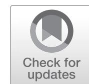

Identifying and Remediating Personal Prejudice: What Does the Evidence Say?

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Abstract

In behavioral health settings, prejudice is a serious problem with significant implications for service delivery. Despite genuine efforts to help, clinicians behave in prejudiced ways toward clients and patients, often leading to problems in treatment or to the abandonment of treatment altogether. In this chapter, we outline the history of prejudice research, discuss definitions of prejudice, and review the empirical research on prejudice reduction interventions. We then critique prejudice reduction research from the perspective that collective action may more effectively produce social change. Finally, we return to the necessity of prejudice reduction in behavioral health care, offering practical suggestions from the literature and from our own experience as clinicians, researchers, and educators.

Keywords

Prejudice · Bias · Behavioral health · Prejudice reduction · Collective action

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Susan, a 61-year-old white clinical psychologist in private practice, agreed to an initial consult with Elías, a 24-year-old light-skinned Dominican American man who has been struggling with insomnia. Susan specializes in sleep disorders, and typically uses a cognitive-behavioral approach that has been very effective for many of her patients. On the day of the appointment, Susan noticed Elías's eyes darting to the framed paintings and certificates in her office. When asked if he was comfortable, Elías assured Susan that he was. Elías answered all of Susan's questions quickly and directly, and he listened closely as Susan described the treatment approach. Finally, at the end of the hour, Susan asked Elías about the fee. Would he be able to afford the $250 per session Susan normally charges, or would he need a sliding scale? To Susan's surprise, Elías looked her in the eye and said, "That's racist." Susan was taken aback, and stumbled over her reply. "I—I'm sorry, I didn't mean to—" Elías then drew out his checkbook and said, "I'm assuming I pay you for this one?" He quickly wrote a check and handed it to Susan, who was blushing with embarrassment. As Elías got up

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to leave, he said, “See you next week, doc. I hope you can help me sleep.”

Bella, a Taiwanese American counseling psychologist, has been seeing Julie, a 46-year-old white law clerk who became disabled after a car accident one year ago, and now uses a wheelchair. Bella has worked with patients with physical disabilities before, but accommodating a patient in a wheelchair is a new experience for her. Each week at the time of their appointment, Bella goes to the waiting area of the community mental health clinic and greets Julie. She then wheels Julie into her small office, where she has carefully rearranged the furniture to provide adequate space. On the day of their fifth appointment, Bella completed this ritual and sat down in her chair when she noticed Julie looking at her anxiously. “Dr. Lin, I want to thank you for all the help you’ve been, but I don’t think we can work together anymore. Ever since the accident, I have been educating myself about disability rights. I need someone who is a bit more aware of those issues. I’m very sorry.” Bella looked at Julie in disbelief, wondering what had prompted this.

Introduction

In behavioral health settings, prejudice is a serious problem with significant implications for service delivery. Despite genuine efforts to help, clinicians behave in prejudiced ways toward clients and patients, often leading to problems in treatment or to the abandonment of treatment altogether (Fitzgerald & Hurst, 2017; Institute of Medicine, 2003). Like the general population, clinicians engage in behaviors that are racist (Burke et al., 2017; Cheng, Iwamoto, & McMullen, 2016; Shin, Smith, Welch, & Ezeofor, 2016), gender biased (Ali, Caplan, & Fagnant, 2010; Colbert et al., 2015), classist (Garb, 1997; Thompson, Cole, & Nitzarim, 2012), homophobic and homonegative (J. A. Hayes & Erkis, 2000; Shelton & Delgado-Romero, 2011), transphobic and transnegative (Mizock & Lundquist, 2016; Riggs & Sion, 2017), ableist (Shyman, 2016; Smith, Foley, & Chaney, 2008), xenophobic (Alda Díez, García Campayo, & Sobradiel, 2010; Johnson & Orrell, 1996), or prejudiced in other ways against marginalized groups. Historically, prejudice research has typically focused on single dimensions of identity and has failed to reflect the fact that every individual belongs to many groups. Recent research has begun to document more complex forms of prejudice at the intersections of race and age (Burgess et al., 2014), HIV status and age (Emlet, 2006), and sexual orientation and race (Calabrese, Earnshaw, Underhill, Hansen, & Dovidio, 2014), to name a few examples. See Table 1 for brief descriptions of the above findings.

Prejudice and bias in the helping professions have been identified as contributing factors to disparities in the quality of care to racial/ethnic minority populations, sexual minorities, the poor, and other oppressed groups (Dovidio & Fiske, 2012; Herek & Garnets, 2007; Institute of Medicine, 2003). As the population becomes increasingly diverse, individual-level prejudice may increase rather than decrease over time. In the United Kingdom in the 1960s, where comparably less racial and cultural diversity existed than today, severity of diagnosis predicted clinician assessments of insight in psychiatric inpatients, whereas patient race and ethnicity did not (Johnson & Orrell, 1996). By the 1990s, as immigration and racial diversity increased in the UK, patient race and ethnicity were the *only* predictors of how much insight patients were believed to possess, with White British patients rated as having more insight than Black Caribbean and Black African patients (Johnson & Orrell, 1996). Clearly, to improve the quality of care and reduce service inequities, interventions are needed to reduce prejudicial attitudes among mental health providers and the harmful behaviors that stem from them. But the science surrounding this obvious need is not straightforward.

In this chapter, we take a seemingly simple task—reviewing the empirical literature on prejudice reduction—and complicate it. Prejudice has received more attention in social psychological research than almost any other subject. For that reason, one might expect the literature to be brimming with well-documented, practical strategies that anyone could use to identify and reduce their own prejudicial attitudes and behaviors. That is unfortunately not the case. In the first part of this chapter, we briefly outline the history of prejudice research, discuss definitions of prejudice, and then review the (surprisingly limited)

Table 1 Examples of prejudice in behavioral health settings

Finding	Reference
Instructors' disparaging remarks encourage trainee racial bias	Burke et al. (2017)
Model minority stereotype predicts underdiagnosis of Asian Americans	Cheng et al. (2016)
Clinicians are less likely to invite a prospective client with an African American name to start therapy than a prospective client with a White name	Shin et al. (2016)
Women are less likely to be referred for effective treatment for heart disease	Colbert et al. (2015)
Women are overdiagnosed in terms of mood and personality disorders	Ali et al. (2010)
Therapists display status symbols in their offices that convey elitism	Thompson et al. (2012)
Low-income clients are overdiagnosed	Garb (1997)
Microaggressions against LGBTQ people occur in therapy (e.g., pathologizing sexual orientation)	Shelton and Delgado-Romero (2011)
Therapist homophobia predicts blaming HIV+ clients for their status	Hayes and Erkis (2000)
Cisgender men psychologists are more negative toward transgender people than cisgender women psychologists	Riggs and Sion (2017)
Transgender clients are burdened with educating their therapist	Mizock and Lundquist (2016)
Medical model reinforces ableist assumptions about clients	Shyman (2016)[a]
(Dis)ability-related competence training is lacking	Smith et al. (2008)[a]
Immigrants are offered less treatment and are subject to greater security restraints than native-born inpatients	Alda Díez et al. (2010)
White native-born patients are rated most insightful by clinicians; Black Africans and Caribbeans are rated least insightful	Johnson and Orrell (1996)
Older Black veterans are given more pain medication for low-intensity pain than Whites; younger Black veterans are given less pain medication for high-intensity pain than Whites	Burgess et al. (2014)
Clinicians are less likely to prescribe PrEP to Black men than White men	Calabrese et al. (2014)

[a]Indicates theoretical paper. Other references are empirical studies or literature reviews

empirical research on prejudice reduction interventions. Next, we discuss a critique of prejudice reduction research, the possibility that *collective action* is a more effective mechanism to produce social change. Finally, we return to the necessity of prejudice reduction in behavioral health care and offer practical suggestions drawn from the empirical literature and our own experience.

A few words about who we are and how we approached this topic. We are a professor (Doris F. Chang) and her current and former doctoral students in clinical psychology at The New School for Social Research in New York, New York. As clinicians, researchers, and educators who represent diverse social identities and are explicitly guided by social justice frameworks, we approached this chapter with a critical perspective, keeping the following questions in mind: what assumptions do social scientists tend to make about prejudice? Is there received wisdom about prejudice research that needs to be challenged? How do institutional and historical factors shape scientific questions and answers about prejudice and its remedies? We encourage the reader to critically engage these questions with us.

A Brief History of Prejudice Research

Before prejudice became a subject of scientific inquiry, group differences were typically explained through biological narratives of inherited superiority (Duckitt, 1992; Samelson, 1978). When empirical data challenged these narratives, findings were often interpreted in ways that reinforced the biases of the dominant group. For example, in an 1895 study of reaction times between African and European participants, the *faster* reaction times of African participants were interpreted as evidence of their "primitiveness" and presumed lower intelligence (Samelson, 1978). In another example, after the Immigration Act of 1924 dramatically limited the immigration of certain nationalities to the United States, many comparative intelligence studies were abandoned, given that "it was no longer necessary to justify scientifically the exclusion of these undesirable and inferior aliens" (Samelson, 1978, pp. 270–271). These examples illustrate a type of institutional bias known as "scientific racism" (Fairchild,

1991; S. Sue, 1999). In addition to racism, "scientific" sexism, heterosexism, classism, ableism, and other oppressive systems are also readily apparent in the history of research on group differences and have significantly shaped the kind of scientific questions both asked and answered. Although our focus is on prejudice reduction, see Chap. 2 in this volume for a discussion of the impact of scientific "isms" in (Topics).

In the 1920s and 1930s, serious scientists backed away from essentialist notions of individual difference and began looking instead at *perceived* differences between groups (Samelson, 1978). In the 1940s and 1950s, these questions became urgent as the scope of the Holocaust, and the Nazi obsession with racial purity that led to it, came to light (Duckitt, 1992). Over time, "prejudice" became the catchall term for mental operations hypothesized to undergird behaviors such as discrimination, exclusion, and violence perpetrated by members of one group against members of another. In the decades since, prejudice has preoccupied social scientists like no other issue, producing an enormous body of scholarship (Paluck & Green, 2009).

The concept of prejudice has intuitive appeal. Prejudice, or "pre-judgement," is typically considered an error in thinking—a troubling bit of code in the human psyche that might be deleted, or at least edited, if only we knew how. But researchers have struggled to demonstrate this due to competing theories about what prejudice is and how it works. An ongoing debate centers on levels of analysis and definitions of the problem: does prejudice operate primarily at the societal level or at the individual level? Sociologists tend to look at societal-level explanations, while psychologists tend to focus on the individual level. If we restrict our lens to individual-level or "personal" prejudice, other questions arise. Is there such a thing as a "prejudiced personality"? How is prejudice learned? How is it unlearned (and can it be)? Should the focus of prejudice reduction be on explicit attitudes, implicit attitudes, or both?

A historical review of the psychological understandings of prejudice chronicles the field's changing perspectives on the fundamental nature of prejudice (Dovidio, 2001; Duckitt, 1992). In the 1920s and 1930s, prejudice was seen as "irrational and unjustified"; in the 1930s and 1940s, as an "unconscious defense"; in the 1950s, as an "expression of a pathological need"; in the 1960s, as a "social norm"; in the 1970s, as an "expression of group interests"; and in the 1980s, as an "inevitable outcome of social categorization" (Duckitt, 1992, p. 1184). Dovidio (2001) described eras of prejudice research in terms of "waves." In first wave studies, prejudice was seen as psychopathological; in the second wave, it was understood to be rooted in normal processes, and in the third and current wave, prejudice is considered as a multidimensional phenomenon comprised of implicit and explicit processes (Dovidio, 2001). Reflecting the biological and mechanistic turn in psychological research, contemporary conceptualizations of the construct of prejudice describe more general universal cognitive processes that contribute to social stratification. For example, in a recent book edited by some of the field's most renowned scholars, prejudice is defined as "an individual-level attitude (whether subjectively positive or negative) toward groups and their members that creates or maintains hierarchical status relations between groups" (Dovidio, Hewstone, Glick, & Esses, 2010, p. 7). In this definition, the valence of the attitude is irrelevant; it can be "subjectively positive or negative." This definition may come as a surprise to those who think of prejudice as a negative evaluation of the other. Although that idea has been influential for decades (e.g., in Allport's (1954) definition of prejudice as "antipathy based upon a faulty and inflexible generalization" (p. 9)), more recent scholarship suggests that prejudice includes positive attitudes, as well as negative. Glick and Fiske's (2001) theory of *ambivalent sexism* illustrates this by proposing both hostile and "benevolent" forms of sexism. In benevolent sexism, girls and women are seen as fragile creatures requiring protection and provision. The hostile and benevolent forms are hypothesized to work together as two sides of the same coin: women are punished when they seek power and rewarded with chivalrous tokens when they accept lower status (Glick & Fiske, 2001).

Gender-based oppression is not the only area in which "ambivalent" dynamics can be observed.

When chattel slavery was legal in the United States, White slaveholders were more likely to think of themselves as noble and genteel than cruel or oppressive (Ferguson, 1996; Green, 2015). Accordingly, enslaved Africans were often viewed as pitiable and deserving of decency so long as they remained subordinate. This double bind exists today in the form of "respectability politics," which suggests that Black individuals bring violence and oppressive force on themselves by not behaving "respectably" enough (Obasogie & Newman, 2016). The model minority stereotype creates a similar paradox for Asian individuals, who are expected to be both high achieving and nondominant (Berdahl & Min, 2012). Like ambivalent sexism, these race-based examples show that when members of a target group seek more power or inclusion, they are often perceived by the dominant group to be dangerous or needing to be "put in their place." If members of a target group are not actively challenging power structures, the dominant group's attitudes toward them may not be negative, in the usual sense. Returning to the current definition of prejudice given above, the active ingredient in prejudice is not the valence of the attitude but rather its impact—for example, whether or not it "creates or maintains hierarchical status relations between groups" (Dovidio et al., 2010, p. 7). (Space limitations prevent us from delving into an analysis of the processes through which an individual attitude can *create* or *maintain* group dynamics; however see Chap. 3 in this volume for more on this topic. For our purposes, it is important that "prejudice" be understood as a complex construct rooted in larger sociocultural attitudes, and which has changed over time, spawning a diversity of theoretical frameworks and empirical approaches. This helps to explain why prejudice reduction research has taken so many different directions and resulted in so little consensus.

Prejudice Reduction: Review of Reviews

If conceptual and definitional challenges have made prejudice difficult to study, identifying markers of *reduced prejudice* has proven even more difficult. Prejudice reduction has been operationalized in many different ways, and thousands of experiments have been conducted to test the effectiveness of a variety of prejudice reduction interventions. In this section, we summarize recent reviews on this topic. See Table 2 for a summary of interventions most commonly studied.

Among the recent articles, chapters, and books reviewing prejudice reduction research, a comprehensive review by Paluck and Green (2009) stands out in terms of its scope and reach. Those authors reviewed research on all types of prejudice except sexist prejudice (see below for an explanation) and included nonpeer reviewed and unpublished studies in their search. Paluck and Green's (2009) final database included 985 reports, representing most of the available work on prejudice reduction up to that point. The authors excluded studies on sexism due to its "qualitatively different nature" and the opinion that such literature deserves its own review (Paluck & Green, 2009, p. 342). Relevant to that decision, they define prejudice as "a negative bias toward a social category of people, with cognitive, affective, and behavioral components" (p. 340).

Paluck and Green (2009) used the following three categories to organize their review: nonexperimental research in the field, experimental research conducted in the laboratory, and experimental research conducted in the field. Nonexperimental research in the field, a large category making up 60% of the reviewed studies, was judged by those authors to be useful only for "descriptive" purposes due to lack of internal validity. They therefore drew no conclusions about what effectively reduces prejudice from those studies. The next category, experimental laboratory research, made up 29% of the reviewed studies. Paluck and Green (2009) organized those studies according to the theories informing them: *intergroup* approaches, including the contact hypothesis and social identity and categorization, and *individual* approaches, including instruction; expert opinion and norm information; manipulating accountability; consciousness raising; targeting emotions; and targeting value consistency

Table 2 Commonly studied interventions for prejudice reduction

Intervention	Conception of the problem	Proposed solution	Description	Reference
Contact	Prejudice stems from lack of contact with outgroup members	Increase contact but under specific conditions	Conditions must promote equality between individuals; otherwise, hierarchical power relations will occur automatically	Paluck and Green (2009)
Cooperative learning	Prejudice stems from competition between members of different groups	Facilitate cooperation by working toward common goals	Students are divided into teams, and each is given content to teach the rest of the team	Paluck and Green (2009)
Counterstereotypic exemplar	Prejudice is maintained by automatically activated stereotypes	Think of exceptions to stereotypes in order to make stereotypes less influential	Participants think of examples that contradict stereotypes of outgroup members (e.g., thinking of Barack Obama when interacting with a Black man)	Devine, Forscher, Austin, and Cox (2012); Carnes et al. (2015)
Education/ diversity training/ multicultural competence	Prejudice stems from ignorance	Acquire accurate information about self and others	(Training objectives, content, and processes vary widely. See reference for overview)	Bezrukova, Spell, Perry, and Jehn (2016)
Evaluative conditioning	Prejudice is maintained by negative affect toward outgroup members	Change valence of attitudes toward outgroup members	Participants undergo repeated conditioning tasks in which representations of outgroup members are paired with positive stimuli	Hofmann, De Houwer, Perugini, Baeyens, and Crombez (2010)
Expert opinion/ norm information	Prejudice is believed to be normal or inevitable	Challenge normalcy/ inevitability of prejudice	Authority figures and respected information sources are used to challenge the idea that prejudice is "normal"	Paluck and Green (2009)
Increase of self-worth	Prejudice stems from low self-worth	Increase sense of self-worth	Participants affirm themselves by writing about important values or receiving positive feedback about personal traits	Paluck and Green (2009)
Individuation	Prejudice is maintained by stereotypes, which are automatically activated	Attend to individual characteristics of outgroup members	Participants focus on outgroup members' clothing, mannerisms, or other features instead of focusing on group membership (e.g., race)	Devine et al. (2012); Carnes et al. (2015)
Manipulating accountability	Prejudice persists because individuals have not thought about how irrational their prejudices are	Think about the irrationality of prejudice	Participants provide concrete reasons for choices (e.g., how much money to divide between different charities, how to judge disciplinary cases)	Paluck and Green (2009)
Mindfulness-based approaches	Prejudiced behavior occurs outside of awareness	Increase awareness of unconscious prejudice	Participants develop mindfulness through the practice of nonjudgmental attending to thoughts and feelings, with the goal of having more agency over behavior	Burgess, Beach, and Saha (2017); Masuda, Hill, Morgan, and Cohen (2012)

(continued)

Table 2 (continued)

Intervention	Conception of the problem	Proposed solution	Description	Reference
Perspective taking	Prejudice stems from a lack of empathy	Increase empathy through imaginal exercises	Participants imagine what it feels like to be the target of harmful stereotypes (e.g., being thought of as lazy or dangerous)	Devine et al. (2012); Carnes et al. (2015)
Prejudice habit-breaking intervention	Prejudice is a "habit"	Break the habit through training and practice	Participants learn and practice five strategies: stereotype replacement, counterstereotypic exemplars, individuation, perspective taking, and increasing contact (see elsewhere in this table for descriptions)	Devine et al. (2012); Carnes et al. (2015)
Social identity/ categorization	Prejudice stems from categorization, which is malleable	Reassign self and others to new or different categories	Participants are asked to "decategorize" (focus on individual identity versus group identity) or "recategorize" (focus on membership in superordinate group, e.g., "Americans")	Paluck and Green (2009)
Stereotype replacement	Prejudice is maintained by automatically activated stereotypes	Replace stereotypic responses with nonstereotypic responses	After a stereotypic response has occurred (e.g., avoiding eye contact with someone), participants (1) label it as a stereotypical response, (2) evaluate the situation to try to learn from it, and (3) replace the stereotypic response with a nonstereotypic one (e.g., looking at the person and smiling)	Devine et al. (2012); Carnes et al. (2015)
Thought suppression	Prejudice is maintained by automatically activated stereotypes	Suppress stereotypic thoughts	Participants attempt to ignore the characteristics of outgroup members (e.g., gender) or put stereotypic thoughts out of mind when they arise	Paluck and Green (2009)
Value consistency	Prejudice has not been considered in relation to other important values	Highlight contradiction between prejudices and other held values	Participants are asked to write statements of support for outgroup members	Paluck and Green (2009)

and self-worth (see Table 2 for definitions and examples). Paluck and Green (2009) noted the success of many of the reviewed experiments but argued that researchers' drive for simplification and abstraction compromised the external validity of laboratory studies. They therefore drew no conclusions about what works to reduce prejudice from that category either. The final category, experimental field research, was seen as meeting the highest standard of evidence, given the balanced considerations of external and internal validity. However, that category included only 107 studies (11% of the total). Furthermore, over a third of the studies in that category focused on one intervention, cooperative learning, in which classrooms are split into small teams and students educate each other. Of the 71 remaining studies, 40 tested interventions that lasted 1 day or less. The lack of longer-term interventions is an issue that we will return to in the following

pages. Overall, Paluck and Green (2009) concluded that no method they reviewed definitively "works" to reduce prejudice due to methodological limitations and a push to rolling out packaged solutions that have not been sufficiently tested, if at all.

Other recent reviews have used less restrictive evaluation criteria than Paluck and Green's (2009) and have drawn slightly more optimistic conclusions. For example, Bartoş, Berger, and Hegarty (2014) reviewed 146 published and unpublished reports on interventions to reduce "sexual prejudice" (the term those authors prefer to homophobia or homonegativity), approximately half of which were randomized experiments. They concluded that four types of interventions were effective: *education*, which effectively increased knowledge but had modest effects on attitudes and emotions; *contact* (i.e., real or imagined interactions with lesbian, gay, and bisexual people under specific conditions), which produced moderately positive effects on attitudes; *contact and education together*, which produced moderate improvements in attitudes, emotions, and participants' intentions for future actions; and the *induction of tolerant social norms*, which improved behavior but not attitudes (Bartoş et al., 2014, pp. 376–377). Among the limitations of the reviewed studies, the authors noted that the most commonly used outcome measures were self-reported attitudes and that measures of cognition (including implicit bias), emotion, and behavior were rarely used.

Aboud et al. (2012) conducted a systematic review of 32 ethnic prejudice reduction interventions for children eight and younger. The authors defined prejudice in terms of "negative evaluations of people on the basis of their group membership," thereby limiting the scope of the review to antipathy-based theories only. Contact (i.e., exposure to members of the target group under specific conditions) was the intervention used in 14 of the studies, whereas some form of media or instruction were used in the remaining studies. Outcome measures were improved attitudes toward members of a target group or improved relations or other behavioral markers. Using a frequency count of effects reported in all studies, the authors found 40% positive effects (i.e., improvements in at least one domain), 50% nonsignificant effects, and 10% negative effects (i.e., change for the worse in at least one domain). They found slightly more support for effects on attitudes (55% positive effects) than for peer relations or behavior (25% positive effects). Media and instruction were more effective (47% of overall effects positive) than contact (36% positive). Somewhat problematically, studies that produced positive attitude changes for *all* children were rated more highly by the authors than studies that produced positive attitude changes for one group only (Aboud et al., 2012, p. 313). This means that interventions that effectively changed the attitudes or behaviors of White children, but not children of color, received lower quality ratings by those authors.

Bezrukova et al. (2016) conducted a meta-analysis of 40 years' worth of diversity training evaluations, a dataset comprised of 260 samples. Noting that previous systematic reviews of the diversity training literature had produced contradictory results, Bezrukova et al. (2016) undertook a larger, more comprehensive meta-analysis. Their primary findings showed that diversity training has not been particularly effective in changing attitudes or behaviors and that changes in those domains tend to decay over time, whereas cognitive learning persists, and occasionally increases, over time. Other findings included participants' more positive reactions to diversity training in educational settings compared to organizational settings and increased effectiveness of diversity training when it is part of a larger program of institutional efforts, versus a stand-alone intervention. Regarding differences between voluntary and mandatory trainings (an issue often debated in the field), the authors found no statistically significant overall effect. However, they observed that mandatory diversity training has had greater effects on behavioral outcomes (such as discouraging prejudiced comments or jokes), whereas voluntary trainings tend to be rated more favorably by attendees. The authors found no strong effects

for the focus of the trainings (e.g., if the topic focused on one dimension of identity versus multiple dimensions). They did find a strong and significant relationship between the *length* of trainings and effect size, indicating that longer training programs tend to be more effective (Bezrukova et al., 2016). The comparative effectiveness of longer trainings has been observed elsewhere in the literature (Pedersen, Walker, Paradies, & Guerin, 2011).

To summarize, reviews of interventions to reduce personal prejudice report the following trends: (1) interventions tend to focus on reducing negative attitudes toward target groups (reflecting antipathy-based conceptualizations of prejudice); (2) interventions show modest or null effects with differential impacts on cognitive learning, attitudes, and behaviors; (3) interventions tend to be brief, which diminishes effect sizes across outcome domains; and (4) most studies tend to focus on self-report outcomes, with fewer focusing on real-world interpersonal outcomes.

Prejudice Reduction Research: Noteworthy Recent Work

Interventions to Address Implicit Bias

Implicit bias is a major focus in "third wave" prejudice research (Dovidio, 2001), which uses newer technologies to examine the automatic and unconscious processes influencing prejudiced behaviors. Interventions targeting implicit bias are typically designed and tested in the laboratory, and long-term effects have not been sufficiently examined (Paluck & Green, 2009). To address external validity issues in this area of research, Lai and colleagues tested 17 single-session interventions to reduce implicit racial bias (Lai et al., 2014) and then retested the most effective of those to determine the durability of the effects (Lai et al., 2016). The results were published in two separate articles. For the first article, the authors collected and analyzed data from 17,021 participants via the Project Implicit website (https://implicit.harvard.edu). A significant reduction in implicit racial bias was observed for 8 of the 17 interventions tested; however, the posttest measurements of implicit racial bias were administered immediately after the interventions, a fact noted by the authors as a limitation (Lai et al., 2014). In the follow-up article, the authors addressed that limitation by testing the eight most effective interventions from the earlier studies, plus one sham intervention as a control group, on 6321 students from multiple American universities. The interventions tested used counterstereotypical exemplars, appeals to egalitarian values, evaluative conditioning (e.g., repeatedly pairing Black faces with positive words and White faces with negative words), and intentional strategies to overcome bias (e.g., "If I see a Black face, then I will respond by thinking 'good'"; Lai et al., 2016, p. 1006). Implicit racial bias was measured at intervals ranging from several hours to several days after the interventions. The analyses produced a discouraging result: whereas all nine interventions significantly reduced implicit bias immediately, the effects did not hold after a delay (Lai et al., 2016). Although the authors concluded that implicit biases may be "stable over time and are not susceptible to long-term change" (Lai et al., 2016, p. 1012), this conclusion may be overstated due to the fact that only single-session interventions were tested. In fact, single-session studies dominate this area of research. A meta-analysis of 494 implicit bias studies notes that only 3% of the reviewed studies tested multiple-session implicit bias interventions, and only 6.6% of the studies were longitudinal (Forscher et al., 2019).

The Prejudice Habit-Breaking Intervention

Unlike single-session intervention research, the work of Patricia Devine and colleagues is based on the perspective that prejudice is a complex "habit" whose component parts require repeated, intentional effort and engagement to dismantle

(Carnes et al., 2015; Devine et al., 2012; Forscher, Mitamura, Dix, Cox, & Devine, 2017). Devine and colleagues' model is less theoretically specific than others due to its utilization of several mechanisms of change simultaneously. The prejudice habit-breaking intervention includes two sections, one for education and one for training (Forscher, Mitamura, et al., 2017). In the education section, participants first take the Implicit Association Test (Greenwald, McGhee, & Schwartz, 1998) and then navigate through a semi-interactive slideshow to learn about the nature and consequences of automatic bias. (Readers are encouraged to read through the slideshow text, available online at https://osf.io/gkjxs/.) This material links social problems such as faulty medical decisions, police brutality, and discriminatory hiring practices to automatic (i.e., implicit) bias. The concepts are explained in a way that normalizes implicit bias and invites acceptance versus defensiveness. Participants are then shown their score on the IAT in order to increase awareness and concern about their own implicit bias. Finally, they are given five strategies to counter the effects of implicit bias: stereotype replacement, counterstereotypic imaging, individuation, perspective taking, and increasing opportunities for contact (see Devine et al., 2012, for the descriptions of these strategies in a racial bias context, and Carnes et al., 2015, for their use in a gender-bias context). Following the education section, participants begin an unsupervised "training" section in which they are asked to practice the strategies in their day-to-day lives (Forscher, Mitamura, et al., 2017).

Among the handful of interventions that have been tested in experimental field studies, the prejudice habit-breaking intervention is one of the most effective. Participants in these studies have outperformed control conditions on several measures, including "long term" (from 12 weeks to 2 years) increases in the awareness of personal bias, changes in IAT scores, and concern about the effects of bias (Carnes et al., 2015; Devine et al., 2012; Forscher, Mitamura, et al., 2017). Notably, a 2-year follow-up to Carnes et al.'s (2015) study of a gender-bias intervention for academic departments showed promising real-world results: the proportion of women hired increased 18% in the departments that utilized the intervention, whereas there was no increase in the control group departments (Devine et al., 2017). Compared to the bleak picture painted by Paluck and Green in 2009, the prejudice reduction landscape is decidedly more hopeful as a result of this work.

What explains the comparative success of Devine and colleagues' model? One important, and strangely novel, contribution of the habit-breaking intervention is the idea that "because one-shot interventions must counteract a large accretion of associative learning, they are unlikely to produce enduring change in automatic responses. Such change is likely only after the application of considerable goal-directed effort over time" (Forscher & Devine, 2014, p. 475). Furthermore, Devine and colleagues tap into the motivation necessary for prejudice reduction by turning "situational awareness" (e.g., knowledge of one's own IAT score) into "chronic awareness" of the harmful effects of bias in society (Forscher & Devine, 2014). By making both the effects of bias and the reality of one's own bias concrete and clear, and eliciting more attention and energy for the work it takes to reduce implicit bias, the habit-breaking intervention engages a critical motivational component that other interventions do not as successfully engage.

As is the case for all promising new work, the habit-breaking intervention will benefit from further innovation and experimentation. In particular, the bias reduction strategies bear revisiting. In most of Devine and colleagues' studies (e.g., Carnes et al., 2015; Devine et al., 2012), participants were not asked which of the five strategies they used, and effectiveness of the strategies was measured collectively. However, in a recent study (Forscher, Mitamura, et al., 2017), the use of each strategy was measured and correlated with outcome variables. Troublingly, the use of counterstereotypic exemplars was associated with *decreased* concern about racial discrimination in society (Forscher, Mitamura, et al., 2017). Additional research is needed to determine whether that was an anomalous finding or evidence of a problem with the strategy itself.

Another potential challenge for the prejudice habit-breaking intervention is the assumption that individuals need only to learn about implicit bias and its harmful effects in order to be motivated to change it. But is it safe to assume that *all* clinicians, teachers, and researchers will be motivated by that information? If not, how do we deal with more resolute and explicit demonstrations of prejudice in our field?

Mindfulness-Based Approaches

Mindfulness-based approaches offer another promising direction in prejudice reduction research (Burgess et al., 2017). Mindfulness involves learning metacognitive skills to regulate voluntary attention to a chosen stimulus, leading to present-focused awareness, sustained attention, nonjudgmental acceptance, enhanced emotional regulation, increased compassion, stress reduction, and improved cognitive functioning (MacLean et al., 2010; Rosenberg et al., 2015; Shapiro, Astin, Bishop, & Cordova, 2005; van den Hurk, Janssen, Giommi, Barendregt, & Gielen, 2010). Although the application of mindfulness to the area of prejudice reduction is still in its infancy, there are some indications that it can be effective. However, the significant variability across studies regarding the type and length of the mindfulness-based interventions and study designs has made it difficult to compare results across studies. Lueke and Gibson (2015) found that a 10-minute mindfulness intervention caused a decrease in implicit race bias and age bias due to weaker automatically activated associations as measured by the IAT. Another study found that a 7-minute loving-kindness meditation exercise led to decreased automatic processing, increased controlled processing, and reduced implicit prejudice toward members of specific racial groups (Stell & Farsides, 2016). In a longer study, 6 weeks of loving-kindness meditation was more effective than a discussion-based control group in reducing implicit bias against two populations, Black people and homeless people (Kang, Gray, & Dovidio, 2014). More broadly, a study of experienced meditators from a range of religious traditions showed significantly lower levels of self-reported racial prejudice and higher levels of empathy compared to individuals who did not have a meditation practice (Hunsinger, Livingston, & Isbell, 2014).

Indirectly related to prejudice reduction, a systematic review of 29 studies of mindfulness-based stress reduction (MSBR) found that health care professionals who practiced MBSR reported significant improvement in their ability to identify and accept their own emotions, as well as identify others' emotions (Lamothe, Rondeau, Malboeuf-Hurtubise, Duval, & Sultan, 2016). Health care providers in an MBSR study not included in that review reported an enhanced ability to regulate attention and emotion during clinical encounters, as well as an increased awareness of their thoughts in a nonjudgmental way (Irving et al., 2014), which may facilitate self-awareness and intentional responding regarding automatically activated biases and stereotypes. Related findings have shown mindfulness and loving-kindness meditation to reduce reactivity to stress, increase cognitive and affective dimensions of empathy, improve client- and patient-centered communication, and modulate the activation of prejudiced behaviors (Dobkin, Bernardi, & Bagnis, 2016; Krasner et al., 2009; Lamothe et al., 2016; Regehr, Glancy, Pitts, & LeBlanc, 2014). These studies suggest that mindfulness may promote cognitive, affective, and attitudinal processes conducive to prejudice reduction efforts.

The mindfulness-based psychotherapy modality, acceptance and commitment therapy (ACT), offers strategies for prejudice reduction by targeting behaviors independent of cognitions (S. C. Hayes, 2004). In the ACT model, it is theoretically possible to increase behaviors consistent with one's values (e.g., respect and care for clients and patients) in the presence of contradictory cognitions (e.g., prejudiced attitudes), through the practice of skills such as cognitive defusion, acceptance, and present-moment awareness. ACT's behavioral focus can be seen in the title of a recent literature review of an "intervention for *modulating the impact* of stigma

and prejudice" (emphasis added) versus *reducing* prejudice, the focus of most other interventions (Masuda et al., 2012). In a study of substance abuse counselors, a 1-day ACT anti-stigma training was tested against a multicultural competence training and a biologically oriented educational control condition in order to see which was most effective in reducing counselor stigma and burnout (S. C. Hayes et al., 2004). Three months after the interventions, only the ACT training succeeded in reducing the *believability* of statements such as "My client is not going to change no matter what I do" and "If my clients really wanted to get sober, they would." Recipients of the ACT training also reported the lowest postintervention levels of stigmatizing attitudes toward clients, compared to the other two groups (S. C. Hayes et al., 2004). A similar study found that ACT significantly reduced mental health stigma among college students regardless of their preintervention levels of psychological flexibility, whereas an education control condition reduced stigma only for students who were already high in psychological flexibility (Masuda et al., 2007). In a study of prejudice reduction for undergraduate students, ACT concepts were used to teach mindful noticing of prejudicial thoughts and choosing value-consistent behaviors despite the thoughts (Lillis & Hayes, 2007). Compared to a prejudice awareness training control condition, the ACT intervention led to significant changes in students' behavioral intentions, including their interest in seeking contact with students of other races or ethnicities, joining diversity-related organizations, and attending events where they would be the only person of their race present (Lillis & Hayes, 2007). As ACT becomes better known in behavioral health, it is likely to be used more frequently in prejudice reduction interventions.

From "What Works?" to What Is Already Working: Allies, Accomplices, Costrugglers, and Followers

Another approach to identifying effective prejudice reduction strategies is examining the qualities and behaviors of individuals who have already successfully reduced personal prejudice. Literature in this area includes research on "allies," "accomplices," and "co-strugglers," as well as the concept of "followership" (Villalobos, 2015). These terms share an emphasis on action and connection, suggesting that effective prejudice reduction is neither passive nor solitary work. The "White Allies: Current Perspectives" special issue of *The Counseling Psychologist* (Volume 45, Issue 5) provides a helpful starting point for this topic as it relates to race. In the introduction to the issue, Spanierman and Smith (2017) urge White psychologists to work in solidarity with colleagues of color and caution against paternalistic styles of helping. Articles from the special issue include a qualitative study of 12 White researchers working in the area of multicultural psychology, a theoretical article on White professors teaching about race and racism, and a qualitative study of 12 White clinicians working with people of color. Sue's (2017) reaction to the special issue's articles provides a useful contextualization of the findings.

In a qualitative study on allyship, Gross (2015) observed that most research has focused on specific kinds of allies (e.g., men learning antisexist practices) or contexts (e.g., college campuses) and addressed relevant gaps in the literature by exploring ally identity development more generally. Gross (2015) and her team interviewed 28 individuals who had been identified as allies by their peers or colleagues and then analyzed the interviews using constant comparative analysis. She found that "being" an ally and "becoming" an ally are not separate processes; instead, learning and action work together iteratively. Participants in the study learned about systemic oppression and their own privilege, sharpened their knowledge through dialogue with others, and then acted to support members of oppressed groups while challenging members of their own group. Lessons learned from action then translated into deeper conceptual knowledge, recursively, over participants' lifetimes. Although not referenced in the paper, this dynamic interaction is similar to the concept of *praxis*, in which reflection and action are seen to be interrelated

components of social transformation (Freire, 1970).

Conclusions Drawn from Reviewed Research

Our review of the literature indicates that, despite the extraordinary amount of research conducted in this area, surprisingly few interventions have been able to demonstrate empirical evidence of prejudice reduction. However, absence of evidence is not evidence of absence, and it is likely that effective interventions are currently in use but are simply not being studied empirically (e.g., semester-long undergraduate and graduate courses, affinity groups). It appears that many interventions that *are* being studied empirically suffer from faulty assumptions. The fact that single-session interventions are so common in this area of research suggests that the field has yet to fully grapple with the deeply rooted, habitual nature of prejudice. Devine and colleagues are among the few researchers who embed this perspective in their intervention by asking study participants to consider lifelong socialization processes that have led to their own bias and also to repetitively practice learned strategies over days or weeks in order to "break" the prejudice habit. Similarly, in Bezrukova et al.'s (2016) review of diversity training, longer trainings were correlated with better outcomes, indicating the importance of time and effort.

A Radical Aside: The "Beyond Prejudice" Argument

Critiquing status quo theories of prejudice and efforts to remediate it, Dixon and colleagues argue that psychology must move "beyond prejudice" to address social inequality (Dixon, Durrheim, & Tredoux, 2005; Dixon, Levine, Reicher, & Durrheim, 2012; Dixon & Levine, 2012). Psychological understandings of prejudice tend to presume a theory of action flowing from the micro level (e.g., an individual whose attitudes need to be changed) to a meso level (e.g., through intervention, people learn to reject harmful stereotypes) to a macro level (e.g., prosocial interpersonal interactions positively influence institutional and intergroup relations, ostensibly decreasing discrimination and creating a more just society). In other words, most psychological research on prejudice is based on the idea that what happens inside our heads directly influences other levels of social reality. In a cheekily titled paper, Dixon and colleagues ask, "Are negative evaluations the problem and is getting us to like one another more the solution?" (Dixon et al., 2012). "Getting us to like one another more" seems like an obvious goal, and anyone who has taught an undergraduate class on race or facilitated a diversity training may rightly balk at the question. But the authors provide a poignant critique of the assumptions embedded within the prejudice reduction model, which, they argue (and our review of the research literature largely corroborates), has done very little to change social relations in the real world. After critiquing prejudice as an intervention target, Dixon and colleagues make a case for *collective action* as a more effective mechanism for social change. Compared to prejudice reduction paradigms, which problematically individualize historical, structural, and political facets of intergroup conflict, collective action acknowledges that members of dominant groups rarely give away power or privilege. Social change requires mass mobilization, a process that typically produces conflict between historically disadvantaged groups and historically advantaged groups (Dixon et al., 2012; Wright & Baray, 2012). The analytic focus therefore shifts away from the member of the dominant group whose attitudes need to change and toward the resistance of target group individuals and their allies demanding social change. Importantly, all units of analysis are relevant. One of the primary psychological questions in collective action is, what motivates individuals to join resistance efforts?

Although it would seem that prejudice reduction and collective action would complement each other, the two models entail psychological processes that appear to work in opposing direc-

tions (Dixon et al., 2012; Wright, 2003; Wright & Baray, 2012; Wright & Lubensky, 2013). Historically, prejudice reduction has attempted to attenuate an "us" versus "them" thinking and has worked to engender positive emotions, such as empathy and trust, toward outgroup members. The objective in this model of social change is to reduce intergroup conflict in historically divided societies. But does this model work together with, or work against, a collective action toward social change? In one set of studies, positive contact with White people led to a *decreased* support for social change among people of color (Dixon, Durrheim, & Tredoux, 2007; Dixon, Tropp, Durrheim, & Tredoux, 2010). In collective action, "us" and "them" are useful heuristics that allow members of disadvantaged groups to display in-group loyalty, form coalitions with other groups, and act together in the service of common interests. Collective action sees anger as constructive, rather than destructive, and works to heighten, not diminish, awareness of social conditions. This allows individuals to recognize injustice and strive to change it (Dixon et al., 2012). Although combining collective action and prejudice reduction models may be challenging, in our view, this is the necessary course for behavioral health professionals.

Identifying and Remediating Personal Prejudice: Tools and Strategies for Behavioral Health Professionals

Despite arguments favoring collective action over prejudice reduction, behavioral health professionals have an ethical responsibility to address personal prejudice. We owe it to our clients and patients, students, and research participants. It is a both/and, not an either/or: in addition to engaging collective action for social change, we also have the opportunity to identify and address personal prejudices that negatively impact the individuals we serve.

As the vignettes that open the chapter illustrate, each of us harbor engrained biased associations to different social identity groups. The Implicit Association Test (IAT) can help bring those associations into conscious awareness. We invite readers to take an IAT via the website https://implicit.harvard.edu/implicit/. After you have completed a test of your choosing, we recommend reading through the text of Devine's (2016) prejudice habit-breaking intervention (available online at https://osf.io/gkjxs/) as a way of reflecting on your own biased associations to various target groups. To the degree that it is conceivable that bias is part of your repertoire and that biased behavior may be having a negative impact on your work, even unintentionally, the following pages provide more actionable suggestions.

To readers who are open to the idea that cultural influences have led to your being biased against particular groups (whether you consciously endorse those biases or not), we offer the following recommendations from our own experiences as clinicians, educators, and researchers. First, given the preponderance of single-session interventions that have failed to produce change, we recommend abandoning the idea that addressing personal prejudice will be a quick or painless process. One of the only consistent findings in the prejudice reduction literature is that time and effort tend to produce more reliable change. In this regard, Devine et al.' (2012) framing of prejudice as a "habit" is especially useful. We would not expect a decades-long smoking habit to be broken overnight, nor would we expect someone who grew up speaking one language to be able to learn another in only a few weeks. Addressing the roots of your own prejudices, and learning new, more equitable behaviors, will take time and effort.

Second, we recommend developing at least a cursory knowledge of the histories of the groups whose members you regularly interact with. As there are many sources for this kind of learning, we invite the reader to consider the thought "But I don't know where to start!" as resistance to the challenge of delving in. Even if you don't know where to start, we recommend searching for information that will provide a more contextual understanding of a current patient's, client's, or student's reality. This might involve searching for

“History of ______” in scholarly databases, on websites, or on YouTube; attending a lecture or workshop that you would not normally attend; or following a scholar or activist on Twitter. We encourage mindful, active *listening* and *learning* as the most important aspects of early work in this area. In meetings and classrooms, we recommend noting and checking urges to challenge what is said by members of target groups. Be ready to ask yourself, “What is coming up for me right now? Is my bias being activated?” In line with the mindfulness-based approaches reviewed above, we recommend mindfully noting any reactions or associations that arise without judgment and working to reengage with humility, openness, and curiosity.

At some point in your process, you are likely to experience negative emotion. This is not only normal but is also a potentially powerful part of the process. In accordance with the ACT model, we believe that it is neither desirable nor beneficial to push these feelings away when they arise; however, displaying strong emotions can be disruptive in certain contexts. Although it is important to be able to feel guilt and sadness about one’s participation in systems of oppression, it is *not* helpful to expect members of oppressed groups to comfort and soothe us when those feelings arise. A mindfulness practice, along with a supportive community of other multiculturally oriented colleagues, can help you develop the skills necessary to acknowledge, name, explore, and regulate these emotions when they come up.

Using Assessment Tools to Reduce the Effects of Bias

In addition to these intentional efforts to reduce bias and prejudice at the individual level, procedural interventions may help limit the impact that conscious or unconscious biases have on clinical assessment, case conceptualization, and treatment. For example, to counteract biases affecting clinical judgment (e.g., assuming that African American women are less vulnerable to developing eating disorders than White women; Gordon, Brattole, Wingate, & Joiner, 2006), clinicians can implement strategies to improve both the quality of information we obtain from the client or patient (the clinical “data”) and the clinical decisions we make based on that information.

In addition to bias against members of outgroups, clinical judgments are often shaped by other cognitive biases, such as pathology bias, confirmatory bias, hindsight bias, misestimation of covariance, decision heuristics, false consensus effect, and overconfidence in clinical judgment (Garb, 1998; Shemberg & Doherty, 1999). To minimize diagnostic errors stemming from such biases, Suhr (2015) recommends viewing the initial interview as an opportunity to develop hypotheses about the symptoms and problems presented by the client or patient and then systematically obtaining data to both confirm and disconfirm various diagnostic possibilities as the alliance develops. Along these lines, clinicians can use standardized diagnostic interviews to ensure that a comprehensive history and assessment of symptoms are conducted for all clients and patients. In medical settings, the use of checklists has been found to reduce errors in complex procedures such as surgery to improve clinical outcomes (van Klei et al., 2012). Similarly, using standardized diagnostic interviews such as the SCID-5, rather than relying on biased diagnostic impressions, prompts clinicians to systematically assess for all diagnostic categories, including those that may not immediately come to mind.

Using multiple methods of assessment, such as administering a standardized self-report measure alongside the clinical interview, also provides an opportunity to confirm or disconfirm initial hypotheses. Given cultural variability in self-disclosure norms, psychiatric stigma, and cultural mistrust, offering clients and patients alternative means of conveying symptoms and concerns improves the likelihood of obtaining a complete and accurate diagnostic picture. However, clinicians should take care to use measures that have been validated (and translated, if necessary) for use with the clients or patients being assessed.

To avoid over- or underpathologizing the patient, we also recommend that clinicians regu-

larly consider how patients' group memberships and social locations may be affecting their key concerns, symptom presentation, and interpersonal style. The Cultural Formulation Interview (CFI) is a useful tool as it systematizes the assessment of cultural background information to obtain a "mini-ethnography" of the client or patient in context (Lewis-Fernández, Aggarwal, Hinton, Hinton, & Kirmayer, 2016). To minimize biased interpretations of the information collected, clinicians also should consider consulting with culturally knowledgeable peers and clinical experts (Kirmayer, Groleaud, Guzder, Blake, & Jarvis, 2003).

Institutional-Level Interventions

Finally, we recommend going beyond individual-level interventions to implement changes at the institutional level. Focusing on prejudice reduction at the individual level tends to center dominant group members' efforts to appear "politically correct" or be "good allies" since the very nature of inequality is to center dominant identities (Nnawulezi, Ryan, & O'Connor, 2016). Although individual efforts to reduce prejudice may involve learning extensively about oppression and demonstrating how aligned one is with those who are oppressed, individuals often struggle to acknowledge the ways that one benefits from and perpetuates privilege and hegemony (Helms, 2017). A model proposed by Villalobos (2015) addresses these problems through the framework of "followership." In this model, which was developed to address racist dynamics that occur in racial justice work, White individuals are encouraged to actively follow the lead of people of color. Principles of White followership include investing time and thought in followership, doing homework (e.g., learning the history of White supremacy and efforts to dismantle it), "showing your cards" (being authentic, humble, and unafraid), connecting (being present and making the time to develop networks), practicing acts of followership (e.g., asking "what do you need?" instead of making assumptions), and being strategic (using racial justice frames for organizing and action). Although this model was developed specifically for racial power dynamics, members of any dominant group would arguably be more effective through the practice of followership (Villalobos, 2015). Furthermore, dominant group members' adoption of a followership stance may allow leadership styles from nondominant cultures to emerge, such as collectivism, authenticity, and "pushing from behind" (Chin, 2013).

Evidence from organizational settings also suggests that greater equity is achieved by increasing awareness of the systems of oppression and the effects of biases within institutions or organizations and of the ways that clients and patients experience discrimination in treatment settings (Block, 2016). Institutional considerations include the ability to see individuals' behaviors as embedded within social relations, for example, recognizing how being evaluated by a White clinician may be experienced differently by a White patient versus a patient of color or the effect of being an LGBT trainee in an organization where members of one's group are underrepresented (Block, 2016). Because people of color experience cognitive depletion and poorer cognitive performance after interacting with White people who act racially color-blind (Holoien & Shelton, 2012), it also is important to consider whether an organization is racially diverse in its leadership, its staff, and the clients or patients it serves (Abramovitz & Blitz, 2015). Similarly, organizations should work to recruit and retain staff that represent other diverse social identities (sexual and gender identity, religion, etc.) to reflect the communities and populations that they serve. Explicit accountability practices, such as goal setting, monitoring, and reporting on diversity, can increase minority representation in leadership roles (Motel, 2016). Additionally, organizations can benefit from identity-based caucuses or affinity groups meeting separately on an ongoing basis in order to become more aware of the processes particular to their groups in the organization (e.g., identifying stereotype threat, implicit biases in hiring, etc.) and then finding ways to integrate this feedback toward accountability for organizational change (Nnawulezi et al., 2016). In light of Dixon and Levine's

(2012) argument above, these recommendations may be considered examples of collective action in the service of institutional change.

Vignettes, Revisited

After Elías left her office, Susan took a deep breath and began to process her thoughts and feelings. She reviewed the interaction with openness and curiosity, practicing non-judgmental awareness of her feelings of embarrassment, shame, and—to her surprise—irritation. Rather than criticizing herself for being irritated, Susan worked to make space for that feeling, along with the others. She thought, "I've been offering sliding scale to patients for decades, and have never been accused of being racist… What just happened?" At that moment, Susan was able to speculate about Elías' unique experience. In the past, he may have had bad experiences with White people, clinicians, people older than him, or other groups she represents. After reviewing the incident to see if there was anything she would want to do differently in the future, Susan decided that her fee discussion language did not need to be overhauled. Instead, she needed to repair the rupture with this patient. She thought of calling Elías that afternoon, but decided to address the issue in person at their next meeting. Elías arrived on time for their scheduled session, and appeared focused and ready to begin. Susan asked, "If it's OK, I'd like to address what happened last week?" Elías froze for a moment, and then nodded. Susan continued, "I'm sorry that my offer of sliding scale came across the way that it did. Would you be able to say a little about how that affected you, or what was coming up for you in that moment?" Elías cautiously described his experience of being offered "favors" by white people in the past, and how patronizing it was. Susan responded non-defensively to this, and thanked Elías for taking the risk to open up. He then shared that he regretted his reaction last week, and had felt embarrassed about it after he left. Susan helped to normalize his reaction, given his previous experiences. After a few more minutes of discussion, both Elías and Susan were ready to work on his insomnia.

Bella quickly composed herself and said, "Julie, wow—this just comes as a surprise! Are you able to say more about what you need? If I'm not the right therapist for you, maybe I can find a good referral for you." Julie considered for a moment, and then said, "I'm sorry Dr. Lin, I know it must seem rude, or at least very abrupt. I've actually already found another therapist I think I will be more comfortable with. No offense. And thank you again!" Bella worked to contain her feelings of disappointment. "If that's your decision, Julie, I can't force you to stay. But I do wonder if you'd be willing to share what made you uncomfortable. I want to learn, and my patients deserve the best possible care I can give them. If you'd rather not, I completely understand." Julie thought for a moment, and then said, "I didn't like the way you always wheeled me in here without asking if I wanted that. And the way you totally rearranged your office for me… I don't know, it just made me feel weird. I appreciate the effort, but it made me uncomfortable. I found it kind of… distracting?" Bella thanked Julie for her honesty, and confirmed again that Julie wished to terminate therapy. In the days following, Bella thought hard about what Julie had said. She found articles online about disability rights, and was surprised to learn that it is considered a violation of personal space to touch an assistive device without permission. When thinking about her upbringing in Taiwan, Bella realized she had never heard of this rule before. This helped her understand why she was so caught off guard by Julie's concerns, and also made her want to learn more about disability rights. Bella brought the incident up with her supervisor, discussed it in her multicultural peer supervision group, and consulted coworkers who had extensive experience working with patients with disabilities. After working through the incident in this way, Bella had a much richer understanding of what had happened, and what she would do differently in the future. She regretted not being able to continue seeing Julie, but felt better knowing that Julie had found a provider with whom she felt com-

fortable and that she, Bella, would be better prepared the next time.

Conclusion

Our initial goal for this chapter was to conduct a straightforward literature review of empirically supported prejudice reduction interventions. What we found was an enormous research literature with little consensus on the nature of its primary construct and an array of interventions so diverse that making solid evidence-based recommendations presented a significant challenge. As a result, our recommendations for reducing personal prejudice draw on available empirical evidence alongside ours and others' practice-based experiences as clinicians, educators, and social justice advocates.

As the vignettes above illustrate, prejudices and biases can affect professional practice in unexpected ways. Even as we proactively deepen our knowledge base, explore our biases in a supportive community, and engage in intentional efforts to dismantle inaccurate associations, it is inevitable that misattunements and missteps will occur. In these moments, as Bella and Susan demonstrate, cultivating an open and compassionate approach to self-reflection may enable us to learn from these moments and take corrective action.

We believe that the question "What does the evidence say?" will be answered more satisfactorily when our field is able to address a few key issues. First, although experts on prejudice argue that antipathy does not adequately capture the essence of prejudice, virtually every review we summarized used an antipathy-based definition of prejudice. The field therefore needs definitions of prejudice, and related interventions, which address "ambivalent" forms of prejudice. Second, the vast majority of research has been conducted on single-session interventions for prejudice reduction, none of which have produced reliable long-term effects. On the other hand, the few interventions that *do* require more motivation and effort on the part of participants show promise. The field should therefore make a concerted move in this direction by developing creative, engaging interventions that acknowledge that reducing prejudice takes significant work. We suspect that Devine and colleagues' habit-breaking intervention is the best documented of those types of interventions but not the only approach that can be effective. Finally, rather than focusing primarily on individual prejudice reduction interventions, which do not address the institutional structures that create and perpetuate societal inequities, more psychological research should be devoted to the study of collective action. This will require scientific gatekeepers to evaluate research proposals through a critical lens and will likely include more emphasis on longitudinal studies and real-world behavioral outcomes. Despite the tangled history of prejudice reduction research, we remain optimistic that scientific questions can be asked, and answers produced, that can lead to more equity and justice in behavioral health and in society at large.

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