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EDITORIAL

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The February 2021 issue of *Academic Psychiatry* features a special collection of articles on diversity, equity, and inclusion [1]. This collection stems from a symposium by the American Psychiatric Association (APA) and the American Association of Directors of Psychiatric Residency Training (AADPRT) held at the APA Annual Meeting in May 2019, which, in turn, rose from AADPRT President Donna Sudak's presidential initiative on diversity, equity, and inclusion. Titled "Creating a Culture of Diversity and Inclusion in the Clinical Learning Environment," the symposium described the roles of residents and fellows, training programs, departments, institutions, and leaders of national organizations in contributing to a culture of diversity, equity, and inclusion in psychiatry and psychiatry training. The opening presenter, then APA President Altha Stewart, urged the symposium chair to "write this all up," and so this special issue had its genesis.

What people in the USA have experienced between May 2019 and today has been well documented in the media and will be part of US history forever: the killings of George Floyd, Breonna Taylor, and others by police highlighted the systemic racism in policing and justice systems; the COVID-19 pandemic magnified the health care inequities across the USA along racial and socioeconomic lines; the US President, who had told congressional people of color to "go back where [they came] from" issued an executive order forbidding the teaching of anti-racism by government-funded entities. These events, and more, heightened the outrage at racial injustice across the USA. Black Lives Matter grew as a social force. Books like *White Fragility* [2] and *How to Be an Anti-Racist* [3] flew off the shelves of stores and libraries. White allies joined Blacks in acknowledging that structural racism—an explicit and implicit system that assigns value and privilege on the basis of skin color, with Whites at the top of the hierarchy receiving unwarranted advantages—has been foundational to the USA.

US institutions, medicine, and psychiatry have inevitably been entangled with these systems. There have been historical instances of overt racism in psychiatric diagnosis (e.g., drapetomania) and implicit racism leading to, for example, overdiagnosis of schizophrenia in Black men [4]. It is widely understood that racism leads to structural disadvantages which worsen outcomes of mental illness in minority communities, including disparities in mental health services that create profound inequities in care. While it is always easier to see the blind spots of the past, it is essential to examine carefully how oppressive social forces like racism, sexism, homophobia, and ableism are currently active in medical centers, hospitals, departments, training programs, and journals. These forces negatively affect some members of the academic community and stakeholders and provide unwarranted advantages to others. It is necessary to understand and dismantle the effects these social forces have in clinical settings, training programs, and research agendas and to engage in repair using a restorative justice framework.

As editors who identify as White, we also underwent a growth in awareness during this time. We found ourselves re-thinking some of our academic conventions and asking many questions, such as How can we best ensure that the voices of different racial, cultural, gender, geographic, and political groups are expressed? What about intersectionality? These questions developed into, Is the direct expression of anger always out of place in scholarly writing, or might it convey an urgent expression of outrage necessary to spur change? Are words such as *oppression* and *liberated space* "too political" for an academic medical journal? In the end, we believe that in order to be maximally impactful, this special collection of articles should encompass a diversity of tone and terminology that reflects the diverse voices and language of those seeking to be heard.

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We write this editorial days after a national election. The outcome of that election will determine, at least in part, the political trajectory of the narrative described earlier. A commitment to growing toward a diverse, equitable, and inclusive learning environment is an *educational* mandate, however, that arises out of professionalism and ethical responsibility to patients, psychiatrists, and the profession. As DeBonis writes in her Faculty Voice perspective piece "Potential Space" [1], "We urge our students and residents to have a growth mindset—to stretch and challenge themselves and reflect and learn from mistakes. As teachers, clinicians, and mentors, we must demand the same of ourselves."

In that spirit, we invite our readers to have an open mind and "growth mindset" as they learn about residents' efforts to dismantle prior myths ("Race, Metaphor, and Myth in Academic Medicine" [1]), create a "liberated space" in which those who are underrepresented in medicine (URM) may thrive ("The Creation of the Minority Housestaff Organization: A Liberated Space for Underrepresented Minority Physicians to Thrive in Medicine" [1]), and find ways to promote resilience, including in intersectional groups such as women trainees of color ("Building Community and Promoting Resilience for Trainees who Identify as Women of Color through an Original, Resident-led Seminar Series" [1]) and international medical graduate (IMG) physicians ("How an 'IMG-Friendly' Program Serving an Immigrant Community Fosters Diversity, Equity, and Inclusion Among Its Residents" [1]).

We invite you to think individually and as a learning community about reconceptualizing the process of application to psychiatric residency and fellowship ("Re-imagining Merit and Representation: Promoting Equity and Reducing Bias in GME through Holistic Review" [1]); whether the future needs of patients will be met by the current psychiatric workforce-in-training, including women ("Women in Academic Medicine: Current Disparities and Promising Solutions" [1]) and physicians from outside the USA ("International Medical Graduate Resident Physicians in Psychiatry: Decreasing Numbers, Geographic Variation, Community Correlations, and Implications"); and how bias might be affecting what we teach ("Racial and Ethnic Considerations Across Child and Adolescent Development" [1]). The published canon of psychiatric literature itself is biased in favor of men ("Promoting Women to Editorial Leadership Positions at *Academic Psychiatry*" [1]). To what extent might this problem also be one of intersectionality, with fewer women *and* fewer URM psychiatrists represented in editorial leadership?

Psychiatric educators need to reflect on how best to teach about health equity ("Equity in Progress: Development of Health Equity Curricula in Three Psychiatry Residency Programs" [1]) and prevent health disparities ("The Time is Now: Teaching Psychiatry Residents to Understand and Respond to Oppression through the Development of The Human Experience Track" [1]). Psychiatric educators need to think about not only *what* they teach but *how* they teach it ("Beyond Diversity and Inclusion: Reparative Justice in Medical Education" [1]). For example, how affirming is one-on-one supervision for diverse supervisors and supervisees? Do programs foster learning cultures where supervisors can be open to accepting their errors with minority trainees and repairing these injuries? How can faculty and staff be educated to be upstanders who call out harassment when they see it in the clinical setting, even when it is perpetrated by patients on trainees?

The value of all the work in education rests on whether patients ultimately receive the care they need and deserve. The impact of training on the equitable care of diverse patients must be considered ("Racial Implicit Associations in Psychiatric Diagnosis, Treatment, and Compliance Expectations" [1]). Does bias affect prescribing patterns by residents ("Racial and Ethnic Differences in Psychiatry Resident Prescribing: A Quality Improvement Education Intervention to Address Health Equity" [1])? How does immigrant experience contribute to mental health ("Immigration as a Social Determinant of Mental Health: Implications for Training and Education in Psychiatry" [1])? Psychiatric educators must think across the life span of patients and include child and adolescent psychiatry fellowship training ("Foundations in Racism: A Novel and Contemporary Curriculum for Child and Adolescent Psychiatry Fellows" [1]).

A recent survey of AADPRT members ("Who We Are Today: A National Survey of Diversity Among Psychiatry Program Directors" [1]) found that two thirds are White (64.45%), followed by Asian/Southeast Asian (17.58%), Hispanic/Latinx (4.3%), Black (1.56%), and Native American, Pacific Islander, and others (0.78%). "We," in other words, are predominantly White and do not reflect current US demographics. If change is to occur, psychiatric educators must listen with empathic curiosity. Patients, if asked, can describe their experience of care. Learners and faculty, if invited, can help educators understand their experience in the learning environment. While listening is fundamental to the reform process, action to transform institutional cultures and support URM trainees is crucial to diversity efforts ("Intentions vs. Experiences: Opening the Door to Fundamental Conversations about Diversity, Intersectionality, and Race" [1]) and sends the message that URM residents and fellows are vital to twenty-first century psychiatry. While allyship between predominantly White psychiatric educators and their URM colleagues can lead to change, promotion of URM educators into leadership positions is critical to this change effort. Admittedly, as noted in the review of the book *Black Mental Health*, "We still have a long way to go," [1] but acting together, we are much more likely to get there.

Declarations

Disclosures On behalf of all authors, the corresponding author states that the authors have no conflicts of interest.

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