Women's bodies harm and healing

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It was a crisp autumn morning when I attended my first psychiatry on call shift. I had to see a patient in seclusion due to 'chaotic behaviour' amid a manic episode. Not sure what to expect, and nervous about leading the review, I reluctantly waited outside the suite as the response team gathered. Suddenly, we were inside the suite. She was a slim woman in her 40s, sat on the bare mattress in rapt docility. I noticed the wispy autumnal light catching the lines around her eyes. She hadn't slept. In a flash, she bounded up and launched a verbal attack. "You are the reason I can't have children. Lithium, valproate…" she spat out the words contemptuously before collapsing back on the mattress, crying I was dumbstruck. Entirely unsure of myself, I tried to introduce myself. She wailed louder, drowning my awkward stammering. The staff looked unimpressed. Not sure what else to do, I felt a surge of bitter resentment. Why was she attacking me? Why couldn't she just quietly take her medication? What sort of mother would she be anyway?

These thoughts collided around my head with a burning irritation. "Don't worry doc, she probably has P.D," the unit co-ordinator consoled me as we agreed to continue seclusion. Years later, I recall these judgements with shame and reflect if I would have been similarly stung by a male patient. Am I sexist? Psychiatry is based on dividing the sane and insane but these parameters often reflected the prejudices of their period. Women were more often the victims of barbaric lobotomies and labelled with misogynistic diagnoses like nymphomania and hysteria (1). Our attitudes to gender equality have evolved with time but inequality still exists in different forms. This essay will explore the extent to which gender bias continues to cause harm to female patients and their bodies and how we can confront these to promote healing.

Is Psychiatry Sexist?

Towards the end of my core training, I was fortunate enough to be involved in a psychoeducation group for service users with Complex Emotional Needs during my psychotherapy placement. The group was filled with young women with borderline personality disorder. After delivering the PowerPoint, we invited questions. One young woman bravely opened a discussion. "In the past women were told they had hysteria. How do we know that borderline personality isn't the same thing? Just another label for women." We acknowledged her feelings but there wasn't a clear-cut answer. Borderline has historically been considered to affect women more frequently, with DSM-IV enshrining the ratio as 3:1 (2). This has been true since at least the 1980s. More recent epidemiological studies cast significant doubt on this assertion, with well-funded studies from the U.S reporting roughly equal prevalence (3). A Norwegian study reported a borderline personality disorder (BPD) prevalence of 0.4% in men and 0.9% in women, while a UK study found the opposite, with 1% in men and 0.4% in women (4,5). Yet clinically, more women seem to attract a diagnosis of EUPD than their male counterparts. One questions if our attitudes are influenced by gender bias and propagate this disparity.

This has been a question which researchers have studied for decades. The simplest explanation has been that women traditionally seek help more often than men and so this disparity could be a function of sampling bias. A study from 1983 by Henry and Cohen provided 277 undergraduates and graduates, with no psychiatric diagnosis, with a questionnaire and found that men showed more traits of BPD than women. They concluded that a labelling process may explain why women are overrepresented in cases of borderline personality disorder as well as arguing that the diagnostic construct of BPD is biased, in that women are more likely to be 'penalised' for certain symptoms like uncontrollable anger than men (6). This could point to a gender bias, where traditionally masculine emotions that

overlap with the criteria for BPD such as anger and impulsivity are more likely to be identified in women which informs part of the reason for this gender disparity.

This gender bias, where traditionally masculine emotions such as anger and impulsivity are more likely to be identified in women, suggests that our subjective experiences as clinicians may influence diagnostic outcomes. One of the most important concepts that I learned during my psychotherapy placement was countertransference or, *how does the patient make you feel.* This understanding of the feelings which arise in you when seeing a patient is used for diagnostic purposes. Despite how objective psychiatry attempts to be, there remains a layer of subjectivity. There has been very little written about the subjective experiences of psychiatrists when dealing with patients. Dazzi et al examined the subjective experience of male and female clinicians on a cohort of patients in Rome, to measure the emotional response clinicians may have to gender differences. The study reported that male clinicians experienced heightened tension, alertness, anger, and a sense of being judged, rejected, or manipulated, particularly in conflicts and challenges to their professional role. This stings with familiarly when I recall my first seclusion review.

The study also reported that female clinicians felt more emotionally engaged with patients but struggled with empathic failure, frustration, and a sense of impotence (7). These subjective emotional responses can unconsciously shape the diagnostic lens. Male clinicians could interpret a female patient's challenging behaviour as fitting the criteria for borderline personality disorder. Similarly, female clinicians' feelings of frustration and helplessness could also predispose them to label women's difficult behaviours as signs of BPD. These biases compel clinicians to incorrectly conflate difficult interactions with psychopathology. For instance, there are cases of women initially diagnosed with BPD who were later found to have autism, suggesting that clinicians are vulnerable to attributing difficult behaviours to a personality disorder (8). Women are more readily labelled as having a personality disorder without an exploration of neurodevelopmental difficulties to explain the difficulties they present with.

Impact on Bodies

The misdiagnosis and overrepresentation of female patients with borderline personality disorder have ramifications for their physical health. This is due to the prescription of antipsychotics to manage 'challenging behaviour'. Traditionally, the treatment of BPD is managed through therapy. Still, the prescription of antipsychotics has been used to attenuate the emotional dysregulation and behavioural difficulties that some patients can present with. A large study identified that women with personality disorders, but no serious mental illness were more likely to be prescribed antipsychotics than men (9). The metabolic burden of these prescriptions is more significant when such prescriptions could have been avoided completely. It is necessary to note that women are more likely to suffer from cardiac complications than men due to antipsychotics (10). It is difficult to understand why exactly women seem to be prescribed antipsychotics more freely than their male counterparts. This could reflect a unconscious bias, where clinicians respond more aggressively to less gender-typical behaviour in women and 'label' their behaviour as requiring chemical restraint.

Despite the disparity in psychotropic use in personality disorders, it is generally accepted that women with schizophrenia have a better prognosis than men. However, there is little evidence about the subjective experiences of recovery between the sexes. One study that attempted to illuminate this area discovered that women experienced a lower quality of life and had more unmet needs during the rehabilitation period (11). More specifically, women felt they had more struggles relating to female identity such as desire for motherhood and the negative effects of antipsychotic medication. These findings point to an ignorance of the female experience in mental health which could be alleviated by more specific training.

This lack of training increases the oppurtunity for gender bias to affect care and produce more negative interactions. My own ignorance would have benefitted greatly from such training.

Promoting Healing

Returning, briefly, to my earlier days as a core trainee, I remember making the faux pax in an MDT meeting when I asked the Peer Worker what 'lived experience' meant, effectively outing their mental health issues to the team. They graciously accepted my red-faced apology and I was able to make use of their experience with the multitude of patients who had disengaged with services. She was a woman diagnosed with BPD.

The weight of unconscious bias and institutional sexism clouds many women's experiences of mental health services. I have been a part of the service and unconsciously made similar judgements as a well-intentioned young psychiatrist. It can be daunting to consider how to improve this situation pragmatically given the submerged level at which sexism can operate and how it imbues much of our clinical interactions. There is a gap between women's expectations and the care they receive.

A practical solution to this problem is to make greater use of Peer Workers who have lived through the obstacles that our biases create for our patients. Women with lived experience of discrimination should be invited to work with medical professionals and patients. Their experience can act as a conduit to foster more productive relationships between services and service users. Peer workers are a relatively new addition to mental health services. Still, there is a growing body of evidence to suggest that they improve quality of life and physical and mental health outcomes (12). Specific roles of peer workers could involve teaching in medical schools to de-stigmatise mental illness as well as educate students on the discrimination that women face. Such personal experiences when shared with students at the beginning of their career can produce a crop of doctors equipped to recognise and respond appropriately to the discrimination that women face.

Conclusion

When I was still a medical student and revising for finals, I l half-heartedly flicked to the psychiatry section and the quote 'to understand me, you have to swallow a world' caught my attention. It kindled a curiosity that has led me to this point today. It is a curiosity that also shut down when confronted with a 'difficult woman'. But of course, she probably had P.D. Our speciality is not immune to the perniciousness of bias which negatively affects our patients whether through inappropriate prescribing or poorly thought out, impulsive diagnoses. These biases can be addressed through being aware of their existence. This can be achieved using peer workers with lived experience who can enhance the understanding of discrimination that women with mental health difficulties face. They can help us swallow worlds. I can only wonder how different my experience would have been if equipped with a visceral understanding of the pain that poor woman experienced when contemplating the possible loss of motherhood. It could be that she simply wanted that pain, that loss to be acknowledged and not because she had P.D.

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