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Race and Microaggression in Nursing Knowledge Development

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Race is a social environmental element in many nursing knowledge contexts. We explore how race and racism have been conceptualized in nursing research and theory, situating these issues in the debate between Critical Race Theory and postracialism. Contemporarily, racism is more subtle than overt. Subtle racism takes the form of microaggressions in everyday discourse and practices by whites toward African Americans. This occurs with little to no awareness on the part of whites. Using this concept, practice and education are explored. We hold that microaggressions contribute to stress for the target person, which may partly account for racial health disparities. **Key words:** *Critical Race Theory*, *health care interaction*, *health disparities*, *microaggression*, *nursing practice*, *nursing research*, *nursing theory*, *postracialism*, *race*, *racism*, *social environment*

NURSING has prided itself on openness to all social groups, and especially espouses the needs of marginalized and vulnerable populations. Yet, the question remains: Have we done enough to decrease racial health disparities? We as nurses must analyze environments, social and physical, for evidences of racism in the United States because it undoubtedly affects the way nursing collectively and interpersonally functions to develop and use knowledge. We first examine 2 disparate approaches to discourse about racism in the United States to situate our discussion of knowledge development and, in particular, racial microaggression within the larger discursive environment.

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POSTRACIAL DISCOURSE AND CRITICAL RACE THEORY

Jones[1] categorizes racism as individual, institutional, and cultural. Hesse[2] holds that current postracial discourse depoliticizes racism. Postracial discourse constitutes recent claims by media and scholars that in the US society, categories of race and the issue of racism are largely irrelevant. This is an appealing line of reasoning because it assuages white unease and guilt and subsumes racial inequities in a more palatable universalistic language. Cho[3] cites postracialism's 4 features: emphasis on racial progress, universalized terms, equivocation of white racism and "black racism," and distancing from civil rights advocates and Critical Race Theorists.

The postracial claim has been symbolized in the election of Obama, an African American, to the presidency. According to Robinson and Thompson,[4,5] Obama's electoral strategy followed postracial lines, for example, in his oft-repeated phrase, "There is not a Black America and a White America, there is only the United States of America." The hope is that Obama's achievements signaled the culmination, and thus the end, of the civil rights era.[4,5]

Scholars such as Ford[6] and Gilroy[7] advocate postracialism as the end of concepts of race and racism, insisting that these notions are passé and actually increase bias and division. To mention race in everyday as well as political discussions, according to Ford, is playing the race card and is thus deemed an unfair and ineffective tactic. It is disconcerting, however, that they oppose these ideas against claims of racial injustice by Critical Race theorists such as Cornel West[8] and Bell Hooks.[9,10] Robinson sees postracialism as reshaping of an older myth, that of colorblindness, a denial of racial inequalities by those who do not "see" color and fail to take racism into account.[4]

In this article, we hold the tenets of Critical Race Theory (CRT) as summarized by Ford and Airhihenbuwa[11] and Delgado and Stephancic.[12] Accordingly, CRT is interdisciplinary, and takes the viewpoints of the racially marginalized, critiquing colorblindness, and has as its goal the dismantling of racially based hierarchies. The CRT emphasis on the ordinariness of racism makes it a logical backdrop for examining institutional as well as individual racism, of which microaggression is an example. On the basis of CRT, we propose that it is not possible to be postracial as a society wherein people of color (POC) (a term that is in itself problematic as we will explain) are disproportionately prone to poverty, incarceration, exposure to environmental toxins, violent victimization, and shorter life spans, as is summarized by Roediger.[13]

EVIDENCES OF RACIAL HEALTH DISPARITIES

There is ample evidence supporting the racial health disparities among POC, and African Americans in particular, as compared with whites and the general population. Increased morbidity and mortality; decreased access; differential treatment; and disproportionate numbers of cases and severity of diabetes, cardiovascular disease, and cancer are well-documented in the Institute of Medicine (IOM) report, *Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Health Care,*[14] a document also analyzed by Smedley et al.[15]

A second classic compendium of racial inequality associated with health effects across the spectrum is available from Shavers and Shavers.[16] Utsey et al,[17] for example, also show racism's effects on coping, self-esteem, and life satisfaction. In nursing, for example, Kendall and Hatton[18] document racial disparities for children with attention-deficit/hyperactivity disorder with educational and social consequences, and Benkert et al[19] explain how perceived racism interacts with mistrust of health care providers. Williams and Williams-Morris[20] provide an excellent review of mental health disparities in diagnosis and treatment affecting African Americans.

PURPOSE

Having established a theoretical beginning and evidence of continuing disparities, our purpose in this article is to critically explore how race and racism affect theory and research aspects of nursing knowledge development in the United States. Continuing that process, the concept of microaggression, developed outside of nursing to a large extent by Sue et al,[21] will be applied to contexts of practice and education, in which knowledge is also created and disseminated. We will argue that microaggression is a key dynamic in framing nurse-client and teacher-student interactions. Microaggression may be thought of as the means by which the personal (subjective) and social environmental dialectic of racism is carried on in everyday interactions, with little to no awareness on the part of the white interactors, in specific social situations.[22] Racism in general and microaggressions in particular are embedded in the social environment and often operate in unconscious processes. These processes need to

be made more explicit, which is an aim of this article.

ASSUMPTIONS

This critical exploration begins with several premises. First, racial differences, from a genetic perspective, are rare. According to Brewer[23] and Goodman,[24] very few diseases occur only in particular racially categorized groups because of related genetic causes. Second, as held by Smedley and Smedley,[25] race as a social construction is an important reality, however, and is consequential in terms of stressors associated with discrimination, differences in access to care, and a diminished quality of care given to POC.[25] There is considerable evidence that racial inequality and discriminatory care lead to stress-related biological changes in POC that lead to health disparities (eg, see reference [26]).

Third, we recognize that race and racism are embedded in language and that as Phillips and Drevdahl[26] maintain, a postmodern perspective might best be used to untangle the sociolinguistics involved in constructing these terms. We suggest consulting their work for further exploration of language and race in nursing.[27] In this article, the term *people of color* (POC) is inclusive of many ethnic groups who have characteristic skin colors including red, yellow, brown, black, and white, but it is a problematic term because it is usually based on the presumption that white people have no color, and that they are still the referent group to which others are compared.[28] For lack of more accurate language, we will use the term "POC" to refer to groups not considered by the dominant majority to be white in phenotype and culture. The terms "African American" and "black" will refer to those seen by the dominant majority to have brown to dark-brown skin and to be of African or Afro-Caribbean heritage. The term "dominant majority" refers here to those who are socially considered white, who benefit from white privilege, and who consciously or unconsciously hold white culture as superior to others. We will, for the most part, use terms as they appear in cited sources. Fourth, Roediger[13] and Painter[29] explain that because of the historical vestiges of slavery, segregation, and legalized discrimination, black people face more, and qualitatively different, discrimination and devaluation than do other POC in the United States. In other words, we assume that systemic racism operates more squarely as a black-white dichotomy in the United States, albeit there are regional variations on this point. More detailed historical analyses of racism are beyond the scope of this article but are available in the work of Roediger and Painter. Likewise, we acknowledge that our dichotomy is purposeful but is an oversimplification because, increasingly, people identify as mixed race, as is discussed by Tashiro.[30]

NURSING RESEARCH AND RACIAL CATEGORIES

An ongoing problem is how to account for race in research, how it should be categorized, and how it should play out in data analysis. Nurse researchers Drevdahl et al[28] completed an analysis of how race has been handled in past nursing research. The following summarizes their work and that of others in nursing and other health disciplines.

Government funding agencies, including National Institutes of Health, force nurse researchers to use a limited set of race categories that actually ensures that racial demographic information will be incomplete. The current categorization is inconsistent with the reality that many people are of mixed ancestry, and, with the exception of whether or not one is of Hispanic heritage, ethnicity is not included. Likewise, census categorizations shift over time, with changing social and political consequences. This is not to argue that race differences need not be accounted for, but it requires us to acknowledge the inadequacies in these categorizations and their use.[28]

In a recent study of 156 randomized control trials by Berger et al,[31] on which

cardiovascular guidelines for women were based, only 46% included race as a demographic; of these, the number of African Americans actually tested in trials was reported in only 13% of studies. Thus, inclusion of race categories can be sporadic, and follow-through analyses may be missing. Upon literature review, NeSmith[32] concluded that nursing research, including analysis, about racial health disparities is needed in more specialized areas of clinical practice, such as acute, life-threatening injuries.

Drevdahl et al[28] reviewed more than 300 nursing research studies in *Nursing Research* from 1955 to 2000. Only 27% of studies that included race categories had further mention of them in data analysis. Many studies revealed the number of white participants but did not mention any other racial groups. Some researchers mentioned these groups as ethnic minorities, "other" or in some cases, "nonwhite." According to Drevdahl et al, in nursing studies:

> Understanding the links between individuals and their health requires knowing who people are . . . through race and ethnicity categorization. Yet how does nursing advance knowledge without understanding . . . the placement of an individual into a particular category within a single study at a specific time in history? . . . Arbitrary and non-rationalized criteria for restricting or increasing racial and ethnic diversity of research samples, inconsistent use of race and ethnicity variables within research projects, and unsubstantiated and inadequate analysis of race and ethnicity . . . are significant factors in determining the integrity of nursing research and subsequent knowledge development.[28(p53)]

Drevdahl et al hold that we must acknowledge the dominance nurse researchers have in determining how and when race is incorporated in their research. It may be that some nurse researchers simply classify participants on the basis of their own perceptions of color, language, facial features, and so forth: few had participants define themselves. Drevdahl et al urge attention to (*a*) transparency, that is, who is included in the racial and ethnic divisions, (*b*) hidden assumptions about race, and (*c*) objectives of future studies regarding race, adding that it is highly possible that these factors may harm the very groups researchers are aiming to help.

> . . . Such categories "should not be treated as 'natural' or self-evident." . . . Scientists may unintentionally reify the categories and differences in health status or rates of disease. This reinforces the belief that biologic differences are responsible for the disparities between different groups, in spite of genetic science showing that these differences are relatively miniscule.[28(pp57-58)]

These researchers still advocate using race categories, carefully explained and designated, for specific purposes: to determine the social effects of racism and demonstrate effects of race on health care encounters.

Epstein[33] raises questions about the many strategies recently developed to recruit POC into studies. This situation is fraught with political tensions around trust in the research process. How can we deal with the tensions of having persistent exploitation in some research, while assuring the "others" we recruit that there are no current risks at play?[33]

A historic example of pathologizing research toward POC and African Americans in particular is that concerning IQ and race, originating in the US and German eugenics movements and gaining momentum in the burgeoning of psychological test development in the 1950s.[29,34] Painter details nativist fears of immigrants from Eastern and Southern Europe, as well as blacks, threatening the favored white "stock," producing "inferior offspring." The eugenics movement, popularized from the turn of the 20th century into the 1950s, was based on pseudoscientific research that served as the basis for sterilization programs for the mentally disabled and those of undesirable racial "stock." An example of the reasoning behind racial inferiority was that blacks were more suited to the slave life and thus had difficulty coping with "civilized" institutions.[29] The pseudoscience was gradually dismissed by more rigorous genetic research (eg, in the 1960s). Psychological testing, however, reinvigorated the myth

of black inferiority, because a consistent gap was seen in IQ scores between blacks and whites. Eventually, it was determined that the intelligence test scores varied according to the economic investments in segregated educational institutions,[29,34,35] and that the tests (including the Stanford Binet and Wechsler scales) were culturally biased.[35]

If this seems like ancient history, Rushton and Jensen concluded after reviews in 2005[36] and 2006[37] that "the mean Black-White IQ difference is 80% heritable."[37(p921)] The Tuskegee study[38] is often referred to as engendering a collective memory of African Americans that is detrimental to research participation, but fear of pathologization via standardized tests in general, and their use in research, is another such example.

Ethical concerns about race and research still need to be grappled with. More study is needed to handle the complexities of racial health disparities and nursing's role in not only perpetuating disparate health outcomes but also examining the dynamics of the political environments in which empirical knowledge development takes place. For example, when most research projects have their inception in the still-too-white halls of academia, there is a bigger hurdle to overcome in terms of fostering critical knowledge regarding diversity and not in simply including POC as research participants.

NURSING THEORY AND RACE

Understanding knowledge development and how racial categories are used, or not, also includes examining nursing theories for bias and/or omission of consideration of racial inequalities. For example, most theories encompassing the nexus of person, health, and environment have not explicitly held that race is a significant concept related to being a person, whereas POC would likely say that it ranks among the most essential aspects of the quality and trajectories of their lives. Nurses, insofar as we are a predominantly white group, do not have this minority experience based on *race*. This is not to say that nursing has not been affected by gender and professional hierarchical bias, especially in the interface of (historically male) physicians and female nurses. Comparing forms of oppression takes them out of context and may leave one with an oversimplified view of persons' experiences of environments of inequality. The majority of nurse theorists have been white and, unsurprisingly, race has not been highlighted as an explicit, major aspect of person, environment, and health in most of nursing theory.

Culture care and cultural competency

Arguably, an exception to this thesis is Transcultural Nursing, specifically Culture Care Theory, developed by Leininger,[39] that deals with color, especially as it relates to ethnicity, and wherein differences are assumed to be primarily cultural. Goals of cultural care are to increase and respect diversity and to engender harmony within and among groups in society and in the health care encounter.[39-41] Lancellotti,[42] also a transcultural nursing author, argues that culture care proponents have seldom dealt squarely with, nor taught students at depth about, institutionalized racism and interpersonal racist dynamics. The general cultural care/cultural competency approaches are derived from anthropology, and these approaches make their strongest and most important critique on the phenomenon of ethnocentrism (which is still a problem).[43] Mulholland[44] argues that the culturally based theories in nursing often do not go far enough in depth about the historical and political realities of bias and suffering involved in racism, because they depend on a humanistic stance. To move beyond culture to an analysis of power dynamics would focus on conflict that would compromise the implicit humanistic imperative that we all should "get along" as in Rodney King's plea. Drevdahl et al state, " . . . we agree that individuals . . . benefit from care that acknowledges cultural differences. We argue, however, that healthcare disparities exist at a population level and therefore require broader theoretical acknowledgement of structural processes and practices of power."[45(p14)]

Culturally based nursing models can also reify essentialist descriptions of particular groups such that intragroup differences, often related to individual or subgroup disempowerment, may be lost.

Many culturally based conceptualizations might too easily presume an "equality" between white ethnic/cultural groups and blacks, which often does not exist in view of social opportunity and economic standpoints. Allen's[46] review showed that despite cultural competence inclusion in advanced nursing education, poor understandings of racism persisted, with a lack of explicitly antiracist material gleaned from cultural competence education.

Critical theoretical developments

There are, however, recent examples of more critical knowledge developments in nursing with implications for practice and research. Dailey's[47] concept of clarification on perceived racism begins with a contextual explanation of racism and concludes with a useful diagrammatic model that illustrates perceived racism as a mediator of health outcomes. Hardy's[48] concept of exploration of race led her to conclude that demographic collection of research data should include not only physical but also social attributes of race, and that eventually a tool could be developed that would show and clarify contributing factors to health disparities. Theoretical needs include inductive reasoning based on factor analyses, building upon critical descriptive studies, to isolate various factors involved in disparate access. In the future then, nurses could measure and assess what mechanisms of care are in place, how individuals and families are treated when they do access care, and to what degree they are marginalized as a result, as alluded to by Pauly.[49]

Accounting for other sources of disparities

Racial health disparities have been acknowledged in terms of environments of care and treatment in health care interactions but are also affected by societal environmental realities. For example, hospitals located in predominantly African American neighborhoods are likely to be inferior in resources as compared with hospitals in white areas.[50] Moreover, despite the civil rights movement's successes, de facto segregation is a stark reality. This is the case not only in terms of inequitable geographic location but also in terms of value received for the money regarding education, lending, and quality of services and goods.[13]

Disparities are multiply caused, for example, when a low-income black person gets a less-invasive medical procedure, does not get a needed one, or is "missed" if his or her symptoms differ from the "norm." Differential care based on gender and race may be given despite identical symptom profiles, as was the case in studies of disparities in cardiac care upon presentation to the emergency department (see, eg, references [51] and [52] for further information on these points). Yet additionally, the client may also have no insurance to pay for preventive or proactive care and may be treated with prejudice, avoidance, or even hostility on the part of a provider in health care encounters. In this case, assumptions, economic constraints, misunderstanding of needs, and failure to treat with dignity merge in a perfect storm that happens too often for POC seeking health care. Theories in nursing are needed to account for this multiple causation. We emphasize that while we have not specified relationships among race, gender, class, and sexual orientation, new theories in nursing must conceptually encompass the full range of sources of marginalization to guide research and practice that is reflective of the sociopolitical environments of care.

Other theoretical needs in nursing include more concept analyses of race-related language and of processes leading to disparities. For example, concepts such as differential care, microaggression, and belongingness could be framed in the context of racial dynamics in daily experiences and especially health care encounters. We will focus here on one of these, racial microaggression.

MICROAGGRESSION IN PRACTICE

Microaggression as interpersonal racism

Policy changes, diversity programs, and new organizational frameworks can be useful in decreasing discrimination in a general way, though enforcement of these changes also depends ultimately on individuals within structures and how they interact with POC and make decisions about specific cases. Interpersonal racism can be overt, such as name-calling and bullying. More often in contemporary environments, it is subtle and oblique, especially in language and nonverbal behavior of white people.[53] Dovidio and Gaertner[54] discuss subtle racism as *aversive racism*, referring to subconscious negative tendencies toward POC that occur even in white people who consider themselves fair and nonbiased regarding race. The subtle forms of racism are largely communicated through racial microaggressions, defined by Sue et al as "brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group."[21(p273)]

Being ignored by a sales clerk, told by an employer that "the most qualified person should get the job" and that "I don't see color," or even complimented for speaking "good English" may all constitute racial microaggression because they communicate denigrating hidden messages: "You are not important enough to be noticed"; "People of color are less qualified"; "I don't notice color, so I can't be racist"; and "You are not a true American but a foreigner."[55]

White people may view their comments as innocuous, and aversive body language as minor, but as experienced by the target POC, these aspects of interaction are perceived as part of a daily pattern of slights and have negative consequences that stem from, and contribute to, marginalization. Even so-called positive statements such as "I work with a lot of black people," or a practice of "helping" a person of color, when it is not needed, can constitute microaggression; these may be construed as whites' attempts to avoid being seen as racist.[56]

Microaggression and stress

Microaggression is a concept that can concretize the general perception of being invalidated by breaking biased behavior down into explicit taxonomies. The effects of microaggression are believed to accumulate for the target person. This stress contributes to allostatic load through social microtrauma.[57] Nurses need to be aware that accumulating microaggressions from one's daily life as a black person might result in chronically increased cortisol, and the exhaustion phase of the stress response is thought to be implicated in host of health problems.[58] These may include, for example, hypertension and depression. In addition, nurses themselves might unwittingly contribute to microaggressions by perpetrating them in the nurse-patient encounter or ignoring them when perpetrated by another provider. Thus, careful studies of microaggression in health care environments should be undertaken.

Insights from the counseling field

Constantine[56] studied cross-racial counseling in terms of African American clients' perceptions of racial microaggressions in relating to white counselors, and how this affected their working therapeutic alliance and satisfaction with counseling. Identified microaggressions attributed to white therapists included colorblindness ("I don't see color"); overidentification with the black client (I understand because that happened to me as well); denial of individual racism; minimization of racial issues (everything is not about race, you know); and designating special status to the client (as if the person is an "exception" to his/her racial group). Also included are stereotyping (eg, assuming that the client likes jazz music); telling the client that he or she is too sensitive about race; assuming that if people work hard they will merit regardless

of race; giving culturally inappropriate care or referrals; and accepting less in terms of achievement of therapeutic goals from black clients. This can also take the form of idealizing racial groups (eg, "Because of being African American, you are a strong woman") and patronizing responses (eg, assuming that the client cannot pay for services).[56]

Microaggressions affected African Americans' perceptions of the therapeutic working alliance and resulted in decreased satisfaction with the counseling process as a whole. Thus, a danger is that clients of color might avoid therapy or health care in general and/or prematurely terminate treatment. Constantine[56] holds that microaggression in a person who is designated as a helper, deserving of confidential information, and so forth, might have worse consequences than when microaggression is perpetrated by nonhelpers. Furthermore, "Because such microaggressions may parallel the experiences of these clients outside of therapeutic settings, African American clients could be retraumatized in the context of these settings, which are presumed to be safe harbors . . . in fact [they] might feel worse after their counseling experiences than before."[56(pp12-13)] Constantine[56] recommends future research that will focus on teaching therapists to recognize microaggressions and work to overcome them.

Sellers and Shelton[59] examined some factors that affect the perception of microaggression by African Americans and the degree to which combinations of these measures resulted in psychological distress. First is *race centrality*: how much one identifies with one's racial group. The second is *race ideology*, of which they identify 4 types. These include the nationalist (the uniqueness of one's racial group) and assimilationist (stressing similarities across all racial groups), oppressed minority (stressing similarities across minority groups), and humanist (stressing the commonalities of all humans) ideologies. The third factor is *race regard* or beliefs of African Americans that others regard African Americans, in general, positively or negatively.[59] Examples of microaggressions included not being given service, being treated rudely, being treated suspiciously, being observed or followed in public places, being "talked down to," having opinions or ideas devalued or ignored, being called an offensive name, and overhearing a racist joke.[59]

Greater race centrality was associated with more perceived discrimination, yet the meaning attributed to the discrimination had a different effect. Those with nationalistic or oppressed minority ideological stances and those believing that regard for African Americans is low suffered *less* psychological distress (trait anxiety and depression) than did others, for example, who had a humanistic stance. This suggests that *expecting discrimination to occur* was actually protective for the participants. Sellers and Shelton[59] surmised that vigilance may decrease stress, or that congruence of experience and worldview is associated with less psychological distress.

If nurses' view of equality means ignoring color and minimizing group differences based on race, they might problematically endorse humanistic or assimilationist ideologies which provide *less* psychological protection to their African American clients. We hold that it is realistic only for clinical nurses to assume that microaggression occurs. Moreover, in counseling clients of color, nurses might wisely communicate that microaggression sometimes occurs in African Americans' daily interactions, rather than encourage clients of color to ignore these painful behavioral messages. In addition, if nursing is silent about microaggressions, it likely discourages POC to speak of them, despite the possibilities that they are sources of health distress.

Narrative as a clinical approach

Delgado and Stephancic[12] state that CRT includes the use of narratives from the standpoint of POC to understand their oppression. Hall and Powell[60] recommend clinically approaching POC from a narrative perspective to counter assumptions with concrete information, tying experiences and symptom patterns to life contexts. This works because

narratives can depict or represent social actors and interactional environments that are important to clients. Stories reveal one's personal history and future expectations. In practice, knowing the person's narrative can be an essential safeguard against virtually free-floating racialized assumptions and stereotypes in the sociopolitical milieu. These racialized assumptions constitute the "default" in situations in which there is a vacuum of concrete personal information known about the individual.[60] If these assumptions are not overcome, a black person, for example, does not feel known at depth by the provider. Narratives also can flesh out the context of health problems and health resources in which the client is situated. Then one can apply critical analysis that includes assessment of the kinds of biases that are faced by POC.

MICROAGGRESSION IN EDUCATIONAL CONTEXTS

Although nursing's *commitment* to diversity in the profession, in our student bodies and specifically in faculty, is widely evident, the results of our efforts have not yet resulted in the profession being racially representative of the wider culture. We will discuss elements of microaggression that apply to these contexts. Because a diverse faculty is essential in recruiting POC into nursing, we must take this into account when considering knowledge development and dissemination in teaching as it relates to microaggression and provide insights for white faculty dealing with classroom racial issues.

One faculty's concerns

Work on microaggression in education has been done in the counseling field.[61] Butler-Byrd[61] is 1 of 6 African Americans among 780 tenure/tenure-track faculty members at San Diego University. As a teacher and supervisor of counseling students, she is often the first African American teacher whom students at her university encounter. She uses decolonization theory, examining and countering Eurocentric models, as a basis for what she calls transformative education, and many students seek her practicum class out. She says of her teaching:

> I stress the importance of self-knowledge as critical to the well-being and competence of multicultural counselors. Self-knowledge includes understanding our historical and current cultural context and . . . social location, ethnicity, class, gender, and ability. Self-knowledge also includes awareness of the effects of one's behavior on others . . . I challenge [students] to lean into their discomfort regarding their own interpersonal and intrapersonal issues . . . using decolonizing, person-centered approaches, critical transformative empowerment and deliberative democratic decision-making processes.[61(p12)]

Equally important in understanding the faculty experience is to acknowledge the barriers faced by faculty who are POC. Butler-Byrd finds that she is challenged more often in class than are white faculty members, especially by males espousing Eurocentric models. Students have reported to her that initially they were concerned that she would not be able to teach them as well as would her more Eurocentric colleagues. Of her own struggles as an African American teacher, she says:

> I have often felt I have to work "twice as hard" to prove I am as good or better than European American . . . faculty . . . self-consciousness about my appearance and how I present myself still emerges. This is reflected in my deliberate choice of clothing, hairstyle and manner of speech as well as my tendency to overwork and overcompensate.[61(p12)]

She reports that her students who are POC feel silenced and have experienced racially related trauma for which they need to seek therapy for themselves. She notes that white students have to work to see verbal and nonverbal microaggression in their interactions with clients and peers. One white student reported that as a result of a raised consciousness, she no longer thinks of herself as "cultureless . . . within a sea of my own kind."[61(p14)] Despite her own successes in countering oppression, Butler-Byrd still sees the academic environment as colonizing,

characterized by humiliation. The prominence of bullying in general education, nursing education, and practice suggests that humiliation is still a common experience, and it is likely that some bullying occurs on the part of whites toward nurses of color in overt as well as aversive racism.

Difficult racial discussion in the classroom

Sue et al[55] reported that difficult, emotionally charged dialogues on race often come on the heels of microaggressions or in response to racially biased course materials. They describe difficult racial dialogues as:

> . . . Potentially threatening conversations or interactions between members of different racial or ethnic groups when they (a) involve an unequal status relationship of power and privilege, (b) highlight major differences in worldviews, personalities and perspectives, (c) are challenged publicly, (d) are found to be offensive to others, (e) may reveal biases and prejudices, and (f) trigger intense emotional responses. Any individual or group engaged in a difficult dialogue may feel at risk for potentially disclosing intimate thoughts, beliefs or feelings related to the topic of race.[55(p184)]

They conducted 2 focus groups with students who self-identified as POC, most of whom had at least a bachelor's degree. The analysis of the qualitative data was done in 3 contexts: subteams, entire research team, and an audit group, which was designed to challenge all themes identified, to enhance objectivity. Recruitment included the provision that participants had experienced microaggression in the forms of being put-down, ignored, or insulted, based on race. Open-ended questions were used to elicit data on whether POC had experienced a classroom situation in which race was involved, what makes these race-based dialogues difficult, and how these situations were handled by the teacher.

Focus group members easily and consensually identified microaggressions (though they did not use that term) in the classroom, such as having one's intelligence questioned, feeling like an alien, having racial experiences denied by others, and being assumed to be criminal. They were not cued to do so, but their attention was focused on classes with white teachers. Sue et al said: " . . . none of the participants disagreed with each other when incidents were described. More often than not, they seemed to indicate they had either witnessed or experienced similar situations."[55(p186)] Regarding ascriptions of intelligence, students of color reported others speaking for them or trying to explain to others what the POC was saying. Conversely, some Asian students reported being assumed to have special abilities in math.[22] Regarding feeling like an alien/foreigner, students described others speaking more slowly to them and looking surprised when they spoke English quite well. When speaking of a racially related experience, the students of color reported that whites would disagree, deny that race was involved, find an alternative explanation for the experience, or state that they did not understand the POC's experience because it was "unclear" or "irrelevant."[55(p186)] One informant described other's nonverbal behavior, rolling of the eyes, as something that "scream(s) at you, 'here we go again.'"[55(p186)]

African Americans especially noted the suspicion of criminality they experienced when seeing whites grasp at their belongings. This underscores the assumption of blacks to be criminals and untrustworthy. Similarly, when classroom materials or films depicted angry blacks, whites asked what to do if they (blacks) became violent or dangerous, to which the teacher replied that one should place oneself near an exit. According to the students of color, during difficult racial discussions, white students' physical reactions included "eyeball rolling, shifting or slouching in chairs, doodling, turning red, avoiding eye contact or looking down, fidgeting, becoming quiet, and the most common, crying."[55(p187)] Students of color interpreted such crying as an attempt to gain empathy and as manipulation for the topic of race to be dropped.

Helpful and unhelpful responses by faculty

In terms of helpful reactions by instructors, the students of color included affirming the legitimacy of the race discussion, validating feelings of the POC in class, accepting a different worldview of the POC, displaying comfort with racial discussions, and a direct approach in managing discussions. Unhelpful white teacher responses were passively letting students control the dialogue, disengaging, dismissing the topic as unimportant, changing the topic, becoming emotional, and treating the POC as an expert on the topic of race. White teachers were perceived as "hung up" on the topic of race presumably because of not wanting to appear biased. Students seemed to perceive the negative behaviors of teachers as continuation of the microaggression that often had initiated the conversation in the first place, and so these are not benign teacher responses.[55]

In comparing students' and instructors' perceptions of overt and subtle bias (racial, ethnic, religious, sexual orientation, gender, and ability-related) in the classroom, Boysen and Vogel[62] surveyed 2523 graduate and undergraduate students (52% female, 77% white) and reanalyzed data from a previous study with 2148 professors. Their research questions were directed at finding how much bias is perceived, professors' response to it, the effectiveness of responses, and how similar students' versus faculty's responses were. In addition to surveys, bias was described in open-ended questions. They found that graduate instructors and professors did not vary in their perceptions of overt bias. The 2 groups did vary, however, in their noticing subtle bias (ie, microaggression), with graduate instructors seeing more of it than professors.[53]

Twenty-two percent of undergraduates reported being the target of overt bias in classrooms during the previous year, the majority of which pointed to racial, gender, or ethnic bias. Undergraduates perceived subtle bias (gender followed by race and ethnicity) more frequently than did teachers, with graduate instructors again seeing it more than did professors. Students' ratings of successful teacher responses were significantly lower than were teachers' ratings of success in dealing with bias. Teacher responses most frequently included direct confrontation, providing information, group discussion (all perceived by students as helpful), and ignoring bias (perceived as unhelpful), with a substantial number of undergraduates perceiving the teacher as joining in with or being the source of the bias. In sum, about 25% of teachers and half of students reported bias in the previous year, with about 25% of students reporting being a *target* of overt or subtle bias in the previous year. Although about 40% of teachers reported that they dealt successfully with bias, about the same percentage reported *not knowing whether their response was effective*. Implications included that since graduate instructors are more likely to perceive bias, they should be adequately trained to handle it, and bias should be addressed proactively with policies and direct statements of nondiscrimination in syllabi, and so forth, to make the classroom environment safer for POC.[53]

Nursing education and bias

We have gone into some detail with current research on counselor education and college education in general to show the complexities involved and the trends indicating that bias, especially racial bias, is fairly common in educational settings. There is little reason to hold that nursing education is different, and in fact, in view of our diversity numbers, the situation may well be worse. Students who feel bias may leave, and students of color may avoid nursing as a major. This is especially stark in view of the fact that in the current economic climate, and considering that there is a nursing shortage, entering this field holds the promise of full employment. Of course, the studies cited above need to be replicated in nursing in order to verify our claims.

Studying microaggression in the classroom, in clinical settings, and in the community is a useful way to begin to unravel

structural racism and make connections between structural and interpersonal racism on an individual behavioral and discursive basis. As an antidote to racist dynamics, through consciousness-raising in nursing students, Taylor et al[63] employ racial self-narratives or autoethnography to have students explore how they learned about race, situated in a critique of class, race, and gender. Another forward-looking approach by Van Herk et al is to use an intersectionality viewpoint to include "othered voices" by examining "interlocking oppressions of race, gender and socioeconomic status . . . ."[64(p37)] Meleis and Im[65] recommend development and dissemination of knowledge targeting specific marginalized groups in an integrated way so that education itself is not marginalizing.

Barbee[66] cites factors fostering racism that should be combated in nursing education. These include claims to empathy, which then engender the assumption that racism cannot come into play; an intolerance for conflict; the tendency for faculty to favor homogeneity in students, who are like-minded and Eurocentric in outlook; and a focus on individuals instead of the larger political environment.[66] The generation and dissemination of nursing knowledge in nursing academia affects clinical practice. Eliason[67] points out that white guilt and denial of racism can be paralyzing in both education and practice. More research is needed to close the gap between "big racism" in societal policies and health-related educational institutions and overt and subtle biases in interpersonal interactions, that is, microaggression.

CONCLUSION

Beginning with disagreement that we live in a postracial society, we have explored some aspects of racial bias and consequent results in terms of theory, research, practice, and education, including omission of race as key to many nursing-related phenomena. Several things are clearer, if not established. First, health disparities are complex, involving little genetic basis but much more possible basis in African Americans' experience of racial bias. Some bias results when race is encountered as both a descriptor and a variable in the processes of research. In much research, race is treated quite variously and usually not analyzed in terms of its impact on the whole study. Second, the generation of relevant nursing theories should incorporate concepts useful to understanding the person as often racialized by others, categorized as a person, and marginalized within a group environment. Microaggression is such a concept. It represents one means by which marginalization takes place. As such, it will prove useful in producing theories that realistically deal with the power dynamics involved in the interface of person and environment, whether that is a geographic environment, a place of de facto segregation, or the social environment.

The most accessible locus at which we might have an impact on racial health disparities from a nursing perspective is to examine the care encounter for evidence of racial microaggression, as well as to identify strategies that counter it, such as approaching persons narratively and preserving individuality and the life context, which includes racial identities and experiences. Likewise, this entails urgent attention to the study of how access, trust, and microaggression are related, and in what specific ways these factors affect the stress load and subsequent health outcomes of POC.

Lastly, we as nurses will not have that impact on practice until we address microaggression and the omission of meaningful and up-to-date dialogue about race in nursing academia. Beyond efforts for diversity which invite racially diverse others into the fold, there need to be efforts at retention, which again means examining and stopping microaggression from student to student and from teacher to student. We have not significantly addressed the convergence of marginalizing factors that can affect patients as well as students. This will necessitate exploratory research to generate the taxonomy of forms

that microaggression takes when not based on racial bias but on other stigmatizing, targeting, and marginalizing bases, such as class, gender, and sexual orientation.[22] Nursing has much to gain by examining the person-environment nexus of racial and other microaggressions and the profession's role in perpetuating or diminishing racial health disparities. Moving forward on these fronts is imperative, and the time is now.

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