

**Aversive Racism, Implicit Bias, and Microaggressions**

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The Civil Rights Legislation of the 1960's not only defined many forms of discrimination as illegal but also made egalitarianism a more prominent and widely-accepted principle governing intergroup relations in the United States (US) (Pearson, Dovidio, & Gaertner, 2009). Although blatant biases against Black Americans and other traditionally devalued groups in US society continue to exist, subtle forms of bias toward these groups also play a major role in shaping intergroup relations and contributing to the social disadvantage and persistent disparities (economically, socially, and in health) experienced by members of these groups. Moreover, because these biases may be deeply rooted in history and reinforced by current societal ideologies, White Americans, the traditionally socially dominant group in the US, may express their bias without conscious intention or even awareness. Nevertheless, this subtle discrimination can have a profound impact on intergroup relations and ultimately reinforce the hierarchical nature of these relations in American society.

In this chapter, we consider the role of one form of contemporary bias, aversive racism, in the expression of racial microaggressions. Microaggressions are “everyday subtle and often automatic ‘put-downs’ and insults directed toward Black Americans” (Sue, 2010, p. 5). Here, we describe underlying psychological processes that may prompt behavioral manifestations of prejudice, including those that manifest within social interactions, such as microaggressions. Although the dynamics of aversive racism and microaggressions can relate to many socially devalued groups in the US and internationally (Dovidio, Gaertner, & Pearson, 2017), to illustrate how these concepts relate to one another we focus on racial bias among White Americans.

Specifically, we explain the origin and dynamics of aversive racism, discussing the role of implicit racial bias in both subtle and blatant forms of discrimination. We then show how aversive racism among White Americans can affect the ways they communicate with Black Americans in interracial interactions and identify how these processes, in turn, can produce racial misunderstandings and divergent perspectives. Next, we illustrate how biases in both verbal and nonverbal behavior in social interactions can contribute to societal disparities, using research in the context of healthcare as a case example. We conclude by considering the implications of research on aversive racism and implicit bias for developing interventions designed to combat subtle forms of discriminatory behavior, including microaggressions, and identify key challenges and productive avenues for future research.

### **Aversive Racism and Implicit Bias**

The profound changes in law and values initiated, in part, by the Civil Rights Legislation does not mean that Whites are necessarily becoming less racially biased. Instead, for many White Americans who endorse egalitarian values, the nature of their racial bias has evolved to a more subtle, but still pernicious, form of racial bias – aversive racism (Dovidio, Gaertner, & Pearson, 2017; Gaertner & Dovidio, 1986).

In contrast to traditional forms of racial bias, aversive racism operates often unconsciously in subtle, indirect, and rationalizable ways. At a conscious (or explicit) level, aversive racists may sympathize with victims of past injustice, support principles of racial equality, and genuinely regard themselves as nonprejudiced. However, at the same time, they possess nonconscious negative feelings and beliefs about Blacks rooted in basic psychological processes (e.g., social categorization) that manifest at an implicit

level (Dovidio, Gaertner, & Pearson, 2017; Gaertner & Dovidio, 1986). The combination of conscious, explicit egalitarian attitudes coupled with nonconscious, implicit racial bias characterizes aversive racism.

Implicit biases, which are most commonly measured using response-latency tasks such as the Implicit Association Test (IAT; Greenwald, Poehlman, Uhlmann, & Banaji, 2009), are automatically activated responses that can occur without conscious awareness. Although most White Americans eschew racist attitudes explicitly, a substantial percentage of them (estimated from 44% to 70%; Nosek, Hawkins, & Frazier, 2011; Pew Research Center, 2015) show evidence of implicit negative attitudes toward Black Americans. Implicit attitudes result from repeated exposure to positive or negative information about a group, either through socialization or direct experience, and can be relatively resistant to change in response to new information. Because they can reflect cultural associations, unlike explicit biases, implicit racial biases often do not vary substantially as a function of socio-demographic characteristics (e.g., education or socioeconomic status) or an individual's profession. Moreover, because the two types of bias differ in a person's awareness and ability to control them, explicit and implicit racial biases are typically weakly correlated and both independently predict discriminatory behavior (Greenwald et al., 2009).

### **Aversive Racism, Implicit Bias, and Interracial Interaction**

Explicit and implicit attitudes shape the ways White Americans interact with Black Americans in different but consequential ways. Because aversive racists have egalitarian explicit attitudes and can readily recognize and thus inhibit blatant forms of discrimination, they may avoid overt displays of bias in interpersonal exchanges with

Black Americans. However, because many aversive racists are unaware of their implicit biases, these biases can affect subtle behaviors that they are less aware of, are less able to control, or that they do not recognize as discriminatory. These behaviors can include nonverbal signals (e.g., physical distancing) as well as verbal comments that may not be recognized as racist by well-intentioned Whites but may be experienced as demeaning by Blacks (i.e., microaggressions; Sue, 2010).

Different orientations of Whites toward Black relative to White interaction partners are particularly reflected in Whites' subtle communicative behaviors. In general, Whites interact differently with Black compared to White partners in social encounters in ways that may be both positive and negative. In some cases, Whites may appear more anxious or avoidant and less friendly nonverbally, and may show less behavioral synchrony in their interactions with a Black relative to a White partner (for a review, see Toosi, Babbitt, Ambady, & Sommers, 2011). In other cases, to the extent Whites are concerned about appearing prejudiced, they may show *greater* verbal or nonverbal friendliness in interactions with Blacks, which may be perceived as compensating for prejudice in ways that can engender threat among minorities (Mendes & Koslov, 2013).

Although both aversive racism and microaggression approaches focus primarily on subtle forms of bias, there are several key distinctions. As Sue (2010) observed, "Racial microaggressions are most similar to aversive racism in that they generally occur below the level of awareness of well-intentioned people" (p. 9). However, researchers investigating aversive racism and those studying microaggressions have typically emphasized different levels of analysis. Whereas research on aversive racism has studied underlying *psychological* mechanisms, such as conflicting conscious and nonconscious

attitudes and the processes and conditions under which these attitudes predict discrimination toward Blacks, research on microaggressions has focused primarily on different *behavioral* manifestations of racial biases and their societal consequences. As summarized by Sue (2010), “researchers of microaggressions focus primarily on describing the dynamic interplay between perpetrator and recipient, classifying everyday manifestations, deconstructing hidden messages, and exploring internal (psychological) and external (disparities in education, employment, and health care) consequences” (p. 9). However, recent work on implicit bias, aversive racism, and nonverbal and verbal communication bridges these different research traditions.

For example, research on aversive racism and communication has found that explicit and implicit racial biases predict different types of behaviors toward Blacks. For example, Dovidio et al. (1997) showed that whereas Whites’ explicit prejudice predicted more overt forms of bias shown in their self-reported evaluations of Blacks, Whites’ implicit bias predicted negative nonverbal behaviors reflecting discomfort (rate of blinking) and dislike (gaze aversion). Similarly, McConnell and Leibold (2001) reported that White Americans’ implicit racial bias, but not their explicit racial attitudes, predicted how much Whites talked and the frequency with which they made speech errors and speech hesitations in interactions with Black Americans. These socially distant and potentially dismissive behaviors, which may be perceived by Blacks as slights or invalidations in social exchanges, represent common forms of microaggressions (Sue, 2010).

The different effects of explicit and implicit biases can also fuel divergent perspectives and experiences of Whites and Blacks in interracial interactions. Dovidio,

Kawakami, and Gaertner (2002) demonstrated that whereas White Americans' explicit (self-reported) racial attitudes predicted their relatively controllable verbal expressions in their interactions with Black partners, Whites' implicit attitudes predicted negative nonverbal behaviors. Moreover, Whites' explicit attitudes and positive verbal behaviors predicted their assessments of how friendly they appeared during exchanges with a Black partner. Black interaction partners, in contrast, weighed Whites' nonverbal behavior more heavily than verbal behavior in their impressions of their partner and the interaction. Consequently, Whites and Blacks had differing assessments of the same interaction, and Blacks' awareness of conflicting positive verbal and negative nonverbal behavior undermined how trustworthy they saw the White partner. Thus, research on microaggressions and aversive racism converge in examining how biases are expressed, perceived, and interpreted in social exchanges.

Although the subtle verbal expressions and nonverbal behaviors driven by aversive racists' implicit racial bias may be expressed without their awareness, these behaviors continue to have a significant negative impact on the economic, physical, and mental well being of Black Americans and to be perceived by Blacks as racial discrimination. Indeed, a recent meta-analysis on effects of subtle (including implicit bias and microaggressions) and overt (i.e., blatant) forms of racial and gender discrimination on psychological and physical health and workplace performance found relationships similar in magnitude (Jones, Peddie, Gilrane, King, & Gray, 2016). Next, we illustrate these effects in the context of healthcare interactions.

### **Health and Healthcare Interactions**

Across the lifespan, Blacks experience poorer health than Whites in the US (as well as in Europe and Australia; see Dovidio, Penner, Calabrese, & Pearl, 2017). In the US, for example, deaths due to heart diseases are 22% higher among Blacks than Whites, and the mortality rate due to cancer among Blacks is about 13%% higher than it is for Whites (National Center for Health Statistics, 2016). Importantly, differences in death rates typically exceed differences in incidence rates. For example, in 2015, the Black-White difference in the incidence of breast cancer was quite small; it was 3% higher for Black women than for White women. In the same year, deaths due to breast cancer were 40% higher among Black than White women (National Center for Health Statistics, 2016).

Although a variety of different factors (e.g., access to healthcare, differential exposure to environmental toxins) likely play a role in racial disparities in health, there is mounting evidence that racial bias among healthcare providers may also be involved. For example, Black patients are less likely to be prescribed pain medications and, when given medication, are administered lower quantities, compared to Whites, even for life-threatening and terminal conditions (e.g., metastatic cancer; see Hoffman, Trawalter, Axt, & Oliver, 2016). Moreover, an analysis of over one million clinical visits for children diagnosed with respiratory infections found that, even after controlling for relevant medical and socio-economic variables, Black children were significantly less likely than White children to receive antibiotics from their physicians (Gerber et al., 2013).

In general, physicians in the US tend to display relatively low levels of explicit (self-reported) racial prejudice and report conscious efforts to not discriminate against Black patients, often asserting that Black patients receive even higher quality care than

White patients in their practice (Sabin, Rivara, & Greenwald, 2008). As with the general population, however, physicians may harbor negative implicit attitudes about Blacks. For example, in a sample of approximately 2500 US physicians, Sabin, Nosek, Greenwald, and Rivara (2009) found evidence of negative implicit racial biases against Blacks among White, Hispanic/Latino, and Asian physicians. By contrast, Black physicians, on average, displayed low or no implicit racial bias. Students in US medical schools show similarly strong levels of implicit racial bias when they begin medical training and display comparable levels when they complete medical school (van Ryn et al., 2015). Thus, physicians can also conform to the profile of an aversive racist – nonprejudiced explicitly but racially biased implicitly.

Given that the vast majority of physicians in the US are not Black, subtle bias in patient-physician interactions can disproportionately impact the quality of care that Blacks receive, relative to Whites. Patient-centered care, in which the doctor-patient interaction is characterized by trust and mutual respect, predicts greater patient satisfaction and, in turn, greater adherence by patients to treatments and better health outcomes (Stewart et al., 2003). Relative to medical interactions between a doctor and patient of the same race, racially discordant medical interactions are shorter in length and involve less positive affect and are less patient-centered (for reviews, see Penner, Phelan, Earnshaw, Albrecht, & Dovidio, 2017; Shen et al., 2017). In particular, White physicians spend significantly less time answering questions, providing health education, planning treatment, and building a relationship with Black relative to White patients, and also make less effort to involve Black patients in medical decision-making.

Consistent with work on aversive racism, whereas White physicians' explicit

racial bias is typically a weak predictor of the quality of patient care (Penner & Dovidio, 2016), implicit racial bias systematically predicts lower quality medical interactions with Black patients (Hall et al., 2015; Maina, Belton, Ginzberg & Johnson, 2017). Moreover, consistent with research on microaggressions, physicians' implicit racial bias typically affects their behavior in subtle ways that may nevertheless be recognized and perceived as disrespectful by Black patients. Indeed, Cooper et al. (2012; see also Blair et al., 2013) found that Black patients rated more implicitly biased physicians as expressing less positive affect and providing lower quality care compared to those with lower levels of implicit bias. Also, Hagiwara and colleagues have found that physicians higher in implicit bias talked more and used more anxiety-related words when interacting with Black patients (Hagiwara et al., 2013; Hagiwara, Slatcher, Eggly, & Penner 2017). Both kinds of behaviors might reasonably be seen as microaggressions by the Black patients.

A sample of oncologists who appeared nonprejudiced on a self-report measure showed similar effects (Penner et al., 2016). Oncologists higher in implicit racial bias had shorter interactions, and patients and observers rated these oncologists' communication as less patient-centered and supportive. The oncologists' higher implicit bias was also associated with patients showing less trust of their physician, having less confidence in recommended treatments, and perceiving treatments as more difficult to adhere to and complete successfully. Ratings of independent coders corroborate these perceptions: In medical interactions with Black patients, healthcare providers higher in implicit racial bias speak faster, are less patient-centered, and spend less time with the patients (Cooper et al., 2012).

Although Black patients generally perceive doctors higher in implicit racial bias

less favorably, this effect may be particularly pronounced when doctors are low in explicit prejudice – the aversive racist profile. Specifically, Penner et al. (2010) found that Black patients who interacted with aversive racist physicians were less satisfied with the interaction and felt less close to their physicians than Black patients who interacted with other physicians, including physicians who were high on both implicit and explicit bias. These effects may be due, in part, to a lack of awareness of personal bias among implicitly biased physicians who indicate low levels of bias on self-report measures. Indeed, doctors low in explicit bias reported that they involved Black patients more in the medical decision-making process during the visit than did those high in explicit bias.

Hagiwara, Dovidio, Eggle, and Penner (2016) further compared how physicians who fit the unique profile of an aversive racist (low in explicit racial bias and high on implicit bias) responded to different types of patients. On average, these physicians did not differ from the other physicians in the affect they displayed toward Black patients, however, their responses did differ as a function of whether their patients' previously reported experiences with everyday discrimination. When these physicians interacted with patients who reported more personal experiences with discrimination, they exhibited lower levels of positive affect and higher levels of negative affect during the interaction, relative to their interactions with patients who reported low levels of past discrimination. If the cause was simply that the high discrimination patients were more difficult, these effects should have been observed across all physicians' reactions. Rather, only the aversive racist physicians responded in this manner to the high discrimination patients, suggesting that aversive racism among White physicians' can impact the quality of patient care that Blacks receive, and particularly those with a history of experiencing

discrimination.

Together, these findings suggest that subtle bias, expressed in verbal and nonverbal slights consistent with microaggressions, can contribute to racial disparities in healthcare. Behavioral manifestations of bias can lead to miscommunication, divergent perspectives, and, ultimately, mistrust in both informal (e.g., casual conversations) and formal settings (e.g., medical interactions). Although these biases may be expressed unintentionally and go unrecognized as slights by Whites, they can nonetheless shape interactions in consequential ways that disadvantage Blacks and been seen by Blacks as bias. For example, Black patients who experience these slights in their medical encounters are less satisfied with their medical care and, because of the mistrust aroused by these behaviors, are less likely to adhere to guidance offered by White doctors. Therefore, subtle bias can pose a substantial barrier to realizing quality medical care.

Research on aversive racism and implicit bias, including within medical contexts, dovetails with several tenets of work on microaggressions. In explaining the dynamics of microaggressions, Sue (2010) observed that “socialization and cultural conditioning imbue within people unconscious and biased attitudes and beliefs that ... make their appearance in unintentional biased behaviors” (p. 48). Sue (2010) further noted, “While most of us are willing to acknowledge the harmful impact of overt racism ... racial microaggressions are usually considered banal or small offenses.... Trivializing and minimizing racial microaggressions by some Whites often appear to be a defensive reaction to being blamed and guilty” (p. 51). Aversive racists may not only fail to recognize subtle ways they discriminate against Black, but when confronted by the possibility that their behavior is racially motivated, they may seek nonracial explanations

for their behavior to preserve a nonprejudiced self-image (Dovidio, Gaertner, & Pearson, 2017).

The work that we have reviewed in this chapter helps bridge research on implicit bias and aversive racism with studies of microaggressions by illuminating how subtle forms of bias shape communication and impressions in interracial interactions. These connections help to integrate work on microaggressions with the sizable empirical literatures on racial prejudice and discrimination, as recommended by Lilienfeld (2017), bringing insight and theory from research on social cognition, communication, and intergroup relations. However, future work might reduce the gap further between studies of aversive racism that have traditionally focused on the causes of subtle bias, and research on behavioral manifestations of bias characterized by microaggressions. In the next section, we consider theoretical and practical benefits of further integrating these two areas of research.

### **Aversive Racism, Implicit Bias, and Microaggressions: Integration**

Work on aversive racism and interracial communication has identified some specific behaviors (e.g., lack of visual contact; Dovidio et al., 1997) that can fuel mistrust in social exchanges, but this research could benefit from further consideration of microaggressions in these effects. Microaggression research offers a useful taxonomy for understanding behavioral manifestations of prejudice within everyday social exchanges. Adopting the complementary perspectives of aversive racism and microaggressions can guide research and intervention to more formally identify and address the types of verbal and nonverbal slights that are most commonly expressed by aversive racists, and most consistently experienced by Blacks as offensive.

For example, in a recent study (Voigt et al., 2017), untrained participants rated the level of (dis)respect communicated by police officers to Black and White community members based on statements transcribed from information captured with police body cameras during police stops. Blacks have a particularly strong motivation to be respected by Whites in their interracial encounters (Bergsieker, Shelton, & Richeson, 2010; Shelton & Richeson, 2015). The participants' ratings showed that police officers expressed greater disrespect when they were interacting with Black than a White community member. Furthermore, linguistic analyses by Voigt et al. (2017) of police statements during police-community member interactions indicated that verbal disrespect toward Blacks was most strongly associated with addressing the community member with informal (e.g., "dude" or "bud") rather than formal titles (e.g., "sir," or "Ms."), greater speech disfluencies (e.g., "w- well"), and greater use of negative words. Greater respect for Whites compared to Blacks was communicated through reassuring statements (e.g., "don't worry"), use of positive words, and mentions of safety (e.g., "drive safely now"). Understanding the specific patterns of behaviors that contribute to mistrust among Blacks can help to inform interventions designed to bolster trust between law enforcement and the communities they serve.

Similarly, research on racial microaggressions could benefit from insights from aversive racism. The particular way a microaggression toward a Black person is expressed likely differs between aversive racists and explicitly racist Whites. Explicitly racist Whites may tend to use more directly demeaning terms (e.g., informal titles, such as "buddy"). By contrast, the microaggressions expressed by aversive racists may manifest more nonverbally, or in some cases, may be in the form of overcorrecting for

bias through exaggerated verbal or nonverbal *positivity* (e.g., Mendes & Koslov, 2013), which may be perceived as condescending by Blacks.

Work on aversive racism, and on implicit racial bias generally, has identified underlying processes that correspond to subtle behaviors that adversely affect the dynamics of interracial interactions. Nevertheless, evidence for *causal* relationships between implicit bias and discriminatory behavior (e.g., whether changes in implicit bias produce changes in behavior) remains mixed, leaving open the question of what types of interventions may be most effective for reducing microaggressions and other behavioral manifestations of prejudice (see Forscher & Devine, 2017).

In their meta-analysis of over 400 studies, Forscher et al. (2017) found that implicit bias is malleable, but that changing implicit bias does not necessarily lead to changes in explicit bias or behavior. However, they revealed little evidence that *changes* in implicit bias mediate changes in explicit prejudice or discriminatory behavior. Thus, Forscher et al. (2017) proposed that interventions that focus on improving structural features that cause biases on both behavioral and cognitive tasks (e.g., enhancing opportunities for intergroup contact) or provide people with strategies to resist biasing influences in the environment may be more effective than those that target implicit biases alone (see Devine, Forscher, Austin, & Cox, 2012; see also Penner, Blair, Albrecht, & Dovidio, 2014).

### **Future Directions in Research on Subtle Bias and Microaggressions**

Increasing knowledge about whether (and perhaps when) microaggressions are expressed intentionally or unintentionally has important implications for understanding the different perspectives that Whites and Blacks have about race relations. As Lilienfeld

(2017) explained, because it implies a form of aggression, the term microaggression may suggest to broad audiences an intentional negative act, thus obscuring the substantial role that unconscious bias may play in shaping these behaviors. Moreover, if confronted and described as a microaggression, a White person who is an aversive racist may be quick to deny the action or its negative impact because it is inconsistent with a nonprejudiced self-image. To the extent that such accusations elicit defensiveness or emphasize external (versus internal) reasons to control prejudice (i.e., to avoid social sanctions rather than affirm one's egalitarian values), they may be counterproductive and *increase* rather than reduce explicit and implicit bias, at least temporarily (see Legault, Gutsell, & Inzlicht, 2011). Longer term, such experiences may increase Whites' likelihood of adopting a colorblind ideology to help protect themselves from being accused of being racist, which can reduce intergroup trust by signaling to Blacks that their unique perspectives are not valued (Apfelbaum, Sommers, & Norton, 2008).

These types of responses can be damaging to race relations not only for developing interpersonal relationships but also for addressing hostility and resentment between Whites and Blacks more broadly. Blacks, who tend to show heightened sensitivity to subtle and nonverbal cues of prejudice (Richeson & Shelton, 2005; see also Shelton & Richeson, 2015), may readily detect microaggressions and perceive them as discriminatory. Moreover, because of their frequent experience of discrimination in daily life (Pew Research Center, 2016), Blacks may interpret these slights as intentional and thus as evidence of blatant racism. Moreover, the denial of these actions or their harm may be seen as a further attempt to invalidate the experience of the target. Nevertheless, communicating the discriminatory and harmful nature of microaggressions, which Whites

may tend to dismiss as racial bias because of the often ambiguous nature of such expressions, may paradoxically strengthen and reinforce growing perceptions of anti-White bias among some US Whites (Norton & Sommers, 2011). Thus, understanding the communication aspects of microaggressions from the perspectives of both Whites and Blacks, as well the social psychological impact of microaggression terminology in everyday exchanges, is a critical avenue for future scholarship.

Future research might also further investigate factors that can escalate miscommunication around microaggressions into race-based tension and conflict, as well as identify ways to effectively enhance mutual recognition and understanding of the harm of microaggressions. Both approaches can help increase the effectiveness of interventions designed to limit expressions of microaggressions and reduce their adverse interracial consequences. For instance, viewing interracial encounters as learning or “growth” opportunities can significantly improve intergroup relations generally (Migacheva & Tropp, 2013), which may also be an effective approach for building mutual understanding around microaggressions and their impact.

One of our basic premises is that aversive racists, because they harbor implicit biases, will be likely to discriminate against Blacks and members of other traditionally-devalued groups when norms permit such expressions or obscure the recognition of the action as unfair, harmful treatment. Overtly discriminatory rhetoric, such as comments articulated during the most recent US presidential campaign devaluing historically stigmatized and marginalized groups, may thus give license to some White Americans to engage in more direct forms of discrimination. Some of these actions may be extreme. For example, such comments may play a role in the 66% increase in hate crimes against

Muslims in the US from 2014 to 2015 (Ansari, 2016), with a notable increase occurring after presidential candidate Trump's speech announcing a proposed ban on Muslim immigrants (Levin, 2017). Although awareness of a greater prevalence of blatant forms of bias might make aversive racists' egalitarian values more salient and thus inhibit their own expression of bias, it is also possible that, because their bias is unconsciously motivated and unintentional, it may facilitate their display of subtle biases. A political climate in which blatant bias is increasingly common might not only relax normative constraints against bias but also make subtle forms of bias, by contrast, appear less harmful or discriminatory, which may desensitize aversive racists to their own potential for bias. To address this issue further, research might investigate the extent to which exposure to blatant expressions of bias may reduce Whites' perceptions that more subtle forms of discrimination, such as microaggressions, constitute bias, or disinhibit them (consciously or unconsciously) from engaging in such behaviors.

Additional research might also productively explore the positive and negative psychological and physiological consequences of the use of microaggression terminology in everyday exchanges. The growing popularity of microaggression language in public discourse suggests its utility for characterizing the lived experiences of Blacks and members of other stigmatized groups. For these individuals, the use of microaggression language may reduce uncertainty in interpreting ambiguous behaviors that can be stress-inducing. Attributions to discrimination can shift explanations for causes of rejection from internal to external reasons, which can bolster self-esteem and buffer stress responses, reflected in increased anger and physiological reactivity indicative of a challenge rather than threat response (Mendes, Major, McCoy, & Blascovich, 2008).

Nevertheless, perceived discrimination and physiological responses associated with anger are also related to increased risk of cardiovascular disease and hypertension. Thus, the long-term psychological and health consequences of these attributions remain an important avenue of inquiry.

### **Conclusion**

In conclusion, we believe that the shared assumptions and converging evidence of research on aversive racism and on microaggressions are mutually informative, theoretically and practically. Moreover, the somewhat different emphases of these two scholarly perspectives – attention to intrapsychic dynamics of the perpetrators of subtle bias in the study of aversive racism and the different behavioral manifestations of these processes in research on microaggressions – provide complementary insights into interracial interactions and race relations more generally.

Research on aversive racism, which we illustrated in terms of relations between White and Black Americans but which also applies to relations with other historically stigmatized groups, illuminates how unintentional slights, which may be communicated nonverbally as well as verbally, may be expressed toward Blacks by well-intentioned Whites. Moreover, because these expressions are rooted in unconscious processes, Whites may engage in these behaviors without intention or awareness and may be motivated to deny evidence of the race-based nature of their actions. Because of the unconscious influences underlying these processes, discriminatory behavior can occur even in highly structured settings, such as in physician-patient interactions. Although the bias may be subtle, the consequences are significant, as illustrated in this chapter. Future research, practice, and policy can thus benefit from understanding more fully the

relationship between aversive racism and microaggressions and pursuing new insights guided by the similarities and differences in these approaches.

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John F. Dovidio is the Carl Iver Hovland Professor of Psychology, as well as Dean of Academic Affairs of the Faculty of Arts and Sciences, at Yale University. His research interests are in stereotyping, prejudice, and discrimination. Much of his scholarship, in collaboration with Dr. Samuel L. Gaertner, has focused on “aversive racism,” a subtle form of contemporary racism.

Adam R. Pearson is an Associate Professor of Psychology at Pomona College. His research explores how intergroup biases shape interaction, perception, and nonverbal behavior. He is recipient of an APA Early Career Achievement Award, the Morton Deutsch Award from the International Society for Justice Research, and the Social Psychology Network’s Action Teaching Award for innovative teaching.

Louis A. Penner is a Professor of Oncology at Wayne State University and the Karmanos Cancer Institute. His work focuses on social psychological aspects of physician-patient interactions, with a special emphasis on racial healthcare disparities. Much of this work concerns how race-related attitudes can affect what transpires during racially discordant medical interactions. He has authored or co-authored over 150 scholarly articles, book chapters, and books.