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| **THE FEMALE PSYCHIATRIST IN THE 21ST CENTURY: A VISION OF THE FUTURE** |
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**Introduction**

*“Women will have achieved true equality when men share with them the responsibility of bringing up the next generation.”1*

*Ruth Bader Ginsburg*

When future US Supreme Court Justice Ruth Bader Ginsburg studied at Harvard Law School in the 1950s, she was asked by the school’s head how she could ‘justify taking the place of a qualified male’2 . By the time she died on 18th September 2020, aged 87, she was a household name and feminist icon. Following her passing, former US president George W Bush said she had ‘inspired more than one generation of women’3

The 1950s was also the beginning of the psychopharmacological era, which has come to shape modern psychiatric practice4. Therapies existing prior have been rightly criticised, none more so than the frontal lobotomy. An uncomfortable truth not taught enough at medical schools is the majority of patients lobotomized were women, often for symptoms that do not appear, in retrospect, to justify such an extreme solution5. As for female contributions to the history of psychiatry, it could be argued this exists mostly in the stories of women treated by male psychiatrists6. Fortunately this painful past was something we could begin to look back on by 1995, when The Royal College of Psychiatrists set up a special interest group for women and psychiatry, recognising in a formal manner the unique issues faced by both female psychiatrists and patients7.

There can be no doubt of the progress achieved in women’s equality over the last century, both on the global stage and within the field of psychiatry. In this essay however, I will argue change continues to be necessary.

**The Gender Gap**

*“People ask me sometimes… ‘When will there be enough women on the court?’ And my answer is, ‘When there are nine.’ People are shocked, but there’d been nine men, and nobody’s ever raised a question about that.”1*

*Ruth Bader Ginsburg*

In the 1970s, medical school applications became formalised, making it more difficult for universities to discriminate based on race, class or gender8.  As a result, the percentage of women applying increased, and today over half of all medical students in the UK are female9. In 2018, 48% of practicing doctors were women10. When it comes to choosing a speciality, women are recognised to be more attracted to psychiatry (possibly as it is people-oriented)11. While this phenomenal shift in a traditionally male-dominated profession must be recognised, parity in numbers does not mean equal representation.

There remain fewer women in senior managerial roles and academia, both in the UK and globally12. Women also continue to earn less than men (the gap reduces when controlling for factors such as less than full time working and career breaks, though is still present).  In addition more men apply for and are successful in winning clinical excellence awards13.

Only 42.8% of consultant psychiatrists were women in 201714, despite more women than men choosing to train in the field between 1974 and 199915. This puts into doubt the common explanation that as men have historically made up the majority of medical students, women are still in the process of ‘filtering though’ to top positions. When you also consider 50% of medical students were female as far back as the 1990s8, this explanationappears increasingly unlikely, and suggests the present environment continues to contribute to the disparity.

**Female Psychiatrists in Academia**

Academia specifically has been described as a ‘leaky pipeline’ or a ‘sticky floor’, with women at entry level positions outperformed by male colleagues as their career progresses. In 2012 26.3% of clinical academics in the UK were women. While women made up 42.3% of Lecturers, they represented only 30.1% of Senior Lecturers and a mere 15.1% of Professors16.

Publication is a key indicator of academic success, important when applying for research grants or leadership positions. Several studies have examined authorship levels for women in academic psychiatry17-19.  Sußenbacher et al looked at articles from three high impact psychiatry journals to find a significant increase in female authorship from 24.6% in 1994 to 38.9% in 201418.  More recently, Hart et al examined 58,331 articles across 33 psychiatry journals between 2008 to 2018 to find 40% of authors in 2008 and 44.8% in 2018 were female19. These studies provide evidence of an encouraging and sustained increase in parity in academic psychiatry. Despite this, Hart et al also found a lower and slower conversion rate for women to last author19, suggesting ongoing challenges in representation at senior researcher level.

Though not always recognised, gender bias in science affects patients directly. Philosophical bias has been described as an unavoidable one, and is used to recognise the effect the researcher’s individual perspective has on the science they practise20. Some evidence regarding gender bias has been recognised in literature. For example in studies when gender is ignored, findings relevant to male participants can be generalised inappropriately to women. Worryingly, abstracts addressing gender bias (and therefore needed in order to progress further change) have also been shown to receive more negative reviews by male researchers21. Equal representation (though gender is the focus of this essay, this is of course pertinent for race, class, sexuality and disability also) is needed for more than just to ensure that those most proficient are enabled to participate. It is also required in order to focus areas of research, and to undertake projects in a manner that will optimally advance patient care for those in minority groups.

**Can Women Ever ‘Have it All’?**

*"Not a law firm in the entire city of New York would employ me, I struck out on three grounds: I was Jewish, a woman and a mother."22*

*Ruth Bader Ginsburg*

Referencing the ‘leaky pipeline’ metaphor, then where do all the women go? One explanation is increased social and familial responsibilities; culturally more is expected of women in their roles as wives and mothers. Studies in the 1980s-1990s explored the effect this could have on female psychiatrists’ careers23-25.  Robonowitz et al interviewed 24 female academic psychiatrists in 1981. Issues emerged including the expectation a female spouse should and would assume housekeeping and childcare duties, and the reality that they would reduce hours or stop working altogether if needed23. Goldstein et al surveyed 370 male and 68 female psychiatrists, again finding women were more likely to combine home and work responsibilities (men commonly had a stay-at-home spouse). They also found that 20.6% of women would consider their spouse’s career before relocation, compared to only 2.7% of men24.

But is this data relevant to the 21st century? Considering recent evidence shows after the birth of a first child, a father’s wage increases while a mother’s decreases (in what is termed the motherhood penalty) it continues to be exceptionally relevant26. This year Brown et al published a qualitative study interviewing 32 medical students and 9 faculty members, which echoes many of the feelings from the older studies discussed above. They found motherhood was still perceived as an impediment to a medical career, with it triggering negative assumptions in reference to both commitment and ability27.

It is important however to recognise that there have been positive changes. Psychiatry is regarded as a ‘family-friendly’ speciality, and has a positive relationship with less than full time training (indeed introducing it prior to its formal introduction in 1966)28. The vast majority of less than full time (LTFT) trainees are female, more often than not those with children. 11% of trainees are LTFT29, and this has proven to be an excellent way to retain female doctors allowing them to complete their training while balancing other commitments. We must acknowledge that this is not an opportunity women are given in similarly competitive careers, while also continuing to push for positive change. Having consultant representatives for LTFT trainees, and maintaining their visibility (so they are not seen as inferior to full-timers) continues to be important.

Structural concerns continue to be an issue. Only 2% of new fathers take up shared parental leave in the UK30 and only 19% of LTFT trainees are male29. Sußenbacher et al found that Scandinavian countries had the most balanced gender ratio for publications in psychiatry journals in both 2004 and 201418. A possible explanation is pioneering Scandinavian policies to encourage women into the workplace (including generous childcare provision and a father’s use-or-lose quota of parental leave). Can we truly ‘have it all’ until men are able and willing to take up childcare and LTFT? I would argue psychiatrists need to have an awareness of wider policy, and champion changes which encourage equality in our work environments.

**What about our patients?**

*“As long as women are over-represented among mental patients and family caretakers and under-represented among psychiatrists, administrators and politicians, their lives will continue to be unhappily affected by decisions in which they take no part’31.*

*Elaine Showalter*

So how does the current environment affect our patients? Women have different mental health needs to men, representing more of those suffering from anxiety, depression and eating disorders. Women uniquely experience pregnancy and childbirth and are more commonly carers, all of which have significant mental health effects32. Women are also more likely to be victims of abuse, with a clear relationship to many mental health conditions established in literature33. Women in minority groups may be more vulnerable to mental ill health, necessitating services sensitive to their needs. Specialist services catering specifically or mostly to women (including perinatal, eating disorder and trauma services) also remain patchy in terms of provision across the UK34.

I would argue that women are especially in need of trauma sensitive services. The Me Too movement gained unprecedented global traction in 2017 when thousands of women shared their experiences of sexual violence on social media. It highlighted not only the shocking prevalence of sexual trauma, but also women’s ongoing struggle to be heard35. Studies show the prevalence amongst women with mental health conditions is even higher; with over 50% having experienced violence or abuse32. This is likely to increase, considering domestic violence against women has intensified during the COVID-19 pandemic36.

Female service users want to be heard and understood by services regarding their experiences. In 2001, Harris and Fallot first outlined principles of a trauma-informed approach to care, explaining the need to understand an individual in the context of previous trauma, rather than focusing on symptoms in isolation (‘what has happened to you’ rather than ‘what is wrong with you’)37-38. First included in the ICD-11 (despite being proposed in 1992), complex post-traumatic stress disorder (c-PTSD) is a controversial diagnosis39-40. In c-PTSD diagnostic requirements for PTSD are met, however it also encompasses emotional dysregulation, low self-worth and difficulties with interpersonal relationships41. These symptoms are more traditionally associated with and diagnosed in the context of borderline personality disorder (BPD). A key difference in c-PTSD is these are recognised as sequelae of sustained trauma42. While the answer lies beyond the scope of this essay, is there a subset of BPD patients where we could do more to recognise behaviours as a response to trauma? Would doing so help to reduce the stigma associated with these symptoms?

We must also recognise and combat the risk that services can retraumatise women, often unintentionally. Ways in which services can do so include restraint, forced medication administration, seclusion and indeed by not listening to and involving women in their care. A trauma-informed approach would encourage staff members to engage with service users collaboratively, and to avoid ‘power-over’ strategies. Evidence suggests that trauma-focused approaches can result in better outcomes and an improved patient experience, though more research is undoubtedly needed in this area37-38.

**Conclusion**

*"Real change, enduring change, happens one step at a time."43*

*Ruth Bader Ginsburg*

Women have made impressive strides in psychiatry over the last century. Unfortunately, the gender gap persists for pay, representation in leadership roles and in academia. Female psychiatrists can help bridge this gap. They can do so by advocating for structural change that aids retention of female trainees, and by acting as mentors who understand through experience the difficulties that can affect women pursuing a medical career.

We are also beginning to recognise the unique needs of female patients. Encouragingly, the Women’s Mental Health Taskforce was formed in 2018, and works at a national level to help influence future service design33. Equitable specialist team provision continues to be needed, and wider services could further incorporate gender and trauma sensitive approaches into standard care. Women are also more likely to hold dual minority statuses, and further action is needed to combat the double discrimination these patients experience.

Female psychiatrists are in a unique position to support and enact ongoing change, both for future generations of doctors and for our patients.

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