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You Can't Dismantle What You Don't Recognize: The Effect of Learning Critical Black History in Healthcare on Perspective-Taking

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Black (compared to White) Americans endure worse healthcare and health outcomes, and discrimination perpetuates these disparities. However, many White Americans deny that racial injustice exists. Two studies ($N = 1{,}853$ White Americans) tested whether learning Critical Black History (history of injustice) in healthcare increased perspective-taking and its subsequent impact on racism recognition. When participants learned Critical Black History, perspective-taking was positively associated with isolated and systemic racism recognition (Study 1). In Study 2, participants were randomly assigned to learn Critical Black History, Celebratory Black History (history of achievement), or a Control lesson. Participants who learned Critical Black History (vs. Celebratory or Control) engaged in higher levels of perspective-taking which, in turn, increased racism recognition/acknowledgment, support for anti-racist healthcare policies, and recognition of systemic contributors to Black–White health disparities; no change in negative stereotype endorsement was observed. These findings suggest learning about racial injustice, coupled with perspective-taking, engenders support for racial equity in healthcare.

Public Significance Statement
Two studies demonstrated that learning Critical Black History in healthcare (i.e., racial injustice experienced by Black Americans) can increase White Americans' perspective-taking. Higher perspective-taking was also related to more recognition of and support for addressing racism. These findings suggest that learning an accurate history of racial injustice may be societally beneficial, particularly for White Americans.

Keywords: perspective-taking, Black history, healthcare, health equity, racism

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> History, despite its wrenching pain, cannot be unlived, but if faced with courage, need not be lived again. (Angelou, 1993)

Historically and presently, Black people experience medical mistreatment and racism in the U.S. healthcare system. The reality of anti-Black medical racism in the United States perpetuated by medical professionals and within healthcare systems finds its roots in the enslavement of Black people (e.g., medical and broader national and government agencies supported harmful, unconsented, and even fatal medical experimentation to advance medical research; see Kenny, 2015; Vedantam & Gamble, 2016; Washington, 2007). The disproportionate and life-threatening mistreatment of Black Americans in the healthcare system continues.

Health and Healthcare Disparities

Black Americans have poorer health outcomes than White Americans in many domains, including infant mortality, life expectancy, hypertension, and heart disease (Centers for Disease Control and Prevention, 2021). Both isolated (e.g., interpersonal interactions)

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and systemic racism (i.e., racism that operates in and is maintained by public institutions, social policies, and cultural norms; Nelson et al., 2013; Ture & Hamilton, 1967) contribute to health disparities for Black Americans. This includes inequitable treatment of Black patients by physicians (Williams & Rucker, 2000) and widespread discriminatory practices that are associated with worse health outcomes for Black Americans (e.g., anxiety, hypertension, and cardiac health; Hill et al., 2017; Lewis et al., 2015).

For example, in a 2020 study which examined 1.8 million birth records from 1992 to 2015, Greenwood et al. (2020) found that Black newborns were three times more likely to die if they were cared for by White (as compared to Black) physicians. However, there was no difference in infant mortality for White newborns as a result of race of physician (Greenwood et al., 2020). Additional research found that in a sample of medical students and residents, 50% of participants endorsed false anti-Black stereotypes (e.g., Black people have thicker skin, smaller brains, or less sensitive nerve endings than White people; Hoffman et al., 2016). Endorsing these stereotypes predicted medical students' and residents' beliefs that Black people felt less pain and their failure to provide Black people with accurate treatment recommendations (Hoffman et al., 2016). Furthermore, in a sample of nonmedical professionals, 73% of participants supported false biological stereotypes (Hoffman et al., 2016).

Medical doctors are also less likely to provide needed medical treatment to Black (as compared to White) patients. For instance, when Black and White Americans with identical symptoms of heart disease seek medical treatment, Black Americans are less likely to be referred for heart health screenings (i.e., cardiac catheterization; Schulman et al., 1999). This disparity in referrals remains strong even after accounting for heart disease risk and age (Schulman et al., 1999). Furthermore, this disparity is even more egregious considering that Black Americans are 1.3 times more likely to die of heart disease than White Americans (The Office of Minority Health, 2021). Additionally, despite Black women having the highest mortality rate of breast cancer in the United States, healthcare professionals are less likely to refer Black (compared to White) women for mammograms (Alsheik et al., 2021). Black women breast cancer survivors also report experiencing racism and being stereotyped and disrespected by healthcare providers (Martin et al., 2023). Medical doctors are also less likely to prescribe pain medication to Black patients even when both Black and White patients present with the same injury and report identical levels of pain (K. H. Todd et al., 2000). Within this context, Black people experience racial discrimination in healthcare (Lewis et al., 2015) and report feeling less cared for by their primary care physicians than White Americans, thereby resulting in lower levels of medical trust (Martin et al., 2022).

Importantly, such examples of medical mistreatment occur within a broader system of inequity and anti-Black racism. Black people have and continue to endure racism in numerous domains. For instance, racial segregation (which remains prevalent in the United States) concentrates essential resources (e.g., grocery stores and hospitals) in predominantly White neighborhoods (Gee & Ford, 2011) and disproportionately exposes Black people to pollutants (Henderson & Wells, 2021). Additionally, Black (as compared to White) people in the United States are three times more likely to be killed by police (Mapping Police Violence, 2022), more than twice as likely to be denied mortgage funding (even with excellent credit and high incomes; Harney, 2019; Kamin, 2022), and are more likely to experience hiring discrimination (Quillian et al., 2017). For example, from 1989 to 2015, White Americans consistently received an average of 36% more callbacks after submitting job applications (Quillian et al., 2017). These systemic examples of racism, perpetuated and carried out by the beliefs and behaviors of individuals, negatively impact Black people's lives, physical and mental health, well-being, and economic opportunities.

Denying Racism

Despite evidence of medical mistreatment and racism directed toward Black Americans, many White Americans fail to identify or refuse to acknowledge that anti-Black racism exists in society, broadly, and in the healthcare system, specifically. Indeed, White Americans routinely deny the extent of both isolated and systemic racism despite centuries of continuous anti-Black racism coupled with documented evidence of how racism negatively impacts Black lives. Reports consistently show that White Americans do not believe that Black Americans experience racism, as merely 33% of White (vs. 76% of Black) Americans believe that Black Americans are treated less fairly than White Americans in healthcare (Horowitz et al., 2020). Furthermore, this racism denial is evident in other domains as well: 58% of White (vs. 91% of Black) Americans and 41% of White (vs. 86% of Black) Americans believe that Black people are treated less fairly in policing and home loan applications, respectively.

Taken together, these reports highlight that when White Americans are asked if Black people experience racism they are significantly more likely to answer this question incorrectly. White Americans' denial of and/or refusal to recognize the reality of racism is an example of how many White Americans are operating within epistemologies of ignorance. Previous work on epistemologies of ignorance suggests that on a systemic level, White supremacy affords people (and White people specifically) the privilege of "see[ing] the world wrongly, but with the assurance that this set of mistaken perceptions will be validated by White epistemic authority" (Mills, 1997, p. 20). As such, the very structure of White supremacy (e.g., prohibiting and restricting the teaching of accurate Black history in schools and the widespread, false, and harmful stereotypes about Black people that were historically used to justify Black enslavement) perpetuates White Americans' misunderstanding of (or refusal to acknowledge) (a) the racism that White Americans routinely perpetuate against Black Americans and (b) the societal systems that privilege White people (Mills, 1997).

This inability or reluctance to recognize racism in healthcare can directly impact the health, well-being, and lives of Black people. Dismantling, addressing, and eradicating racism is made exceedingly more difficult when many of the most powerful and privileged people in U.S. society fail to acknowledge the problem even exists and/or perpetuate racism themselves. Black people are therefore shouldering multiple burdens: enduring/battling both isolated and systemic racism (within healthcare and other contexts) and contending with racial gaslighting (i.e., "the political, social, economic, and cultural process that perpetuates and normalizes a White supremacist reality through pathologizing those who resist," Davis & Ernst, 2017, p. 763). Indeed, 67% of White Americans maintain that medical racism does not currently exist. The denial of medical racism is one example of how Black Americans are routinely treated as though racism is not real in today's society but instead only exists in the minds of Black people (Benjamin, 2022; Van Dijk, 1992). Consequently, Black people continue to be harmed. Importantly,

when people acknowledge that systemic factors impact racial health disparities, they demonstrate more support for policies that address inequity (Price et al., 2014).

Addressing the Denial of Racism

Learning Critical Black History

One factor that contributes to White Americans' ability, or lack thereof, to acknowledge racism is a widespread ignorance of history. The Marley hypothesis suggests that racial differences in perceptions of racism stem from privileged group members' (e.g., White Americans) lack of knowledge about Black history (Nelson et al., 2013). These authors found that White (compared to Black) Americans lacked knowledge about Critical Black History (i.e., Black history of injustice), which explained their inability to recognize racism, relative to Black Americans. Such effects were exacerbated by White Americans' preference to engage with Celebratory Black History (i.e., history that acknowledges Black achievements) than with Critical Black History (Salter & Adams, 2016). Importantly, these impacts can be overcome. Bonam et al. (2019) exposed White Americans to Critical Black History (vs. control information). Exposure to Critical Black History significantly improved White Americans' ability to identify and recognize systemic, but not isolated, racism. Furthermore, these authors found a significant indirect effect, such that learning Critical Black History (vs. control information) increased White Americans' knowledge of racism in the United States, which led to increased acknowledgment of the role of the U.S. government in discriminatory housing practices, and in turn, higher rates of isolated and systemic racism recognition. Collectively, these findings show that knowledge of Critical Black History is an important factor for White Americans to recognize racism, and further research on the mechanisms by which this occurs could be advantageous.

Perspective-Taking

Another factor that contributes to White Americans' ability to recognize racism is the degree to which they engage in perspective-taking (i.e., attempting to understand other's thoughts, feelings, and experiences; Batson et al., 1997). When instructed to take the perspective of a Black American (in a photograph vs. a control condition), participants demonstrated enhanced acknowledgment of racism, recognition that racial inequality is caused by discrimination, and support for affirmative action policies (A. R. Todd et al., 2012). More generally, perspective-taking predicts improved intergroup perceptions including reduced explicit and implicit racial bias (A. R. Todd et al., 2011), increased empathy (Batson et al., 1997), and reduced stereotyping (Galinsky & Moskowitz, 2000). While such benefits of perspective-taking are well documented, a majority of research has focused on its outcomes (e.g., changes in racial bias), rather than on the factors that might compel it (Ku et al., 2015). That is, participants are experimentally instructed to take the perspective of another person (e.g., a Black American) or not. In naturalistic settings, however, people are unlikely to be instructed to perspective-take with outgroup members. Additionally, much of perspective-taking literature on intergroup relations provides participants with examples of Black people devoid of context (e.g., a photograph of a Black American and no other information). Given the previously documented benefits of perspective-taking, particularly in intergroup contexts, identifying what specific information might engender spontaneous perspective-taking with Black Americans (i.e., perspective-taking that happens without prompting) may be particularly important for harnessing its value in daily life.

Taken together, the epistemologies of ignorance, Marley hypothesis, and perspective-taking literature highlight that White Americans: (a) harbor a largely different (and incorrect) perspective on racism than Black Americans, (b) lack historical knowledge that could help to give them a more informed perspective, and (c) could address their societal misunderstanding by considering Black Americans' points of view. Thus, it could be essential to correct White Americans' inaccurate perceptions of racism by enhancing their knowledge of Critical Black History. Such knowledge might equip White Americans with a foundation to better understand the experiences of Black Americans. In other words, it could be critical to give White Americans perspective so that they can take it. If White Americans learned the realities of anti-Black racism and considered the experiences of Black Americans, perhaps this would compel racism recognition and support for addressing racism. However, to date, research has yet to test this specific pathway.

Present Studies

Both knowledge of Critical Black History and engaging in perspective-taking are known to impact White Americans' ability to recognize racism. However, while Critical Black History research and perspective-taking research have focused on similar constructs, thus far, these literatures have been largely separate.

Here we combined insights from these distinct areas of research to test whether exposure to Critical Black History in healthcare compelled perspective-taking among White Americans and, in turn, whether spontaneous perspective-taking improves racism recognition. In Study 1, we exposed White Americans to a Critical Black History lesson focused on Black American experiences in healthcare settings, and we tested whether explicit perspective-taking instructions (vs. control) provided an added benefit. In Study 2, we tested the determinants and effectiveness of spontaneous perspective-taking by exposing White Americans to a lesson of Critical, Celebratory, or Control Black History and measuring both the degree of spontaneous perspective-taking and the recognition of racism and support for policies to ameliorate disparities. All manipulations, measures, and exclusions are reported for both studies.

Study 1

Study 1 provided a sample of White American adults with a Critical Black History lesson in healthcare, experimentally manipulated whether or not they were explicitly told to take the perspective of those they learned about, and measured both self-reported degree of perspective-taking and racism recognition. This allowed us to compare whether instructions to perspective take were necessary to improve White Americans' ability to recognize racism if they learned about Critical Black History.

Method

Participants

The present study was approved by the University of California, Los Angeles Institutional Review Board and each participant provided consent to participate. White American participants were recruited online

via Prolific to participate in an online study where they would "answer questions about social attitudes and feelings." Based on previous research on the effects of learning Critical Black History (Bonam et al., 2019) as well as an a priori power analysis conducted in G*Power (Faul et al., 2007), the target sample size was 364, assuming a small effect of the experimental manipulation at 80% power and $\alpha = .05$. To this end, 401 participants were recruited to ensure ample power after any exclusions. Seven participants were excluded (four for not identifying as White and three for failing a simple attention check) which left a final sample of 394 for analyses (48.5% women, 46.7% men, 4.1% gender-expansive; $M_{age} = 38.16$, $SD_{age} = 14.94$, $range_{age} = 18–78$).

Constraints on Generality

The current studies targeted White American participants specifically because previous reports and research show that they are the demographic that is least able to recognize racism (e.g., Horowitz et al., 2020; Nelson et al., 2013). White Americans are also among the most powerful and privileged people in the United States which could make their recognition of and support for addressing anti-Black racism particularly helpful in creating a more equitable society. With this said, future research can assess if similar results would be found in a more racially diverse population or in addressing anti-Black racism outside of a U.S. context.

Procedure

All participants engaged with a Critical Black History lesson consisting of five captioned photographs describing healthcare injustices experienced by Black Americans (1800s–present). For example, in 1951, Fannie Lou Hamer underwent what was to be a routine medical procedure, but instead, doctors removed her uterus without her consent (Public Broadcasting Service, 2022). This lesson was intentionally designed to not only provide participants with multiple specific examples of isolated racism but to also place those examples within a broader context of systemic racism (e.g., medical doctors were disproportionately removing Black women's uteruses without their consent during this time). Participants engaged with this Black history lesson in two distinct conditions. In the perspective-taking condition, participants were instructed to focus on the potential thoughts, feelings, and experiences of each person they saw in the photographs, consistent with previous perspective-taking and intergroup relations research (e.g., A. R. Todd et al., 2011). In the Control condition, participants were simply told to view each photograph and read each caption. Subsequently, participants reported their level of perspective-taking, completed a scale to assess their level of systemic and isolated racism recognition, and answered demographic questions.

Measures

Self-Reported Perspective-Taking. Participants indicated their degree of perspective-taking with the individuals described in the history lesson on five items anchored by 1 (*not at all*) and 7 (*very much so*). Sample items included: "I imagined what the person in each picture might be thinking" and "I tried to take the perspective of the person in each picture" (Cronbach's $\alpha = .95$).

Isolated and Systemic Racism Recognition. Participants then completed measures designed to probe their ability to recognize isolated (Cronbach's $\alpha = .84$) and systemic (Cronbach's $\alpha = .93$) racism (Nelson et al., 2013). This measure included nine instances of systemic racism (e.g., "the negative portrayal of African Americans in U.S. entertainment media") and five instances of isolated racism (e.g., "Lashandra Jenkins and Amy Conner applied for the same job. They have nearly identical qualifications. Amy gets called for an interview and Lashandra does not"; Nelson et al., 2013). Participants indicated the degree to which each item constituted an instance of racism on a scale anchored by 1 (*not at all*) and 7 (*certainly*).

Transparency and Openness

Data were analyzed in SPSS 28 and R (4.0.2). Group differences by condition were assessed via analysis of variance (ANOVA). Main effects and interactions of condition and reported perspective-taking on isolated and systemic racism recognition were assessed via linear regression. All reported confidence intervals (CIs) are at 95%. This study was not preregistered. Data, measures, and code for both studies are available on the Open Science Framework (Martin & Johnson, 2023).

Results

Manipulation Check

First, the degree to which participants indicated that they engaged in perspective-taking was compared. Unsurprisingly, participants in the control condition ($M = 5.75$, $SD = 1.30$) reported lower levels of self-reported perspective-taking than those in the perspective-taking condition ($M = 6.22$, $SD = 1.08$), $b = -0.47$, $t(390) = -3.91$, $p < .001$, 95% CI = [−0.71, −0.24], $d = 0.40$.

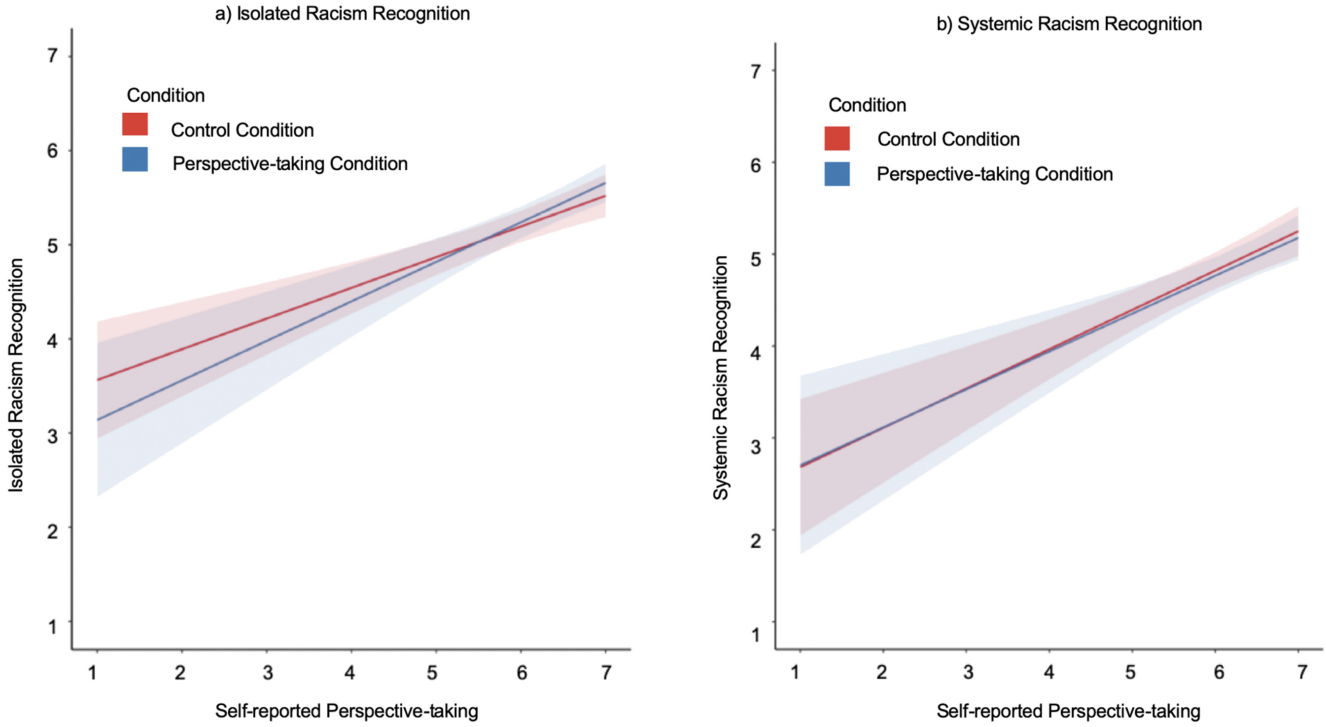
Isolated and Systemic Racism Recognition

Next, we sought to determine whether racism recognition differed by condition. Interestingly, isolated racism recognition did not significantly differ between the control and perspective-taking conditions, Ms and SDs = 5.12 (1.24) and 5.34 (1.26), respectively, $b = 0.05$, $t(389) = 0.39$, $p = .698$, 95% CI [−0.19, 0.28]. Similarly, systemic racism recognition did not differ between the control and perspective-taking conditions, Ms and SDs = 4.72 (1.55) and 4.86 (1.42), respectively, $b = -0.06$, $t(389) = -0.39$, $p = .694$, 95% CI [−0.34, 0.23]. Thus, when participants learned Critical Black History, instructing them to perspective-take did not enhance participants' ability to recognize racism.

We also sought to determine whether the degree of self-reported perspective-taking was significantly associated with isolated and systemic racism recognition. As predicted, self-reported perspective-taking was significantly associated with both isolated, $b = 0.36$, $t(389) = 7.31$, $p < .001$, 95% CI [0.27, 0.46], and systemic racism recognition, $b = 0.42$, $t(389) = 7.12$, $p < .001$, [0.31, 0.54]. These results indicated that when participants reported higher levels of perspective-taking they also reported higher levels of racism recognition. Moreover, the association between self-reported perspective-taking and racism recognition did not differ by condition (Figure 1a and 1b) for isolated racism, $b = 0.09$, $t(388) = 0.92$, $p = .356$, 95% CI [−0.11, 0.29], or for systemic racism recognition, $b = -0.02$, $t(388) = -0.13$, $p = .898$, [−0.25, 0.22]. These patterns indicated that when participants learned Critical Black History, instructing participants to perspective-take (vs. not giving those instructions), did not enhance the effect of subsequent self-reported perspective-taking on racism recognition.

Figure 1

Interaction of Reported Perspective-Taking on Racism Recognition by Experimental Condition



Note. Reported errors are 95% confidence intervals. See the online article for the color version of this figure.

Discussion

In Study 1 we found that, generally, when White Americans learned Critical Black History, self-reported perspective-taking was positively associated with racism recognition. This pattern was not accentuated when perspective-taking instructions were included in the lesson. Although prior research established that instructing participants to perspective-take (vs. not) related to meaningful intergroup outcomes, to the best of our knowledge, the present study is the first to test how learning Critical Black History and perspective-taking work together. Study 1 provided evidence that when participants are given a Critical Black History lesson (i.e., context that could help them to better understand the experiences of Black people), higher levels of reported perspective-taking were significantly associated with more isolated and systemic racism recognition. Furthermore, this association was not different if they were told explicitly to take the perspective of the Black Americans they learned about in the lesson.

Our findings support the possibility that learning Critical Black History about Black American healthcare experiences (without explicit perspective-taking instructions) may compel spontaneous perspective-taking. In turn, the degree to which perspective-taking occurs is associated with higher isolated and systemic racism recognition. This finding has important implications as it provides evidence that explicit instruction to perspective-take might not be necessary for the benefits of perspective-taking to be realized. Thus, when White Americans learn Critical Black History (even when not told explicitly to perspective-take), they may nevertheless engage in beneficial perspective-taking. While plausible, the lack of a control condition in Study 1 limited our ability to make causal claims. Additionally, because participants in this study learned only Critical Black History, it remains unclear whether learning any form of Black history, including the Celebratory Black History preferred by a majority of White Americans (Salter & Adams, 2016), may be sufficient to engender spontaneous perspective-taking that enables racism recognition. Study 2 tested these possibilities.

Study 2

Study 2 exposed White Americans to three distinct forms of Black history (Critical, Celebratory, and Control) and measured spontaneous perspective-taking, racism recognition, and other important factors to gauge the determinants of the effects observed in Study 1. We predicted that participants who learned Critical Black History (vs. Celebratory or Control) would report higher levels of spontaneous perspective-taking. We also hypothesized a significant indirect path, such that when combined with learning Critical Black History, higher levels of perspective-taking would relate to improved racism recognition and support for taking actions to address racism, including measures of: (a) isolated and systemic racism recognition, (b) acknowledgment of the existence of racial inequality in the United States, (c) support for policies to address racism in healthcare, (d) decreased endorsement of false biological stereotypes about Black people, (e) decreased attributions that racial health disparities are caused by stereotypes about Black Americans' behaviors, and (f) increased attributions that racial health disparities are caused by systemic factors. Notably, our dependent variables probed participants' perceptions of both racism within the context of healthcare

and racism more broadly. This allowed us to test whether changes in participants' perceptions were limited to the healthcare domain or were applied to perceptions of racism in the United States more generally.

Method

Participants

Recruitment procedures for Study 2 were identical to Study 1. The University of California, Los Angeles Institutional Review Board approved this study and all participants provided informed consent. White Americans were recruited through Prolific to participate in an online study about "social attitudes and feelings." Sample size was determined based on a pilot study (available in the online supplemental materials) to test the effects of the hypothesized mediation paths (Schoemann et al., n.d.). This analysis determined a sample size of 1,452 at 80% power and $\alpha = .05$. Thus, 1,501 participants were recruited for Study 2 to ensure ample power after exclusions. Forty-two participants were excluded (20 for not identifying as White and 22 for failing a simple attention check) which left a final sample of 1,459 for analyses ($M_{age} = 42.43$, $SD_{age} = 14.95$, $range_{age} = 18–92$; 47.9% women, 49.3% men, 2.5% gender-expansive).

Procedure

In Study 2, participants were randomly assigned to one of three gender and era (historical period) matched conditions: a Critical Black History condition, a Celebratory Black History condition, or a Control condition. The Critical Black History condition was identical to Study 1. Using an identical procedure, the Celebratory Black History condition included five photographs with captions of Black Americans from the 1800s to the present who made achievements in healthcare. For example, one photograph depicted Dr. Patricia Bath, a medical doctor specializing in ophthalmology who created a surgical tool and method to remove cataracts in the eye (National Institutes of Health, 2003). The Control condition included five photographs of Black Americans throughout history (1800s–present) with captions that simply described the photograph (e.g., what the person was wearing). After completing one of these three lessons, participants reported their level of perspective-taking, completed key dependent measures described below, and provided demographic information.

Measures

Perspective-Taking. Participants completed the same perspective-taking measure as in Study 1, in which they indicated how much they attempted to imagine what the person in each photograph was thinking, feeling, and experiencing on a scale ranging from 1 (*not at all*) to 7 (*very much so*; Cronbach's $\alpha = .96$).

Isolated and Systemic Racism Recognition. Participants completed the same isolated and systemic racism measure from Study 1 (Nelson et al., 2013). Again, this measure assessed the degree to which participants recognized racism in isolated incidents (Cronbach's $\alpha = .86$) and in systemic manifestations (Cronbach's $\alpha = .93$).

Acknowledgment of the Existence of Racial Inequality in the United States. Participants completed a measure (Horowitz et al., 2020) to assess their level of acknowledgment that racial inequality currently exists in the United States. Participants indicated the degree to which they thought racial inequality existed in seven situations (e.g., "when applying for a loan" and "when seeking medical treatment") on a scale (Cronbach's $\alpha = .94$) anchored by 1 (*White people are treated much less fairly than Black people*) to 5 (*Black people are treated much less fairly than White people*).

Support for Anti-Racist Policies. To assess their level of support for policies to address racism in healthcare, participants indicated the degree to which they agreed with a list of five policies (Cronbach's $\alpha = .94$) on a scale anchored by 1 (*strongly disagree*) to 7 (*strongly agree*). Four items were adapted from Senator Elizabeth Warren's Anti-Racism in Public Health Act of 2020 (Warren et al., 2020). A sample item included: "Efforts should be made to educate the public on the public health impacts of racism." Additionally, participants were asked if "Efforts should be made to promote equal access to healthcare for Black Americans," an item adapted from Kaiser et al. (2009).

False Biological Stereotype Endorsement. To assess their level of endorsement of false biological stereotypes about Black Americans (Hoffman et al., 2016), participants indicated the degree to which they believed a list of statements about Black people on a scale anchored by 1 (*definitely untrue*) to 6 (*definitely true*). The list of statements included four true statements (e.g., "Black people are less likely to contract spinal cord diseases like multiple sclerosis") and 11 false stereotypes (e.g., "White people, on average, have larger brains than Black people"; Hoffman et al., 2016). Key analyses tested endorsement of false biological stereotypes (Cronbach's $\alpha = .91$).

Attribution of Racial/Ethnic Health Disparities Scale. To assess how much they attributed Black–White health disparities to negative stereotypes about Black Americans or systemic issues, participants completed 10 items from the Attribution of Racial/Ethnic Health Disparities Scale (Price et al., 2014). For the purposes of this study, which focuses on Black Americans, the scale was adapted slightly to probe perceptions of Black Americans. Participants indicated the degree to which they believed a list of statements was relevant to Black–White health disparities on a scale anchored by 1 (*not relevant at all*) to 7 (*highly relevant*). Sample items include: "The persistent level of discrimination in society against Black Americans" and "The high proportion of Black people who expect government 'handouts' (e.g., food stamps, Medicaid, etc."; Price et al., 2014). For analyses, attributions to systemic problems and individual stereotypes were assessed separately to create an Attributing Health Disparities to Systemic Issues variable (Cronbach's $\alpha = .91$) and an Attributing Health Disparities to Stereotypes variable (Cronbach's $\alpha = .86$).

Analytic Plan

For each dependent measure, a mean score was computed for each participant. ANOVAs tested hypothesized mean differences between conditions in perspective-taking. Mediation analyses were conducted (SPSS 28, Process model 4; Hayes, 2018) to test each hypothesized indirect effect. Each mediation path analysis was tested in bootstrapped models with 10,000 samples. CIs (95%) are reported. Effect sizes (Cohen's *d*) are reported where appropriate.

Importantly, based on the findings from Study 1 and previous research on the efficacy of Critical Black History (e.g., Bonam et al., 2019; Salter & Adams, 2016), we were agnostic about whether learning Critical Black History would show a total effect on key

dependent measures without the hypothesized indirect effect of perspective-taking. Based on current statistical best practices, total effects are not necessary to test for indirect effects (Hayes, 2018). Thus, we conducted mediation analyses (SPSS 28, Process model 4; Hayes, 2018) to test the hypothesized indirect effects.

Results

Perspective-Taking

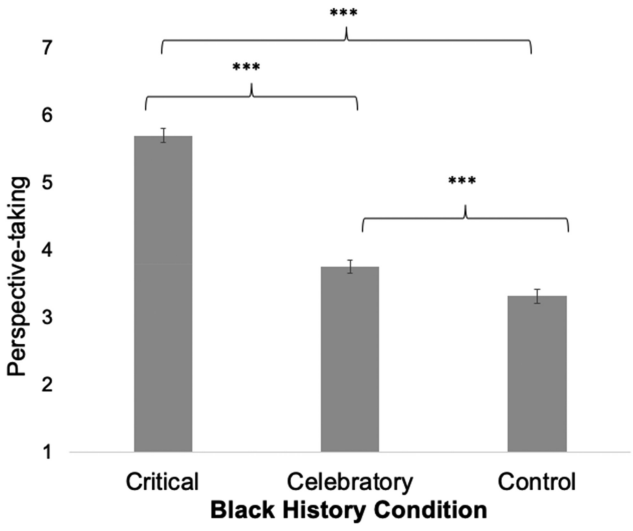
We predicted that when White Americans learned about Critical Black History in healthcare (vs. Celebratory or Control), they would report higher levels of perspective-taking. A one-way between-subjects ANOVA tested whether perspective-taking differed between conditions. The results indicated a significant effect of condition on perspective-taking, $F(2, 1{,}449) = 300.70$, $p < .001$. Next, post hoc comparisons tested the nature of this effect. As hypothesized and seen in Figure 2, participants who learned Critical Black History in healthcare ($M = 5.71$, $SD = 1.35$) reported significantly higher levels of perspective-taking than either the Control ($M = 3.32$, $SD = 1.69$) or Celebratory Black History ($M = 3.76$, $SD = 1.75$) conditions, bs = 2.38 and 1.94, ts(1,449) = 23.12 and 18.73, respectively, ps < .001, 95% CIs [2.18, 2.59] and [1.74, 2.15], ds = 1.56 and1.24, respectively. Although not hypothesized, participants in the Celebratory Black History condition reported significantly higher levels of perspective-taking than those in the Control condition, $b = 0.44$, $t(1,452) = 4.28$, $p < .001$, 95% CI [0.24, 0.64], $d = 0.26$.

Mediation Models

We predicted that learning Critical Black History in healthcare (vs. Celebratory or Control) would produce significantly higher perspective-taking, which in turn would be associated significantly with higher recognition, acknowledgment, and support to address racism toward Black Americans. Thus, indirect effects (rather than total or direct effects) were hypothesized. This hypothesis entailed that influencing racism recognition, as measured broadly herein, may first require learning Critical Black History and then spontaneously perspective-taking. Figure 3 displays indirect effect results.

Figure 2

Perspective-Taking by Experimental Condition



Note. Mean values for perspective-taking for Critical Black History, Celebratory Black History, and Control conditions. Error bars show standard error.

*** $p < .001$.

Isolated and Systemic Racism Recognition

As predicted, White American participants who learned Critical Black History (vs. control information) reported significantly higher levels of perspective-taking which, in turn, was associated with significantly higher isolated and systemic racism recognition (bs = 0.36 and 0.35, SEs = 0.06 and 0.07, 95% CIs [0.23, 0.48] and [0.22, 0.49], respectively). An identical pattern was observed when comparing Critical Black History to Celebratory Black History. When participants learned Critical (vs. Celebratory) Black history in healthcare, their higher reported perspective-taking predicted more isolated and systemic racism recognition (bs = 0.29 and 0.29, SEs = 0.05 and 0.06, 95% CIs [0.19, 0.39] and [0.18, 0.40], respectively).

Acknowledgment of the Existence of Racial Inequality in the United States

As expected, the Critical Black History (vs. Control) condition produced higher perspective-taking, which was associated with significantly greater acknowledgment that Black Americans are treated less fairly than White Americans in the United States today ($b = 0.11$, $SE = 0.03$, 95% CI [0.05, 0.17]). An identical pattern was observed when comparing the Critical Black History condition to the Celebratory Black History condition ($b = 0.09$, $SE = 0.02$, 95% CI [0.04, 0.14]).

Support for Anti-Racist Policies

As expected, participants who learned Critical Black History (vs. Control) evidenced significantly greater perspective-taking, which was associated with significantly more support for policies to address racism in healthcare ($b = 0.56$, $SE = 0.08$, 95% CI [0.41, 0.72]). An identical pattern was observed when comparing the Critical Black History condition to the Celebratory Black History condition ($b = 0.46$, $SE = 0.07$, 95% CI [0.33, 0.59]).

False Biological Stereotype Endorsement

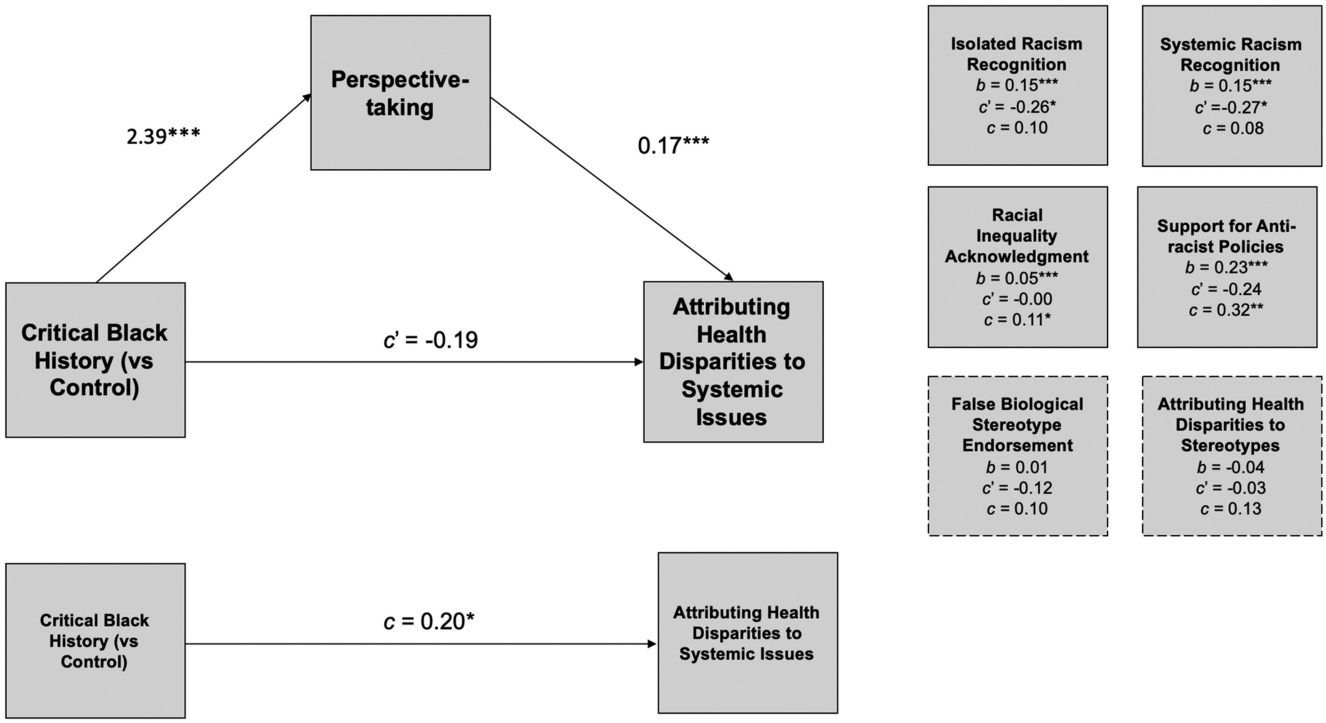
Unexpectedly, when participants learned Critical Black History (vs. Control), higher perspective-taking did not predict less false biological stereotype endorsement ($b = 0.02$, $SE = 0.03$, 95% CI [−0.04, 0.09]). An identical pattern was observed when comparing the Critical Black History condition to the Celebratory Black History condition ($b = 0.02$, $SE = 0.03$, 95% CI [−0.04, 0.07]).

Attribution of Racial/Ethnic Health Disparities Scale

Attributing Health Disparities to Stereotypes. Unexpectedly, when participants learned Critical Black History (vs. Control), higher perspective-taking did not predict being less likely to attribute health disparities between Black and White people to individual stereotypes ($b = -0.10$, $SE = 0.06$, 95% CI [−0.22, 0.03]). An

Figure 3

Critical History → Perspective-Taking → Attributing Health Disparities to Systemic Issues (and Other Dependent Variables)



Note. Indirect effect model for Critical Black History (vs. Control) condition predicting perspective-taking and in turn attributing health disparities to systemic societal issues. As noted, the Critical Black History (vs. Celebratory Black History) conditions indirect effect results demonstrated the same pattern for all indirect paths. Solid outlines indicate significant indirect effect results. Dashed outlines indicate insignificant results for indirect paths. *b* indicates the coefficient for the path between perspective-taking and the dependent variable; *c′* indicates the path for the direct effect; and *c* is the total effect. Additional indirect effect information can be found in the online supplemental materials.

* $p < .05$. *** $p < .001$.

identical pattern was observed when comparing the Critical Black History condition to the Celebratory Black History condition ($b = -0.08$, $SE = 0.05$, 95% CI [−0.18, 0.02]).

Attributing Health Disparities to Systemic Issues. As expected, when participants learned Critical Black History (vs. Control), higher perspective-taking predicted being significantly more likely to attribute health disparities between Black and White people to systemic problems ($b = 0.40$, $SE = 0.07$, 95% CI [0.26, 0.54]). An identical pattern was observed when comparing the Critical Black History condition to the Celebratory Black History condition ($b = 0.32$, $SE = 0.06$, 95% CI [0.21, 0.44]).

Discussion

Study 2 provided experimental evidence that learning Critical (vs. Celebratory or Control) Black history in healthcare produced greater perspective-taking among White Americans and that it, in turn, facilitated the recognition of racism. These findings suggest learning about societal injustice may facilitate a deeper consideration of minoritized people's perspectives.

Specifically, we found that when White Americans learned Critical Black History, their higher perspective-taking was associated with significantly higher: (a) recognition of isolated and systemic racism, (b) acknowledgment of U.S. racial inequality, (c) anti-racist healthcare policy support, and (d) attributing Black–White health disparities to systemic issues. These findings suggest that the indirect effect of learning Critical Black History on perspective-taking can lead to acknowledging that inequality exists, improving intergroup perceptions, and supporting policy initiatives to address current inequality.

The indirect effects of Critical Black History on perspective-taking did not reliably relate to lower levels of false biological stereotype endorsement or attributing health disparities to negative stereotypes. Decades of research demonstrate the consistent presence of negative stereotypes about Black Americans in the United States (Ghavami & Peplau, 2013; Katz & Braly, 1933; Madon et al., 2001). This nonsignificant finding may suggest that although this intervention elicited perspective-taking that was related to other outcomes, it failed to mitigate stereotyping. Notably, false biological stereotypes were not strongly endorsed in this sample of participants (*M*s range 1.98–2.09), which may have reduced the possible mitigating effect of perspective-taking on this important measure.

Additionally, as compared to the Critical and Celebratory History conditions, the Control condition contained no individuating information about Black Americans in the photograph descriptions (e.g., nothing personal about the individuals). While choosing to keep neutral descriptions allowed the experimental design to include a Control condition that is more similar to traditional perspective-taking methods which often give a photograph without any individuating

information, this is a limitation of the study. However, the observed differences between the Critical and Celebratory conditions in perspective-taking, which both included individuating information, provide key evidence that Critical Black History uniquely compels beneficial perspective-taking.

Also, in some cases, the Critical Black History condition (vs. Celebratory or Control conditions) resulted in significant main effects (e.g., support for policies), but in other cases, it did not (e.g., systemic racism recognition; Figure 3). These findings further highlight that perspective-taking may be an important mechanism to elicit change.

General Discussion

The present research tested how spontaneously perspective-taking with Black Americans (i.e., considering what Black Americans might think, feel, and experience without being explicitly prompted) might improve White Americans' recognition of and support for addressing racism. Across two studies, we found learning Critical Black History bolstered White American perspective-taking.

In Study 1, when White Americans learned Critical Black History, explicit instructions to perspective-take did not enhance isolated and systemic racism recognition. Nevertheless, the degree to which participants reported perspective-taking was positively associated with isolated and systemic racism recognition, which did not differ for White Americans told to perspective-take versus those who were not.

In Study 2, White Americans who learned Critical (vs. Celebratory or Control) Black history reported significantly higher perspective-taking with Black Americans. This effect on perspective-taking was associated with higher recognition of and support for addressing racism. Interestingly, participants in the Celebratory Black History condition also reported significantly more perspective-taking than those in the Control condition. However, the Critical Black History condition had a stronger effect on perspective-taking. Future research can examine if there are added benefits to learning both Critical and Celebratory Black History simultaneously.

These findings have important implications. First, the findings further our understanding about the determinants and impacts of perspective-taking. Research has long demonstrated that instructed perspective-taking is beneficial to improving perceptions of others (e.g., Batson et al., 1997; A. R. Todd et al., 2011). Importantly, the present research demonstrates that instructed perspective-taking might not be necessary as, under some circumstances, people may engage in it spontaneously. Furthermore, we identified what information elicits perspective-taking (i.e., Critical Black History).

Additionally, the present findings contribute to the growing literature on the importance of increasing people's knowledge of past and present racial injustice. Specifically, this research identified a new mechanism by which learning Critical Black History likely improves White Americans' racism recognition. Moreover, we extended the research on the effects of perspective-taking and Critical Black History by centering the experiences of Black Americans in healthcare. Racism in healthcare and racism in the United States more broadly are interconnected, interactive, and contribute to health and healthcare disparities for Black Americans. As examples, discriminatory hiring practices (Quillian et al., 2017) can exclude Black people from obtaining healthcare coverage, and discriminatory housing loan practices can relegate Black people to living in areas that have higher pollutants and less access to nutritious food (Henderson & Wells, 2021). All of these factors negatively impact the health of Black Americans. Importantly, we found that learning about Critical Black History in healthcare increased White Americans' perspective-taking and led to more recognition of and support for addressing racism broadly, and racism in healthcare specifically. Establishing perspective-taking as a mechanism through which learning Critical Black History can increase racism recognition and support for addressing inequity could be foundational for testing this mechanism in real-world contexts (e.g., hospitals, schools). Future research could examine the efficacy of learning Critical Black History and perspective-taking on improving physician–Black patient interactions and promoting systemic changes in healthcare (e.g., policies). Additionally, future research may benefit from considering additional mechanisms through which Critical Black History may lead to more recognition of and support for addressing racism (e.g., empathy). For the purposes of the present study, we sought to bolster White Americans' ability to consider the perspectives of Black Americans (who continuously experience racism) and imagine what they endure (i.e., perspective-take) rather than how to engender soft-hearted feelings toward Black Americans (i.e., empathy; Batson et al., 1997). With that said, we acknowledge that it is impossible for people who are not members of an oppressed group to fully understand the experiences of oppressed people. However, our data add to decades of research suggesting that attempting to think about what others are going through can be socially and societally beneficial.

This research also contributes important evidence to the discussion about the value of learning Black history. Historically and presently, stories of racial injustice are actively silenced. For example, at the time of this writing, many U.S. states have now passed laws to prohibit the teaching of race or racial injustice in classrooms (Alfonseca, 2022). This research adds to our understanding of the detrimental impact that such political stances and policies might have on White Americans' perceptions. Such policies rob people of the beneficial impacts of learning an accurate history about racial injustice.

In conclusion, our results highlight the current relevance of Maya Angelou's quote. Indeed, the United States does have a deeply painful history, including racism in healthcare. We demonstrated that learning about this painful history can compel spontaneous perspective-taking that facilitates both recognizing and supporting efforts to reduce injustice. Uncovering this important pathway could be critical to understanding how to create a more equitable society and prevent history from repeating itself.

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