Special Issue: The Intersection of Child Psychiatry and Sociocultural Issues

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Welcome to JAACAP Connect!

What is JAACAP Connect?
All are invited! JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), the leading journal focused exclusively on psychiatric research and treatment of children and adolescents. A core mission of JAACAP Connect is to engage trainees and practitioners in the process of lifelong learning via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.

Why do we need JAACAP Connect?
The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. JAACAP Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences.

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All students, trainees, and clinicians who are interested in child and adolescent mental health will benefit from reading JAACAP Connect, available online at www.jaacap.com/content/connect. AACAP members will receive emails announcing new quarterly issues.

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JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our first edition, the topic and format can vary widely, from neuroscience to teen music choices.

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Motivated by the ACGME/ABPN Psychiatry Milestone Project©, JAACAP Connect aims to promote the development of the skill set necessary for translating scientific research into clinical practice. The process of science-based publication creates a vital set of skills that is rarely acquired elsewhere, and models the real-life thought process of translating scientific findings into clinical care. To bring this experience to more trainees and providers, JAACAP Connect aims to enhance mastery of translating scientific findings into clinical reality by encouraging publishing as education.

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Start Thinking About Authorship With JAACAP Connect
What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome and you are invited.
Tilling Our Own Cultural Identity to Understand Sociocultural Evolution

Michelle S. Horner, DO

Culture. How can something so integral to our daily lives be so challenging to understand in ourselves and others? As clinicians, parents, and patients, nearly all that we say and do passes through our own cultural filter, often influencing our thoughts and actions without our active awareness. In its most sterile form, culture can be defined as “the customary beliefs, social forms, and material traits of a racial, religious, or social group; the characteristic features of everyday existence as diversions or a way of life.” At the individual level, cultural identity considers the influence of race, ethnicity, religion, family history, gender identity, and other factors on social, psychological, and biological functioning and wellbeing.

Regardless of what we choose to consider within the framework of culture, our understanding of cultural identity and its impact on our patients’ mental health is constantly broadening and evolving. It is fitting, therefore, that the etymology of the word culture is the Latin colere, which translates to the English concepts of “tend, guard, cultivate, till.” The term culture was taken figuratively from the agricultural practice of caring, cultivating, and honoring the land. In the 1500s, the word culture became synonymous with the intellect of the people; the cultivation of a people through education. As travel and relocation became more common, groups of individuals became known for their collective cultural identity, first in terms of their geographic origin, then later for other facets we consider today, such as ethnicity, race, religion, and gender and sexual identity.

In a nation with many blended cultures, cultural identity tends to be assumed by overt characteristics such as skin color, religious adornments, language, and social mannerisms. As child and adolescent psychiatrists, we are tasked with understanding the depth and impact of culture, for our patients and ourselves. The Outline for Cultural Formulation (OCF), first published in the DSM-IV and advanced with the semi-structured Cultural Formulation Interview (CFI) in the DSM-5, provides formal methods for assessment. The American Academy of Child and Adolescent Psychiatry (AACAP) offers practice parameters on cultural competence, and there are numerous books, guides, and even whole journals dedicated to improving cultural integration in psychiatric care. Advancing our skills in assessment and formulation is important. This culturally themed issue of JAACAP Connect, however, has the primary purpose of tilling.

In gardening, tilling describes the process of breaking up the surface soil to aerate and add nutrients. It is common that untilled soil becomes too compacted, thus lessening the chance for growth. So too for us: it is important to step back and begin tilling the surface of our own cultural identity, with the greater purpose of integrating ourselves into the larger culture of understanding, tolerance, and acceptance.

This issue of JAACAP Connect provides in-the-trenches insight into some of the most culturally relevant issues in child and adolescent psychiatry. Patrice Janell Holmes, MD, begins by explaining intersectionality of clinician and patient culture as a means of enriching our biopsychosocial formulation with sociocultural identity. Cortlyn Brown, BA, provides a two-part article on biracial identity and working with biracial patients, and Jerome H. Taylor, MD, delves into race and recent events, including the Yale Halloween controversy of 2015. Dalia N. Balsamo, MD, helps to demystify gender identity and nonconformity, offering a reverent approach for asking about these challenging issues. In the spirit of JAACAP Connect, each article provides practical tips and considerations that can help us improve patient care today. Time to start tilling!
Tilling Our Own Cultural Identity to Understand Sociocultural Evolution

About the Author
Michelle Horner, DO, is the editor-in-chief of JAACAP Connect and assistant professor of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine.

References

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Intersectionality (or, the Whole Is Greater Than the Sum of Its Parts): Informing Sociocultural Formulation and Improving Mental Health Inequities

Patrice Janell Holmes, MD

I will not have my life narrowed down.  
I will not bow down to somebody else’s whim or to someone else’s ignorance.

~ bell hooks

A tense climate of race relations, conflict over sociocultural identity, and the ongoing problem of discrimination have been highlighted in recent events across the nation. Children and families fall across a broad spectrum of cultures, ethnic backgrounds, races, genders, and sexual orientations. The conceptualization of these varied identities deepens our understanding of families and their access or barriers to care. As child and adolescent psychiatrists providing care for diverse families, we must consider whether the connection between a given provider and family is culturally appropriate. Is the provider’s conceptualization of the family formed from a full picture, complete with an understanding of their culture, or are key parts excluded through the omission of the unfamiliar? For example, within the social sciences, the concept of intersectionality has been presented as a means of formulating, among other things, relevant aspects of oppression and privilege, given that people’s social standings often expose them to privilege, marginalization, or a combination of the two. Incorporating intersectionality can thus enrich a biopsychosocial formulation of sociocultural identity.¹

More broadly, intersectionality refers to the confluence of gender, sexuality, race, class, and other facets of social identity that contribute to an individual’s experience across multiple contexts. Intersectionality seeks to improve our understanding of marginalized social identities by proposing that features of an individual’s identity in isolation are an oversimplification that ignores a rich and complex interplay between social facets.¹ In other words, the theory postulates that social identities impart privilege, disadvantage, or a combination of the two depending on circumstances. This concept of the “interconnected nature of inequalities” underlying the complexity of discrimination was first described in the early 1980s by bell hooks and Gloria Hull. Noticing that the movements for race and gender equality largely relied on the perspectives of black men and white women, hooks, Hull, and their colleagues arrived at this theory, which would later be termed “intersectionality” by Kimberlé Crenshaw.²

Kimberlé Crenshaw, a feminist and currently a professor of law at UCLA, first used the term “intersectionality” in her 1989 paper “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Anti-racist Politics.”¹,³ In her paper, Crenshaw examined attitudes toward discrimination as they related to black women across disparate contexts: the legal system, within the black community, and in the feminist literature. Crenshaw highlighted the “single-issue framework for discrimination” as a device to marginalize multiply disadvantaged people, for example black women who are subject to “double discrimination” based on their race and sex, and who lacked a voice in the race and sex equality movements. Her paper presented a history of the black woman’s experience being viewed as either female or black, as opposed to the more complex concept of a combination of the two identities, which yields outcomes that differ from other women and black men. She cited court opinions that failed to recognize...
Intersectionality (or, the Whole Is Greater Than the Sum of Its Parts): Informing Sociocultural Formulation and Improving Mental Health Inequities

black women as a protected minority group because of the view that sex discrimination and race discrimination are separate processes that cannot co-occur.

Intersectionality is especially relevant to families living in underserved areas that commonly encounter discrimination attributable to multiple factors. Conventional practice examines the impact of these aspects of identity one facet at a time, for instance evaluating only the effect of poverty on a family, which leads to facile understandings, such as “the family does not come to treatment because they are poor.” The family that struggles with poverty at the same time might be black, a minority in their regional community, and have a single parent as the family leader, which could result in a different conceptualization: “the family does not come to treatment because of the stigma within their cultural community, discriminatory processes that lower the family’s confidence in the healthcare system, and a single parent having to choose between the visit and work obligations.” In reality, these social components of identity converge and simultaneously shape an individual’s experience and have the potential to act as barriers to healthcare. The concept of intersectionality offers a deepening understanding of the complexity of social identity by considering the interaction of multiple social facets, as opposed to a succession of disjointed sociocultural features.

Sociologists and medical professionals have increased the understanding of healthcare inequity by applying the theory of intersectionality to their investigations of mental health outcomes. Gerry Veenstra4 examined the impact of interactions between an individual’s race, class, sexual orientation, and gender on self-report measures of health outcomes, including mental well-being. The study analyzed Canadian Community Health Survey (CCHS) data and found that bisexual, lower social class, aboriginal and Asian respondents reported poor health outcomes, and that homosexual individuals with low income and South Asian women were more likely to report fair-to-poor health outcomes. However, low-income women and low-income Asian Canadians reported lower rates of fair-to-poor health. These sample results suggest that an individual’s demographics will interact in ways that both ameliorate and exacerbate health status factors. High levels of discrimination have been associated with a lower sense of wellbeing and high levels of anxiety.2 Seng et al.5 examined the quantifiable impact of intersectionality on health outcomes by retrospectively analyzing data from measures of post-traumatic stress disorder (PTSD), discrimination, and the number of marginalized social identities in a population of pregnant women in Ann Arbor and Detroit, MI. The authors used data collected during a prospective, cross-sectional study of the impact of PTSD on birth outcomes. Participants from the maternity clinic in Ann Arbor were privately insured, and the women served by the Detroit clinics were largely publicly insured. In the retrospective analysis, 619 women were included; 55.3% were white and 33.9% were black. The study classified participants by race/ethnicity, income, whether their residence was in a high crime area, education level, whether they were classed as a minority in their city, episodes of trauma, number of PTSD symptoms, quality of life, frequency of discrimination, and the social identity to which the discrimination was attributed. PTSD symptoms were measured using the National Women’s Study PTSD Module; the Quality of Life Inventory was used to quantify life satisfaction, and the Everyday Discrimination Scale indicated the frequency of discrimination experiences and assessed for attributions for discrimination (number of marginalized identities). There was a significant and negative correlation between high frequency of discrimination and quality of life. The frequency of discrimination scores were significantly and positively correlated with the degree of PTSD symptomatology. The sum of attributions for discrimination on the Everyday Discrimination Scale indicated the frequency of discrimination experiences and assessed for attributions for discrimination (number of marginalized identities). There was a significant and negative correlation between high frequency of discrimination and quality of life. The frequency of discrimination scores were significantly and positively correlated with the degree of PTSD symptomatology. The sum of attributions for discrimination on the Everyday Discrimination Scale was significantly associated with PTSD symptomatology, and this
Intersectionality as it relates to mental health outcomes and access helps clinicians to more accurately appraise the social experiences of their patients. Population health research points toward intersectionality’s potential to enhance the accuracy with which health inequities are identified, guide the development of interventions, and increase the utility of targeted efforts in particular groups.1

An individual is a mosaic of disparate social identities that coalesce to form the image of the self that interacts with society. This is the image around which society builds its expectations, privileges, and discriminatory processes. Bauer likened the theory of intersectionality to the biopsychosocial model in respect to the shared acknowledgement of and emphasis on the complicated interaction of multiple factors that when considered in isolation produces an incomplete picture. Intersectionality guides the formulation of the child’s sociocultural identity, which can enrich the provider’s understanding of the family and their societal experience.

**Take Home Summary**

- Intersectionality refers to the intersection of gender, sexuality, race, class, and other facets of social identity that together interact in a complex (and not simply additive) fashion to influence an individual’s experience across social contexts.
- Intersectionality can provide an individual with privileged status, disadvantage, or a combination of the two, depending on the circumstances.
- Intersectionality provides a framework for conceptualizing the sociocultural identities of children and families and recognizes the complexity of an individual’s interaction with his/her environment.

**Resources**

- The Intergroup Resources website provides online educational materials related to intersectionality and social justice. [http://www.intergroupresources.com/intersectionality](http://www.intergroupresources.com/intersectionality).

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**John F. McDermott, Jr., MD (1929-2015)**

In early December, we learned that Dr. John F. McDermott, Editor Emeritus of the *Journal*, had passed away peacefully in his sleep. Jack was a leader in our field and a great mentor and friend. His incredible work for the Academy and his commitment to teaching are only a small part of his legacy. Later this year, we will remember and honor Jack in the pages of both the *Journal* and *Connect*. Until then, our thoughts and sympathies are with his family and the many friends whose lives he touched.
Intersectionality (or, the Whole Is Greater Than the Sum of Its Parts): Informing Sociocultural Formulation and Improving Mental Health Inequities

About the Author
Patrice Janell Holmes, MD, earned a Bachelor of Science degree in Psychology and was inducted into Phi Beta Kappa at the University of Oklahoma in 2006. In 2010 she earned her MD from the University of Oklahoma. After medical school she completed a preliminary year in general surgery at the Greenville Hospital System, an affiliate of the University of South Carolina School of Medicine. Dr. Holmes began her life-long learning in psychiatry at Georgetown University Hospital in 2011 and completed her adult requirements in 2014, before training at the Yale Child Study Center. Currently a second-year child and adolescent psychiatry fellow at the Yale Child Study Center, Dr. Holmes will complete her chief residency year in June 2016. Since joining the Yale Child Study Center, Dr. Holmes has travelled to Brazil for an international experience in child psychiatry, organized and presented lectures on child and adolescent psychiatry to the Yale School of Medicine students, and served as a member of the Medical Student Education Committee.

Disclosure: Dr. Holmes would like to acknowledge the trainees and faculty of the Yale Child Study Center for their support. Dr. Holmes reports no biomedical financial interests or potential conflicts of interest.

References

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Dr. Paramjit Joshi, AACAP President and Distinguished Member Award Recipients at the 2014 AACAP Annual Meeting.
A

JAACAP PUBLICATION

JAACAP Connect

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Too Busy in the Residency Race to Think About Race

Jerome H. Taylor, MD

...Institutions allow inequities to continue without successfully addressing them, in turn making resentment build.

~Meghan O’Rourke, “Yale’s Unsafe Spaces,” The New Yorker, November 13, 2015

E-mails with the subject line “We need your help!!!!” flooded my inbox. It was an email thread initiated by a black friend and sent to some of the racial, ethnic, and sexual minorities in Yale’s Psychiatry Residency Training Program. The email was related to the recent race-related events on Yale’s campus—a debate about wearing racial/ethnic Halloween costumes and an alleged “White Girls Only” frat party. After skimming the email, I clicked back to the patient note I was typing. Trayvon Martin’s shooting on February 26, 2012 and the subsequent trial were emotionally draining. Trayvon was an unarmed teenager who was shot and killed by a man who said he was defending himself; ultimately, a jury acquitted the shooter. Since then, I have been mostly successful at avoiding dialogue and too much thought about the Black Lives Matter movement, Michael Brown and Ferguson, the removal of the Confederate flag from the South Carolina statehouse, Freddie Gray and the Baltimore protests, and Sandra Bland. I filter out race-related news and social media. I type patient notes and study psychopharmacology. At times I feel I am shirking my duties as an African-American man, but I do not have the time to emotionally process the recurrent tragedies. I have socioeconomic privilege and am protected from some of the most pernicious racial and ethnic inequities. Relative to blacks with lower incomes and fewer educational degrees, I have access to more legal resources, am less likely to be unemployed due to discrimination, and am less likely to be a victim of predatory lending. I have less at stake, so I keep up with the news superficially and mostly disengage.

And then on November 11, 2015, I got the “We need your help!!!!” email. It invited me to a forum on recent racial events on Yale’s campus and issues affecting women of color. The Yale students called the forum a “teach-in.” Friends texted me requesting that I go, and I acquiesced. Yale’s Battell Chapel was packed to capacity for the teach-in, and the press was interviewing attendees outside. During the teach-in, students read moving spoken word poems. Panels of professors and students spoke about race and intersectionality. The students emphasized their protest was not about an email or party; rather, their discontent was with what they perceived as a culture of indifference toward minority issues on campus. The emotions were raw, and it was imperfect and brilliant. Most of the attendees were white, they listened, and I felt encouraged. I went home eager to read more about recent race issues at Yale. I became angry and disappointed when I came across overly simplistic articles calling the students “hypersensitive.” The media skewered a student who wrote in The Yale Herald, “I don’t want to debate, I want to talk about my pain” (the letter has since been taken down). The student’s statement made sense to me.

Later that week, I asked a friend who is a white co-resident, “What am I missing?” She hesitated and then cautiously said, “I honestly could not understand why the ethnic Halloween costumes issue was a big deal at first. It took me a while…but really, what was so bad about it?” It was a great discussion that lasted over an hour. She listened to me, and I hope she feels I listened to her. I felt heard and unburdened. I could finally begin to empathize with the faculty members at the center of the Halloween costume controversy. Emotions had likely been intense on all sides as the events unfolded, a completely understandable reaction. My friend joked,
“Now I’ve got you feeling bad for white people. Isn’t that the typical white person response?” After our conversation, my co-resident rushed to pick up her daughter from daycare, and I finished my patient note. Later that evening, my co-resident emailed me a link to an article about the race-related events at Yale that echoed my sentiments. She cared and had valued the time we spent talking. I drafted this piece the following weekend. Since then, my co-resident and I have both returned to patient notes and psychopharmacology as we train to become curious and empathetic listeners.

Yale Halloween Controversy 101

A few days before Halloween of 2015, the Yale Intercultural Affairs Counsel (a collaborative of the University’s student-led cultural organizations) sent an email to undergraduates encouraging students to consider the feelings of others when choosing a costume. Among other recommendations, it discouraged redface, blackface, skin tone alteration, headdresses, and turbans. The email asked students to consider whether the costume was based on stereotypes, propagated historical inaccuracies, implied a joke about human traits, or made light of a group’s heritage or faith. As a counterpoint, a Yale lecturer sent an email to students that discussed the perils of censorship and how institutional suppression of student rights (even if it is the right to wear “offensive” Halloween costumes) may negatively impact child and young adult development. She viewed the Halloween recommendations as another way in which adults try to control children/youth. Many minority students expressed concerns about the Yale lecturer’s email and felt the subsequent faculty and university responses to student concerns were invalidating and emblematic of a culturally callous environment. Yale students protested, which garnered national media attention. Videos of highly emotional minority students yelling were widely circulated. The events culminated in a list of student demands that included the creation of an “Ethnicity, Race and Migration” Department, establishment of mental health professional positions in each of the four cultural centers, increased funding for the cultural centers, and removal of the two faculty members at the nucleus of the email controversy from their roles as “Master” and “Associate Master” (student-related positions distinct from their academic positions). Similar protests related to various racial issues also occurred at the University of Missouri, Virginia Commonwealth University, and Ithaca College and sparked a national conversation about race on college campuses.

Much of the controversy at Yale involved different views on the Yale lecturer’s role. In her email to the residents of her affiliated “college” (a dormitory that students are assigned to be affiliated with throughout their undergraduate experience at Yale), the Yale lecturer explicitly stated her views were from the perspective of an educator interested in child development, and she made many thoughtful points in that context. She is also a college associate master, and one of her responsibilities is to foster a safe, cohesive, and culturally enriching dormitory living environment for students. Instances of dual roles are woven throughout this story: students are naughty and limit-testing but also obedient and learning; Halloween is another day but also a time for adventure and tricks; and Yale University is a place for education and also a place of inclusion. As for me, I continue to navigate my roles as a resident trainee learning to listen better and also as a physician learning to become an advocate.

Conclusion

With all of these roles and costumes, I began to think about what this will mean for the children and families I will work with. They too have roles and wear costumes. Race, ethnicity, religion, sex, and sexual orientation often influence how we see patients and how they see us. Asking patients and families to explain how their cultural background affects how they interact with the world and validating their experiences can be therapeutic. Reflecting on how the roles we play influence our perspective on day-to-day events may help us to identify our own cultural biases.
Take Home Summary
Clinicians should initiate conversations with their patients about how race, ethnicity, religion, sexual orientation, gender, and other cultural factors may affect the patient–clinician dynamic. The American Academy of Child and Adolescent Psychiatry Practice Parameter on Culture Competence\(^1\) and the DSM-5 Cultural Formulation Interview\(^1\) are great guides for how to start identity and culture conversations with patients. Finally, when a colleague or friend from a different background initiates a conversation about cultural issues, reciprocal listening with empathy and curiosity can be eye-opening for both parties (with the caveat that there may not be time for such discussions).

References

About the Author
Jerome Taylor, MD, is a chief resident and post-graduate year 5 in the Albert J. Solnit Integrated Training Program in Child and Adult Psychiatry and Research at the Yale Child Study Center and Department of Psychiatry at the Yale School of Medicine, New Haven, CT.

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The purpose of JAACAP’s Here & There – the first pages in each issue – is two-fold: to highlight trends and important findings in the current issue, and to pick up the thread of something significant happening outside our pages and explore its relevance to child and adolescent psychiatry on a broader scale. This month, in his Here & There, “Wielding Weapons: The Intersection Between Firearms and Child Psychiatry,” Contributing Editor Dr. David S. Hong tackles one of the most contentious issues facing the field in 2016: guns. Citing scientific studies linking access to firearms with increased risk of suicide, homicide, and history of alcohol or drug abuse, and reviewing recent legislative actions, Dr. Hong argues not for one side or the other, but simply that child and adolescent psychiatrists have a responsibility to remain aware of the role firearms can play in the lives of their patients, both at the bedside and in policy discussions across the country.
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Conceptualizing Gender Identity and Gender Nonconformity

Dalia N. Balsamo, MD

Case: “Shane” is a 16-year-old transgender male (assigned female at birth but identifies as male) who is admitted to the hospital for suicidal ideation. Even though he identifies as male, his electronic records refer to him as female. Staff also keep referring to him as “she” and address him by his birth certificate name (“Shauna”) despite his repeated requests to call him by his preferred name. They also feel that Shane is currently just going through a phase and insist on housing him with another female. Shane’s feelings of depression and isolation worsen as he continues to feel invalidated and misunderstood.

While gender nonconformity and transgender issues are not new topics, they have gathered increased attention over the past few years. The show *Transparent* (which depicts the gender transition of a retired college professor) has received critical acclaim, and Caitlyn Jenner has become a household name. NBC started a series titled *Transgender Youth* and LOGO has a web series titled *Beautiful as I Want to Be* (which pairs four transgender youths with mentors who help them affirm and realize their potential). Discussions on gender nonconformity are becoming the norm rather than the exception in youth circles. The expressions “gender fluid” and “gender queer” are much more common than we may think. The singular “they” is becoming an acceptable pronoun. The *New York Times* has recently been using “Mx.” (pronounced “mix”) as a gender-neutral honorific. While “Mx.” may sound fringe to some of us, it was introduced back in 1977 and is currently included in Oxford dictionaries. The goal of this article is to provide a brief overview on how we, as clinicians, can create a gender-sensitive environment for our patients.

Terminology

The first step in being able to work effectively with transgender youth is to understand the terminology that they use. The National Center for Transgender Equality, a leading advocacy organization founded by transgender activists, has a glossary that provides a good introduction into some of the commonly used terms. According to the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter, *gender identity* is an individual’s personal sense of self as male or female. It is usually established by the age of 3. While most people’s gender identity remains stable over their lifetime, it may change for others. The word *transgender* is used as an umbrella term to designate individuals whose gender identity, behavior, and/or expression is not congruent with the sex assigned to them at birth. Some people use the expression *trans* (with an asterisk) to be inclusive of all gender variant people. *Cisgender* is used to refer to people whose gender identity is congruent with the sex they were assigned at birth (also referred to as their natal sex). *Gender nonconforming* usually refers to individuals whose gender expression does not conform to cultural and societal expectations. Often, the terms *transgender*, *gender nonconforming*, and *gender variant* are used interchangeably. Another key point to keep in mind is that these words are adjectives, meaning that the expression “transgender people” is acceptable, but “transgenders” (as a noun) is offensive. *Gender binary* refers to our society’s tendency to define gender as two rigid categories of male and female. While the concept of a non-binary approach to gender may seem alien to some of us, some cultures have in fact a non-binary approach to gender. For example, Two Spirit people from First Nations and Native American cultures and the *hijras* in India are recognized as a third gender.
The Need to Create a Safe Place for Gender Variant Youth

An invalidating and insensitive environment eventually inflicts emotional and psychological harm on gender nonconforming youth. The American Academy of Pediatrics has issued a policy statement that recommends providers be supportive and affirming towards gender variant youth. It also recommends using gender-neutral verbal histories and/or written questionnaires in their assessments.

Genderbread Person and Gender Unicorn

The Genderbread Person was introduced in order to educate people about the complexities of gender and sexuality. It has been used in various settings, ranging from hospital staff training to schools. Its graphical design usually makes it easy for people to obtain a rough conceptualization of the distinctions between gender identity (our own sense of our gender), sexual orientation (to whom we are sexually attracted), gender expression (how we dress, talk, act, etc.), and biological sex (the physical sexual characteristics we are born with). The first version of the Genderbread Person was more binary in its presentation (female ↔ male), while the 2.0 version...

**TABLE 1.**

**SOME PHRASES THAT ONE CAN USE:**
- “How would you like to be called?”
- “How do you identify yourself?”
- “What is your preferred pronoun?”

**SOME PHRASES NOT TO USE:**
- “I couldn’t tell you’re actually a boy! You pass so well!”
- “I thought you were a real girl!”

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*Figure 1: The Gender Unicorn (graphic by Landyn Pan and Anna Moore, courtesy of Trans Student Educational Resources).*
was upgraded to take a non-binary approach. The newest version (referred to as v 3.3) makes a distinction between romantic and sexual attraction. While many people find it useful as a learning tool, some members of the transgender community do not feel comfortable with the term “biological sex” and prefer to use the term “sex assigned at birth” instead. The Genderbread Person graphic has also become the subject of controversy for another reason, namely the question of who originated the design and that person’s position as a voice for the gender nonconforming community. The Gender Unicorn (see Figure 1) was designed to reflect this. It also emphasizes the existence of genders other than male and female. As a healthcare provider, I find it useful to know about these graphical tools, as they are quite popular among adolescents.

**Tips for Creating a Gender-Sensitive and Inclusive Environment**

The Genderbread Person and Gender Unicorn are just two of many tools that adolescents use to express themselves in terms of their gender and sexuality. They can mark where they stand on the continuum for each of the categories. It should be noted that these are evolving concepts, and each individual’s experience is unique. Sometimes, just having the person draw their own sense of their gender and sexuality is more beneficial than any clinical tool. The most valuable thing that a child psychiatrist can do is to be nonjudgmental and willing to learn. Most of us are under the wrong impression that we should “know it all” and feel reluctant to step out of our comfort zone and acknowledge a lack of expertise. A simple request to “help me understand” goes a long way. Table 1 provides some phrases one can use in history taking.

In the case of Shane, the child psychiatrist on the team provided additional training and education to the staff on how to care for gender nonconforming youth and their families. She also referred Shane and his parents to their local PFLAG (formerly known as Parents, Families, and Friends of Lesbians and Gays) chapter, as well as other nonprofit organizations within the area.

**Where to Learn More?**

One of the best ways for clinicians to become educated about transgender issues is to attend annual transgender conferences. These events are great in that they provide a forum where people from different disciplines can exchange knowledge and ideas. One of the best attended is the Philadelphia Trans Health Conference (PTHC). In addition, below is a list of books and websites that are a good place to start. This list is not exhaustive.

**Books:**
- *Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children* by Diane Ehrensaft
- *The Transgender Child: A Handbook for Families and Children* by Stephanie Brill and Rachel Pepper
- *Helping Your Transgender Teen: A Guide for Parents* by Irwin Krieger
- *Jacob’s New Dress* by Sarah and Ian Hoffman
- *Beyond Magenta: A Transgender Teen Speaks Out* by Susan Kuklin
- *I Am Jazz* by Jessica Hertel (for ages 4 to 8)
- *Becoming Nicole: The Transformation of an American Family* by Deckle Edge

**Websites:**
- [web.mit.edu/trans](http://web.mit.edu/trans)
- [www.genderspectrum.org](http://www.genderspectrum.org) – This website is intended to create a gender-sensitive environment for children and adolescents.
- [www.wpath.org](http://www.wpath.org) – This website is for the World Professional Association for Transgender Health. It has the Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People available for download.

**Conclusion**

Child and adolescent psychiatrists play a crucial role in creating a safe and inclusive environment for gender nonconforming youth.
**Take Home Summary**

As mental health professionals, it is essential for us to educate ourselves about transgender issues and build a safe environment for gender nonconforming youth. There are various resources available as educational tools for mental health professionals, parents, educators, and youth.

**About the Author**

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**References**


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We are living in an era of a biracial baby boom. Forty-two percent of the 6.8 million people who self-identified as biracial in the 2000 census were under the age of 18.\textsuperscript{1,2} Thanks to genetics, I am in a unique position to talk about biracial identity development. I am blond-haired, green-eyed, and fair-skinned. And black—when forced to pick. As the daughter of a white mother raised in a trailer park and an Ivy League-educated black father, I am biracial, although I add the caveat that I have a “comfort zone” of black. In this article I discuss biracial identity models in the US and, at the same time, examine how I felt I was perceived and treated by society, often influenced by these models.

Is There a Conflict in Me?
Prior to the 1990s, biracial individuals were by and large expected to subscribe to monoracial or deficit identity models based on a principle of hypodescent: the principle that posited that mixed-race children should be categorized according to the racial group of the “lower status” parent.\textsuperscript{3,5} In 1990, however, Poston proposed a Biracial Identity Model based on the tenet that proper development consisted of conflict and maladjustment.\textsuperscript{6} His model was broken down into 5 stages: 1) personal identity: the child has a personal identity of selfhood that exists independent of racial criteria; 2) choice of group categorization: external forces such as parents, community, school, and peers push the child to endorse one racial group; 3) enmeshment/denial: the child becomes embarrassed about their denial of the other racial group and develops “pseudo-identification” with both groups; alternatively, the guilt can develop into self-hatred; 4) appreciation: the pseudo-identification is cultivated, and the individual learns about the previously ignored group; and lastly, 5) integration of both races into a healthy multiracial identity.

From birth until around age 18 (when Poston’s model was prominent), society expected me to go through all 5 stages and viewed it as “strange” and “unhealthy” when I did not. At the current age of 27, I identify as biracial but would consider black as a reference group. If you forced me to choose a side, I would say black. This is for several reasons: 1) I am more connected to my father’s black heritage and history, and 2) it means more to society, specifically children looking for role models, to be a black female future doctor than a white future doctor. In this sense, although I believe I have reached stage 5, I continue to be drawn back to stage 2.

There were only a few times when I felt external pressure to choose a side. One of these times occurred when I was 9 and wanted to play with kids in the Pittsburgh Jack and Jill Club. The goal of Jack and Jill is to “… create a medium of contact for children which will stimulate growth and development and provide children constructive educational, cultural, civic, health, recreational and social programs.” My parents applied for what would surely be acceptance into the club given that my father was a past Pittsburgh NAACP president. We were denied, and even at that young age, I innately knew it was because my mom was white.

When Should I Start to See Race?
Two years later, Kich returned to the stage model but unlike Poston, his proposed stages were based on age (Hall CC, unpublished doctoral dissertation, 1980). His model begins when children enter school and start peer interactions. In this stage they learn that they are “different.” Although there are many similarities between the models proposed by Kich and Poston, Kich’s model focuses more on the incongruity between self and
external perceptions and self-acceptance, whereas Poston focuses more on external influences and the effects of these external influences. In addition, Kich does not address the guilt that serves as the basis for Poston's stage 3.

In the same year, Jacobs proposed a different stage model based upon doll-play methodology. Stage 1 is pre-color constancy. Children begin to see color differences but do not understand the significance or that skin color is stable. Stage 2 is post-color constancy, in which children reject both racial groups. In stage 3, the child learns that skin color does not determine racial group membership but rather that they are related. It could be argued that Jacobs' stage 1 could be a stepping stone between Poston's stage 1 and 2. Jacobs, however, proposes a stage that neither Poston nor Kich addresses: rejection of both racial groups.

Wardle (1992) proposed an age-dependent biracial identity model that integrated five ecological components, specifically family, community, minority context, majority context, and group antagonism. In stage 1, similar to pre-color constancy by Jacobs, children identify differences including hair texture and skin color, but they do not make the connection between these differences and being a part of a racial minority. They also begin the process of understanding societal interpretation of race. The second stage is similar to Erikson's psychological initiative versus guilt stage. The adolescent takes the initiative to experiment within the greater social world. The guilt is largely formed by the positive or negative influence that external forces, such as parents, have on the exploration.

Do I Have to Pick a Side?

Similar to Kich and Wardle, Kerwin and Ponterotto (1995) base their models around age. They propose 6 stages: 1) preschool stage: initial recognition of differences similar to Jacobs' pre-color constancy; 2) entry-to-school stage: adoption of monoracial identification when in presence of other groups of children (one can see the influence of Poston's stage 2; however, Poston would argue that Kerwin and Ponterotto's stage 3 occurs prior to stage 2); 3) preadolescence stage: first awareness of societal labels; 4) adolescence: need to identify with the parent of color; 5) college/young adulthood: increasing awareness while maintaining monoracial identity; 6) adulthood: exploration of both races and adaptation in each racial niche. Unlike other models, Kerwin and Ponterotto do not end their model with an acceptance of a single mixed-race identity.

Much of the work of Poston, Kirk, Kerwin, and Ponterotto focuses on development through the lens of conflicts between the races, naturally reflecting, perhaps, a long history of racial antagonism. More recently, Henriksen (1997) proposed the Black/White Biracial Identity Model based on the individuals’ perception of the positivity vs. negativity of their interactions with other groups. Similar to Root's model, this model is fluid, and an individual can revisit any stage based on current experiences. The first stage is neutrality, where the individual is not cognizant of race. This is similar to Poston’s stage 1. Then there is acceptance, where individuals are made aware of racial differences but may not grasp the significance of these differences. This is most similar to Jacobs’ pre-color constancy and Wardle’s stage 1. Awareness then occurs when an individual understands their racial heritage and that they do not have a racial reference group. The last stage is experimentation, where interactions define identity.

While these models have many strengths, such as identifying being biracial as a unique state, not merely an addition of black and white, there are still shortcomings. In general, the models tend to assume that a fully integrated biracial identity is the healthy end point. But identity is a fluid and dynamic process without a defined “healthy” endpoint, and the assumption that this will be reached with a final equivalence between the two heritages is not necessarily valid.

In the Continuum of Biracial Identity model (COBI), Rockquemore and Laszloffy attempt to address this issue. They argue for a unique identity located along a continuum where the parents’ racial compositions are the poles. This model states that it is “possible for any singular identity to be valid and rational choice and can
result in a well-adjusted individual with high self-esteem." This strays from Rockquemore’s earlier model with Brunsma in which they define identity as the individual’s self-understanding of what and where he or she is socially. In this sense, it relies on the perceptions of others and internal perception. They proposed 4 identity categories: 1) singular: monoracial identification; 2) protean: changing and shifting according to the group of people they are with and social context; 3) border: existence in a border between 2 distinct groups as a hybrid; 4) transcendent: individuals consider racial identity a false identification and do not consider being a part of any race.

In terms of the differences between the models, first, protean identity becomes situation identity. A protean identity where individuals change their identity to fit the social needs at the time was considered healthy. In contrast, a situational identity is unhealthy: “The difference between a healthy situational identity and an unhealthy situational identity is that in an unhealthy situational identity a person’s racial identity changes instead of his or her behaviors.” I believe that for my whole life, I have been more representative of the COBI model. I have a “blended identity” but an emphasis on blackness. It is not the final label but rather the pathway that the COBI model considers healthy or unhealthy. My pathway has been one of self-pride and internal and external acceptance. They contend, however, that it is more likely for individuals to go through an unhealthy pathway characterized by denial and self-hatred if 1) an individual phenotypically looks only like one race or 2) if there is a negative relationship with one parent. As stated previously, I look 100% white.

Is It Natural to Feel Like a Chameleon?
Rockquemore and Laszlofﬁy describe situational identity as a positive thing. According to my friends, although unintentional and unnoticed, I speak differently when around predominantly white vs. black crowds. Miville proposed the “chameleon” experience in which “participants expressed that their approach to social relations was one with flexible, rather than rigid, social group boundaries, and they emphasized their ability to adapt to the cultural norms or demands of the situation.” The chameleon experience is similar to Kerwin and Ponterotto’s stage 6, where ﬂuidity is an awareness and adaptability to certain situations. An individual is not changing his or her identity, just selectively portraying certain aspects. In contrast, Root and Henrickson would argue that ﬂuidity is one’s ability to evolve and change one’s identity based on certain situations.

A participant in the Miville study explained, “I think a lot of us are chameleons. We can sit in a group of white people and feel different, but still ﬁt in. …But we can turn around and sit in a group of black people and feel comfortable, even though we are not black in the same way.” I have a clear identity but can engage in race “shifting” depending on the environment. Rockquemore and Laszlofﬁ further explain this phenomenon by stating that what “changes is [the biracial individual’s] presentation of self, not his fundamental self-understanding. Code-switching is used from one context to another because in order to literally play different roles, one must shift his or her self-presentation enough to ﬁt others’ expectations.” I change my behaviors but not my identity, and according to Rockquemore and Laszlofﬁ, that is the key to a healthy situational identity. I noticed a change in societal views relating to my situational identity changes from pre- and post-18 years old. Prior to when I was 18 (when the Rockquemore and Laszlofﬁ model was proposed), any situational identity changes were viewed as my trying to escape or run away from my “biracialness.” It was seen as confusion, as if I were unable to pick a side. From around age 18 on, however, those with whom I would interact began to realize situational identity switching is normal and also a healthy practice.

What Should Guide Me on This Journey?
Miville introduced the concept of critical people, critical places, and critical periods. Miville’s critical periods seem to model the identity development models by Erikson, Kerwin, and Ponterotto. I was very active in the Black Student Union in high school. When I went to college, however, I was afraid and uncomfortable joining the Black Student Union. I was concerned about
being rejected or questioned. I never did join. In medical school, however, I made my decision to join the Student National Medical Association (SNMA), the oldest and largest student-run organization devoted to the needs of minority medical school students. I later became school SNMA president and am now national vice president. Without any doubt, I would say that my critical period centered on attending my first local SNMA meeting.

In general, the most influential critical people are the parents. I was raised in a home where my parents let me explore my own identity. Miville suggested that children identify with the race of the most “dominant” family member or whom they feel closest to. A biracial individual in their study that identified as Chinese said, “She [his mom] was like the God figure in the house…. I would say my mother has been a very strong influence, in identifying [as] primarily foreign Chinese…. Our house is decorated primarily like I said in Chinese type decorations.”23 While neither parent was “dominant” in my family, my father did have a dominant identity. He had a black identity, whereas I would describe my mom’s identity as non-black but also not strongly white. Hers was more of a void of something unique.

My father was born in 1929 with a silver spoon in his mouth and potential to open all doors. The caveat to this, however, was that those doors were not only locked, but labeled “For Whites Only.” His dad was Homer S. Brown, Pittsburgh’s first black judge. My father attended undergrad and law school at Yale. He even eventually maneuvered his way to be recognized as one of Pittsburgh’s “most eligible bachelors.”

On the other hand, my mom was raised without any luxuries. She is the daughter of a single mother, as my mom’s dad left them the day she was born. In their community, the word n***** was commonplace and finishing high school was a major accomplishment. My mom broke the mold and ended up in graduate school. When she brought my dad back home so she could have him meet her family, grandma’s first reaction was, “You always did go for the underdog.”

It would be inaccurate to state that all biracial children have trouble with identity development. Even those with a healthy identity from the beginning, however, have to face issues from society such as stares, lack of acceptance in peer groups, and comments about being the “other.” Although my parents tried to protect me from such harm, it was not always possible. While walking with my mom as a child and holding a black baby doll, a stranger shouted out of the car window, “Get that girl a white baby doll like she deserves.” More recently, I attended medical school interviews. At most interviews there is a separate informal “meet and greet” for minority applicants. On 10 out of 15 interviews, upon my walking to the meet and greet, a current student or applicant would assume I was lost and comment, “You do know this is for the minority applicants, right?” These individuals were not trying to be disrespectful or harmful. They are, however, the future doctors of America and if such highly educated and worldly people are making these assumptions, how do you think that will translate into patient care?

References


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DOUGLAS B. HANSEN, MD
Hypodescent is a way of categorizing multiracial individuals such that they are defined by their minority racial heritage, no matter how small a percentage of their genetic makeup is associated with that racial group. By that definition, anyone with even 1% of black heritage is deemed black, which prior to the abolishment of slavery meant enslavement, stripping of one’s identity, and, in the era of Jim Crow laws, de facto loss of the right to vote and restriction from many public facilities. Hypodescent no longer dominates how we view multiracial identity, which has allowed biracial/multiracial individuals to have more identity options available. With so many options available, it is inevitable that many biracial individuals will struggle with identity development. This is particularly true for those whose external appearance is more monoracial, like me. Although technically biracial (half black, half white), I have green eyes, blond hair, and fair skin. Although many biracial children will not have identity development issues, we all have to handle issues ranging from minor stares to more serious issues such as being called and treated as an imposter. This is particularly relevant for child psychiatrists, as we are now in the era of the biracial baby boom, and multicultural children are the fastest-growing youth group in the country (an increase by 50% since 2010).1

One of my first memories as a child is actually having several elderly black women come to my house uninvited (I should preface this story by noting that my dad was very prominent in the Pittsburgh civil rights movement, so the fact that he fell in love with, married, and had a child with a white woman was very taboo to some). They proceeded to check behind my ears to look for my “true” skin color. Although I was very young, I remember wondering if something was wrong with the skin color on the rest of my body (again, very fair) that they had to look elsewhere for a “better” color. Below I present tools to use when working with biracial families such as mine.

- Help the parents create an acceptable name for their child’s ethnicity so that the child does not feel he or she has to choose sides. This label should be shared with the child’s school so that there is consistency. It is often the case that, depending on who is talking, a child’s identity is called several different things. For example, at home a child may be biracial but at school, multiracial. One friend may call the child mixed while another may use the term “blended,” or even “mulatto.” This can confuse the child and hinder his or her formation of one identity. You can also encourage the parents to establish “monoracial” labels. Therefore, if at a certain point in development the child identifies as monoracial or is more “connected” to one race, the child already feels like he or she has an appropriate label that both the child and the parents will understand. This provides the child with the tools to establish the complex identity.

- Encourage the parents to create a cultural narrative and share these stories with their children. Both parents should tell of their heritage and history so that the child may feel connected to both. This can also be through play therapy such as making picture books with old family photographs or family trees. Alternatively, the child can draw the family as well as cultural items (such as African drums). An alternative game is making a collage or papier-mâché creations with copies of old family photographs. The parents can also work with their children to create a play about their history and act it out with them, perhaps even performing or including their friends so that their friends can understand their heritage. Including the child’s friends also breaks the ice for any future
conversation the child may want to have with friends about his or her identity. The child knows that the friend has some baseline understanding, making the conversation, particularly its initiation, much easier.

- Encourage the parents to discuss pressures they felt from society throughout their lives and the coping strategies that they used. They can also role-play a potential situation with their child so the parents can observe their child’s coping strategies in a live environment and determine strengths/weaknesses with this strategy.

- Show the family how identity formation occurs and push the family to encourage their children to openly discuss and acknowledge their heritage. You can then explain to the family that they can develop and establish themselves as an “interracial unit” so that the child, while isolated in being biracial, is part of a group and included in the interracial unit.

- Clinicians should assess clients’ social support networks (from childhood to present) to gain a better understanding of the types of reference groups to which their clients may be oriented.

- Ensure as a counselor that you are aware of your own personal bias.

- It has been said that most biracial individuals identify on a personal level as biracial but have a monoracial community as a reference group. It is believed that this is because of the limited access to a multiracial community. As a clinician you can stress the importance that the parents expose the child to other biracial individuals.

- Introduce parents to children’s books about biracial identity such as:
  - *Mixed Like Me* by Gina Golliday-Cabell
  - *Black, White, Just Right!* by Marquerite Davol
  - *Dirty Sally* by Myrtice Edwards

- There are also books for adolescents such as:
  - *What Are You?: Voices of Mixed-Race Young People* by Pearl Fuyo Gaskin
  - *Mixed: An Anthology of Short Fiction on the Multiracial Experience* by Chandra Prasad
  - *Mixed: Multiracial College Students Tell Their Life Stories* by Andrew Garrod
  - And my favorite, *The Color of Water: A Black Man’s Tribute to His White Mother* by James McBride

- For older adolescents, there are several options for more academic books that examine the history of mixed-race representation, such as:
  - *The Souls of Mixed Folk: Race, Politics, and Aesthetics in the New Millennium* by Michele Elam

- There are also movies and children’s TV shows for children where the main characters are biracial, such as:
  - *Big Hero 6*
  - *Sid the Science KID*
  - *Super Why*, which highlights an interracial couple
  - *Little White Lie* by Lacey Schwartz
  - *The Wizards of Waverly Place*
  - *Sister, Sister* (particularly the episode where the sisters learn that they are biracial)

- Alternatively, there are children’s shows where the actors are biracial, such as:
  - *Shake It Up* (Zendaya Coleman is black/white)
  - *Victorious* (Victoria Justice is white/Puerto Rican)

- There are also books written for parents on how to raise a biracial child, such as:
  - *Raising Biracial Children* by Kerry Rockquemore and Tracey A. Laszloffy
  - *I’m Chocolate, You’re Vanilla: Raising Healthy Black and Biracial Children in a Race Conscious World* by Marquerite Wright
  - *Does Anybody Else Look Like Me?: A Parent’s Guide to Raising Multiracial Children* by Donna Jackson Nakazawa
While there is no one “correct” identity and no one “correct” way to raise a biracial child, I will end this article with the Bill of Rights for People of Mixed Heritage by Maria P.P. Root.

Bill of Rights for People of Mixed Heritage

I have the right...

Not to justify my existence in this world.
Not to keep the races separate within me.
Not to justify my ethnic legitimacy.
Not to be responsible for people’s discomfort with my physical or ethnic ambiguity.

I have the right...

To identify myself differently than strangers expect me to identify.
To identify myself differently than how my parents identify me.
To identify myself differently than my brothers and sisters.
To identify myself differently in different situations.

I have the right...

To create a vocabulary to communicate about being multiracial or multiethnic.
To change my identity over my lifetime—and more than once.
To have loyalties and identification with more than one group of people.
To freely choose whom I befriend and love.

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Take Home Summary

We are living in an era of a biracial baby boom. Forty-two percent of the 6.8 million people who self-identified as biracial in the 2000 census were under the age of 18. Thanks to genetics, not all multiracial individuals’ racial identities align with how society sees them. As someone who is blond and has fair skin but is biracial and identifies as black, I am in a unique position to talk about biracial identity development. In this article I discuss biracial identity models in the US and, at the same time, examine how I felt I was perceived and treated by society, often influenced by these models.

About the Author

Cortlyn Brown, BA, is currently a fourth-year medical student at the Yale School of Medicine. She was born in Pittsburgh, PA and graduated with honors in biology from the University of Chicago. Throughout medical school Ms. Brown has been very active in student groups and currently serves as the national vice president for the Student National Medical Association (SNMA), the nation’s oldest and largest student-run group focused on the needs of minority medical school students. In this role she helps oversee the execution of an executive agenda centered on mental health. Given her monoracial external appearance but biracial identity, she is particularly interested in the effects of biracial identity development on mental health and has published several articles and given talks on the topic.

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Reference

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