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From the Editor's Desk

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Gender, power and mental illness

Structural sources of gender inequality

Improving the health of women around the world is a critical global health goal, with implications for the health and well-being of women, children and families.[1,2] The actions must include the prevention of violence and emotional and sexual abuse of women and children, these being among the most powerful and effective public health interventions ensuring positive impacts over the life course.[3,4] Although there are improvements in global indices of maternal mortality and access to education and career development, anxiety and depression are more common in women, suicide is a leading cause of death in younger and older women,[1] and violence toward women is especially problematic in conflict zones[5,6] where prevention efforts have to be married with empowering interventions.[7] Strain in culturally defined gender roles, stigma of poor mental health and discrimination by gender and by other forms of minority status – sexual or ethnic identity – all combined to lead to poorer mental health.[8–10]

At the time of writing, we are celebrating 100 years of women being legally entitled to the vote in the UK, yet we seem in many ways to be no further forward. There is a sudden epidemic, a realisation, a breaking into conscious of the prevalent aggression and sexual violence toward women in all industries. So how far have we come? Inequalities in pay, exposure to risk factors for poor mental health and violence are still significant and visible. There are numerous less visible instances of discrimination, subtle enactments through power relationships in everyday life, daily hassles and occurrences that perhaps are either not recognised and remedied or not accepted as having pernicious effects. The concept of microaggressions has arisen in the racism and sexual identity discrimination literature;[11–13] this concept applies to the persistent and subtle erosion of respect and limitations of opportunity that women face, as they are overlooked and assumed to not be sufficiently strong or powerful or robust to deal with the demands of senior roles in health services, academic institutions and in board positions in industry. The structural sources of gender disadvantage operate even in high-income countries with established policies on gender equalities. How widespread must they be where there is no policy or where there are ingrained and societally sanctioned structures that afford a lower status to women and their human rights? Societal disadvantages are engineered into the structures through which power relationships operate, and permeate organisations to influence the conversations and interpersonal behaviours. These seemingly ordinary experiences leave a negative experience or impression on the lives of women, and children and younger women will be growing up in such environments, accommodating to expectations. It is painful to see young girls and women live their lives in fear of emotional or physical attacks, of interpersonal violence and sexual abuse, and needing to overcome structural disadvantages that constrain opportunities to flourish. Bartlett & Hollins' editorial on women in prisons (pp. 134–136) illustrates how disadvantage and early violence can lead to later incarceration with little awareness of the needs to address victimisation in therapeutic or healthcare contexts. The stories we tell ourselves about gender disadvantage in society and in our institutions now need to be challenged.

Power and psychiatric practice

Power imbalances are a concern in clinical practice in general; patients feel ill informed and experience limited choices, and professionals recommend a course of action for the care plan that does not attend to the personalised stories and the world views of the patient. This means that care practices can become oppressive or be experienced as detached and remote from the concerns of patients, although this is not intentional. For example, women with pre-eclampsia are more likely to have children with autism, and although Dachew *et al* (pp. 142–147) recommend screening of children of mothers with pre-eclampsia, the potential value and harms needs careful weighing to avoid further enactments of power that deprive people of choice. Power in psychiatric settings is especially visible when a person is detained against their will and compulsorily treated, with medication, with electroconvulsive therapy (ECT) or with a social and psychological regimen of treatment. Community treatment orders (CTO) aim to support the community-based treatment of patients with less need for in-patient care and detention; yet Trevithick *et al* (pp. 175–179) find that the number of CTOs is proportional to the growing rise in detentions in general. CTOs are more likely after forensic sections, and the variation in the use of CTOs is not consistent with the patterns of detention and compulsory treatment in hospital settings. The exercise of such power demands great care to ensure equity, safety and the protection of dignity and rights in the care process, otherwise complaints about coercion abound. Restraint as a form of intervention can be harmful; Sethi *et al* (pp. 137–141) suggest no specific form of restraint is better than another, and all carry risk but become necessary in rare instances.

Vulnerability and power

People with intellectual disability face enormous imbalances of power during interactions with care services. Practitioners who learn positive behavioural support appear to not reduce challenging behaviours of patients with intellectual disabilities (Hassiotis *et al*, pp. 161–168), but safe, careful and respectful management of challenging behaviour is still essential. Patients and professionals are concerned about how a lack of power in positions of lesser influence can promote coping that involves accommodation to incivilities; this can lead to low self-esteem and compound self-stigma. Morris *et al* (pp. 169–174) offer a new way of measuring self-stigma, which should be carefully assessed as a by-product of care processes. Alongside cautions about care processes, other scientific advances offer powerful new treatments, for example, to reduce cognitive decline and mortality in people with Down syndrome and Alzheimer's disease (Eady *et al*, pp. 155–160).

Psychosis, depression and persistent mental illnesses are disabling, and also associated with loss of power in clinical encounters; recovery is possible and promoted by careful use of social, psychological and pharmacological interventions.[14] In this regard, several research findings in this month's issue of *BJPsych* offer the power to better foster recovery. For example, van den Berg *et al* (pp. 180–182) show that trauma-focused psychological interventions are effective even in the presence of psychosis, which by some is considered to be a negative prognostic indicator. Treatment-resistant depression has been a focus of a number of recent papers in *BJPsych*;[15,16] ketamine may offer earlier improvement in treatment-resistant depression (Andrade, pp. 129–130; Heslin & Young, pp. 131–133) but appears no better than ECT in the longer term; the concerns about some selective serotonin reuptake inhibitors leading to a greater risk of suicide in the treatment of depression appear to not be warranted by a new analysis (Näslund, pp. 148–154).[17] Finally, our nosologies as powerful schema require ongoing refinement.[18] The status of psychotic

depression is being reconsidered, as a heterogeneous and potential fluctuating set of symptoms and experiences (Heslin & Young, pp. 131–133) in need of more research efforts.

The Psychiatry Ashes

As outlined last month, the friendly competition between the editorial boards of the *BJPsych* and the *Australian & New Zealand Journal of Psychiatry* has begun in earnest. Ten members of the Editorial Board are joining me in donning whites for *BJPsych*: Simon Wessely, Glyn Lewis, Pim Cuijpers, Allan Young, Matthew Hotopf, Michael King, Emily Simonoff, Francis Anthony O'Neill, Navneet Kapur and Louise Howard. Detailed scoring rules and a full list of the chosen batting papers (BPs) appear in our opponent's February issue.[19] Briefly, each player's BPs have been picked, assigned a stroke power and sent into the field to score runs (citations). Final scores will depend on a BP's stroke power (a measure of its initial impact) and the number of runs (citations) it earns in 2018. We will publish score updates throughout the course of the year.

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