Towards a Culture Shift: Advocating for Diversity, Equity, and Inclusion for Women in Child Psychiatry

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"Diversity is being asked to the party. Inclusion is being asked to dance."
– Verna Myers, American activist[1]

This simple quote captures the essence of diversity and inclusion perfectly. Equity involves understanding a person's journey, meeting them where they are, and providing what they need to achieve an equal footing in life.

The Association of American Medical Colleges (AAMC) defines diversity as "a catalyst for change resulting in health equity."[2] Without diversity in the workplace, underserved communities may experience further health disparities. In recent years, changes have occurred in the medical field leading to a more diverse workforce to better reflect the population served. However, diversity without equity—access, opportunity, fair treatment and elimination of barriers—is incomplete. For women, even more challenges lie in the intersection of multiple domains of diversity, such as gender, race, and ethnicity, and there is inadequate information on how to address them. In this article, we discuss individual, community and institutional level changes that can be enacted to advocate for diversity, equity, and inclusion (DEI) for women in psychiatry.

Why should we care about DEI? We need to care because our world and communities are becoming increasingly diverse in race and ethnicity. However, this diversity is not adequately reflected among healthcare providers. Studies have linked the lack of racial and ethnic diversity in the workplace with mental health disparities, in terms of quality of and access to care. For racial and ethnic minoritized groups, these disparities are further aggravated by the lack of providers who can address patients' specific needs within the context of culture, family, and community.[3] Within mental health, this can lead to stigmatization and devaluation of vulnerable populations. Shameful errors in psychiatry include the diagnosis of drapetomania to describe enslaved Africans fleeing captivity, categorizing homosexual and transgender individuals as having a pathological illness, and overdiagnosis of schizophrenia in African Americans.[4] To improve our quality of care and reduce disparities, it is important to increase the diversity in our workforce, so we can sensitively and adequately treat our patients.

How does medicine fare with regards to workforce diversity? In recent years, there have been efforts to recruit more diverse medical students and physicians in domains of race, ethnicity, and gender. In 2018, the statistics from the AAMC reported 64.1% of physicians were men and 56.2% were White. However, among younger physicians, women outnumbered men and there was an overall higher percentage of physicians from minoritized populations.[5] Amongst medical specialties, child and adolescent psychiatry has a majority of women.[6] While our workforce has increased in diversity, there remain barriers to ensure inclusion and equity – "guaranteeing access, opportunity, and fair treatment to all individuals."[7] Discrimination and bias in the workplace due to factors such as race, ethnicity and religion occur every day. Examples reported in the literature include bigoted and inappropriate comments from patients towards providers, patients requesting a change in provider due to discrimination, and overall, unsafe and unwelcoming workplaces.[3]

Particularly for women in medicine and psychiatry, inequity and lack of inclusion have been ongoing issues

for decades. To name a few examples: women face sexual harassment from colleagues and patients, have more barriers to advancing their careers and acquiring promotions, and continue to earn lower income than their male counterparts.[8] Furthermore, intersectionality—the framework that cumulative domains of discrimination (ie, sexual orientation, gender identity, and race) can combine or intersect in the experiences of minoritized individuals—creates even more barriers. Situations where women of minoritized groups must navigate contradictory misconceptions like being perceived both as not assertive enough as a woman and as a member of an aggressive racially or ethnically minoritized group is described as a "double-bind."[9] Ultimately, the challenges associated with poor understanding of intersectionality contribute to inequity and lack of inclusiveness in the workplace.

How do we advocate for a safer and more inclusive environment for women? Refer to Table 1. At an individual level, we can encourage people to be mindful of their conscious and unconscious or implicit biases. The first step is to acknowledge that implicit bias is inevitable. The Implicit Association Test, a useful tool developed by Harvard University, allows individuals to recognize automatic reactions towards others that lead to unintentional prejudice and discrimination.[3] Implicit bias can be managed by introspection, mindfulness, perspective taking, and individuation. By encouraging workforce members to participate in workshops, as well as leading training on unconscious bias, we can raise awareness and advocacy for DEI.[4]

Institutions can develop strategic training programs to enhance cultural sensitivity and address implicit bias and the impact of microaggressions. Leaders in institutions may consider implementing a multidisciplinary task force or committee to promote DEI initiatives and awareness.[4] At an institutional level, it is important to recruit and retain diverse workforce members. This includes having leaders who believe in the values of DEI and making that transparent throughout the department. Although organizations can create a Chief Diversity Officer (CDO) position to increase representation and visibility of underrepresented minoritized groups, it is not enough to simply add a person to oversee diversity efforts. The organization as a whole must value diversity and inclusion as central to their mission and consistently assess these diverse groups and their perception of progress.

Engaging with local communities and schools can ensure that female students from underrepresented groups get early exposure to fields in medicine. Schools can create programs to mentor middle school, high school, and college students and create a pipeline for more diverse physicians in the future, enhancing diversity in medicine.[10] Medical schools may integrate DEI series into their curriculum and recruit leadership and faculty who reflect a diverse demographic, including

Table 1: Tips to Promote Diversity, Equity, and Inclusion (DEI) in the Workplace

Individual	■ Be aware of implicit bias ■ Learn to manage implicit bias ■ Evaluate people based on their personal characteristics rather than those of the group they belong to
Institution	■ Create a culture by making DEI initiatives integral to the mission and goals of the organization. ■ Inclusivity on committees from all disciplines ■ Standardize outcomes for hiring and promoting
School and community	■ Create mentorship programs ■ Integrate DEI series in curriculum ■ Recruit and retain diverse leadership and faculty

women and those underrepresented in medicine. This commitment can also translate into their recruitment of students, development of curriculum, and support groups within the school.

Overall, closing the diversity gap for women in child and adolescent psychiatry is a long-term process that requires daily and regular efforts at the individual, institutional, and community levels. Although efforts above are generalized, advocates for women can follow these models as guides, and ensure adequate representation of women. Hopefully, this can create a more inclusive and equitable workplace for women and intersecting underrepresented identities.

Take Home Summary

Women in psychiatry have faced longstanding inequity and lack of inclusion, with minoritized women having an even higher cumulative burden of discrimination. By bringing awareness and advocating for DEI, individuals, institutions, and communities can develop safer and more inclusive workplaces.

References

1. *Diversity and inclusion training: The Verna Myers Company: Official website*. Verna Myers. (2022, February 8). Retrieved May 21, 2022, from https://www.vernamyers.com/
2. *AAMC*. AAMC. (n.d.). Retrieved May 21, 2022, from https://www.aamc.org/what-we-do/aamc-awards
3. Moreno FA, Chhatwal J. Diversity and inclusion in psychiatry: the pursuit of health equity. *Focus*. 2020;18(1):2-7. https://doi.org/10.1176/appi.focus.10.1176/appi.focus.20190029
4. Simonsen KA, Shim RS. Embracing diversity and inclusion in psychiatry leadership. *Psychiatric Clinics of North America*. 2019;42(3):463-471. https://doi.org/10.1016/j.psc.2019.05.006
5. Percentage of physicians by sex and race/ethnicity. AAMC. 2018. https://www.aamc.org/data-reports/workforce/interactive-data/figure-20-percentage-physicians-sex-and-race/ethnicity-2018. Accessed 10, August 2021.
6. Hosoda M, Veenstra-VanderWeele J, Stroeh OM. Gender disparities in the child psychiatry ranks. *J Am Acad Child Adolesc Psychiatry*. 2021; 60(7):793-795. https://doi.org/10.1016/j.jaac.2021.02.020
7. Amonoo HL, Levy-Carrick NC, Nadkarni A, *et al*. Diversity, equity, and inclusion committee: an instrument to champion diversity efforts within a large academic psychiatry department. *Psychiatric Services.* 2021:73(2):223-226. https://doi.org/10.1176/appi.ps.202000934
8. Kang SK, Kaplan S. Working toward gender diversity and inclusion in medicine: Myths and solutions. *The Lancet,* 2019;393(10171):579-586. https://doi.org/10.1016/s0140-6736(18)33138-6
9. Borlik MF, Godoy SM, Wadell PM, *et al.* Women in academic psychiatry: inequities, barriers, and promising solutions. *Academic Psychiatry.* 2021; 45(1):110-119. https://doi.org/10.1007/s40596-020-01389-5
10. Schuster MA, Conwell WD, Connelly MT, Humphrey HJ. Building equity, inclusion, and diversity into the fabric of a new medical school: early experiences of the Kaiser Permanente Bernard J. Tyson School of Medicine. *Academic Medicine*. 2020;95(12S). https://doi.org/10.1097/acm.0000000000003695

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