Addressing Implicit Bias in Child and Adolescent Psychiatry

Mamatha Challa, MD, Aditi Hajirnis, MD, Christina T. Khan, MD, PhD, Consuelo C. Cagande, MD

"I don't want to hear her talk anymore, her voice is so annoying. Let HIM talk!"

I was a first-year psychiatry resident, attempting to lead an interview with my patient with mania on our inpatient unit with male colleagues present. When my patient interrupted me mid-interview to demand that I (M.C.) stop speaking, I wasn't sure how to respond. While I objectively recognized that his comment came from a state of thought disorganization and mood lability, a part of me couldn't help but take it a little personally. I felt embarrassed; was there actually something irritating about my high-pitched voice? Was there something I was doing to seem like a less respectable physician than my male colleagues?

Unfortunately, this was one of multiple instances in psychiatry training where I experienced patients, their families, or even staff approaching me in ways that seemed affected by my gender. At times it would be subtle and innocuous; patients and staff members accidentally mistook me for a nurse or requested to call me by my first name while my male colleague was addressed as doctor. At other times it would be more explicit; patients made lewd comments about my appearance, or even threatened to follow me outside the hospital. I generally took these situations in stride, as medical trainees commonly experience moments of harassment during their training irrespective of race or gender. Nonetheless, these experiences certainly stuck with me as I transitioned into child psychiatry fellowship.

In medicine, child and adolescent psychiatry is one of the most well-represented specialties for female providers; 52.7% of practicing child and adolescent psychiatrists and 62.5% of child psychiatry trainees are women.[1] However, there is a steep decline in female physicians within the higher ranks of our field. While female child psychiatrists occupy 58% of clinical lecturer and assistant professor positions, only 31% are full professors, and just 14% are endowed faculty.[1] This data demonstrates a difficulty in advancing women into leadership, which is mirrored by other female-predominant specialties like pediatrics and obstetrics. This disparity is compounded for women at the intersection of multiple minoritized identities, as only 5.5% of full-time US medical school faculty are Hispanic or Latinx and only 3.8% are Black.[2]

Why does this happen? While this is a complex issue with many contributing factors, implicit bias has been shown to play a role in disparities in health care settings. The concept of implicit bias refers to negative attitudes, stereotypes, or associations that people unconsciously and unintentionally link with members of marginalized groups. Implicit bias can affect how people make decisions and treat others in society, whether we want it to or not. Studies have found that healthcare providers are just as likely to have implicit bias as the general population and that these biases impact treatment decisions and outcomes.[3] In addition, studies of physicians have found that implicit gender bias may specifically lead both male and female physicians to favor men in health care leadership roles over women.[4]

We must recognize that both our individual and institutional difficulties with bias ultimately impact how we operate our organizations and provide patient care. While our opening anecdote explored how gender may influence the way patients see providers, it is even more crucial for clinicians to understand how our biases affect how we see and treat patients. Literature suggests that neurodevelopmental disorders like attention-deficit/hyperactivity disorder (ADHD) and autism are more likely to be missed in girls,[5] but meanwhile disorders

like borderline personality may be underdiagnosed in boys.[6] While the cause of these discrepancies is multifactorial, unchecked bias increases the risk of misinterpreting and undertreating important patient symptoms and behaviors.

So, what can we do to mitigate this risk? On the individual level, we must acknowledge and understand our own implicit biases across intersections of race, age, gender, sexuality, nationality, body habitus, and ability, to name a few. One tool that can be used to explore this is the Harvard Implicit Association Test (IAT).[7] The IAT measures people's automatic associations between groups and words, such as gender with profession, or race with violence. IAT results can help providers recognize that we are all susceptible to unconscious bias that may impact our decision-making. Providers can then work to reduce bias with a number of strategies, including proactively creating egalitarian goals when working with others, looking for common identities and counter-stereotypical information about minoritized groups, thoughtfully taking on the perspective of marginalized communities, and seeking out opportunities for increased contact with people from diverse backgrounds.[8]

Even so, simply addressing individual bias is not enough; institutions must take action. At an organizational level, department leaders should 1) recognize that implicit bias is universal; 2) normalize attempts to label and uncover bias; 3) create a workplace culture where pausing and checking for bias is the norm and not stigmatized; 4) develop concrete, objective, and standardized indicators and outcomes for hiring, evaluation, and promotion to reduce the influence of bias; and 5) provide implicit bias training for all staff.[9] Specific initiatives that institutions may use to achieve these goals include increasing diversity on staff recruitment committees, blinding hiring applications, eliminating biased language in clinical teaching, and offering more flexible scheduling options for both providers and patients with children.[10]

Structural efforts to minimize unconscious bias must start with learning to recognize it and understand its impact. However, this is just the beginning. Managing implicit bias at both an organizational and individual level should be a core strategy for any institution committed to diversity and inclusion. Above all, reducing the impact of unconscious bias is not only important for our interpersonal interactions and institutional efficacy; it can also boost provider morale and ultimately improve healthcare outcomes for our patients.

Take Home Summary

Implicit bias exists throughout society and medicine and has been demonstrated in child and adolescent psychiatry. Institutions must make both structural and interpersonal efforts to address unconscious bias, starting with recognizing it and understanding its impact on providers and patients.

References

1. Hosoda M, Veenstra-VanderWeele J, Stroeh OM. Gender disparities in the child psychiatry ranks. *J Am Acad Child Adolesc Psychiatry*. 2021 Jul 1;60(7):793-5. https://doi.org/10.1016/j.jaac.2021.02.020
2. Figure 15. Percentage of full-time U.S. medical school faculty by race/ethnicity, 2018 AAMC. Accessed August, 19, 2021. https://www.aamc.org/data-reports/workforce/interactive-data/figure-15-percentage-full-time-us-medical-school-faculty-race/ethnicity-2018.
3. Dehon E, Weiss N, Jones J, Faulconer W, Hinton E, Sterling S. A systematic review of the impact of physician implicit racial bias on clinical decision making. *Acad Emerg Med Off J Soc Acad Emerg Med.* 2017 Aug;24(8):895–904. https://doi.org/10.1111/acem.13214
4. Hansen M, Schoonover A, Skarica B, Harrod T, Bahr N, Guise J-M. Implicit gender bias among US resident physicians. *BMC Med Educ.* 2019 Oct 29;19:396. https://doi.org/10.1186/s12909-019-1818-1
5. May T, Adesina I, McGillivray J, Rinehart NJ. Sex differences in neurodevelopmental disorders. *Curr Opin Neurol.* 2019 Aug;32(4):622–6. https://doi.org/10.1097/WCO.0000000000000714

6. Bjorklund P. No man's land: gender bias and social constructivism in the diagnosis of borderline personality disorder. *Issues Ment Health Nurs*. 2006 Jan;27(1):3–23. https://doi.org/10.1080/01612840500312753
7. About Us. Project Implicit. Accessed August, 19, 2021. https://implicit.harvard.edu/implicit/aboutus.html
8. Stone J, Moskowitz GB. Non-conscious bias in medical decision making: what can be done to reduce it? *Med Educ.* 2011;45(8):768-76. https://doi.org/10.1111/j.1365-2923.2011.04026.x
9. Carnes M, Devine PG, Isaac C, *et al.* Promoting institutional change through bias literacy. J Divers High Educ. 2012 Jun;5(2):63-77. https://doi.org/10.1037/a0028128
10. Hui K, Sukhera J, Vigod S, Taylor VH, Zaheer J. Recognizing and addressing implicit gender bias in medicine. *CMAJ Can Med Assoc J.* 2020 Oct 19;192(42):E1269-70. https://doi.org/10.1503/cmaj.200286

About the Authors

Mamatha Challa, MD, is a second-year child and adolescent psychiatry fellow at Cambridge Health Alliance/Harvard Medical School, Cambridge, Massachusetts. She completed her general psychiatry training at the Stanford University School of Medicine, California. Her interests include LGBTQ+ health, social justice, medical education, and inpatient psychiatry. She serves as a trainee member of the AACAP Women in Child and Adolescent Psychiatry Committee.

Christina T. Khan, MD, PhD, is a clinical associate professor and co-chief of the Diversity and Cultural Mental Health Section in the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine, California. Her interests include trauma, LGBTQ+ health, physician wellness, and global mental health. Dr. Khan serves as president of the Association of Women Psychiatrists, and she is a founding member of the AACAP Women in Child and Adolescent Psychiatry Committee. She also serves on the Council on Minority Mental Health and Health Disparities of the American Psychiatric Association.

Aditi Hajirnis, MD, is an assistant professor of psychiatry at the Warren Alpert Medical School of Brown University, Providence, Rhode Island, and attending psychiatrist at Emma Pendleton Bradley Hospital, Providence, Rhode Island. She is a member of the AACAP Women in Child and Adolescent Psychiatry Committee and delegate to the assembly for the Rhode Island Council of Child Psychiatry. Her interests include ADHD, anxiety, mood disorders, and wellness.

Consuelo C. Cagande, MD, is an associate professor at the Perelman School of Medicine, University of Pennsylvania, Philadelphia, and division chief of Community Care and Wellness in the Department of Child and Adolescent Psychiatry and Behavioral Sciences at Children's Hospital of Philadelphia (CHOP.) She is also the senior associate program director and advisor of the CHOP Child and Adolescent Psychiatry Fellowship Program. She is co-chair of the AACAP Women in Child and Adolescent Psychiatry Committee. Her interests include anxiety, trauma, systems of care/access to care, positive psychiatry, and medical education.

The authors have reported no funding for this work.

Disclosure: Drs. Challa, Hajirnis, Khan, and Cagande have reported no biomedical financial interests or potential conflicts of interest.

Correspondence to Mamatha Challa, MD; e-mail: mamathachalla@gmail.com

This article was edited by Anne B. McBride, MD.