Using Critical Reflection to Mitigate Racial Implicit Bias and Enhance Cultural Humility: A Nursing Faculty Action Research Study

Teresa Stafford Cronell

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USING CRITICAL REFLECTION TO MITIGATE RACIAL IMPLICIT BIAS
AND ENHANCE CULTURAL HUMILITY:
A NURSING FACULTY ACTION RESEARCH STUDY

by

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DEDICATION

I would like to dedicate this journey to my wonderful children. Preston, thank you for always telling me to keep going and that I could do this. Your encouragement has meant the world to me and your wisdom beyond your years has held me up when I felt like giving up. To Erik, I appreciate your listening and keeping an open mind as I walked along this path to completion. I am grateful for your open support in social justice matters. Thank you both for being with me as champions for those who are marginalized, oppressed, and treated as outsiders. I love you both beyond words and actions. You are my life and my legacy. I thank God every day that I have been blessed to be your mom.

From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked.

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I want to take this opportunity to thank those who have supported me in this endeavor and assured me that this is but a season in time. To my sisterhood within the College of Education--Molly, Jillian, and Christi—thank you all for being with me in this adventure. I am so very grateful to each of you, and we are sisters for life. You all have your special gifts and through our different strengths we were able to support one another through one of the most difficult challenges of our academic careers.

A very special thanks to Dr. Jeffries for providing the final nurturing I needed to complete this dissertation. You were truly the wind beneath my wings that sustained my writing even through exhaustion. To my dissertation committee members, I am eternally grateful. Dr. Tamim, you have an amazing ability to inspire students to write exceptional works within a short amount of time. I appreciate you being my professor for the literature review and the organizational change courses. These two courses reinforced the importance of clarity in scholarly writing. Dr. Silvernail, you taught one of my favorite courses—gender diversity. I learned so much about championing gender affirmation through a better understanding of the historical foundations of gender oppression. I will continue to fight and advocate for nursing education inclusivity for all. To my colleague, mentor, and friend, Dr. Holton, words cannot fully express how much you have meant to me throughout my career as a nursing educator and leader. I love you so much and appreciate you always being there for me. I would be lost without your insight.
ABSTRACT

Formal American nursing education has existed since the late 19th century, but its historically deep-seated white framing continues to influence how current nurses are educated, enculturated, and professionalized. Insufficient inclusivity and diversity deficit have endured despite decades-long demands to do otherwise. To most nursing educators, the white frame is invisible. This unseen framing allows ongoing harmful implicit biases and microaggressions towards underrepresented nursing students and colleagues to persist. Nursing students are taught to provide culturally humble, unbiased patient care. Should not nursing faculty likewise demonstrate the same unbiased attitudes and humility towards their students? Faculty risk perpetuating the white frame normative without acquiring the knowledge, skills, and attitudes needed to enhance inclusive excellence, redress biases, and confidently question oppressive exclusionary practices in nursing education. Transforming nursing educators' hidden assumptions using a critical lens of equity and justice is vital to creating inclusive learning experiences for underrepresented student nurses. Increasing nursing faculty awareness of biases, mitigating bias impact, and enhancing cultural humility in nursing education spaces supports inclusive excellence.

This complex, two-phase, sequential explanatory mixed-methods action research study sought to determine nursing faculty: 1) implicit bias attitudes, 2) perceptions of cultural humility, and 3) the effect of critical self-reflection on assumptions related to study constructs. Qualitative data analysis derived six themes: unknown identity and
impact, racial avoidance and disempowerment, wide lens viewpoint, and hopeful optimism. Additionally, this study posits three assertions: communication is a catalyst for increasing racial bias awareness, learning is transformative when utilizing critical reflection, and affirmation is fuel for cultivating cultural humility. The use of critical reflection by nursing faculty in this study demonstrated positive gains in bias self-awareness and enhancement of cultural humility descriptors. Using communication level setting and psychological safety was crucial to promoting faculty collaboration and dialectical discourse during team learning sessions on racial implicit bias, its negative impact on healthcare provision and education, and cultivating cultural humility. A three-phase action plan for progressing this study’s work utilizes socioecological leveling: Phase 1 begins at the micro-level with building nursing educator capacity (agency), Phase 2 expands out into the meso-level with organizational change (engagement), and Phase 3 describes macro-level activism and power of policy mandates (advocacy).

Keywords: critical reflection, nursing, nursing education, implicit bias, critical race theory, cultural humility, cultural humbleness, inclusive excellence, intersectionality, race, racism, transformative learning theory
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<td>DEI</td>
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<td>FT</td>
<td>Full-time</td>
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<td>IAT</td>
<td>Implicit Association Test</td>
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CHAPTER 1
INTRODUCTION

When I began my nursing career over three decades ago, I never once gave thought to the lack of diversity within the profession. The concept of diversity was not even on my radar as I went about my daily work as a practicing nurse. My mindset was simply focused on implementing the core nursing values of holistic care no matter what the patient’s race, religion, creed, or beliefs. Caring nursing practices dictate assisting all patients back to their highest level of health possible with an attitude of altruism and compassion. Within the context of nursing care, cultural competency has been discussed for many years. Yet cultural competency has many nuances and intricacies that make it difficult for any nurse to be fully culturally competent (National Academies of Sciences, Engineering, and Medicine, 2021). Current nursing research and literature have urged shifting away from cultural competency and moving towards developing cultural humility (Hughes et al., 2020; NASEM, 2021). Cultural humility is especially vital to nursing care practices in an increasingly diverse society.

Later in my career, I became a nursing educator. As a White, middle-aged female nursing faculty member educating future nurses, I am acutely attuned to how I mentor and model caring practices towards all patients, especially those from racially and ethnically diverse backgrounds. I idealized that student nurse demographics matched the diversity in patients for whom nursing care is provided. Yet as I looked at my students, I noticed an overwhelming White majority staring back at me. A few diverse students were
nested here and there within the group, but the disparity was glaringly obvious. As I researched this problem, I had a grandiose aim to rapidly increase diversity, equity, and inclusion (DEI) within the nursing educational space of my university. I have since learned that seeking immediate solutions are unrealistic and short-lived. There is an appreciation for the complexity involved in such diversity deficit and a need for focused clarity that employs thoughtful, high-quality engagement in collaborative efforts to address the problem.

To make DEI an achievable goal, I pondered the root cause for the diversity deficit in nursing education. A reasonable and feasible action research study was needed to focus first on the educator. Continuing to narrow the problem focus, I became fascinated by human cognition and the origin of implicit bias (IB). I learned how hidden assumptions and beliefs drive actions and behaviors (Senge, 2012). Would it be possible to tackle DEI in nursing education spaces by first unpacking the hidden assumptions and IB of nursing faculty? By digging down deep within the roots of the problem, I wondered if facilitating faculty recognition and management of IB would have any influence on their cultural humility and teaching practices. For this great and awesome task, I prepared myself with the knowledge, skills, and attitude necessary for changing my university’s nursing culture to support ongoing efforts towards inclusive excellence.

The time is right to fully recognize the reality that IB exists in nursing education and mitigating its negative impact for the betterment of underrepresented (UR) student nurse experiences is critical. While I agree that creating and supporting inclusive practices in nursing education requires ongoing, continuous attention and work (Evans, 2001), the outcome is well worth the arduous effort. This work cannot, and will not, be a
“one and done” moment for nurse educators, but rather equated to a stone thrown into a pond with promising ripples that gain increasing momentum as faculty humble themselves towards inclusive excellence in nursing education.

**Problem of Practice and Research Questions**

There exists an overwhelming White frame of homogeneity within nursing programs. In 2021, only 30% of baccalaureate and graduate students reported being from diverse backgrounds (AACN, 2022). Moreover, a recent workforce survey noted that 81% of registered nurses are White and 90% female (Smiley et al., 2021). The over-representation of White females in both student and faculty populations, and the White lens by which future nurses are educated and enculturated, is evident in nursing research literature (Bonini & Matias, 2021; Hantke, Denis, & Graham, 2022; Schroeder & DiAngelo, 2010). As a nursing lecturer in a prelicensure undergraduate (UG) baccalaureate nursing program, my problem of practice is faculty unawareness of biased attitudes towards UR students and the impact this potentially has on faculty cultural humility and inclusive practices. Using a critical lens, I wondered if faculty “see” students for who they are as individuals outside of and beyond the educational spaces of nursing programs.

Personal evidence of the problem of IB unawareness came to my attention during a conversation about my research interests with school of nursing (SON) leadership. The Director of Nursing explained how an UR nursing student experienced faculty instigated microaggressions in class. The student had been singled out not once, but on multiple occasions. “Singling out a student” means that a student is asked to “speak for” and educate others about members of the group to which the student belongs (Portman et al.,


What is shocking is that this is not the only time an UR student had been microaggressed by nursing faculty within the program. This conversation made clear that faculty are both unaware of their biases and unaware of the IBI have on UR students in the nursing program. The habits of mind can be persistent and can be difficult to change (Evans, 2001; Kitchenham, 2008, Mezirow, 1997), but change can be possible (APA, 2022). This problem of practice called for increasing nursing faculty awareness of biases, mitigating impact, and recognizing the need for increasing cultural humility in nursing educational spaces to support inclusive excellence.

Approaching the problem of faculty unawareness of IB is both timely and supportive of national initiatives calling for nursing educators to prepare future nurses to provide unbiased care to an increasingly diverse population (NASEM, 2021). This research also meets the SON strategic plan to promote discussions and develop activities to address DEI. Nursing educators have a powerful impact on students’ educational experiences. For nurse educators to prepare the next generation of nurses, they must mentor and model cultural humbleness by fully embracing DEI in the classroom and clinical setting through learning to mitigate biases that negatively impact the education of UR students as well as the care of diverse patient populations.

This action research study sought to answer three questions:

RQ1 What are nursing faculty racial implicit bias perceptions?

RQ2 To what degree are nursing faculty culturally humble?

RQ3 How does critical reflection affect racial IB and cultural humility attitudes?
Background and Problem Impact

This research aimed to discern faculty attitudes and perceptions of IB in nursing and nursing education. Increasing faculty awareness and management of IB may work towards mitigating negativity brought into nursing education experiences. Further, this study sought to push beyond simply increasing awareness of the issue. Reducing biased behaviors of faculty required cultivating inclusive excellence that will benefit all. An overview of the current state of nursing education and professional practice demographics is important to contextualize the lack of diversity within the discipline. The far-reaching effects of IB extend out from nursing educational spaces into clinical practice settings where nursing judgment and decision-making has the potential to influence health outcomes of diverse communities (Thirsk et al., 2022).

The Problem in Nursing Demographics

An ongoing emphasis on increasing student diversity in nursing programs has shown evidence that UR students have increased in baccalaureate nursing programs annually over the past five years (AACNb, 2022). According to 2022 data, 40.3% of baccalaureate nursing students were from UR groups (AACNa, 2023), up from 37.9% the prior year (AACNb, 2021). An increase in male nursing students now account for 12.8% of the student population (AACNb, 2021) and 9.4% of the nursing workforce (Smiley et al., 2021). However, the nursing workforce lacks racial diversity. The 2020 National Nursing Workforce Survey found that 81% of registered nurses in the U.S. are White, while Blacks represent 6.7%, Hispanics 5.6%, and Asians 7.2% (Smiley et al., 2021). Nursing remains a majority White female healthcare profession.
While the increasing student nurse diversity population statistics are encouraging, the data trends noted in nursing practice demographic data remain disparate. These statistics also cause concern as there are not equivalent UR students completing and graduating from nursing programs as there are entering nursing programs. Additionally, UR students are still facing a majority White female faculty (Alexander, 2021). It is yet to be seen if the current continual rise in UR nursing students will add to the nursing workforce diversity. Lack of UR students completing nursing programs also impacts the potential pipeline of diverse faculty and the future diversification of nursing academia leadership.

Though an overall shortage of nursing faculty exists, there is an even greater disparate number of UR faculty. According to the American Association of Colleges of Nursing (AACNa, 2022), the current vacancies of full-time nursing faculty in the U.S. ranges from seven to nine percent, depending on the region of the country. Current statistics indicate that only 17% of nursing faculty are from UR groups (Alexander, 2021). The deficit of UR faculty limits their potential progression into nursing academia leadership. Currently, only 10% of nursing program deans are from diverse backgrounds (Thompson, 2021). Further, AACN (2017) stressed the need for diversification in both the workforce and academia to better support diverse nursing students. Abdul-Raheem (2016) agreed and urged White faculty to use their power to support UR faculty development and tenure because students of color, “will feel adequately represented and supported” (p. 55).

More recently, the National Academies of Sciences, Engineering, and Medicine released the third in a series of reports entitled, *The Future of Nursing 2020-2030:*
Charting a Path to Achieve Health Equity (NASEM, 2021). This report stressed the important role nurses will play over the next decade in the equitable health care of an increasingly diverse population (NASEM, 2021). Therefore, nursing educators are charged with ensuring that future nurses are armed with the skills, knowledge, and attitudes to be “prepared to help promote health equity, reduce health disparities, and improve the health and well-being of everyone” (NASEM, 2021, p. 189). Moreover, the committee proclaimed a change is needed in “what is taught, how it is taught, who the students are, and who teaches them” (NASEM, 2021, p. 190).

**Diversity Deficit, Insufficient Inclusion, and Implicit Bias**

Diversity is only one part of the DEI problem noted in healthcare and healthcare provider education. There is ample evidence of how the diversity deficit, inequitable practices, and lack of inclusivity impacts health and wellness of communities (Zescott et al., 2016; Sullivan, 2020). Moreover, the shortage of diversity in the nursing workforce greatly impacts cultural competence of healthcare provision in UR communities and can result in poorer health outcomes for these groups (Wilbur et al., 2020). On the other hand, healthcare workers representative of diverse populations are better positioned to understand the unique cultural needs of diverse groups, build improved trusting relationships with them, and advance their overall health outcomes by eliminating health disparities (Sullivan, 2020; Green, 2020; Wilbur et al., 2020; Phillips & Malone, 2014). Bringing diverse, authentic voices into all nursing student learning spaces will not only empower future nurses but improve safety and accountability of the interdisciplinary team (Day & Beard, 2019). Still, pressure to increase diversity in nursing education institutions has continued for several decades without appreciable gains to the
diversification of the nursing workforce (Green, 2020; Noone et al., 2020, Phillips & Malone, 2014).

Before nursing can achieve meaningful diverse and equitable changes, we must deal with creating inclusivity. Inclusivity is, “the intentional incorporation of practices that foster a sense of belonging by promoting meaningful interactions among persons and groups representing different traits, perceptions and experiences” (Metzger et al., 2020, p. 5). Creating diverse perspectives necessitates inclusion of others into group dynamics. Inclusion is about valuing the opinions and contributions of others (NeuroLeadership Institute, 2022). Weller (2020) argued that creating feelings of inclusion within groups is driven by unconscious positive biased behaviors towards others, making the two concepts very closely interrelated. It is then understood that unconscious negative biased behaviors can leave others feeling excluded without a sense of belonging (Weller, 2020).

Specifically, current research links healthcare provider IB as a contributing factor to healthcare inequities, health disparities, and negative patient experiences (Zescott et al., 2016; Salmond & Dorsen, 2022; Thirsk et al., 2022). Furthermore, UR faculty who experience racism and negatively biased behaviors in academia demonstrated less persistence to stay in nursing education (Beard & Julion, 2016; Orelus, 2013). Likewise, UR nursing students who are subjected to faculty biased microaggressions reported negative educational experiences and less persistence which resulted in increased nursing program attrition for these students (Graham et al., 2016; Green, 2020). Therefore, nursing faculty need the necessary knowledge and skills to mitigate IB especially, given that assumptions, beliefs, and behaviors directly impact the education climate and nurse caring practices (Crandlemire, 2020).
Theoretical Framework

This study was framed by Crenshaw’s critical race theory (CRT) and Mezirow’s transformative learning theory (TLT). Critical race theory provided the context for how IB impacts the learning spaces of UR students. Part of faculty unawareness of IB towards UR students is the ignorance as to how reality is socially constructed, how race is a dominant factor in inequity in the U.S. (Ladson-Billings & Tate, 1995), and how institutionalized racism intersects with other -isms to become a normalized discourse in many settings (George, 2021). Transformative learning theory provided the structure for the team learning sessions and faculty intervention using critical reflection. Mezirow (1994) described the transformation of meaning structures through critical self-reflection of one’s beliefs, especially the “unexamined assumptions of our beliefs when the beliefs are no longer working well for us, or where old ways of thinking are no longer functional” (p. 223). Transforming assumptions of nursing faculty under the critical lens of inequity will be key to creating more inclusive learning experiences for UR nursing students.

Critical Race Theory

The foundation for what would become critical race theory (CRT) began several decades before the critical legal studies movement of the 1970s with work of early leaders and law professors, Derrick Bell and Alan Freeman (Delgado & Stefancic, 2017). A spin off movement into education occurred in the late 1980s and into the mid-1990s when Kimberle Crenshaw, who coined critical race theory, returned to the University of Wisconsin as a visiting fellow and subsequently developed learning sessions on race and legal theory (Ladson-Billings, 2009). Crenshaw (1991) also popularized the term
intersectionality in early writings related to how race and gender intersect, reinforcing each other in the inequitable treatment of Black women. Ladson-Billings and Tate (1995) expanded CRT into the American education system as a framework for understanding how racism drives primary and secondary school inequities.

Recent emancipatory approaches to cultural competency in nursing has used CRT as a framework to address the specific tenets of *ordinariness of racism* manifested as colorblindness, economic and psychological power interests of Whites noted in *interest convergence*, and *race as a social construct* that subjugates others to a nonracialized dominant group (Wesp et al., 2018). The tenet of ordinariness of racism allows its persistence because it is not acknowledged (Delgado & Stefancic, 2017). Without truly “seeing” the diversity and ethnicity of nursing students, faculty remain colorblind. Color blindness allows for continued subtle structural racism to remain embedded, manifesting as microaggressions against UR students (Hall & Fields, 2013). These microaggressions are rooted in IB and faculty ignorance of how overlapping intersectional oppression operates to reinforce each other (Bell, 2016).

Nursing needs to acknowledge the gap in critical reflection of racism and develop a language skillset to have safe, honest, and productive discussions about implicit biases (Wesp et al., 2018). If nursing students are expected to provide unbiased care through cultural competency and humility towards their patients, should not nursing faculty likewise demonstrate the same towards nursing students? Critical conversations related to faculty perceptions of race, diversity, inclusion, educational equity, and implicit bias are necessary in nursing education (Breslin et al., 2018).
Transformative Learning Theory

Jack Mezirow first developed what would become transformative learning theory (TLT) while researching college re-entry programs designed for women who sought to return to employment after being away for an extended period of time (Mezirow, 1978). A key theoretical finding of Mezirow’s (1978) early research was the perspective transformation in how women defined themselves and their relationships with others. The theory includes eleven phases of transformative learning, with special focus on relationships and the importance of critical self-reflection, beginning with a “disorienting dilemma” (Mezirow, 1994, p. 224) and ending with a reintegration of a new meaning perspective (Mezirow, 1991). This research study dealt with content that could cause dissonance in participants; therefore, the learning sessions were expected to be quite disorienting and evocative. This study endeavored to determine if participants’ perspectives could be changed using a critical reflective frame of reference.

Frames of reference shape the process of learning broadly by changing meaning perspectives (psychocultural assumptions) or specifically by changing meaning schemes (beliefs, judgements, or feelings) that influence interpretations (Mezirow, 1994). Three types of reflection are integral to the process of transformation. Content (what) and process (how) reflection can transform meaning schemes, while premise (why) reflection results in the most transformational learning through perspective meaning changes (Kitchenham, 2008). Figure 2.1 visualizes the three types of critical reflection.

Both CRT and TLT are effective supportive theoretical frameworks for addressing the issues related to diversity, equity, and inclusion in nursing education with specific focus on IB and developing nursing faculty cultural humility. Expounding upon
the tenets of CRT in nursing education can illuminate the detrimental effects of the normalization of racism, colorblindness, implicit bias, and resultant microaggressions (Delgado & Stefancic, 2017). IB limits inclusivity in educational spaces by “singling out” those that are different from the majority (dominant) group (Portman et al., 2008).

Transforming nursing faculty meaning perspectives required creating a disorienting dilemma by increasing the level of awareness of study participants’ IB. TLT was used as a structured framework for supporting profound change to meaning schemes and perspectives. Moreover, critical reflection aids ongoing support for enhancing inclusive educational experiences, mitigating IB, and cultivating faculty cultural humility.

**The Role of Cultural Humility**

Cross-cultural care rose to prominence in the 1960s, with a movement from cultural sensitivity towards cultural competence to address the inequities in medical care in the latter half of the 20th century (Smedley et al., 2003). Cultural competence is the ability to develop functional interpersonal relationships despite cultural differences (Smedley et al., 2003). However, a false sense of cultural confidence (Marcelin et al., 2019) can occur because of failure to practice “constructive uncertainty” required to remain culturally humble (Ross, 2014, p.14). *Constructive uncertainty* is humbleness in not always having the correct answer or remaining uncertain about the answer (Ross, 2014).

Nearly 25 years ago, Tervalon and Murray-Garcia (1998) wrote their seminal article that challenged the mindset of cultural competency by proposing a lifelong commitment to cultural humility. Foronda et al. (2016) defined *cultural humility* as the lifelong learning process of supportive openness towards various cultural, social, and
interprofessional contexts, such as socioeconomic status, racial and ethnic differences, and sexual preferences, to name a few. Tervalon & Murray-Garcia (1998) added that cultural humility prevents paternalist physician-patient relationships and shifts towards more partnership, goal-directed interactions. They also argued for ongoing self-reflection and for healthcare workers to remain “flexible and humble enough to assess anew the cultural dimensions of the experiences of each patient” (Tervalon & Murray-Garcia, 1998, p. 119).

Recognizing the difficulty for nurses to be competent in every culture, the nursing profession has switched from the impossible to attain cultural competency to promoting cultural humility (NASEM, 2021). Foronda and colleagues (2016) concluded a formal concept analysis and found that cultural humility is a lifelong endeavor, with those exemplifying humility being open, self-aware, humble, reflective, and supportive of others. Hughes and colleagues (2020) argued that early and ongoing cultural humility education for healthcare providers might increase bias awareness and openness to other identities, decrease burnout, improve patient care, and enhance communication efforts.

**Purpose of Study and Rationale**

The aim of this action research study was to understand nursing faculty IB attitudes and perceptions. Also important was to discern how faculty construct their identities within nursing programs and what cultural humility means to them. Nursing faculty were not critiqued or judged. Rather, this research examined how assumptions and IB relate to nursing faculty perceptions of what it means to be themselves and what it means to be culturally humble. Therefore, the purpose of this complex two-phase explanatory sequential mixed-methods action research study was to determine the IB
attitudes and perceptions and the degree of cultural humility of nursing faculty in a prelicensure baccalaureate nursing program. The quantitative data from phase one provided a foundation starting point for an enhanced explanation of key results using rich qualitative data collected during and after planned team learning sessions in phase two. Team learning session participants moved towards acknowledging the need for enhanced inclusive education practice, IB mitigation, and cultural humility development.

**Rationale for Study**

The contextual constructs of this research included racism, IB, transformative learning, cultural humbleness, and cultural humility. The realization of race as socially constructed and racism as institutionalized (George, 2021) may not be fully appreciated by White nursing faculty. Becoming aware of unconscious biases can be uncomfortable because these implicit notions go against explicit thoughts and beliefs (APA, 2022). It is clear these constructs were evocative for participants. Yet for nursing educators to continue the work that facilitates achievement of diverse, equitable, and inclusive educational spaces, critical exploration regarding attitudes and perceptions of racial IB was necessary (RQ1). There may also be a difference in the degree of faculty humbleness and reflective perceptions of cultural humility (RQ2). This study also explored the impact of racial IB awareness on nursing faculty cultural humbleness development (RQ3).

Faculty may not be fully aware of how racial IB influences educational practices and experiences within diverse groups, be it in the classroom or clinical setting (RQ3). Critical conversation and dialogue may bring about heightened sensitivity to the impact on UR nursing students. Faculty awareness of IB may increase utilization of strategies to mitigate the occurrence of IB in nursing education, but this is yet to be determined,
requiring long term reinforcement (Sukhera et al., 2020) and innovative skills-based learning opportunities for mitigated bias (Gonzalez et al., 2022). Increased bias awareness and the importance of mitigation may reduce negative effects of unintended verbalizations and visualizations within learning spaces. Finally, an additional aim of this study was to determine if IB mitigation interventions alter cultural humility perceptions of nursing faculty and possibly inform inclusive excellence in teaching practices.

**Researcher Positionality**

Action researchers define positionality as their position and role in the research setting (Herr & Anderson, 2015). First, I had to get to know and grow myself. In my preparation for this doctoral work, one of the first books I read was Robin DiAngelo’s *White Fragility*, which was profoundly wonderful and uncomfortably dreadful at the same time. Nevertheless, I pushed through the discomfort, diving headfirst into the sociocultural context of DiAngelo’s text. I continued researching and gaining insight into my “whiteness”, biases, and faulty understandings of race and racism. Continuous immersion in this research added to my confidence and my courage to face my role in perpetuating my problem of practice.

Reflecting upon my positionality as an action researcher, the study purpose, and assumptions related to the study constructs: racial IB, cultural humility, and transformative learning, I recognized the possibility of misperceptions, biases, and assumptions that must be delineated to maintain study validity (Bourke, 2014; Creswell & Miller, 2000). Bourke (2014) added that researchers must understand how positionality affects participants’ responses and reactions to the researcher. Given the sensitive nature of the constructs of this research, special care was taken by all participants, including myself, regarding raised awareness related to racial biases.
Echoing Mezirow (1994), care for self and participants relayed the normalness in the disequilibrium and dissonance felt among participants during the phase two team learning sessions and the semi-structured group interviews. The planned structure of these sessions allowed the data collection to continue in authenticity. As the principal investigator (PI), I worked to bracket feelings, preconceived notions, and assumptions during data collection and analysis process. I remained continually cognizant of potential bias in the research process and reflected on my feelings often throughout the study.

The research process is impacted by recognizing I am a White, middle-class, female, cis-gender, middle-aged lecturer in an undergraduate nursing program that includes students, faculty, and colleagues from diverse racial and ethnic backgrounds. This planned study included understanding faculty attitudes towards IB in nursing education and increasing awareness of potential biases towards UR students in a collaborative, dialogical manner. Additionally, some of my fellow faculty in the SON are doctoral-prepared and experienced researchers, which is intimidating to this novice researcher. However, my stance remained as colleague and collaborator with participants throughout the study.

On the continuum of positionality, my position remained that of an insider in collaboration with others (Herr & Anderson, 2015), focusing specifically on faculty perceptions and practices in nursing education. The goal is ongoing critical inquiry of what is occurring in education and meeting the unique needs of all learners (Adams, 2016). Having this mindset increases the awareness of educators to drive the practice of education beyond simply accepting an assumption when that assumption may be faulty, unreliable, or untrue (Teacher Inquiry, 2017).
Research Design

The use of action research in nursing is limited but it is posited this methodology could add to nursing knowledge in a more systematic and meaningful manner (Moch et al., 2016). Specifically, the use of critical transformative action research seeks to expose inequities by raising the consciousness of participants in order to bring about social change (Efron & Ravid, 2020). Action research in nursing education has been defined as:

- a systematic research process that can be articulated by the researcher, involving data collection and analysis as well as reflection and discussion with coresearchers or others for the purpose of making change in a situation over time (Moch et al., 2016, p. 3).

This study maintained a critical lens focused on elucidating perceptions of the research variables with the understanding that making meaningful change takes both persistence and time (Evans, 2001). Evans (2001) relayed the duality that change presents as “we both embrace and resist it” at the same time (p. 21). It is hoped that this study transformed participants through increasing faculty IB awareness while also providing strategies for IB mitigation in an effort to positively impact nursing education inclusivity and cultural humbleness. Both quantitative and qualitative methods were utilized to address the specifics of the proposed research questions.

Combining quantitative (closed-ended, numerical) and qualitative data (open-ended, text) is an essential explanation of a mixed methods study (Creswell & Creswell, 2018). The integration of both methodological approaches provides a richer depth to research than if only one method is used. A quantitative design investigates the relationships of variables that can be measured and quantified, while qualitative data
investigates the subjective meanings of the participants actions and perceptions by what is said (Efron & Ravid, 2020). A complex explanatory sequential core design was appropriate for this study as two phases were planned, with quantitative data (phase one) informing qualitative research question development and deployment (phase two) with an embedded intervention (team learning sessions) (Creswell & Creswell, 2018).

A case study design was implemented for the interventional portion of phase two. A case study is an inquiry approach that gathers multiple sources of qualitative data to provide an in-depth exploration of a problem (racial IB) using a case (nursing faculty) to illuminate the issue being studied (Creswell & Poth, 2018). The case was bounded as nursing faculty participated in team learning sessions, engaged in semi-structured focused group interviews, and completed personal journals that include pre-session and post-session critical self-reflections on assumptions. Interpretation of the results of an explanatory sequential design lies in how the qualitative assists in the explanation of the quantitative data (Creswell & Creswell, 2018).

**Setting and Context**

The SON is one of many competitive undergraduate and graduate programs in the College of Health and Human Sciences (CHHS). CHHS is one of eight colleges, plus the graduate school, within a large public university campus. The university is located in the southeastern region of the U.S. and has over 30,000 enrolled students. Many undergraduate students may declare a pre-nursing major. However, fewer than 60 are accepted into each of the two application cycles during the academic year. Accepted students begin their nursing major in the junior year of college. According to 2021 BSN
student demographic data (Table 1.1) from the SON, there were 203 enrolled nursing students, most of whom identified as White females.

Table 1.1  Student Demographics, 2021

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>≥ Two Ethnicities</th>
<th>Asian</th>
<th>Black/AA</th>
<th>White</th>
<th>Hispanic</th>
<th>Gender</th>
<th>Total Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing BSN</td>
<td>2.96%</td>
<td>9.36%</td>
<td>8.87%</td>
<td>69.46%</td>
<td>8.87%</td>
<td>93.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Pre-Nursing</td>
<td>5.43%</td>
<td>9.06%</td>
<td>22.10%</td>
<td>44.38%</td>
<td>16.49%</td>
<td>90.94%</td>
<td>9.06%</td>
</tr>
</tbody>
</table>

**Nursing Faculty**

The SON consists of both full (FT) and part-time (PT) faculty who teach in either the prelicensure undergraduate (UG) or the graduate programs with a few FT faculty teaching across both. PT faculty fluctuations prevent a specified generalized number, but currently 25 adjuncts are employed with the SON. Of the 37 FT nursing faculty teaching in the SON, 16 teach consistently in the UG prelicensure baccalaureate nursing program. The majority of FT faculty teach across several tracts in the graduate nursing programs. Interestingly, less diversity is noted amongst FT UG faculty with 12 identifying as White and 14 as females. A recent climate survey (2022) of responding FT faculty found 77.4% were female and 61.2% White. Four of the 30 respondents felt discriminated against in the last three months. Most concerning is one respondent who stated, “I feel that we talk too much about DEI in the SON.”

**Nursing Students**

The 2021 student demographics noted more diversity in the declared pre-nursing student population than are accepted into the nursing program. Specifically, there are more White nursing students accepted into the major than all of the diverse students combined. On a positive note, there is an increase in UR students admitted into the nursing program. The 2022 admissions statistical data indicated 47% of incoming first
semester students accepted into the nursing program are from diverse backgrounds. A positive trend continues as first semester 2023 admission data demonstrated an increase to 51%. This increase in diversity does not negate the fact that UR students are still facing a White female majority nursing faculty.

**Study Participants**

Phase one of this study invited All FT (37) and PT (25) nursing faculty to voluntarily participate in the quantitative survey administered via Qualtrics. The mode of contact was via the SON distribution email list (Appendix E). The voluntary consent included a statement regarding upholding anonymity as well as the ability to withdraw from the study at any time as the consent was nonbinding. Even though the SON employs several PT clinical adjuncts who teach across the curriculum, they were excluded from the second phase (intervention/learning sessions) as their role within the SON is limited to mostly clinical or laboratory teaching and they are not required to serve on committees or teach in the classroom setting.

Some FT faculty serve on the Admissions Committee. Others teach across the curriculum, and many participate in clinical/laboratory experiences. Research has demonstrated that faculty IB plays a role in diverse students admitted to nursing programs as well as nursing student educational experiences (Pusey-Reid & Blackman-Richards, 2022; Noone & Najjar, 2021; Ackerman-Barger et al., 2020). Therefore, the second phase of the study planned to limit participants to a convenient, purposeful sample of FT UG prelicensure nursing faculty willing to participate in the team learning sessions and who have at least one semester of teaching experience. Those interested in phase two were sent a follow up email with further details (Appendix F).
Ideally, it was hoped that at least five to eight faculty would volunteer to participate, with the final case being a purposeful sample of no more than four FT UG prelicensure nursing faculty representing diverse backgrounds. Those not chosen were waitlisted for inclusion in repeat future sessions outside of the current study. There was no incentive to participate, other than informing future practice of nursing faculty. My role in this study was as both principal investigator (PI) and the facilitator of the team learning sessions.

**Overview of Data Collection and Analysis**

Data was collected by the PI during both phases of this study. Pre-session/ pre-intervention quantitative data collected was analyzed during phase one. Collection and analysis of qualitative data occurred during and after phase two. The qualitative data helped richly describe and explain the quantitative data, hence the explanatory sequential design (Creswell & Creswell, 2018).

**Data Collection**

All faculty were contacted via the SON email distribution list and invited to participate. The email contained the PI introduction, contact information, and the invitation letter that described the study purpose, expected procedures, ability to withdraw, and confidentiality statement. Faculty were notified that their agreement to proceed to the anonymous Qualtrics survey via embedded link in the study introduction email indicated voluntary consent to participate in the quantitative survey.

Quantitative data included the *Attitude Toward Implicit Bias Instrument* (modified for nursing with developer permission; Appendix A, C), *Foronda’s Cultural Humility Scale* (used with permission, Appendix B, D), followed by faculty demographics and PI
created questions relating to previous DEI or IB education or training. It was my desire to determine if previous instruction in DEI or IB influenced attitudes or cultural humbleness of nursing faculty. Finally, respondents willing to participate in phase two were asked to email the PI directly. Faculty were informed that phase two involved face-to-face weekly team learning sessions (15 to 20 minutes) followed by semi-structured focused group interviews (40 to 45 minutes) for three consecutive weeks.

Semi-structured focused group interviews occurred after the brief PI led weekly instructional team learning sessions. Team learning sessions are an ideal platform for gathering data that supports the defined premise of action research in nursing education as participants learn from each other and transform perspectives (Moch et al., 2016). Team learning sessions included discussions about mental models and intersectionality, acknowledging and mitigating IB (verbal and visual recognition) and cultural humbleness and cultural humility.

Qualitative data derived from PI notes, transcriptions of the semi-structured focused group interviews, and faculty reflective journals. Focused interview questions mostly stemmed from the original quantitative survey but were open-ended. Interviews remained flexible and open, allowing freely flowing organic responses. Qualitative data allows for awareness, perception, and experiences to enrich the data gathering, especially if the quantitative results are unexpected, surprising, or contradictory (Creswell & Creswell, 2018).

Psychological safety during the team learning sessions was important given the evocative nature of the content and to create a safe, nonjudgmental space where all feel they belong and their voices are heard (Luther & Flattes, 2022). Use of self-awareness,
modeling openness towards others’ viewpoints with the goal of listening to understand, expressing gratitude for team member input, feeling safe to challenge the status quo, and being accountable for outcomes are just a few examples of how psychological safety was honored and maintained during all sessions (Clark, 2022; Luther & Flattes, 2022).

The participants used online reflective journals developed by the PI in Google Docs (Appendix K), accessible to the individual respondent and PI only. The journal included pre-session and post session question prompt responses. Journals add a deeply personal subjective layer to the data on the meanings participants ascribe to the research variables. For example, participants may be more likely to journal thoughts and perceptions rather than openly discuss within the team learning sessions or participants may begin to consider the larger picture through reflection and transform their meaning perspective of the variables (Kitchenham, 2008). In addition, the act of journaling allows time for critical self-reflection on the evocative content discussed in a more comfortable environment for the participant (Creswell & Poth, 2018).

**Data Analysis**

The quantitative data helped me to have preliminary understanding of the faculty attitudes related to the research constructs of racial IB and cultural humility. The results were analyzed using Qualtrics data software for descriptive statistics about the variables under study. Quality control in action research specific to quantitative data involves controlling as many variables as possible to determine the cause and effect (Efron & Ravid, 2020). The novel quantitative instruments used have been validated by their developers and were used with permission (Gonzalez et al., 2021; Foronda et al., 2021). This study added to the efficacy of these instruments studying racial IB attitudes and
faculty cultural humbleness. Additionally, I sought expert guidance as needed from the SON staff methodologist for analysis of the quantitative data results from the Qualtrics platform.

Analysis of qualitative data was conducted using an inductive to deductive procedure throughout the second phase of the study. This process guided additional and rising questions that could benefit thematic clarification. Data include “descriptions, direct quotations, and observer comments” (Merriam & Tisdell, 2016, p. 161). Wertz (2005) suggested reading the transcribed text aloud without research intent to understand expression and meaning from a broad context. Triangulating data using multiple sources enhances the trustworthiness of the different perspectives obtained during qualitative action research (Efron & Ravid, 2020). The multiple data sources from this study include semi-structured focused group transcribed data, PI notes, open-ended responses, and faculty reflective online journals. Member checking ensured capture of participants’ perspectives accurately by discussing interpretations and analysis during one-on-one meetings (Efron & Ravid, 2020). The researcher is the instrument in qualitative data collection. Therefore, I felt it highly valuable to maintain reflexivity (self-reflection), especially given the construct of racial IB, past experiences of all participants, and how these experiences potentially influence IB and faculty cultural humility (Creswell & Creswell, 2018).

**Significance of Study**

Formal nursing education has been in place for well over one hundred years. Interwoven in this education is a specific culture of nursing which includes compassion and caring practices as central concepts yet persists with a dominant White framing. This
framing risks silently instilling biases that impact nursing judgment and clinical decision-making (Thirsk et al., 2022). This study sought to shine a light on how racial IB intersects with cultural humbleness of nursing faculty. The intersection of these constructs can conflict with individuality and what faculty explicitly think about diversity, equity, and inclusion in nursing educational spaces. Participant knowledge related to the research constructs were determined so that clarity could be achieved in the faculty ways of knowing. Additionally, this study sought to elucidate perceptions, spotlight issues, open dialogue related to IB awareness and mitigation, and add to efforts to increase cultural humbleness and humility within nursing education (NASEM, 2021).

While the knowledge generated from this study is not intended to be generalized to large populations, it does provide insight that nursing educators and others in education will find beneficial. The data collection, team learning sessions, and group interviews dealt with sensitive emotional laden content based upon individual perceptions and unique ways of knowing. For example, White faculty may be unaware of IB that negatively impacts nursing education climate and the educational experiences of UR nursing students. Some faculty may feel defensive. However, illumination of these dynamics, within an air of psychological safety, is vital towards reaching and achieving cultural humble practices and creating inclusive excellence in nursing education.

**Limitations of Study**

Researchers, especially those conducting qualitative research, understand the inherent biases that occur in convenience sampling of participants included in research studies. Additionally, conducting action research as a member of the nursing faculty on one campus limits broad perspectives which can introduce bias on the part of the
researcher. Further, those faculty who chose not to participate could have added richness and depth to the study or perhaps gained wisdom useful in their practice as nursing educators. I also recognize limitations as a White faculty member collaborating in raising IB awareness of fellow, mostly White, coworkers. The research data may be limited in the number of “authentic voices of people of color” (Ladson-Billings & Tate, 1995) in a mostly White sample of faculty. However, action researchers choose to complete research within their respective settings as the problem is discovered in practice. Action research aims to address the problem of practice for all stakeholders yet holds back assumptions throughout the research process (Herr & Anderson, 2015).

**Organization of Dissertation**

This dissertation is arranged in five chapters. Chapter One introduces the problem and purpose of the study, the theoretical underpinnings, and the research design with significance and limitations. Chapter Two reviews the literature to support the importance of the study with relevant themes clearly elucidated and framed theoretically and conceptually within historical context of nursing education. Chapter Three describes the research design and methodology. Chapter Four presents the study findings, results, and analysis of the data based upon the research questions. Chapter Five summarizes an overview of the study, implications for nursing education practice with an action plan, and recommendations for future research.

**Key Definitions**

- **Aversive racism**: subtle form of racism whereby people consciously sympathize with and support social justice equality, but “when guidelines for appropriate behavior are vague, when the basis for social judgment is ambiguous, or when one can justify or rationalize a negative response on the basis of some factor other than race, harmful discrimination will occur” (Dovidio et al., 2016, p. 271)
▪ **Cultural humility:** “used in a variety of contexts from individuals having ethnic and racial differences, to differences in sexual preference, social status, interprofessional roles, to health care provider–patient relationship… [with the] following attributes: openness, self-awareness, egoless, supportive interactions, and self-reflection and critique…a lifelong process” (Foronda et al., 2016, p. 211).

▪ **Diversity:** “affirming the uniqueness of and differences among persons, ideas, values, and ethnicities” (NLN, 2017, p. 2).

▪ **Equity:** “…equitable, just, and fair society—one that promotes racial equity, as well as equity across circumstances, communities, and abilities” (NASEM, 2021, p. x).

▪ **Inclusion:** “environmental and organizational cultures in which faculty, students, staff, and administrators with diverse characteristics thrive…Everyone works to ensure the perspectives and experiences of others are invited, welcomed, acknowledged, and respected” (AACNa, 2021, p. 1).

▪ **Inclusive excellence:** “A framework designed to integrate diversity, equity, and educational quality efforts into institutional missions and institutional operations as a shared responsibility among all members…. an active ongoing process of continuous improvement through inquiry, action, accountability, and assessment as a driving force for organizing efforts to build and sustain a climate and culture that invites and leverages diversity to guide innovation…. (UNC Charlotte, 2023)

▪ **Implicit bias:** An “algorithm of the mind” (Gupta, 2017); unconscious bias in judgement or behavior that “is not limited to race…[and]… can exist for characteristics such as gender, age, sexual orientation, gender identity, disability status, and physical appearance such as height or weight” (Institute for Healthcare Improvement, 2017, para 3).

▪ **Explicit bias:** Overt, conscious “attitudes and beliefs” about groups, many times driven by perceived threat and seen as justification for unfair targeted negative treatment of ethnic groups. (Perception Institute, n.d.).

▪ **Underrepresented:** “nondominant groups such as people of color; people with disabilities; people from a lower socioeconomic status; people who are gay, lesbian, bisexual, and transgendered; people of a nondominant religion; and retirees” (Allen, 2017, para 1). In this study, underrepresented will be used to signify students of color, people of color, faculty of color.
CHAPTER 2
LITERATURE REVIEW

The deficient representation of diverse nursing professionals entering the workforce (AACNb, 2022; Smiley et al., 2021) impacts nurses' culturally competent healthcare practices, which can result in poorer health outcomes for those entrusted to their care (Smedley et al., 2003). Healthcare workers reflective of diverse populations are better able to understand the unique cultural needs of and build better trusting relationships with the communities they serve and improve overall health outcomes through the elimination of health disparities (Sullivan, 2020; Green, 2020; Wilbur et al., 2020; Phillips & Malone, 2014). Nursing research has demonstrated that IB impacts nurse decision-making and clinical judgment. However, limited research exists on nursing faculty and perceptions of implicit biases (Haen, 2022; Thirk et al., 2022; Gonzalez et al., 2022).

Purpose of Literature Review

Nursing programs and educators have been charged with, and have responded to, increasing diversification of the student population in programs across the U.S. (NASEM, 2021, AACNb, 2022). However, increasing underrepresented (UR) students in nursing programs without promoting inclusive education practices does not support student academic success, program progression, and completion to graduation (Metzger et al., 2020). This study purposed to explore the problem of nursing faculty perceptions and attitudes towards IB, their unawareness of racial IB, and the impact IB potentially has on
faculty cultural humility and inclusive excellence. It is crucial to explore the historical underpinning of why there is a lack of diversity in nursing programs and how IB limits full demonstration of inclusivity.

Two reasons diversity, equity, and inclusion initiatives fall short are programs that do not fully embrace equitable practices and are not addressing the influence of IB (Breslin et al., 2018). Ignorance of racism and IB in nursing education perpetuates color blindness and White dominance in nursing (Wesp et al., 2018). Raising awareness of IB and intentionally mitigating its presence is a constructive step toward creating inclusive excellence in nursing education and the profession. Since everyone possesses implicit biases which influence decision-making and actions (Gonzalez et al., 2019), this may be an essential starting point to positively impact nursing educational practices. Understanding how nursing educators define cultural humbleness and how they can demonstrate cultural humility in education practices will aid efforts to support the progression of UR students along their nursing education journey to completion.

**Research Questions**

This complex two-phase explanatory sequential mixed-methods action research study included two phases to fully explore faculty IB attitudes and perceptions of cultural humbleness using critical self-reflection. The first phase gathered quantitative data that was further explored in-depth during qualitative data gathering in phase two. The faculty participants completed critical reflective journal entries, including targeted questions before and standard prompts after team learning sessions. This study sought to answer the following research questions:

RQ1 What are nursing faculty racial implicit bias perceptions?
RQ2 To what degree are nursing faculty culturally humble?

RQ3 How does critical reflection affect racial IB and cultural humility attitudes?

**Rationale for Study**

Calls to increase racial diversity in nursing educational institutions and nursing professional practice have continued for decades without substantial gains (Green, 2020; Noone et al., 2020; Phillips & Malone, 2014). Nursing programs in the United States remain overwhelmingly White and majority female (AACNa, 2020). Recent statistical data over the last several years has demonstrated progressive increases in admission rates of UR students in entry-level baccalaureate nursing programs in the U.S., up to 40.3% in 2021 (AACNb, 2022) from 26.8% in 2010 (AACNa, 2020). Nevertheless, completion rates have demonstrated only modest gains, 33.1% from 24.6% (AACNa, 2020).

Specifically, there has been minimal change in graduation rates over the last decade among Black students in prelicensure baccalaureate programs (9.7% to 9.1%) (AACNa, 2020). However, there has been a noticeable gain in Hispanic students compared to other UR students, 6.7% to 11.8% (AACNa, 2020).

Even though there is an increase in UR students admitted into nursing programs, the dearth of UR students, especially Black students, completing baccalaureate programs is cause for concern. Differences in the experiences of Black students include lack of diverse representation in learning contexts, overt and covert racism in class and clinical experiences, perceived unfair faculty grading practices, and lack of belonging in addition to feelings of loneliness (Graham et al., 2016; Metzger et al., 2020). Faculty of color have similar experiences. Normative whiteness, “othering” (placing UR faculty in roles outside
of SON), explicit or implicit racism, and discrimination accepted as workplace culture norms were described as barriers to retaining diversity in nursing education (Hamilton & Haozous, 2017).

Though specific research on IB in nursing and its impact on patient care outcomes is limited, studies have found that cognitive and implicit biases influence nurses’ clinical judgment and decision-making (Thirsk et al., 2022). Research has included faculty perceptions of engaging students to address their own implicit biases through active learning (Teall et al., 2019; Gatewood et al., 2019), faculty preparation to teach IB awareness to student nurses (Edwards-Maddox et al., 2022; Noone, 2022), and the impact of racial microaggression (visual and verbal unconscious bias) experienced by UR healthcare students (Ackerman-Barger et al., 2020). Nevertheless, gaps remain in direct, intentional faculty and curriculum development to better understand IB (Edwards-Maddox et al., 2022). Even less research is focused on nursing faculty perception of racial IB exists, mainly limited dissertations such as Fitzsimmons (2009) nursing faculty perceptions, while Gunther (2020) and Price (2022) focused on nursing and healthcare faculty improvement of professional education. Consequently, further study is needed regarding faculty attitudes and perceptions of their own IB, the impact of implementing IB mitigation strategies, and perceptions faculty have regarding cultural humbleness and humility in an effort to create more inclusive experiences for all stakeholders.

**Chapter Overview and Organization**

First, the theoretical frameworks providing structure and support to this study, Critical Race Theory (CRT) and Transformative Learning Theory (TLT), will be discussed and made cogent with the problem of implicit bias unawareness and its
mitigation. Second, a brief overview of nursing education contextualizes the historical underpinning of deeply and unconsciously embedded White frame foundation of nursing instructional practices and the nursing profession in America through the theoretical lens of CRT. Presenting the history clarifies the normalization of racism and colorblindness in nursing. The DEI deficiencies stem partly from hidden assumptions and implicit biases that nursing faculty carry unknowingly into the education spaces of nursing classrooms and clinical experiences. TLT will outline how to effectively transform the meaning perspectives of nursing faculty towards mitigating implicit bias impact using critical self-reflection on assumptions. Third, tracing IB from its social-cognitive psychology beginnings to its current impact on health outcomes and presence in healthcare education provides not only potential root causes of biases but also insight into how thoughts and behaviors drive actions of providers and nurses which can ultimately impact patients in negative ways (Fitzgerald & Hurst, 2017; Thirsk et al., 2022; Zescott et al., 2016).

Exploring research that exposes implicit biases in nursing and other disciplines may help nursing faculty "see" the problem in a new light. Seeing the problem may help faculty transformation to become effective models and mentors with increased cultural humility toward nursing students. Being "blind" to one's biases and actions allows subtle racism and microaggressions to continue because the problem is not "seen" by the offender (Hall & Fields, 2013). Nursing faculty may enhance cultural humility by recognizing, managing, and mitigating IB. If IB is not recognized and managed, all stakeholders suffer the consequences. Nursing students eventually graduate and become future nurses rendering caring practices in increasingly diverse communities. They may even become advanced care nurse practitioners or nursing educators. Ineffective
mentoring and modeling of cultural humility, coupled with ongoing IB unawareness, will perpetuate acceptance of racism, colorblindness, and inequitable healthcare practices among nursing professionals (Wesp et al., 2018). Thus, a deep dive into research literature that included implicit cognition as a driver of biased and prejudiced behaviors of healthcare workers, especially nurses and nursing faculty, is necessary.

**Literature Review Methodology**

In the research process, access to the online university library website used a Boolean search focused on keywords: “nursing faculty” + “education” + “implicit bias” using CINAHL Complete returned five hits, which included a dissertation and literature reviews. Searching “racial bias” + “nursing faculty” + “prelicensure nursing” in CINAHL Complete, Medline (EBSCO) with full text, OVID Nursing Database, and PubMed-Medline returned 24 hits, from 1998 to the present, including four dissertations. The advanced search feature narrowed the search to peer-reviewed and research articles delineating 13 additional articles. Most IB research over the last two decades has been in the psychological and medical fields, with particular attention to medical students, patient experiences, health equity, and health outcomes.

There is limited research on faculty perceptions and measurement of implicit bias (broadly), racial bias (specifically), and its impact on nursing education practices. Other research was mined from the articles obtained in the first search and included direct journal searches in the university’s online library based on cross-referencing. Research on nursing student enrollees and graduation rates was obtained mainly from professional nursing organization websites, including the American Association of Colleges of
Nursing. Other research came from articles obtained in the first literature search based on cross-referencing and direct journal searches from the university's online library.

Theoretical framework literature was obtained in the same manner using Boolean search with a specific focus on the following words: “critical race theory” + “nursing faculty” using the university library website. The timeframe was narrowed to 2000 to 2021 for current relevance. There was a return hit of 136 items, of which 30 were analyzed for inclusion in the current research, and most were dissertations. Foundational theoretical literature was explored related to CRT as well as the use of the theory in nursing and nursing education. Additional theoretical framework support included searches related to “transformative learning theory,” with most of the literature obtained from within the discipline of education and the Journal of Transformative Learning.

**Theoretical Framework**

The theoretical framework researchers use to support their studies is not arbitrary or lightly chosen. On the contrary, a clearly stated and interwoven theoretical framework acts as a supportive “blueprint” upon which the study flows clearly and effortlessly from the beginning to the conclusion (Grant & Osanloo, 2014, p.13). Using a double-layered theoretical lens, Critical Race Theory (CRT) and Transformative Learning Theory (TLT) will offer structure to the problem's seriousness and clarity in the analysis of outcomes. Since the problem of IB is rooted in racial inequities, CRT is discussed first. Following this, TLT will provide theoretical support for implementing the team learning sessions and add depth to the qualitative phase of the study.
Critical Race Theory (CRT)

Gloria Ladson-Billings (2009) suggested that the origins of critical race theory (CRT) “emerged as a response to a response” (p. 110) aimed at race, class, and gender misrepresentation in legal education and professional writings in the 1960s and 1970s. Especially the legal work and writings of Derrick Bell, whom many consider the father of CRT (Cobb, 2021). Seeking to increase efforts to focus on racial inequities in education, Ladson-Billings (1998) wrote of the need to move beyond “equal opportunity” for underrepresented students to “redress pas[t] inequities” to improve curriculum, instruction, assessment, school funding, and desegregation (pp. 17–18). She argued that educators use caution to maintain sight of the goal of engaging, educating, and improving outcomes for all students, especially marginalized students. Educators who merely scratched the surface of inequitable education and who were only appropriating CRT as an answer without incorporating its tenets into solutions for addressing racism and social injustice are not going far enough (Ladson-Billings, 1998). The current increased interest in CRT due to racial unrest in America informs us that the work is not done and will require ongoing engagement in difficult conversations and actionable outcomes.

Prior to the senseless shooting death of Breonna Taylor and the public killing of George Floyd under the knee of a police officer in 2020, most of American society had never heard of CRT (NPR, 2022). However, the racial climate in the summer of 2020 thrust CRT into the spotlight to frame the ongoing inequitable treatment, injustices, and disparate societal outcomes across racial and ethnic groups, especially among Black Americans (NPR, 2022). Academic scholars and legal analysts have discussed CRT tenets for over four decades. The specific tenets explored in this study include race as a
social construct, ordinariness of racism, interest convergence, and intersectionality (Delgado & Stefancic, 2017).

It is also essential to review critical empirical analysis of implicit associations (implicit bias) and microaggressions. These situations create othering and signaling out individuals because of differences which further burden UR people (Bell, 2016). Specifically, burdens include inequitable healthcare, inadequate education, housing, jobs, misrepresentation in the criminal justice system, the media, and exclusionary political tactics (Bell et al., 2016; Delgado & Stefancic, 2017). The misappropriation of the theoretical tenets of CRT in nursing education through increasing diversity without addressing inclusive teaching practices could be seen as box-checking, not life-changing.

**Race as a Social Construct**

Early in the founding of America, the construct of race was created by the dominant Anglo, White English-speaking colonists to categorize individuals using physical traits as being “White” or Indian (DiAngelo, 2018). To protect the “White advantage,” racial categorization deemed those who were non-White as inferior, using race to legitimize the enslavement of Blacks in the 1700s to 1800s and later the discrimination against immigrants in the early 20th century (DiAngelo, 2018, p. 17). The “one drop rule” of the Jim Crowe South was the assigning of persons to the Black race if they had even one drop of “Black blood” (Davis, 1991, para 1). Even though this labeling is ridiculous, knowledge of such categorization helps to understand why those of mixed heritage would seek to avoid the “Black” label in early 20th century America. DiAngelo (2018) stated that in an effort to avoid discrimination and segregation, many lighter-skinned multiracial people would “pass” for White; however, the backlash of isolation
and resentment would often be worse for them. Those “passing” for White were not perceived as, “‘real’ people of color or ‘real’ Whites” (DiAngelo, 2018, p. xvi).

Race is neither a biological nor a scientific category. Medical research has indicated there is no biological foundation for race in the genome of individuals (Cooper et al., 2003). According to the National Human Genome Research Institute (2018), humans are more alike than different, sharing 99.9% of genetic makeup with very few differences. Nevertheless, healthcare professionals have been taught for years that racial differences help guide the assessment of diseases and determine the appropriate treatment of individuals belonging to certain groups (Cooper et al., 2003). Clinical decision-making of healthcare providers based on race is fallible, given advancing knowledge about the genetic similarities and variations among individuals—even those from the same geographical regions, and shared among all populations (Cooper et al., 2003).

A personal example in the teaching of nursing students is the race-based explanation of why laboratory data related to kidney functioning had an “African American” variation in the glomerular filtration rate (GFR) data. Based on the evidence at the time, even this researcher taught that Blacks had more lean muscle and filtered creatinine (waste product of metabolism) differently and this was not considered an anomaly. Therefore, laboratory reporting on estimated kidney GFR adjusted based upon race possibly led to delayed treatment of Blacks with chronic kidney disease, thereby worsening preventable kidney function deterioration (Delgado et al., 2022). Recent research on laboratory markers of chronic kidney disease has removed race as an estimate for factoring differences in GFR to standardize recognition and treatment of chronic kidney disease in all people (Delgado et al., 2022).
Another area of high research traffic is the false beliefs of pain perception amongst Blacks, along with incorrect understanding of pain tolerance and pain management needs based upon race (Hoffman et. al., 2016). Hoffman and colleagues’ (2016) study of pain judgment among study participants reinforced long held false beliefs that Blacks feel less pain and therefore were inadequately provided appropriate treatment for pain relief. It is urgent that nurse educators remove any connection of race to disease processes, pathophysiology, and interventions in the instruction of nursing students and nurse practitioners.

**Ordinariness of Racism**

The ordinariness of racism means that it is real and permeates every aspect of society and the lived experiences of those who endure the daily struggles of oppression (Delgado & Stefancic, 2017). The normalization of racism makes it invisible and allows for colorblindness to be equated to being “not racist” (Wesp et al., 2018, p. 321). Ten years after Hall and Fields (2013) stated, “issues regarding race remain difficult to breach in conversation” (p. 164), the difficulty of open dialogue remains. The challenge stems from the history of nursing education.

The historical education of nurses in the late 1800s had been through a White lens with Eurocentric references, predominantly led by male physician oversight (Anderson, 1981). In the mid-20th century, racism was explicit for the few nursing students who matriculated in predominantly White nursing programs (Ackerman-Barger & Hummel, 2015). Using CRT narrative storytelling, Ackerman-Barger and Hummel (2015) provided participant narratives whereby Black nursing students were referred to as “you” instead of by name and not providing worksheets because there “were not enough” (pp. 41-42).
Recognizing that overt racism is wrong, the nursing profession has denied race altogether, which rejects the reality of UR nursing student experience in predominantly White programs (Cahn, 2022). Racism in nursing has become more subtle in the 21st century, manifesting as verbal and nonverbal slights of microaggressions towards UR nursing students as colorblindness continues to be the norm (Wesp et al., 2018).

Conversely, CRT scholars recommend aggressive “color-conscious” efforts to change “how things are done” (Delgado & Stefancic, 2017, p. 27). There is no shame in “seeing” nursing students through a lens of understanding how multiple lived experiences and identities impact them daily.

**Intersectionality**

Not one person has a single description of who they are as an individual (Delgado & Stefancic, 2017). For example, I am a White female, but also a middle-aged, nursing educator, American, Christian, cis-gender, and politically progressive. All identities walk with me as I enter sociocultural spaces. Yet, they are not fully presented to others due to my fear of presenting them or others’ perceptual ignorance of how my identities influence my experience. In their *Matrix of Oppression*, Anderson and Stolen (2019) described how a person’s “world experience is based on the interplay of…identities within multiple dimensions [race, age, gender, sexual orientation, class, ability, and religion] of societal oppression.” DiAngelo (2018) described how our understanding of racism could be transformed by recognizing how our “other social identities…inform how [we are] socialized into the racial system” (p. 143).

Crenshaw (1991), who popularized the term intersectionality, specifically defined the intersectional location of Black women and their marginalization within dominant
discourses, especially in employment experiences, domestic violence, and sexual violence. The Black female is marginalized by her race and her gender, which cannot be separated from one another. This internal and external identity struggle is reminiscent of Du Bois, who identified his “othering” as the “double consciousness” whereby African Americans feel their “two-ness” (Ladson-Billings & Tate, 1995, p. 50). Aside from the external struggle of racism in America, Du Bois described the internal struggle of African American double consciousness as the individual is split between who he is as an “African” and who he is as an “American” (Bruce, 1992, p. 301).

Several nursing student identities intersect to affect the persistence of diverse nursing students. The context of social, community, health, economic stability, and environment (Barbe et al., 2018) in nursing education creates a sort of “othering” as the student nurse must acculturate to the profession. Upon entering a nursing program, the nursing student faces a new culture different from their own. The nursing culture includes a new language (medical terminology, nursing diagnoses, medical diseases, etc.), new dress code (scrubs, personal protective equipment), mental processing (critical thinking, clinical reasoning, clinical judgment), and standardized complex learning assessments (Lancellotti, 2008). Instead of the UR student fitting into the dominant culture of nursing, Lancellotti (2008) recommended that the focus should be on realizing the White Eurocentric educational structure is not supportive of the values of nursing or the current societal trends of an increasingly diverse communities served by nurses.

Even though the tenet of intersectionality described race as a central construct, the concept has been appropriated to include various other -isms that White people experience (Anderson et al., 2020). In nursing education, marginalized students include
males, nontraditional students (older), LGBTQ+, and those with invisible health conditions (depression, anxiety, auditory impairments) (Anderson et al., 2020). Thus, the appropriation of intersectionality has shifted the original focus away from race, becoming distanced from the true intent and even ignoring race as a component (Anderson et al., 2020). Inclusivity invites all people to the table of discourse and dialogue. However, it is imperative that racial identity not be forgotten as it intersects with multiple other identities, complicating the experiences of UR individuals.

**Interest Convergence**

Because Whites enjoy the comforts of White privilege, also considered racial comfort, there is no urgency to change racism in America (DiAngelo, 2018). Whites do not have to carry the burden of race through society, through the grocery store, while driving, or even while walking down the street. This “freedom from responsibility” leads to “racial relaxation” that is not experienced by Black Americans (DiAngelo, 2018, p. 55). *Interest convergence* means Whites may be willing to make concessions for racially marginalized groups when and if it benefits Whites and possibly both races (Delgado & Stefancic, 2017). Unfortunately, “little happens out of altruism alone,” such as the convergence of Black and White interests during the Cold War of the 1950s when America, desiring to be seen in a positive light among Black, Brown, and Asian international communities, tempered negativity towards racial-ethnic minority groups (Delgado & Stefancic, 2017, p. 22).

Much conversation surrounds the growing diversity in the United States and the modifiable social determinants of health (SDoH). SDoH examples include socioeconomics, education, food insecurity, housing, healthcare access (WHO, 2022),
racism, and discrimination that impact the health of communities and individuals within communities (DHHS, n.d.). With 3.8 million registered nurses in the United States (Smiley et al., 2018), the profession is best positioned to impact the SDoH positively. The National Advisory Council on Nurse Education and Practice (NACNEP) (2020) recommends diversification of the nursing workforce as diverse nurses are better able to provide culturally competent care to diverse populations (Green, 2020; Phillips & Malone, 2014; Smedley et al., 2003; Sullivan, 2020; Wilbur et al., 2020). Considering the influence that a diverse nursing workforce can have on the health of vulnerable populations, supporting diverse students in nursing education and increasing diverse nursing faculty is imperative. However, it is vital that nursing educators do not take interest convergence lightly. The heightened DEI discussions and the push for increasing UR student nurses in nursing programs does not eliminate the powerful influence of the White majority, who influence policy and procedural processes (Hall & Fields, 2013). Thus, inclusive excellence is vital to the success of UR students in nursing programs.

**Transformational Learning Theory (TLT)**

Transformative learning theory (TLT) was posited by Mezirow (1978) after a qualitative study of women who described their return to the workforce or the university after an extended period. The original study identified ten phases the women experienced in their learning process of personal transformation (Mezirow, 1978). Mezirow (1991) revised the original phases based on the importance of critical self-reflection to derive personal meaning through interaction and communication with others.
Frames of Reference

The importance of critical reflection on assumptions (CRA) established how frames of reference (structures of assumption) could be significantly changed by increasing one's awareness, thereby allowing one to learn without systemic restrictions (Mezirow, 1998). There are two dimensions to frames of reference, habits of mind and points of view. The habits of mind are a durable set of codes about the ways of thinking and acting that are influenced by “cultural, social, educational, economic, political, or psychological” assumptions (Mezirow, 1997, p. 6). Points of view are the articulated meaning schemes of the habits of mind that may be more malleable and subject to change as one reflects on the content or process and identifies a need to modify based on increasing awareness or feedback from others (Mezirow, 1997). Habits become more engrained and difficult to change, while points of view are subject to change with increased awareness (Mezirow, 2003). It is these frames of reference that shape how learning and interpretation of experience occurs through meaning schemes and meaning perspectives.

Types of Reflection

Mezirow (1995) explained three types of reflection important to transformational learning and modification of meaning schemes and perspectives: content reflection, process reflection, and premise reflection. Our meaning structures are transformed through reflection, defined as attending to the grounds (justification) for one’s beliefs. We reflect on the unexamined assumptions of our beliefs when the beliefs are not working well for us, or where old ways of thinking are no longer functional. We are confronted with a
disorienting dilemma which serves to trigger for reflection…The most significant learning involves critical premise reflection of premises about oneself (Mezirow, 1994, pp. 223-224).

Aligning Mezirow’s three types of reflection to the nursing education provides contextual understanding to this study. In content reflection, nursing faculty were encouraged to personally reflect on the meaning of implicit bias, the impact on students and colleagues, and the impact on the profession. Nursing faculty also defined what cultural humbleness and humility mean to them personally and reflected on how nursing has traditionally embraced all cultures in caring practices. Process reflection involved nursing faculty learning to recognize IB in self and mitigating its impact on the learning discourse. Content and process reflection are considered straightforward and easier to transform (Kitchenham, 2008). Reflection on premise involves learning through meaning transformation and does require action beyond simply knowing and recognizing (Mezirow, 1995). This level of reflection is a disorienting process and evocative to the personal meaning schemes of nursing faculty as they confront implicit biases (Mezirow, 1994). Through active engagement with the study constructs, a profound change in understanding occurred as to why it is crucial to mitigate IB and participate in critically reflective discourse with self and others. Ultimately, shared problem-solving occurred as nursing faculty begin to see the big picture (Kitchenham, 2008).

**Phases of Transformative Learning**

Significant learning through meaning transformation occurs through critical premise reflection during the following series of phases:

1. A disorienting dilemma
2. Examination of self with feelings of guilt and shame, seek religious support
3. A critical reflection of assumptions
4. Discontent recognition and the process of transformation are shared with others who negotiated similar changes
5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquisition of knowledge and skills needed for implementing course of change
8. Provisionally trying out new roles
9. Renegotiating relationships and negotiating new relationships
10. Building competence and self-confidence in new roles and relationships
11. Reintegration into one’s life on the basis of conditions dictated by one’s new perspective (Mezirow, 1994, p. 224)

**Critical Reflection of Assumptions**

Frames of reference “should be considered more functional and more ideal when they are more inclusive, differentiating, critically reflective, open to other points of view, and integrative of experience,” which are all conditions of universal principles of discourse (Mezirow, 1998, p. 188). The taxonomy of critical reflection (Figure 2.1) includes two types of reflections. The first is a critical reflection of assumptions (CRA) which are both the content and the process of prior beliefs, thoughts, and assumptions (Kitchenham, 2008). The second is subjective reframing through analysis of critical self-reflection on assumptions (CSRA). Reflection on premise leads to consciousness-raising and learning through meaning transformation (Mezirow, 1998). Also, entering into
discourse with others regarding a (problematic or not) belief that one has and critically examining the origins of this belief may lead to the highest level of learning and transformation of the meaning (Mezirow, 2003). Systemic CSRA involving collaborative critical reflection leads to social action and other consciousness-raising to liberate traditional ideologies that foster oppression, thus emancipating learning (Mezirow, 1998).

![Figure 2.1 Critical Reflections and Transformation of Learning](https://doi.org/10.1177/1541344608322678)

**Figure 2.1** Critical Reflections and Transformation of Learning

### Nursing Education’s Historical White Frame

An overview of the historical white framing of nursing education will help to elucidate how racism and white racial preferencing is embedded in the profession.

Formal nursing education began in the late 19th century in America, inspired by British nursing pioneer and early nursing researcher Florence Nightingale (Anderson, 1981). American nurses were initially taught by White male physicians and medical residents using the “curative” model, which foundationally stands in stark contrast to the “carative” model by which nursing care practices began to be framed in the mid-20th century (Anderson, 1981; Leininger, 1997). Due to racial segregation in the South and racial
quotas in the North, the admittance of UR students to nursing programs was greatly limited in the late 1800s and early 1900s (Bennett et al., 2019).

In 1879, Mary Eliza Mahoney graduated from New England Hospital, an accredited nursing program, and became the first Black female in America to obtain a registered nurse license (Minority Nurse, 2013). Because of racial discrimination, the program that Mahoney attended allowed only one Black student in each training class (Minority Nurse, 2013). In response to limited opportunity for Blacks to attend already established White nursing institutions, Provident Hospital and Nurses Training School opened in 1891 in Chicago as the nation’s first training school for African American women (Lyman & Collier, 2011). Further, Bennett and colleagues (2019) explained how collaboration between Black physicians and the communities they served in the South supported the opening of their own hospitals and schools of nursing in the late 19th century to educate Black healthcare providers and compassionately care for Southern Blacks. The historical roots of exclusion and inequity in nursing education and the profession run deep.

The white frame of early nursing implied the demographic majority of White students socialized in a majority White nursing profession with women at the center of the work (Lancellotti, 2008). The white frame can be deeply seated in the unconsciousness, leading to racial bias unawareness (DiAngelo, 2018). Lancellotti (2008) further described how nursing education causes confusion to learners assessing a patient using the white framed lens while disregarding those features that diverse populations demonstrate in a typical assessment. She clarified by describing skin tones, growth charts, and the textbooks used in nursing education as having the white frame of
reference without regard to individual racial and ethnic differences (Lancellotti, 2008). Iheduru-Anderson and Alexander (2022) added that healthy individuals are described with a skin tone of “pink,” which objectively leaves non-white skin to be “othered” (p. 179). Darcy-Mahoney and colleagues (2020) concurred that the profession continues to mirror the White society and all the influences within a White frame of reference. “Despite its democratic and humanistic traditions, [nursing] still has an enormous wealth divide and a history of racism, nativism, homophobia, and sexism” (Darcy-Mahoney et al., 2020, p. 413).

**Nursing Program Admission**

Diversity within the nursing profession is reliant upon UR students being accepted into and graduating from nursing programs with supportive structures for passing national licensure (Bennett et al., 2020). Admission committees attempt to base decisions for acceptance into programs upon academic evidence, among various other criteria, which applicants are most likely to successfully complete the program as well as most likely to successfully pass the National Council Licensure Examination (NCLEX-RN) (Jefferys et al., 2017). Without consideration for other student attributes, using standardized testing and academics alone can be a barrier for diverse students seeking admission to nursing programs (Green, 2020). There is a push to create more holistic approaches to nursing program admissions (Jung et al., 2020; Grossbach & Kuncel, 2011; Bennett et al., 2019; NACNEP, 2020). Jung et al. (2020) described the holistic process as a review of the applicant's life experiences, work history, and other personal attributes (such as internal/external motivation) in addition to scores and grade point averages to avoid solely admitting students based upon academic markers of success.
Using holistic admissions criteria can boost the admittance of UR students into nursing programs. However, effective implementation of holistic admissions has failed to change the predictive academic progression among diverse student nurses (AACNa, 2020). In fact, the American Association of Colleges of Nursing (AACNb, 2020) recently released *Promising practices in holistic admissions review: Implementation in academic nursing*, which outlined strategies for successful retention of diverse nursing students, including support before and after admission, evidence-based admissions processes and supporting an inclusive academic environment.

Noone and Najjar (2021) suggested minimizing IB influence on nursing program admissions by increasing committee member bias awareness, completing IB mitigation strategy training in non-threatening spaces, reviewing the mission and vision statements with each meeting, creating guidelines if using race and ethnicity in admissions, increasing diversity among members of the admissions committee. Increased IB can be prevented by decreasing workload stress through limiting the number of applicants each member must review, allowing enough time for thoughtful reviews, using applicant attributes in addition to academics, and establishing interrater reliability through teams of reviewers working together (Noone & Najjar, 2021). Bennett and colleagues (2019) and Jung et al. (2020) have found that utilizing a holistic admissions strategy without other supportive processes along the educational journey led to mixed results in successful completion of nursing programs.

**Nursing Program Progression**

Once students are admitted into the nursing program, they are assumed to be the brightest and best. When students are disengaged in class or learning experiences or
failing a course, faculty may say the student needs to “read before class” and “work harder.” Through such statements, faculty are assuming students are not preparing. If this assumption is so, it is believed the student is either not prioritizing their education or the student is lazy. Important to note is how the value of academic excellence disregards any outside barrier to that student may be experiencing or has historically experienced. The student is not seen as human but a product of a mechanistic system (Senge, 2012). This dehumanization makes the student muted and invisible.

Retention of nursing students to completion of programs not only affects overall attrition rates of academic institutions but also impacts the student, the profession of nursing, and ultimately the communities which rely on nursing care. Reasons for UR student attrition included lack of faculty support, cultural unawareness of peers and faculty, isolation and aloneness, and not being viewed as individuals (Gardner, 2005). Underrepresented nursing students have expressed isolation, depression, and loneliness when they feel excluded and not appropriately supported through socialization (Gona et al., 2019; Muronda, 2016). Breslin et al. (2018) stated, “Inclusive environments require intentionality to embrace differences, not merely tolerate them” (p. 104). The lived experiences of UR students while in nursing programs continues to demonstrate inequities, racism, and discrimination (Green, 2020; Gona et al., 2019). Gona and colleagues (2019) suggest that faculty utilize culturally appropriate educational interventions to aid UR students' retention and graduation.

A qualitative exploratory study by Gona and colleagues (2019) described the lived experiences of 16 Black alumni while at a Predominantly White Institution’s nursing program. The alumni described challenges of social isolation and exclusion, lack
of diversity among faculty, staff, and peers, lack of mentors, and cultural assumptions regarding ability and learning style. To persist in completion of the nursing program, Black alumni provided success strategies such as seeking Black peers, finding helpful mentors, developing resilience, and withdrawing from the dominant group, known as self-silencing which is a form of becoming invisible (Gona et al., 2019). The desire to be invisible may result in a loss of one’s culture and a feeling of not being valued as an individual, that results in a decrease in integration and acceptance in the learning experiences in nursing programs that are predominantly White in both students and faculty (Graham et al., 2016). Similar results were found in the scoping review of 30 studies by Metzger and colleagues (2020) in which discrimination, disengagement, self-silencing, and lack of inclusion and belongingness in the learning community negatively impacted UR nursing students’ experiences, academic progression, and program completion.

**Nursing Professional Practice**

Negative lived experiences while student nurses impact the professional practice of UR nurses as they carry these memories into their workplaces. Underrepresented professional nurses feel the same isolation in nursing practice that was felt while in nursing programs (Gona et al., 2019; Metzger et al., 2020). Major professional and nursing organizations have called for increasing DEI in academia and advanced nurse practitioners to close the gap in healthcare access, improve patient health-related education, and promote quality healthcare outcomes among traditionally marginalized groups (NLN, 2017; AACNa, 2021; AACNc, 2021; NACNEP, 2020; NASEM, 2021).
Additionally, diverse faculty often encourage UR students to advance their careers and promote the attainment of higher education in education or leadership (Abdul-Raheem, 2016). There is evidence of a steady increase in higher degrees among racial and ethnically diverse students. From 2015-2019, underrepresented students were more likely to graduate with advanced nursing degrees than their White counterparts, whose rates have declined over the same period (AACNa, 2020). Specifically, UR nurses completing master’s degrees increased by 3.9%, research-focused doctoral (Ph.D.) degrees increased by 4.5%, and Doctorate in Nursing Practice degrees increased by 7.9% during the five years mentioned (AACNa, 2020).

**Nursing Education**

The influence of the deeply embedded white frame in nursing education cannot be easily forgotten (Breslin et al., 2018). Lack of diversity among faculty insensitive to cultural differences among students was a perceived challenge to success of UR students (Gona et al., 2019). Also apparent is the misunderstanding of the principles of social justice, specifically the understanding of the differences between equality and equity among White faculty (Valderama-Wallace & Apesoa-Varano, 2019). In a recent descriptive qualitative study, Valderama-Wallace and Apesoa-Varano (2019) found diverse faculty could better convey the meaning of equity and equality than fellow White faculty. UR faculty could readily describe the equitable needs of diverse students. However, the White faculty described the equitable recommendations as unfair, secondary to confusion about the meaning of equality versus equity (Valderama-Wallace & Apesoa-Varano, 2019).
Critical Empirical Analysis

The historical pattern of racial discrimination in the education of nurses is clear. To address efforts to promote DEI requires getting to the heart of the matter. Failure to increase diversity in higher education and embrace equitable educational practices is made more complicated by the lack of understanding about how IB permeates the learning community (Breslin et al., 2018). Diversity without inclusion is for naught without addressing unconscious bias (Noone & Najjar, 2021). Accordingly, UR nursing students and faculty who endure verbal and nonverbal slights, known as microaggressions, are experiencing IB in academia (Ro & Villarreal, 2021). Remediating and managing IB requires intentional, deliberate work. According to Breslin and colleagues (2018), IB is unconscious and requires time, open dialogue, and dedication to ascertain an active solution to negate its harmful effects. To dig below the surface of the problem of IB requires clearly explicating its cognitive and social-psychological foundation and exploring the proliferation of IB research in healthcare professions.

Human Cognition and Hidden Biases

Increasing understanding of cognitive processes provides a foundation for realizing the origin of implicit, unconscious thinking. Human cognition is complex, relying upon large amounts of stored information for decision-making. Quick decisions are unconsciously derived based on what is familiar while filtering out irrelevant, extraneous information (Sweller et al., 2011). In contrast, conscious decisions use methodical, slow processing reliant on thoughtful comprehension (Sweller et al., 2011; Agarwal, 2020). This dual processing has been extensively explored in recent research on healthcare provider decision-making. Specifically, clinical decision-making uses either
the cognitive processing that is slow, analytical, and rational. At the same time, the other mode is automatic and intuitive yet prone to biased rationalizations due to time constraints and emergent patient needs (Thirsk et al., 2022).

Explicit cognition includes four features: knowing intent, conscious availability, thought control, and active use of mental resources (FitzGerald & Hurst, 2017). However, human cognition depends upon schemata to maintain efficiency for rapid information processing. Automation of schemata frees up cognitive processing for problem solving and comprehension (Driscoll, 2005). Sweller and colleagues (2011) defined schemata as cognitive constructs held in long-term memory that help determine how the working memory processes incoming sensory information. In order to avoid cognitive overload, an individual is only conscious of a few pieces of information in the working memory at any given moment. The rest of the incoming stimuli are unconsciously held in long term memory and may not necessarily require sensory input (Driscoll, 2005).

These schemata, or “packets of knowledge,” (Driscoll, 2005, p. 129) allow quick interpretation and categorization of received information. Even though rapidly processed, unconscious human cognition can make interpretation faulty as it “can prevent us from seeing what would otherwise be obvious” (Sweller et al., 2011, p. 23). Adding to processing difficulty is the notion that different cognitive processors are used for either auditory or visual input (Sweller et al., 2011). Thus, biased visual and auditory stimuli, whether conscious or unconsciously expressed, can be perceived as disturbingly discriminatory to the receiver and can be quickly pushed into unconscious cognition. Therefore, hidden biases warrant surfacing and exploration better to understand the personal origin, interpretation, and impact. Ultimately, it is essential to gently bring to the
surface bias awareness and carefully present why changing negative assumptions is necessary (Senge, 2012).

Personal interpretation of stimuli involves an awareness of the source of individual thinking (Senge, 2012). It is not often that one ponders the back story of a line of thinking, especially if the thinking is unconscious and automatic. The source of individual thinking derives from mental models. A mental model is a construct that derives from an individual’s assumptions, beliefs, and behaviors (Senge, 2012; Zuieback, 2015). Mental models are commonly demonstrated through shared ideas, languages, values, and beliefs (Community Magic, 2020). As such, they become entrenched in the organizational culture and systemic structure. An analogy of an iceberg fits perfectly in describing how to move towards real systemic change. By focusing on the tip of the iceberg, problem perpetuation continues because “events on the surface are usually symptoms of something bigger” falling far below in the depths of human cognitive awareness (Senge, 2012, p. 126). To produce real change requires diving deep below the tip to what lies below the surface—to what is hidden and invisible at the very bottom.

Furthermore, mental models, like personal schemata, can be incomplete assumptions that lack accuracy or generalizability to all situations. However, these assumptions can “evolve with experience” (Driscoll, 2005, p. 130). Mental models can include negative assumptions, such as “Why bother with that nursing student, they are not committed to passing this course anyway.” Alternatively, mental models can be founded on faulty optimistic assumptions. For instance, “We have an equitable nursing program admissions process because our admissions matrix tells us so.” Mental models are mostly “invisible to us,” lying well below a “level of awareness” (Senge, 2012, p. 99).
Nevertheless, mental models can be analyzed and are amenable to change with motivated effort for optimal systemic and positive structural outcomes (Senge, 2012). What is known is that an individual’s experiences, social circumstances, and personal memories produce both positive and negative unconscious biases (Agarwal, 2020). Acknowledging the positive of implicit processing is noting how it aids efficient processing (TOSU Kirwan Institute, 2018). Psychologists admit that implicit processing was helpful to early humans for survival and quick decision-making. The brain “is an exquisite machine that perceives reality in the services of survival, not accuracy” (NOVA, 2023, 50:27). This inaccuracy can lead to negative assumptions that affect interpersonal communications, relationships, and meaningful collaborations (APA, 2022; Agarwal, 2020).

Accordingly, mental models can help make quicker decisions and derive potentially better courses of action, but to do so, they must be made clear and visible (Zuieback, 2015). Making courses of action consistently clear is difficult due to each individual’s unique mental models specific to personal and differing life experiences. Yet courageous conversations are imperative because implicit evaluations can be based on inaccurate information or stereotypes perpetuating inequitable, negatively biased decision-making (TOSU Kirwan Institute, 2018). Hence the importance of understanding IB and the powerful impact hidden biases have in relational experiences with others.

We all have biases. Bias in and of itself is not inherently bad— and trying to completely eliminate bias drives it further into the unconscious (Ross, 2014). Ross (2014) added that bias can have constructive or destructive outcomes. The focus should not be on driving others “toward guilt, but to move us all toward responsibility” (Ross, 2014, p.
5). Before nursing faculty can ameliorate faulty assumptions, they must dive below the tip of the iceberg to what lies deep within their mental models. To merely become aware of hidden negative biases is not enough and may even be detrimental, worsening biases that threaten self-concept and cause personal identity crises when awareness gives rise to guilt without proper processing of this new self-awareness (Sukhera et al., 2019b).

The Rise of Implicit Bias Research

A historical review of research related to IB provides the context of how implicit biases enter healthcare professionals’ decision-making and teaching practices in health educators. The earlier focus on the history of nursing education contemplated the possible contribution white framing had on implicit biases in education and professional nursing. Several decades of research have noted IB presence and impact in medicine (Zescott et al., 2016; FitzGerald & Hurst, 2017). The research on nursing professionals' implicit biases influencing judgment and decision-making has been limited (Thirsk et al., 2022), with even less research directly including nursing faculty (Gonzalez et al., 2022). The existing research literature exploring IB perceptions and presence in nursing faculty is limited mainly to dissertations (Fitzsimmons, 2009; Gunther, 2020; Price, 2022). A time of reckoning has arrived for nursing faculty to increase awareness of and be accountable for the implicit biases carried into classrooms and clinical educational spaces of student nurses.

Almost a century has passed since social psychologists’ research literature theorized about the cognitive mediated drivers of biased behavior (Blair, 2002; Greenwald & Banaji, 1995). The movement from cognitive and social psychology discipline research to healthcare research exploded after the Institute of Medicine’s
(IOM) 2003 publication of Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Even when controlling for socioeconomic factors and access to care, the IOM study found that healthcare providers “stereotyping, biases, and uncertainty” added to the inequitable treatment of racial and ethnically diverse individuals (Smedley et al., 2003, p. 1). Threading the historical origins of IB research from psychology to healthcare providers is essential to understanding its ubiquity and the importance of addressing an impactful unseen problem.

Prior to Greenwald and Banaji’s (1995) research review that described the unconscious (implicit) cognitive mediation of social behavior, most social psychologists argued that attitudes and stereotypes derived from a conscious (explicit) mode. Such belief meant that conscious awareness of attitudes and stereotypes could be captured fully by self-report (Greenwald & Banaji, 1995). Early research associating race with attributes demonstrated that participants were quicker to ascribe stereotyped negative attributes to Blacks (e.g., Blacks = lazy versus Blacks = ambitious) and Whites paired with positive attitudes (Gaertner & McLaughlin, 1983). Graf and Schacter (1985) noted that past experiences could influence association performance, even if the previous experiences were not directly, consciously, or explicitly remembered. Using the label “implicit memory,” Graf and Schacter (1985) described how task performance occurred without explicit, conscious recollection in individuals suffering from amnesic disorders. Thus, implicit memory is defined as an unconscious influence on current performance without the full awareness of the individual. Greenwald and Banaji (1995) conducted groundbreaking cognitive biases studies and were the first to coin the term implicit bias.
The use of implicit and explicit cognition mirrored the terminology driving a surge of memory research in the 1990s (Greenwald & Banaji, 1997). Implicit bias is unconscious assumptions individuals make about others which may affect behaviors towards them (Gonzalez et al., 2018). As defined by psychologists, prejudice is different in that it is an explicit conscious expression (APA, 2022) that can be positive or negative, yet not necessarily based upon personal experience (Cole, 2020). Cole (2020) further described prejudice as distinct from racism in that while anyone can experience prejudice, racism is the belief that there are superior races that result in unequal distribution of power based on race. Banaji (APA, 2022) clarified that while learning about individual implicit biases may be uncomfortable, biases are not inherently racist. Evidence has shown that though individuals espouse egalitarianism and reject prejudice, they still have implicit biases (APA, 2022). Further, Banaji added that even though implicit bias is not racism, it is an association in our minds with deep “roots of prejudice” (APA, 2022, 4:40).

**Project Implicit**

Greenwald et al. (1998) sought to determine the feasibility of scientifically measuring automatic evaluations that trigger unconscious associations that are distinctly separate from explicit associations to advance knowledge of implicit associations. Their research measured participant keyboard response times in milliseconds between images/faces/social groups and descriptive words/attributes in a combined response. They then reversed the combination of associative pleasant/unpleasant attributes to increase the complexity and validity of responses. For example, Black + good is easier (faster) to associate if one has a stronger association between Blacks and a pleasant word.
In the original study, data cross-correlated with explicit data measures demonstrated divergence of the constructs of implicit versus explicit attitudes (Greenwald et al., 1998). The self-reported explicit responses of participant belief in egalitarian ideals did not directly match the implicit computerized responses. The divergence occurred because respondents were either reluctant to report biases or were likelier to be unaware of implicit attitudes (Greenwald et al., 1998).

This earlier work led to the creation of Project Implicit by Greenwald, Banaji, & Nosek in 1998 and the launching of the online implicit association test (IAT) (Project Implicit, 2011). The online IAT measures the strength of association between images and words (Black-good; White-bad, etc.) by response times and frequency of errors. The strength of an association, measured as a positive, is determined by quicker times and fewer errors (Maina et al., 2018). Since its beginning, Project Implicit has administered over 25 million IATs (over different association categories such as age, race, skin tone, sexuality, weight, disability, etc.), commenced over 3100 studies, and contributed to over 150 peer-reviewed papers (Project Implicit, n.d.).

Though the IAT is not without controversy and opposition (Albano, 2021; Schimmack, 2021; Jussim, 2022), research has supported the validity of the IAT to measure implicit attitudes to which self-report surveys are not sensitive (Greenwald et al., 1998; Greenwald et al., 2015). Unconscious bias is hidden from awareness and is the opposite of what people think they believe (Agarwal, 2020; APA, 2022). Nonetheless, researchers urge that results obtained from the IAT should be used for informative rather than prescriptive purposes (Greenwald & Nosek, 2001; Nosek et al., 2007; Greenwald et
Much of the research literature reviewed regarding implicit bias utilized the IAT as a measuring instrument or an awareness tool.

**Implicit Bias Investigative Modalities**

Implicit cognition and memory research increased significantly at the turn of the 21st century, mainly related to biases, prejudices, and stereotyping (Blair, 2002; Greenwald & Banaji, 2017). Multiple investigative modalities have been used to conduct IB research, ranging from cognitive/affective measures to computational methods (the online IAT, for example) and the latest advanced functional neuroimaging (APA, 2022; Burgess et al., 2017). Neuroimaging has provided a window to visualize neuronal activation via functional magnetic resonance imaging (MRI) scans while participants are asked to complete a task. The functional MRI (fMRI) measures the increase in blood flow to areas of the brain triggered by increased neuronal activity (RSNA, 2022). Researchers can now pinpoint areas of the brain that are active during specific tasks or thoughts of participants.

Though research linking neuroimaging and IB is nascent, neuroimaging offers a deeper physiological understanding about how brain areas become triggered during specific task performances related to biases (Burgess et al., 2017). Specifically, scientists are interested in an area of the brain known as the amygdala, part of the limbic system responsible for controlling emotions and behavior with subsequent memory formation between the two (AbuHasan et al., 2022). Also, the amygdala plays an important role in fear and threat level activation, especially if the input connects to prior perceptions or memories of harm rather than safety (Agarwal, 2020). Individuals are more comfortable and feel safer with familiarity. For example, the amygdala quickly, unconsciously, and
efficiently categorizes data from the prefrontal cortex into “like me” versus “not like me” or “in group” versus “out group” (Agarwal, 2020). Favoritism for familiarity hinders effective, successful collaboration with others (APA, 2022). The “out group” and comfort with “in group” line of cognitive processing lies at the heart of prejudicial discrimination (Agarwal, 2020).

**Overview of Recognizing and Altering Bias Automaticity**

Recognizing and managing IB (Sukhera & Watling, 2018; Sukhera et al., 2020) and utilizing strategies to reduce IB (Burgess et al., 2007; Boscardin, 2015; Burgess et al., 2017; Marcelin et al., 2019; Narayan, 2019) have been suggested to address societal discrimination, health professional negative assumptions, and biased healthcare provider decision-making. Still, Greenwald and Banaji (2017) posited that implicit attitudes and stereotypes are deeply rooted in a “cumulatively construct[ed]…overlearned repertoire of cultural expertise” (p. 866) that may be “impossible to unlearn” (p. 867). This “learning” happens over many years and many experiences. Their stance conflicted with other researchers who suggest that implicit biases are amenable to change with deliberate effort (Blair, 2002) and can be seen as habits to be broken (Forscher et al., 2017). Agarwal (2020) also disagreed with Greenwald and Banaji’s (2017) assumption that biases are impossible to unlearn based on recent ground-breaking research from the neuroscience discipline, specifically neuroplasticity.

*Neuroplasticity* is the ability of brain structures to adapt, modify, and change based on short- and long-term experiences which impact neuronal processing (Voss et al., 2017). Increased interest in neuroplasticity is driving research related to how cognitive neuronal processing determines stereotypes and IB (Agarwal, 2020). Agarwal (2020)
added that implicit biases are not hard-wired into us and can change over time, place, and cultural experiences. Since biases and stereotypes are learned from our experiences, Agarwal (2020) argued that they could be unlearned by creating new neural pathways of cognition. Recently, Banaji (APA, 2022) recanted the position that biases are impossible to unlearn. However, she added that since biases are learned and nestled within the individual's cultural default, support for change is only easily achieved or sustained with societal macro-level institutional and policy changes. Individuals are motivated to change automatic stereotype attitudes when it benefits their self-image, or their stereotypes contradict social norms (Blair, 2002). Even with individual commitment to change, though, there remains a 'mental residue' (Joint Commission, 2016, p. 2) that requires continuous effort and acknowledgment.

**Implicit Bias Research in Health Professions**

Everyone has biases that are not necessarily bad and often serve the purpose of efficiency in cognitive functioning that favors familiarity (Ross, 2014; Agarwal, 2020). In healthcare professionals, biases for the familiar aid efficient thinking when quick decisions are necessary, especially in emergencies (APA, 2022). Biases become harmful when cognition ‘blinds’ the provider to the unique needs of patients or when the provider treats the patient disparately based upon hidden assumptions and biases (Burgess, 2010; Johnson et al., 2016). Additionally, healthcare provider uncertainty, stress, and cognitive load may lead to negative psychological processing and may instigate IB impact (Burgess, 2010). Ross (2014) suggested leaning into awkwardness and discomfort when IB awareness increases. When noticing the feelings of fear that the amygdala interprets as danger, realize that this could be a flawed interpretation based upon faulty assumptions.
especially when there are increased psychological and physical stressors (Brockett-Walker et al., 2021) or cognitive overload (Burgess, 2010).

Ross (2014) argued that by practicing “constructive uncertainty,” (p. 14) health professionals can learn to pause in their practice to increase self-awareness. Uncertainty allows individuals to accept not always having the correct answer and remain open to learning (Ross, 2014). Healthcare research has focused on the recognition, management, and mitigation of IB because of the negative impact on patient experiences and health outcomes (van Ryn et al., 2015; Lai et al., 2016; Zescott et al., 2016; FitzGerald & Hurst, 2017; FitzGerald et al., 2019). Current research in health professional education and curricula development aims to equip providers with the knowledge, skills, and attitudes needed to provide equitable healthcare in an increasingly diverse society (Corsino et al., 2021; Gonzalez et al., 2019; Gonzalez et al., 2022; Sukhera et al., 2020).

Gonzalez et al. (2019) conducted an exploratory qualitative design study to investigate first through fourth-year medical student perceptions of IB instruction. The researchers conducted small focus group interviews with open-ended questions which asked participants about their perspectives of IB in themselves and others and its significance to clinical care. These focused groups occurred after instructional overview of IB definition and its historical impact on clinical care. The ongoing data analysis occurred inductively until thematic saturation occurred. Investigators analyzed the data over three phases: codebook development, conceptual theme development, and member checking to ensure the validity and accuracy of the themes. The identified four themes were resistance, shame, the negative role of the hidden curriculum, and structural barriers to student engagement (Gonzalez et al., 2019).
Zescott and colleagues (2016) published a narrative review that examined the role of healthcare provider IB on health disparities and sought to determine what interventions have been developed to reduce IB among providers. Their review found three general causes linked to health disparities, genetic/biological factors, socioeconomic status, and psychological processes. Zescott et al. (2016) noted that psychological processes, specifically related to IB, had more impact on provider clinical decision-making and actions towards certain marginalized groups than the other two causes. Racial/ethnic minorities receive differences in care provision, dissatisfaction with care provided, especially when the provider is of a different ethnicity, poor communication with providers, and disrespectful treatment during a healthcare visit. Healthcare providers have more negative attitudes towards African Americans and Hispanics, overweight/obese individuals, gay and lesbian people, lower socioeconomic class, intravenous drug abusers, and disabled individuals.

While the evidence indicated providers hold increased negative implicit biases, explicit expression was limited. Examples of explicit bias include believing that, compared to the total population, Blacks or Hispanics are more noncompliant and obese patients are lazier than those of average weight (Zescott et al., 2016). Hoffman and colleagues’ (2016) study provided evidence of false beliefs in pain perception and experience among Blacks. Zescott and colleagues (2016) included a model of paths showing how provider implicit bias can influence provider judgment and clinical decisions (path A) and communication and trust with patients (path B). The two paths interact and exacerbate each other, which can alter the patient’s adherence to treatment and worsen health disparities.
Zescott and colleagues (2016) did not find a clear association between provider IB and treatment decisions or judgment, indicating that healthcare provider decisions are variable and more complex, relying on multiple data points that are only sometimes explained by IB. In many cases, evidence-based guidelines specifically direct care practices that “leave little room for the influence of providers’ feelings and beliefs” (Zescott et al., 2016, p. 533). Zook et al. (2016) concurred that while African American and Hispanic patients received lower emergency department triage scores for breathing difficulty, abdominal pain, or fever, there was no statistical difference in triage scores for head injury or lacerations based upon race.

Blair et al. (2014) reported no impact of IB on the escalation of treatment for hypertensive patients in their study of 138 primary care providers. Participants completed the Ethnic and Racial Bias IAT and a review of their patient medical records (N=4794), which included Blacks, Latinos, and Whites, to determine the treatment intensification level and hypertension control among the groups. Blacks received the same treatment intensification (escalation based on blood pressure) but had lower adherence to therapy and worse hypertension control. Of interest was the patient's perception and judgments of clinicians directly influenced patient adherence to therapy and control of blood pressure; however, Blair et al. (2014) admitted that this was not a construct of their study. Nonetheless, Blair and colleagues’ (2014) conceptual model is supported by later research stressing the importance of communication between patient-provider to develop trust, increase patient satisfaction, and influence positive (or negative) patient-provider engagement (Hagiwara et al., 2019; Maina et al., 2018). Caution should be extended to
avoid burdening the patient with responsibility for healthcare provider biased behaviors and communications (Thirsk et al., 2022).

FitzGerald and Hurst’s (2017) systematic review sought to determine if healthcare professionals display IB towards certain types of patients (age, race, ability, mental and physical illness, and weight). Of the 42 international research articles meeting criteria, 17 used the IAT, 25 used vignettes, and an overwhelming majority (27) studied racial/ethnic bias. Most of the study populations were of physicians and advanced care practitioners from a variety of health specialties including oncology, cardiology, addiction, psychiatry, emergency services, primary care, internal medicine, and pediatrics (FitzGerald & Hurst, 2017). None of the multiple bias studies, race plus one or more other categories, included nurses. Of those studies specific to racial/ethnic bias, the only study to include nurses was a cross-sectional study by Cooper et al. (2012) that included four advanced nurse practitioners and 36 physicians comparing race IAT and audiotapes of interpersonal communication along with patient’s perception of the experience.

One study of nurse educators (Aaberg, 2012) used the Disability Attitude IAT and found a stronger implicit preference for abled individuals among the 124 (21% response rate) respondents compared to the overall population. Aaberg (2012) argued that ability preference could impact the admission of students with physical disabilities into nursing programs and urged opening dialogue to create more inclusive practices in nursing education. Evidence of the negative impact of IB on the quality of care provided was found in all 42 studies reviewed, with thirty-five studies finding IB present in healthcare providers at the same propensity as the total population despite respondents' explicit attitudes to the contrary. Zescott and colleagues’ (2016) narrative review offered further
evidence of provider divergence between high IB and low outward expression of negative explicit biases towards marginalized groups.

FitzGerald and Hurst (2017) posited that even though health professionals explicitly express aversive racism, they may be influenced by the cultural immersion where individuals are negatively stereotyped by society. Additionally, biases present in healthcare professionals become a problem when they lead to negative assessments of an already vulnerable population or lead to clinician decision-making or actions based upon assumptions that are not true about a group of people or a characteristic of an individual. Intersectionality added to the complexity of IB and provider-patient interactions, assumptions, clinical decisions, and prejudicial actions of healthcare providers (FitzGerald and Hurst, 2017). Moreover, the lack of individuation in health professionals may cause a provider to misdiagnose or over-diagnose based upon a stereotype or category attribute of patients, especially amongst Black patients. The “gap between the norm of impartiality and the extent to which it is embraced by healthcare professionals” is an area that requires further exploration (FitzGerald & Hurst, 2017, p. 15).

Sukhera and coresearchers (2019a) conducted a meta-narrative review that included 38 articles that used the IAT to increase health professionals' IB awareness. As educators, they sought to understand how and why the IAT was used in teaching and learning among various adult learners such as undergraduate students, medical students, teacher trainees, occupational therapy students, social worker students, and dieticians (Sukhera et al., 2019a). Their review did not include nurses, nursing students, or nurse educators. The researchers admit that the review was not meant to be exhaustive, but the absence of a nursing perspective in their methodological search is disappointing.
Nonetheless, the review is helpful information regarding the use of IAT in research. Most studies (21) used the Race IAT, while others included weight, age, mental illness, disability, gender, or multiple biases in one study. Most of the research articles measured the success of an educational program using the IAT to determine the change in IB. Other studies used the IAT as a primer to promote discussions and reflection.

Researchers who use the IAT must prepare for the intense evocation of emotional responses of defensiveness among participants who may be critical of the results (Sukhera et al., 2019a; Sukhera et al., 2019b). Sukhera et al. (2019a) suggested that participants use “critical reflexivity” (p. 273) when confronted with discordant results between explicit and implicit assumptions that the IAT may bring to light. Adult learners who face such dissonance may transform their frame of reference, or what Mezirow called “habits of mind,” by critically reflecting on these assumptions (Mezirow, 1997, p. 6). Ten of the 38 studies reviewed demonstrated that a pre-post-intervention design resulted in no remarkable change in IB among participants. Sukhera and colleagues (2019a) urged researchers to be clear about why they use the IAT and whether it can change IB or be a catalyst to prompt more profound reflection on hidden assumptions. Given the controversy surrounding the IAT as a metric of change, it is best to use it as a primer for constructive conversations, dialogue, and discussions. Demonstrated behavioral changes and transformation can occur once participants know their biases and are encouraged to critically reflect on the dissonance felt and supported to sustain behavioral changes even if this goes against sociocultural norms (Sukhera et al., 2018). IB reduction alone is unrealistic since bias awareness must be ongoing, the use of multiple interventions to sustain positive change is required to mitigate effects, and
organizational and institutional change must address and support the mitigation of harmful IB (Sukhera et al., 2019a).

Johnson and colleagues (2016) conducted a study of pre- and post-shift implicit and explicit racial bias measures of 91, primarily White (N= 67) physician residents working in a large pediatric emergency department in the northeastern U. S. They also sought to determine any associations between participant demographics and cognitive stressors (fatigue, busyness, stress, number of patients, number of shifts). Mental shortcuts, which rely on heuristics, are more likely to be used in emergency department care because decisions need to be made quickly without delay. Because they hypothesized that medical residents would experience greater cognitive load and fatigue than experienced physicians, making them rely more on mental shortcuts such as racial bias, researchers chose this population for their study. The Race IAT was used to measure IB, finding that respondents had a moderate pro-White/ anti-Black preference pre-shift, which did not differ statistically post-shift. However, sub-analysis of variants demonstrated increased racial bias when the ED was overcrowded, and participants were responsible for providing care for multiple patients in a shift. Explicit bias was measured by rater preference for Blacks and Whites, where 0 = strong preference for Blacks, 5 = neutral, and 10= strong preference for Whites. The second explicit tool used temperature scales, where 0= cool, 5 = neutral, and 10 = warm. The effect size of IB was three times higher than explicit bias supporting the divergence between implicit and explicit bias in earlier research (Greenwald et al., 1998).

Johnson and colleagues’ (2016) research supported earlier research by Burgess (2010) that increased cognitive load contributes to poorer physician clinical and care
decisions. Racial stereotyping in healthcare providers is associated with health disparities among marginalized groups (Burgess, 2010; Smedley et al., 2003). The amount and type of attention a perceiver pays to an individual can influence stereotypes, especially when one is cognitively “busy” (Blair, 2002, p. 250). Participants are less likely to express stereotypic judgments when completing cognitive tasks, especially when provided positive feedback (Blair, 2002). Blair (2002) admitted that automatic attitude measurements, like self-report surveys, are bound to personal, social, and contextual factors influencing results. Hence, solutions are not readily explainable for automatic stereotyped social cognition.

Maxfield and colleagues (2020) completed a follow-up study to better understand discrimination and IB among radiology faculty in their selection process of radiology medical residents. Thirty-one of the original 51 faculty in a simulated resident physician admission selection study agreed to partake in the current study, with a 61% response rate. Participants completed the race and weight IAT and were questioned about race and weight bias awareness and if they had any prior diversity training. All data were aggregated and compared to see if prior diversity training influenced implicit or explicit responses. Greenwald et al. (2015) supported the aggregation of IAT meta-analysis data because the data “were large enough to explain discriminatory impacts that are societally significant either because they can affect many people simultaneously or because they can repeatedly affect single persons” (p. 553).

Regarding weight bias, 74% of the radiology faculty demonstrated IB, concordant to explicit anti-obese bias in selecting non-obese radiology residents (Maxfield et al., 2020). Only 23% of faculty respondents reported awareness of weight bias. However, a
discordant response was noted in racial bias, in which 71% demonstrated implicit anti-
Black preference, yet there was higher acceptance for Black and Hispanic residents over
White and Asian residents among the simulated applicants (Maxfield et al., 2020).
Interestingly, 84% of respondents reported explicit awareness of racial bias during the
original applicant review, which may have positively impacted the acceptance of diverse
radiology residents. Maxfield and colleagues (2020) suggested that bias awareness may
be largely acquired through cultural immersion but demonstrated efforts to diverge from
pro-White bias, as opposed to FitzGerald and Hurst (2017) who posited that negative
biases persist even when providers espouse egalitarian ideals. Formal diversity training
did not affect implicit or explicit bias reporting (Maxfield et al., 2020). The results of this
study demonstrate that a lack of bias awareness, regardless of diversity training, can lead
to biased decision-making against certain groups but not necessarily discriminatory
behavior (Maxfield et al., 2020). They suggested that along with awareness, there needs
to be awareness of the effects of bias on others.

**Implicit Bias and Provider Communication**

Maina and colleagues (2018) completed a review of 37 studies assessing racial/
ethnic IB in healthcare providers using the IAT. Most of the studies included physicians
(23), while ten included healthcare students in pharmacy, medicine, nursing, psychology,
and counseling. The remaining four studies included counselors, nurses, and occupational
therapists. They aimed to review research on racial/ethnic IB among healthcare providers,
describe knowledge related to the impact on patient healthcare outcomes, and determine
if IB reduction strategies influence healthcare practices (Maina et al., 2018). Real-world
studies (eight of nine) and two simulation-based studies demonstrated an association
between provider IB and disparities in care more so than vignette-based studies (four of 12).

Interestingly, most real-world studies focused on provider communication, while vignette-based studies mainly focused on treatments and decision-making (Maina et al., 2018). Studies report a complex triad interaction of physician explicit bias, implicit bias, and patient perceptions based upon past discrimination perpetuating negative experiences of patient-provider interactions that contribute to health disparities (Maina et al., 2018). Vignettes may not accurately capture implicit bias activation by nonverbal or paraverbal communication between providers and patients. Therefore, they argued against using vignettes as both measure of and use of reductionistic strategy—as information is already provided, lack of face-to-face, and artificial setting potentially influences provider performance during vignette, but may not necessarily translate into clinical practice (Maina et al., 2018; Maxfield et al., 2020).

Additionally, those care practices that are more objective and standardized, such as care for hypertension, trauma, and urinary tract infections are less susceptible to implicit biased decision-making than subjective communication interactions. Those less algorithmic and ambiguous interactions are likely to lean towards aversive racism interactions, given the subjective, fluid nature of patient-provider communication (Dovidio et al., 2017). Overall, findings from the systematic review found that most healthcare providers had racial/ethnic IB, that Blacks are less likely to demonstrate IB compared to Whites or other racial groups, and that most research had been vignette-based with limited real-world patient care studies (Maina et al., 2018). Maina and colleagues (2018) found mixed results post IB reduction in two studies with one
multicultural class (IB present) and the other virtual cultural training module (absent IB). Providers without racial/ethnic IB were practicing amongst primarily Black and Hispanic populations, which could indicate positive interactions with and desire to care for racial-ethnic minority groups while sharing common treatment goals (Maina et al., 2018). Discrepant results may be viewed as counter to using the IAT for prescriptive purposes. Nonetheless, ample research supports the IAT as a reliable and valid tool for measuring IB (Greenwald et al., 2009).

Hagiwara and colleagues (2019) reported a possible link between implicit bias and communication behaviors of healthcare providers, but determining what those exact communications entail was fraught with difficulty. Seeking feedback from racially and ethnically marginalized patients on their perceptions of provider-patient communication is critical to elucidate the specific details of which communication behaviors are more likely to be negative or positive (Hagiwara et al., 2019). More than increasing IB awareness is required, and change in mindset takes time (Agarwal, 2020; Voss et al., 2017). Hagiwara et al. (2019) argued that implementing provider communication changes is feasible and easily integrated into healthcare provider education.

Therefore, Hagiwara et al. (2019) developed a conceptual model to demonstrate how “communication behaviors can disrupt the negative association between provider implicit racial bias and improve patient satisfaction and trust” (p. 1739), which leads to adherence to therapies, trust in providers, and improvement in health outcomes, especially if the communication utilized shared decision-making. Further, the model suggested that provider IB may be reduced by ongoing positive communication and interactions between patient and provider (Hagiwara et al., 2019). Future research should
include data triangulation using complementary (mixed-methods) qualitative and quantitative approaches to study—described as narratives from patients (qualitative) which can be used to develop quantifiable communication behaviors coding systems for future research in creating “culturally respectful provider communication skills training programs” to address an unseen “wicked problem” (Hagiwara et al., 2019, p. 1741).

The importance of assessing nonverbal (hands, eyes, posture) and paraverbal (inflection, tone, amount of time) over direct verbal communication for IB while also giving healthcare providers, specific timely feedback regarding perceived negative communication cannot be overstated (Hagiwara et al., 2019). Efforts such as bystander training benefit timely, specific, and targeted feedback. Ackerman-Barger and Jacobs (2020) described the bystander response using ARISE. When one witnesses negative communication or microaggression, ARISE is helpful to maintain the focus on what was seen and heard, not the individual. The bystander’s response is as follows: Awareness of what is happening in the moment, Respond with nonjudgment and empathy, Inquire about meaning of comments for clarification and exploration, begin Statements with “I” to note what was heard, felt, and observed, and Educate and engage the speaker as to intent and impact while engaging towards mission, values, and goals that are shared (Ackerman-Barger & Jacobs, 2020, p. S31). This approach may help in intervening through openness, honesty, and humbleness.

Healthcare providers may also make stereotypical assumptions and attempt to overidentify the patient’s cultural background in communicating with them (Brockett-Walker et al., 2021). For example, when trying to obtain a health history, a practitioner may make derogatory comments based on stereotypes, such as “Do all of your children
have the same baby daddy” or “People like you that have lots of kids” (Brockett-Walker et al., 2021, p. 91). In the narrative review conducted by Zescott et al. (2016), several studies revealed how interpersonal communication might be affected by IB, with a resultant decrease in trust and less follow-up care sought on the patient’s behalf. The lack of adherence to therapies ultimately leads to poor health outcomes. Thus, research is consistent that patient perceptions and subjective experiences with their healthcare providers can be especially damaging to Black patients (Brockett-Walker et al., 2021; Hagiwara et al., 2019; Maina et al., 2018; Maxfield et al., 2020; Zescott et al., 2016).

**Implicit Bias and the Nursing Profession**

As noted thus far, the review of the literature demonstrates a plethora of research regarding IB and its impact on patient care provided by medical practitioners and various other healthcare disciplines (FitzGerald & Hurst, 2017; Zescott et al., 2016). Very few studies included nursing professionals (Maina et al., 2018; Thirsk et al., 2022; Kruse et al., 2022; Gonzalez et al., 2022). Over half of the nursing research studies reviewed by Thirsk and colleagues (2022) occurred in the U.S. within the last 13 years, even though cognitive psychological bias research first appeared in the 1980s. Of the 37 research articles included in the integrative review of educational strategies to address implicit bias conducted by Kruse and colleagues (2022), six focused exclusively on the discipline of nursing, with four involving nursing students (Carter & McMillan-Bohler, 2020; Gatewood et al., 2019; Schultz & Baker, 2017; & Vandermause et al., 2021). One study included nurse educators’ perceptions of engaging graduate nursing students’ sexual orientation implicit bias (Teall et al., 2019). Ogilvie and coresearchers (2021) sampled hospital nurse managers and assistant nurse managers unconscious and implicit biases.
Nurses spend more time with patients than any other member of the healthcare team and have a keen awareness and “hands-on knowledge” of patient needs (Haider et al., 2015, p. 1080). Further, the nurse determines how and when to implement provider-prescribed interventions and escalates care to the interdisciplinary team members (Cavalier et al., 2018). Nurses' critical thinking and clinical judgment determine the outcomes and experiences of the patients to whom they provide care. Even as nurses hold compassionate care as a core value, the profession is not immune to the potential adverse effect of implicit biases on their decision-making capacity.

Thirsk and colleagues’ (2022) scoping review focused on nursing IB and its influence on clinical judgment and decision-making. An interesting distinction is made between medical and nursing decision-making. For example, physicians tend to follow explicit diagnostic decision-making based on best practice guidelines (Zescott et al., 2016), while nurses' decision-making is more contextual and intuitive (Thirsk et al., 2022). The physician' curative' model of decision-making starkly contrasts nursing’s 'carative' model of clinical judgment (Anderson, 1981; Leininger, 1997). This nuanced clinical judgment makes decision-making difficult to articulate because of fluctuating, dynamic changes in patient needs throughout caring experiences (Thirsk et al., 2022).

The difficulty in pinning down how IB factors into nurses’ decisions and use of clinical judgment is exacerbated by limited research using observation and real-world examples. Of the 77 studies meeting inclusion criteria in Thirsk and colleagues’ (2022) scoping review, only five tested an intervention to mitigate bias, and most did not include real-world data collection, relying instead on surveys, vignettes, and recall, with most (N=56) using quantitative methodology designs. The two common scenarios used in
nursing research were pain management and emergency department triage scoring, possibly due to the ease of quantifying pain level and scoring the severity of illness (Thirsk et al., 2022). The studies confirmed that most nurses’ judgments and decisions are influenced by cognitive and implicit biases with the potential to result in poor patient outcomes because the nurse failed to communicate concerns and escalate care to the interdisciplinary team. Two suggestions for future research include developing and testing bias reduction strategies in real-world context and educating on the impact biases have on the developing therapeutic relationships between nurses and patients (Thirsk et al., 2022).

Haider and colleagues (2015) used eight multi-staged randomly altered acute care clinical vignettes to determine whether registered nurses’ implicit race or class biases had any bearing on patient care decisions. A prospective study included 245 majority female nurses (88.5%) and White (82.9%). In contrast to explicit denial of race preference (71%), only 14.7% demonstrated an absence of implicit racial preference using the Race IAT. Similar results were obtained for participants’ class explicit and implicit preferences, 44.1% and 6.53%, respectively. Even though nurses had an implicit preference for Whites and upper-class patients according to the IAT in this study, this did not correlate with their overall clinical decision-making (Haider et al., 2015). Curiously, nurses older than 35 had a higher implicit bias for pro-White bias and a preference for upper-class patients. The divergence between explicit and implicit bias supports earlier research (Greenwald et al., 1998) and conscious intent conflicting with unconscious thoughts (APA, 2022). Stratification of race to class, their study found that Black patients of lower socioeconomic status were more likely to be restrained and sedated due to
perceived agitation that is unresponsive to directions from nursing staff (Haider et al., 2015). Haider and colleagues (2015) posited that nurse communication and relationships with patients as frontline workers buffer implicit bias expression in clinical decision-making. However, they recognized that their study is limited to vignettes and recommend observational, real-world research on implicit bias and nurse decision-making.

**Implicit Bias and Nursing Education**

Though Thirsk et al. (2022) and Haider et al. (2015) did not include nursing faculty or nursing education, their studies highlight the presence of IB specific to the discipline of nursing. The scarce nursing faculty IB research highlights the ongoing need for discipline specific studies, especially given the potential impact faculty bias can have on their student nurses (Kruse et al., 2022). Nursing education IB research is beginning to increase. However, most of the focus on nursing faculty discusses the deployment of DEI and IB in the education of future nurses caring for diverse populations (Edwards-Maddox et al., 2022; Gatewood et al., 2019), not a focus on faculty perceptions of their own IB.

Gatewood and colleagues (2019) conducted a mixed-method study to increase IB awareness among all nursing students, entry-level BSN (13), MSN (33), and doctoral student nurse practitioners (64) through curricular training and education. The researchers organized their study into three steps: an introduction to implicit bias by watching a video and reading an article, completing one of the implicit association tests from Project Implicit, and finally, a discussion activity. The data collected after the three-step assignment included a Likert scale survey (six questions) and an open-ended narrative section asking how participants can change their care approaches based on their learning. Data analysis revealed five themes: awareness and mindfulness, pausing, surprise,
disbelief, and deliberate exposure to people of different backgrounds (Gatewood et al., 2019).

Unawareness of IB towards UR students may impact how nursing faculty deploy their teaching strategies (Haen, 2022). A recent study by Teall and colleagues (2019) did include nursing faculty perceptions, but it was their perceptions of engaging students, not faculty IB. Also, their study was specific to graduate nursing students’ IB recognition and mitigation using video vignettes of a lesbian couple’s prenatal visit (Teall et al., 2019).

There is a persistent gap in nursing educator self-awareness of IB and the direct impact of faculty IB on UR student experiences (Haen, 2022). The phenomenological qualitative study by Haen (2022) revealed that raising nursing faculty IB awareness and having them critically reflect afterwards increased motivation to change teaching practices. Follow up research regarding the expressed motivation with observationally demonstrated change exemplars would benefit nursing education.

**Related Research**

This literature review has covered the problem of IB and how it affects healthcare (generally) and nursing faculty and students (specifically). Practicing nurses and other healthcare provider decision-making and clinical judgment ultimately affects patients and communities who deserve equitable treatment and care. What is known is that the complete elimination of IB is unrealistic, harmful IB reduction is usually short-lived without bearing on behavioral changes, and the implementation of a skillset to engage in an ongoing manner with IB is necessary to prevent unintended worsening of biases in healthcare professionals (TOSU Kirwan Institute, 2018; Gonzalez et al., 2022). Some suggestions for future research based on limitations and previously mentioned studies
have been presented. Specific research on IB awareness and mitigation, including legal and policy mandates, is further discussed using a socio ecological leveling: micro- (individual), meso- (groups), and macro- (institutions and policies) (DeCarlo, 2018).

**Micro-level Implicit Bias Research**

Mitigating IB requires an awareness of its existence. However, increased IB awareness triggers dissonance, frustration with self, criticism of implicit bias research, and potential healthcare provider identity crisis (Sukhera et al., 2018; Sukhera et al., 2019b). Gonzalez and colleagues (2019) found that IB awareness and instruction led to participant denial of implicit bias, thereby resisting change in practice. Other participants expressed shame or an inability to impact the hidden curriculum and structural barriers that impede engaging with such evocative dialogue (Gonzalez et al., 2019). Researchers seeking to raise awareness of IB must remember these potential reactions in participants who experience the conflict between their idealized healthcare provider identity and the results that indicate the presence of implicit bias (Sukhera et al., 2018).

Providing instructional methods and feedback help increase knowledge, skills, and attitudes toward mitigating negative IB (Kruse et al., 2022). However, Sukhera and colleagues (2019b) have found that the most effective method for dealing with what they call the “feedback paradox” (p. 1208) is facilitated reflective debriefing in a safe environment. Discussing fears openly with peers increased confidence in the ability to change the work environment and enhanced learner agency and self-efficacy (Sukhera et al., 2018). Effective communication, collaboration, and role modeling increased the confidence of participants to influence biased-laden environments towards improvement (Sukhera et al., 2019b). Mitigation strategies tend to work quickly and immediately to
reduce IB, but without long-term effectiveness (Lai et al., 2016), indicating the need for ongoing faculty development and curricula changes (Gonzalez et al., 2018) with instruction on using multiple strategies for sustained IB reduction (Forscher et al., 2017). Table 2.1 lists several specific micro-level strategies for IB mitigation.

Adding to the earlier work of Devine et al. (2012), who framed IB as a habit that could be broken by raising awareness, increasing motivation and concern, and teaching strategies to reduce its effects, Forscher and colleagues (2017) replicated the original study; however they increased the sample to 292 (67% White, 25% Asian, 68% female), from 91 (85% White, 67% female), non-Black participants from an introductory psychology course. Non-Black participants were chosen because of evidence that they demonstrate higher levels of anti-Black bias (Devine et al., 2012). Forscher et al. (2017) used a two-phase design, with the second phase occurring two years after phase one, extending study longevity beyond the original two months. The first phase randomly assigned participants to intervention and control groups who completed several outcomes every other day for two weeks. IB was measured using the Black-White IAT, while explicit bias was measured using racial attitudes, nonprejudiced motivations, concern about discrimination, race-related thoughts and conversations, and interracial interactions (should-would discrepancies). The control group (N=164) received IAT results and were dismissed without further explanation. The intervention group took the IAT, received education on IB immediately after taking the IAT, reflected on learning benefits through essays, obtained their IAT score, and then completed bias mitigation training. Every other day, all participants were emailed a survey that repeated the measured implicit and explicit measures mentioned previously.
Table 2.1 Micro-level IB Mitigation Strategies

<table>
<thead>
<tr>
<th>Individual Level Strategy</th>
<th>Description of Strategy</th>
<th>Reference for Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuation</td>
<td>Be intentional about recognizing the uniqueness of an individual, not a member of a group, develop personal relationships (contact)</td>
<td>IHI, 2017; OMH, 2021</td>
</tr>
<tr>
<td>Stereotype replacement</td>
<td>Replace the stereotyped response or reaction with an alternative that is non-stereotypical</td>
<td>IHI, 2017; OMH, 2021</td>
</tr>
<tr>
<td>Counter-stereotypic imaging</td>
<td>Replace the stereotyped image of a person or group with positive imaging</td>
<td>IHI, 2017; OMH, 2021</td>
</tr>
<tr>
<td>Perspective-taking</td>
<td>Use empathy to put oneself in the place of another</td>
<td>JC, 2016</td>
</tr>
<tr>
<td>Increasing Contact</td>
<td>Seek ways of knowing people from different social groups outside of usual social circles</td>
<td>IHI, 2017; OMH, 2021; Charlesworth &amp; Banaji, 2022</td>
</tr>
<tr>
<td>Emotional Regulation</td>
<td>Use skills to control negative emotions (fear, disgust, dislike); avoid being defensive; use positive emotions during patient care experiences</td>
<td>JC, 2016</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>Mindfulness meditation: being aware of the present moment and feelings of assumptions that may be faulty. Use of self-regulation that keeps focus in the present to counter stereotypes &amp; increase compassion and lovingkindness</td>
<td></td>
</tr>
<tr>
<td>Mindfulness-based Stress Reduction (MBSR)</td>
<td><em>fMRI</em> shows it modulates activation of the amygdala decreasing threat response; increases prefrontal cortex which increases empathy</td>
<td>Burgess et al., 2017; OMH, 2021</td>
</tr>
<tr>
<td>Check Your Messaging</td>
<td>Use language of inclusivity; avoid colorblind statements; demonstrate welcoming stance</td>
<td>Edgoose et al., 2022; <a href="https://www.multco.us/diversity-equity/equity-and-empowerment-lens">https://www.multco.us/diversity-equity/equity-and-empowerment-lens</a></td>
</tr>
<tr>
<td>Partnership building</td>
<td>Create common goals between patient and nurse</td>
<td>JC, 2016; IHI, 2017; Hagiwara et al., 2019</td>
</tr>
<tr>
<td>Habit Replacement</td>
<td>Recognize bad habits and replace them. Nurse replaces biased thinking with compassionate care for all patients</td>
<td>Devine et al., 2012</td>
</tr>
<tr>
<td>P.A.U.S. E</td>
<td>Pay attention to what is happening (mindfulness) Acknowledge reactions (self-regulation) Understand the origins and interpretations Search for productive way to handle situation Execute a respectful plan of action</td>
<td>Ross, 2014</td>
</tr>
<tr>
<td>Cultural Humility</td>
<td>Willingness to learn and be respectful of other cultures; is lifelong and continuous, self-reflective, shared vision, connectedness; question systems of oppression</td>
<td>Tervalon &amp; Murray-Garcia, 1998; Foronda et al., 2016; Foronda, 2020</td>
</tr>
</tbody>
</table>

Key: *fMRI* = functional magnetic resonance imaging, IHI = Institute for Healthcare Improvement, JC = Joint Commission, OMH = Office of Minority Health

Forscher and colleagues’ (2017) study supported Devine et al. (2012) that “concern about discrimination” (p. 143) increased in the intervention group but not the control group, adding that concern may be a more meaningful measure to reduce implicit
bias. In contrast to Devine and colleagues (2012), Forscher et al. (2017) found no sustained effect on self-reported responses to how one would act, think, and feel as opposed to how they should act, think, and feel in interpersonal, intergroup situations relating the power of social influences on biases. However, Forscher and colleagues (2017) found that those in the intervention group increased awareness of implicit bias around them, labeled it as wrong, and were more likely to have interracial interactions with strangers. Haider et al. (2015) also suggested that interaction with diverse groups of patients, communication, and roles as advocates help to mitigate biased clinical decision-making.

Phase two of Forscher and colleagues’ study (2017) occurred two years later, whereby both control and intervention participants, without awareness of the tie into phase one, were invited to privately rate their agreement or disagreement with a fictional student essay submitted to the university newspaper. There were 108 respondents from phase one, a 37% response rate. The essay argued racial stereotypes as harmless and only unpopular when a person wants to be seen as politically correct. All respondents privately disagreed with the essay, but the intervention group were likelier to disagree publicly with racial stereotyping. Overall, the study demonstrated that noticing and labeling IB as wrong increased the recognition of and sensitivity to discrimination as a societal problem. Devine et al. (2012) and Forscher et al. (2017) agreed that change in knowledge and beliefs are primary targets leading to sustained change, not necessarily measures of IB. It is posited that when people notice and label bias of others with increased concern for discrimination, it creates a feedback loop of increased noticing and labeling of the bias of others with increased concern (Devine et al., 2012; Forscher et al., 2017).
Meso-level Implicit Bias Research

Sukhera and colleagues (2018) explored the interaction between individual mental health IB awareness and the workplace environment of a purposeful sample of emergency department physicians and nurses over 12 months. This iterative longitudinal grounded theory qualitative case study design used an educational intervention meant to disrupt the workplace environment to explore how participants responded to the disruption and how it changed workplace social dynamics to move towards meso-level changes (see Table 2.2 for specific strategies). The study participants attended a four-hour learning activity on how IB leads to perceptions of discrimination among healthcare professionals. The curriculum included lectures, group discussions, role play, debriefing, and self-reflection exercises. The aim of the study was twofold: to raise conscious awareness of mental illness bias and to promote critical reflection of participants in an effort to reduce the bias.

Participants expressed conflict between how they explicitly perceive mental illness and implicit biases, which caused them to reflect on barriers to change in the workplace environment critically (Sukhera et al., 2018). Learner dissonance created behavioral changes facilitated by communication, collaboration, and role modeling within a safe environment that allowed open discussion of biases whereby participants were transformed. The participants' profound transformation supports how a disorienting dilemma and critical reflection can ultimately lead to the integration of a new perspective, such as posited by Mezirow's (1991, 1994, 1998) transformative learning theory.


Table 2.2 *Meso-level IB Mitigation Strategies*

<table>
<thead>
<tr>
<th>System Level Strategy</th>
<th>Description of Strategy</th>
<th>Reference for Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Load Reduction</td>
<td>Decrease nurse/faculty workload, increase access to resources and time to complete job</td>
<td>Brockett-Walker et al., 2021; Johnson et al., 2016</td>
</tr>
<tr>
<td>Increase Diversity &amp; Inclusion</td>
<td>Increase faculty/nurses of diverse backgrounds to support diverse students, patients, and communities</td>
<td>AACN New Essentials, 2021; AACN, 2021; NASEM, 2021</td>
</tr>
<tr>
<td>Bystander Training for Inclusive Excellence: ARISE</td>
<td>Awareness of microaggression  Respond with empathy  Inquiry of facts to increase understanding  Start statements with “I”  Educate and Engage</td>
<td>Ackerman-Barger &amp; Jacobs, 2020</td>
</tr>
<tr>
<td>Allyship</td>
<td>Active bystanders and allies from dominant group who take action to foster inclusive learning environment</td>
<td>Ackerman-Barger et al., 2020; Pusey-Reid &amp; Blackman-Richards, 2022</td>
</tr>
<tr>
<td>Cultural Humility Development</td>
<td>Intrapersonal—critical reflexivity to recognize biases and assumptions  Interpersonal—critical engagement with others from different cultures to develop understanding</td>
<td>Foronda et al., 2016; Hughes et al., 2020</td>
</tr>
</tbody>
</table>

Kruise and colleagues (2022) conducted an integrative literature review that analyzed 39 articles to determine what health profession educators are using as educational strategies to improve student learner knowledge of IB, reduce strategies, and improve biased attitudes. Multiple modes of education were used across the research, including pre-testing for awareness, simulation, case-based scenarios, discussions, and debriefing. Content experts facilitate successful programs, support participants, create thoughtful program planning, and apply broader systemic supportive efforts to reduce IB (Kruise et al., 2022). Systemic support, social adaptation, and learner modeling led participants to reinvent their workplace environment through shared experiences and the realization of the power of each individual to change the institutional and organizational culture over time (Sukhera et al., 2018). Ross (2014) also stressed the importance of creating organizational cultural commitment to making conscious decisions to reduce
negative, destructive IB where all stakeholders feel safe to dialogue and are treated professionally and respectfully.

**Power of Macro-level Policies and Legal Mandates**

The World Health Organization stated that social determinants of health (SDoH) affect health equity in both positive and negative ways (WHO, 2022). These SDoH, while outside of the healthcare system, affect the quality of life (DHHS, n.d.) and the level of health and wellness of individuals and communities (WHO, 2022). SDoH examples include socioeconomics, education, food insecurity, housing, healthcare access (WHO, 2022), racism, and discrimination (DHHS, n.d.). Socially determined health inequities prevent poorer populations from reaching their highest potential (WHO, 2022). Even within the walls of healthcare institutions, the full appreciation of the SDoH effects on marginalized groups only exacerbates health outcomes when healthcare providers see these factors as outside of their realm of impact (Agrawal & Enekwechi, 2020). One of the first interventions recommended to address health disparities is to include biases in the formal training of healthcare providers and personnel working in health facilities, so they recognize when bias is occurring and learn how to address IB with the appropriate skill set (Agrawal & Enekwechi, 2020). Some states and institutions are now mandating IB training for healthcare professional licensing and licensing renewal.

Healthcare worker IB is accentuated by high stress and uncertainty (Burgess, 2010; Smedley et al., 2003), and no time in modern history was that more palpable than during the height of the Covid-19 pandemic (Fotsch, 2021). According to race/ethnic group data from the CDC (2022), one-quarter of the reported Covid cases have occurred in Hispanics/Latinos, who account for only 18.45% of the U.S. population. Blacks have
been stricken with Covid at the same rate as their percentage of the population (12.54%), while 13.2% of the deaths from the virus have been from the Black community (CDC, 2022). The contribution of SDoH cannot be understated as many from the Hispanic/Latino and Black communities are essential workers with unavoidable high exposures, which makes them three times as likely to contract Covid as compared to Whites (McCormack, 2020). The increased attention to disparate health outcomes and implicit biases of healthcare providers has brought forth discussions about increased support of mandatory training to recognize, manage, and mitigate biases to improve health equity and diverse patient health outcomes (Fotsch, 2022; Weis, 2020).

Mandating IB education and training may be the impetus needed to promote positive change toward recognizing and addressing bias-driven inequities in healthcare through the accountability of individuals and institutions (Cooper, Saha, & van Ryn, 2022). Fotsch (2021) argued in support of healthcare provider IB education and training as a condition for licensure renewal. Several states (California, Washington, Maryland, Michigan, and Minnesota) have already enacted laws requiring implicit bias training for some healthcare providers, while others are in the process of implicit bias legislation (Cooper, Saha, & van Ryn, 2022). Banaji (APA, 2022), a pioneer in IB research, added that legislative and governmental law changes may have brought about the largest changes to previously negatively held anti-gay bias sentiment. In a recent trend analysis review of the changes in the sexuality IAT available via Project Implicit over 14 years, anti-gay bias demonstrated the most change, with a 65% decrease in bias (Charlesworth & Banaji, 2022). Implicit association decrease in anti-gay bias is posited not only due to increased personal experiences and increased contact with the LGBTQ+ community but
also to legislative changes across the nation in legalize same-sex marriages (APA, 2022).

These positive trends in decreasing bias do not negate opposition, especially from the medical community, regarding mandating IB training. Cooper et al. (2022) warned that inconsistent, ineffective, and varying implicit bias training programs risk providing a false sense of accomplishment without guaranteeing benefits and instead exacerbate biases. Arkes (2022) argued against mandating training for three reasons. Firstly, interventions not proven consistently with positive change may worsen biases. Secondly, using an instrument of measure (the IAT) that is already controversial with lower than acceptable reliability may be ineffective. Finally, research supporting the benefit of implicit bias training is lacking. Sanky and Appel (2022) supported Arkes’ argument that implicit bias training should be evidentiary, not merely symbolic of a desired state that health equity is easy to achieve when the historical context of antiracism is complicated and evocative, requiring systemic changes rather than focus on changing individuals.

Summary

It was crucial that this literature review include the historical foundation of nursing education that contextualized the “white frame” that is deeply embedded into how nurses are admitted, educated, and enculturated to the profession. The colorblind mentality has allowed subtle racism, implicit bias, and microaggressions to occur which negatively impact UR students in nursing programs taught by majority White females (Gardner, 2005; Gona et al., 2019; Muronda, 2016 Wesp, 2018). Multiple research studies have delineated the impact of IB on patient health outcomes and experiences. Limited research exists on nursing implicit bias, but it is evident that IB affects the
clinical judgment of nurses especially in situations where faulty cultural confidence leads to inadequate or inappropriate care (Thirsk et al., 2022).

What has been gleaned from this research review is that IB mitigation strategies are helpful at the micro-level and meso-level, with more promising broader systemic macro-level support from policy changes and mandates. Complete elimination of IB is unrealistic and long-term positive change is unsustainable without ongoing engagement (TOSU Kirwan Institute, 2018; Gonzalez et al., 2022). Positive receptivity towards IB recognition and management requires personal critical reflection on assumptions (Sukhera et al., 2019a) and nonjudgmental dialogue spaces (Sukhera et al., 2019b) using psychological safety (Clark, 2022; Luther & Flattes, 2022).

Nursing educators are just beginning to struggle with how to teach nursing students to develop IB awareness in patient care situations (Edwards-Maddox et al., 2022). National nursing education guidelines and standards recommend that nursing programs promote diversity, equity, and inclusivity in education efforts (NASEM, 2021; AACNa, 2021; AACNc, 2021). More research is needed regarding nursing faculty perceptions of IB and its correlating effect on students, especially UR students. Ignorance can no longer be an excuse for not stepping up to change present teaching and practice habits. This study aimed to explore faculty attitudes and perceptions of racial IB and cultural humility along with affect critical reflection would have on both of these study constructs. Cultural humbleness may allow for increased openness to being more self-aware, reflective, and supportive of others from different backgrounds (Foronda et al., 2016). Additionally, with continual recognition of the presence of IB (Hughes et al., 2020) mitigation strategies may be used to decrease its effects on all stakeholders.
CHAPTER 3

METHODOLOGY

As communities across America become increasingly multicultural, demands for expanding diversity in the nursing profession continue (AACNa, 2021; NASEM, 2021), with only modest gains in underrepresented (UR) student matriculation in and completion of nursing programs (AACNb, 2022). Further, nursing education core competencies require nurse educators to create “equitable and inclusive learning environments” supporting the admission, retention, and graduation of underrepresented nursing students by “actively combating structural racism, discrimination, systemic inequity, exclusion, and bias” (AACNc, 2021, p. 6). Implicit bias (IB) is the automatic, unconscious attitudes that lead to inequitable judgments, decision-making, and behaviors (NIH, 2022). Addressing nursing faculty bias is essential to creating inclusive learning spaces in nursing education and modeling bias-free caring practices in the education of nursing students (Brown & Waller, 2022). This study explored the problem of nursing faculty IB unawareness, their perceptions and attitudes towards racial IB, how they define cultural humbleness, and how critical reflection influences biases, cultural humility, and desire to cultivate inclusive excellence.

Chapter Overview and Organization

This chapter begins with the significance of this study and what the study adds to the knowledge of nursing faculty perceptions and attitudes towards racial implicit bias and cultural humility. The research questions are then restated and aligned to the research
design. Next, action research is defined, the methodology utilized is described, and how the research data validity was guarded. Then the context, setting, participants, ethical considerations, researcher role as the PI, and researcher positionality are discussed. Afterward, research data collection and tools, research procedures, and data analysis are discussed. The chapter concludes with a summarization of the study methodology.

**Significance of Study**

White faculty may be especially unaware of implicit biases they bring into the classroom, which then negatively impact UR students, with possible consequences for all students beyond the classroom and into communities where nurses provide care (Fitzsimmons, 2009; Gunther, 2020; Price, 2022). The illumination of these biases may be evocative, but to do so is vital for reaching and achieving cultural humility, developing equitable practices, and creating inclusive spaces for nursing students to thrive in their journey to becoming future nurses. Holland (2011) found that nursing faculty were not prepared, nor did they fully understand how, to approach issues of race, racism, and anti-racism in nursing. This study hoped to promote faculty inclusive educational practices by arming nursing faculty with the knowledge, skills, and attitudes to rectify their levels of harmful IB. Inclusivity supports nurse educator core competencies and needs of UR students’ successful entry, progression, and graduation from nursing programs (AACNC, 2021). Nursing educational spaces are improved by considering all stakeholders at the intersection of race, diversity, and equity focusing specifically on implicit bias. Transformative learning is necessary for increasing faculty awareness of biases while providing mitigation strategies benefits nursing educators’ and the nursing profession's development of inclusivity, cultural humbleness, and cultural humility.
Research Questions

This study sought to uncover nursing faculty attitudes and perceptions of racial implicit bias, the impact of mitigation strategies on IB attitudes, and perceptions of cultural humility using critical self-reflection on assumptions (CSRA) that offers potential for transformative learning in support of inclusive excellence. This complex explanatory sequential mixed methods core design with an embedded intervention collected quantitative survey data during phase one and then explained those key results using rich qualitative data collected during the second phase. This study sought to answer three research questions:

RQ1 What are nursing faculty racial implicit bias perceptions?
RQ2 To what degree are nursing faculty culturally humble?
RQ3 How does critical reflection affect racial IB and cultural humility attitudes?

Research Design

This study ultimately derived from action researcher inquiry and problem solving relevant to my current practice as a nursing educator. Specifically, action research focuses on problems that are deeply meaningful to improving practice, derives questions from needs specific to addressing the problem, and finds research results highly valuable and usable immediately (Efron & Ravid, 2020). The central core study constructs are denoted in Figure 3.1. In this study, racial implicit bias is the problem construct; transforming faculty learning through developing a keen awareness of IB and increasing cultural humility could pivot biased individual frames of reference to address the problem (Mezirow, 1994). Although action research is generated from a local problem, it may
apply to larger contexts with implications beyond the local setting (Herr & Anderson, 2015). I am steadfastly and deeply committed to increasing diversity and equity in nursing education by championing inclusivity and cultural humility within education spaces. By doing so, all nursing students, faculty, and colleagues can thrive.

Figure 3.1 Core Study Constructs

A mixed-method core design was used for data collection to address the proposed research questions. Quantitative research determines relationships deductively among variables measured using instruments to obtain numerical data using statistical methods (Creswell & Creswell, 2018). Qualitative researchers utilize open-ended questions and interview data to derive emerging themes inductively (Creswell & Creswell, 2018). Creswell and Creswell (2018) stated that there are strengths and inherent weaknesses to both quantitative and qualitative research. Mixing the two methodologies provided a deeper “data mining” to limit deficits and provide a richer understanding of the problem (Creswell & Creswell, 2018, p. 213).

Although there are several mixed methods designs, this two-phase study used an explanatory sequential design. An explanatory sequential design is appropriate for this study as there were two phases, with the quantitative collected and analyzed during phase
one and prior to the second phase of qualitative data collection and analysis (Creswell & Creswell, 2018). The study is considered complex due to the addition of an embedded intervention within the team learning sessions, followed by semi-structured focused group interviews. A case study design explored nursing faculty IB awareness, perception, and experiences before and after team learning sessions. A case study is an inquiry approach that collects qualitative data from many sources (pre- and post-session reflections, PI field notes, and journaling) to delve into a problem (racial implicit bias) using a case (nursing faculty) to derive meaning perspective of the problem under study and nurture transformative learning (Creswell & Poth, 2018).

**Rationale for Methodology**

A specific consideration of the explanatory sequential mixed-methods design is the need for the researcher to explore all quantitative data for potential options for a further explanation during the qualitative phase of the study. I chose to use the data from phase one as a primer for phase two of the study. Conflicting or surprising quantitative data may diverge from what is expected in qualitative data (Creswell & Creswell, 2018). Careful data extrapolation avoids missing key intersecting points that need further investigation from the quantitative data analysis. Clarifying open-ended questions are derived from quantitative data and organically during the semi-structured group interviews and team learning sessions. The faculty served as the case bounded by their role as nursing educators in the team learning sessions. Additionally, keeping the same sample (participants) as part of both phases of the study helps to validate how the qualitative data assists in explaining the quantitative data (Creswell & Creswell, 2018).
Hegney and Francis (2015) described how active members in a research team using the philosophical tenets of social critical theory could change nursing practice and lead to transformative social change. As an example of transformative change, Ashlee et al. (2017) used intersectionality as an interpretative framework in their collaborative critical autoethnography to expose the oppression they experienced as graduate students based on gender and race as *womxn* of color. Raising their critical consciousness, or “wokeness,” helped them not only recognize oppression but to reject its “unjust nature” (Ashlee et al., 2017, p. 90). Transformative change in nursing educator perceptions and attitudes has the potential to result in a positive classroom experience for UR nursing students.

**Research Design Validity**

Researchers must ensure that the data collected is reliable and valid through a carefully designed research study (Merriam & Tisdell, 2016). Quantitative data from survey results relied on self-report that may impact the information obtained and, thus, required results to be interpreted cautiously (Efron & Ravid, 2020). Both instruments used for the quantitative data collection have been validated by developers (Gonzalez et al., 2021; Foronda et al., 2021). Qualitative data validity is strengthened by triangulating data, using member checking, and ensuring data saturation (Merriam & Tisdell, 2016).

Objectivity to the qualitative data collected is vital, as is a thorough awareness of researcher bias since I am one of the nursing faculty and a peer to participants. Those who accepted the invitation to participate in phase two might have done so because of their interest in the topic or desire to assist me in my research endeavors. Therefore, triangulation of the data using multiple data points was necessary to enhance validity and
accurately capture participant meaning (Creswell & Poth, 2018). Open-ended questions, pre- and post-session reflective journaling, and the semi-structured focused group interviews all assisted in justifying the validity of themes in the current study. Member checking was also used to validate the data.

Member checking ensured accurate capture of participants’ assertions. *Member checking* is the process of sharing the researcher’s interpretation with participants, so they judge the accuracy and credibility of descriptions and emerging themes (Creswell & Poth, 2018). They should be able to “recognize their experience in [my] interpretation or suggest some fine-tuning to better capture their perspectives” (Merriam & Tisdell, 2016, p. 246). Planned one-on-one meetings with each participant from phase two occurred within one month of the final team learning session. Time was essential to properly prepare descriptions and emerging themes for participant review (Creswell & Poth, 2018).

Engagement with the data occurred in an ongoing manner. This level of engagement emphasized the importance of detailed data collection procedures, data collection, and analysis to ensure consistency during each step. As themes begin to emerge and the same information is noted repetitively, then saturation in data had been reached (Merriam & Tisdell, 2016). Providing multiple perspectives on a given theme added to the validity of findings (Cresswell & Cresswell, 2018).

**Context and Setting of Study**

This study included nursing faculty from the school of nursing (SON) on the campus of a large public university in the southeastern United States. The pre-licensure baccalaureate program is highly competitive, and out of the many seeking to enter the
program, only about a third of applicants are admitted during each of the two annual admission cycles. The nursing program has utilized a holistic admission process for the past several years, which includes applicant responses to four essay prompts about community service, healthcare experience, how they have overcome a barrier or challenge, and how an encounter with an individual(s) from different backgrounds influenced their way of thinking. Unfortunately, students with high GPAs are still seen as stronger candidates for admission due to initial ranking based on academics.

There has been an increase in the admission of UR students into the nursing program, with 51% of the latest cohort (2023) identified as being from diverse backgrounds, with several identifying as Indigenous Americans. While this is wonderful and welcome progress, the UR students still face an overwhelmingly White female majority nursing faculty. Over half of full-time (FT) faculty are White (61%) and female (77.4%), with a mean age of 48.5 years (SON climate survey, 2022).

FT and part-time (PT) faculty teach across the curriculum in the pre-licensure BSN or graduate and doctoral programs. The fluctuation in PT faculty makes it difficult to capture accurate numbers at any given time; however, there are approximately 25 on staff, who mostly assist in clinical education. Of the 37 full-time nursing faculty, 16 consistently teach in the pre-licensure undergraduate (UG) nursing program, 75% White and 87.5% female. A recent climate survey (2022) of FT faculty noted that 13.3% (N=4) felt discriminated against, with two respondents indicating race/ethnicity as the reason. Qualitative data from the faculty climate survey indicated that faculty are “Feeling frustrated, unvalued, isolated, etc.,” while another stated, “I feel that we talk too much about DEI in the SON.”
Role and Positionality of Researcher

My role in this study was primary investigator (PI) and facilitator during the team learning sessions during phase two. I collected and analyzed the quantitative data to prepare for the qualitative phase of the study, during which the researcher is considered to be the primary instrument of data collection. The interpretation of data, especially qualitative, required the maintenance of reflexivity. Reflexivity requires researchers to divulge how their position, experiences, and role within the research may impact result interpretation (Creswell & Creswell, 2018). Critical self-reflection on assumptions (CSRA) is the highest level of reflection that leads to learning through meaning transformation (Mezirow, 1995, 1998).

Being a primary research instrument is humbling and overwhelming because of understanding the inherent biases that can influence the research process. I collaborated with the participants during the team learning sessions. As a novice researcher, I had to reassure myself that I was making sense of my philosophical influences by remaining honest and forthright in disclaiming my biases to avoid detracting from the study goals. Additionally, flexibility was a must. Being less rigid took me out of my comfort zone towards developing a “high tolerance for ambiguity” required of qualitative researchers (Merriam & Tisdell, 2016, p. 18). This challenging ambiguity required honing listening skills and “word data” abstraction to think more inductively from specific to the abstract and from particular to the general (Creswell & Poth, 2018).

My action researcher positionality was an insider in collaboration with others (Herr & Anderson, 2015), especially during the team learning sessions. The participants were peers, fellow faculty members. Critical inquiry drove the qualitative data to
maintain authenticity (Herr & Anderson, 2015) to understand faculty implicit bias perceptions, attitudes, and assumptions. As a White female, middle-aged, cis-gender, middle-class lecturer in the SON, I recognized this could have impact how others responded to my facilitation of the team learning sessions. Some faculty are more experienced in research, and some have limited experience, but this did not deter from the study purpose.

The intersecting identities of participants had to be realized and recognized from the beginning. Intersectionality operates on an individual and institutional level and may cause power imbalances during the study (Bell et al., 2016). For example, a fellow faculty with similar identities as me, except for whiteness, have and will experience forms of oppression that I will never experience. Therefore, I sought to bracket my feelings and assumptions throughout the study. I was also continuously mindful of nonverbal and paraverbal communication during the qualitative phase, as these specific types of communication are more impactful to the receiver than verbal communication (Hagiwara et al., 2019).

**Ethical Considerations**

Early in the research, I met with the Director of Nursing and the Associate Director, Undergraduate Programs and SON Operations to discuss the problem of practice and tentative plans for interventional sessions. Leadership remained supportive of my efforts as the premise of the study would add to the DEI strategic goals of the SON and the university. Prior to launching data collection, Internal Review Board (IRB) approval was obtained from the University of South Carolina (Appendix J) and my university IRB.
The evocative nature of being faced with a discomforting aspect, such as implicit bias, that conflicts with central nursing core values can cause an identity crisis between the idealized professional self and the explicit egalitarian self (Sukhera et al., 2018). Respondents may experience guilt and shame or may even resist acknowledging IB presence due to their disbelief (Gonzalez et al., 2019). However, a level of optimism makes it apparent that resistance is necessary to adapt to change (Evans, 2001). Putting in the necessary work undoubtedly surfaces tensions and causes anxiety and feelings of loss (Evans, 2001). Communication level setting (Appendix G) was instituted to reduce fear of engagement and provide assurance of psychological safety (Evans, 2001; Clark, 2022; Luther & Flattes, 2022). Communication level setting early in the qualitative phase prepared all participants for the potential heightened emotional responses caused by the disorienting dilemma (Mezirow, 1991, 1994).

Consent was obtained from respondents through the SON email distribution list. The email provided the topic under study and the voluntariness to participate in the quantitative data collection during phase one. Additionally, the email informed consent also assured respondents of confidentiality by not including names or identifiers in the quantitative data of phase one and by using pseudonyms for the qualitative data in phase two. Data aggregation confirmed anonymity any time there was a risk of identification. Email respondents were informed that by clicking to proceed to the Qualtrics survey, they were consenting to participate but that they have the option not to answer any question they felt was uncomfortable and that they could exit the survey at any time.

In the proposed teaming learning sessions, all participants were reminded that the sessions were safe zones that require respectful communication to be upheld. Having
crucial conversations about behaviors or verbalizations stemming from implicit bias can elicit anxiety and fear of judgment. I remained cognizant of the possibility that faculty may struggle personally with feelings brought to the surface and try to pin them to the binaries of “right” and “wrong” (Evans, 2001, p. 27) or “good and bad” (DiAngelo, 2018, p.71). It was vital that everyone be allowed to engage in open, honest communication devoid of any conception of personal attack. All participants were encouraged to balance advocacy for one viewpoint against inquiry into another’s viewpoint and practice skillful dialogue as made visible with the Advocacy/Inquiry Palette (Senge, 2012, p. 107). Keeping the Advocacy/Inquiry Palette visible helped faculty maintain awareness of how to focus on generating skillful discussions during the team learning sessions (Appendix H).

**Participants**

Phase one involved sending all FT (N=37) and PT (N=25) nursing faculty an email (Appendix E) through the SON distribution list inviting them to complete a Qualtrics survey with the quantitative measures. Eighteen FT faculty completed the survey (48.6%), with Part III and IV missing for one respondent, resulting in a loss of demographic data and an invitation to phase two for this individual. PT faculty completed the survey at a rate of 16% (4 of 25).

Research has demonstrated that faculty IB impacts UR student admissions and UR nursing student educational experiences either in class or clinical settings (Pusey-Reid & Blackman-Richards, 2022; Noone & Najjar, 2021; Ackerman-Barger et al., 2020; Crandlemire, 2020). Because of the study context from a prelicensure UG nursing program viewpoint, and since FT nursing faculty serve on the Admissions Committee,
teach across the curriculum, and some participate in clinical education, the intent was that phase two (qualitative data) of this study would be limited to FT faculty from the UG program.

The SON has had a turnover of at least one faculty member in the FT faculty teaching in the UG program per semester so that participants may have nursing education experience but not necessarily at the university. A possible advantage of new faculty inclusion would be their perspective of outsiders moving towards an insider view of the nursing program that could prove more objective. However, the team learning sessions were limited to nursing faculty with at least one semester of teaching experience. The rationale for this stipulation is that new faculty have intense onboarding and the need to avoid burdening new faculty while they are still acclimating to the university. I had hoped that five to eight FT faculty, including diverse representation, would volunteer to participate in phase two. Seven faculty emailed about their desire to be a part of the sessions.

Of those interested, three taught in the UG program, with one excluded due to lacking teaching experience of at least one semester. The other four interested were from the graduate program and post-licensure RN to BSN program. One of the graduate faculty interested, one self-identified as PT and therefore excluded. An email requesting phase two consent was sent to those interested participants with further details of content, commitment, and assurance of confidentiality (Appendix F). Those not chosen were notified via email that they were waitlisted for future sessions outside the current study. The original plan was to include only UG faculty, but due to low response, two consenting graduate faculty were added to attend the sessions. Therefore, the study
consisted of a convenient, purposeful sample of four participants (two from UG, two from graduate). Participants were given pseudonyms for reporting data (see Table 3.1; note: member checking clarified descriptions for inclusion).

The idea behind limiting the participants in the second phase was to maintain intimacy and engagement while keeping the group small enough to be perceived as non-threatening. Additionally, the inclusion of the graduate faculty did not compromise the purpose of conducting the team learning sessions and the collection of qualitative data. Sessions began one week after the collection of quantitative data concluded to allow for analysis and preparation for the qualitative phase of the study.

Voluntary response bias is likely to be present in this study by those who agreed to participate, driven by an interest in the topic or assisting in my research endeavors. All participants completed phase two and the member checking follow up sessions. There was no incentive to participate other than to inform the future practice of nursing faculty, and feedback will aid in developing future DEI learning initiatives. It was no surprise that there was a low response from the UG faculty to participate in phase two. Nairn et al. (2012) described faculty as uncomfortable, lacking confidence, and experiencing conflict while trying to maintain “political correctness” when it came to crucial conversations surrounding diversity, culture, and racism, which led nursing faculty to “skirting around the issue” (p. 205).
Table 3.1 Overview of Phase Two Participants

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Description</th>
<th>Teaching Responsibility</th>
<th>Why participating?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>White female, cis-gender Age 40-49, she/her/hers Doctor of Nursing Practice Educator for 10 years</td>
<td>UG didactic DNP practicum Online RN to BSN</td>
<td>“Excited to be on this journey! Looking forward to it!”</td>
</tr>
<tr>
<td>Participant 2</td>
<td>Black female, cis-gender Age 60-69, she/her/hers Ph.D. in Nursing Educator for 38 years</td>
<td>Online RN to BSN Graduate level courses Leadership, Research DNP courses</td>
<td>“This will be beneficial to me”</td>
</tr>
<tr>
<td>Participant 3</td>
<td>White female cis-gender Age 50-59, she/her/hers Doctor of Nursing Practice Educator for three years</td>
<td>UG didactic Online courses</td>
<td>“I am always willing to learn and be better.”</td>
</tr>
<tr>
<td>Participant 4</td>
<td>White female, cis-gender Age 50-59, she/her/hers Doctor of Nursing Practice Educator for five years</td>
<td>Graduate program DNP practicum</td>
<td>“Implicit bias is something that I am working on personally and trying to incorporate with my students.”</td>
</tr>
</tbody>
</table>

Data Collection and Measurement Tools

Phase One

Phase one of the study used pre-session/ pre-intervention quantitative data collection using a four-part survey. Part I was the validated novel instrument modified to nursing and nursing education with permission, the *Attitudes Towards Implicit Bias Instrument* (ATIBI) (Gonzalez et al., 2021) (Appendix A, C), Part II was Foronda’s *Cultural Humility Scale* (Foronda et al., 2021) (Appendix B, D). Demographic data followed these two surveys as part III (detailed data in Table 4.1). Part IV included PI-developed focal questions (Table 3.2) and the invite for respondents to email PI directly if interested in participating in phase two. The quantitative data collected addressed RQ1 and RQ2.

All FT and PT nursing faculty in the SON received this four-part survey via Qualtrics link via their SON work email. The email provided the PI introduction and
invitation letter describing the study purpose, procedures, confidentiality statement, and ability to withdraw consent. The Part I and Part II validated instruments are described generally as an overview of their content.

**Part I The ATIBI**

The ATIBI (Appendix B) is a validated novel instrument used by developers (Gonzalez et al., 2021) who wanted to determine learner attitudes towards implicit bias instruction. Score consistency of items had high reliability ($\alpha = .90$) and a mean score of 89.4 with SD of 11.7 (N=950). The results of their research sought to inform curriculum development on implicit bias recognition and management. The ATIBI is an 18-item, evenly Likert-scaled instrument anchored by *strongly disagree* (1) to *strongly agree* (6), resulting in a score range of 18 to 108. The higher the score, the more positive the attitude toward IB content and instruction. ATIBI content addressed RQ1 with focus on the perception of racism and implicit bias, the importance of learning about IB, and minimizing its effects on clinical decision-making (Gonzalez et al., 2021).

**Part II Foronda’s Cultural Humility Scale**

Foronda’s *Cultural Humility Scale* (Appendix D) is a novel instrument validated and psychometrically tested to measure cultural humility (Foronda et al., 2021). Six faculty experts rated item relevance to cultural humility with a resultant content validity index of 0.8 or higher for all 19 items. The reliability of the scale was 0.85 (N=322) and all items were retained from the original. The scale uses a Likert-type scale with five options (1) *never/rarely*, (2) *once in a while*, (3) *sometimes*, (4) *usually*, and (5) *all the time* in response to 19 items. These items addressed RQ2 by measuring faculty perception of cultural humility. The items are aligned thematically after completing exploratory
factor analysis: context for difference in perspective (items 1-7), self-attributes (items 8-11), and outcomes of cultural humility (items 12-19). The content of the factors is based upon antecedents of differing perspectives such as diversity, historical, power imbalances, and situational. The individual attributes content includes self-reflection, flexibility, awareness of IB, and shedding of ego. The third factor seeks to understand outcomes and consequences of cultural humility through inquiry related to respect, empowering others, partnerships, and life-long learning. Scoring ranges from 19 to 38 = rarely culturally humble, 39-75 = sometimes culturally humble, 76 to 85 = usually culturally humble, and 86 to 95 = habitually culturally humble (Foronda et al., 2021).

Part III Demographic Data

Demographic data (details provided in Table 4.1) were obtained in the third part to avoid prejudicing survey responses and limit the possibility of stereotype threat. Stereotype threat is when “…when one recognizes that a negative stereotype about a group to which one belongs [is threatening] …because one then realizes that one could be seen or treated in terms of that negative group… [and] stereotypes can have powerful effects on important performances and identities of the individual even when the threat of prejudicial treatment is slight….” (Steele, 1998, pp. 680-681). Demographic data included age, sex, race, ethnicity, education, university rank, employment status, and experience as an educator and nurse.

Part IV Prior Knowledge and Interest in DEI

The last part of the quantitative data collection were three questions developed by the PI. The questions (Table 3.2) asked respondents whether their knowledge was gained from formal (or required) sources, nonformal (community group education), or informal
The first question related to how general DEI education, training or knowledge has been gained, with the second question asking about specific personal interests in DEI. The third question asked respondents had ever had any specific racial implicit bias knowledge, education, or training. It was of interest if any prior DEI or implicit bias knowledge, education, and training would affect implicit bias attitudes or cultural humility of nursing faculty. The final prompt invited faculty to contact PI directly if interested in proceeding to phase two.

Table 3.2 Part IV Focal Questions Prior Knowledge & Interest

<table>
<thead>
<tr>
<th>1. General diversity, equity, and inclusion education/training/knowledge has been received from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Formal: required by employer/university/college</td>
</tr>
<tr>
<td>Nonformal: community group or organization activity</td>
</tr>
<tr>
<td>Informal: social interactions with peers, family, coworkers</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Personal interest specific to diversity, equity, and inclusion has been received from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Formal: seminar, conference, course of study, research journals</td>
</tr>
<tr>
<td>Nonformal: community group or organization activity</td>
</tr>
<tr>
<td>Informal: social media, newspapers, magazines, blogs, opinions</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Prior specifically focused racial implicit bias education/training/knowledge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Formal: required by employer/university/college</td>
</tr>
<tr>
<td>Nonformal: community group or organization activity</td>
</tr>
<tr>
<td>Informal: social interactions with peers, family, coworkers</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

| 4. I am seeking willing participates for phase two of this study, to include weekly reflections and in person team learning sessions (15 minutes) with semi-structured focused group interviews (45 minutes) for three consecutive weeks, please email me directly at tcronell@email.sc.edu Please include days and times that are most convenient for the in-person sessions. Quantitative data is not connected to data collected during phase two. |

Phase Two

Phase two qualitative data sought to explain the quantitative results more deeply (explanatory sequential). This explanation is especially vital if quantitative data reveal
contradictions or surprises (Creswell & Creswell, 2018). The team learning sessions (Table 3.4) occurred within a week of the quantitative data analysis. The convenient, purposeful sample of four FT nursing faculty (Table 3.1) had completed phase one of the study and provided informed consent to proceed to phase two. Total time commitment and overall expectations were provided in the phase two participant consent email. The qualitative data collected addressed all research questions, with special focus on RQ3.

Each team learning session was to occur face-to-face in one of the conference rooms in the SON. However, following regional health facilities dropping long-held mask mandates, the local area saw an uptick in Covid-19 cases which caused concern for potential participants. Therefore, out of caution, the sessions pivoted to virtual attendance for convenience via Zoom video conferencing. This change did not alter the experience or compromise the collection of data. All faculty are well versed in Zoom, as courses were administered during the pandemic using the platform, and all virtual meetings not requiring in-person gatherings use Zoom. The switch did not increase the burden on faculty and likely eased attendance and participation.

A recent study by Price (2022) concluded that online learning activities promoted positive change in raising nursing faculty awareness of IB. Further research by Kula et al. (2021) demonstrated that an online program increased nursing student knowledge of health inequities of racially and ethnically marginalized groups; however, participants needed increased confidence in patient advocacy and their bias recognition. Therefore, research confirmed the need for ongoing immersion inequitable practices and inclusive excellence, but that knowledge gains are not affected by virtual learning platforms.
The virtual sessions engaged the group in discussions. Examples include thoughts regarding the ladder of inference situation and the intersectionality word cloud in session one, completing pre-session Race and the Skin tone IAT to raise IB awareness in week two and reflecting on mitigation strategies and reviewing difference between cultural competence and cultural humility in week three. Qualitative data included PI session field notes and reflections, faculty pre-session, and pre-intervention reflective journals. Finally, participants completed the following standard prompts in their online journal within two days of each team learning session conclusion:

1. What did you learn during this session that surprised you? About yourself? About others?
2. Did any moment during the session disturb you? How did you feel? What were you thinking?
3. Is there anything that you wish to share that you held back during the learning session?

**Research Timeline and Procedures**

The research timeline (Table 3.3) developed for this two-phase mixed-method action research includes dates and details of study progress to completion. Support from the SON leadership was vital to the study, so a meeting with the Director and the Associate Director occurred early in the research efforts. I maintained flexibility throughout the development and launch of the study as the dates needed adjusting due to the requirement of university IRB approval after receiving the University of South Carolina (USC) IRB approval letter (Appendix J). While awaiting final study site IRB approval, a pre-invite email was sent to all faculty through the SON email distribution to
alert them of a forthcoming formal invite to participate. The pre-invite email did not have study details but included participant protection, notification of their rights as participants, as well as the contact information for the university IRB.

**Table 3.3 Research Timeline**

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2022</td>
<td>Met with nursing program leadership to discuss preliminary research ideas, content, alignment with DEI strategic goals 06/29/22 Approval to use ATIBI</td>
</tr>
<tr>
<td>November 2022</td>
<td>11/13/22 Approval to use Cultural Humility Scale</td>
</tr>
<tr>
<td>March 2023</td>
<td>Sought IRB approval from USC and university IRB Entered measurement tools into Qualtrics Finalized session content 03/28/23 IRB approval received USC Pro00127785</td>
</tr>
<tr>
<td>April 2023</td>
<td>04/01/23 Pre-invite email sent to SON distribution list 04/03/23 IRB-23-0785 approval received from university</td>
</tr>
<tr>
<td>Phase One</td>
<td>04/05/23 Invitation to Qualtrics survey via SON email 04/17/23 Quantitative data collection completed Quantitative analysis and ongoing refinement of qualitative questions 04/17/23 Invitation to phase two consents sent via email</td>
</tr>
<tr>
<td>Phase Two</td>
<td>04/24/23 Team Learning Session #1 05/01/23 Team Learning Session #2 05/08/23 Team Learning Session #3 Sessions manually transcribed, started coding Qualitative analysis, emergence of themes</td>
</tr>
<tr>
<td>Member Checking</td>
<td>06/02/23 to 06/08/23 Conducted 1:1 member checking Validated accurate capture of assumptions, reflections Thematic mergence with TLT and critical reflection</td>
</tr>
</tbody>
</table>

During phase one, quantitative data was collected from participants using the described data collection tools. The four survey sections were entered into the Qualtrics online survey software. A link was generated and entered into the Participant Consent letter (Appendix E) sent to faculty via the SON email distribution list. Data were collected for almost two weeks, with one reminder sent a week into the survey to encourage completion. Once the survey was closed, the quantitative data were analyzed.
before the purposeful development and collection of qualitative data. Phase two participant consent (Appendix F) was then sent to those interested.

Preparation for phase two required development of a Google doc online journal for each participant and development of the team learning sessions to expand knowledge, skills and attitudes necessary for change. These were called team learning sessions, as we all collaborated to enhance each other’s perspectives as we learned about the study constructs, ourselves, and the culture of our nursing program. Team learning is designed to get all team members “thinking and acting together…of regularly transforming day-to-day communication skills” in all areas of the system (Senge, 2012, p. 115, emphasis in original). Action researchers embrace authentic collaboration, not just a means to an end, but “how to best work together....to ensure that multiple needs are met and enhanced in the research process” (Herr & Anderson, 2015, p. 151).

During the first session of phase two, I made sure that everyone had access to their own Google Docs online journal. These password-protected journals were only accessible to the participant and the PI. The journals (Appendix K) included pre-session/pre-interventional critical reflection questions before sessions two and three with standard prompts after each learning session. In addition, the communication was level set (Appendix G) and participants were provided a copy of Senge’s Advocacy/Inquiry Palette (Appendix H), explaining that skillful communication was the target and that everyone should avoid dysfunctional patterns as much as possible. Finally, the Matrix of Oppression (Appendix I) was reviewed with participants as we discussed intersectionality. Table 3.4 lists the instructional content overview of the team learning sessions (see Appendix L for detailed overview of session content).
Semi-structured focused group interviews followed the brief instructional sessions with questions (Appendix M) derived from the quantitative data that needed clarity, while other questions arose organically. Openness and honesty were always encouraged, aiming to obtain rich emerging data from participants (Creswell & Creswell, 2018) while maintaining psychological safety (Clark, 2022; Luther & Flattes, 2022). Depth of expression was encouraged without having participants feeling interrogated. I reiterated that at any time, if participants wished to turn off the camera feed or leave the sessions, they could do so without judgment or consequence. Anonymity was maintained with exclusion of any specific identifiers from quoted data or participant descriptions.

Table 3.4 Team Learning Sessions Outline

<table>
<thead>
<tr>
<th>Team Learning Session</th>
<th>Instructional Content</th>
</tr>
</thead>
</table>
| #1 Mental models, assumptions, and intersectionality | Silence Breaker, Introduction, Advocacy/Inquiry Palette  
Reviewed journal procedure, verified online access  
Problem of practice, purpose of study  
What is a mental model?  
Ladder of Inference example—group discussion  
Intervention: Intersectionality and Matrix of Oppression  
How are we similar? How are we unique? |
| Instruction time: 20 min  
Total time: 60 min | **RQ1** |

| #2 Acknowledging IB and developing mitigation strategies | Advocacy/Inquiry Palette visible  
What is implicit bias and how is it measured?  
Color blindness versus color consciousness  
Implicit bias and the healthcare provider  
Implicit bias in nursing and nursing education  
Intervention: Implicit bias mitigation strategies (individuation [intentional], mindfulness [emotion regulation], counterstereotypic imaging) |
| Instruction time: 15 min  
Total time: 60 min | **RQ1—perception of IB, impact on UR students** |

| #3 Developing Cultural Humility | Advocacy/Inquiry Palette visible  
Cultural humility: what it is not  
Define cultural humbleness, cultural humility, culture of nursing  
Cultural competence versus cultural humility  
Integration of cultural humility into nursing education  
Intervention: Achieving cultural humility |
| Instruction time: 15 min  
Total time: 60 min | **RQ1, RQ2, RQ3—perception of cultural humbleness, IB effect on cultural humility** |
Rationale for Embedded Instruction

The content interventions described in the Team Learning Sessions Outline (Table 3.4) align with addressing the study questions. The quick burst of 15 to 20 minutes of instructional content at the beginning of the sessions were mental exercises to enhance group collaboration. Sessions were well-received by participants, and through the instruction and interventions, participants learned about themselves and each other. The study constructs of racial implicit bias, cultural humility, and transformative learning supported the interventions including the semi-structured focused group interviews and critical self-reflections. Specifically, the CRT tenet of intersectionality was important for participants to understand up front the multiple forms of unseen oppression that others experience (Bell et al., 2016).

The mental models process is useful for identifying underlying tensions that keep systems locked into the present state instead of towards desired change (Zuieback, n.d.). Making the unseen thinking processes seen was done using the ladders of inference that expose mental models of others within an organization’s culture. Faculty were gently moved below the surface of what appeared to be obvious, harkening back to the iceberg analogy to dive into their mental models’ depths (Senge, 2012). By allowing the “unseen” to remain invisible, faulty assumptions and implicit biases persist (APA, 2022) that can limit explicit cultural humility (Foronda et al., 2022). In addition, research has demonstrated the importance of including the effect of IB on others (Maxfield et al., 2020).

It is not enough to become aware of IB and may even be detrimental to learners without developing mitigating skills to manage biases (Sukhera et al., 2019b). The
chosen mitigation strategies were based upon those which have demonstrated to be most effective. A systematic review by Fitzgerald and colleagues (2019) found successful strategies included counterstereotypic imaging (most promising), being intentional, and inducing emotion. It may seem an aggressive goal to include cultural humility development. However, the aim of doing so married well with active engagement that faculty undertook in their intrapersonal growth through critical self-reflection of assumptions (Mezirow, 1998) and interpersonal growth learning to constructive engagement with their fellow faculty (Hughes et al., 2020). Having a defined goal provides a point of reference towards which to aim.

**Data Transcription**

During the sessions, I took bullet notes of what participants said, especially during particularly poignant moments or when the speaker spoke with emotion. I remained cognizant of my researcher bias and tried to remain reflexive at all times. The sessions were recorded in order to go back and transcribe the data for accuracy; thus, researcher notes added context to the spoken words. Data cleaning removed redundancy and eliminated irrelevant stuttering from the transcription, which made my data easier to manage.

To prepare the document for analysis, a side column was added to each Word document of the session transcription to be used for coding. I then color coded the font with a specific color for each participant to visually note word count and engagement in discussions, or participants said nothing at all when in silent contemplation. Approximately a week after the last team learning session, I downloaded the completed
journals from each participant after verifying faculty were done with entries. Data
Triangulation included the PI notes, the session transcripts, and the participant journals.

Data Analysis

Using the ATIBI and Foronda’s Cultural Humility Scale added to the efficacy of these two novel instruments. The study sample was small (N=23). Descriptive statistical analysis of the quantitative data was utilized. Qualtrics provided an accessible platform for statistical results useful in data extrapolation. Of interest were the nursing faculty's attitude towards implicit bias and perceived cultural humility. Additionally, I was interested to see if there was any effect on implicit bias attitudes and humbleness in those with prior knowledge, education, and training in DEI and which type of education is most impactful (formal, informal, nonformal). I consulted with the SON methodologist to ensure interpretation of the statistics from Qualtrics was accurate.

The primary analysis of the qualitative analysis used the discourse analytical approach. Discourse analysis is a newer approach to qualitative research that highlights language “as a socially contextual performance and that brings a socially critical lens to its study of science and human life” (Wertz et al., 2011, p. 4). This strategy matched my interest in individual messaging (verbal, nonverbal, paraverbal). Also, extracting multiple sources of context helps to explain discursive language subjectively while avoiding objectively analyzing the person (McMullen, 2011). Furthermore, discourse analysis examines language used and dialogue of participants (Collins et al., 2021). There are instances in the current study whereby participants connected a narrative discourse to the study constructs. Other instances demonstrated the organic development of conversations
amongst the group. The three core features of discourse analysis are then noted in this study:

1. Action orientation: the discourse is a form of social interaction
2. Situation: the discourse is sequentially shaped by what precedes and follows it, and situated institutionally within norms
3. Construction: the discourse is both constructed and constructive (McMullen, 2011, p.207).

An inductive (open coding) procedure was used for the qualitative data to determine initial themes from open-ended faculty responses, journaling, and interview notes. Inductive analysis establishes general themes arising directly from responses (Wertz et al., 2011). Furthermore, Padilla-Diaz (2015) described analyzing text for what is expressed (explicitly) and then moving to how it is expressed (implicitly). For example, if there were delays in answering questions or intonation, merging PI notes with the transcribed sessions assisted in contextualizing the word data. Using a case study of the bound nursing faculty, I wanted to code using participant’s own words. Saldana (2022) defines this process as In Vivo coding. By rooting the analysis in quoted statements of participants, I was able to best capture evocative meaning in from the data (Saldana, 2022). I was careful with the subjective nature of the data and aimed for the interpretation to be inductive, not predictive.

The accuracy of coding qualitative data cannot be overstated. I desired increased confidence in personal ability to interpret what Braun and Clark (2013) call using “words as data” (p. 3, emphasis in original). However, I did feel more confident over time working through the data. The participants’ voices became the primary focal point
Initially, I read through each session transcription and the online journals once without making notes on the first reading. During the second reading, I highlighted key words through each of the sessions using a critical lens framed by both CRT and TLT. During the third reading, a word or word phrases were added into the coding column of each document based upon noted keywords. I began with session one and worked my way through each of the sessions using this inductive, iterative process.

Finally, I returned to the documents in a more directed manner, considering Mezirow’s critical reflections (1998) and transformative learning as an overarching guide. Themes emerged from this analytical process and placed in each of the three critical reflections. Discourse patterns began to align with the emerging themes in each document reviewed using a line-by-line analysis. Next, the online reflective journals were reviewed one at a time against the emerging themes.

Avoiding code drift helped maintain reliability in the data themes (Creswell & Creswell, 2018). I referred back to the initial sample coding to ensure all remained consistent and accurate with the final sample coding. An initial reading over the data and talking aloud to garner a sense of emerging themes was quite helpful (Wertz, 2005). I had planned to use coding software to assist in analyzing collected data, especially given the novice stance as a researcher. However, the bound case was small enough to effectively manage manually coding the data. This also gave the opportunity to become fully immersed in the discourse data, which eased reflexivity needed in qualitative data analysis.

Research participants validated the essence and meanings of the qualitative data during scheduled one-on-one member checking (Padilla-Diaz, 2015; Creswell & Miller,
2000). This validation avoided misinterpretations of the participant's expressions. This process also helped to expose potential researcher bias and areas for improvement regarding data analysis (Merriam & Tisdell, 2016). The member checking validated emerging themes from captured data from both the group sessions and reflective journals.

Historically, White faculty are not fully aware of biases or may become defensive as awareness is raised, while some UR faculty may be less willing to rock the boat, making it easier to maintain the status quo (Bell et al., 2016). Therefore, analyzing rising themes from triangulating the data conveyed a “rich, thick description…that may transport readers to the setting and give the discussion an element of shared experiences” (Creswell & Creswell, 2018, p. 200). Nursing faculty critical self-reflection journals provided data that could not be gleaned from the semi-structured group interviews alone. Furthermore, journaling allows the participants psychological safety to express themselves freely, especially when the topic of discussion is more contentious, such as racial implicit bias (Creswell & Poth, 2018).

Summary

This chapter sought to align the problem of practice to an action research-guided plan to study the key constructs of racial implicit bias, cultural humility, and transformative learning. The appropriate research design for this study was the complex two-phase explanatory sequential mixed methods with an embedded intervention using a case study (nursing faculty) to explore the problem (racial implicit bias). The qualitative data provided clarity to the quantitative data, thus fully fleshing out a more in-depth understanding of the results (Creswell & Creswell, 2018). In action research, the origin of inquiry and the research process management remains in the hands of those who directly
stand to benefit from the results, including the educators and the student learners (Herr & Anderson, 2015; Efron & Ravid, 2020). All stakeholders will benefit by increasing faculty knowledge and awareness to recognize and manage racial IB skillfully using reflection and cultural humility. However, change is difficult, takes time (Evans, 2001), and takes a team that is willing to put forth the effort necessary to endure the emotion of the process (Senge, 2012).

Those involved in the team learning sessions needed support and encouragement to trust the process. Team learning sessions created a data-rich dialogue that ultimately supports a shared vision of DEI with full awareness of how IB plays into decision-making and behaviors impacting UR students (Breslin et al., 2018). Nursing has traditionally been seen as a “calling” and a “noble” profession undertaken by those who frame their work through the lens of service to humanity. Evans (2001) relayed that if “assumptions and beliefs emphasize the nobility of the work, a ‘can-do’ attitude, and a strong commitment to one another” (p. 141), then participants may be more open, accepting, and willing to take the first steps towards the work necessary to implement change.
CHAPTER 4
PRESENTATION AND ANALYSIS OF DATA

To prepare for presenting collected and analyzed data, this chapter begins with a review of the study's purpose, succinctly describing the importance of addressing nursing faculty unawareness of implicit bias and their perceptions of cultural humility. This study was guided by action research to address the problem of practice and answer the proposed research questions. The study overview briefly reiterates the data collection methods utilized and participant characteristics. An overview of the problem of practice is made cogent with critical race theory tenets and transformative learning theory critical self-reflections. Finally, the organization of general findings is presented through descriptive statistics from the survey results and qualitative data thematic emergence elucidated by participant statements. Alignment of themes using the critical reflections of the TLT demonstrated progressive depths of learner transformation through their discursive dialogue. A summary concludes the chapter.

Purpose of Study

Nursing whiteness frames how nurses are educated, enculturated, and professionalized in modern society. The diversity deficit in nursing originates from the disparate admission rates among UR students. *Highlights from AACN’s 2022 Annual Survey* (AACNa, 2023) found UR students accounted for 43% of those admitted to pre-licensure UG baccalaureate programs. This represents an increase from the previously reported 37.9% (AACNb, 2021). While it is encouraging to see gains in diversity within
nursing program student populations, 83% of nursing faculty are White (Thompson, 2021) and 91% female (NLN, 2021). In addition, nursing education leadership also demonstrates a disparate trend, with 10% of deans from racial-ethnic diverse backgrounds (Thompson, 2021). The 2022 National Nursing Workforce Survey (2023) found that 80% of U.S. nurses are White, while Blacks represent 6.3%, Hispanics 6.9%, and Asians 7.4% (Smiley et al., 2023).

The overwhelming whiteness in nursing education allows ongoing color blindness, subtle racism, and implicit bias to manifest as microaggressions (Ackerman-Barger et al., 2020). Once UR nursing students graduate and begin their practice as professional nurses, the exclusionary and inequitable experiences persist (Ackerman-Barger & Hummel, 2015). The Robert Wood Johnson Foundation (2023) sponsored a recent survey of practicing nurses to ascertain how racism and discrimination impact nurses, the nursing profession, and nursing education. The report found that 59% of nurses surveyed experience high levels of racism and discrimination from peers and 25% from management. Only 23% stated they had filed formal complaints. A substantial percentage (40%) believed the nursing school culture supported racism and discrimination. Specifically, 53% of respondents reported that microaggressions were a part of the nursing school culture (RWJF, 2023). The persistence of the problem of implicit bias and its negative manifestation in nursing programs declared the necessity and timeliness of this study.

The plethora of research from the medical profession has illuminated how provider implicit bias impacts individual and community health equity. (Smedley et al., 2003; FitzGerald & Hurst, 2017; Zescott et al., 2016). Nevertheless, limited research has
specifically explored nursing implicit bias awareness and its influence on patient care and outcomes (Thirsk et al., 2022; Kruse et al., 2022; Gonzalez et al., 2022). The scarce research within the domain of nursing education has focused mainly on faculty implementation of DEI education and IB awareness into nursing program curricula (Schultz & Baker, 2017; Gatewood et al., 2019; Teall et al., 2019). Seventy-nine percent of practicing nurses have reported the need for more DEI education while in pre-licensure nursing programs (RWJF, 2023).

Before nurse educators can implement guided DEI education, and claim inclusive excellence, they need awareness, education, and skill development to address these crucial matters in a meaningful manner. To prepare nursing faculty to effectively teach implicit bias awareness and model cultural humility, they must first acknowledge their biased assumptions and their position of power within the imbalanced power structure of nursing education. The dearth of research on nursing faculty self-perceptions of their implicit bias is limited to dissertations (Fitzsimmons, 2009; Gunther, 2020; Price, 2022). However, Haen (2022) conducted a qualitative study that raised IB awareness of nursing faculty and utilized critical reflection as an intervention for mitigation with positive results. The changing landscape of nursing education and diversity in communities served by nurses requires that faculty first prepare themselves so that they can most effectively prepare future nurses.

**Study Overview**

Action research originates with inquiry, and the research process management remains in the hands of those who benefit from the results, including the educators (Herr & Anderson, 2015; Efron & Ravid, 2020). This complex two-phase explanatory
sequential mixed-methods action research study addressed the problem of faculty unawareness of racial implicit bias and their perceptions of cultural humbleness and humility in an UG pre-licensure nursing program. As PI, I facilitated faculty participation in three learning sessions during phase two of this study. Participants’ increasingly supportive discourse enhanced their understanding of the study constructs of racial implicit bias and their need for cultural humility. Transformative learning theory (TLT) helped to frame the team learning sessions, especially critical self-reflection on assumptions and the transformation of learners’ perspectives, while content derived from the tenets related to critical race theory (CRT). Further, the qualitative data focused on the potential impact IB unawareness has on nursing educator practices, the development of cultural humility, and creation of inclusive excellence. This study answered the following questions:

RQ1  What are nursing faculty racial implicit bias perceptions?
RQ2  To what degree are nursing faculty culturally humble?
RQ3  How does critical reflection affect racial IB and cultural humility attitudes?

Phase one of this study collected quantitative data as a primer for question development used for further probing during phase two qualitative data collection. The two validated surveys were sent to all FT and PT nursing faculty to gather data on the study constructs of racial implicit bias and cultural humility. At the survey's completion, respondents were invited to participate in the second phase. Seven volunteers indicated interest, three from the UG program and the rest from graduate programs. The final case consisted of four nursing faculty who met criteria with details provided in Table 3.1.
**Summarization of Measurement Tools**

The details of the measurement tools are described in Chapter Three. A brief reiteration is provided here. Part I of quantitative data collection used Gonzalez et al. (2021) validated novel survey, *Attitudes Towards Implicit Bias Instrument*. This survey provided data on faculty attitudes towards racism and implicit bias. *Foronda’s Cultural Humility Scale*, developed and validated by Foronda and colleagues (2021), was used for Part II of quantitative survey data collection. Foronda’s survey provided data on faculty perceptions regarding differing perspectives, self-attributes, and cultural humility. Part III to gather faculty demographics and Part IV to garner prior learning related to DEI (generally) and implicit bias (specifically).

**Synopsis of Study Intervention**

Three one-hour virtual team learning sessions provided brief instructional content and interventions related to the study constructs with special emphasis on racial implicit bias and cultural humility. Brief instructional content was followed by semi-structured group interviews. The focal instructional content was derived from CRT: race as a social construct, normalization of racism in nursing, intersectionality, microaggressions, and implicit bias. The third session added content about cultural humbleness and cultural humility to prior instruction on IB (see Table 3.4 for session outline and Appendix L.1-L.3 for session details). The instructional content gave nursing faculty the knowledge, skills, and attitudes to begin their journey towards recognizing implicit bias, mitigating its effects, and enhancing personal and professional cultural humility as a point toward which to achieve inclusive excellence.
Organization of Study Findings

The quantitative data findings are organized by each measurement tool and discussed as data are presented. Demographic data are provided first, followed by responses to questions about previous DEI and implicit bias learning. Next, the ATIBI and Cultural Humility Scale descriptive statistics are provided. Quantitative data helped prime development of qualitative data collection and to better understand faculty attitudes and perceptions of the study constructs before phase two. General findings for the data are discussed in a synoptical manner prior to full explication in the chapter analysis section whereby this study’s research questions are answered. Data collected from participant reflective journals, session transcriptions, and PI notes offered emerging themes framed by Mezirow’s (1998) critical reflection on assumptions (see Figure 2.1). After phase two conclusion, all participants completed one-on-one member checking sessions to determine accurate capture of their perceptions and reflections related to thematic capture with no changes needed.

Presentation of Quantitative Findings

All faculty employed by the SON as FT and PT were sent the Qualtrics survey via email. Twenty-three responses were received for a total faculty response rate of 37.1%. One respondent completed only Part I and Part II; therefore, demographic information from this individual is missing. When Qualtrics Crosstab comparison of specific responses with demographic data, the total number of complete responses (N=22) was used. Response rates for the FT faculty was 48.6% (18 of 37), while PT faculty response was 16% (4 of 25). Table 4.1 provides detailed demographic data. Most respondents
identified as middle-aged, White, female, FT, Lecturer, with doctorate degrees. No respondents identified as Hispanic.

Table 4.1 Demographic Data

<table>
<thead>
<tr>
<th>Demographics</th>
<th>N= 22 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>≤30</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>31-39</td>
<td>0</td>
</tr>
<tr>
<td>40-49</td>
<td>6 (27.3)</td>
</tr>
<tr>
<td>50-59</td>
<td>8 (36.4)</td>
</tr>
<tr>
<td>60-69</td>
<td>6 (27.3)</td>
</tr>
<tr>
<td>≥70</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>Female</td>
<td>21 (95.5)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Black/ African American</td>
<td>4 (18.2)</td>
</tr>
<tr>
<td>Asian/ Asian American</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0</td>
</tr>
<tr>
<td>Native American/American Indian/Alaska Native</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>17 (77.3)</td>
</tr>
<tr>
<td>Bi-Racial or Multi-Racial</td>
<td>0</td>
</tr>
<tr>
<td>Ethnicity (Note: US Census-based approach is used, where “Hispanic ethnicity is recorded separate from race):</td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>0</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>22 (1 did not provide demographics)</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>0</td>
</tr>
<tr>
<td>Master’s</td>
<td>9 (40.9)</td>
</tr>
<tr>
<td>Doctorate</td>
<td>13 (59.1)</td>
</tr>
<tr>
<td>Time as Registered Nurse:</td>
<td></td>
</tr>
<tr>
<td>1-10 yrs.</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>11-20 yrs.</td>
<td>4 (18.2)</td>
</tr>
<tr>
<td>21-30 yrs.</td>
<td>8 (36.4)</td>
</tr>
<tr>
<td>31-39 yrs.</td>
<td>4 (18.2)</td>
</tr>
<tr>
<td>≥40 yrs.</td>
<td>5 (22.7)</td>
</tr>
<tr>
<td>Time as Nursing Educator:</td>
<td></td>
</tr>
<tr>
<td>1-10 yrs.</td>
<td>10 (45.5)</td>
</tr>
<tr>
<td>11-20 yrs.</td>
<td>4 (18.2)</td>
</tr>
<tr>
<td>21-30 yrs.</td>
<td>5 (22.7)</td>
</tr>
<tr>
<td>31-39 yrs.</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>≥40 yrs.</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>Employment at University</td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>18 (81.8)</td>
</tr>
<tr>
<td>Part time</td>
<td>4 (18.2)</td>
</tr>
<tr>
<td>Position at University</td>
<td></td>
</tr>
<tr>
<td>Lecturer</td>
<td>7 (31.8)</td>
</tr>
<tr>
<td>Associate Professor</td>
<td>5 (22.7)</td>
</tr>
<tr>
<td>Professor</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>Clinical Assistant Professor</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>Clinical Associate Professor</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td>Clinical Adjunct</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>Other: Simulation</td>
<td>1 (4.5)</td>
</tr>
</tbody>
</table>
Figure 4.1 notes time as educator and Figure 4.2 notes time as registered nurse. Most respondents have been a nurse for two to three decades, while the majority have been nursing educators for ≤ 10 years. These relatively novice educators have entered academia at a time that large nursing professional organizations and accrediting bodies are pushing nursing education to advance DEI to better prepare competent future nurses (NASEM, 2021; AACNa, 2021). It is hoped that new faculty will demonstrate open attitudes to DEI initiatives and will help to sustain an inclusive excellence cultural norm.

**Figure 4.1** Time as Nursing Educator

**Figure 4.2** Time as Registered Nurse
Prior Knowledge and Interest in DEI

Part IV of the survey asked about formal, informal, and nonformal education as it relates to general DEI training and knowledge, personal interest in DEI, and specific racial implicit bias education. Formal education is defined learning that occurs in a structured setting, such as K-12, colleges, universities, or employment institutions to gain knowledge, skills, and competencies (Smith, 2021). This study asked respondents if formal DEI education had been required by their employer, college or university. In contrast to formal education, informal education is nonstructured learning whereby most individuals gain knowledge through everyday experiences such as work, play, or leisure activities (Smith, 2021). Most informal learning occurs through social interactions with family, friends, and peers and is often referred to as experiential learning. Nonformal education can have structure and objectives with learning that is either initiated by the individual’s interest or within groups, mostly occurring in community settings (COE, 2023). In this study, nonformal was described as learning from a community group or organization activity.

At least half of those responding expressed personal interest in formal DEI education by attending conferences or seminars, taking a course of study, or conducting journal readings. Most (N=16, 72.7%) stated they obtained formal DEI training as required by their employer, college or university. It was surprising to note that 63.6% had required formal IB training. However, I have since learned the university requires special training related to DEI and IB for all faculty and staff who take part in search committees for new hires. The College of Health and Human Services had several positions change
due to retiring professors or those taking positions elsewhere. This increase in required training could have influenced data obtained in this study.

Figure 4.3 Formal DEI, Implicit Bias Education / Training

The least type of education related to DEI or implicit bias took place informally (through social circles, social media, newspapers, magazines, blogs, and opinions (Figure 4.4).

Figure 4.4 Informal DEI, Implicit Bias Education / Training

Given the higher-than-expected DEI and IB educational experiences among faculty responding to this survey, the qualitative data added clarification of participant IB awareness and its negative impact on educational practices. The sample in phase two is small, but the honesty and openness garnered a starting point for those in attendance. A deeper level of knowledge was added to information that faculty had already gained from
prior DEI and IB learning experiences, as noted in participant interactions in the team learning sessions and their journal responses. Research is clear that ongoing and consistent engagement in IB recognition and management is imperative to mitigating its negative effects in education spaces (Sukhera et al., 2019a; TOSU Kirwan Institute, 2018; Gonzalez et al., 2022). Therefore, this work is the beginning of an ongoing effort to change the culture within the SON.

**Attitudes Toward Implicit Bias Instrument**

Part I of the Qualtrics survey used the *ATIBI* (Gonzalez et al., 2021), modified to nursing and nursing education with permission. The 18-item, evenly Likert-scaled from one to six, has a potential score range of 18 to 108. The higher the score, the more positive the attitude toward IB content and instruction (Gonzalez et al., 2021). Appendix B provides the complete instrument. FT faculty (N=18) score ranges on the ATIBI were 69 to 97 (\(\bar{x} = 83.89\), median = 85), while PT faculty (N=4) score ranges were 70 to 84 (\(\bar{x} = 79.5\)). One respondent without demographic information scored 85. These scores indicate that faculty are mostly positive toward implicit bias content and instruction. Interestingly, Black faculty respondents had higher mean positive scores than White faculty. Figure 4.5 shows the total mean score for all faculty and the breakout based on race using Qualtrics Crosstab iQ.
Overall, response scores had acceptable standard deviation (SD) all <2 and close to mean score for each item. The highest SDs occurred in Q2 (SD= 1.29) *Racial and ethnic minority groups are often treated in subtly disrespectful ways*, and Q17 (SD=1.52), *The assumptions I make about racial and/or ethnic minorities may affect the way I treat them*. The lowest SDs were observed in Q4 (0.51), *It is important for me to learn how to recognize when one of my own implicit biases is activated* and Q18 (0.46), *It is important to discuss race, ethnicity, and culture during nursing school.*

Three questions had low mean scores indicating disagree and strongly disagree, which was opposite of the other questions on the measurement tool. These questions were Q10 ($\bar{x} = 2.83$, SD= 1.58) *I worry my actions won’t match my values when I interact with patients who are racially or ethnically different than me*, Q11 ($\bar{x} = 1.83$, SD = 1.37) *Racism is only an issue of the past*, and Q14 ($\bar{x} 2.39$, SD= 1.17) *When I have faculty research and/or class preparation looming I don’t want to waste time learning about implicit bias*. Table 4.2 summarizes the statistical data. Qualitative questions derived from this data addressed treatment of racial and ethnic minority groups, assumptions and
perceptions of others affecting interactions and treatment of them, perceptions of racial IB, and IB influence on nurse educator practices.

**Table 4.2 ATIBI Questions, Content Brief, and Statistics**

<table>
<thead>
<tr>
<th>Question #</th>
<th>Content</th>
<th>Mean</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unawareness of assumptions, IB</td>
<td>5.74</td>
<td>0.53</td>
<td>0.28</td>
</tr>
<tr>
<td>2</td>
<td>Racial/ethnic treated disrespectful</td>
<td>4.74</td>
<td>1.29</td>
<td>1.67</td>
</tr>
<tr>
<td>3</td>
<td>Learning about IB important to nursing</td>
<td>5.57</td>
<td>0.58</td>
<td>0.33</td>
</tr>
<tr>
<td>4</td>
<td>Important to recognize my IB activation</td>
<td>5.78</td>
<td>0.51</td>
<td>0.26</td>
</tr>
<tr>
<td>5</td>
<td>Able to define IB</td>
<td>5.0</td>
<td>0.66</td>
<td>0.43</td>
</tr>
<tr>
<td>6</td>
<td>Racial/ethnic IB may affect quality of care</td>
<td>5.22</td>
<td>1.10</td>
<td>1.21</td>
</tr>
<tr>
<td>7</td>
<td>Worry about saying wrong thing</td>
<td>5.0</td>
<td>1.14</td>
<td>1.30</td>
</tr>
<tr>
<td>8</td>
<td>Nursing student’s competency r/t IB</td>
<td>4.78</td>
<td>1.10</td>
<td>1.21</td>
</tr>
<tr>
<td>9</td>
<td>Made incorrect racial/ethnic assumptions</td>
<td>4.17</td>
<td>1.13</td>
<td>1.27</td>
</tr>
<tr>
<td>10</td>
<td>Worry actions won’t match values</td>
<td>2.83</td>
<td>1.58</td>
<td>2.49</td>
</tr>
<tr>
<td>11</td>
<td>Racism is issue in the past</td>
<td>1.83</td>
<td>1.37</td>
<td>1.88</td>
</tr>
<tr>
<td>12</td>
<td>Important to learn minimize IB</td>
<td>5.13</td>
<td>1.15</td>
<td>1.33</td>
</tr>
<tr>
<td>13</td>
<td>Learning IB as important as communication</td>
<td>5.26</td>
<td>0.79</td>
<td>0.63</td>
</tr>
<tr>
<td>14</td>
<td>IB is waste of time in competing priorities</td>
<td>2.39</td>
<td>1.17</td>
<td>1.37</td>
</tr>
<tr>
<td>15</td>
<td>I have skills to address my IB</td>
<td>4.30</td>
<td>1.08</td>
<td>1.17</td>
</tr>
<tr>
<td>16</td>
<td>IB can affect behavior</td>
<td>5.57</td>
<td>0.58</td>
<td>0.33</td>
</tr>
<tr>
<td>17</td>
<td>Racial/ethnic assumptions affect my treat of them</td>
<td>4.17</td>
<td>1.52</td>
<td>2.32</td>
</tr>
<tr>
<td>18</td>
<td>Discussing race, ethnic, culture is important</td>
<td>5.70</td>
<td>0.46</td>
<td>0.21</td>
</tr>
</tbody>
</table>

**Cultural Humility Scale**

Foronda’s Cultural Humility Scale (2021) is a 19-item Likert scaled survey, where 1= never and 5= all the time, measuring responses across three content area factors: perspective, attributes, and outcomes of cultural humility (see Appendix D for detailed survey). Scale total scores range from 19, rarely culturally humble to 95 habitually culturally humble. This study found FT faculty (N=18) score ranges were 69 to 95 (\( \bar{x} = 79.5 \), median = 77), indicating on average they usually feel culturally humble. PT faculty (N=4) score ranges were 69 to 80 (\( \bar{x} = 75 \)), indicating on average they sometimes feel culturally humble. One respondent without demographic information scored 83, indicating they are usually culturally humble. Figure 4.6 demonstrates the mean scores of respondents based on race using Qualtrics Crosstab iQ. Black faculty respondents report overall greater cultural humbleness perception than White faculty.
Scores on Foronda’s Cultural Humility Scale were mainly positive, with the highest deviation (SD = 0.88, $\bar{x} = 3.52$) on Q2 from content grouping in Factor 1, *How often do you consider the physical environment as a factor for difference in perspective.* Factor 1 incorporated context for difference in perspectives which includes antecedents of diversity, historical precedent, political climate, power imbalances, situational context, and openness. Faculty had the lowest overall mean scores in factor 1, responding that they sometimes to usually consider the antecedents ($\bar{x} = 3.86$). This is an area of potential future exploration and growth for the nursing faculty. Factor 2 provided data regarding faculty self-attributes, asserting they usually are self-reflective, flexible, aware of biases and attempt to shed ego, with $\bar{x} = 4.09$. Factor 3 provided data on outcomes of cultural humility, $\bar{x} = 4.44$, indicating that faculty were usually culturally humble related to the content grouping in this factor. Table 4.3 details each factor content area statistics.
Table 4.3 Cultural Humility Scale Questions, Factors, and Statistics

<table>
<thead>
<tr>
<th>Question #</th>
<th>Factor &amp; Content</th>
<th>Mean</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diversity</td>
<td>4.0</td>
<td>0.59</td>
<td>0.35</td>
</tr>
<tr>
<td>2</td>
<td>Physical environment</td>
<td>3.52</td>
<td>0.88</td>
<td>0.77</td>
</tr>
<tr>
<td>3</td>
<td>Historical precedent</td>
<td>3.61</td>
<td>0.82</td>
<td>0.67</td>
</tr>
<tr>
<td>4</td>
<td>Political climate</td>
<td>3.96</td>
<td>0.69</td>
<td>0.48</td>
</tr>
<tr>
<td>5</td>
<td>Power imbalances</td>
<td>3.70</td>
<td>0.75</td>
<td>0.56</td>
</tr>
<tr>
<td>6</td>
<td>Situational context</td>
<td>3.91</td>
<td>0.65</td>
<td>0.43</td>
</tr>
<tr>
<td>7</td>
<td>Attempt to be open</td>
<td>4.30</td>
<td>0.55</td>
<td>0.30</td>
</tr>
<tr>
<td></td>
<td>Factor ( x ) = 3.86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Self-reflect and self-critique</td>
<td>4.26</td>
<td>0.53</td>
<td>0.28</td>
</tr>
<tr>
<td>9</td>
<td>Flexible</td>
<td>4.22</td>
<td>0.72</td>
<td>0.52</td>
</tr>
<tr>
<td>10</td>
<td>Aware of your own biases</td>
<td>3.87</td>
<td>0.45</td>
<td>0.20</td>
</tr>
<tr>
<td>11</td>
<td>Shed ego</td>
<td>4.0</td>
<td>0.78</td>
<td>0.61</td>
</tr>
<tr>
<td></td>
<td>Factor ( x ) = 4.09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Establish respect</td>
<td>4.22</td>
<td>0.72</td>
<td>0.52</td>
</tr>
<tr>
<td>13</td>
<td>Provide optimal care</td>
<td>4.74</td>
<td>0.44</td>
<td>0.19</td>
</tr>
<tr>
<td>14</td>
<td>Focus on others</td>
<td>4.39</td>
<td>0.71</td>
<td>0.50</td>
</tr>
<tr>
<td>15</td>
<td>Empower others</td>
<td>4.48</td>
<td>0.50</td>
<td>0.25</td>
</tr>
<tr>
<td>16</td>
<td>Work toward mutual benefit</td>
<td>4.22</td>
<td>0.59</td>
<td>0.34</td>
</tr>
<tr>
<td>17</td>
<td>Seek partnership</td>
<td>4.17</td>
<td>0.64</td>
<td>0.40</td>
</tr>
<tr>
<td>18</td>
<td>Supportive interaction</td>
<td>4.48</td>
<td>0.58</td>
<td>0.34</td>
</tr>
<tr>
<td>19</td>
<td>Lifelong learner</td>
<td>4.83</td>
<td>0.38</td>
<td>0.14</td>
</tr>
<tr>
<td></td>
<td>Factor ( x ) = 4.44</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Presentation of Qualitative Findings

The bounded case study was comprised of four female nursing faculty who provided informed voluntary consent to proceed to phase two (see Table 3.1 for participant details). Participants 1 and 3 are UG pre-licensure program nursing faculty (both White) and Participant 2 (Black) and Participant 4 (White) are graduate program nursing faculty. The participants attended all three sessions (Table 3.4 contains session content outline), completed the reflective journal entries, and the one-on-one member checking sessions. Demographically, they are middle-aged, have doctorate degrees and have been in nursing education for several years. When asked why they were participating in phase two, their comments indicated internal motivation to join the sessions. Participants were eager to personally learn all they could about themselves as
well as how they could use the knowledge gained from the sessions professionally in their daily work as nurse educators and practitioners.

The qualitative data was extrapolated from the team learning sessions, participant online reflective journals, and PI notes taken during the sessions. Using triangulation, data was reliable across multiple sources. Conducting one-on-one member checking sessions at the conclusion of phase two validated the accuracy of participants’ perceptions and agreement with emerging categories and themes. PI notes were integrated with session and participant data. Participants provided their own unique perspectives on what they gained from their involvement in this study.

Prior to facilitating these sessions, I reflected on my positionality as an action researcher, my purpose in this research, and my assumptions related to the study constructs: racial implicit bias, cultural humility, and transformative learning. I attempted to avoid interjecting judgment or expressions into the sessions while analyzing all data. Personal interjection remained a struggle throughout the qualitative phase, requiring constant vigilance. However, I recognized personal biases and commitment to the study constructs and how this possibly influenced the data analysis and results. Reflexivity was paramount to temper personal bias as much as possible.

**Data Coding**

Each manually transcribed session was read through once without taking notes to gain familiarity with participants’ discourse and engagement with each other while answering the prepared questions, as well as responses to the unscripted questions that arose. To help navigate participant responses within each of the three sessions, statements were color coded. The second reading allowed for line-by-line inductive data coding.
whereby key words were highlighted and individual statements were pulled from the discourse. Notes, concepts, emerging categories and themes were typed into the coding column that I had added to each page of the transcription using a blend of manual In Vivo coding (Saldana, 2022) and an inductive to deductive process of discourse analysis. A coding document was created for each participant; each outlined to the session, pre-session reflections, and the completed standard prompts. The document assisted in organizing the data to each participant for deeper analysis.

The coding was iterative and ongoing as data immersion revealed consistent categories and emerging themes across subsequent team learning sessions, the participant journals, and PI notes. Participant responses were categorized and aligned to themes to “provide rich and detailed insight into the micro....level of intersubjective experience” (Williams, 2008, p. 248). Discourse analysis and manual In Vivo coding aided the emergence of the themes while looking through the theoretical lenses of CRT and TLT. Instead of lumping the data, I found that being a data splitter provided deeper nuance for capturing the essence of perceptions that fit the case study design (Saldana, 2022). With the shift to deductive thinking, data saturation was achieved, and no new information was gleaned from the qualitative data (Merriam & Tisdell, 2016). All session semi-structured and organic questions are in Appendix M. Appendix N provides the detailed In Vivo codes with emerging conceptual themes for each session and the journal reflections.

**Synopsis of Emerging Themes**

Emerging themes were captured as they arose from the discourse. A copy of Figure 2.1 was kept close so themes within each reflection were consistent. Final qualitative data themes were all aligned to each of the three TLT critical self-reflections.
to ensure accurate capture of participant statements within each type of reflection (Table 4.4). Further alignment of the critical reflections to Mezirow’s (1991) 11 phases (from Chapter One) of TLT aided in noting participant movement towards transformed learning. Participants described experiencing disorienting dilemmas (Mezirow, 1998) during the discussion of the ladder of inference (LOI) example as well as while reflecting on their IAT results. The ongoing data review demonstrated participant movement through the phases towards building confidence and trying out new perspectives gained in the reintegration that occurs in phase 10 and 11, respectively.

<table>
<thead>
<tr>
<th>Reflection Type</th>
<th>Session #1</th>
<th>Session #2</th>
<th>Session #3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity (7)</td>
<td>Invisibility (2)</td>
<td>Identity (9) Self-aware (1)</td>
<td>Identity (5) Self-aware (5)</td>
</tr>
<tr>
<td>Reflection (7)</td>
<td></td>
<td>Reflection (5)</td>
<td>Reflection (7)</td>
</tr>
<tr>
<td>Avoidance (9)</td>
<td></td>
<td>Avoidance (7)</td>
<td>Avoidance (7)</td>
</tr>
<tr>
<td>Discourse silence (5)</td>
<td>Discourse silence (2)</td>
<td>Discourse silence (1)</td>
<td></td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact (9)</td>
<td></td>
<td>Impact (10)</td>
<td>Impact (3)</td>
</tr>
<tr>
<td>Disempowerment (6)</td>
<td></td>
<td>Disempowerment (2)</td>
<td>Disempowerment (4)</td>
</tr>
<tr>
<td>Racism as ordinary (3)</td>
<td>Openness (1)</td>
<td>Openness (3)</td>
<td></td>
</tr>
<tr>
<td><strong>Premise</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wide lens viewpoint (4)</td>
<td>Wide lens viewpoint</td>
<td>Wide lens viewpoint (2)</td>
<td></td>
</tr>
<tr>
<td>Advocacy (2) student view (2)</td>
<td>Supportive (5)</td>
<td>Supportive discourse (4)</td>
<td></td>
</tr>
<tr>
<td>Hopeful optimism (1)</td>
<td>Hopeful optimism (5)</td>
<td>Hopeful optimism (1)</td>
<td></td>
</tr>
<tr>
<td>Inclusion (1)</td>
<td></td>
<td>Supportive discourse (1)</td>
<td></td>
</tr>
</tbody>
</table>

Emancipatory learning required participants to critically reflect on their frame of reference, which are tied to assumptions, by increasing awareness (content reflection), considering origins (process reflection), and meaning transformation while considering why change is important to self and others (premise reflection) (Mezirow, 1998). As participants were exposed to the study constructs, they realized how unknown identities greatly impacted how they interacted with other individuals described as different from them. Unknown identities created racial invisibility resulting in racial avoidance, whether
intentional or not. Ultimately, racial disempowerment is perpetuated by lack of knowledge and unawareness of messaging (verbal, nonverbal, paraverbal) and its impact.

A wide lens viewpoint is noted when participants considered the premise behind why change is important for themselves and others. Some statements were coded hopeful optimism for the future, further supporting premise reflection—the highest level of transformative learning. Figure 4.7 provides visualization of the themes, aligned to Mezirow’s 11 phases and critical reflections of TLT. A prelude to data supportive of emerging themes is discussed within each of the sessions and reflections, with deeper thematic discussion later in this chapter.

![Figure 4.7 Themes Aligned to Types of Reflection, Transformative Phases](image)

**Journal Reflections**

After the review of the transcribed sessions, the same process was used with the journal reflections. The IN Vivo codes were added to each session table for validation of emerging categories and themes. Pre-session reflections focused on completing the Race and Skin Tone IAT (prior to Session #2) and practicing IB mitigation strategies (prior to Session #3). Three standard reflection prompts were completed throughout the study and a final reflection concluded the session. PI notes were added to the standard prompts and the final reflection section to add depth to participants’ narratives.
Standard Prompt Responses

The following prompts were to be completed by participants within two days of each session’s conclusion. The use of standard prompts maintained consistent questioning related to knowledge gains, surprising information, moments of disturbance, and any other openly expressed thoughts from their journals.

What did you learn during this session that surprised you? About yourself?

About others? During Session #1, most participants were surprised by the intersectionality exercise of our group’s identities and demographics—mostly White and all females. During the session, I shared with the group that national statistics indicate that only 17% of nursing faculty are from underrepresented groups (Alexander, 2021). Participant 2 was most surprised by the Matrix of Oppression (Appendix I) that denoted privileged social groups. In fact, she was the only one to reflect on the matrix. As a Black faculty member, her lived experiences makes her more sensitive to oppression and more likely to speak out. As she replied in her journal, “I liked the Matrix of Oppression, but I find that those who are privileged do not see that they have privilege and target those who are not privileged.” P2 was so impacted by this blind privilege that she reflected in both Session #1 and #3 on the privilege of others. Most of the White faculty reflected on the LOI but were not shocked. However, it created the realness of racial implicit bias in nursing education and its negative impact on students, faculty, and others.

Session #2 found that participants were more open in their discourse during the session. Both Participants 3 and 4 journaled this session had moved to more honesty and openness through the development of trust within the group. During the session, I gave an example of how we all carry a backpack of our life experiences. This idea of a backpack
originated from McIntosh’s (1989) publication entitled, *White privilege: Unpacking the invisible knapsack*. I desired to make clear that every person carries with them their life experiences. This was not meant to belittle the racial experience, but to open participants to what they hold close within themselves, yet which seeps out indirectly in our engagement (or not) with others, especially those who are unfamiliar or different than us. I reinforced the White advantage with participants by relaying how I, as the mother of two White young men, do not have to worry about their navigation within a majority White privileged society. This is not the same for UR individuals who are kept at the margins and unfairly judged and scrutinized just for being. Unless everyone is willing to share their experiences, no one knows what is in their backpack.

The backpack discussion was particularly impactful to P3, who stated, “By taking the time to have difficult conversations, we gain a better understanding of others’ backpacks and can have more meaningful relationships.” Another memorable session moment was reflected by P2:

I do not feel that I heard something new. I was impressed that XXX is advancing diversity differences with her class. That was exciting to hear, and I have a new appreciation for her. For those attending these sessions that have to appreciate and value differences among others and are willing to look inward.

Session #3 focused on both constructs of racial IB and cultural humility. P4 journaled, “It was easier to talk…over time, willingness to share had improved. [She learned] that the other participants struggled with similar issues.” Participants 1 and 3 noted their lack of understanding related to the shift to cultural humility. In order to implement and enculturate humility, there needs to be a full understanding of what it
means to be humble and how to achieve cultural humility. I reflected on this as a need for the SON, especially as it relates to the antecedents of humility in the quantitative data results.

**Did any moment during the session disturb you? How did you feel? What were you thinking?** There were periods of silence in the first session, which made me, as the facilitator, uncomfortable, though most did not indicate being disturbed per se. I had to bracket my thoughts as my mind was racing as to the cause for silence. I then realized it is okay to allow the participants to reflect in real time. Silent reflection is necessary so that processing can occur regarding what was being discussed; to lean into the uncomfortableness and not shut down. I affirmed to the participants that they could privately chat me during the virtual sessions (none did) or share in their journals how they feel, and that open expression in front of peers was not required for all interview questions. Silent contemplation has a purpose. Mezirow’s (1994) content reflection is the beginning step needed as one advances towards transformative change.

Participants 1 and 2 did not feel disturbance in session #1, but P1 did mention “feeling a bit intimidated….if I say the wrong thing….[but] realized it was a safe space.” P3 was especially impacted by discussions based on race. She reflected on the “guilt” she feels “at being White… We don’t know what others have been through…we should not assume to understand anyone’s lived experiences.” P4 reflected on how her perceptions of others and how it impacts her verbal and visual interactions with them.

I feel safe in a hospital, with all employees regardless of race, gender, age, religious practices, etc. However, in the public, say walking down the street, a
man that was Black/Brown would intimate me the most, especially if I was by myself.

Session #2 was not disturbing to any of the participants. P3 reflected on how P4 shared a story about her friend who had hid her same sex relationship from her for years because her friend was afraid to do so. P3 stated it “took courage to share that, especially how it made her feel.” The safe space within the sessions cultivated free expression of such an impactful moment. In fact, P4 said she was “surprised” that she shared the story.

Moving into Session #3, participants continued to reflect no disturbance and feeling well supported and confident in the session. P2 was especially comfortable in discussing DEI topics, cultural humility and cultural differences. Both Participants 3 and 4 indicated how cultural humility is a good starting point for education in the SON, as well as how powerful the session was for them. P4 stated, “I am not sure the SON does a good job with celebrating differences in many areas.”

Is there anything you wish to share that you held back during the learning session? Session #1 caused the participants to begin to reflect on the contents discussed. P2 indicated that reflection is important, while P4 indicated she was not “ready to be very talkative.” P3 reflected, “I feel like [my race] defines me for some people….there are some [UR faculty and staff] that I feel very self-conscious around.” Additionally, one participant felt intimidated by another participant who had, in conversations outside of this study, implied that the SON is racist. During her member checking session, I asked the faculty about this intimidation. She stated she no longer felt intimidated and acknowledged a better understanding of the origins of the comments about racism. She conferred that she asked another UR faculty member, whom she is more comfortably able
to engage, who stated there “are pockets of racism” in the SON where some faculty feel they do not belong. This sentiment is echoed by comments from P2.

During Session #2, P2 felt she “could share how I felt and as an individual [I] typically do not hold back.” P3 reflected on how color blind and color conscious were new concepts for her, but she “was a little afraid to [ask]” for further explanation. Thus, she remained silent. During our member checking session, I clarified these concepts to be sure she understood them. P3 journaled that she felt very motivated to utilize the mitigation strategies, especially mindfulness.

In Session #3, P3 reflected how the session “opened my eyes to my own biases and to the need for cultural humility.” P2 stated that she “did not hold back anything and would not. I believe in being respectful and considerate.”

**Team Learning Sessions**

**Session #1**

Session #1 was an introduction to the study, the study purpose, and learning content. I felt tense during the semi-structured interview. I did not want to say the wrong thing as I questioned participants. After this session, I reflected on the need to better drill down the qualitative questioning so that I probe, but not interrogate participants.

Participant 2, the only UR faculty in the study, was mostly silent except for the LOI which really got her thinking. The collective sigh from the group was unmistakable as she opened up about the impact of the LOI. As she became more engaged, participants began to open up more. Our discourse became a form of social interaction, situationally shaped, and constructed (McMullen, 2011).
We all participated in an intersectionality exercise by creating a word cloud of our identities (see Appendix L). Participants could enter as many identities as they desired. This intervention was an important silence breaker and getting to know each other. We shared our known identities and became aware of the unknown identities of others within our small group. We were more alike than different (women, mothers, nurses, nursing educators), which allowed us to see unknown or unseen identities, such as one participant being surprised at a mostly White group. The unperceived racial identities (African American, White) help to shape our experiences as individuals differently (Crenshaw, 1991). These identities cannot and should not be assumed to be one way or another. A real example using the LOI demonstrated the danger in assumptions and proved to be the first disorienting dilemma for participants. The data from this exchange began to elucidate the thematic emergence of unknown identities and unknown impact. The participants began to move from content (what) reflection to a higher level of process (how) reflection. It is important to provide context of the two dilemmas that faculty experienced.

**Disorienting Dilemmas**

Mezirow (1994) described how learners “resist learning anything that does not comfortably fit our meaning structures” (p. 223). Reflection helps transform meaning structures (1998), and a disorienting dilemma triggers this reflective process (1994). The participants experienced two disorienting dilemmas (Mezirow, 1991). The first dilemma occurred in Session #1. Participants were asked what surprised them most about the LOI example. The second dilemma occurred after participants took the Race IAT and Skin Tone IAT to prepare for Session #2. Both situations struck participants in such a way that
discourse narratives demonstrated the emerging understanding of the impact microaggressions have on students and how ignorance to this negative impact perpetuates the problem (Ro & Villarreal, 2021). Also, some faculty expressed surprise and disappointment regarding their own biases. They likewise reflected deeply on these examples in their online journals.

*Ladders of Inference.* Figure 4.8 and Figure 4.9 demonstrate the critical incident LOI examples shared with participants. I became aware of this critical incident in my meeting with the Director of the SON as we discussed my planned research. Sadly, this was not the first time this UR student had this experience in the SON. To address how implicit bias impacts nursing students there must be first recognition that it is occurring (Gatewood et al., 2019). Using the LOI process made it abundantly clear to the faculty that microaggressions and overtly harmful comments can impact a student’s actions in the classroom (disengagement) and could ultimately impact their performance in nursing school.

Figure 4.8 visualizes the nursing faculty LOI. Placing participants at the depths to the bottom of the iceberg put them within clear view of the nursing faculty cognitive processes that have allowed the thought, action, and behavior to continue (Senge, 2012). The thematic emergence of unknown impact becomes apparent as participants struggled with realizing how an unintentionally harmful act of trying to get students involved in learning can be detrimental. As Participant 3 stated:

I can certainly see it happening and not in a mean way and maybe when you call out somebody it is just trying to get people involved, but it may be taken the wrong way...I can definitely see that happening. And when you look at it through
the lens of the student….how that comes across would definitely want to make her shut down.

Participant 1 concurred in her journal that, “even if there was not ill intent and how this was demonstrated on the ladder visual….the impact is very significant for the student.”

Participant 2 had a different view of the LOI. She was surprised the student would go to leadership. As one of few Black faculty in the SON, her perspective keenly focused on power imbalance and racial inequity. The weight of despair is palpable as P2 openly described to others how UR students’ internalization of faculty microaggressions and being singled out can cause isolation and loss. P2’s discourse was coded as racial disempowerment:

....what I find is that a lot of times students won’t take that action and as a result they will internalize things and as a result of internalizing they take a lot upon themselves and as a result they are no longer successful in our programs. They fall out because they don’t have peer support to go to... But the one who felt she was singled out or the one that felt oppressed—I don’t think she would actually go [to the director]. Over the years, I have not seen that happen. If it does it rarely happens.

| I continue the same classroom techniques as I am unaware of how my students are affected by my in-class behaviors and actions |
| I adopt the belief that my classroom techniques are okay since there is silent approval. |
| I conclude that this student did not prepare for the lecture, is not interested in the content, and is disengaged and this may negatively impact their performance |
| I assume the student is not prepared for class because she looks down and does not look at me; based on the student’s response and body language I also assume that the student is not listening and disinterested |
| I attempt to engage a student of color to share their knowledge of and experience related to the course content |
| During community health lecture, I discuss lack access & health inequities in marginalized communities |

*Figure 4.8* Ladder of Inference—Nursing Faculty
Reflection on Implicit Association Tests. The LOI example, though evocative, was safely external to the participants. It gave them a scenario between a faculty and an UR student upon which to reflect. In contrast, the IAT was a personal exercise in raising their awareness of their own racial and skin-tone biases. The following questions were asked in the online journal for reflection prior to Session #2: What surprised you the most about the results? How did the results make you feel? Are the results different from your explicit assumptions? Anything else you would like to share?

Each participant shared their results from taking the IATs. The following excerpts are transcribed from participant personal online journals.

Participant 1: I was really surprised when the results showed I have a strong automatic preference for White people over Black people. It made me feel very surprised, and a bit disappointed in myself to be honest because in my day to day I don’t feel like this (I thought). I am reflecting on these results every day and incorporating them into my actions, decisions, and conversations. [P1 replied this was different than her explicit assumptions].
**Participant 2:** Your responses suggested a moderate automatic preference for African Americans over European Americans. No change in my feelings. [P2 stated this was no difference between her implicit and explicit assumptions and she was not surprised by the results].

**Participant 3:** I didn’t think much about skin tone, but it said I had a slight autonomic preference for light skinned people. I usually try to treat people as individuals rather than judging them based on the color of their skin. However, I guess this is trying to show that we may make judgments before we ever get to know the person. [P3 felt] curious. I wonder if some of my results were because of a true bias or because I was frustrated with the [IAT] game. I tended to zone out. I had never really thought about my assumptions, especially with skin tone. However, the activity did make me think about how I perceive others before I get to know them. I always think of other qualities that can cause me to have biases before I get to know someone– how they are dressed, how they present themselves, body art, body language etc. For me, color of skin is one piece of the bigger picture.

**Participant 4:** In the 2 tests, my scores are very similar. Even though I have done work in this area for 2 years [DEI Committee work and graduate student simulation experiences], it still shows strong implicit bias (68%) of European over African; and light over dark (68%). Unfortunately, [the results] are what I expected. I had hoped that with my conscious efforts I would have improved. I know that I have implicit bias; I have tried to identify them, label them, and yet I
remained very biased. Very depressing. How has this negatively affected others around me, especially my students?

As noted in the excerpts, White faculty reflections ranged from surprise to depression and curiosity to questioning the IAT. P1 became reflective, realizing the discordance from her explicit perception of self, while P4 began to wonder how others have been impacted by her biases, especially her students. The discordance between implicit and explicit self is well documented in research (Haider et al., 2015; Sukhera et al., 2019a; Sukhera et al., 2019b; Maxfield et al., 2020).

P3 avoided directly answering whether the results were different from her explicit assumptions. Instead, she responded, “I had never really thought about my assumptions, especially with skin tone.” Race avoidance and color blindness is apparent as she questions the IAT validity and is troubled by accuracy of detecting individual racial skin tones. Only P2, who is African American, stated that explicit and implicit biases were concordant. This result concurs with Maina and colleagues (2018) who found Black respondents less likely to demonstrate discordant IB compared to White or other racial group respondents.

Session #2

Session #2 included instructional content on implicit bias, the origins of assumptions, IB impact on healthcare provider and nursing clinical decision-making, and the impact of IB in nursing education. The participants prepared for this session by taking the IAT (reflections mentioned earlier). There is an interesting dynamic between racial avoidance and the increase in hopeful optimism among the White faculty. At times, statements would be racially avoidant, and at other times there would be hopeful
optimism. Additionally, there is a divergence from the hopeful optimism of White faculty to unfulfilled destiny of DEI when viewed from the perspective of the Black participant. For instance, despair and disempowerment are profoundly noted in P2’s statements, “nothing has changed” and “It won’t change in my lifetime.”

Reflection on Mitigation Strategies

The mitigation strategies shared with the attendees were counterstereotypic imaging, individuation, and mindfulness. After Session #2 they were to practice for a week and write in their journals. P2 described the strategies as helping her to “reflect each day on what I do and why I did it...I felt renewed...It forces you to be consciously aware of your actions and decisions.” This mindfulness matched P3, who used this strategy in committee meetings to “keep the issue [of biases] at the front of mind.” P3 described carrying this strategy into her committee work as she influenced others by forming questions such as, “I might be biased in this situation because...” She also described shifting the conversation related to the IAT to her personal circles of her family. P3 exclaimed in her journal, “At least we are talking about it!”

Communication, then, became a catalyst for awareness for some in our sessions and it spread to their outer circles. Just as P3 above communicated in committees and her family, P4 became the most curious as she sought to better understand her bias and its impact on others. As she reflects in her journal, she had conversations with colleagues, friends, and students. No distinct mitigation strategy was mentioned as the most used, but individuation is deduced in these interactions, as she determined to see the uniqueness in individuals, not as members of a group (IHI, 2017; OMH, 2021). A particularly poignant moment is shared in her journal.
Had a conversation with one of my colleagues, who is in a biracial relationship, and asked how I could better support a biracial student that she is precepting. She told me how the student did not feel comfortable at [the hospital] – was ‘an other’ – did not fit the blonde hair, blue eyed [preceptors]. It is sad that it took me to my mid-50’s to see more of my blind areas. It was hard to implement. Just need to be more willing to be in circles outside of my usual ones.

On the other hand, P1 used more of what Ross (2014) described as the PAUSE method, which incorporates both mindfulness and self-regulation. The PAUSE method includes paying attention, acknowledging reactions, understanding origins of assumptions, seeking to be positive, and executing the plan (see Table 2.1 for other micro-level detailed strategies). P1 reminded herself, “to incorporate [the] strategy before hitting send on an email or before making a final decision regarding academic decisions. I felt more well-rounded, professional....empathetic.”

**Session #3**

Session #3 delved into cultural humbleness and humility. Prior to the content instruction, faculty shared their definitions of these terms. Responses were varied. Quantitatively, faculty respondents scored high on humility attributes of self-reflection, flexibility, awareness of biases, and shedding ego (Foronda et al., 2021). However, relating the attributes to cultural humility was powerful new information for participants. Faculty were unaware of the movement of nursing education away from cultural competence to promoting increased cultural humility (NASEM, 2021; Foronda et al., 2022). Therefore, this session was both timely and purposeful for all participants.

Foronda and colleagues (2016) described how supportive interactions and openness are
indicative of cultural humility. As the group became more comfortable, these two factors (supportive and openness) began to emerge in coded data in Session #2 and #3.

Analysis of Results

Analyzing the data on a deeper level added to the knowledge related to the study constructs. Data from the measurement tools and the qualitative data answered the study research questions. A comparison of ATIBI (RQ1) to Cultural Humility (RQ2) scores is noted in Table 4.5. No definitive pattern was determined based upon measurement scores, as they were relatively equivalent and generally positive. However, data from surveys are interpreted cautiously because of self-reporting and the potential for response bias that can occur when there are non-responders to the survey invitation (Creswell & Creswell, 2018). Those who did respond provided data and context for further probing during the qualitative data collection and analysis. The Qualtrics software was used mainly for descriptive quantitative statistics, but some data was analyzed using Qualtrics Crosstab iQ feature to determine relationships between variables (Creswell & Creswell, 2018). The qualitative data is analyzed with the intent to answer RQ3 as well as refine themes by connecting them to coded data and personal participant narratives.

Attitudes Toward Implicit Bias Instrument

The ATIBI answered RQ1: What are nursing faculty racial implicit bias perceptions? Scores on the ATIBI demonstrated that nursing faculty who responded are positively receptive to implicit bias content and instruction. Comparing respondents across demographics, UR faculty are more positive than White faculty, and FT faculty are more positive than PT faculty. Half of respondents (N=12) strongly disagreed and 39.1% (N=9) disagreed that racism is an issue of the past. Even though most respondents
agree that racism is a current issue, 13.6% (N=3) disagreed and 4.5% (N=1) slightly disagreed (mostly White respondents) that racial/ethnic minorities are often treated in subtly disrespectful ways. Since this response was surprising, a similar open-ended version was added to the qualitative question list (Appendix M).

Further data indicated 92.8% of nursing faculty agreed or strongly agreed that IB affects behaviors of individuals, but 22.7% (White = 4, Black = 1) disagreed or strongly disagreed that it affects the way they treat racial/ethnic minorities. Additionally, 65.2% do not worry their actions won’t match their values when they interact with patients who are racially or ethnically different from them. Though faculty do not worry that their actions won’t match their values, most research presented in the literature review indicated otherwise. Numerous studies have found that cognitive and IB affect nursing judgement and decisions (Thirsk et al., 2022). Figure 4.10 shows the breakout of race to worry about actions not matching values while interacting with other racial-ethnic groups using Qualtrics Crosstab iQ. Length of time as educator and respondent age did not identify noteworthy descriptive statistics for comparison.

*Figure 4.10 Worry Actions won’t Match Values*
The majority of faculty (N= 22, 95.7%) agree to strongly agree that individuals are unaware of their IB and agree that learning how to recognize when their IB is activated is important. However, 26% indicated they need skills to address their biases. Most faculty agree or strongly agree that IB recognition and management is a nursing student competency (78.3%), while 13% (N=3) disagree or slightly disagree. All faculty strongly agreed that discussing race, ethnicity, and culture is important during nursing school. Faculty need further knowledge and skills relevant to IB awareness and how to effectively manage and mitigate negative IB impact on student nurses.

**Cultural Humility Scale**

The Culture Humility Scale answered Q2: *To what degree are nursing faculty culturally humble?* On average, nursing faculty cultural humility scores indicated they are usually culturally humble (\( \bar{x} = 78.9 \)). Faculty had the lowest overall mean scores in content grouping of Factor 1 related to perspectives (\( \bar{x} = 3.86 \)). Most (N=19) considered diversity a factor for perspective, but 18.1% (N=4, mostly White) indicated they sometimes do. UR faculty responded they usually consider the physical environment (N=2) or do so all the time (N=2) compared to 31.8% of White faculty while one White faculty indicated they never do so. UR faculty are more likely (75%) than White faculty (52.9%) to consider historical precedent, political climate (UR = 100%, Whites = 54.5%), and situational context (UR=75%, Whites = 70.6%). Divergent viewpoints considering power imbalances was not surprising. Black faculty are more likely (75%) than White faculty (58.8%) to consider power imbalances when dealing with a conflict or difference in perspective. Almost all faculty (N=22) are open to other perspectives. Factor 1, perspectives, is an area of opportunity for faculty professional development.
Factor 2 provided data regarding personal attributes of respondents. The highest score was seen in self-reflectivity of faculty and the lowest being aware of biases. Scores at usually (4) or all the time (5) indicated that almost all nursing faculty (N= 22, 95.7%) are self-reflective, 82.2% (N= 19) are flexible, 82.2% (N=19) are aware of their own biases, and 78.3% (N=18) attempt to shed ego. Analysis based upon race indicated that Black faculty are less likely to shed ego (25%) than Whites (88.2%) when encountering conflict or differing perspective. The ego originates in the conscious mind when a person thinks about themselves and how they are to be perceived by others (Mcleod, 2023).

Freud (1923) stated the ego [conscious reality and principled] is “that part of the id [unconscious urges and impulses] which has been modified by the direct influence of the external world.” This is an interesting survey finding, but not one that I openly explored in this study. I dare correlate increased cultural humility perspectives among Black faculty such as reading the room (physical environment and situational awareness) and more likely to consider political and power imbalances when dealing with conflict with the strength to maintain ego projection externally.

Factor 3 provided data on outcomes of cultural humility, with \( \bar{x} = 4.44 \), indicating faculty see themselves as usually culturally humble. The data was reviewed for percentage of faculty who responded usually (4) or all the time (5) to the consequences in Factor 3. Seeking to develop partnerships had the lowest faculty response, 87%. Research has demonstrated that partnership development helps to mitigate IB (JC,2016; IHI, 2017; Hagiwara et al., 2019), so this is an area of ongoing opportunity for nursing faculty.

Seeking to establish respect and working towards mutual benefit, both had 91.3% faculty response. All faculty seek optimal care, focus on the other person, strive for
supportive interaction, and are life-long learners. The consequences listed in Factor 3 are typical cultural norms for the nursing profession. During the development of the Theory of Cultural Humility, Foronda (2020) derived the following assumptions: all humans are diverse, are inherently altruistic, have equal value, are life-long learners, and expect cultural conflict as normal.

**Table 4.5 Comparison of ATIBI and Cultural Humility Scores**

<table>
<thead>
<tr>
<th>Respondent</th>
<th>ATIBI</th>
<th>Cultural Humility</th>
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<tr>
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<td>90</td>
<td>95</td>
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</table>

**Team Learning Sessions and Reflections**

All three learning sessions progressively moved faculty to a deeper understanding of the study constructs and laid the necessary groundwork for exploring and answering the final research question. During session one, participants were introduced to Mezirow’s types of reflections. Each participant used critical reflection in their online journals through standard prompts and session specific questioning. Based upon faculty responses, depth and progression of reflections increased throughout the study, as the
alignment of themes to the types of reflections noted. Additionally, these reflections tracked progression through Mezirow’s phases of transformative learning.

**Defining Cultural Humbleness and Humility**

Interest in learning what cultural humbleness and cultural humility mean to nursing faculty helped clarify how this qualitative question was answered. All participants defined cultural humbleness and cultural humility in their own words. Similarly, these responses tied back to the three factors of cultural humility (Foronda et al., 2021) and this study’s identified themes: identity, impact, racial avoidance and disempowerment, wide lens viewpoint, and hopeful optimism. Examples related to factors of cultural humility include open mindedness and historical precedent (perspectives), reflection, self-awareness, and introspective (attributes), and interactions with others through applying knowledge gains (outcomes).

P3 defined humbleness as “understanding self, the positive and the negative, and the effects on other cultures. A looking inwards and an overview of self.” When asked to define humility, she said it was “looking outward.” P1 also described humbleness as “awareness of self” but could not articulate a definition for humility. P4, who had demonstrated the most curiosity throughout the study, stated it is “wanting to know about others,” while humility is “using the knowledge gained by applying it.” P2 stated, “Both [humbleness and humility] require introspection.”

**Integration of Nursing Culture Perspectives**

Appreciating participant perceptions of nursing culture within the SON helped to understand the antecedents of cultural humility and the spaces in which communication and messaging occur within the school. The antecedents included in Factor 1
(perspectives) were the lowest mean scores on the *Cultural Humility Scale*, even though overall scores indicated that faculty were usually culturally humble. I was particularly struck by physical environment, historical precedent, and power imbalances within Factor 1. When asked about the nursing culture, P3 stated, “it is not discussed…. [it] seems more operational level understanding of others, but not personal level of knowing each other. We just don’t know each other.” P4 concurred with this sentiment, adding, “Pandemic hibernation did not help the culture of nursing or cultural learning.” She shared that the fear of being offensive limits “learning about others and the culture.”

The discordant perception of the SON culture between the White and Black faculty was clarified through further participant discourse. For example, P1’s statement communicated a more hopeful optimism, "the culture is professional, diverse in both students and faculty. It is positive." While P2 asserted the culture “…is fragile…everyone wants to have a sense of belonging, but they don’t know how to get there. We haven’t shown them because we don’t know how to get there. It involves action.” The heaviness of P2’s response that everyone wants a sense of belonging lends credence to an unfulfilled destiny of inclusivity and belonging within the SON. From these discourses, I conclude our SON culture to be a powerful unseen force that is not fully understood, similarly defined, or perceived by those within it.

During Session #3, each participant was asked, *How does implicit bias awareness and mitigation transform nursing faculty perception and practice of cultural humility?* When faculty practice cultural humility “their self-awareness would be enhanced” (P2). Cultural humility becomes “more multidimensional and open minded….doing the exercises in this study [I have found] that we are not as open minded as we think we are”
(P1). Further, P1 added that her “mentoring of [UR] students” and “cultural curiosity” had increased. This wide lens viewpoint demonstrated why the work to recognize and reduce biases is important (premise reflection). Similarly, P4 stated, “I have reflected back on my most recent interactions with patients….students…” Particularly impactful moments occurred while she conversed with students, colleagues, and within our session:

A student that is prepping to apply for a fellowship shared with me that she is on the DEI Committee, and I asked the student, “How do you identify?” [racially, sexually, gender] Another student is Brown and tattooed but has a preceptor who is blonde and White. As a matter of fact, most of the preceptors are White blonde, young females. The student described to me the feeling of being different was palpable. We talked last week about [identifiers] on student admission applications…I think of the school of nursing website that lists all of the instructors. I ask, “If I were Black or Brown, do I want to be taught by a bunch of old White women?” They want to see people that look like them. Instructors they can relate to.

P4’s response demonstrated how unknown identities and unknown impact had changed her perspective on knowing others and increased her curiosity and engagement with others. P3 took on a more historical reflective perspective:

When you are able to understand where you are coming from it helps to understand where you are going—you understand the world—it is looking ahead. Now that I can see, I can see clearly, though I know there is more to learn I am feeling more comfortable….If we don’t talk about [the culture] it makes it difficult to talk about it with students.
Final Critical Reflections on IB and Cultural Humility

Final reflections provided further evidence of discordance between White and Black participants’ attitudes towards IB and cultural humility. Each participant is presented as they completed their final reflections. As PI, my notes are woven into their reflections. These final reflections answer RQ3 fully: How does critical reflection affect racial IB and cultural humility attitudes?

Participant 1. P1 was the most optimistic and positive in her reflections related to the study constructs. The LOI example and the IAT moved P1 to self-examine and critically assess her assumptions (phases 1-3, Mezirow, 1991). She admits to being “naïve about implicit bias and how this can (and does) impact our students, friends, colleagues and patients every day.” She began to reflect on her “own behaviors that perhaps I have been completely oblivious to.” She therefore quickly moved to process reflection (Kitchenham, 2008) in considering how to explore and implement new actions (phases 4-7, Mezirow, 1991) related to cultural humility “personally and professionally.” Building competence and self-confidence (phase 10) is evident in her increased mentorship and engagement with UR students and her hopeful optimistic final reflection statement, “I have learned so much and feel like I am equipped to be a change agent!”

Participant 2. P2 critically reflected differently than the other participants in the study. Her reflections maintained an outward projection of concern towards others instead of a specific internal change within herself. Her thinking about IB had not changed, “I am just more aware of processes and content.” Reflecting on cultural humility, again she noted, “it is an action process that requires people to be motivated to become humble about something.” A need for others to effectuate change within
themselves is surmised by statements relating the impact of blind privilege, racial
disempowerment in how UR students, faculty, and colleagues are negatively treated, the
fragile nursing culture, sense of lack of belonging, and the extension of the problem
beyond the SON. Concern for others and how their treatment bothered and disturbed her
was present, for example, by her experience of another’s ageism experience and the LOI
example. However, during the sessions she felt safe and willing to share her perspectives.

P2 was an integral part of our group with unique and meaningful discourse that
impacted others. As an African American older female, she lives daily with intersecting
oppressions and is keenly aware of content and process reflections. A turning point
occurred when she affirmed participants’ “appreciation and value differences among
others” and provided verbal positive affirmation toward another participant’s diversity
work within the SON. Clearly, this demonstrated a renegotiating of new relationships
within our group, as she felt supported and supportive of others (phase 9, Mezirow,
1991). Finally, she stated, “I enjoyed the sessions and look forward to learning more.”

**Participant 3.** P3 was the most reflective participant. Her journal was extensive
as she intently reflected on the study constructs. She was open to answering questions
during learning sessions but would veer conversations away from race and racial bias.
For example, when the group was asked about changing messaging (nonverbal/ verbal)
when in the company of someone from a different racial or ethnic group, her response
was “it is not so much race as it is characteristics of what they are wearing or…[clothing,
piercings, tattoos].” She wrote of feeling “guilt at being White” and her frustration with
taking IAT and then questioning the results. These disorienting dilemmas caused her to
self-exam her feelings (phases 1 and 2, Mezirow, 1991). The IAT compelled her “think about how I perceive others before I get to know them.”

She added in her journal, “We should not assume to understand anyone’s lived experiences.” This statement stemmed from an exchange she witnessed between a Black female coworker and a White male who described his experience growing up poor. “She actually said that she was surprised that he had such a difficult past because of his (White male) privilege.” All lived experiences should not be assumed, I agree. Yet denying racial differences in experiences and the existence of White privilege perpetuates the myth of meritocracy and lack of racial humility (DiAngelo, 2018).

P3 admitted in her final reflection that she is still troubled by her IB. “It seems like we should have none, like I was ‘bad’ if any biases were found.” These initial attitudes are normal as one begins to contemplate a personal connection to racism. The good-bad binary is irrelevant, as racism can be manifest in people with blind spots and is deeply embedded in our culture (DiAngelo, 2018) and as has been discussed, surfaces through subtle slights and microaggressions. Through P3’s engaging work in the reflective process, she began to see the big picture and the importance of bias awareness. “The main goal is to recognize the biases and work through them. Thank you for offering these sessions. It has definitely opened my eyes to my own biases and to the need for cultural humility. I think this is definitely a journey rather than a destination!”

Participant 4. As mentioned earlier, P4 was the most curious and courageous conversationalist in the group. Her quick confidence to engage others in crucial conversations about racism and implicit bias portrayed an ongoing reintegration of her new perspectives (phase 11, Mezirow, 1991) gained from this study. Admittedly, she
agreed, “I have made a lot of those assumptions [like the LOI],” but then she began to look through the lens of the student. Hope and hopeful were two words of discourse that she used frequently in sessions and in her journal. Thus, hopeful optimism is objectified. Though she was disappointed in her IB, she is “continuing to grow in my consciousness of my bias. To identify them, and hopefully chart a different path.” She plans to continue to “expand circles to different groups with more diverse backgrounds” firmly placing her in TLT’s premise reflection whereby she is negotiating new relationships, increasing competence, courage, and confidence in these group dynamics (phases 9 and 10, Mezirow, 1991). Finally, she added, “Humility….is interwoven with implicit bias…using open ended questions….[such as] tell me about your culture….I appreciated this opportunity to learn and grow.”

**Exploration of Study Themes**

Themes identified were not necessarily based upon frequency but on what best describes the tacit meanings within participant discourse (Saldana, 2022). By utilizing content reflection, participants realized how multiple identities shape experiences and perceptions, while process reflection exposed origins of assumptions and beliefs. Group supportive affirmation increased desire for enhanced engagement and connection with one another as some learned they have the same struggles. Transformation was especially evident when personal impact narratives within the identified themes were shared with either the group, in their reflective journal, or during their one-on-one member checking session.
Unknown Identities

One of the first themes to emerge from the data was unknown identities. P2 reflected on the comfort of familiarity in, “I do know that we tend to gravitate toward those who look like us or have similar characteristics. That is part of human nature.” The diversity deficit in nursing education and the profession was unperceived by some prior to the learning sessions. Expanding to gender, one participant expressed curiosity about the male student nurse experience (P4). A couple of participants did not use their race as an identifier during the intersectionality exercise until they saw that others had done so. As P3 journaled, “I rarely describe myself based on my skin tone.” CRT purports how dominant group color blindness perpetuates racism as normal because the dominant group does not have a personal connection to its presence and consequences (Wesp et al., 2018). However, as the intersectionality exercise provided an excellent visual that, “No person has a single, easily stated, unitary identity” (Delgado & Stefancic, 2017, p. 10).

We all are impacted by the identities and experiences we carry in our backpack.

P1’s impact narrative involved southern culture shock in caring for Black patients when she moved from the northern to the southern U.S. Being faced with this unknown racial identity required ongoing immersion in the African American culture to become comfortable and competent. As she described,

I grew up in the north. I did not have Blacks in my schools. I did not graduate with Blacks. I did not even have Blacks as patients. Not until I moved to the south, did I see Black people and [began] taking care of Black patients. I was out of my comfort zone. I felt very anxious. I was not prepared for their viewpoints, their culture on death and dying. There were multiple generations living under the
same roof. I was not used to that. Here I am a White woman from up north and they are thinking, ‘who is this woman, she has no idea what she is doing.’ I went into these situations blind. It took me about a year to get comfortable. I was open to knowing the culture.

It is clear from her narrative that unknown identities can shape the way in which nurses approach patient care within cultural norms. The nurse is anxious, and the patient (or family) is concerned about the quality of care given.

**Racial Avoidance**

The uncomfortableness of the unknown can cause one to avoid voluntarily stepping into these experiences. *Avoidance* is defined as “choosing the comfort of one’s own racial group over interaction with another racial group” (NRC, 2004, p. 57). The limited faculty, especially UG, interest in phase two focused on racial implicit bias, is construed as avoidant. As P2 stated, “It’s human nature” to “gravitate toward those who look like us or have similar characteristics.” Human cognitive psychologists posit that humans most efficiently connect with the known, but when faced with conditions outside of the comfort of the norm faulty assumptions can affect interpersonal communications, relationships, and meaningful collaborations (APA, 2022; Agarwal, 2020). So, avoidance was not completely surprising, but definitely disappointing. This work required leaning into and embracing the uncomfortable. Some are just not ready to deal with that level of uncomfortableness, even with the most knowledgeable content experts and skilled facilitators.

Furthermore, racial avoidance during Session #2 was revealed in the inability to openly articulate responses to questions about race, racism, and the treatment of racial
and ethnic minorities. This contradicts the quantitative data that all faculty strongly agreed that discussing race, ethnicity, and culture is important during nursing school. There is comfort in anonymous survey responses that is not completely true in group semi-structured interviews. Participants were not required to answer questions that made them uncomfortable. They could instead sit in silent contemplation, though they were encouraged to reflect in their journal. None directly wrote in their reflection journals regarding the following unanswered question. *Do you feel that racial/ethnic minority groups are treated in subtly disrespectful ways?* There was a long silence to this question and finally no response from participants. As noted from the quantitative data, 17.9% of respondents (mostly White, N=3) disagreed or strongly disagreed with this statement, meaning they believe there is no subtle racial/ethnic disrespectful treatment of minoritized groups.

Lack of response during the session regarding this question may be multifactorial. Group demographics, mostly White, could have played a role. Additionally, this was the first session, and they did not “know” each other at a level to discuss such an evocative question. Finally, participants had yet to participate in critical reflection through their journaling and needed the time to reflect—though none reflected on this question in their journals. Only P2 provided her perceptions of racial implicit bias in nursing and nursing education. As she stated, “I didn’t disagree with anything.” Further, she described how one of the largest nursing professional organizations, the American Nurses Association, released the *ANA Racial Reckoning Statement* (2022) acknowledging how they “treated ethnic minority nurses,” excluding them which led them to create their own “ethnic minority associations.” This document also issues a formal apology “not only to nurses of
color but to all patients, families and communities that depend on ANA as the national leader of the nursing profession” (ANA, 2022, p. 6).

Another evidence of avoidance was veering off the topic of race and racism by focusing on external characteristics of individuals such as piercings, tattoos, and clothing. Or sharing narratives regarding other oppressed groups such as the LGBTQ+ community and a witnessed ageism experience. This open discourse within the group was allowed to continue organically as the participants continued a deep dive into various biases and connected to each other through this level of open expression. The affirmation of support in this session fueled further engagement and openness that defines developing cultural humility.

P3’s racial avoidance comes from a place of not wanting to hurt others, maintaining racial harmony, and because she had to “walk on eggshells around some people because of my race [White]. Trepagnier’s (2001) research described how the inclination of Whites to avoid mentioning race or race aversion stems from, “confusion about what is racist and apprehension about being perceived as racist” (p. 146). P3’s impact narrative response to messaging when around someone from a different racial or ethnic group demonstrated this deflection:

I have to be very careful with how I interact with people because I tend to …you know…for the sake of not hurting feelings or coming across the wrong way I tend to back off…but because they [have piercings, tattoos, wear a hajib] or that sort of thing. Those are the kinds of things I find myself filtering what I say and watching myself a little bit more. Moreso than the color of one’s skin. I think that is where I find myself a little bit more protective of how I interact with people. That is just
being honest. It’s just because I don’t know them. I don’t know much about them or what their beliefs are and that sort of thing. So I tend to kind of shy away from those conversations.

**Unknown Impact**

The impact of covert racism, subtle slights, and microaggressions caused participants to reflect on their assumptions and beliefs. Moving through the types of reflection, they were able to connect how they had possibly contributed to exclusionary behaviors as nursing faculty. Mezirow (1998) explained how frames of reference, how we learn, and meaning schemes can be changed because they become nonfunctional in light of new information through discourse. As he relayed, “Discourse is central to human communication and learning.” Nurses are compassionate, caring, and altruistic. We often turn our attention to others, instead of ourselves. P2 stated, “I am constantly thinking about how I can make people feel included and that they belong.” Discussing the LOI exam example, participants were moved by the negative impact on the UR student. They began to reflect on their assumptions. Fowler (2013) described the insidiousness in the mobilization of bias as one dimension of power because mechanisms tied to organizational structures and social norms. Until implicit biases, or power mechanisms are recognized, those wielding it over others do not recognize they are doing so (Fowler, 2013).

The impact narrative shared by P4 was not directly related to race but affected all in the session as she shared. However, it demonstrated how unknown identity and unknown impact leads to hiding of true selves:
To confront my own biases. You know it was shocking. It [my bias] was out there. I have a friend of mine who her partner is a woman, and she did not tell me for years because she said that she did not think that I would accept that. And I thought well then, I got a lot of work to do. So, that was a catalyst for me. To say, you know—who am I really?

The unknown impact became clearer when participants looked through the lens of others, especially students, colleagues, and friends. Empathetically putting oneself into the shoes of another is perspective-taking, a recommended IB mitigation strategy (JC, 2016).

**Racial Disempowerment**

A consequence of unknown identity and unknown impact is racial disempowerment. P2’s data was coded most often to this theme. In Session #1, the LOI was a powerful example of resultant disempowerment an UR student experienced in a nursing classroom. P2 was keen to point out the boldness of the student in the LOI. Taking the concern to leadership is highly unusual. The recent study from the RWJF (2023) supports her assumption, finding racism and microaggressions against UR nurses is reported only 23% of the time. Interestingly, P2 connected boldness to privilege. As she pointed out:

Collectively they will probably do something like that, but not as an individual student. That is why I was looking at it. I was like that student took action that is pretty bold on their part, but I just don’t see students taking that action. Unless they feel like they are part of that privileged society.

Throughout the learning sessions, P2 did not share any personal experiences related specifically to the study constructs. But in the one-on-one member checking session, she
was more open. The hopelessness that nursing and nursing education will not “change in [her] lifetime” contrasts the hopeful optimism of the other faculty in the learning sessions. As she shared her personal impact narrative, it became clear this hopelessness and despair originates from isolation and avoidance:

I have talked to people in the school of nursing. We have conversations and talk, but when we get into meetings, they do not talk [to me]. They ignore me. It is difficult when people don’t get curious or complement or build inclusivity because we do not talk to each other. Or it is always the same people in these [DEI] meetings because we want to change but others do not. Everyone needs to have cultural curiosity.

The content and the process reflection were less of a reflective need for P2, as her personal experience of racial silence and avoidance above indicated. She is intimately aware of antecedents of bias and the origin of assumptions. A need for a “sense of belonging” is repetitively mentioned, but with an undertone of hopelessness. “Everyone wants to have a sense of belonging, but they don’t know how to get there…. we don’t know how to get there.” However, an important moment for her that tempered her despair was the affirming support she felt in another faculty’s efforts to advance diversity, equity, and inclusion within the SON.

**Wide Lens Viewpoint**

Wide lens viewpoint was the chosen theme to denote how faculty began to look beyond themselves to the systemic structure of the SON. All session participants verbally agreed that implicit bias recognition and management is a competence that nursing students need to be introduced to while in nursing school. When the participants took on
the perspective of others, “lens of the student” for example, the impact of implicit bias provided an eye-opening learning moment. Faculty positioned themselves at the hidden structures that lie below the surface, well below the tip of the iceberg. Using premise reflection began to change their meaning perspectives as they ascertained why awareness of IB and mitigating its harmful effects are important for all stakeholders and the SON culture. Mezirow (1991) stated to change meaning perspectives, both competence and self-confidence are necessary, phase 10 of TLT. Foronda and colleagues (2021) added how differing perspectives and openness to unlike perspectives are foundational antecedents for cultural humility development.

The complexity of systems requires a wide lens viewpoint to clearly visualize there are multiple factors at play within the SON, with the individual being only “one piece of a much larger puzzle” (Hinnant-Crawford, 2020, p. 100). Individual bias is the micro-level consequence of systemic oppression (Love & Beneke, 2021). Premise reflection and openness to perspectives will be an ongoing professional development need for the nursing faculty. More likely, this can be achieved through “the accumulative result of related transformations in meaning schemes” that occur through content and process reflection (Mezirow, 1994, p. 224). Research has indicated positive outcomes with ongoing faculty development, curricular improvements, effective communication, and collaborative engagement (Forscher et al., 2017; Wesp et al., 2018; Sukhera et al., 2019a; Hagiwara et al., 2019; & Gonzalez et al., 2019).

**Hopeful Optimism**

The final theme derived from this study is hopeful optimism. This theme was more frequently coded to the White participants’ statements. As noted above,
hopelessness was expressed by P2 when considering the future of nursing and nursing education achievement of diversity, equity, and inclusive excellence. P4 stated, “I hope that I have grown.” She reflected on her work in DEI over the past few years but was disappointed that she “had not improved [her] implicit bias.” A couple of participants mentioned being optimistic about the next generation of nurses and beginning the work necessary to embrace DEI initiatives. Possibly that this could “shift the dial” towards more inclusivity. The hopeful optimism and energy for change are fueled through affirming conversations the participants had throughout the learning sessions. During Session #2, participants’ coded data noted increased openness, trust, and support. As they developed trust in one another, they felt comfortable in discussing topics related to their own bias. Admittedly, one participant reflected that there is resistance to change. Further, the willingness to openly discuss racism and racial bias remained constrained.

**Transformative Learning through Critical Self-Reflection**

The participants moved through phases in this study that matched Mezirow’s TLT. The data clearly aligned to the types of reflection they were using as they continued to be transformed. The most transformative changes started to be elucidated as the participants gained a wide lens viewpoint. They began to consider why a change in perspective is necessary and how this changed perspective led to a hopeful optimism. From the qualitative data analysis, three assertions (Figure 4.11) arise: communication, critical reflection, and affirmation. Table 4.6 displays the expression across study constructs and themes to align with the assertions.
Figure 4.11 Assertions from Thematic Analysis

Table 4.6 Thematic Expression using Study Constructs and TLT Reflections

<table>
<thead>
<tr>
<th>TLT Phase</th>
<th>Types of Reflection</th>
<th>Themes</th>
<th>Assertions</th>
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<tbody>
<tr>
<td><strong>Content:</strong></td>
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<tr>
<td>1, 2, 3</td>
<td>Racism, IB</td>
<td>Unknown identities</td>
<td>Communication as catalyst for awareness</td>
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<tr>
<td></td>
<td>Cultural humbleness</td>
<td>Racial disempowerment</td>
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<td></td>
<td>Cultural humility</td>
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<tr>
<td><strong>Process:</strong></td>
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<tr>
<td>4, 5, 6, 7</td>
<td>Exploration</td>
<td>Unknown impact</td>
<td>Critical reflection as transformative</td>
</tr>
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<td></td>
<td>Antecedents</td>
<td>Racial avoidance</td>
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<td></td>
<td>Self-reflection</td>
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<tr>
<td><strong>Premise:</strong></td>
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<tr>
<td>8, 9, 10, 11</td>
<td>Dialectical discourses</td>
<td>Wide lens viewpoint</td>
<td>Affirmation as fuel for humility</td>
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<td></td>
<td>Supportive engagement</td>
<td>Hopeful optimism</td>
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Summary

This chapter reiterated the study purpose in addressing the problem of racial implicit bias in nursing faculty. A brief overview of the methodology and the research procedures utilized was presented. The three research questions were answered using complex two-phase explanatory sequential mixed-methods action research with embedded instructional content across three team learning sessions. These sessions were combined with participant critical reflection journaling. This study determined nursing faculty: 1) IB attitudes, 2) degree of cultural humility, and 3) use of critical reflection in IB awareness and mitigation, along with enhancing cultural humility. Study findings were discussed in relation to the specific measurement tool and the qualitative questions.
Analysis of the qualitative data answered RQ3 and resulted in the following notable themes: unknown identities, unknown impact, racial avoidance, racial disempowerment, wide lens viewpoint, and hopeful optimism. Additionally, three assertions derived from the study to support achievement of increased inclusive excellence through team learning, communication, critical reflection, and affirmation. Ultimately, it is important to gently bring to the surface awareness of a need for change (Senge, 2012). Communication, then, became a catalyst for increasing awareness, sharing, and getting to know each other. Strengthening support and comfort within the small group discourse did not negate steering clear of racism or racial implicit bias discussions as faculty dug deeper and into the depths of their mental models. The use of critical reflection promoted a deeper awareness of study participants’ biases, how this affects others within personal and professional circles, and their intent to use what is learned in their daily practice as nursing educators. Affirmation of identities, impact, feelings, and the work of others towards DEI initiatives was powerful and fueled cultural humility outcomes and attributes in participants.

RQ1 was answered by the ATIBI and further explored throughout the qualitative data review and analysis. Overall, the ATIBI results indicated responding nursing faculty are mostly positive towards racial implicit bias content and instruction, with UR faculty scoring more positive than White faculty. All faculty agree it is important to discuss race, ethnicity, and culture but direct questions about racism within small groups during phase two were silently contemplated and unanswered. A follow-up question for clarity would need to include with whom this discussion is important, students or other faculty. Phase two journal reflections noted intense fear among White faculty of “being wrong,” “saying
the wrong thing,” and feeling “intimidated” by the study constructs. Lacking language skills to openly discuss racism and racial implicit bias hinders collaborative engagement nursing faculty can use for enhancing inclusive spaces, personally and professionally.

Overall, nursing faculty respondents are usually culturally humble (RQ2), with FT scoring higher than PT and Black faculty scoring higher than White faculty. However, of all mean scores, the lowest occurred in the perspectives factor, which are the antecedents of cultural humility. The lowest mean scores were noted in the perspective of historical precedent, power imbalances, situational context, and physical environment, especially among White faculty. Black faculty were more likely than White faculty to read the room (physical environment) and use situational context awareness when considering others’ perspectives.

Progression over the course of the team learning sessions and journal reflections, faculty demonstrated growth in openness, self-reflection, awareness of biases, focus on others, and supportive interactions. This progression supported enhanced perspectives, attributes, and outcomes of cultural humility. There remains a need for developing language skills related to racism and racial implicit bias. Ongoing critical reflection and supportive engaging relationships within the SON will be necessary for the reintegration of the new perspectives gained from this study. Discussion of the study implications for nursing education through the double theoretical frameworks, viewing the assertions through action research, and suggestions for future research will be presented in Chapter Five.
CHAPTER 5
DISCUSSION AND RECOMMENDATIONS

Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly affects all indirectly. Never again can we afford to live with the narrow, provincial "outside agitator" idea. Anyone who lives inside the United States can never be considered an outsider. (Rev. Martin Luther King, Jr., *Letter from Birmingham City Jail*, April 16, 1963, p. 2).

The above quote by Dr. King is as applicable today as it was sixty years ago. By not explicitly addressing the problem of racial bias unawareness in nursing and nursing education, an unfulfilled destiny persists whereby some, feeling like outsiders, long for a sense of belonging as valuable members of the nursing community. Until negative racial bias is recognized and removed the subtle exclusionary, white frame mindset will continue to influence the education of nursing students and, by extension, the patients and communities these future nurses will serve. This study supported existing research that UR nursing faculty also experience the impact of racial bias, whether intentionally inflicted or not. To reiterate P2’s comment, “[Colleagues] talk in meetings… they do not talk [to me]. They ignore me.” The research makes clear that exclusionary practices, driven by implicit bias unawareness in nursing education and nursing practice, perpetuate racism, microaggressions, isolation, loneliness, inequity, and lack of belonging (Graham et al., 2016; Hamilton & Haozous, 2017; Metzger et al., 2020; RWJF, 2023).
This chapter begins with an overview summation of the current study and concludes with a nursing faculty action research plan. Implications for nursing education are made plausible by threading this study’s assertions of communication, critical reflection, and affirmation, within relevant research literature and theoretical framing. Study themes will be embedded in this discussion. The action research plan discusses future study suggestions as well as potential professional development for nursing educators through socioecological systems leveling including micro-level (individuals, one-on-one), meso-level (groups, nursing schools/organizations), and macro-level (larger institutions, systems, and policies) (DeCarlo, 2018; Foronda et al., 2022).

**Study Summarization**

Nursing educators make a difference in the lives of their students, patients, and social circles on a daily basis. These experiences can leave lasting impressions. Under the broad conceptual umbrella of DEI lies the problem of negative implicit bias. The literature review made evident how IB penetrates many areas of societal existence and how negatively biased thoughts and behaviors impact the healthcare and well-being of individuals. Feasibility for this study's completion dictated a focus specifically on racial IB within nursing education, especially among nursing educators. Addressing the problem of racial IB in nursing education required faculty to acknowledge its presence and actively work to ameliorate its effects on all stakeholders. Enhancing cultural humility remains an area for further exploration in the development of inclusive educational spaces in nursing education, as both quantitative and qualitative data indicated the need for enhancement of humble perspective factors such as power imbalances and situational context.
Utilizing cognitive schemata to distinguish friend from foe and for categorization naturally creates an efficient thought processing, but when people are categorized, it precipitates stereotypical prejudiced discrimination (JC, 2016). Hidden racial implicit bias compromises nursing faculty's ability to change what they do not and, at times, what they refuse to see. The most impactful positive experience for any student is the perception "of being seen" and validated (Senge, 2012, p. 3). Raising nursing faculty awareness of hidden implicit biases is important because ignorance lends permission to outward expressions that have harmful effects on UR nursing students. Faculty must be made aware of their verbal, paraverbal and nonverbal messaging as they communicate with students, especially underrepresented students. Participants in this study were encouraged to embrace color consciousness (Delgado & Stefancic, 2017) and see students as unique individuals instead of based upon assumptions, categorizations, and presumed identities.

This study quantified nursing faculty racial implicit bias attitudes and perceptions of cultural humility. Qualitative case study results found that critical reflection positively affected four nursing faculty participating in team learning sessions in which they were briefly instructed on racism, IB, transformative learning, cultural humbleness, and cultural humility. I am optimistic about my personal efforts to continue work relating to IB awareness and mitigation but understand the reality and need for steady progress to yield the best results in change efforts (Evans, 2001). Quick fixes and rapid-fire problem solving may seem ideal on the surface but can cause more harm than good. These fixes may cause momentary resolution, only to resurface later with possibly a higher degree of urgency and potential insult. Such band-aiding perpetuates problems rather than
preventing them from occurring in the first place (Senge, 2012). Ignoring the diversity deficit completely is unacceptable. Complacency is condoning the systemic oppression within the culture of nursing and cannot be allowed to continue.

This study demonstrated that faculty awareness of their racial (and other) implicit bias and the negative impact IB has on UR students can begin the transformation of thoughts and actions. IB awareness and amelioration can create more positive educational experiences for all stakeholders. For example, outward expression through microaggressions can be eliminated using mindfulness (Ackerman-Barger & Jacobs, 2020). The team learning sessions proved to be a fruitful beginning for participants in the qualitative phase of the study. Faculty support was exercised because bias awareness without actionable processing for behavioral change can worsen biased discrimination by the dominant majority (Sukhera et al., 2019b; TOSU Kirwan Institute, 2018; Gonzalez et al., 2022). Hence, care was taken during the instructional team learning sessions and semi-structured interviews to level set communication and provide psychological safety for all in attendance. The four participants in the team learning sessions provided rich data upon which to draw conclusions that critical reflection can be effective towards positive change in nursing faculty perspectives related to racial implicit bias. Also, faculty use of critical reflection became transformative for participants and aided cultivation of cultural humility which supports inclusive excellence.

**Implications for Nursing Education**

The reviewed literature provided the historical deep roots of nursing’s white frame that has continued to blind both the education and the profession of modern nursing to the negative effects of racial implicit bias. If racial implicit bias is not
recognized and mitigated in nursing education the consequences will continue to extend beyond nursing students. The missed opportunity for individual students to gain a rewarding profession and for diverse voices to be heard is devastating to increasingly diverse communities. Unsuccessful nursing student program completion has an additive effect on the ongoing nursing shortage and financially burdens students secondary to program costs without gainful entrance to the profession (Merritt, 2021; Turner & McCarthy, 2017). The study assertions provide implications for nursing education to begin the journey towards breaking down barriers, unframing nursing education’s whiteness, and creating inclusive spaces for all stakeholders.

The team learning sessions led to rich data that brought forth themes that demonstrated progression across Mezirow’s phases of TLT as presented in Chapter Four. From the qualitative data and the resultant themes, three assertions are made. These assertions propose that communication acts as a catalyst for awareness, critical self-reflection on assumptions transforms those determined to dig deep within their true selves, and affirmation of identities and social justice efforts fuels progress toward inclusive excellence.

**Communication and Culture**

The disorienting dilemmas (Mezirow, 1994) that entailed unpacking who we are and exposing our vulnerabilities were unsettling to participants, to say the least. When critical racial conversations need to be had, there is a delicate dance that takes place whereby dialoguers attempt to not step on each other’s toes. Why must we carefully “dance this dance?” It is often necessary due to the fragile self-concept many people have of their racial identities, especially the fragility seen among dominant Whites (DiAngelo,
Listening more and talking less (Zepeda, 2019) enforces humility as to the realities of others. Additionally, racial humility leads to openness in understanding perspectives of all members within diverse groups (DiAngelo, 2018). Being reactive instead of proactive in dealing with racial injustice and inequitable practices leaves a bad taste in the mouths of everyone. But I caution against sugar coating to make these conversations easier. These conversations are necessarily complex. It is vital to lean into the difficult conversations and the willingness to experience the discomfort that comes packaged with these conversations (Ngounou & Gutierrez, 2017). Arguably, this openness to complex conversations dictates that nothing be taken personally. After all, an outcome of cultural humility is supportive interactions (Foronda, 2021). In the team learning sessions, we agreed that we were all learners and grew in our openness to others’ perspectives.

During semi-structured group interviews that followed the brief instructional sessions, a noticeable spark occurred as the group increased knowledge of their own identities and the identities of the other participants. Through group communication, they realized they were alike more than different, with the exception of how racial differences impacted individual experiences and expression of those experiences. Unknown identities cause one to look only at the outward appearance and make assumptions. These assumptions then lead to biased thoughts about what is seen that may not be accurate to the individual, which leads to discriminatory behaviors.

I could see how the team learning sessions were changing the discourse patterns of the group. Initially, the White participants were hesitant, fearful, and closed to open expression. The avoidance of racial discussions was evident as I had to redirect the group
at times back to the study constructs. However, dialogue was mostly allowed to progress among the participants so as not to disrupt the openness and flow. The free-flowing discourse cast a broader net into perspectives that were not directly a part of the study constructs, such as ageism, gender identity, and sexual orientation.

As the sessions moved along, all participants expressed cultural curiosity as they desired to learn from, and about, others. Additionally, the newfound knowledge, skills, and attitudes to recognize biases in themselves and others increased boldness to question the larger systemic structure of the SON, such as admission into nursing programs. Participants questioned why age, gender, and race were visible on prospective applicants’ documents when such information can bias admission decision making (Noone & Najjar, 2021). Additionally, participants sought to have conversations and connections with others that were racially or ethnically different. P4 demonstrated this curiosity and boldness in her efforts to seek how to best support an UR graduate student who expressed feeling as “an other” because the majority of nurse preceptors were “mostly blonde and blue-eyed.”

Both critical race theory (CRT) and transformative learning theory (TLT) support narratives and storytelling as integral methods by which people share their lived experiences and reflect on communication with others. Ladson-Billings and Tate (1995) explained CRTs healing narrative disrupts the “mental health violence towards oneself” (p. 57) through the telling of one’s story, which can also affect the oppressor by connecting situational realism to the experiences of others. During the team learning sessions and throughout the journal critical reflections, each participant shared their individual stories, as well as how they were impacted by the stories of others. Their
narratives, presented in Chapter Four, were personal and evocative. Mezirow (2003) added that contextual understanding of what is being communicated is important on a grander scale when considering critical discourse:

As economic, social, and psychological conditions fostering social justice are essential for inclusion in effective critical-dialectical discourse—the process by which we come to understand our own experience—overcoming the threat of exclusion constitutes a significant epistemological rationale for adult educators to commit themselves to economic, cultural, and social action initiatives. It is important to understand that the only alternatives to critical-dialectical discourse for assessing and choosing among beliefs are the appeal to tradition, an authority figure, or the use of force. (p. 60)

Participants learned that they were not alone and felt supported through team learning session discourse and dialogue. The openly shared stories affected participants as they recognized similar progression in their transformation. They became more attuned to their racial (and other) bias and the impact of bias as it manifests in subtle ways. TLT posits how discourse validates what is being communicated and learners assess competing interpretations by critically examining alternative points of view (Mezirow, 1997). The participants began to renegotiate relationships and build new perspectives with confidence as they moved through the phases of transformation (Mezirow, 1994).

The final team learning session content centered on how nursing faculty communicate with students and how this communication can enhance cultural humility. I found it necessary to bring to the forefront how messaging influences our ability to recognize, reflect, and integrate the principles of cultural humility. Entering nursing
education and the profession adds to what I call the language of marginalization for racially and ethnically diverse individuals. Nursing inherently has its own unique lexicon and medical terminology not part of common discourse. Not only do UR students need to navigate nursing culture’s white framed dominance, but also the unique language that may be quite different from their known, everyday language. Figure 5.1 demonstrates messaging and the end result of cultural humility as presented in team learning Session #3 using recognition, removing, and replacing steps needed for change.

**Figure 5.1** Communication Messaging and Cultural Humility

**Critical Reflection**

As the previous section noted, communication was the needed catalyst to move participants towards better understanding of the study constructs. Participants’ critical reflection journals and team learning transcripts demonstrated how unknown identities precipitated racial avoidance and how discomfort with racial discussions exacerbated discourse avoidance. Utilizing critical reflection, participants began to move out from themselves to consider the perspective of others. While Gambrell (2016) argued that TLT alone is not enough for full social justice transformation as it focuses too much on the individual and on adult learning, Kitchenham (2008) reasoned that Mezirow’s inspiration from Freire and Habermas supported emancipatory learning. The systemic critical self-
reflection on assumptions (CRSA) helps one recognize the “taken for granted cultural systems” and encourages collaborative social action (Mezirow, 1998, p. 193). My decision to integrate CRT tenets added social justice context needed to address nursing faculty implicit bias and theoretically justified use of CRSA supported highest level of transformation in learning focused on the premise behind participants’ thoughts and actions (Mezirow, 1998).

The stark difference between Whites in the study and the Black faculty keenly exposed the ignorance of how race impacts movement through society. P2’s statements were coded as racial disempowerment as she fears racism and racial implicit bias “won’t change” in her lifetime. P2’s statement rings clear that the blind privilege of others who “do not see they have privilege” are emboldened to blindly (or openly) use this privilege for their own advantage. In the qualitative study by Gambrell (2016), similarity is noted in how “persons in positions of privilege… had difficult cognitive and emotional work to break free of prejudiced ways of seeing the world” (p. 112). In the current study, the White faculty had a level of racial ease and racial comfort that was unrecognized and unappreciated (DiAngelo, 2018). They had to experience the disorienting dilemmas associated with the ladder of inference example and the completion of the IAT to understand the previously unknown impact on UR students and their implicit perceptions of race. Using CRSA in their online journals, White faculty were able to grapple with their feelings and perceptions safely and process the previously unknown impact of racial implicit bias.

Using a critical lens means not taking for granted what is within view and analyzing all sensory input for possible faulty interpretations. It also means remaining
skeptical, questioning the larger system that impacts our lives. Mezirow (1998) posited that critical reflection can change frames of reference, of which points of view were considered most malleable. Data from the team learning sessions supported Mezirow’s TLT as faculty moved through the phases of transformation. The addition of learning through emotional experiences such as the LOI, IAT, and sharing of personal stories facilitated decision making to change points of view. Another helpful exemplar, similar to McIntosh’s (1989) invisible knapsack, was the backpack of experiences that everyone carries with them. Inside of our backpacks are our individual stories. The backpack metaphor was especially impactful for P3, who struggled the most throughout the sessions, vacillating between guilt at being White and seeing the big picture of sociocultural impact of biases. The backpack validated for her that everyone’s story is different and adds meaning to why we think and act in the manner in which we do. P3’s reflections helped her effectively dialogue within the group about “issues that must be understood and resolved” (Senge, 2012, p. 115).

Tying exemplars to emotion and relaying that participants needed emotional stamina to believe they could reach “reflectively redefined goals” was helpful in moving towards change (Mezirow, 1998, p. 190). Again, I remain optimistic, but reiterate here that the task of IB mitigation is not easy and requires ongoing work for long term successful change (Evans, 2001; Lai et al., 2016; Forscher et al., 2017). Ideally, using communicative learning assisted the participants in this study to “become critically reflective of the assumptions underlying intentions, values, beliefs, and feelings.” (Mezirow, 1997, p. 6).
**Affirmation**

To deny or challenge the existence of something is the opposite of affirming its existence openly and publicly (Merrium-Webster, n.d.). The participants in this bound case study were brought to the depths and origins of their thought processes. They had to look inside their backpacks with a critical lens to better understand how their identities and lived experiences shape their experiences and perceptions. When the participants utilized affirmation, I recognized this as fuel that created energy for the difficult discussions and tasks required of them in this action research. Participants gained an appreciation for differences and similarities among the group. They began to learn each other’s stories. The power of affirmation to enhance cultural humility, especially in regard to respect, partnerships, and supportive interactions with others became evident in their discourse and reflections (Foronda et al., 2021).

The study themes of *wide lens viewpoint* and *hopeful optimism* fall under this assertion. TLT posited how learners will try out new roles, relationships, and build competence and confidence as they reintegrate this new perspective in their daily lives (Mezirow, 1994). Faculty in this study used premise reflection leading to the most transformative changes in their perspectives (Mezirow, 1997) as they began to use a wide-angle lens. White faculty viewpoints shifted from themselves and their inner circles towards a larger sphere, widening their viewpoints. I analyzed participant discourse and coded it as hopeful optimism for the future of nursing to fully embrace the principles set forth in the DEI initiatives.

On the contrary, P2 most often reflected outwardly. She turned the lens beyond the circles in which she engaged and beyond the walls of the SON. P2’s comments and
analysis were concordant with quantitative data among Black respondents in this study who were more likely to read the room and physical environment, while also considering the situational context. P2 was not as hopefully optimistic about nursing’s future integration of DEI. However, she reflected on how she was impressed by another graduate faculty member who was advancing diverse differences with graduate students. P2 reflected, “I have a new appreciation for her.” P2 openly commended this faculty member’s efforts in Session #2. P4 thanked P2 for her comments and expressed how much this meant coming from a well-respected member of the faculty. Likewise, P4 reflected in her journal, “For the first time, I heard some positive affirmations from one of the other participants.”

The assertions have overall implications for nursing educators to utilize effective communication in a safe dialectical discourse that embraces all perspectives. We cannot assume the realities of others. Learning of others’ perspectives is the first step towards enhancing cultural humility (Foronda et al., 2021). Critical reflection is highly effective in getting to depths of assumptions and to consider the premise behind why we think and behave in the manner in which we do. Finally, affirmation is a powerful tool that helps everyone enhance cultural humility by focusing on and empowering others, working towards a mutual goal through supportive engagement and partnerships (Foronda et al., 2021). The action plan discussed next will describe professional development for nursing educators as well as action for schools of nursing to challenge the status quo that will help the nursing profession achieve its destiny of inclusive excellence.
Action Research Plan Thematic Alignment and the 3Rs

Action research is driven by a local problem, engaging local participants, whose highly valued knowledge gains may be applied beyond an immediate setting (Herr & Anderson, 2015). Keywords to describe action research (AR) include participative, reflective, cyclical, and value laden. Efron and Ravid (2020) provided the benefit of using AR to solve problems in practice includes research conducted by "insiders" who understand the unique context driving the need for change. The reflective nature of AR leads to its cyclical nature, which provides a richer and more meaningful action to address problems in particular settings. Herr and Anderson (2015) further stated that cyclical reflection increases AR's value, as the researcher and the participants are not separated but are fully engaged in the research process.

Figure 5.2 is a visualization of study assertions and thematic integration of the unknown identity and impact, racial avoidance and disempowerment, wide lens viewpoint, and hopeful optimism in a cyclical balancing action research loop. The 3Rs are purposefully repetitive and cyclical (Fitzmaurice, 2017), mirroring the cyclical nature of action research to ensure a continual improvement in practice and “betterment of the world” (Beaulieu, 2013, p. 32) by “improving quality of human life, acquiring knowledge to become better practitioners, and developing strategies to address problems” (Beaulieu, 2013, p. 33). Fitzmaurice’s (2017) 3Rs add extra leverage for mitigating the negative effects of implicit bias, enhancing cultural humility, and supporting inclusive excellence.
Recognize, Remove, and Replace

Recognizing that increasing DEI, mitigating implicit biases, and cultivating cultural humility are imperative to strategically preparing 21st century nurses in a multicultural, diverse society, nursing programs need to accelerate efforts aimed at these directives. Echoing Hinnant-Crawford (2020), “We have common problems in unique contexts” (p. 189) with “competing priorities” (p. 190), but there is much work to be done within and outside the walls of nursing programs. Of course, complete removal of IB is unrealistic; however, removing its negative impact is possible. This can only be done by first recognizing its presence. We cannot change what we refuse to see (DiAngelo, 2018).

With removal, there must be a replacement to fill the void (Fitzmaurice, 2017). Herein lies the suggestion to replace the void with enhanced nursing faculty cultural humility.
**Recognize**

Fitzmaurice (2017) described the necessarily cyclical nature of the 3Rs to solve problems so that one is constantly vigilant to recognize issues as they arise. Additionally, recognizing a problem creates a target removal (Fitzmaurice, 2017). It is said that ignorance is bliss, but I would add ignorance is also dangerous. Ignoring a change in a mole does not make the mole improve or go away. In fact, ignoring the signs of potential skin cancer can lead to metastasis whereby the cancer spreads beyond the original tiny mole. The same holds true for ignoring racism and racial implicit bias in nursing education and the insidious spread, taking root in sociocultural structures of nursing programs. The harm an individual experiences from racism and IB leaves an indelible impression.

Recognizing IB requires the acquisition of knowledge, sensitivity, and awareness. Hinnant-Crawford (2020) described the two types of knowledge: content matter expertise and “knowledge of how to improve” (p. 29). Having knowledge of needed change or systemic issues without action is for naught. The action plan begins at the individual microlevel through communication as a catalyst for awareness and change.

**Remove**

Vigilant repetition is necessary during the removal step (Fitzmaurice, 2017). Habits of mind are durable and difficult to change due to sociocultural, psychological, economic, political, etc. influences (Mezirow, 1997). Therefore, without addressing problems that are recognized they become solidified in the habits of mind (Fitzmaurice, 2017). Harkening back to the mental models and schemata of cognitive processing assures those seeking to uproot any deep-seated problem, much effort will be required
(Senge, 2012). It will be difficult to break through long held beliefs, assumptions, and mindsets without raising desirability for change. To challenge the status quo, it will be necessary to elevate dissatisfaction with the diversity deficit and insufficient inclusivity in the SON (Evans, 2001). Reinforcing understanding of IB and how it subtly manifests and negatively impacts others will keep the issue at the forefront. Relating the tenant of nursing as caring and compassionate as discordant with racism and IB should raise accountability for mitigation and removal.

**Replace**

Nursing faculty need relevant professional development (PD) to increase awareness of biases they bring into the classroom and the diversity deficit that impacts the specific experiences of UR students and the curriculum. The complexity of systems require a wide-angle lens to clearly visualize there are multiple factors at play in the educational system, with the individual being only “one piece of a much larger puzzle” (Hinnant-Crawford, 2020, p. 100). Individual bias is the micro-level consequence of systemic oppression (Love & Beneke, 2021). Actions for the greater good should be essential and relevant, without disregarding the struggles (the -isms and the disparities) facing many people in society by those who try to maintain power, order, and control (Brookfield, 2004).

By no means should educator agency be reduced. If nursing faculty do not have input, they lose agency (Zepeda, 2019). Raising the agency of educators will increase their likelihood to change and accept risks, such as stepping outside of their comfort zone to integrate DEI and cultural humility precepts in class and clinical rotations. Nursing faculty agency is enhanced by seeking to improve nursing capacity as a change agent.
The ongoing work is important to avoid the notion of “one and done” mentality (Zepeda, 2019). Hinnant-Crawford (2020) eloquently commented, “Equity is a long game; it is easy to feel tired, fatigued, and defeated when you look narrowly at your plan…” (p. 100). In the following detailed plan, I urge nursing faculty to look with eyes wide open in full awareness of “whatever affects one directly affects all indirectly” (King, 1963, p. 2).

**Envisioning Nursing Education’s Inclusive Destiny**

This study focused on micro-level changes in individuals that were willing to participate in team learning sessions. Knowing that educators have an important role in much more than what goes on inside the classroom, I felt the need to focus firstly on nursing faculty. Creating and implementing a solution to a problem will only be embraced if it is useful and if the solution has implementor input (Evans, 2001). Understanding of the context and needs of learners, educators, and all stakeholders is necessary to reach intended outcomes. The complexity of organizational change, especially in education, is achievable when moving beyond procedural processes to the psychology of change (Evans, 2001). Change agents need clarity in their intent and be willingness to lean into difficult contexts that affect students outside the walls of educational institutions (Fullan, 2020).

This action plan has three broad phases, beginning with micro-level changes, creating a core group of change agent champions, and the implementation of cognitive coaching model to support sustained change. Building upon the ripple effect that change agents create, meso-level changes widen the view to groups such as the nursing faculty organization as a whole and interdisciplinary learning within the College of Health and Human Services (CHHS). The final phase will extend further into macro-level activism
acutely attuned to policies and procedures of our university as well as state legislative bodies such as the board of nursing and state legislatures. The cyclical nature of action research recognizes that not everyone will be at the same phase, but that all will be supported no matter where they are in their willingness to participate.

**Phase 1: Building Nurse Educator Capacity for Change--Agency**

The goals of Phase 1 are to build nurse educator capacity for awareness and mitigation of IB and enhancement of inclusive excellence. To champion these DEI initiatives, it is important to begin at the individual micro-level. In the current study, the interventional group was intentionally small to create safety and intimacy whereby participants did not feel overwhelmed as they grappled with complex content. This helped the group to learn about each other and themselves, developing vital personal connections that will hopefully last in the long term. “Real change is always personal” (Evans, 2001, p. 299). Several micro-level strategies for IB mitigation were offered in Table 2.1, Chapter 2.

Phase 1 will continue to deploy the team learning sessions in small groups of no more than four, with the same content and use of personal online critical reflection exercises. Another standalone workshop will focus completely on cultural humility enhancement. This workshop is advised to be taken after completion of the original team learning sessions. The necessity of this workshop derives from Cultural Humility Scale data, especially Factor 1: Perspectives as it relates to historical context, situational awareness, and power imbalance (Foronda, 2020). Qualitative data also indicated this as a need for faculty as participants were unaware of the movement away from the unobtainable cultural competence to cultural humility.
Since our nursing program is approved for granting continuing education credit, I plan to partner with the Strategic Partnership Coordinator within the SON to give faculty professional development credit for engaging in the sessions. Additionally, adding a coaching model will support long term nursing faculty development through designating content champions who coach other nursing faculty towards achieving Phase 1 goals.

**Education Planning Using Cognitive Coaching**

Job-embedded professional learning takes into consideration what nursing faculty already know, what they desire to know, and what is applicable and relevant to daily practice (Zepeda, 2019). Cognitive coaching can be embedded into the peer evaluation process that is already used in the SON to limit faculty burden while adding one on one support. Figure 5.3 provides a schema of how to integrate the coaching model into messaging. Modeling communication in this manner integrates cultural humility development, recognizing attributes and assumptions, with communication messaging as shown in Figure 5.1. Cognitive coaching seeks to develop trusting relationships between the coach and coachee, promoting movement toward expectations and goals with the belief that “anyone can change” and improve their “cognitive processes…and teaching behaviors” (Zepeda, 2019, p. 114-115).

Literature on coaching model implementation in nursing education is sparse, however, mentoring for both novice educators as well as seasoned educators who join a new institution is more common. Hom (2003) described mentoring and coaching as “intertwined” (para. 21). In speaking with a secondary school instructional coach, she poignantly agreed, “One can be a mentor without coaching, but cannot be a coach without mentoring” (C. Edwards, personal communication, April 30, 2023). Coaching is
developing a partnership between the coach and the coachee (learner) who devise a plan together through mutual understanding and goal setting (Diak et al., 2020). Using cognitive coaching as a professional development framework for advancing complex DEI initiatives can prove successful.

![Figure 5.3 Cognitive Coaching Schema](image)

The cognitive coaching schema (Figure 5.3) is to be used by the coach not only as a peer evaluation guideline, but also for the coach to model and mentor the coachee. For example, the coach will develop rapport with the coachee being mindful of how messaging is coming across to the coached faculty member. During the pre-observation session, the coach will listen closely and ask open ended questions to assist the learner to see their own attributes (Diak et al., 2020) in relation to cultural humility attributes of openness, self-awareness, egoless, supportive interaction, and self-reflective with introspection (Foronda et al., 2016).

During the observation of educators, the coach will monitor messaging occurring in the class. Diverse nursing students endure verbal and nonverbal slights known as microaggressions stemming from implicit bias and lack of cultural awareness (Ro & Villarreal, 2021). Therefore, nonverbal, paraverbal, and verbal messaging should be noted, and feedback provided for improvement as needed.
Coaching in nursing could prove especially helpful as it involves interpersonal engagement, personal self-knowledge, and professional support to achieve an end outcome through a structured process (Costeira et al., 2022). During the post observation conferences the coach models and mentors the nursing faculty by using reflective questioning, paraphrasing, accepting, clarifying, and using silence at appropriate times to listen attentively (Zepeda, 2019). The trust built between coach and coachee will support the honesty necessary to work towards mutual goal of inclusive excellence.

**Phase 2: The Ripple Effect and Organizational Change--Engagement**

Increasing educator motivation towards achieving learning community goals through interdisciplinary education requires leadership support for finding time for professional development and support faculty need to sustain the change (Penuel et al., 2020). During Phase 2, the action plan extends out into the nursing Faculty Organization group (all nursing educators and staff) within the SON and interdisciplinary learning throughout the CHHS. While micro-level is individual and personal; meso-level change is “organizational change” and “is always incremental” (Evans, 2001, p. 299). Zepeda (2019) described a “leadership for learning” (p. 204) that empowers educators by building their capacity for effectiveness and moving towards a more collaborative culture where “leaders engage as learners alongside their faculties” (p. 205).

Leaders and committee chairs are recommended to add DEI as a standing agenda item. In the CHHS, placing a standing item on the All-Colleague meeting agenda as well as the Faculty Organization monthly meeting will keep this information on the forefront. Items for discussion should include policies and procedures at the organizational and college level that impact inclusive excellence and DEI initiatives. Cultural humility
allows for openness to “questioning current practices and proposing changes to improve the efficiency and quality of care, equality, and social justice (NASEM, 2021, p. 207).

Collaboration among educators and leaders is beneficial for many reasons. The development of trust, collegiality, and support aids professional development by increasing both faculty agency and self-efficacy (Zepeda, 2019). There are many times faculty feel isolated. This can be especially damaging to developing new nursing educators. Using interdisciplinary learning is a key component in 21st century healthcare provider education. The *Future of Nursing* (2021) expounded upon nine recommendations and several research priorities that included workforce development, health equity, public health, and nurse well-being to create a nursing workforce that is a: stronger, more diversified workforce that is prepared to provide care; promote health and well-being among nurses, individuals, and communities; and address the systemic inequities that have fueled wide and persistent health disparities (NASEM, 2021, p. 355).

Phase 2 will support achievement of the Future of Nursing recommendations by incorporating several educational opportunities to bridge the divide between the multiple healthcare programs within the CHHS. Accelerated learning related to IB and its negative impact while enhancing cultural humility can be achieved through “networked communities” (Hinnant-Crawford, 2020, p. 41). Recalling that “we have common problems in unique contexts” (Hinnant-Crawford, 2020, p. 189) demonstrates the necessity of providing DEI educational opportunities across disciplines. As a college, we can approach racial implicit bias together and therefore begin to influence and level set a culture of inclusive excellence within the CHHS.
There are several ways to achieve organizational change. These suggestions are recommended for faculty and staff but could be offered to students as well. Ideally, students may feel comfortable being in their own group of peers and not blended with faculty and staff. The first suggestion is to invite one member from each college to be an agent of change, willing to attend the same team learning sessions provided within the SON. The current study has provided the experience necessary to facilitate such learning opportunities. These change agents can then impart the information within their respective colleges as a change agent champion.

Secondly, the use of interdisciplinary simulation exercises creates a learning community focused on the mutual benefit of inclusive excellence. These clinical simulations should ideally include standardized patients, which are actors who authentically portray a patient during healthcare scenarios. Faculty and staff should participate in these, along with student nurses in both undergraduate and graduate programs. Simulation provides safety in a complex task, such as dealing with the knowledge and skills using the ARISE method for bystander training (Ackerman-Barger, Jacobs, 2020) and allyship (Pusey-Reid & Blackman-Richards, 2022).

Finally, implementing a voluntary book study group for faculty and staff within the CHHS that addresses specific areas of focus on DEI initiatives. This idea has already been discussed with the Assistant Dean of Inclusive Excellence, who is willing to liaison with CHHS leadership in support of this effort. The first book will be Sensoy and DiAngelo’s (2017) *Is everyone really equal? An introduction to key concepts in social justice education*. This book provides end of chapter discussion questions that would be great to delve into social justice concepts in a methodical, orderly manner. This text could
provide the knowledge and language skills necessary to embolden allies to champion DEI initiatives, of which IB is just one area of concern. I would eventually like to explore White advantage using DiAngelo’s (2018) *White fragility* and a more antiracism activism approach through Bonilla-Silva’s (2014) *Racism without racists*. Participants will need time to process and dialogue through the book study. Sukhera and colleagues (2019b) have found that the most effective method for dealing with complex DEI issues is facilitated reflective debriefing in a safe environment. These sessions can be a hybrid of in-person and virtual discussions with the addition of reflective journaling. Reflective journaling would support subjective reframing of habits of mind and encourage premise reflection leading to the most transformative learning (Mezirow, 1998).

**Phase 3: Revisiting the Power of Policy Mandates--Advocacy**

Macro-level changes occur at the policy and procedural level. Educators need to understand the inherent power policies and policy making process have over institutions and individuals. Fowler (2013) relayed that lack of knowledge regarding policies initiates a “reactive rather than proactive” (p. v) stance whereby those responsible for implementing stumble around blindly, scrambling to maintain accountability to meeting a predetermined standard. Higher level policy mandates are usually written broadly and then interpreted locally through institutional policies (Hinnant-Crawford, 2020). Phase 3 of the action research plan branches out towards external, larger forces that impact the SON by focusing on the legislative system. Nurses are active in this socioecological level through advocacy work in various areas that are either personal (volunteering or assisting in health equity groups) and/ or professional (licensure, legislation, or nursing education).
Recall, an individual's cultural default influences biases and as such, support for change is only easily achieved or sustained with the assistance of societal macro-level institutional and policy changes (APA, 2022). Examples of a rapid shift in cultural viewpoint have occurred in anti-gay bias reduction due to legislative changes supporting equal rights in this marginalized group (Charlesworth & Banaji, 2022). When participants in the current study reflected on the premise behind biases and the impact on UR students, they gained a wider viewpoint that helped see systemic structures that perpetuate the marginalization of UR individuals. Having a narrow view limits the discernment of the interplay of the many variables involved in the larger system (Hinnant-Crawford, 2020).

Relating this research and work from a legislative lens is to illuminate how state policy makers are introducing, with some signed into law, legislation prohibiting or banning DEI offices, education, and efforts across the nation, with Florida and Texas having the most restrictive laws (Chronicle Staff, 2023). In the University of North Carolina System, applicants are no longer required to submit a statement with their application about how their work would advance DEI (Chronicle Staff, 2023). In addition, the recent Supreme Court decision to ban colleges and universities from using race in the admissions and applicant process upended decades of progress made towards equitable opportunities for UR individuals in education and employment (Gonzales, 2023). These legislative trends add urgency to the need for macro-level nursing educator activism to prevent rolling back progress made toward inclusive excellence in healthcare education and diversification in nursing programs, which ultimately impacts diversity within the profession.
Progress met with reversal is not surprising in anti-DEI initiatives. The late Derrick Bell, whom many consider the godfather of CRT, was thought to be a pessimist who doubted that there would ever be racial equity achievement was actually realistic in his understanding of how the system fights back against racial equity progress (Cobb, 2021). Bell (1992) sought not to bring about “despair” through truth telling that racism is “an integral, permanent, indestructible component of this society” (p. ix), but rather as an empowering opportunity to see that if the enslaved “survived the ultimate form of racism,” social justice champions should “at least view racial oppression in its many contemporary forms” (12). Knowing the normalcy of racial climate vacillation and shifts from either seemingly supportive in interest convergence or complete reversal and pushback when there is hint of progress towards racial equity should encourage advocacy and stamina in those seeking to not lose ground on these issues (Cobb, 2021).

Baccalaureate and graduate nursing programs have an advantage to prevent legislation that undermines DEI efforts. The American Association of Colleges of Nursing (2021c) publication, *The Essentials: Core Competencies for Professional Nursing Education* will require every Commission on Collegiate Nursing Education accredited SON to adopt a competency-based curriculum to prepare future nurses to be practice ready. Included in the *Essentials* are ten domains (ranging from knowledge in nursing to professional leadership) and eight major concepts including clinical judgment, social determinants of health, and DEI explicitly naming IB, among others (AACNc, 2021). Furthermore, educational and professional integration of DEI and cultural humility is supported by national nursing professional organizations (AACN, 2021c; NASEM, 2021; ANA, 2022; NLN, 2017). The AACN core competencies dictate
that nurses be prepared to openly address race, racism, and systemic inequities by first raising awareness of their own IB so that they can be better positioned to act “as stewards of the profession, they can fulfill their responsibility to influence both nursing and societal attitudes and behaviors toward eradicating structural/systemic racism and discrimination and promoting social justice (AACN, 2021c, p. 6).

Action in Phase 3 includes increasing awareness of state and local legislative body decisions by previewing agenda items and monitoring anytime DEI efforts are brought to committee work for discussion. Legislative representatives may not be aware of nursing standards and practices that explicitly require DEI curricular integration. Each nursing program should have a dedicated faculty member who attends the state board of nursing meetings as well as preview state and national legislature trends. According to Curley and Stone (2023), there are 68 nurse legislatures in 34 states, but nationally there are only three nurses in the House of Representatives and no nurse has ever served in the U.S. Senate (Summers & Gordon, 2022). Summers and Gordon recommend nurses be informed and vote for matters closely aligned with the profession, be encouraged to run for state and national legislatures, and collaborate with others to win a legislative seat. In North Carolina, there are five nurses who are in the legislature and two nurse lobbyists (NCNA, 2023). Connecting with state nurse legislatures will help maintain a reciprocal awareness of how anti-DEI legislation would conflict with state boards of nursing, nursing academic standards through AACN, and program accreditation through CCNE. I challenge every nursing program to know who their nurse legislature liaisons are and how to contact state nurse lobbyists.
Thus far, a summarization of the study and implications for nursing practice have been presented. A phased and socioecological systems leveling action research plan is provided including activities that begin with the individual awareness and development which ideally ripples outwards into the institutions in which nursing educators practice. The increased knowledge and skills can assist nurses and nursing educators beyond the micro and meso-levels into the larger sociopolitical structures of legislative action. Nurses are urged to use their power of advocacy to become involved in maintaining DEI efforts at the state, and possibly national, level.

Unframing the Whiteness in Nursing Education

Prior to summarizing this chapter, it is important to circle back to what this study adds to the current literature and why it is time to unframe the whiteness of nursing. Dr. King’s quote at the beginning of this chapter described all of humanity’s deep connection that is inescapable and destined to remain intertwined. In this study, participants, including myself, recognized our common thread of nursing compassion and caring. These tenets in nursing are undeniable. Echoing Dr. King, nurses are tied together in altruistic giving of ourselves to others on a daily basis—no matter who the other person is, their religion, color, or creed. Yet, the white framing continues to hold the dominant mindset of the status quo, whether purposeful or not. What is known is that racial IB is insidious and creeps down to the depths of our mental models, through our sociocultural experiences, and causes practitioners to think and behave in ways that are contrary to the health professional ideal (Zescott et al., 2016).

It is time to completely unframe the whiteness that pervades nursing education and the nursing profession. First, this study offered strategies to equip nursing faculty
with the knowledge, skills, and attitudes necessary to manage and mitigate negative IB. By recognizing and removing the negative IB impact, nursing education and the profession can move towards inclusive excellence. Faculty will then be equipped to impart this knowledge to their students through modeling and mentorship. Second, by raising awareness of IB, it is possible to remove the colorblind mentality by adopting CRT’s color conscious perspective (Delgado & Stefancic, 2017). It is okay to “see color.” To not see color is to invoke the invisibility that UR students and faculty have been subject to under the white frame in nursing education. When colorblindness is made acceptable, it permits “redress [of] only extremely egregious racial harms, ones that everyone would notice” (Delgado & Stefancic, 2017, p. 27).

Nurse educators are challenged to not be afraid, but step boldly towards shedding of the ego in the service of others (Foronda et al., 2016). It is not about the self or our individualism. DiAngelo (2010) stated it best, “Discourse of Individualism is one of the primary barriers preventing well-meaning (and other) white people from understanding racism” (p 1). Nursing has always been about others in the provision of selfless, compassionate care. It is time that we fully achieve nursing’s inclusive destiny where indeed all are welcome, and all are assured they belong.

**Conclusions and Summary**

Several conclusions are derived from this tremendous work and research. Nursing’s historical white framing continues to influence the culture of how future nurses are educated and welcomed into the profession. Framed in this manner, nursing education is dominated by the white perspective. This dominant perspective must be interrogated under a continual spotlight. The myth of meritocracy blinds the dominant majority to the
experiences, oppressions, and burdens of marginalized groups (DiAngelo, 2010). Paradoxically, effort does not ensure equality or equitable opportunity for UR people in society. Those with racial comfort fail to "see" the impact of these firsthand experiences.

Faculty are urged to “see” their students beyond mere academics. Saying “I do not see color” is colorblindness. Actively engaging in cultural and color consciousness is important to decreasing faculty blindness to racial and ethnic differences for the sake of maintaining the rigid nursing culture standard. Intersectionality speaks specifically to the marginalization of UR based upon gender (females) and race (Blacks), adding additional burden that Whites will never experience. Everyone has intersecting identities, but race intersecting with other identities shapes experiences uniquely for those in marginalized groups (Crenshaw, 1991). Denying racial differences attempts to “see” everyone as the same (Ackerman-Barger & Hummel, 2015) and upholds the dominant white frame. Affirming who one is, the work they do, and how they fit in the puzzle that is a complex and diverse society fuels cultural humility that can replace the exclusionary mindset.

Cultural humility decreases IB, opens learners to other perspectives, and improves dialogue and discourse while creating partnerships that work towards mutual benefit (Foronda et al., 2021). Zepeda (2019) stated that a culture of humility is when everyone is open to learning from and about each other. Doing so helps to build trust, collaboration, and engagement. In healthcare, research has found that health inequities occur when patients mistrust their providers, communication is poor, and dissatisfaction reduces patient-provided engagement (Zescott et al, 2016; Hagiwara et al., 2019; Maina et al., 2018).
Both diversity deficit and inclusive insufficiency will continue to limit the rich depths that multiple diverse perspectives can bring to nursing education and the professional practice of nursing. The effects of these deficiencies are far reaching, especially the healthcare needs of diverse communities future nurses will serve. Everyone has implicit biases—positive (helpful) and negative (harmful) that influence assumptions, decision making and judgments, especially the manner by which we communicate (verbal, paraverbal, nonverbal) (Ross, 2014; Hagiwara et al., 2019).

Communication is powerful; either perpetuating IB or acting as a catalyst for awareness. In research, communication changes are feasible and easily integrated into professional development (Hagiwara et al., 2019). In this study, exploring messaging and how to use it for IB mitigation can prove beneficial. IB awareness alone is insufficient and requires learner skills in management and mitigation. Learner transformation is possible through critical self-reflection on assumptions and reintegration of a new perspective of inclusive excellence. (Mezirow, 1994, 1998; Kitchenham, 2008).

Imani Perry, a contemporary of Derrick Bell stated, “The gap between words and reality in the American project—that is what critical race theory is, where it lies.” (Cobb, 2021, para 37). Nursing’s challenge is to not just speak these truths, but to act on these truths. In the matter of interest divergence, we need to ask what is behind the effort and urgency of the call to action. Is it for the selfish interests to increase diversity in nursing or is it really to assist in the betterment of those who have been shut out for numerous reasons—grades aren’t good enough, inaccessible funding, lack of support, or burdens that hinder future selves. We cannot let this happen. Let us aim to make our classrooms match our communities. In the garden of life there are many colors and varieties. That is
what makes the garden beautiful. Let us cultivate and grow the garden that everyone desires to walk through.
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Medical school experiences associated with change in implicit racial bias among
3547 students: A medical student CHANGES study report. Journal of General
Internal Medicine, 30(12), 1748-1756. https://www.doi.org/10.1007/s11606-015-
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The “seeing place”: teaching nurse practitioners about cultural difference through
https://doi.org/10.1016/j.nedt.2020.104689

brains and the changing rules of neuroplasticity: Implications for learning and
https://doi.org/10.3389/fpsyg.2017.01657

Weller, C. (2020, July 8). *Here’s why bias and inclusion are fundamentally different.*


https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1


https://www.youtube.com/watch?v=81mJnpKJlc4
APPENDIX A

PERMISSION TO USE ATIBI

From: Cristina Gonzalez <CRGONZAL@montefiore.org>
Sent: Wednesday, June 29, 2022 11:37 PM
To: Cronell, Teresa <TCRONELL@email.sc.edu>
Subject: Re: Attitudes Toward Implicit Bias Instrument

Hello,

You can use the survey with the conditions you have outlined in your email. The scoring instructions are in
the manuscript but are straight forward since they are self-report.

I'm pretty sure the instructions and the survey are in the appendix as well, no? If not, email me back and I'll
send them to you in July.

Also, I'd love to see the results of your study and of course won't share them either.

Thank you,

Cristina M. Gonzalez, MD, MEd
Professor of Medicine
Albert Einstein College of Medicine
Academic Hospitalist

From: Cronell, Teresa <TCRONELL@email.sc.edu>
Sent: Monday, June 20, 2022 12:04 PM
To: Cristina Gonzalez <CRGONZAL@montefiore.org>
Cc: Cronell, Teresa <TCRONELL@email.sc.edu>
Subject: Attitudes Toward Implicit Bias Instrument

Good Morning Dr. Gonzalez

I am a doctoral student at the University of South Carolina completing a dissertation in Educational
Practice & Innovation--Curriculum Studies concentration. I am writing to ask for written permission to use
the Attitudes Toward Implicit Bias Instrument in my research study to be conducted later this fall, 2022.
This instrument is presented in the following reference:

Gonzalez, C.M., Grochowalski, J.H., Garba, R.J., Bonner, S., & Marantz, P. R. (2021). Validity evidence
for a novel instrument assessing medical student attitudes toward instruction in implicit bias
02640-9

As a nursing lecturer in a prelicensure undergraduate baccalaureate nursing program, my problem of
practice is faculty unawareness of their potential biased attitudes toward underrepresented students. I would
like to utilize the ATIBI survey prior to implementing faculty team learning sessions on acknowledging
implicit bias, mitigating implicit bias using self-interventions, and developing faculty cultural humility.
My research is being supervised by my professor, Dr. Aisha Haynes.

My study is focused on nursing faculty attitudes. The survey would be administered electronically
(Qualtrics) to the nursing faculty (approximately 35-40) prior to the team learning sessions. These
questions will guide and inform the learning session discussions, which will be conducted with smaller focused groups. The survey will include all 18 items listed in Table 1 of Gonzalez et al. (2021). I plan to use a 6-item Likert scale with a range from strongly disagree to strongly agree. However, since my participants are nursing faculty, I would desire to modify the following questions (see bolded words) to reflect the participants of my study:

- Question #4. Learning about implicit bias is as important to the practice of **nursing** as learning about basic science.
- Question #7. The personal implicit biases that other **faculty and** students hold about racial and/or ethnic minorities may affect the quality of care they provide to patients.
- Question #9. Implicit bias recognition and management is a competency students should master before obtaining their **nursing** degree.
- Question #16. Learning about implicit bias is as important to the practice of **nursing** as learning about patient-**nurse** communication skills.
- Question #17. When I have **faculty research and/or class preparation** looming I don't want to waste time learning about implicit bias.
- Question #22. It is important to discuss race, ethnicity, and culture during **nursing** school.

I would also appreciate receiving copies of any supplemental material that you believe will help administer the survey and analyze the results. For example (1) the instrument questionnaire (with allowance for modification as above), (2) the standard instructions for administering the survey, and (3) and scoring procedures.

In addition to using the instrument, I also ask your permission to reproduce it in my dissertation appendix. The dissertation may be published in the University of South Carolina Scholar Commons at [https://scholarcommons.sc.edu/](https://scholarcommons.sc.edu/)

I would like to use and reproduce the survey under the following conditions:

- I will use the ATIBI only for my research study and will not sell or use it for any other purposes
- I will include a statement of attribution and copyright on all copies of the instrument. If you have a specific statement of attribution that you would like for me to include, please provide it in your response.
- At your request, I will send a copy of my completed research study to you upon completion of the study and/or provide a hyperlink to the final manuscript.

If you do not control the copyright for these materials, I would appreciate any information you can provide concerning the proper person or organization I should contact. If these are acceptable terms and conditions, please indicate so by replying to me through e-mail at TCRONELL@email.sc.edu

Sincerely,

Teresa

**Teresa S. Cronell**  
Student, EdD Educational Practice & Innovation  
Curriculum Studies Concentration  
**College of Education**  
**University of South Carolina**
APPENDIX B

PERMISSION TO USE FORONDA’S CULTURAL HUMILITY SCALE

From: Foronda, Cynthia L <c.foronda@miami.edu>
Sent: Sunday, November 13, 2022, 10:33 AM
To: Cronell, Teresa <TCRONELL@email.sc.edu>
Subject: Re: [EXTERNAL] Foronda's Cultural Humility Scale

Dear Teresa,

Yes, you have my permission to use the tool. Best of luck with your study!

Best,
Cindy

Cynthia Foronda, PhD, RN, CNE, CHSE, ANEF, FAAN
Assistant Dean for Innovation, Clinical Research, and Scholarship
Professor of Clinical

From: Cronell, Teresa <TCRONELL@email.sc.edu>
Sent: Friday, November 11, 2022 3:07 PM
To: Foronda, Cynthia L <c.foronda@miami.edu>
Subject: [EXTERNAL] Foronda’s Cultural Humility Scale

Good Morning Dr. Foronda,

I am a doctoral student at the University of South Carolina completing a dissertation in Educational Practice & Innovation--Curriculum Studies concentration. I am writing to ask for written permission to use Foronda’s Cultural Humility Scale in my action research study to be conducted later in the spring of 2023. This instrument is presented in the following reference:

https://doi.org/10.1177/1043659620950420

As a nursing lecturer in a prelicensure undergraduate baccalaureate nursing program, my problem of practice is faculty unawareness of biased attitudes toward underrepresented students. My study aims to raise faculty awareness of biases, provide faculty with debiasing strategies that can be used in their personal and professional spaces, and determine faculty cultural humility. My hope is to create more inclusive educational experiences for nursing faculty and nursing students. I will be planning team learning sessions to increase faculty awareness of implicit bias, mitigate implicit bias through the use of self-interventions, and determine achievement of faculty cultural humility through the use of Foronda’s Cultural Humility Scale in its entirety (all 19 items).

My research is being supervised by my professor, Dr. Toni Williams.
Additionally, if there is any supplemental material that you believe will help in the deployment and analysis of the results, I would appreciate the information. For example (1) the instrument (2) the standard instructions for administering the exercise, and (3) and scoring procedures.

In addition to using the exercise, I also ask your permission to reproduce it in my dissertation appendix. The dissertation may be published in the University of South Carolina Scholar Commons at https://scholarcommons.sc.edu/

I would like to use and reproduce the survey under the following conditions:

- I will use Foronda's Cultural Humility Scale only for my research study and will not sell or use it for any other purposes

- I will include a statement of attribution and copyright on all copies of the instrument. If you have a specific statement of attribution that you would like for me to include, please provide it in your response.

- At your request, I will send a copy of my completed research study to you upon completion of the study and/or provide a hyperlink to the final manuscript.

If you do not control the copyright for these materials, I would appreciate any information you can provide concerning the proper person or organization I should contact.

If these are acceptable terms and conditions, please indicate so by replying to me through e-mail at TCRONELL@email.sc.edu

Sincerely,

Teresa

**Teresa S. Cronell**
Student, EdD Educational Practice & Innovation
Curriculum Studies Concentration
**College of Education**
**University of South Carolina**
APPENDIX C
ATIBI SURVEY

1. Individuals carry assumptions and opinions in their subconscious (in the form of implicit bias) that they are not aware of.  
   1  2  3  4  5  6
2. Racial and ethnic minority groups are often treated in subtly disrespectful ways.  
   1  2  3  4  5  6
3. Learning about implicit bias is as important to the practice of nursing as learning about basic science.  
   1  2  3  4  5  6
4. It is important to me to learn how to recognize when one of my own implicit biases is activated.  
   1  2  3  4  5  6
5. I am able to define implicit bias in my own words.  
   1  2  3  4  5  6
6. The personal implicit biases that other faculty and students hold about racial and/or ethnic minorities may affect the quality of care they provide to patients.  
   1  2  3  4  5  6
7. I worry about saying the wrong thing during discussions about racial and ethnic implicit bias.  
   1  2  3  4  5  6
8. Implicit bias recognition and management is a competency students should master before attaining their nursing degree  
   1  2  3  4  5  6
9. I have made assumptions about racial and/or ethnic minorities that have proven to be incorrect  
   1  2  3  4  5  6
10. I worry that my actions won’t match my values when I interact with patients who are racially or ethnically different than me.  
   1  2  3  4  5  6
11. Racism is only an issue of the past.  
   1  2  3  4  5  6
12. It is important to me to learn how to minimize the effects my implicit biases may have on my clinical decision-making.  
   1  2  3  4  5  6
13. Learning about implicit bias is as important to the practice of nursing as learning about patient-nurse communication skills. 
   1  2  3  4  5  6
14. When I have faculty research and/or class preparation looming I don’t want to waste time learning about implicit bias.  
   1  2  3  4  5  6
15. I have the skills to address my own implicit biases that come up in the course of delivering nursing education and care.  
   1  2  3  4  5  6
16. An individual’s implicit bias can affect her/his/their behavior.  
   1  2  3  4  5  6
17. The assumptions I make about racial and/or ethnic minorities may affect the way I treat them  
   1  2  3  4  5  6
18. It is important to discuss race, ethnicity, and culture during nursing school.  
   1  2  3  4  5  6

Scale 1=strongly disagree 2=disagree 3=slightly disagree 4=slightly agree 5=agree 6=strongly agree
### APPENDIX D

#### FORONDA’S CULTURAL HUMILITY SCALE

When encountering a conflict or difference in perspective, how often:

1. Do you consider diversity as a factor for difference in perspective?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

2. Do you consider the physical environment as a factor for difference in perspective?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

3. Do you consider the historical precedent as a factor for difference in perspective?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

4. Do you consider the political climate as a factor for difference in perspective?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

5. Do you consider the power imbalances as factors for difference in perspective?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

6. Do you consider the situational context as a factor for the difference in perspective?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

7. Do you attempt to be open to considering the differing perspective?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

8. Do you self-reflect and critique yourself afterward?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

9. Do you attempt to be flexible?
   - Never/Rarely
   - Once in a while
   - Sometimes
   - Usually
   - All the time

10. Are you aware of your own biases?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

11. Do you attempt to shed your ego?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

12. Do you seek to establish respect?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

13. Do you seek to provide optimal care?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

14. Do you focus on the other person in addition to yourself?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

15. Do you seek to empower others?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

16. Do you work towards a mutual benefit?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

17. Do you seek to develop a partnership?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

18. Do you strive for a supportive interaction?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

19. Do you see yourself as a lifelong leaner?
    - Never/Rarely
    - Once in a while
    - Sometimes
    - Usually
    - All the time

**Scale Interpretation Guide:** Score 19-38 = Rarely Culturally Humble; Scores 39-75 = Sometimes Culturally Humble; Scores 76-85 = Usually Culturally Humble; Score of 86-95 = Habitually Culturally Humble
APPENDIX E

PARTICIPANT CONSENT

Seeking Nursing Faculty Participants for Study on Implicit Bias and Cultural Humility

1 message

Teresa Connell <tconnell@xxx.edu>  Tue: Apr 5, 2023 at 10:15 AM

Dear Colleague,

My name is Teresa Connell, and I am a Lecturer in the undergraduate nursing program. I am also a doctoral candidate in the Education Department at the University of South Carolina. I am conducting a research study as part of the requirements of my Doctor of Education and would like to invite all nursing faculty to participate. This study is sponsored by Dr. Rhonda Jeffries.

I am studying implicit bias and cultural humility in nursing education. Phase one is an anonymous online survey that will take no more than 20 minutes to complete. If you are nursing faculty and decide to participate, please follow the link below to survey via Qualtrics. Please answer honestly and truthfully. At the end of the survey, you will also be asked if you would be willing to participate in phase two of the study. You may feel uncomfortable answering some of the questions on the survey. You do not have to answer any questions that you do not wish to answer and may exit the survey at any time.

Phase two is a series of three face-to-face weekly (no more than) one-hour focus groups. The first 15 minutes are instructional, with the remainder of the time being semi-structured focus group interviews. Volunteering participants for the focus groups will be provided a separate email that describes content topics, instructions for completing independent personal critical self-reflection journaling, and a follow-up 1:1 member checking session with me (the primary investigator). Those willing to participate in phase two but not chosen will be waitlisted for a later session outside of the current study.

Although I have described the general nature of the Team Learning sessions in phase two, the full intent and purpose of the Team Learning sessions cannot be explained because doing so would bias the study results. The focus group session days/times are to be determined based upon interest and availability but are best implemented in person and as soon as possible after the online survey. These sessions will be audio taped for transcription purposes to ensure data accuracy. The audio recording will be deleted upon completion of the study. Because we will be talking in a group, I will ask that focus group members respect the privacy of everyone present.

Participation is confidential and your identity will remain unknown. The results of the study may be published or presented at professional meetings, but your identity will not be revealed. Where there is a chance of identification, data aggregation will be done. Focus group participants will be given a pseudonym.

I will be happy to answer any questions you may have about the study. You may contact me at 704-687-8493 or tconnell@email.unc.edu. My faculty advisor, Dr. Rhonda Jeffries, may be contacted by email rjeffries@email.unc.edu. If you have any questions about your rights as a research participant, please contact the Office of Research Compliance at the University of South Carolina at (803) 777-7085.

Thank you for your consideration. Your consent to participate is desired by voluntarily clicking on the survey link provided here: https://xxx.qualtrics.com/jfe/form/SV_7rg0kHEW69v8

With kind regards,

Teresa S. Connell

Teresa S. Connell MSN RN CC CN | Lecturer
College of Health & Human Services | School of Nursing
APPENDIX F

PHASE TWO PARTICIPANT CONSENT

Phase Two Participant Consent

Teresa Connell
tconnell@XXXX.edu
To: Participant@XXX.edu

Mon, Apr 17, 2023 at 2:54 PM

Dear Colleague,

Thank you so much for your willingness to participate in phase 2 of my study. This phase will include the qualitative data collection portion of my research. I want to learn more about your perceptions and reflections on the constructs of this study, racial implicit bias and cultural humility. The exploratory sequential nature of this mixed methods study will help to clarify quantitative data, especially if some of the data is surprising or unexpected. I hope that you will find these sessions to be transformative and beneficial in your practice as both an educator and a registered nurse. Confidentiality shall be maintained at all times. What is discussed in these sessions is not to be discussed outside of the session.

These weekly Team Learning sessions will open with a quick burst instruction for 15 minutes on the following content:

Team Learning Session #1, April 14 4pm: Mental Models, Assumptions & Interactionality
Team Learning Session #2, May 1 4pm: Acknowledging BI & Developing Migration Strategies
Team Learning Session #3, May 8 6:30pm due to SON commitment/Developing Cultural Humility

The instructional portion will be followed by semi-structured group interview sessions of no more than 45 minutes. Total group commitment is 3.5 hours, which includes the one-hour sessions and the one-on-one phone checking (30 minutes maximum). Total independent time includes critical reflection journals based upon pre-session prompts and standard post-session prompts which will vary depending upon responses but potentially up to 1 to 2 hours. Therefore, the total time for phase 2 of this study is no more than 5.5 hours. I understand that your time is valuable and I do appreciate your participation. All participants will be receiving a group Zoom link for each session; the last session will be hybrid and I hope to meet earlier due to Senior graduation obligations.

Some of the content related to implicit bias is evocative and participants may feel uncomfortable. Be assured that you may step out at any time. You are not required to answer all questions and you may instead actively listen instead of speaking. It is important to allow for open, honest communication devoid of any conception of personal attack. The use of self-awareness, modeling openness towards others’ viewpoints with the goal of listening to understand, expressing gratitude for team member input, and being accountable for outcomes (Clark, 2022) will maintain a safe zone within these Team Learning sessions.

You will be given access to your own individual Google Doc for reflective journaling under a pseudonym. No one will know who you are as the document will remain private. Only you and I will have access to the link. Your name will not be attached to the journal. Any publication will occur under a pseudonym or if there is a chance of identification, data will be aggregated. No identifiable data will be published. Confidentiality of participants will be assured.

If you agree to voluntarily participate, please respond to this email stating your agreement. I look forward to learning with you. Please let me know by Friday of your ability to participate in phase two.

With kind regards,

Teresa S. Connell

Teresa S. Connell MSH RN CCM | Lecturer
College of Health & Human Services | School of Nursing
APPENDIX G

COMMUNICATION LEVEL SET

Good day everyone

First of all, I would like to thank you for graciously extending your time to these very important learning sessions. My name is Teresa Cronell, and I am a doctoral student at the University of South Carolina in the Department of Education. This mixed methods explanatory study will explore the constructs of racial implicit bias and cultural humility. I hope that you will find these sessions to be transformative and beneficial in your practice as both an educator and a registered nurse. Confidentiality shall be maintained at all times. What is discussed in these sessions is not to be discussed outside of the session.

Before we begin, I would like to level set the communication expectations. Everyone has a copy of the Advocacy/Inquiry palette as described in Senge (2012). This palette will help us along our journey and will help us to maintain skillful discussions. If you will notice, there are parameters for high levels of advocacy and inquiry. There are also noted to be communication styles that are deemed to be dysfunctional that will not help us to have productive courageous conversations. I would like us to remember that these sessions are to be considered both confidential and safe. The palette will remain in view at all times.

Every member present is respected, supported, and valued. If at any time you feel uncomfortable answering a question or participating, you will not be coerced to do so. You may also step out of the room or even leave if you feel that is necessary.

Mezirow (1991) described the transformative learning that occurs when one uses critical self-reflection to derive meaning through both the interaction and communication with others. We do not learn in a void. We learn from each other. We learn through frames of reference that include both ingrained habits of mind and malleable points of view. We learn by others giving us feedback as well as by becoming more aware of ourselves and how others respond to our verbal, paraverbal, and nonverbal communication. The raising of this awareness of ourselves that may be different from who we explicitly believe we are may be very disorienting. Mezirow (1991) called this initial phase a disorienting dilemma. Critical self-reflection on assumptions is important to get at the origin of our beliefs. I am going to ask you to lean into the conversation and the experience as we learn from each other to get at the origin of assumptions, engage in productive discourse, and transform our points of view.

Again, if you feel uncomfortable at any time you may step out. You are also not required to answer all questions and you may instead actively listen instead of speaking.
APPENDIX H

ADVOCACY/INQUIRY PALETTE (ADAPTED FROM SENGE, 2012, p.107)

High Testing: Here’s what I say. What do you think of it?”

Dictating: Here’s what I say, and never mind why.” (dysfunctional)

Asserting: “Here’s what I say, and here’s why I say it.”

Explaining: “Here’s how the world works and why I can see it that way.”

Skillful discussion: Balancing advocacy & inquiry, genuinely curious, makes reasons explicit, asks others about assumptions without being critical or accusing.

Dialogue: Suspending all assumptions, creating a container in which collective thinking can emerge.

Politicking: Giving the impression of balancing advocacy and inquiry, while being close-minded (dysfunctional)

Clarifying: “What is the question we are trying to answer?”

Interrogating: “Why can’t you see that your point of view is wrong?” (dysfunctional)

Interviewing: Exploring others’ points of view and the reasons behind them.

Low Bystanding: making comments which pertain to the group process, but not to the content

Sensing: Watching the conversation flow without saying much, but keenly aware of all that transpires

Withdrawing: Mentally checking out of the room and not paying attention (dysfunctional)

Observing

Advocacy

Inquiry
## APPENDIX I
### MATRIX OF OPPRESSION*

<table>
<thead>
<tr>
<th>Social Identity Categories</th>
<th>Privileged Social Groups</th>
<th>Border Social Groups</th>
<th>Targeted Social Groups</th>
<th>Biases with Power/“-ism’s”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>White</td>
<td>Biracial/Multiracial</td>
<td>Asian, Black, Latinx, Native/Indigenous</td>
<td>Racism</td>
</tr>
<tr>
<td>Sex</td>
<td>Assigned Male at birth</td>
<td>Intersex</td>
<td>Assigned Female at birth</td>
<td>Sexism</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender Conforming (Cisgender), Identify as Male or Female</td>
<td>Gender Ambiguous, Gender Queer, Agender</td>
<td>Transgender, Gender Queer, Intersex, Gender Ambiguous, Agender</td>
<td>Transphobia/Trans* Oppression</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Heterosexual</td>
<td>Bisexual, Queer, Lesbian, Gay, Questioning, Aces (Asexual/Aromantic), Polyamorous</td>
<td>Lesbian, Gay, Queer, Questioning, Aces (Asexual/Aromantic), Polyamorous</td>
<td>Heterosexism, Homophobia</td>
</tr>
<tr>
<td>Social Status/Class</td>
<td>Wealthy, Upper Class</td>
<td>Middle Class</td>
<td>Working Class, Poor</td>
<td>Classism</td>
</tr>
<tr>
<td>Ability/Disability</td>
<td>Temporarily Able-Bodied</td>
<td>People with Temporary Disabilities, and/or “Invisible” Disability</td>
<td>People with Disabilities (often physically identifiable)</td>
<td>Ableism</td>
</tr>
<tr>
<td>Religion</td>
<td>Protestant, Christian</td>
<td>Roman Catholic (Historically), Spiritual</td>
<td>Jewish, Muslim, Hindu, Atheist</td>
<td>Religious Oppression/Intolerance</td>
</tr>
<tr>
<td>Age/Generational</td>
<td>Adults (Ages 35-55)</td>
<td>Young Adults (Ages 25-35)</td>
<td>Elders (55+) &amp; Adolescents &amp; Children (≤25)</td>
<td>Ageism/Adultism</td>
</tr>
</tbody>
</table>

NOTE*: You cannot enter a room as ONE identity or as one part of yourself. All your identities work together simultaneously. Your world experience is based on the interplay of your identities within multiple dimensions of societal oppression i.e. *intersectionality*.

*Used with permission from Sara D. Anderson and Karissa Stolen (2019) Office of Equity at the University of Colorado Denver and University of Colorado Anschutz Medical Campus*
APPENDIX J
IRB APPROVAL LETTER

UNIVERSITY OF SOUTH CAROLINA

OFFICE OF RESEARCH COMPLIANCE

INSTITUTIONAL REVIEW BOARD FOR HUMAN RESEARCH
APPROVAL LETTER for EXEMPT REVIEW

Teresa Cronell
College of Health & Human Services
440-568-4675
Teresa.Cronell@USC.edu

Re: Pro00127785

Dear Teresa Cronell:

This is to certify that the research study Nursing Faculty Implicit Bias Unawareness and Perceptions of Cultural Humbleness: A Mixed Methods Action Research Study was reviewed in accordance with 45 CFR 46.104(d)(2) and 45 CFR 46.111(a)(7), the study received an exemption from Human Research Subject Regulations on 3/28/2023. No further action or Institutional Review Board (IRB) oversight is required, as long as the study remains the same. However, the Principal Investigator must inform the Office of Research Compliance of any changes in procedures involving human subjects. Changes to the current research study could result in a reclassification of the study and further review by the IRB.

Because this study was determined to be exempt from further IRB oversight, consent document(s), if applicable, are not stamped with an expiration date.

All research related records are to be retained for at least three (3) years after termination of the study.

The Office of Research Compliance is an administrative office that supports the University of South Carolina Institutional Review Board (USC IRB). If you have questions, contact Lisa Johnson at lisa@mailbox.ac.edu or (803) 777-8670.

Sincerely,

Lisa M. Johnson
ORC Assistant Director and IRB Manager
Participant XXX
Thank you for your willingness to join the Team Learning Sessions! I hope you will find these sessions transformative and beneficial in your practice as a registered nurse and an educator. Confidentiality will be maintained at all times. What is discussed in these sessions is not to be discussed outside of the session. Additionally, what you write in this online journal is available only to you and me as the PI. The document is password protected. Once you write in your journal, do not change responses when you return to it. This journal captures your perceptions, feelings, and thoughts in real time. Additional thoughts may be added as you critically reflect.

Mezirow (1991) described the transformative learning that occurs when one uses critical self-reflection to derive meaning through both interaction and communication with others. We do not learn in a void. We learn from each other. We learn through frames of reference that include ingrained habits of mind and malleable points of view. We learn by others giving us feedback and becoming more aware of ourselves and how others respond to our verbal, paraverbal, and nonverbal communication. Raising awareness of ourselves that may differ from who we explicitly believe we are may be discomforting. Mezirow (1991) called this initial transformative phase a disorienting dilemma. Critical self-reflection on assumptions is essential to get at the origin of our beliefs. I will ask you to lean into the conversations and the experiences as we learn from each other to determine the roots of our assumptions, engage in productive discourse, and transform our points of view.

Pre-session (1)
There will be no prep work before TL Session #1.

Standard Prompts Team Learning Session #1
Critically reflect on standard prompts w/in two days of TL:
1. What did you learn during this session that surprised you? About yourself? About others?
2. Did any moment during the session disturb you? How did you feel? What were you thinking?
3. Is there anything you wish to share that you held back during the learning session?
Pre-session (2)
Before TL Session #2, complete the race & skin tone implicit association tests https://implicit.harvard.edu/
Both tests are free and take roughly 5 minutes to complete.
Reflect on the results.

Reflection on IAT:
- What surprised you the most about the results?
- How did the results make you feel?
- Are the results different from your explicit assumptions?
- Anything else you would like to share?

Standard Prompts Team Learning Session #2
Critically reflect on standard prompts w/in two days of TL:
1. What did you learn during this session that surprised you? About yourself? About others?
2. Did any moment during the session disturb you? How did you feel? What were you thinking?
3. Is there anything you wish to share that you held back during the learning session?

Pre-session (3)
Before TL Session #3, Practice de-biasing strategies, and choose to be intentional in your chosen mitigation strategy/strategies.
Reflect on the results.

Reflection on Strategies:
- Were de-biasing strategies challenging to implement? Easy to implement? Why so?
- Describe how you felt after the strategy.
- How can you choose to incorporate the de-bias strategy into a habit?
- Anything else you would like to share?

Standard Prompts Team Learning Session #3
Critically reflect on standard prompts w/in two days of TL:
1. What did you learn during this session that surprised you? About yourself? About others?
2. Did any moment during the session disturb you? How did you feel? What were you thinking?
3. Is there anything you wish to share that you held back during the learning session?

Team Learning Session Wrap-Up
Thank you for joining the TL Sessions. The final entry in the online reflective journal is below. I will contact you in a couple of weeks to schedule a member-checking session to ensure accurate capture of perceptions and themes.

Final Reflection:
- How has your thinking changed about IB?
- About cultural humility?
- Anything else you would like to share?
Welcome to the first Team Learning Session!

I am excited that you have joined me on this wonderful journey.

And I appreciate of you taking time out of your busy schedule to participate. The first session will cover Mental Models, Assumptions, and Intersectionality. These concepts may be new to you, but are necessary to lay the foundation for this and the next two learning sessions.

Reviewed the documents sent to participants: Communication Level Set, Advocacy/Inquiry Palette. Asked if everyone had access to their journals. Explained the pre/post session reflection expectations as well as the standard prompts to be completed.

Next week, you will complete two Implicit Association Tests and the following week you will practice implicit bias mitigation strategies.

PoP: Diversity deficit within nursing education, faculty and students that eventually spills over into the profession and ultimately leads back to education. In 2021, only 30% of baccalaureate and graduate students reported being from diverse backgrounds (AACNb, 2022). Moreover, a recent workforce survey noted that 81% of registered nurses recognized as White and 90% female (Smiley et al., 2021). 17.3% of faculty, and 10% of Deans are from diverse backgrounds (Thompson, 2021).

PoS: This study seeks to understand nursing faculty implicit bias (IB) attitudes and perceptions—-I focus on faculty unawareness of racial IB and how IB relates to cultural humility

Ways of explaining reality: There is more going on below the surface than we can easily see or describe. Real leverage for change lies below the surface, move from generalized view or events in isolation to seeing how multiple events are connected on a deeper level. The mental model (MM) is the deepest and most submerged part of the iceberg; is where underlying assumptions and beliefs about a problem or event are located. MM determine how we interpret what is seen, our attitudes, and the actions we take in any given situation. These assumptions and beliefs can be difficult to change because they are often based on personal experiences and worldviews. (Senge, 2012). Two people looking at the same situation draw different conclusions—everyone has different experiences and different MM. Diving to the MM level helps people to understand why they think and behave the way they do. It also helps people to understand how their personal experiences and worldviews can impact the way they see and interact with the world.
Present to participants the LOI (Senge, 2012)

Provide an overview of the Faculty LOI and the Student LOI.

Allow participants to discuss how this made them feel.

What surprised you about the mental model (Ladder of Inference) example?

Intersectionality: the interplay of one’s identities, the status of those identities, and the situational context of how, when, and where those identities show up and influence personal experience(s) within multiple dimensions of societal oppression. Crenshaw: coined term intersectionality in 1989 in her early writings related to how race and gender intersect & cannot be separated. The intersections of race and gender reinforce each other in the inequitable treatment of Black women; especially their marginalization within dominant discourses Overlapping intersectional oppression operate to reinforce each other within inequitable systems (Bell, 2016). Race is the focal point, but the term has been appropriated to include other identities and -isms. In their Matrix of Oppression, Anderson and Stolen (2019) described how a person’s “world experience is based on the interplay of…identities within multiple dimensions [race, age, gender, sexual orientation, class, ability, and religion] of societal oppression.” DiAngelo (2018) described how our understanding of racism could be transformed by recognizing how our “other social identities…inform how [we are] socialized into the racial system” (p. 143).

Several identities intersect to affect the persistence of diverse nursing students. The context of social, community, health, economic stability, and environment (Barbe et al., 2018) in nursing education creates a sort of “othering” as the student nurse must acculturate to the profession. Upon entering a nursing program, the nursing student is faced with a new culture different from their own—with a new language (medical) and dress code (scrubs), as examples.

What surprised you about your own intersectionality? The intersections of the group?
Word cloud developed in the learning session.

Resources for further learning shared with faculty:
Takes about an hour to complete. There are five modules that follow an introduction. Certificate of completion provided at the conclusion

Great resource for DEI, intersectionality, gender visibility, and bystander intervention

Table L.2: Team Learning Session #2

Welcome to the second session! Today’s presentation is about implicit bias. You will learn about its impact on medical/nursing decision making and judgements and how the decisions affect health equity, health outcomes. Additionally, I will teach you three mitigating strategies you will use over the next week to counter biases

Prior to the explosion of research from the late 80s to mid-90s leading to the implicit bias research of Greenwald, Nosek and Banaji most social cognitive psychologists believed that stereotypes and attitudes derived from conscious mode and could be fully captured by self-report; work of Graf and Schacter (1985) found that amnesic patients could perform tasks and make associations based upon past experiences even though they could not explicitly recollect learning "Explicit Bias": overt, conscious explicit "attitudes and beliefs" about groups --isms, many times driven by perceived threat and seen as justification for unfair targeted negative treatment of UR groups OR to look at cognition we explicitly proclaim to hold care and compassion for all people no matter race, color, creed

You each took a couple of the IAT assessments to determine level of implicit bias: The IAT measures latency of response based upon the strength of association between images and words (flowers-beautiful, Black-good; White-bad, etc.), by response times and frequency of errors. The strength of an association, measured as a positive, is determined by quicker times and less errors. Quicker responses occur with the familiar based upon formed schemas in cognition; latency increases when one is unable to use the familiar schema—more processing needed. Herein lies the hidden assumptions. Unconscious (hidden) biases can be uncomfortable because these implicit notions go against our explicit thoughts and beliefs (APA, 2022). Echoing Mezirow (1994), it is important to relay the normalness in the disequilibrium and dissonance felt in this process. The IAT is INFORMATIVE and not prescriptive, so it is used to raise awareness. 25 million tests administered & used extensively in research

IAT researchers urge for raising awareness and the test has the disclaimer the results may fluctuate and should not be used to make important decisions. The results are influenced by variables related to the test (e.g., the words or images used to represent categories) and the person (e.g.,
Implicit bias: An “algorithm of the mind” ingrained habits of thought (Gupta, 2017) unconscious bias in judgment or behavior that “is not limited to race…[and]… can exist for characteristics such as gender, age, sexual orientation, gender identity, disability status, and physical appearance such as height or weight” (Institute for Healthcare Improvement, 2017, para 3) that can lead to errors in perceptions, reasoning, decision making.

Neuroimaging: provides a window to visualize neuronal activation via magnetic resonance imaging (MRI) scans provides a deeper physiological level of understanding how areas of the brain are triggered during specific task performances related to bias unawareness—the amygdala, part of the limbic system, responsible for control of emotions and behavior with subsequent memory formation between the two. When noticing the feelings of fear that the amygdala interprets as danger, realize that this could be a flawed interpretation based upon faulty assumptions (APA, 2022) especially when the perceiver experiences increased psychological and physical stressors (Brockett-Walker et al., 2021) or cognitive overload (Burgess, 2010).

Color Blindness vs Color Consciousness

- Race is a social construct
- Racism as ordinary (blind to color)
- Raising Awareness—know your bias
- Social circles
- Emancipatory Learning
- Emotionally Self-Reflection on Assumptions (CSRA)

Founding of America: To protect white advantage White vs Indian 1700-1800s race used to justify enslavement and the discrimination of immigrants in the early 1900s. Proposal to change 2030 Census to allow for response to race OR ethnicity with the addition of “Middle Eastern or North African” (MENA) to the already “Hispanic or Latino” ethnicity and only 5 race categories: 1) American Indian/Alaska Native 2) Asian 3) Black or African American 4) Native Hawaiian or Other Pacific Islander or 5) White—decision to be made summer, 2024

Humans are more alike than different, sharing 99.9% of genetic makeup with very few differences. Color Blindness can be “admirable” when decisions are made to avoid prejudices… but “harmful” when a neutral stance is taken that normalizes the “ordinariness of racism” which allows colorblindness to be equated with “not racist.” Used by those who have racial privilege (WHITES) to overlook the racial/ethnic differences and experiences of others in an effort to promote racial harmony. BUT colorblindness manifests as unintended negative IB and macroaggressions.

Increased research regarding IB and medical decision making, education, and mitigation strategies has been well documented since the release of Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine HTN escalation—AA had no difference in escalation, but did have difference in hypertension control (Blair, 2014)—following algorithm, but how was communication/connection—this study took place in primary healthcare setting. Sabin et al. (2009) found that MDs’ implicit and explicit attitudes about race follow the same general pattern seen in the very large, heterogeneous public samples: the majority held implicit preferences for Whites over Blacks. Second, AA showed no IB, on average. Finally, providers demonstrated modestly related implicit and explicit attitudes about race.
Poor communication/interaction/perceptions of care could undermine trust and engagement leading to nonadherence and less follow up. Providers with higher IB against Blacks were rated lower in patient centered care by their Black patients.

Visualization exercise for Counter Stereotypic Imaging: I want you to close your eyes and take a deep breath. I want you to imagine that you are taking a flight to attend a national nursing conference. Prior to boarding the plane, you see the pilot entering the walkway that leads to the cockpit. The flight is uneventful, and you arrive at your destination. Before the first session of the conference, you decide to grab a coffee. You see a couple sitting in the coffee shop, smiling at each other and holding hands. While at the conference, the opening session is presented by a top-notch cardiothoracic surgeon who describes new procedures for minimally invasive heart valve repair and replacement. Questions: In your mind, was the pilot a woman? Was the couple in the foyer two men? Was the medical provider Black? Adapted from TEDx Talks. (2018, October 22). How to Outsmart Your Own Unconscious Bias.
fMRI (functional MRI—done while a person is asked questions or completes an activity) shows mindfulness modulates activation of the amygdala decreasing threat response while increasing prefrontal cortex which increases empathy.

Neuroplasticity: ability of brain structures to adapt, modify, and change based upon short- and long-term experiences creation of new neural pathways of cognition.

Table L.3 Team Learning Session #3

Welcome to our last session! In this session we will discuss cultural humbleness and cultural humility.

Again, I thank you so much for your time!

Since this is our final session, all the content covered will be integrated into the semi-structured questions. This session will use more of a Socratic questioning where you will expand critical thinking of the study constructs.

Before we can define and describe what cultural humility is, it is important to note what it is not. Several descriptions and words have described what cultural humility is not (Foronda et al., 2016).

Now, I would like for you to first define cultural humbleness. Now do the same with cultural humility.

Great definitions! Humbleness is individual micro-level output; attitudes, perceptions, and personal experiences that drive cultural humility.

Humility is the outward meso-level expression and output within our community/organization.

Micro—individual meso—impact on others in our organization/community macro—outcomes of interactions, systemic/policy/society/civilization/ (Foronda et al., 2022)

As you can see, both impact the SON culture.

How would you describe the culture of nursing?

Describe how this culture of nursing education potentially impacts underrepresented students?
The -isms are supported by false sense of knowing of others or used as justification for treating others in an exclusionary manner. FitzGerald and Harst (2017) posit how even though health professionals explicitly express ‘aversive racism,’ they may be influenced by the cultural immersion where individuals are negatively stereotyped by society. Competence perpetuates colorblind mentality that ignores power, privilege, and racism in healthcare (FON, p. 206).

On the other hand, cultural humility supports: 1) openness, includes openminded/open to interaction with others 2) self-awareness of one’s values, beliefs, and behaviors 3) Egoless neutrality, lack of superiority, egoless 4) supportive interaction—those that result in positive human exchanges, sharing, taking responsibility for thoughts/actions 5) self-reflection and critique is reflecting on one’s thoughts, feelings, and actions/introspection (Five attributes of humility, Foronda et al., 2016)

I would like to explore your thoughts related to IB and cultural humility. How does IB recognition and mitigation transform nursing faculty perceptions of cultural humility in nursing education?

How can we integrate CH? Environmental scanning what do we see in our environment, who do we see? Simulation manikins of color? what we wear, how we stand in the environment. Learning materials—PPT, textbooks, other visual aids. Check messaging: how we say (paraverbal) what we say (verbal) Discourse is one way purposeful to deliver content Dialogue is cooperative, two-way communication, relationship building, safety & belongingness in conversations. Lexicon of nursing is unique—meaning of medical terminology/note what is being said and why—removal of race as cause of disease/illness Dialectical Discourse then is the goal! Use the 3Rs, recognize, reflect and remove, and then replace/reintegrate the new perspective

Cultural humility becomes a way of being—every individual/every interaction we have to be willing to work together towards embracing and demonstrating cultural humility

When others see flexibility in one, they are more likely to adapt; to shift their perspective.

In developing the Theory of Cultural Humility, Foronda (2020) describes that cultural conflict is normal/expected but cultural ambivalence is not. We are all different with differing perspectives and lived experiences which guide our frame of reference…ambivalence is deciding to not act or deciding to instead treat everyone all the same

What are your next steps to creating cultural humility within nursing education?

Revisiting the opening schematic—we can include Cultural progression that cultivates cultural inclusivity

Cultural curiosity—openness to dialogue and to get to know others, listen to others’ viewpoints, be flexible and dive deeper to the bottom of the iceberg of your assumptions and mental models of discernment and understanding. Can be very difficult to convey in language and in meaning the intent of messaging whether it is verbal, paraverbal, or nonverbal

Cultural complement…what the cultures add to each other—diverse voices are not silenced or isolated—“complementary power of differences” Gozen, TEDx Talks (2021)…cultural differences occur largely as in continent/countries down to small culture that is the family structure (Gozen). Differences complement and strengthen
one another; consider how differences in nursing complement the practice, keep us learning, what are other points of view (Mezirow!!!?) that need to be heard? Counter-narratives name the unnamed, make visible the invisible, and give voice to those silenced. Falsehoods are remedied through counter narration that leads all towards embracing our common humanity (Delgado & Stefancic, 2017)

**Cultural transformation** occurs when a threshold is crossed to build community, — the ethos of the “in common” — occurs when the micro/ meso level no longer enables exclusion, but rather supports **cultural inclusion.**
APPENDIX M

SEMI-STRUCTURED INTERVIEW QUESTIONS

Team Learning Session #1

1. What surprised you about your own intersectionality? The intersections of the group?
2. What surprised you about the mental model (Ladder of Inference) example?
3. How do perceptions of others impact our verbal and visual interactions with them?
   (Addresses RQ1 as the LOI describes a microaggression)

Team Learning Session #2

1. Do you feel that racial/ethnic minority groups are treated in subtly disrespectful ways? What led to that response?
2. Is increasing diversity in nursing focused on the future nurse, their communities, or the system? Is there importance in one over the others? Explain? (**not asked)
3. What is your perception of racial IB in nursing/nursing education?
4. I am interested in learning more about your experience with IB. Do you feel that IB recognition and management is a competency that student nurses should be introduced to in nursing school?
5. Does IB influence nurse educator practices?
6. Tell me about your interactions with UR students in the class? Clinical? UR patients? Do you feel this interaction would have been different had you been the same race/ethnicity?
7. Tell me about a time when you made an assumption about a student. Do you think the assumption impacted your ability to effectively evaluate the student’s performance? If so, how? If not, why?
   (Addresses RQ1–perceptions of IB, impact on UR students, assumptions)

Team learning Session #3

1. Define and describe cultural humbleness. Now do the same with cultural humility
2. How would you describe the culture of nursing?
3. Describe how this culture of nursing education impacts underrepresented students
4. I would like to explore your thoughts related to IB and cultural humility. How is cultural humility influenced by IB? How does IB recognition and mitigation transform nursing faculty perceptions of cultural humility in nursing education?
5. If you could envision cultural humility in the nursing program, what would it look like?
6. Understanding that creating cultural humility within nursing education takes time. It is not a “one and done.” What are your next steps?
   (Addresses RQ1, RQ2, RQ3—perception of cultural humility, IB)
# APPENDIX N

## DATA CODING WITH EMERGING CONCEPTUAL THEMES

### Table N.1 In Vivo Codes Session #1

<table>
<thead>
<tr>
<th>Team Learning Session #1</th>
<th>Emerging Conceptual Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“surprised about identities”</td>
<td>Identity</td>
</tr>
<tr>
<td>“I wonder what [being a male in class] feels like”</td>
<td>Identity</td>
</tr>
<tr>
<td>“lens of the student”</td>
<td>Identity</td>
</tr>
<tr>
<td>“students internalize”</td>
<td>Wild lens viewpoint — student view</td>
</tr>
<tr>
<td>“students are no longer successful”</td>
<td>Disempowerment</td>
</tr>
<tr>
<td>“they fall out...”</td>
<td>Disempowerment</td>
</tr>
<tr>
<td>“makes [student] shut down”</td>
<td>Disempowerment</td>
</tr>
<tr>
<td>“I have made assumptions”</td>
<td>Impact — racism as ordinary</td>
</tr>
<tr>
<td>“advocate for students”</td>
<td>Wide lens viewpoint — advocacy</td>
</tr>
<tr>
<td>“sparking me to think”</td>
<td>Reflection</td>
</tr>
<tr>
<td>“what I am really thinking”</td>
<td>Reflection</td>
</tr>
<tr>
<td>“support our fellow faculty”</td>
<td>Wide lens viewpoint — advocacy</td>
</tr>
<tr>
<td>“sweep [discrimination] under the rug”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“they weren’t heard”</td>
<td>Disempowerment</td>
</tr>
<tr>
<td>“I am not going to say anything”</td>
<td>Avoidance — avoidance</td>
</tr>
<tr>
<td>“taking it the wrong way”</td>
<td>Impact</td>
</tr>
<tr>
<td>“call out somebody”</td>
<td>Impact — racism as ordinary</td>
</tr>
<tr>
<td>“sometimes I shy away”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“I hope that I have grown”</td>
<td>Hopeful optimism</td>
</tr>
<tr>
<td>“not so much about race”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“careful how I interact”</td>
<td>Impact</td>
</tr>
<tr>
<td>“I don’t know much about them”</td>
<td>Identity — avoidance</td>
</tr>
<tr>
<td>“I feel very self-conscious”</td>
<td>Reflection</td>
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### Participant Journal Reflection #1

<table>
<thead>
<tr>
<th>Emerging Conceptual Themes</th>
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<tbody>
<tr>
<td>Identity</td>
</tr>
<tr>
<td>Disclosure silence — avoidance</td>
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<tr>
<td>Disclosure silence — avoidance</td>
</tr>
<tr>
<td>Disempowerment</td>
</tr>
<tr>
<td>Impact</td>
</tr>
<tr>
<td>Impact — racism as ordinary</td>
</tr>
<tr>
<td>Avoidance</td>
</tr>
<tr>
<td>Avoidance — avoidance</td>
</tr>
<tr>
<td>Impact</td>
</tr>
<tr>
<td>Identity — avoidance</td>
</tr>
<tr>
<td>Reflection</td>
</tr>
<tr>
<td>Identity</td>
</tr>
<tr>
<td>Wide lens viewpoint — inclusion</td>
</tr>
<tr>
<td>Reflection</td>
</tr>
<tr>
<td>Reflection</td>
</tr>
<tr>
<td>Impact</td>
</tr>
<tr>
<td>Impact — invisibility</td>
</tr>
<tr>
<td>Impact</td>
</tr>
<tr>
<td>Reflection — identity</td>
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Table N.2 In Vivo Codes Session #2

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<th>Emerging Conceptual Themes</th>
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<tbody>
<tr>
<td>“It won’t change in my lifetime”</td>
<td>Disempowerment</td>
</tr>
<tr>
<td>“generational things are affecting me”</td>
<td>Identity</td>
</tr>
<tr>
<td>“are we giving students the best opportunity?”</td>
<td>Impact-wide lens viewpoint</td>
</tr>
<tr>
<td>“are we looking at race [when creating student groups]?”</td>
<td>Identity</td>
</tr>
<tr>
<td>“awareness is key”</td>
<td>Impact—self-aware</td>
</tr>
<tr>
<td>“[the ageism] bothered me....disturbed me”</td>
<td>Identity</td>
</tr>
<tr>
<td>“didn’t want others to think I wasn’t up to date”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“different race...feeling uncomfortable”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“digging into the whys”</td>
<td>Impact</td>
</tr>
<tr>
<td>“have to put [biases] aside. Hopefully, I don’t know. I try”</td>
<td>Hopeful optimism</td>
</tr>
<tr>
<td>“I am having to grow and change”</td>
<td>Reflection</td>
</tr>
<tr>
<td>“I am not ready for this kind of conversation”</td>
<td>Discourse silence—avoidance</td>
</tr>
<tr>
<td>“I am optimistic for the next generation”</td>
<td>Hopeful optimism</td>
</tr>
<tr>
<td>“I think we start working with the next generation”</td>
<td>Hopeful optimism</td>
</tr>
<tr>
<td>“I was nervous [to have these conversations]”</td>
<td>Impact</td>
</tr>
<tr>
<td>“if [students] are not thinking about...implicit bias is still there”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“important to also talk about the health disparity aspect”</td>
<td>Impact</td>
</tr>
<tr>
<td>“it was shocking to confront my own biases”</td>
<td>Reflection</td>
</tr>
<tr>
<td>“making assumptions [about students]”</td>
<td>Identity</td>
</tr>
<tr>
<td>“may not realize how they come across to others”</td>
<td>Impact</td>
</tr>
<tr>
<td>“maybe we can shift the dial”</td>
<td>Hopeful optimism</td>
</tr>
<tr>
<td>“nothing has changed”</td>
<td>Disempowerment</td>
</tr>
<tr>
<td>“people are not comfortable with implicit biases”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“that was a catalyst for me....to say, who am I really?”</td>
<td>Impact</td>
</tr>
<tr>
<td>“we definitely have biases that continue to exist”</td>
<td>Impact</td>
</tr>
<tr>
<td>“try hard not to make assumptions...based on looks”</td>
<td>Identity</td>
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<tr>
<td>“this seems more like a journey than a destination”</td>
<td>Reflection</td>
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Participant Journal Reflection #2

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<tr>
<td>“this conversation was more open and honest”</td>
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<td>“there was a level of trust among the group members”</td>
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<tr>
<td>“creating a safe space is helpful”</td>
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<td>“I heard some positive affirmations”</td>
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<tr>
<td>“to be more open to people of different ethnicities”</td>
</tr>
<tr>
<td>“my circles are small, mostly White female”</td>
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<tr>
<td>“I learned more about my biases”</td>
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<tr>
<td>“value differences among others”</td>
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<tr>
<td>“willing to look inward”</td>
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<tr>
<td>“gravitate towards those who look like us”</td>
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<td>“it takes time, courage and getting to know each other”</td>
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<td>“danger in assuming that you know”</td>
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<td>“took courage to share that [story]”</td>
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<td>“I didn’t want others to think I wasn’t as up to date”</td>
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Table N.3 In Vivo Codes Session #3

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<tbody>
<tr>
<td>“not a lot of gathering and learning from each other”</td>
<td>Avoidance—identity</td>
</tr>
<tr>
<td>“[the culture] is not discussed”</td>
<td>Avoidance</td>
</tr>
<tr>
<td>“we just don’t know each other”</td>
<td>Identity</td>
</tr>
<tr>
<td>“we are all in different circles”</td>
<td>Avoidance—identity</td>
</tr>
</tbody>
</table>
“[culture in nursing] is fragile”
“leadership... to deal with [discrimination]”
“open to knowing the culture”
“I am definitely using more cultural curiosity”
“always room to grow”
 “[people] don’t want to change”
“people are not curious”
“they don’t want to change because it requires energy”
“This problem extends beyond the school of nursing”
“I don’t want to be offensive”
“there is resistance to change”
“the culture is professional...it is positive”
“I am a White woman, so I don’t know”
“everyone wants to have a sense of belonging”
“I am reflecting a lot...inside me, I am”
“we are not as open minded as we think we are”

**Participant Journal Reflection #3**

“[session] has opened my eyes to my own biases”
“I did not know about cultural humility”
“over time, willingness to share [in sessions] had improved”
“other participants struggled with similar issues”
“having awareness of...biases...is a great first step”

**Emerging Conceptual Themes**

- Discourse—supportive
- Discourse—supportive
- Discourse—supportive
- Impact—self-aware
- Identity
- Reflection
- Reflection
- Reflection
- Reflection
- Discourse—supportive
- Reflection
- Impact—self-awareness

<table>
<thead>
<tr>
<th>Participant Journal Reflection #3</th>
<th>Emerging Conceptual Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I felt good and supported during the session”</td>
<td>Discourse—supportive</td>
</tr>
<tr>
<td>“I felt more confident speaking up and expressing opinions”</td>
<td>Discourse—supportive</td>
</tr>
<tr>
<td>“I am comfortable discussing [these topics]”</td>
<td>Discourse—supportive</td>
</tr>
<tr>
<td>“Awareness is key to DEI initiatives”</td>
<td>Impact—self-aware</td>
</tr>
<tr>
<td>“I love learning about different cultures”</td>
<td>Openness</td>
</tr>
<tr>
<td>“helps to learn about individual rather than the group”</td>
<td>Identity</td>
</tr>
<tr>
<td>“[session] has opened my eyes to my own biases”</td>
<td>Reflection</td>
</tr>
<tr>
<td>“need for cultural humility”</td>
<td>Reflection—self-aware</td>
</tr>
<tr>
<td>“I did not know about cultural humility”</td>
<td>Reflection</td>
</tr>
<tr>
<td>“over time, willingness to share [in sessions] had improved”</td>
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