded both within the one-on-one work we do with clients as well as within the systems in which we work. It is always recommended to start with yourself and understand both your known and unknown biases. Once you have developed your own process for learning and growth, be empowered to make changes within your organization or community group that is providing healthcare services to underserved or marginalized populations. When we work together to dismantle bias, change can happen. It starts with you.

Section 4 Key Words

Micro Level - The focus in micro level work is on one on one relationships with clients and the one on one relationships they have with other persons who are close to them. An example is therapy work with an individual and or their family.

Mezzo Level - The focus in mezzo level work is on the health of the community, and the systems within which a community interacts. An example is how the policies, procedures, and organizational culture of an individual hospital and or clinic support or hinder the health of the community in which it is built.

Macro Level - The focus in macro level work is on the state and or federal laws, policies, and procedures that either help or hinder health equity. Macro practice can also focus on multistate corporation's policies and procedures or if a corporation extends to several types of communities each with their own diverse needs.

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