The JEDI Issue: A JAACAP Connect Special Issue on Justice, Equity, Diversity, and Inclusion

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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.

**Who reads JAACAP Connect?**

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](http://www.jaacap.com/content/connect). AACAP members will receive emails announcing new quarterly issues.

**Who writes JAACAP Connect?**

You do! We seek highly motivated students, trainees, early career, and seasoned clinicians and researchers from all disciplines with compelling observations about child and adolescent psychiatry. We pair authors with mentors when necessary, and work as a team to create the final manuscripts.

**What are the content requirements for JAACAP Connect articles?**

**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.

**How can JAACAP Connect help with my educational requirements?**

Motivated by the ACGME/ABPN Psychiatry Milestone Project©, **JAACAP Connect** aims to promote the development of the skillset 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.

**JAACAP Connect** combines education and skill acquisition with mentorship and guidance to offer new experiences in science-based publication. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles. Opportunities for increasing knowledge and skills through publishing as education will be available through continued contributions and direct involvement with the **JAACAP Connect** editorial team, using an apprenticeship model.

**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.
2020 and 2021 have brought many images of social and medical equity to the forefront, including what some call a syndemic. This term speaks to the interaction of health (COVID-19) and social problems (systemic racism). Others also identify economic issues as part of the syndemic. In the United States, I believe that this includes not only the health disparities related to those who have died disproportionately, but also racially based violence, including violence against those who are of East Asian descent.

This issue of JAACAP Connect is designed to familiarize the reader with important justice, equity, diversity, and inclusion (JEDI) concepts that are relevant to the practice of child and adolescent psychiatry. A complete understanding of social and cultural aspects of psychiatry requires a grounding in concepts describing cultural identity as well as the existence and influences of structural racism. One example of how these factors have become more visible in our professional lives over the past year is the impact of access to broadband internet on telepsychiatry (our new primary mode of care) and virtual learning for many of our patients.

We thank the UCLA Department of Psychiatry for the use of the term JEDI to describe an “antiracist, social justice, structural competency framework” that encompasses the ideals we are discussing in this issue of JAACAP Connect. We thank George Lucas, creator of the Star Wars Universe, for bringing the term Jedi into the world-wide lexicon, referring to the knights that served as guardians of peace and justice a long time ago in a galaxy far, far away.

“Social Determinants of Health, Structural Racism, and the Impact on Child and Adolescent Mental Health” is an excellent lead article for our issue, setting the stage with a firm grounding in this fundamental concept. Social determinants of health are the conditions in which people are born, grow, work, live, and develop; these non-medical factors have a significant influence on health and mental health outcomes. Drs. Cotton and Shim provide a clear description of social determinants and the required cognitive shifts needed for mental health professionals to incorporate this understanding into our care of patients and families.

Social determinants include the impact of the systems in which any or all our patients are involved: community supports, housing quality, educational system, social services, health care, disability services, employment opportunities, juvenile justice systems, and how the society’s values and community dynamics interface with the child’s identities. Drs. Campbell, McClendon, Salem, and McBride introduce us to the disparities in our legal and juvenile justice systems, beginning a series of articles with a spotlight on juvenile justice. This is relevant not only for forensic and correctional psychiatrists, but for all of us, as the themes addressed often directly relate to what is happening within educational systems and other systems that are relevant to most of our patients.

The JEDI issue is written by a diverse set of authors who are often transparent in bringing their own social and cultural experiences into their contributions. We believe that all clinicians should begin to incorporate the impact of the patient’s cultural identity in their perceptions, clinical presentation, interactions, and our diagnosis and treatment. As an African American woman I recognize, as we read the articles in this issue, that there are multiple subsets of individuals who identify themselves as Brown, Black, and Asian. This may be confusing for some who are just beginning to approach these issues, but recognizing the cultural identity is the core of what we need to understand—how every individual identifies themselves, and what that means for how they interact with the world.

Dr. Shadid’s “Race Against the Mental Status Exam,” brings us into the middle of a debate. It is critical to state clearly that we recognize that there is diversity in opinion.
and thought regarding this discussion. Cultural identity is determined by the individual, not the clinician. The debate is regarding whether race should be mentioned in the description of a patient, particularly without asking the question of the patient. There are some who believe that the race should not be mentioned in our clinical histories, as race is not a biological factor. However, it is undeniably a sociocultural factor that can become a determinant of health\(^9\) that impacts mental health and other health disparities, and, given its importance in day-to-day life in the US, seems important for mental health providers from a conceptualization/formulation perspective for that reason alone. In “Building Up and Breaking Down: Youth Cultural Identity Development” by Drs. Arshad, Chua, and Baker, we begin to learn about cultural identity and its development in all individuals. We also begin to learn about intersectionality.

“Implicit Bias in Psychiatry: It’s Time for More Than Uncomfortable Conversations Among Physicians,” by Drs. Rogers, Wadhwa, and Green describes disparities in psychiatry and the protective nature of a strong racial/ethnic identity. They share that the Project Implicit site (https://implicit.harvard.edu/implicit/index.jsp) is useful for those with interest in self-exploration related to bias. With this tool, you can assess your potential for bias related to age, disability, ethnicity, gender, gender identity, race, or sexual orientation as well as other descriptors.

Intersectionality is further addressed in “Supporting LGBTQ2S Youth Who Are Black, Indigenous, and People of Color (BIPOC).” This article by MD candidates Thelwell, Chiwiwi, and Kantor begins by guiding the reader through language, starting with use of the most affirming terms: lesbian, gay, bisexual, transgender, queer, and Two-Spirit, thus providing inclusion, not merely tolerance, for these youth of color for whom we provide care. We then learn more about how we can help our patients and families identify supports with evidence supporting their use. This includes an understanding of two terms. The first is decolonization, “the active resistance against colonial powers and a shifting of power towards political, economic, educational, cultural, psychic independence and power that origi-


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Social Determinants of Health, Structural Racism, and the Impact on Child and Adolescent Mental Health

Nicole King Cotton, MD, and Ruth S. Shim, MD, MPH

In recent years, there has been a greater emphasis on examining the factors, particularly the social factors, that affect health outcomes and contribute to population health inequities. The social determinants of health, as defined by the World Health Organization (WHO), are “the conditions in which people are born, grow, work, live, and develop, and the wider set of forces, including economic policies, social norms, and political systems, that shape the conditions of daily life and impact health outcomes.” These social determinants are influenced by the current political and economic environment in which an individual lives, as well as the long-standing sociocultural norms that have been sewn into the fabric of society. Structural racism is an underlying force that influences all social determinants of mental health in the United States. This article will examine the social determinants of health in youth through the lens of structural racism.

WHO lists 5 major categories of social determinants of health: economic instability, education, social and community context, health and healthcare, and neighborhood and built environment. The social determinants of mental health are not inherently different, but they often receive less focus and study, particularly in children where they may hold even greater significance. Most psychiatric disorders begin in childhood, and the physical, cognitive, emotional, and social development that occurs during this critical time lays the foundation for mental health and well-being in adulthood. Table 1 lists several examples of social determinants of mental health for children and adolescents.

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Note: Adapted from the US Department of Health and Human Services, Office of Disease Prevention and Health Promotion: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
and, as a form of social injustice, it is the driving force behind many of the social determinants of health. While individual and interpersonal racism have direct and clear impacts on the physical and mental health of youth and adults, structural racism impacts the health of both individuals and whole populations. For example and as described below, the structurally racist policies of redlining (and the resulting residential segregation) have led to profound and detrimental health effects on Black (individuals of African descent), Brown (Latinx), and Indigenous families.

Redlining and Residential Segregation and the Social Determinants of Mental Health

In the 20th century, specific policies were enacted to create financial incentives for White people to move to the suburbs of many major US cities, leaving marginalized people, particularly Black people, in cities. Restrictive covenants, present throughout the US from the 1920s until they were ruled unenforceable in 1948, prohibited selling or renting property to people of color and people of Jewish descent. Redlining, a term derived from the legal practice initiated by the Homeowner’s Loan Corporation (HOLC) in 1933 that involved denying mortgages, insurance, and loans in and near Black neighborhoods, effectively restricted favorable lending to White neighborhoods. The federal government and lenders literally drew red lines on maps around neighborhoods in which they would not invest. Although the practice of redlining was made illegal in 1968, its effects, and those of policies that followed, including urban renewal and modern zoning laws, are still seen today in the social geography of cities. The denial of home loans to Black and Brown families meant that, unlike their White counterparts, they were unable to accumulate wealth through homeownership and potentially pass such wealth through generations.

Residential segregation was the basis for broader social disinvestment including infrastructure such as greenspace, recreation facilities, and roads, and economic drivers such as transportation, education, and employment. Highways were constructed, often demolishing marginalized communities and businesses in the process, to reinforce suburban resources, while Black and Brown communities continued to be depleted of resources and opportunity. Those neighborhoods marked as “hazardous” by redlining in the 1930s are currently inhabited primarily by Black and Brown families; however many of these communities have been gentrified by White people returning to urban areas, further destabilizing marginalized communities.

Consequently, structural racism has a significant impact on many social determinants of health. This is especialmente true for children who are undergoing rapid developmental changes and are dependent on their family system and environment to provide space for healthy development. Families living in residentially segregated, disinvested areas have less access to transportation, less walkable space (including sidewalks and parks), and less viable access to fresh air and exercise. Grocery stores are scarce or non-existent in these neighborhoods (ie, food deserts) as grocery and restaurant chains flee these areas or refuse to invest there based on prejudicial marketing assessments. Thus, residential segregation leads to another social determinant of mental health, food insecurity, which has been associated with poor cognitive development, symptoms of depression and anxiety in teens, and hyperactivity and impulsivity in youth across the developmental spectrum. Furthermore, there is less investment in housing, leading to poorer living conditions from which children have no power to escape, including structurally unsafe buildings, substandard insulation and air filtration, and barely lit streets and corridors. These conditions increase the risk of community violence, which in turn increases the risk of emotional dysregulation, and symptoms of posttraumatic stress disorder, depression, and suicidality in children. The amalgamation of these experiences stresses the family system and increases the risk for the interpersonal traumas explored in the original Adverse Childhood Experiences (ACE) study. ACEs are linked to depression, anxiety, posttraumatic stress disorder, substance use, and other mental health disorders in children and adults. While some of these experiences, like food insecurity, are explored in the original study, it largely neglects traumas that
stem from structural racism that need to be included to fully assess adversity experienced by children and adolescents.\textsuperscript{13}

The most striking disadvantage for children and adolescents is in the education system, as quality of education is linked to numerous health outcomes directly by increasing health literacy and healthy behaviors, and indirectly by affecting other social determinants like employment and income.\textsuperscript{14} School is seen as a safe space for children to develop and to learn not only academics, but about themselves and the world. However, this is not true for many marginalized children, as funding for many school districts is derived from property taxes, and with lower property values, as a downstream effect of redlining, schools in these neighborhoods receive significantly less funding. Additionally, children in low-income areas have less access to educational resources, experienced teachers, and advanced coursework. While the schooling experience of Black children is impacted by opportunity gaps linked to income and wealth, structural racism plays a role in shaping schooling beyond these factors. This is seen in communities that are well-sourced and more diverse, yet Black and Brown students continue to have less access to advanced coursework, and they are less likely to be identified and evaluated for special education services.\textsuperscript{15,16}

The result of structural racism is inequitable health outcomes for Black and Brown people, and children and adolescents are particularly vulnerable. Black and Latinx children are less likely to be diagnosed with attention-deficit/hyperactivity disorder as compared to otherwise-matched White children.\textsuperscript{17,18} Black and Brown youth with mental health disorders are more likely to end up in the juvenile justice system rather than with specialty care.\textsuperscript{19} When Black and Brown youth are engaged in care, Black children are less likely to receive guideline-driven care, and Latinx children are more frequently undertreated.\textsuperscript{20} It is likely that explicit and implicit bias, fueled by structural racism, play a role in these differences.

What Can Child and Adolescent Psychiatrists Do?

This article has examined one example of how structural racism underlies the social determinants of mental health, which research shows are associated with a variety of developmental and mental health outcomes in youth. The underlying structural forces that drive these social determinants must be addressed in order to improve health outcomes. If we address these underlying structural forces in children, we can potentially decrease inequities in mental health disorders across the lifespan. This requires a shift from thinking about the individuals we directly treat to thinking about population health. It also requires that we confront and eradicate structural racism. The first and most important step is to educate ourselves and others, both within our profession and without. Child and adolescent psychiatrists must know what structural racism is and how it impacts the social determinants of health and health outcomes. We must also acknowledge how structural racism impacts the mental health system and children and families of color. On the individual level, this prepares us to have those difficult and crucial conversations with our patients and encourage them to discuss their experiences with racism and discrimination. On a population level, we can use our knowledge to advocate for changes in the policies that sustain and enable structural racism. Housing policies, as illustrated in this article, impact the mental health and wellbeing of children. Therefore, it is essential that child and adolescent psychiatrists advocate for equitable housing policies with the same intensity that they provide therapeutic options for their patients. Empowered by a sober understanding of how our society’s long history of structural racism continues to influence social determinants on both individual and population levels, child and adolescent psychiatrists will lead the medical profession, and our communities at large, in improving health outcomes for us all.
Take Home Summary

Structural racism impacts all social determinants of health. In assessing and treating children, child and adolescent psychiatrists should consider the effects of structural racism in their formulation and treatment. To improve the overall mental health of children and families, child and adolescent psychiatrists should serve as advocates for dismantling systemic racism.

References

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What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
Spotlight on Juvenile Justice: How Did We Get Here?
Jorien Campbell, MD, Jasmine McClendon, MD, MPH, Amanie Salem, DO, MPH, Anne B. McBride, MD

Structural racism and inequity permeate the juvenile justice system. The earliest delinquency programs were developed at a time when slavery was still legal in the United States and Indigenous Americans were considered “savages,” representing dehumanizing systems and beliefs which left lasting structural racism. Nearly 200 years later, racism continues to shape and structure our juvenile justice system both directly and indirectly. This article will underscore the historical legacy of structural racism in the juvenile justice system, an understanding necessary to address systemic change.

Think about the last headline or article you read of a crime perpetrated by a youth. The case may have read similar to this: A 16-year-old male has been charged with armed robbery after entering a fast-food restaurant with two 20-year-old males and pointing a loaded handgun at the cashier while demanding money.

When we summarize a person based primarily on the crime they committed, we lose sight of all the factors contributing to the individual’s legal involvement, including the impact of racism. Structural racism informs every stage of the legal process from risk of entry to likelihood of dying within the criminal justice system. For example, as a Black youth in the United States, the youth from the case example—Julian—is nearly 8 times more likely to be arrested for robbery and nearly 6 times more likely to be detained than a White youth. As a minoritized youth, he is 1.4 times more likely to be transferred to criminal court than White youth. Alarming disparities exist for other minoritized youth. An Indigenous American youth is 3.2 times more likely to be detained, and a Latinx youth 1.7 times more likely to be detained than a White youth.

While this initial article will focus on understanding structural racism involving the juvenile justice system through a historical lens, this spotlight series will follow Julian’s pathway into the juvenile justice system, examining the factors contributing to his legal involvement such as racism, age, trauma exposure, and substance use. This series will review evidence-based interventions for diversion and to reduce recidivism, as well as opportunities for advocacy.

Historical Overview
The cornerstone of juvenile justice philosophy in the United States has been the English common law doctrine of parens patriae, Latin for “parent of the nation.” Under this doctrine, the state is empowered and authorized to act as the “parent” in the best interest of a child and provide care and protection equivalent to that of a parent. With this authority, and in the context of industrialization and urbanization, the first juvenile reformatory in the nation, the New York House of Refuge, opened January 1, 1825.

Juvenile reformatories were designed to minimize court proceedings, house juveniles away from adults, rehabilitate youth offenders, and prevent recidivism. However, early disparities were apparent. Black youth in the North were initially excluded from reformatories and then later segregated into inferior facilities with inequitable opportunities following release. Black enslaved youth in the South were considered property, and treatment was thus denied. Following the Emancipation Proclamation, the justice system became a tool to re-enslave Black citizens. Legislation and an exception clause in the Thirteenth Amendment served to criminalize the behaviors
of Black citizens. Convict leasing was a legal practice to exert control over Black individuals, whereby a leaser would use Black convicts as cheap labor. Notably, Black youth made up over 18% of Black convicts.¹

In 1899, the Illinois Juvenile Court Act removed jurisdiction over juveniles under age 16 from the criminal court and established the first juvenile court in the United States. The new court focused on rehabilitation, and early juvenile judges could investigate the backgrounds of predelinquent and delinquent youth, seeking to “identify the moral reputation of problematic children.”² By 1940, Black youth were overrepresented in delinquency cases and cases were less frequently dismissed when compared with White youth.¹

During this period, the Civilization Fund Act also ushered in an era of assimilationist policies leading to the Indian Boarding School era, which lasted from 1860 to 1978. Indigenous families were coerced by the federal government and Catholic Church officials to send their children to boarding schools. The belief was that separation from the tribe was necessary for children to achieve true assimilation into American culture. The systematic removal of generations of Indigenous American children has had a profound and lasting impact on Indigenous American culture. Many Indigenous Americans who attended boarding schools suffered from mental health and substance use problems, and struggled to transition to adulthood due a lack of nurturing role models during their youth.⁶ Today, Indigenous American youth are overrepresented in the juvenile justice system. From 2010 to 2016, an estimated 13% to 19% of youth involved with the federal justice system were Indigenous Americans, even though they account for just 1.6 percent of the national population under age 18.⁷

In the juvenile courts under a rehabilitative framework, youth received minimal due process protections until the US Supreme Court addressed the legal rights of minors in a series of cases (see Kent v United States (1966),⁸ In re Gault (1967),⁹ In re Winship (1970),¹⁰ and Breed v Jones (1975))¹¹ that exemplified the potential for injustice under the parens patriae model which left little room for individual constitutional rights. While due process protections were necessary, juvenile courts became increasingly adversarial.

During the 1980s and 1990s, the juvenile justice system expanded its punitive approach towards juvenile offenders.¹² The rise in juvenile crimes at this time garnered significant media attention, sensationalizing images of Black youth gun violence and reinforcing historical stereotypes of Black people as dangerous “superpredators.”¹³ This led to legislation that was significantly tougher on crime, reflected in the dramatic rise in the number of juvenile arrests, offenders transferred to criminal courts through prosecutorial direct file or automatic transfer,¹²,¹³ and increased racial and ethnic disparities, with 28% youth of color representing detained youth in 1985, growing to 63% and 71% in 1997 and 2010, respectively.¹⁴

In tandem, key legislature (eg, Gun Free Schools Act of 1994) increasingly criminalized the school system through harsh and punitive school policies that made it more likely for Black and Latinx youth¹³,¹⁵ as well as youth receiving special education services to enter the juvenile justice system.¹⁶ This is commonly referred to as the “School-to-Prison Pipeline.” Schools adopted “zero tolerance” policies, punishing by school removal any degree of misconduct equally (eg, from firearms on campus to cafeteria food fights), effectively criminalizing even typical adolescent misbehavior.¹⁶,¹⁷ These policies also led to the expansion of police presence on school grounds especially in racially minoritized communities.¹³ Increased police presence transferred authority
and discretion of handling adolescent misconduct from school officials to school police. These policies were more heavily enacted and enforced in lower academic performing schools, which were in lower income, urban areas. The consequences of these policies led to disproportionate increases of in-school arrests, suspensions, and expulsions of minoritized youth.

Following the rush to punish juveniles that characterized the 1980s and 1990s, advances in neuroscience facilitated increased understanding of adolescent development which underpinned a shift that emerged in the 21st century. The US Supreme Court highlighted that juveniles are inherently different from adults. In 4 strongly worded opinions, the Court referenced scientific evidence that discussed the culpability of juvenile offenders and held that juvenile culpability is mitigated by their youth and immaturity, even for the most serious offenses. The rulings between 2005 to 2016 abolished for juveniles the death penalty, life without parole for non-homicide offenses, and mandatory life without parole sentences for homicide offenses.

With these decisions, the Court reshaped juvenile justice policy across the nation. Under *Miller v Alabama*, the Court held that while life without parole may still be imposed on juvenile homicide offenders, the sentence should consider mitigating characteristics of youth. The 5 mitigating factors from the *Miller* ruling include: the juvenile’s age and immaturity; family home environment; circumstances of the offense, including the role the juvenile had in the offense and any influence of peer pressure; the incapacities of youth that may have disadvantaged the juvenile dealing with the justice system; and the juvenile’s potential for rehabilitation.

Understanding a youth’s family home environment highlights the importance of understanding childhood trauma both in and out of the home and opens the door to recognize the social determinants of mental health that fundamentally impact justice-involved youth. Differential rates of poverty and the social conditions associated with it may be one of the major contributors to the levels of racial inequity seen in the juvenile justice system. Further, racism impacts associated systems such as the child welfare system, a system with its own disproportionate minority representation. Compounding the effects of structural racism within child welfare, youth involved in the child welfare system are at increased risk for delinquency, further increasing risk for juvenile justice entry. Given that the system was structured when slavery was legal and Black and Indigenous American youth were dehumanized, these historical events also highlight the undercurrent of racism contributing to the overrepresentation, disparity, and disproportionate number of minoritized youth entering the juvenile justice system.

Specific attention has been brought to this issue in the 1970s and 1980s through legislature such as the Juvenile Justice and Delinquency Prevention Act of 1974 (JJDPA). However minoritized youth were still incarcerated at rates 3 to 4 times greater than White youth. In 2001, Kenneth B. Nunn wrote:

> One day, when the current crisis is over, when the public’s lust for punishment has been satiated, and when the public realizes that far too many White children have been swept along by punitive policies intended for Blacks, the rehabilitative focus of the juvenile justice system will return. When it does, African American children may benefit to some degree. But, by and large, most African American children will not notice the difference. They will still be arrested, detained, and incarcerated at higher rates. As children of the other, they will be feared and controlled, rather than valued and loved.

Two decades later, despite significant reductions in youth arrests, racial inequity persists within the juvenile justice system. In fact, race and ethnicity negatively affect minoritized youth groups at all decision-making points of the juvenile justice system as compared to White people, with effects leading to cumulative disadvantage and lifetime adverse health effects. Minoritized youth are more likely to be arrested, detained in secure confinement, adjudicated, and receive more punitive sentences/disposition. Disproportionate minority contact (DMC) is best examined while consid-
ering how various complex factors and processes influence each other and are impacted by social injustice. Addressing structural racism within the juvenile justice system will require a comprehensive approach, and true reform cannot be most effective without corresponding changes in adjacent systems such as the education system, child welfare system, and mental health system.

Moving Forward
Child and adolescent psychiatrists can play a critical role in moving the juvenile justice system forward by advancing race and health equity through reflection, education, and intervention. With an understanding of the juvenile justice system historical background and factors contributing to disparities, child psychiatrists can educate other mental health providers, families, systems of care, and institutions (eg, through education and advocacy). We can identify and aggressively intervene using evidence-based practice to address individual needs/risks (eg, trauma, substance use, mental illness, developmental disability) for those juveniles at risk for or involved in juvenile justice. Finally, we can identify, address, and be mindful of our own biases as providers. For example, oppositional defiant disorder (ODD) and conduct disorder (CD) are diagnosed more frequently and attention-deficit/hyperactivity disorder (ADHD) is diagnosed less frequently in racial and ethnic minority youth when compared with White youth, and unconscious bias of the provider likely contributes to this diagnostic disparity. Labeling children with ODD or CD can have significant implications for treatment options and interventions and may further contribute to risk for educational disparities and juvenile justice involvement. However, given that robust evidence-based interventions are available for ODD and CD, ensuring equitable access for such interventions is another critical opportunity for advocacy. Regardless, child and adolescent psychiatrists must take active roles in systemic change.

Returning to our case, while statistically Julian was more likely to be involved in the juvenile justice system, we do not yet know much about his narrative – his specific life story that preceded and contributed to his criminal involvement. And what might happen to Julian? Are effective interventions possible and will they be meaningful? This article represents the first in a multi-part series where we will follow Julian through the legal process, learn about his childhood, and work together towards meaningful change.

Take Home Summary
Racism continues to shape and structure our juvenile justice system both directly and indirectly. Child and adolescent psychiatrists should understand the history contributing to continued racial and ethnic disparities and must take active roles in systemic change.

References


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Race Against the Mental Status Exam

Olivia Shadid, MD

Racism is a system of oppression that justifies inequities through purported differences based in “race.” Race itself was promulgated and enshrined by colonists, enslavers, and imperialists to describe social groups.\(^1\,^2\,^3\) Racial categorization is not determined by genetics, but instead via interaction: how a person understands and experiences herself treated by others as a result of, or in spite of, the color of her skin and the structure of her features.\(^4\) “Race,” as understood as a biological fact, does not predict health, choices, and flourishing.\(^5\) Racism does.\(^6\,^7\) If race is a subjective measure, why is race so often included in the mental status exam (MSE), the objective portion of a child and adolescent psychiatrist’s assessment of a patient?

As I plunged into my first year as a psychiatry resident, I began asking myself this question. It arose from a tumbling together of my roles as an observer and as the observed. As an observer, a busy intern on the psych wards, I was completing several MSE’s day after day, noting the vacillating presentations of my patients over the course of hospitalization. Often, “appearance” is listed as the first domain in the MSE and a racial description as one of the first or second adjectives within this domain. As is commonly taught, I was documenting over and over again what I interpreted a person’s race to be and employed the typical terms, drawing from tidy discrete boxes: “Black,” “Latinx,” “White,” “Indigenous,” etc. Over time, with more nuanced understanding of my patients’ experiences of racial profiling, my own experiences as a Brown woman in a position of visibility, and amidst the cries for racial justice reverberating throughout medicine and the country, I came to find these descriptors limited in utility and far from the objectivity we as physician-scientists want them to hold.

I found that my visibility as a physician can be a wonderful privilege, facilitating intimate encounters with a broad swath of persons. However, being observed by patients also made me acutely aware of how I myself did not fit into the boxes I was forcing my patients into. As with many young people today, I appear ethnically ambiguous.\(^8\) Throughout the year I found patients and staff asking me, “Where are you from?,” “What nationality are you?,” or even “What are you?” Unprompted, many would volunteer their guesses, ranging from South American to Native to Latina, sweeping through Spanish, Middle Eastern, Persian, Indian, and on to Thai. Many of these comments were meant to establish a connection, perhaps to the person’s own heritage, though too often they came from older male patients and seemed tinged with exoticism. Regardless of intent, often I felt myself treated as an “other” in such moments and that those who were asking assumed I did not belong, that my appearance precluded my belonging to the “American” category.

I began to wonder how I would be described in an MSE, and how often I might find myself protesting a conclusion that a clinician would claim as objective. I took that curiosity to my own practices and patient care. I began to notice the features of my patients’ physical presentations which I was skimming over so that each patient would fit into a box. I began to recognize when I was relying on non-physical factors, such as surname and accent, to influence what I deemed their “appearance” to be. I became more uncomfortable with squeezing my patients into these categories and claiming this was an objective observation. Doing so felt like I was affirming biological racial essentialism.

Using pat racial terms in the MSE might seem like a small thing. However, it is these subtle acts of dressing up subjectivity—often as seen through a White, cis-het, able-bodied, male lens—as scientific objectivity that make up the links of the many chains that undergird racism in medical practice, research, and training.\(^9\) Nephrology and pulmonology have recognized the limitations of race-based assessments of glomerular
filtration rate and spirometry.\textsuperscript{10,11} Medical research is increasingly aware of the complexities that come with including race among demographic characteristics.\textsuperscript{12,13} It is now time for psychiatry to recognize our own problematic use of racial categorization. Psychiatry has been complicit in deep and deleterious racism, ranging from the characterization of enslaved Black people’s desire for freedom as pathologic (”dраМетомания”) to the overdiagnosis of psychosis in Black civil rights activists and the simultaneous under-prescription of our most effective antipsychotic to patients identified as Black.\textsuperscript{14,15,16} Evidence suggests that our bias as psychiatrists extends to our youngest patients. We are more likely to diagnose the same presentation as attention deficit/hyperactivity disorder in a child we identify as White and as oppositional defiant disorder or conduct disorder in a child we identify as “non-White,” circumscribing access to treatment and solidifying outcome trajectories for already vulnerable children.\textsuperscript{17} While we address the structural racism woven into psychiatry and research, how do psychiatrists avoid perpetuation of reductionist and racist practices in our individual patient interactions?

Yearning for valid objectivity and a way to avoid the erasure and smudging that racial categorization demands, as a corrective, I began employing that most basic of scientific and writing skills: observation. Rather than patently claim to know a patient’s race, I chose to describe in richer detail the traits I actually observed. Looking beyond the borders of the boxes we usually check, a whole new language erupted. Phrases like tan-complexioned, high cheek-boned, pockmarked cheeks, a mess of dark unkempt curls, and slender build offered more vivid, textured datasets that not only brought patients to life in my documentation, but also offered clues to my patients’ emotional and cognitive states. This practice felt true to the utility of an MSE without assuming I understood how my patient’s appearance had affected his subjective experience. Medical research and clinical medicine continue to move away from using appearance as a proxy for genetics, mean-while recognizing that racial identity and racism do have potent effects on clinical outcomes.\textsuperscript{13} The approach offered here is a middle path that allows the whole of the patient to be present, neither eliminating racial/ethnic identity nor reverting to non-evidence-based, outdated understandings of biological race.

Race cannot be observed by others, it can only be claimed by an individual’s lived experience. If race is assigned by those who assume based on what they observe, it reduces and morphs the lived reality. Identification is mediated by the communities a person has lived among, the racism that has impacted their family, and the cultural narratives they have internalized or struggled against. Identification comes out of the experience of a life lived in a skin, not the skin itself. Any attempt to deduce a patient’s racial identity based on appearance will always be doomed to fail since any apperception of race will always be filtered through the clinician’s own subjective groupings of humans and no two clinicians will share the same filters.

Most people socially identify with a racial or ethnic group and this is important to their experience of themselves, their world, and society’s treatment of them. We can find out how a patient conceptualizes her racial identity, its development over her lifespan, and its impact on her mental health by simply asking. Undoubtedly, a patient’s social identifications should be noted in our subjective assessments and critically factored into our formulations and treatment plans. I am not advocating washing away race, or its intersections with other social groupings such as class and gender, from our assessments; rather, I am encouraging us to adhere to true objectivity when we assert its use. Seeing clearly the patient before us, with all their complexities, contradictions, and social roles, while mindfully teasing apart what they are bringing to the interview room vs what lenses we are applying, are core features of good therapy and good science. Such attentive practice will help us to identify racial essentialism and eradicate it from our everyday practice.
Take Home Summary

A patient’s racial or ethnic identity is not an objective fact that can be observed. Using concrete descriptive language in the appearance portion of the mental status exam avoids assuming a patient’s racial identity, is truly objective, and eschews racial essentialism.

References

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Olivia Shadid, MD, is a second-year psychiatry resident with the University of New Mexico, Albuquerque. Her scholarly, advocacy, and forensic work is with migrant children and families fleeing persecution and seeking asylum. She is interested in how intercultural transitions and cultural categorizations, such as race and gender, affect mental health.

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Building Up and Breaking Down: Youth Cultural Identity Development

Sarah H. Arshad, MD, Jaclyn Datar Chua, DO, Lauren P. Baker, MD

The population of the United States is becoming increasingly culturally diverse; the US Census Bureau reports that almost half of US children are from minority backgrounds and by 2044, minorities will comprise half of the US population. It is therefore crucial to recognize patients’ cultural identities as a part of normal identity formation in their mental health evaluations. In this piece, we first define the concept of cultural identity and discuss some identity factors in young children, demonstrating how this process begins as early as toddlerhood. Then we discuss cultural identity as a developmental milestone for adolescents incorporated with their normal transition to adulthood. Finally, we highlight the importance of intersectionality, or the interplay of different individual identity factors and how they affect each other, to more holistically understand an individual’s cultural identity.

Cultural Identity in Young Children

The Outline for Cultural Formulation (OCF), introduced in the DSM-IV, asks providers to first assess for the “cultural identity of the individual,” including understanding factors such as race, ethnicity, religion/spirituality, sex, gender identity, socioeconomic status/access to resources, migrant status, and language ability. Children begin to make observations about cultural factors, and therefore begin their cultural identity formation, at a young age. Studies show that infants as young as 6 months old begin to consider and differentiate between the race and sex of the faces they see, that 2-year-old children use ‘racial categories’ when they consider behavior, and that 3- to 5-year-old children identify themselves and others using racial specifiers. Moreover, these racial beliefs are not always reflective of caregiver or household beliefs but are also learned from sociocultural norms and observation. For example, Black and White toddlers show pro-White bias when selecting potential playmates as young as 3 years of age. As young children make observations within their families, neighborhoods, or classrooms, they make sense of the world based on the social information they gather and also begin their own cultural identity formation. This includes the color and sex of the people around them, as well as those they see in media and as authority figures. This identity formation continues as a part of normal development, informed by a unique set of factors depending on each child’s circumstances.

Cultural Identity and the Adolescent Transition

As children transition into adolescence, their primary psychological developmental task is identity formation. While providers often consider vocational, romantic, and educational aspirations, this complex task is also influenced by many personal, familial, community and societal factors including race, ethnicity, sexual orientation and religion. Both self-identified and externally perceived identity can affect the way adolescents navigate the world. Several models have been developed to describe the process of identity consolidation for specific social groups such as certain racial or ethnic minorities, individuals with migration histories, gay/lesbian/bisexual individuals, and White/dominant cultural members. The Integrative Model of Racial Identity Development combines many of these notions into a single model of identity development with parallel processes for minority and majority cultural groups. It highlights how initial acceptance of majority cultural norms moves into questioning one’s own and other cultural norms, then recognizing one’s own involvement in those norms and assumptions. Accepting a unique identity for oneself is the culmination of acknowledging positive and negative aspects of multiple cultures. Negotiating these stages begins in youth and progresses over
the lifespan. While the model focuses on racial identity, the theory can also be extrapolated to other identities which often evolve over adolescence. For example, a child may initially operate within a birth-assigned gender, but as they begin to individuate, they may consider alternatives across the gender spectrum. Someone born into a family with certain religious beliefs may explore other perspectives before establishing their unique faith system. This journey to accept, reject or modify the assumed identity can be fraught with emotional turmoil. Understanding how adolescents move through these stages can help providers better support adolescents through the conflicts they face.6

**Intersectionality**

Intersectionality is defined as a “theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, socioeconomic status, and disability interact at the micro level of individual experience to reflect interlocking systems of privilege and oppression (ie, racism, sexism, heterosexism, classism) at the macro social-structural level.”8 The term encompasses the interplay of different identities within one individual. Culture is transmitted and revised within family and social systems, allowing for the creation of a model for normative expectations,2 often defined by the dominant culture. That dominant culture influences a child’s identity formation. At the same time, the many aspects of their dynamic individual identities including race, religion, nationality, education, and gender all “interact and influence one another.”5 For example, familism is a common Latinx value associated with strong feelings of loyalty, reciprocity and solidarity that may lead to residing close to other family members.9 Thus, conflict may naturally arise when identity becomes increasingly self-selected and influenced by factors outside of the family’s identity, such as balancing heritage with peer group identity. This interplay of multiple identity experiences is crucial in the conceptualization of each child’s presentation and allows for a more accurate, personalized framework.5

**Conclusion**

In an increasingly diverse society, incorporating children’s and adolescents’ cultural identities as part of all mental health evaluations is critical. Cultural identity formation begins at a young age, as toddlers observe the world around them, and continues through development. Many factors should be considered including race, ethnicity, sexual orientation, gender identity, religion/spirituality, socioeconomic status, migrant status, and language ability, as well as how these cultural identities interplay for each individual. Seeing children and adolescents through an intersectional lens allows for a healthcare provider to best support the many stages of identity development for a child as well as the family system in which the child lives.

**Take Home Summary**

Cultural identity formation starts at a young age and continues throughout normal development. It’s important to empower patients to share their narratives and experiences to understand their cultural identity, how this impacts them, and how it relates to their mental health journey.

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Implicit Bias in Psychiatry: It’s Time for More Than Uncomfortable Conversations Among Physicians

Christopher Rogers, MD, Ritambhara Wadhwa, DO, Felicia Green, DO

“Of all the forms of inequality, injustice in health is the most shocking and inhuman because it often results in physical death.”

– Rev. Martin Luther King, Jr.

2020 was a year unlike any other with upheavals to our core social structures. A painful yet potentially revolutionizing disruption was the mass outcry against systemic racism. While these particular protests were sparked by yet another senseless killing of a Black man by police, the ramifications and opportunities for change go far beyond police reform. This is not to say that police reform is off limits for psychiatrists fighting for change. In June 2020, the American Medical Association recognized racism in all forms as a direct public health threat and barrier to the medical care we as physicians are dedicated to providing; they also publicly denounced police brutality and all forms of racially-motivated violence. This is an important step for physician advocates and will hopefully lead to a productive change for the better in America. If we seek to fully achieve mental wellness in our country, establishing truly safe communities will be a part of the larger task.

Physicians additionally have plenty of work to do within our own systems and institutions. The medical literature provides abundant evidence of how race-based bias permeates our health systems. The evidence that African Americans have higher rates of death, disease and disability than White people is well documented over the past 150 years. There are also compelling findings that Black people in America have higher levels of psychological distress and lower levels of subjective well-being. Unfortunately, the data suggests that outcomes are getting worse, not better. The common theme throughout the data is that marginalized populations are not being heard. Previously, this was believed to be a result of inadequate access to care, lack of insurance, stigma around mental health and/or language barriers. However, recent data reveals college educated African American women are more likely to suffer adverse medical outcomes compared to White high school educated counterparts. The same is seen for African American women who are fully insured with sufficient encounters with healthcare providers. This suggests subpar treatment received by minority groups goes beyond education or access to care.

Health disparities start early for children in America, even while in utero. One recent study investigating stress on pregnant women found that chronically elevated stress levels contribute to decreased choline, an essential nutrient needed for fetal brain development. When the authors compared choline levels between African American women versus African women living in Uganda, choline levels were significantly lower in American subjects. This increases risk of developing ADHD and other childhood mental illnesses and furthers speculation that systemic racism may impact kids before they are even born.

Psychiatry of course, has its own history of biases and inequities. The evidence is ample that historically, psychiatrists have done a poor job of providing truly equitable care. For example, despite the rates of depression being lower among Black people (24.6%) and Hispanics (19.6%) versus their White counterparts (34.7%), depression tends to be more persistent among them. Implicit bias is perhaps more likely to affect psychiatric diagnosis more than other fields in medicine leading to diagnostic disparities. For example, a comprehensive review published in 2014 showed that Latin/Hispanic and African American populations on average have been disproportionately diagnosed with psychotic disorders.
compared to their White counterparts. Disparity and implicit biases can be even more glaring when we look beyond published articles. Personal accounts from our own clinical practice are many: a young African American female making persecutory comments such as, “I have been harassed by many of you, for many years, and there will be nothing different about you too. Stop treating me like a guinea pig.” Her pan-distrust of the healthcare system may be simplified to a defect in her perception, but one can’t overlook nor deny the underlying harsh truth in her statements.

Shifting focus to child psychiatry, evidence suggests that children as young as 6 years old can identify and display consequences of racial discrimination. African American adolescents who experience discrimination in early childhood tend to have more depressive symptoms and engage in risky behaviors. Similarly, adolescents of Latin and Asian descent who report high levels of discrimination were found to have higher levels of depressive and anxious symptoms negatively impacting education, where lack of motivation for learning and lower levels of engagement were observed. These results demonstrate how young children are adversely affected by racial discrimination leading to psychological distress and worse school functioning. Thanks to social interactions that can provide a child with an ethnic-racial identity led to lower rates of internalizing and externalizing behavioral symptoms and less feelings of hopelessness. A child with a strong ethnic-racial identity has a sense of connection to and understanding of their racial-ethnic group which was shown to act as a buffer to the psychological effects of discrimination. Here lies an opportunity for child psychiatrists to support a positive and protective strategy for change.

Another potential avenue to combat the impact of systemic racism on kids is through behavioral health integration strategies to improve access to care. Pediatricians and emergency physicians have greater contact with children than child psychiatrists thus, embedding mental health services into the primary care setting allows for earlier intervention. One public health initiative that implemented this across various states has seen an improvement in primary care screenings, parent/provider/patient satisfaction and social-emotional functioning in children. What is evident here, is we have an opportunity to be sure the kids we treat get to experience a different and more egalitarian health care system.

Interested readers are encouraged to visit the Project Implicit site (https://implicit.harvard.edu/implicit/index.jsp) to discover your own implicit associations. This may serve as a starting point for discussions with colleagues, friends, and co-workers. These conversations can be hard and at times more awkward and personal than any of us may like. However, if we are to be a part of the change that is needed, we must be willing to engage in more than just uncomfortable conversations. For those with influence on training programs, another way to implement lasting change can involve creating or supporting pipeline programs that encourage minority college students to consider the field of medicine. This would help to improve the much-needed diversity within the medical workforce. Also, adjusting medical school curriculum to incorporate disease presentation within various races and improved cultural competency training could be immensely helpful. Similar changes would be productive in clinical trial design to ensure we have data for all our patients, not just the ones representing the majority. In 2020, we saw major changes in the norms of medicine in response to the pandemic. For example, telehealth platforms were rapidly adapted and utilized. Now is the time to step forward and make the necessary changes in ways that may have seemed impossible previously. Some would even argue that it is part of our obligation to the families and children we serve, inherent in our duty as healers.

We can all be proud that the American Academy of Child & Adolescent Psychiatry has been very active in facilitating change. They have developed an excellent Racism Resource Library with numerous resources for clinicians, adults, and children to foster open discussions about race within families or with your patients: https://www.aacap.org/AACAP/Families_and_Youth/Resource_Libraries/Racism_Resource_Library.aspx. You can also find tools you can use to combat racial bias within institutions. AACAP has been
very active in taking a leadership role in these troubled times and it is motivating to see a professional organization standing up to acknowledge the problems with race in America and working to find solutions. Let’s all join them.

**Take Home Summary**

For many years, minority patients have received subpar treatment within the healthcare system. This has been evident through lack of access to care, higher death rates and misdiagnoses. We have found many elements that contribute to this, but even with this knowledge, the disparity remains. It is now our turn as providers to recognize the role we play in this disparity and start to enact change. This ranges from identifying our own bias, diversity in medical school admissions, incorporating various races in the training curriculum which can all influence our day to day practice positively.

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Supporting LGBTQ2S Youth Who Are Black, Indigenous, and People of Color (BIPOC)

Mikiko Thelwell, MD Candidate, Carly Chiwiwi, MD Candidate, Lane Kantor, MD Candidate

We are in the midst of a movement led by BIPOC young people that seeks to address the deeply ingrained racism that has always existed in our society. In times like this, we are reminded of Marsha P. Johnson and Jewelle Gomez, who stood on the front lines for queer liberation while surviving at the intersection of racism, homophobia, and transphobia. Today LGBTQ2S* BIPOC youth are leading movements for substantive change, while navigating multiple marginalized identities within prevailing systems of oppression. The resulting mental health consequences for youth within this community have been thoroughly evidenced.1–3 Yet mental health disparities continue to persist and are exacerbated by deficit-based approaches to treatment for youth within this community, rather than strength-based approaches. Ultimately, these prevailing mental health disparities highlight the need for an updated examination of the literature on caring and advocating for LGBTQ2S BIPOC youth, whose experiences are broad-ranging and dynamic.

Current literature on caring and advocating for LGBTQ2S BIPOC youth outlines the importance of using an intersectional framework to understand how different identities can be a source of both compounding oppression and resilience for youth. This approach can empower them to explore their identities, rather than viewing them as independent deviation from the norm.1,4 American Indian, and Alaska Native youth (referred to, henceforth, as Native and Indigenous youth in this report.) This article provides a baseline review of how to support the mental and behavioral health of youth in this community. While several acronyms exist in the literature, we use the term LGBTQ2S* BIPOC youth when synthesizing recommendations and also include identifiers specific to individual studies. We outline 4 steps to support youth in this community: 1) listen, support exploration, and commit to self-education; 2) encourage access to social support; 3) help them find diverse representation and providers; and 4) seek accurate, decolonized histories and narratives.

Listen, Support Exploration, and Commit to Self-Education: It has been well-demonstrated that few youths will entirely change their minds about identifying as LGBT and that these identities are not “a phase.”5 That said, it remains important to support exploration of gender and sexuality, including the ways racial/ethnic identity can influence these experiences. For example, the term stud is used to describe a Black masculine lesbian experience and the term Two-Spirit is used by some Indigenous people to describe a spiritual balance of both feminine and masculine energies that exist outside of a colonial context.3,6 Many LGBTQ2S people will shift identity descriptors over time, depending on what feels most affirming. For example, switching from identifying as gay to queer or from transgender to genderqueer. Though it may be confusing at first, it is important to listen to individuals in a non-judgmental manner and support them while they explore different identities, pronouns, gender expressions, or, in some cases, new names. Some of the terminology youth use to describe themselves may be new to you (eg, pansexual, genderqueer), and if so, it can be helpful to do some research before re-engaging in a conversation. Taking proactive steps to understand youths’ pronouns and identities while expressing openness to learning will reaffirm your willingness to support youth who are navigating their developing identities and beliefs.

Encourage Access to Social Support: BIPOC LGBTQ2S youth benefit from robust communities of support that create space for the unique experience of being both LGBTQ2S and BIPOC. For example, studies show that sexual and gender minority youth of color
involved in diverse Gay Straight Alliances (GSAs) were more likely to feel a greater sense of belonging in their school community and less likely to miss school due to safety concerns or feel isolated because of their sexual orientation, compared to students in predominantly White GSAs. Additionally, LGBTQ2S BIPOC youth may develop a greater sense of self-efficacy and agency when given the opportunity to create support networks outside of predominantly White spaces. A study of 162 LGBTQ+ youth of color described the positive influence of “chosen families” on promoting agency and social stability. Other studies of transgender youth of color, 2SLGBTQQIA*, and Gender Non-Conforming Indigenous youth echoed these findings, illustrating the merit of self-determined healing spaces in promoting greater resiliency. Find and promote intersectional social opportunities, such as Ithaca’s Quinfolk, a mental health festival for LGBTQIA+ people of color, and normalize the creation of non-familial kinships as essential forms of social support. In the midst of COVID-19, the harmful impact of isolation on mental health is magnified, making it imperative to promote resiliency strategies that are uniquely informed by youths’ intersectional experiences. Clinicians should connect with local community organizations to identify peer-led support networks for LGBTQ2S BIPOC youth. If none are available, consider establishing similar support groups within your practice or community.

Help Them Find Diverse Representation and Providers: It is incredibly empowering for youth to see genuine and positive representations of people like them; however, there is a dearth of LGBTQ2S BIPOC representation in mainstream media. Studies of racism and heteronormativity have found that a lack of role models of color in media can negatively impact the psychological development and coming out process for LGBTQ2S youth of color. As such, we encourage providers to become aware of and help connect youth with media that genuinely represents the lives and experiences of LGBTQ2S BIPOC individuals. Some helpful examples include Laverne Cox’s documentary The T Word, Nia King’s podcast We Want the Airways, and initiatives like MyStoryOutLoud, a digital storytelling campaign. Seeing representations of thriving LGBTQ2S BIPOC people helps youth envision a future for themselves in which they too can flourish and build meaningful community. It can also be valuable to connect youth with providers that share some of their identities. For example, organizations like the National Queer and Trans Therapists of Color Network aim to provide intersectional mental health services that resist colonial and pathologizing models of medicine while honoring the traditions, creativity, and cultural practices that LGBTQ2S BIPOC people have used to build resilience and survive. Whenever possible, advocate for youth to have access to providers who share some of their identities and for your local health systems to hire more LGBTQ2S BIPOC providers.

Seek Accurate, Decolonized Histories and Narratives: It has been demonstrated that Black, Latinx, AAPI, and Native and Indigenous LGBTQ students who had some positive LGBTQ2S representation in their curricula were less likely to feel unsafe in their sexual orientation and gender expression. For example, California’s adoption of the Fair, Accurate, Inclusive, and Respectful (FAIR) Education Act sought to integrate LGBTQ-focused curricula. However, a recent cross-sectional study indicates intersectional material that adequately represents diverse student bodies remains insufficient. The general lack of accurate and positive inclusion of Indigenous people in curricula at schools further compounds the above issue. Thus, increasing access to this important knowledge is a practical means of helping youth feel more comfortable at school and understanding that people similar to them have existed, fought, and thrived for generations. It is also important for clinicians and educators to seek out diverse and decolonialized histories of LGBTQ2S people that center BIPOC people. For instance, learning about the unique and powerful roles Two-Spirit people hold within their tribal communities can empower Indigenous youth. Encourage your local schools to upgrade their lessons to include this important history and information. Providers can similarly advocate for medical schools and residencies to build comprehensive curricula that addresses best practices to care for LGBTQ2S BIPOC patients.
Conclusion

Providers and advocates are crucial to supporting LGBTQ2S BIPOC youth who face the combined forces of racism, homophobia, and transphobia. Straightforward actions such as listening, believing, and encouraging identity exploration in conjunction with access to social support is essential for improving mental health outcomes among LGBTQ2S BIPOC youth. Yet, support services rarely center intersectional lived-experiences and identities when creating programming. Additionally, helping youth find diverse representation through media, healthcare providers, and school curricula can further promote an environment for youth to flourish. This year, as LGBTQ2S BIPOC youth continue to fight for social change and COVID-19 disproportionately impacts BIPOC communities, especially tribal nations, it is more important than ever for providers and advocates to re-evaluate how they show up and provide support for LGBTQ2S BIPOC youth.

Glossary

2SLGBTQQIA: Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Allies. Acronym coined in Hardy, 2020 with the intentional placement of Two-Spirit at the front “as an act of decolonization, to reclaim and prioritize Indigenous identity in an otherwise White-washed movement that takes place on stolen Indigenous land.”

BIPOC: The term BIPOC is used to highlight the unique relationship to Whiteness that Black and Indigenous people have, which shapes the experiences of and relationship to White supremacy for all people of color within a US context.

LGBTQ2S: Lesbian, gay, bisexual, transgender, queer, Two-Spirit. Only Indigenous people can be Two-Spirit; however, being Indigenous and queer does not automatically make that person Two-Spirit.

Gender Identity: A person’s individual perception of their gender, which may or may not correspond to their sex assigned at birth (eg, cisgender, transgender, non-binary, agender).

Heteronormativity: The societal and interpersonal belief that heterosexuality is the default, preferred, or normal sexual orientation, which also reinforces the false notion of a gender binary by assuming that sexual relations are more normal or appropriate between people of the "opposite sex."

Intersectionality: The theory of intersectionality recognizes how systems of oppression (eg, racism, homophobia, transphobia, capitalism, and ableism) are not isolated and distinct, but rather compound to advantage and disadvantage different groups.

Sexual Orientation: A person’s romantic, physical, and/or emotional attractions (eg, heterosexual, bisexual, queer, pansexual).

Take Home Summary

Today more than ever LGBTQ2S BIPOC youth are leading movements for change while navigating multiple marginalized identities. This article provides a baseline review of how to support the mental and behavioral health of youth within this community.

References


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**About the Authors**

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The authors gratefully acknowledge Amy Weimer, MD, Department of Medicine-Pediatrics/UCLA for her guidance in developing the concept of this paper and Eraka Bath, MD, Department of Psychiatry/UCLA for her continued mentorship and support.

**Disclosure:** MD Candidates Mikiko Thelwell, Carly Chiwiwi, and Lane Kantor have no biomedical financial interests or potential conflicts of interest to declare.

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COMPONENT WORK

Serving on the CME Committee has given me insight into the behind-the-scenes work it takes to provide relevant, engaging opportunities for CME credit. It has also shown me the importance, and challenge, of being able to measure changes in practice over time as a result of the learning opportunities provided by AACAP. Lastly, it reminds me that writing a well-crafted multiple-choice question to test knowledge is no easy task!

Serving as co-chair and working closely with Elizabeth Hughes, Shoshana Gitlin, Jill Brafford, and Quentin Bernhard has reinforced how dedicated and hard-working our AACAP staff are!

MENTORSHIP

The Mentorship Program has been a focus of my attendance at the AACAP Annual Meeting since 2011. I believe that the value of the mentorship events for medical students, residents and fellows, and ECPs is so high that I tell all of my medical students interested in psychiatry to apply for the travel award and do their best to attend. Mentorship has been invaluable for me throughout my career, so serving as a mentor with AACAP is a way for me to give back. I still keep in touch with former medical students I met several years ago.

PATHWAYS TO CAP

I would not be the psychiatrist, or person, that I am had I not been introduced to organized medicine. My first introduction into the world of organized psychiatry was as a 2003 APA/AstraZeneca Minority Fellow. The contacts I made in that program produced lifelong friendships and mentors, and served as a gateway to other enriching opportunities such as involvement in AACAP, PRITE question writing, state and national advocacy, and other professional organizations. Each of those led to further career opportunities, networks, and mentorship.

Visit www.aacap.org/awards to discover available award opportunities!
Antiracism Work in Schools: Using Dialectical Behavioral Therapy Skills to Empower South Texas Educators

Phillip Yang, MA, Yolanda Crous, MESM, Norma Balli-Borrero, MS, Byeong Y. Choi, PhD, Barbara Robles-Ramamurthy, MD

“It is important for me to get the tools needed to be an effective training facilitator. The work that I do, the potential impact I may have on faculty and students that look like me, are the driving force to continue this very important work of an antiracist educator.”

– Train-the-Trainer Workshop Participant

In 2019, the American Academy of Pediatrics declared racism a core social determinant of health.1 Exposure to the chronic stress of racism during childhood results in higher rates of depression, anxiety, conduct problems, and low self-esteem.2 Children and adolescents experience racism nearly everywhere including the education system where Black students are more likely to receive a negative behavioral assessment than White students, especially if the assessment is from a White teacher.3 Teachers often underestimate Black and Hispanic students’ academic abilities, reducing students’ confidence in and expectations for their own achievements.4 Black and Hispanic students are expelled from school at greater rates, contributing to the school-to-prison pipeline and diminishing opportunities for future scholastic and economic success.5 The use of over-policing and harsh punishments in under-resourced schools with high numbers of Black and Latino children increases the risk of legal system involvement, another system affected by racism.6

Reduce the stresses of racism, however, and these outcomes can change. Students of color who attend schools perceived as having a good racial climate do better academically, experience fewer disciplinary actions, and have better cardiometabolic health than those whose schools have a negative racial climate.7 Therefore, creating antiracist learning environments is essential in reducing health and educational inequities.

Data from Project Implicit’s Black-White Implicit Associations Test (IAT) suggest that subconscious implicit biases are a significant factor in racial educational disparities.8 Tools that improve self-awareness have emerged as mechanisms to reduce implicit bias. Dialectical behavioral therapy (DBT), which uses mindfulness as a foundational tool and is classically used to treat borderline personality disorder, has emerged as a potential tool to manage a wide range of behaviors, mental health conditions, and even parenting.9,10 Through a community partnership with the school system, we aimed to empower educators in their antiracism work by providing an antiracism training that incorporated the 4 major skills of DBT: mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation.

Understanding dialectics—the ability to accept that a difficult reality exists and yet, one must find meaningful options to engage in this work and preserve one’s own wellness—is also core to antiracism work. Mindfulness helps increase individuals’ awareness of and response to implicit bias and is often used in implicit bias trainings among health care workers.11 Distress tolerance boosts the effects of mindfulness training and may help educators deal with the difficult emotions inherent in antiracism work.12 Finally, navigating antiracism interventions requires high levels of interpersonal effectiveness.13
For our DBT-based antiracism workshop, we had 2 goals:

1. Provide South Texas educators with antiracism tools and training to empower them to create and lead antiracism programs at their school.
2. Pilot the use of DBT skills to promote antiracism work in schools.

**Community Collaboration**

Upon request of the Education Service Center Region 20 (ESC-20), our team at the UT Health San Antonio Long School of Medicine collaborated with the University of Texas at San Antonio’s (UTSA) Multicultural Student Center for Equity and Justice to create an antiracism workshop. ESC-20 is an organization established by the Texas State Board of Education to provide educational support such as curricular programs and social services to South Texas public schools and serves almost half a million students in 56 school districts. ESC-20 recruited 12 South Texas educators to participate in this pilot study. This project was determined Quality Improvement “Not Regulated Research” by the Institutional Review Board UT Health San Antonio. The results of our project may not be generalizable outside the project setting.

**Empowering our Participants With Antiracism and DBT Tools**

Participants received the following tools:

1. **Antiracism toolkit**

   The toolkit was designed to be concise and informative with sections covering the history of racism, the impact of racism on students, books and media resources, classroom resources, and DBT and self-care information. Each section of the toolkit contains no more than 10 resources. [Click here to see the toolkit.](#)

2. **Train-the-trainer workshop**

   The 2-day virtual workshop took place in November 2020 over Zoom and consisted of 2 sessions that were 1.5-hours. The workshop integrated DBT skills to develop trainers’ ability to promote the understanding of racism, reflect as antiracism facilitators, and role-play scenarios.

3. **Antiracism books**

   After the workshop, participants selected 3 of 5 antiracism books to take home. (They also had the option of requesting resources not on the list).

**Who was Interested in Attending the Workshop?**

Twelve educators representing 4 unique districts and 4 unique schools completed the application for the workshop. Of the 12 applicants, 7 were White, 1 was Black, 3 were Hispanic, and one was biracial (Black and Hispanic). The applicants had been educators for an average of 17 years (range: 5 to 31 years). Seven applicants work at a school district as a counselor or a similar position. Five applicants work at individual schools. Ten applicants had previously attended an antiracism workshop. Only two applicants’ schools had engaged in formal antiracism programs. Participants were asked to estimate the amount of racism among their students and their colleagues on a 5-point scale: “none at all,” “a little,” “a moderate amount,” “a lot,” and “a great deal.” Nine (75%) of the applicants said that there is “a lot” or “a moderate amount” of racism among their students while 7 (58%) said the same about racism among their colleagues.

The applicants were asked to estimate the racial composition of the students (Figure 1A) and the teachers (Figure 1B) at their schools. There was a perceived racial and ethnic disparity, with applicants estimating, on average, that 67% of students are Hispanic and 55% of teachers are White, despite South Texas’s status as a “Minority-Majority” area (69% Hispanic vs 25% White). While the perceived racial distribution of the staff and students may not reflect the true racial distribution at their schools, this disparity is especially significant because minority students who have teachers that share their racial identity tend to feel happier in school and do better academically. Asian, American Indian, and Multiracial students/teachers accounted for less than...
How Effective Was the Workshop?

Nine participants attended the workshop and completed a pre-survey on antiracism attitudes and DBT skills. Eight participants took the optional pre-survey Black-White IAT (https://implicit.harvard.edu/implicit/selectatest.html). Prior to taking the IAT, 5 participants were “very aware” and 3 were “moderately aware” of their personal implicit bias. After taking the IAT, 4 participants were “moderately surprised”, “very surprised”, or “extremely surprised” at their results while 4 participants were “not at all surprised.” Four of the workshop participants had taken the IAT before; however, there was no association between previous test taking and level of surprise.

After the workshop, participants took a post-survey with the identical DBT skills confidence (Figure 2A) and antiracism attitude questions (Figure 2B). Participants’ confidence in teaching and utilizing DBT skills increased in all categories (Figure 2A). Among teaching skills, their confidence grew most in teaching interpersonal effectiveness (27%), which is consistent with the workshop structure to emphasize these skills. When it came to...
using DBT, participants’ confidence improved most in practicing mindfulness (30% growth). Confidence in both teaching and utilizing emotion regulation increased by 19% and 26% respectively.

The participants’ confidence in their antiracism knowledge and ability to teach antiracism concepts also improved in most categories (Figure 2B). The sole exception was in participants’ confidence in leading antiracism discussions, which remained at the same high level (4.78 out of 5) as before the workshop. Of the 6 measured attitudes, confidence in antiracism awareness grew the most (39% growth). All participants found the workshop important and helpful and would recommend it to their colleagues.

Conclusions and Next Steps
Our DBT-centered antiracism train-the-trainer workshop improved participating educators’ DBT skills and antiracism attitudes. The small sample size of our pilot study limits any generalizations of our results; however, it is an important first step to setting the foundation of utilizing DBT as a method of promoting antiracism work. Several next steps are in play to expand our antiracism training program. First, we plan to do 6-month qualitative interviews with the trainers to assess their progress in antiracism work. Second, we aim to continue to offer trainings and have recruited 12 educators for our next cohort. Third, we hope to continue to explore the effectiveness of DBT skills in promoting antiracism by working with the other stakeholders in education, such as students and administrators. We hope that our Train-the-Trainer model will trickle into communities and promote a safe and inclusive environment for all students in South Texas. One challenge to our project was building community in a virtual format. While the virtual format opened accessibility to educators across the region, having a safe space was especially important in our workshop to promote non-judgmental sharing and interpersonal growth. Additionally, practice of DBT skills in an on-going team or group approach is important to maximize their benefits. Finally, we urge the readers to support antiracism work among your local educators, whether with a DBT model or otherwise.

Take Home Summary
Antiracism work in education is critical for the health and academic success for all youth. The use of dialectical behavioral therapy in an antiracism Train-the-Trainer workshop improved antiracism skills and perceptions in educators.

References


About the Authors

**Phillip Yang, MA,** is a former high school educator and second-year medical student at the Long School of Medicine, San Antonio, Texas. Mr. Yang is interested in cultural medicine, social justice, and child and adolescent psychiatry.

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This article was edited by Anne B. McBride, MD, and Kathryn Regan Cullen, MD.
I was 15 years old when my father took me out for my first driving lesson. He carefully explained the importance of checking my blind spots. It was my responsibility to always look carefully over my shoulder because, despite the use of mirrors, there are just some areas that are hard to visualize. I was a good listener and took this chat to heart but, unfortunately, I managed to back into a pole in a parking lot shortly after I turned 16. I felt terrible about this at the time and I apologized quite a bit for damaging the car. Fortunately for me, my parents reminded me to be more careful and still allowed me to drive. It is a lesson I have been thinking about this past year as I tried my best to uncover my blind spots regarding structural racism, reminded myself to be more careful, and committed to the ongoing practice of becoming antiracist. While taking on structural racism can feel overwhelming, engaging with books and articles can support us as individuals taking on our own blind spots. In this Connect Corner we invite our readers to join us and offer the following suggestions to get started.

– Paula Wadell, MD

Cheryl S. Al-Mateen, MD


- This teaches about the universality of the process of structural racism, as well as sexism, homophobia, and other “isms.”


- This book teaches about cultural identity development that is accessible to everyone.


- This is an excellent book from multiple perspectives for children as young as 6.

Rameshwari Tumuluru, MD

Hotel At the Corner of Bitter and Sweet. (Book) Jamie Ford. New York: Ballantine Books; 2009.

- A historical fiction novel based on the internment of Japanese Americans.


- A Young Adult novel inspired by the Black Lives Matter movement.

Lisa Cullins, MD


Susan Daily, MD


- This book is currently in film production.


If I Go Missing. (Book) Brianna Jonnie (Author), Nahanni Shingoose; Neal Shannacappo (Illustrators). Toronto: Lorimer; 2020.


Rhymes for Young Ghouls. (Movie) Directed by Jeff Barnaby. Canada: Prospector Films and Canadian Film Centre (CFC); 2013.


– Southeastern Tribes


– Dine


– Canadian

Black Lodge Singers. (Music) Canyon Records.

– Powwow music for kids.

Sharon Birch. (Music)

– English and Dine language and themes.

– Song: “Colors of My Heart”

Akwesasne Women Singers (Mohawk). (Music)

– https://www.facebook.com/kontiwennenhawi/


– Alaskan Native

Yakari. (TV) Based on Yakari by Job Derib. France; 2005.

– Sioux


– Cree


– Lakota character

Native Pride Dancers. (Dance) https://nativepride-arts.org/

Osage (Wahzhazhe) Ballet. (Dance) www.osage-ballet.com
Author Guidelines

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

Authors are strongly encouraged to submit an initial outline to the editors, so that early feedback and guidance can be provided prior to the development of a full manuscript. An invitation to submit does not ultimately assure acceptance of the manuscript.

Manuscript Format

For full details regarding manuscript format, such as word count and required submission components, please see the Author Guidelines for JAACAP Connect, found here.

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Outlines and manuscripts will be reviewed by the editors, editorial board members, and select experts. We recognize that mentorship for manuscript authorship may not be available to everyone. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles.

Submission/Contact

More information is available at http://www.jaacap.com/content/connect under the “Submit” tab. Please send inquiries, potential topics, outlines, and draft articles to connect@jaacap.org.