Special Issue: Women in Child and Adolescent Psychiatry

Women in Child and Adolescent Psychiatry

Misty C. Richards, MD, MS, Christina T. Khan, MD, PhD

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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. 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.
Imagine a world where community, harmony, and equality exist. A place fueled by innovation where trees grow from balanced soil to provide both shade and oxygen to people who breathe it all in. Where women are valued as community leaders, mothers, and professionals, who are essential for building the future. If you close your eyes and listen in earnest, you can feel that this mystical paradise exists. It is real. And so our journey begins to find this promised land.

This issue of JAACAP Connect focuses on the collective strength, wisdom, and potential of women in child and adolescent psychiatry. Despite the distance we’ve come, there remain enormous inequities for women in medicine. Women attend medical school in numbers equal to or exceeding males. Despite this, robust barriers exist that impact promotion, retention, and quality of life for women. Persistent disparities at all ranks have been noted, even more so for women with multiple intersecting minoritized identities. Woven in this issue are discussions of triumph and challenge: to both celebrate how far we have come, and to pursue a more just and equal world.

The issue opens with “Being a Woman Leader: Reimagining ‘Themyscira’ in Child Psychiatry” by Chen et al. Themyscira is a fictional island nation and the birthplace of Wonder Woman, where women leaders are trained warriors who approach challenges as opportunities. This concept is foundational for women in child psychiatry who battle to help patients, families, colleagues, trainees, and themselves towards living their best lives. To perform this juggling act, values must be prioritized. At the top of this list are justice, equity, diversity, and inclusion (JEDI) efforts.

In this spirit, we introduce “Towards a Culture Shift: Advocating for Equity, Diversity, and Inclusion for Women in Child Psychiatry.” Hua et al. describe the factors contributing to persistent inequities in mental health care for women psychiatrists and for patients. They note the importance of attention to intersectionality and to forming productive habits at the institutional and community levels. They document strategies for promoting JEDI values at the individual, institutional, and community levels and offer a simple call to action.

At the core of addressing JEDI efforts is managing implicit bias. In “Addressing Implicit Bias in Child and Adolescent Psychiatry,” Challa et al. document the importance of addressing implicit bias in order to repair health disparities, for both provider and patient outcomes. They offer concrete strategies at the individual and institutional levels that we hope will inspire you to implement in your own institutions.

Advancing on our journey, the next articles address issues that disproportionately affect women in the profession. Mergler et al. in “Considerations for the Future: Family Planning and Infertility During Psychiatry Training,” discuss an oft-neglected topic that is key to work-life integration: family planning. They adeptly outline the challenges postgraduate training poses upon families, as well as disparate family leave practices across different institutions. They propose a unified approach to policies addressing maternal mental health, family leave, and infertility services for trainees and advocate for broad-based support that aligns with federal law and association guidelines.

We cannot overlook the impact of the COVID-19 pandemic in this special issue on girls and women. Lowder et al. take on this task in “The Impact of COVID-19 on Women: Highlighting Vulnerabilities and Opportunities” and begin with a striking statistic: women comprise 70% of healthcare workers. They describe the jarring impact the pandemic has had on women personally and professionally. They outline contributors to burnout and name opportunities to rebuild with an intentional focus on women, offering hope in a time of uncertainty.
The social isolation brought on by the pandemic contributed to an increased reliance on social media to preserve connection. In a sobering and vulnerable Connect Corner piece entitled “Connect Corner: A Review of My Own Facebook Feed,” Paula Wadell discusses the cycle of unwellness and how Facebook can fuel disenchantment with one’s work-life balance. She calls for the creation of a culture where we undo normalization of unhealthy behaviors to create space for self-care and expectation management.

Finally, we close with “Spotlight on Juvenile Justice: Girls in the System.” Belzince et al. compose a powerful piece exploring the impact of racism, sexism, and oppression that fuel girls’ involvement in juvenile justice. They call for aggressive efforts to treat recurrent trauma and mental health symptoms in girls while more broadly addressing the underlying societal factors that perpetuate gender and racial inequities.

In this special issue, the articles remind us of the values we, as a society, and as professionals in child and adolescent psychiatry, hold close. Many of us entered this field because we believe children are the future, and we also know mothers play a key role in shaping that future. We hope this issue helps us see our greatest challenges as our most important opportunities. In joining our efforts to create a sustainable, resilient, and gender inclusive future in the profession, we form the lush terrain of Themyscira.

Misty C. Richards, MD, MS
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References
Being a Woman Leader: Reimagining “Themyscira” in Child Psychiatry

Tingfang Chen, MD, Marcy Forgey Borlik, MD, MPH, Aditi Hajirnis, MD, Christina T. Khan, MD, PhD, Yael Dvir, MD, Consuelo C. Cagande, MD

“The world is not ready for all you will do.”
– Hippolyta, Wonder Woman 1984

A mystical island shrouded in fog, invisible to the eye, a fortress of limitless potential hidden from the rest of the world. Themyscira is most well-known as being the home of Wonder Woman in the popular DC comics franchise. Child and adolescent psychiatry is a specialty that has a robust majority of women, but there are overall still significant gender disparities in academic rank and leadership positions in the field. As the legendary land of strong women, Themyscira is evocative of concepts of what distinctive leadership in psychiatry and medicine can stand for: guidance of others through motivation and inspiration (managing vs leading,) critical examinations of need for stability and need for evolution and change, support and advocacy (mentorship vs sponsorship,) maintaining integrity to the core values professionally and personally (core values,) and embracing an attitude of growth and empowerment through service (servant leadership.) We explore perspectives of each of these areas crucial to the development and fostering of leadership roles.

Managing vs Leading

“The role of a leader is not to come up with all the great ideas...but to create an environment in which great ideas can happen.”
– Simon Sinek

Being a woman manager or leader brings unique perspectives, challenges, and opportunities. How do we navigate the cultural and historical waters when women have not traditionally been in leadership positions for so long? How do we forge forward to lay down the foundation of our own terrain for our island of strength and fortitude in the shifting landscape of leadership in medicine? Managing and leading are synonyms of each other, yet distinct, as some managers do not exercise leadership, and some may be leaders without having any management positions. Both involve effecting others to achieve set goals. Management, though, nominally consists of controlling a group or set of entities to accomplish a goal, while leadership refers to an individual's ability to impact, motivate, and enable others to contribute toward organizational success. Influence and inspiration separate leaders from managers. Managers often work from a perspective within the system or organization, whereas leaders focus on prioritizing resources and usually operate from the viewpoint of the entire system. Leaders can empower their team and inspire the desire to reach a goal, but without a manager in place to direct staff, they are unlikely to reach that goal. Managers can be essential during crises or emergencies; they set deadlines, create order, establish rules and solve problems. Leaders are crucial during creative discussions; they introduce strategic approaches, inspire behaviors, encourage commitment, and consider strengths of each team member. Leading or managing may not be mutually exclusive. Both leadership and management can be equally important and synergistic for productivity within the workplace. To be an effective leader, though, one must explore their own core values as foundations to inspire managers who will then inspire the team.

Core Values

“Core values are the heartbeat to your ‘why’.”
– Shi Chen
A core thread that ties together why we are compelled to be women leaders must be rooted in the intrinsic values that we build the foundation of our Themyscira on – the pillars of our community to help those that we lead and those that we serve, reflecting “The Golden Rule,” the moral and guiding principles of treating others as one would like to be treated themselves. Individual core values will differ and flex in their prioritization, but the spectrum of these core values are ingrained with self-respect, pride, confidence, and self-awareness in knowing one’s skills, abilities, talents, and experiences and the worth they engender. These core values must be continuously developed. Other core values of being an effective woman leader include cultivating competency and achievement as well as balancing wisdom and humility. One must know when to remain in an observational role, when to speak up, and when to take a step back. Admitting one’s mistakes and learning from them are a natural part of personal and professional development. However, reflecting on those experiences and then utilizing and cultivating lessons learned to the benefit of others further fosters mutual growth and teamwork, which women leaders emphasize. Similarly, a leader should invite collaboration and clear effective communication as core expectations, both within themselves and amongst others, to motivate and inspire both community and autonomy simultaneously.

We highlighted just a few but there are many other core values (Figure 1) that one may have and at different settings. Furthermore, one should reflect on one’s values frequently to be an effective leader, especially a servant leader.
Servant leadership

“...It begins with a natural feeling that one wants to serve...as opposed to wanting power, influence, fame or wealth.”

- Robert K. Greenleaf

What makes a good leader? Confidence and power? Sensitivity to employees' needs? Attention to diversity and inclusion? No leader can do it all. But in health care, a field that is rife with uncertainty and challenge, a woman leader must be sensitive to both the rapidly changing environment and the needs of all stakeholders. An effective leader must be able to balance attention to immediate concerns while also investing in the system that meets those concerns. This means investing in the people that make up the system and their well-being, in addition to prioritizing customer satisfaction and the bottom line.

To borrow from the principles of servant leadership, a leader who helps employees to discern their unique contributions to the mission of the organization, who upends the hierarchy by allocating power broadly, and who is a servant first and a leader second is a “servant leader.” This means a leader who knows what it is like to be in the trenches and makes decisions based on the experiences and needs of those with boots on the ground. Servant leadership requires expressing authentic humility, leading by moral authority, creating the environment for the development of more servant leaders at all levels, and making concern for the professional growth of all employees a priority. These are the traits which women tend to exemplify. By investing in individuals, we can create a culture that feels more equitable and imbues a sense of belonging, regardless of power or status within the organization. In medicine, where the oppressive and often patriarchal hierarchy is ubiquitous, we must demand this approach to leadership to move towards a workplace that is more equitable and just.9

Mentorship vs Sponsorship

“While a mentor is someone who has knowledge and will share it with you, a sponsor is a person who has power and will use it for you.”

- Herminia Ibarra

The principles of mentorship and sponsorship are key elements for leadership and are particularly important for women in leadership to create a culture where women elevate each other. Effective physician leaders recognize that mentorship and sponsorship are critical to their employees’ career advancement in an equitable fashion.10 While mentorship may involve a mentor’s private time, advice, and support, sponsorship involves the sponsor’s public use of connections and leverage to catapult a protegee’s career toward leadership. While mentorship programs are more easily embraced by leadership, formal sponsorship programs may be more challenging to implement as they may require one to publicly recognize someone with whom one has not yet built a trusting relationship. Replacing the binary constructs of mentorship and sponsorship with a continuum from mentorship to sponsorship roles offers leaders a potentially more organic model toward sponsorship. In this regard, a leader may serve in an evolving continuum of private to public roles for an employee from mentor (coach and advise) to strategist (share “insider information” about advancement) to connector (make relationships with influential people) to opportunity giver (provide a high-visibility opportunity) and finally to advocate (publicly advocate for a promotion).11

Using the principles of core values and servant leadership, a woman leader may create an equitable and just culture in which leaders at all levels strive to advance their employees through this continuum from mentorship to sponsorship.

Conclusion

“So, I stay, I fight, and I give, for the world I know it can be.”

- Wonder Woman12
Being a Woman Leader: Reimagining “Themyscira” in Child Psychiatry

Women must be true to their core values that will guide them to be a servant leader who can then mentor others. Mentorship and/or sponsorship is a life-long experience that can also make us accountable to be an effective leader. Women in leadership need to be warriors in the changing landscape of child psychiatry as a catalyst to mold and shape a new and re-imagined Themyscira, a professional home evolving to fit the needs of our patients, our colleagues and teams, our students and trainees, our communities and ourselves.

Take Home Summary
Women face many challenges in becoming leaders within child psychiatry, but can also contribute in unique ways, including leading by empowerment, self-respect and awareness, servant leadership as core values, amongst many others. The world and the landscape of child psychiatry are ever evolving, and women as leaders can play a critical part in its growth by celebrating and strategically utilizing those unique perspectives and skills.

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

Phoebe Hua, MD, Valentina Park, MD, Sumedha R. Sinha, MD, Mariam Rahmani, MD, Christina T. Khan, MD, PhD, Misty C. Richards, MD, MS, Aditi Hajirnis, MD

“Diversity is being asked to the party. Inclusion is being asked to dance.”
– Verna Myers, American activist

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

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

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

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

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

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

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

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

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<th>Table 1: Tips to Promote Diversity, Equity, and Inclusion (DEI) in the Workplace</th>
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| **Individual** | ■ Be aware of implicit bias  
|                 | ■ Learn to manage implicit bias  
|                 | ■ Evaluate people based on their personal characteristics rather than those of the group they belong to |
| **Institution** | ■ Create a culture by making DEI initiatives integral to the mission and goals of the organization.  
|                 | ■ Inclusivity on committees from all disciplines  
|                 | ■ Standardize outcomes for hiring and promoting |
| **School and community** | ■ Create mentorship programs  
|                         | ■ Integrate DEI series in curriculum  
|                         | ■ Recruit and retain diverse leadership and faculty |
women and those underrepresented in medicine. This commitment can also translate into their recruitment of students, development of curriculum, and support groups within the school.

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

**Take Home Summary**

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

**References**

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Addressing Implicit Bias in Child and Adolescent Psychiatry

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

“I don’t want to hear her talk anymore, her voice is so annoying. Let HIM talk!”

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

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

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

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

We must recognize that both our individual and institutional difficulties with bias ultimately impact how we operate our organizations and provide patient care. While our opening anecdote explored how gender may influence the way patients see providers, it is even more crucial for clinicians to understand how our biases affect how we see and treat patients. Literature suggests that neurodevelopmental disorders like attention-deficit/hyperactivity disorder (ADHD) and autism are more likely to be missed in girls,5 but meanwhile disorders
like borderline personality may be underdiagnosed in boys. While the cause of these discrepancies is multifactorial, unchecked bias increases the risk of misinterpreting and undertreating important patient symptoms and behaviors.

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

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

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

Take Home Summary

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

References


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Considerations for the Future: Family Planning and Infertility During Psychiatry Training

Reid J. Mergler, MD, Nancy R. McGinley, MD, MPH, Elizabeth McGuire MD, Christina T. Khan MD, PhD

During medical school, residency, or fellowship, many trainees struggle to find balance between their careers and starting a family. While some may feel the optimal time for parenthood is after they’ve completed their training, the effect of increasing age on fertility is a real consideration for female physicians. Several studies have explored the impact of pregnancy during surgical residency, yet little has been published on parenthood during psychiatry training. This is surprising as psychiatry residents often address the challenges of integrating work and parenthood with their patients, yet it has not traditionally been within the culture of medicine to openly discuss this with colleagues. It is critical to address pregnancy and parenthood routinely during training and in the literature to reiterate the importance of work-life integration. In this paper, we discuss current practices for psychiatry residents and advocate for the development of a standardized policy across psychiatry training programs that covers multiple aspects of childbearing including maternal mental health, family leave, and infertility.

Impact of Pregnancy on Medical Training

A medical residency is especially arduous, with ongoing physical and emotional demands. As most programs rely on residents to provide a significant portion of patient care across numerous specialties, a pregnancy can lead to dilemmas for the program with changes in workload and expectations on other residents. In 1992, 58 psychiatry residents responded to a questionnaire regarding pregnancy during residency. The male residents were more likely to expect personal inconvenience from a coresident’s pregnancy and to assume it would hinder their own work performance. However, the female residents overestimated the negativity from male coresidents and underestimated the level of supportive accommodations their colleagues would be willing to provide. To our knowledge, these attitudes have not been readdressed in the literature for the past 30 years.

Rangel et al. explored the obstacles of pregnancy during a surgical residency. Most residents had no modifications to their work schedules until birth yet worried the lack of modifications negatively affected their health or the health of their baby. Even though psychiatry residents do not work in operating rooms, the intensity of their call schedules and safety of the psychiatric ward must be considered. The psychiatry resident may recognize their own feelings of vulnerability in clinical settings and possible guilt due to work absences. Additionally, pregnancy may impact the therapeutic alliance; for the patient, the physician’s pregnancy may lead to heightened maternal transference, infantile feelings, and possible sexual conflicts. Navigating the reactions of both the physician and the patient can be a meaningful part of the patient’s therapy.

Family Leave Policies

The policies for family leave during medical training are complicated and often program-specific. Magudia et al. studied the policies for childbearing and family leave for residents in multiple specialties at 15 training institutions. Though policies differed among hospitals, the average of 6.6 weeks leave for residents contrasted with policies for faculty members (8.6 weeks) and with the federal law endorsed by the American Academy of Pediatrics (12 weeks).

The American Board of Psychiatry and Neurology (ABPN) has its own leave of absence policy, recently updated in 2022. All training programs must allow at least 4 weeks of leave annually, including vacation and sick days. Programs must allow at least 6 weeks of leave for parental, caregiver, or medical issues at least once during a resident’s 4 years of training, yet
this cannot exhaust all other allowed leave or extend training. Therefore, if residents need to take more time than allotted for parental leave, they might consider unpaid leave through the Family and Medical Leave Act (FMLA). While FMLA is a national policy, many residents do not qualify due to its stringent criteria.

Family leave policies are heterogenous across all psychiatry training programs. Developing more standardized policies that align with national goals and interests would help residents’ well-being and childbearing experiences. We believe that there would be a greater psychological toll for residents if not given enough time to recover during the postpartum period; residents may have increased anxiety and depression, which can impact mother-infant bonding.

**Infertility Services for the Psychiatry Resident**

Resident physicians may be at higher risk of infertility and pregnancy complications given older age, night shifts, and prolonged hours. A 2021 national survey among female surgeons revealed a 42% rate of pregnancy loss, more than twice that of the general population. Additionally, a 2016 study of 327 female physicians across multiple specialties demonstrated an infertility rate of 24.1%, nearly double that of the general female population. The survey indicated that 28.6% of these physicians would have tried to conceive earlier, 17.1% would have chosen a different specialty, and 7.0% would have used cryopreservation to extend fertility. Respondents were further subdivided based on those in “controllable” lifestyle (ie, better work-life balance) specialties, such as psychiatry, vs “uncontrollable” lifestyle specialties, such as general surgery. Notably, a statistically significant number of physicians in controllable specialties (18.2%) reported that in hindsight, they would have used cryopreservation to extend their fertility.

Infertility care is expensive, and for many physician trainees, prohibitively so. Based on 2018 national data, 76-89% of medical school graduates have educational debt, with an average debt of $215,900 for medical school alone. Types of fertility treatments are numerous and require meticulous tailoring to the specific needs of each woman. This is further complicated by a lack of universal insurance coverage for fertility services. A recent study by Muncey et al. analyzed 24 training programs and found only 16 covered costs, to varying degrees, related to the diagnosis of infertility. Of these, only 10 provided coverage for treatment, with the amount of coverage differing widely among programs. Notably, even amongst the programs with coverage options, nearly all have strict “lifetime maximum” caps below the average cost of one standard infertility treatment cycle. Thus, even with insurance, the cost of infertility services may still be prohibitive, particularly for women who require multiple cycles.

It is also unclear based on the literature how much medical insurance covers to care for the emotional toll of infertility. Though the relationship between emotional stress and infertility has been well documented, helping couples handle stressors is not traditionally included as part of infertility care. Initially, the most prevalent issue is anxiety, yet depression is seen in the second and third years of infertility due to the inability to conceive. Thus, attention must be given to psychiatric services, particularly to those dealing with infertility during residency.

**Need for Parity Across Psychiatry Training Programs**

In light of this information, we propose a unified approach to policies around maternal mental health, family leave, and infertility services. Respecting the integral role of family in work-life integration would reduce risk of burnout among trainees. By allowing conversations to occur early in residency about pregnancy planning, it may reduce the stigma that female physicians feel when starting families. Instead of colleagues viewing a resident’s pregnancy as an inconvenience, it is critical to provide a supportive environment. Additionally, trainees’ supervisors can help address the changes in patient-physician dynamics during pregnancy.

We also hope for more practical family leave policies that are aligned with federal laws for other employees. This would help alleviate some of the financial and emotional burden that falls on physician trainees who are also new
parents. Lastly, infertility is burdensome with physical and psychological complications, and residents should feel supported if they choose to undergo assisted reproductive technology.

**Take Home Summary**

Many psychiatry trainees face challenges when balancing their careers and starting families. Aspects of childbearing including maternal mental health, family leave, and infertility should be addressed on a local and national level in order to alleviate the burden on physicians.

**References**

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2019/2020 ADVOCACY AND COLLABORATION GRANT

Opportunities to engage with legislators directly is critical to successful advocacy efforts. At all levels, local, state, and federal, legislation relating to cannabis use are rapidly being pushed through the voting process. I wanted to provide education, but I faced several challenges along the way. Finding a legislator to make time to discuss the opportunity was the first challenge, and finding another to sponsor the event was the next. Ultimately, these proved too great in the first year and I reapplied the following year. After securing a sponsor, date, and time, the Pandemic changed plans for everyone. Undeterred, plans to secure a new event are underway again. In this, as in all things, resilience is key.

2019 AACAP EDUCATIONAL OUTREACH PROGRAM (EOP) FOR CHILD AND ADOLESCENT PSYCHIATRY RESIDENTS

The EOP experience provided the basis for my appreciation of the mentorship and sponsorship provided by AACAP members. I was able to form lasting and meaningful relationships that truly impacted my approach during my CAP interview process, my committee involvement, and the overall direction of my career. I am forever indebted to the mentors in my life.

2019 RESIDENT SCHOLAR FELLOWSHIP

The Resident Scholar Fellowship provided me with insight that is truly invaluable. Working directly with AACAP’s Government Affairs staff was educational and the experiences interacting with legislators was truly awesome. I was able to personally meet with more than twenty Congressional offices and more than five Congress Members. It was one of the most memorable and impactful training opportunities that I was fortunate to attend. If others need help developing rotational core goals and objectives to help with their application, just reach out!

COMMITTEE WORK

Committee work embodies the heart of the mission statement of AACAP, providing meaningful work products for our members, children, and families. The work has been enriching, and the welcomed approach from all members to my voice as a member-in-training was tremendous. My time representing trainee interests and building the Ambassador Program to include all-day access to Assembly Meeting has been a mission of mine that I am proud to have accomplished during my term as the AACAP Assembly Resident Representative. I continue to learn and grow at every committee meeting.

MENTORING/WORKFORCE IMPACT

As a mentee, I was pleasantly surprised at the openness and sincere desire of mentors who provided guidance at the Annual Meeting mentorship events. Information shared improved my ability to interview at the fellowship level and beyond. Recently, I had the great honor and truly amazing experience of paying it forward as a mentor, in gratitude to the many people that have inspired and mentored my career along the way at AACAP.

Visit [www.aacap.org/awards](http://www.aacap.org/awards) to discover available award opportunities!
The Impact of COVID-19 on Women: Highlighting Vulnerabilities and Opportunities

Kimberly Lowder, MD, Desiree Shapiro MD, Misty C. Richards, MD, MS

“Investing in Women means investing in the people who invest in everyone else.”
– Melinda Gates¹

The COVID-19 pandemic disrupted life at home, school, work, and in our community. These disruptions threatened both personal and professional safety and stability. Women were particularly impacted by the global pandemic, as it amplified existing social, economic, and health inequities. In this article, we highlight unique and concerning challenges for women, with a focus on female child and adolescent psychiatrists.

Risk of Burnout
Women are cornerstones of the healthcare industry, holding an astounding 78% of all hospital jobs and 70% of pharmacy jobs, and comprising up to 70% of the healthcare workforce globally.² The pandemic led to higher reported rates of burnout in female healthcare professionals as they absorbed increased case-loads, worked extended hours, and experienced lack of control over their schedules in order to maintain quality patient care.³ Additionally, throughout this process, women caring directly for patients with COVID-19 were exposed to a higher rate of secondary trauma that further impeded their ability to serve as effective healthcare providers.⁴ Career sustainability and longevity have been placed in jeopardy with the increased roles and responsibilities women acquired during the pandemic.

Within the field of child and adolescent psychiatry, 54% of providers are women.⁵ Despite female child and adolescent psychiatrists comprising the majority of the workforce, there are substantial disparities in leadership positions.⁶ Similar to the trend in other academic medicine specialties, a pipeline problem exists in which there are more women in junior faculty roles and significantly less in senior faculty or senior leadership positions.⁶ Women reach their professional ceiling quickly and continue to take on more responsibilities without advancements in their compensation or title. A multitude of factors may contribute to this phenomenon including inadequate mentorship, limited presence of senior role models, and domestic responsibilities outside of medicine. Even prior to the pandemic, female child and adolescent psychiatrists were already concerned about burnout, feeling undervalued, and contemplating career changes.⁷ Throughout the pandemic, practicing child and adolescent psychiatrists and trainees have flexibly navigated challenges—stepping into new roles covering different services, supporting other medical teams, caring for surges of patients, and transitioning to virtual platforms. All of these adjustments and accommodations come with risk. Leaning in and investing emotional energy and empathy may in fact be a driving force of the compassion fatigue many are experiencing, especially women.⁸ There is significant risk of burnout with this model, which can ultimately impact patient care, relationships with colleagues, and the individuals’ own physical and mental health.

Negative Impact on Financial Security
Evidence suggests that women’s economic health and productivity were disproportionately affected compared to men during the pandemic.⁹ On average, pre-pandemic, women in general spent three times as many hours in unpaid dependent/family care and domestic work than their male counterparts.³ During COVID-19, this unequal division of labor intensified, with homeschooing and caring for ill family members adding to the typical workday. Alarmingly, many women were forced to reduce their work hours or leave the workplace altogether in order to fulfill their growing duties at home.¹⁰
According to the US Census Bureau, 1.4 million mothers of school-age children left the workforce from March 2020 to March 2021. For many women, work is not only about revenue; it provides a community, purpose, and pride. Leaving the workplace meant losing connections and a part of one's identity. Some women who remained primarily active in the workforce still required extended leaves to attend to personal matters. These absences may incur long lasting impacts on financial security in the form of career growth, leadership positions, and retirement assets. This is particularly troublesome when women, on average, earn less, save less, and hold less secure employment in an economic downturn.

### Challenges With Work-Life Integration

In the personal lives of many child and adolescent psychiatrists during the pandemic, there was no shortage of additional duties and responsibilities. For child and adolescent psychiatrists with children of their own, balancing the needs of patient care with family obligations was a daunting challenge. Rather than a blissful blend of work and home life, many felt the fierce competition between personal and professional domains. Many children saw their child and adolescent psychiatrist mothers rush from making dinner to a late-night Zoom meeting or responding to work texts during story time. Groceries arrived while dogs barked, and children barged into the background of important meetings or sessions. Schedules were in constant and tumultuous readjustment. Modeling mindfulness was missing in many households with children witnessing blurry boundaries. Many female child and adolescent psychiatrists navigated these challenges alone, not wanting to burden their leadership with the realities of their home lives.

On a larger scale, the stress of the pandemic pressurized conditions and relationships in homes across the country. As schools, businesses and community centers began to shut their doors, most people retreated to their homes seeking safety and solace. Pandemic-related stress seeped into households increasing the likelihood of intimate partner violence, leaving some women at higher risk for abuse or harassment. Now forced to “lockdown” at home with their abusers, many women struggled to find resources including hotlines, crisis centers, shelters, legal aid, protection, and counseling. Furthermore, reports of child abuse followed suit, which may be a reflection of saturated emotional reserve, increased alcohol consumption, and utilization of more primitive methods of discipline including physical violence resulting from the frustration of confinement.

### Opportunity for Restructuring and Growth

We must prepare our child and adolescent psychiatrist workforce to meet the demands of a healing post-pandemic world that has weathered the storm of loss, emotional anguish, and uncertainty. A recent study estimated that more than 140,000 children in the United States lost a parent or caregiver to COVID-19. Mental health needs have surged without a matching growth in our workforce. While children’s mental health-related emergency department visits decreased from early March through May, thought to coincide with implementation of widespread lock-down measures, visits began to steadily increase with an average proportion of children’s mental health-related emergency department visits increasing by approximately 44% by the end of 2020. As the call for increasing numbers of trained child and adolescent psychiatrists continues, we hope to be ready to offer the services in dire demand.

COVID-19 reshaped life as we once knew it, exacerbating existing inequities and posing unique challenges for women across the country. Addressing the pressurized financial, physical, and emotional vulnerabilities during the pandemic is essential when considering women’s unique needs. In re-calibrating the role of female child and adolescent psychiatrists as we enter a new COVID-19 era, it is critical that women are supported and represented. A seat at senior leadership tables where decisions are made may help others to recognize the enormity of contributions women make and help reimagine work-life integration to promote fulfilling careers. Especially during times of crisis like the COVID pandemic, our organizations need women’s voices to generate innovative and inclusive solutions. In the workplace, home, and in our systems, we call on...
women to share their creative solutions for change. In front of us is the possibility to disrupt gender stereotypes, change transitional narratives, and reshape policies and practices long overdue for change. Deliberate inclusion of women in leadership roles and the acknowledgement of the experiences women faced throughout this pandemic may lead to flexible and family-friendly policies paired with increased support for women. Our hope is for a more sustainable, gender-equitable future in the COVID-19 era and beyond.

Take Home Summary
The impact of the COVID-19 pandemic amplified and highlighted existing inequalities women face including risk of burnout, financial security, and challenges of work-life integration. Women must be supported and represented in challenging gender norms, reshaping policies that prioritize women's needs, including a global shift in flexible work arrangements, and achieving equity in the workplace. Women leaders are essential in leadership roles to restructure and grow a more sustainable, resilient, gender inclusive future.

References
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Connect Corner: A Review of My Own Facebook Feed

Paula Wadell, MD

I don’t spend that much time on Facebook and frequently consider deleting it. However, there is one thing that keeps me there: the moms’ groups. I belong to several; the most powerful and important one being my neighborhood group. This group linked me to other mothers when my family moved to the neighborhood, which in turn linked my children to friends. The families we connected with as a result created a village that supports my children and contribute significantly to our family’s happiness. We gained access to childcare opportunities, sports, extracurricular activities, and fun weekend outings. This is arguably Facebook at its best: a fun way to build social connection.

Yet there is another side to Facebook, and we know from studies of wellbeing and social media use that a negative correlation appears to be present. I realized that I needed to ask myself how my Facebook feed could be harming my wellbeing. I thought back to the last post I read in one of my local mothers’ groups. The author asked for tips on how to fit in 1 hour of exercise per day, as instructed by her doctor. She posted her schedule which clearly showed she is working full time and caring for 2 young children. I looked at her schedule and immediately knew the answer: she can’t. Her life does not create a situation in which she can choose to be well. This seemed quite obvious to me, but the 34 replies were quite different. Many suggested she wake up extremely early to get this done, thereby sacrificing sleep. Others suggested she cram in YouTube fitness videos and sets of squats during her workday. The metamessage is: you just find a way to squeeze more in because true wellness is impossible. As I reflected on this idea, I realized it was everywhere, accentuated by the pandemic. If you google the phrase “working parent” the internet answers with all sorts of gems like “the parental shame that haunts working parents” and “what if it never gets easier to be a working parent” and “what America asks of working parents is impossible.” For the purposes of this commentary, the content of these articles does not matter (and I did not read any of them because they sounded depressing). The metamessage for me is that balancing work and parenting in a fulfilling way is hopeless, and wellness is a fantasy. Everyone posts about the impossible pressure they feel, and this becomes the expectation we all have for our lives. To be a working mother is to live in an impossible pressure cooker. This message echoes and reverberates throughout my Facebook feed, confirming that achieving any sort of wellness is beyond reach, and the result is: I continue to work full time, parent 2 young children, neglect my own wellness, feel badly about that, and accept the fact that this is just how it must be.

The seeds of this idea probably started very early on as part of the American ideal of productivity. As a young girl I learned that I was expected to have a career, an expectation I whole-heartedly wanted. I loved school, and it’s no surprise I chose to go to medical school. Yet, in medical school, I learned how health can be achieved, while I also learned that such a thing would not be possible for myself. Doctors routinely laughed at how unwell they were. So much so that the message became “to be a good doctor, one sacrifices their own wellness.” This was made particularly obvious to me during my internal medicine clerkship, when my intern proudly shared how he rounded while ill with gastroenteritis. To make it through the day, he just hooked himself up to an IV he could pull around. Those around him congratulated him on his commitment; I was quietly horrified.

In psychiatry I found colleagues who seemed to have some awareness of wellness and its importance, but we are swimming upstream. Our world has set up a system of expectations for all of us, in particular for mothers, where we accept the idea that being well is forever out of reach.
Before attending medical school, I worked at the CDC during a time when there was growing alarm at the increasing rates of type 2 diabetes in children. I saw a grand rounds presentation where the public health presenter showed the many factors that were contributing to the increasing rates: diminishing opportunities for physical activity, the abundance of processed foods, the relative expense of health foods. He argued that we had created a world in which health could not be obtained for the average American and we have a responsibility to create an environment where one could choose to be healthy. I will add that as a physician and mother, I feel a call to push for change that leads to an environment where we can choose to be well. Part of that choice involves recognizing the voices that normalize (and sometimes elevate) being unwell. My review of my own Facebook feed must therefore conclude that it is ultimately harmful as it encourages me to accept a lifetime of being unwell. I don’t feel that I can or need to delete it because it is still a significant connection tool for my children, but I can limit my engagement with it even more and I can be a voice for change. With small steps, we can create an environment that supports real self-care and realistic expectations of ourselves and others.

Reference

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Julian’s younger sister, Jessica, was sexually abused by her mother’s boyfriend multiple times between the ages of 5-7 years old. While she was in protective custody through Child Protective Services, she received mental health counseling to address depression and trauma symptoms, and many of her symptoms stabilized by the time she reunified with her mother. However, at age 13, Jessica had an argument with her mother and ran away from home. She returned a week later with a new, older boyfriend, who had a known criminal history. She began using drugs, skipping school, and running away frequently. Eventually, she was detained for theft. While in custody, it was learned that she was a victim of commercial sexual exploitation. Additionally, she was found to be 14 weeks pregnant.

In 1980, girls were 4 times less likely to be arrested than boys. During the 1990s, a surge of juvenile arrests gained national attention, with the arrest rate for girls increasing faster than the arrest rate for boys. In response to this increase, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) convened the Girls Study Group in 2004 to better understand girls involvement in delinquency. Prior to 2004, much of the research and programming had focused on boys, as boys have always accounted for the majority of youth arrests. Amongst their findings, the study group attributed the arrest rate gender disparity to mandatory and pro-arrest policies which more strongly affected the likelihood of arrest for girls than boys.

While juvenile arrests have declined since peaking in 1997, girls still comprise a significant proportion of juvenile justice-involved youth. In 2019, girls accounted for 31% of juvenile arrests (33% of juvenile Property Crime Index arrests and 21% of juvenile violent crime arrests). The female share was higher for certain offenses, including girls arrested for prostitution and commercialized vice (71%), liquor law violations (42%), larceny-theft (40%), simple assault (38%), and disorderly conduct (37%). Nearly two-thirds of female juvenile arrests in 2019 involved girls age 15 or older. Racially minoritized girls accounted for 62.1% of detained girls in 2019.

**Intersectionality Within Juvenile Justice Involvement**

Juvenile justice outcomes can be affected by the intersection of race and gender. A study examining the impact of race on severity of disposition in juvenile girls referred to the Florida Department of Juvenile Justice found that with the exception of Hispanic girls, minoritized female youth received more punitive dispositions as compared to White girls, but only up to a certain point of offense severity. Historically, White women have been characterized as feminine, fragile, and law abiding; Black women as masculine, aggressive, and hypersexual; and Hispanic women as hypersexual but family-centered and domestic. These stereotypes likely impact girls in juvenile justice. In the Florida study, White girls whose offenses and criminal histories violated acceptable behavioral expectations for White women, received comparable punitive dispositions as minoritized youth. In a study of 174 juvenile girls in Arizona, court officials acted with more leniency towards Hispanic girls they perceived as more Americanized or who were from English-speaking families.

The impact of racism and sexism, as well as intersectionality of multiple systems of oppression further impacting the individual, undergirds girls involvement in juvenile justice. This intersectionality is reflected in numerous health disparities, vulnerabilities, and specific needs of juvenile justice-involved girls. For example, some risk factors associated with juvenile justice involvement are more salient for girls (eg, maltreatment, caregiver transitions, runaway history, older male friends and partners). Further, there are notable mental health disparities between juvenile justice-involved
boys and girls. Girls are more likely than boys to have a mental health disorder. Juvenile justice-involved girls are also at increased risk for co-occurring substance use and physical health problems when compared with the general population. These gender and racial disparities must be examined through an understanding of the complex and intersecting factors that lead to inequity within the multiple systems of which these girls are involved. Ultimately, the juvenile justice system more severely criminalizes girls compared with boys for their social, economic, and psychological vulnerabilities. Minoritized girls are disproportionately at the forefront of these vulnerabilities, thus increasing their risk of offending and juvenile justice involvement.

Juvenile Justice-Involved Girls and Trauma

The prevalence of trauma exposure and juvenile justice involvement is well documented. The gender differences in the types of traumas experienced by youth warrants further attention. A study of 898 juvenile detainees found that 92.5% of juveniles had experienced one or more traumas, with substantially more females than males reporting being “forced to do something sexual that you did not want to do.” In a study of over 1,300 detained youth, girls were more likely to report being victims of family violence and sexual abuse, while boys were more likely to report experiencing violence in the community.

One type of trauma disproportionately associated with female youth in the juvenile justice system involves commercial sexual exploitation (CSE). Federal law makes it a federal offense to “knowingly recruit, entice, harbor, transport, provide, obtain, or maintain a minor (defined as someone under 18 years of age) knowing or in reckless disregard of the fact that the victim is a minor and would be caused to engage in a commercial sex act.” Any minor who is induced to perform a commercial sex act is considered a victim. There is little valid and reliable data demonstrating the prevalence of CSE in the US; however, girls who are victims of CSE are overrepresented in the juvenile justice system. Youth are often arrested and adjudicated on CSE-related charges (masking charges) such as loitering, violating curfew, running away, truancy, possessing alcohol as a minor, providing law enforcement with false identification, or other status offenses. The majority of youths identified as victims of CSE are cisgender girls and women; however, girls of color and LGBTQ youth are also at a heightened risk of CSE. In a US based juvenile delinquency specialty court for youth affected by CSE in Los Angeles County, youth participants were almost exclusively minoritized female youth. In a study of 51 minoritized transgender females aged 16-25, 59% reported sex in exchange for money, drugs or shelter in their lifetimes.

Recent “Safe Harbor” legislation is an attempt to decriminalize youth victims of CSE and divert them to specialized services. Yet, many youth victims of CSE continue to be arrested and detained on criminal charges for masking charges linked to CSE. Improved screening of all youth in juvenile detention for CSE is critical. Prevention of CSE is the ultimate goal. However, for youth who have survived CSE, decriminalization and alternatives to incarceration including transdisciplinary services and social support are needed to shift from punishment and criminalization to rehabilitation.

Pathways Forward for Juvenile Justice-Involved Girls

For most female juvenile offenders, similar to their male counterparts, criminal behavior ceases as they transition from adolescence to adulthood. Cauffman, Monahan, and Thomas (2015) studied the 178 female participants of the Pathways to Desistance study, a longitudinal study of serious juvenile offenders. They found that only 6.7% of females persistently offended at a high rate by adulthood (age 25), similar to the 7.5% of the total 1,354 participants that were labeled “persistent offenders” in the larger study. Compared to female offenders who desisted prior to adulthood, female offenders who continued offending past adulthood had a greater lifetime exposure to violence and abuse, experienced more adversarial interpersonal relationships, and were more likely to have a mental health diagnosis. The high rate of direct exposure to violence among the persistent female offenders suggests that
treatment should be targeted toward addressing experiences of victimization.

Because males have always accounted for the majority of youth involved in the juvenile justice system, policies and programming were historically developed to address the needs of males. However, evidence-based practice (EBP) targeting general delinquency risks and needs (e.g., multisystemic therapy, functional family therapy, multidimensional family therapy, Treatment Foster Care Oregon (TFCO)) are effective for girls and boys.7 Additionally, the unique vulnerabilities and needs of girls should be considered. Given robust evidence-based treatments available for trauma and other mental health disorders, such treatments must be highly prioritized, available, and accessible to juvenile justice-involved youth.

For Jessica, her entry into the juvenile justice system is tragic yet too common given her risk. It is also a critical intervention point. Aggressive efforts are needed now to address recurrent trauma and mental health symptoms as well as her subsequent substance use and delinquency. Early pregnancy, which is more common in justice-involved female youth, carries additional risks which further perpetuate the cycle of justice system involvement.7 Juvenile justice-involved girls who become mothers are at increased risk for child welfare system involvement as maltreatment perpetrators, and this risk is more pronounced in girls versus boys.7 Thus, interventions should target not only Jessica’s mental health and well-being to reduce recidivism risk, but also, if she chooses to become a young parent, should target maltreatment prevention through evidence-based interventions, while more broadly addressing the underlying structural factors that perpetuate ongoing gender and racial inequity. Interventions must be considered within the context of intersectionality,18 and the more clinicians use an intersectional approach, the more adept we all become in providing more attuned treatment and advocating for systemic change.

**Take Home Summary**

Girls in the juvenile justice system are some of the most vulnerable youth in our communities. Girls with history of sexual trauma carry additional risks related to reproductive health. Clinicians should understand how juvenile justice outcomes can be affected by the intersection of race and gender. Structural and individual interventions must focus on decriminalizing and treating trauma-related behaviors.

**References**

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