Teaching on Gender Issues

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Introduction

Since men and women differ, in their biology and in their life experiences, psychiatrists who take a gender-neutral approach will not provide optimal care for either their male patients or their female patients.

There exists a rapidly growing body of knowledge concerning gender differences relevant to the fields of psychiatry and psychology. Epidemiologic studies of mental disorders have long shown dramatic differences in the prevalence of different mental disorders in men versus women. Table 1 shows DSM-IV disorders that are diagnosed at least twice as often in adults of one gender than the other. Table 2 shows those DSM-IV disorders usually first diagnosed in infancy, childhood, or adolescence, which are diagnosed at least twice as often in one gender than the other (1). Gender differences in prevalence may sometimes be due to differences in reporting and help seeking or to gender bias in diagnosis or research design. However, true differences in prevalence imply that there are important biological, psychological, and social gender differences regarding etiological factors. An example of this would be the increased prevalence of dissociative identity disorder, borderline personality disorder, and somatization disorder in women. Childhood sexual abuse is considered a risk factor for these disorders (2–4), and childhood sexual abuse is 2 to 3 times more common in girls than boys (5).

Gender differences are found not only in prevalence but also in many other aspects of mental disorders. For instance, important gender differences in phenomenology, course, treatment response, and outcome have been demonstrated for alcoholism and for schizophrenia. Women with alcoholism have a later onset, more rapid course, and suffer more severe physical consequences than do men with alcoholism (6). Women with schizophrenia have later onset, more affective symptoms, better responses to neuroleptic medication and to psychosocial treatment programs, and better outcome than men with schizophrenia (7).

Revisions of traditional psychological theories have shown where men's and women's developmental paths diverge (8–10). Recently, the psychological development of gay men and lesbians has also been described (11,12). Newer

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<th>DSM-IV disorders that are diagnosed 2 or more times more frequently in one gender than the other (adult population)</th>
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<tr>
<td>Disorders more frequent in men</td>
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<tr>
<td>Alcohol-related disorders</td>
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<td>Other substance-related disorders (cannabis, hallucinogens, inhalant, opioid, phenylcyclidine)</td>
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<td>Antisocial personality disorder</td>
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<td>Gender identity disorder</td>
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<td>Paraphilias</td>
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<td>Intermittent explosive disorder</td>
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<td>Pyromania</td>
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<td>Pathological gambling</td>
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<th>DSM-IV disorders that are diagnosed 2 or more times more frequently in one gender than the other (child population)</th>
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<td>Disorders more frequent in boys</td>
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<td>Reading disorder</td>
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<td>Stuttering</td>
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<td>Autism disorder</td>
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<td>Attention deficit/hyperactivity disorder</td>
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<td>Conduct disorder</td>
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<td>Tourette's disorder</td>
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<td>Enuresis</td>
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Theories of psychological development have important implications for the practice of psychotherapy. There is continued controversy, however, regarding the extent to which gender differences in individual psychology are biologically versus socioculturally based.

Thus there is considerable knowledge concerning gender differences in prevalence, phenomenology, course, response to treatment, and outcome of mental disorders, as well as differences in psychological development. This makes it clear that any research or clinical endeavour in psychiatry should involve the separate study of men and women. Previously, the separate study of women was generally limited to those disorders related to female reproductive events, such as postpartum disorders. Many studies in the past, whether of psychological development (for example, Erikson’s Life Stages) or of psychopharmacology, used predominantly male subjects, and the results were then extrapolated to females (13,14).

In light of the important discoveries and insights of recent years concerning gender differences, it is instructive to ask why the separate study of men and women was not the usual practice before now. In the past, men were clearly the dominant gender in Western society, and indeed in almost all societies. Today, men continue to hold most of the economic and political power, occupying the higher positions of authority in most of society’s institutions. The experience of the dominant group, whether the dominant gender or the dominant race, tends to be considered the norm. The experience of subordinate groups is usually of less interest, but if such experience is explored and is seen to be different, then differences are apt to be labelled deficiencies (15). It continues to be important today to caution against assigning value judgements to observed gender differences or considering the traits of one gender to be superior to those of the other based on cultural norms.

A final important caveat concerns the fact that gender differences are observed when one studies large groups of men and women. Averages may be different, but the degree of variation within groups of men or women is considerable. Knowledge of average gender difference must not be used to stereotype or to limit individuals.

Goals of Teaching on Gender Issues

Psychiatrists will:

1. Have current knowledge of biological and psychological differences between men and women and of differences in their social experience.

2. Have knowledge of gender differences in various aspects of mental disorders and the implications of these for treatment.

3. Be aware that North American culture has tended to value traits considered masculine and to consider masculine behaviour the norm. They will be aware that this may have led to biases in research on gender differences and in psychiatric diagnosis.

4. Have a balanced approach to the individual man or woman patient, showing sensitivity concerning possible gender differences in experience, but not allowing their judgement to be clouded by cultural stereotypes and expectations.

Educational Objectives

Knowledge Objectives

A. Basic Information on Gender Differences

1. Basic Sciences’ Contributions to Data on Gender Differences (16)

Psychiatrists will be able to:

i) Describe data from anthropological studies of sexual dimorphism and observations of infant behaviour.

ii) Describe the effects of male and female hormones on the developing brain and gender differences in brain function.

iii) Discuss the controversy regarding reported sex differences in brain function.

2. Gender Role Socialization: Changing Expectations of Family and Society (17)

Psychiatrists will be able to:

i) Define sex, gender, gender identity, and gender role socialization.

ii) Describe traditional societal expectations and cultural values concerning men and women, including recent changes in society’s definitions of gender role.

B. Gender and Psychiatric Disorders

1. Gender Bias in Psychiatric Diagnosis and Research

Psychiatrists will be able to:

i) Distinguish those psychiatric diagnoses which are strongly influenced by biology from those strongly influenced by the social and political context (18).

ii) Discuss the risk of overdiagnosing certain disorders in one gender because of similarities between diagnostic criteria and socially stereotyped gender role behaviour. (for example, cluster B personality disorders).

iii) Detect the influence of gender bias on the funding, conduct and analysis of research.

2. Gender Differences in Mental Disorders

Psychiatrists will be able to:

i) Describe gender differences in the prevalence of mental disorders (1,19).
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Describe gender differences in the phenomenology, course, response to treatment and outcome for schizophrenia (1,7,20), mood disorders (1,21), anxiety disorders (1,22), substance-related disorders (1,6,23), personality disorders, eating disorders, somatoform disorders, dissociative disorders, gender identity disorder, paraphilias, and impulse-control disorders (1).

iii) Discuss biological and psychosocial hypotheses that may explain these gender differences (24,25).

3. Mental Disorders Related to Female Reproductive Events

Psychiatrists will be able to:

i) Describe the essential features of premenstrual dysphoric disorder (1,26).

ii) Describe the essential features of postpartum blues, depression, and psychosis (27).

iii) Describe the hormonal changes occurring during menarche, pregnancy, and menopause, as well as possible associated physical and psychological symptoms (28).

C. Gender Differences in Social Experience

Here it should be noted that gender differences in social experience will vary in different cultures and will change as societies change.

i) The Impact of Societal Issues on Women

Psychiatrists will be able to:

i) Discuss the effects of childhood sexual and physical abuse and incest, including:
- Short- and long-term consequences (5,29,30).
- The victim-to-patient process (31).
- Complex posttraumatic stress disorder (32).
- The association of childhood physical and sexual abuse with psychiatric disorders highly prevalent in women (2–4).
- Specific challenges in the establishment of a therapeutic alliance with victims of abuse and in their treatment (33).

ii) Discuss the effects of sexual assault or rape and of prostitution.

iii) Discuss nonsexual violence against women, including battered wives, stalking, and intimate femicide (34).

iv) Discuss violence by women, including infanticide, and the association of violence with psychiatric illness.

v) Discuss sexual harassment, including:
- Definitions; quid pro quo; poisoned environment.
- Prevalence.
- Consequences.
- Therapy that addresses both validation and empowerment (35).

vi) Discuss sexual exploitation of patients, including:
- Prevalence.
- Vulnerable patients, previous sexual abuse, and the traumatic transference.
- Physicians at risk and strategies for prevention.
- Consequences (36).

vii) Discuss economic issues, including the feminization of poverty and wage discrepancies.

viii) Describe life-cycle issues for women, including:
- Sexuality.
- The impact of AIDS.
- Sexual dysfunction.
- Infertility.
- Response to illness and aging.
- Marriage, motherhood, divorce (9).
- Role strain (16).
- Lesbians' experience (37).

2. The Impact of Societal Issues on Men

Psychiatrists will be able to describe the effects of:


ii) Changing social roles for men. In the workplace—the effects of underemployment and unemployment. In the home—changing definitions of men’s and women’s work, more equal division of labour and power, and the occurrence of “role reversal” in some marriages (40).

iii) Gay men and the impact of AIDS (37).

iv) Life-cycle issues for men, including:
- Sexuality, the impact of AIDS, sexual dysfunction, and infertility.
- Response to illness and aging.
- Marriage, fatherhood, divorce (10).

D. Gender, Psychological Development, and Psychotherapy

1. Gender Differences in Psychological Development and Their Implications for Psychotherapy

Psychiatrists will be able to describe:

i) The limitations of classical theory (for example, Freud and Erickson) when applied to women. Revisions of psychoanalytic theory (16).

ii) The Relational Model of women’s psychological development as described by Jordan, Kaplan, Miller and others at the Stone Center: the central importance of relationships, mutuality, connection and disconnection, and the reframing of relational skills as strengths (8).
Gilligan’s model of girls’ development: the sacrifice of the self for relationships in the development of girls through adolescence (41).

iv) The development of moral reasoning in women and men as outlined by Gilligan. The ethic of responsibility and care versus the ethic of fairness and justice (42).

v) Newer theories of men’s psychological development. The suppression of the feminine aspects of the self (10).

vi) Feminist psychological theory and therapy, including the following principles:
   a) The importance of the social context; the “self-in-context”.
   b) The consideration of symptoms as responses to life circumstances and social conditions; “the personal is political”.
   c) The minimization of power imbalance (43).

vii) The psychological development of gay men and lesbians and implications for psychotherapy (11,12).

2. The Effect of Patient and Therapist Gender on the Process and Outcome of Psychotherapy

Psychiatrists will be able to discuss:

i) How therapists’ values, beliefs, gender role socialization, and sociocultural background influence their perception of the patient (44).

ii) How the gender of therapist and patient influence the transference, countertransference, and material brought to therapy (45).

iii) The influence of therapist and patient gender on the potential for sexualization of the therapeutic relationship, abuse of power, sexual exploitation, and other boundary violations (45).

iv) Factors that may influence choice of male or female therapist (46).

Skills Objectives

The psychiatrist will:

1. Be able to appraise critically new findings on gender differences and consider the influence of gender bias on the research.

2. Be able to evaluate their own gender role socialization, its impact on self, and on interactions with patients.


4. Incorporate information on gender differences in mental disorders into assessment, formulation, and treatment planning.

Evaluate the influence of reproductive events on psychiatric symptoms and use this understanding in diagnosis and management.

5. Incorporate inquiry regarding common social stressors for men and women into routine history taking and be aware of the contribution of social stressors to mental disorder.

6. Be able to treat both men and women, including gay men and lesbian women, in psychotherapy using new understandings of the psychological development of men and women.

7. Use language and behaviour that are respectful of, and sensitive to, the gender and the gender role socialization of patients.

8. Monitor transference and countertransference in the doctor-patient relationship and preserve the professional boundaries of the relationship.

Attitude Objectives

Psychiatrists will:

1. Be open to the possibility of gender differences in human experience and in the experience of psychiatric illness.

2. Be aware of their own gender biases and expectations regarding gender roles and avoid gender bias in diagnosis, treatment, and research endeavours.

3. Be as respectful of gender differences as they would be respectful of cultural differences (attempting to understand, not judge, the values and experiences of others).

4. Have an increased appreciation of the different social realities and social stressors for men and women, acknowledging that these social factors may influence individual psychology and psychopathology.

5. Be alert to power differences in various dyads, including man-woman, employer-employee, doctor-patient, teacher-student, and monitor themselves in order to avoid exploitation of those in positions of lesser power.

Strategies For Teaching About Gender Issues

Enabling Objectives

A curriculum for new and continued learning about gender issues in undergraduate, postgraduate, and continuing psychiatric education must be based on well-founded principles of instructional design and attainable goals. Learners select new input, reformulate and restructure previous conceptions, and assimilate it all.

1. Instructional Framework

   A current theory in educational psychology supports the view that individuals do not merely receive knowledge. “Constructivists believe that knowing is a process, and that learners must individually and actively discover, transform and ‘own’ complex information” (47; p259).

   The nature of the instructional environment is important for the overall effectiveness of the educational program. The environment needs to be both authentic and appropriate. An authentic environment is a context where important concepts, principles, skills, and attitudes that are relevant to problem
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...ing in psychiatric care can be demonstrated. An appropriate environment offers a context to integrate students’ participation in their own learning with teaching behaviours that reflect problem solving in expert psychiatric practice.

In recent years there has been an increased interest in case-based instruction to teach medical problem solving (48). In problem solving, one applies particular knowledge and strategy to achieve certain goals. Interactions lead students to be exposed to the problem-solving task, the knowledge used, and the solution procedures (49).

2. Instructional Planning

i) Program Goals. This paper emphasizes the need for and the specific goals for designing a curriculum that integrates gender issues into mainstream psychiatric education. An example is that a seminar on depression should include discussion of gender differences in depression. The curriculum should also feature seminars about the fundamental idea that the approach to psychiatric care is not gender-neutral.

ii) The Learning Population. It is assumed that the adult and professional learning populations have developed strong personal, self-directed learning capabilities and are positively motivated to participate in an experience which might challenge their established opinions, beliefs, and values. The students’ prior experience and knowledge of the topic assessed by questions and discussions will influence instructional methods used in seminars and supervision.

3. Instructional Design

The overall aim is to design a program that enables cognitive processes which lead to successful problem solving.

i) The instructional objectives are derived from the program goals. The learners should participate in setting learning objectives. For example, by the end of a seminar, a student would be expected to be able to list the gender differences in schizophrenia or to describe some attitudinal difficulties that could occur in an emergency situation where a woman from a particular culture does not establish eye contact with a male professional.

ii) The selection and organization of stimulus materials follows. This includes a selected bibliography, audiovisual aids and, most importantly, the cases or problems to be considered.

iii) The sequencing of the material, in terms of content and relative complexity, is necessary to achieve the learning objectives. Learning groups should be kept small in number to encourage the interactive process and the opportunity for active elaboration of concepts presented. The language of these interactions should be gender-sensitive and reflect the values that are inherent in the content.

iv) Finally, instructional design includes the evaluation of student learning based on stated goals. It is important that the goals and evaluation be tied to the learning standard expected and that students participate in this decision. Evaluation can include self and peer evaluations.

4. Instructional Support

To sensitize and educate students and faculty about gender issues in psychiatric practice is a priority in psychiatric education. The support of departmental chairs and educational coordinators is necessary. This means a commitment to allocate teaching time and resources to design and implement such programs.

Understanding effective collaborative learning is another important aspect of developing such educational programs. Knowledge construction is enabled when students share what they know and are guided in a critical thinking approach. With this shift in the student role, teachers need to have a thorough command over the material and to possess the intellectual self-confidence to deal with questions when they themselves do not have the answers.

Instructional programs are also required for faculty, especially those involved in student performance assessment. Authentic learning about gender-related issues in psychiatry should be measured by the national and provincial written and oral examinations. Faculty development on this topic will facilitate integration of real case scenarios about gender issues into both examinations.

“In these complex, rapidly changing, and troubled times we must reinvest in teaching if our specialty is to survive” (50). Now is a timely opportunity for psychiatric educators to establish model programs for teaching and learning about gender issues.

References


27. Stein TS. A curriculum for learning in psychiatric residencies about homosociality, gay men, and lesbians. Acad Psychiatry 1994;18:59–70.