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Unmasking microaggressions: Experiences of women in clinical and academic psychiatry and the need for systemic reform

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ABSTRACT

Microaggressions constitute a pervasive and insidious form of discrimination, frequently manifesting as subtle, unconscious and unintentional actions that disproportionately affect individuals based on gender, race, ethnicity, religion, age, sexual orientation, culture or disability. Although such phenomena are observed across a wide range of contexts, the present perspective article focuses specifically on women working as providers of healthcare services in psychiatry.

For these professionals, microaggressions commonly take the form of implicit biases, dismissive attitudes and unequal treatment, all of which contribute to a professional environment in which their contributions are systematically undervalued. These behaviours are reinforced by cultural norms and entrenched systemic practices, which serve to normalise discrimination, impede career progression and contribute to psychological distress. Addressing such stereotypes and discriminatory practices at both micro and macro levels is therefore essential.

This article draws on both the existing literature and collective personal experiences, arguing that the complexity of microaggressions in psychiatry necessitates a multidimensional analytical approach. By incorporating the perspectives of 21 women psychiatrists and psychologists from 15 countries across six continents, this perspective identifies recurring challenges related to service delivery and career progression. Cross-regional analysis reveals persistent patterns, including commentary on physical appearance, dismissal of professional contributions, violations of personal boundaries and forms of structural marginalisation. These findings extend the academic understanding of microaggressions in psychiatry and underscore the need for systemic reform and cultural transformation.

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INTRODUCTION TO THE CONCEPT

Microaggressions are brief, commonplace verbal, behavioural and environmental indignitieswhether intentional or unintentionalthat communicate hostile, derogatory or negative slights towards individuals or groups on the basis of ethnicity, race, gender, sexual orientation, religion or other identity markers.[1] Although they may be unintentional, microaggressions often reflect unconscious forms of discrimination directed at marginalised and historically oppressed individuals or populations, including those defined by gender, race, ethnicity, religion, age, sexual orientation, culture or disability.[1–3]

This concept was further categorised by Sue and colleagues into four principal types: microassaults, microinsults, microinvalidations and environmental microaggressions.[4–7] Microassaults refer to conscious and deliberate expressions of bias, which may be either explicit or subtly conveyed through language, behaviours or environmental cues.[1 4] Microinsults are characterised by interpersonal or environmental communications that convey stereotypes, rudeness or insensitivity that demean an individual's identity.[1 4] Microinvalidations involve communications or environmental cues that exclude, negate or dismiss the thoughts, feelings or lived experiences of certain groups.[1 2] Environmental microaggressions, by contrast, are embedded within institutional policies, practices and the built environment, creating climates that marginalise under-represented minorities.[4] These structural cues can create unwelcoming or hostile climates in higher education, laboratory settings and workplaces, reinforcing inequities even without overt intent.[2–4 8]

First introduced in the 1970s by Pierce to describe subtle forms of racial discrimination, the concept of microaggression has since expanded to encompass a broad range of biases shaped by societal stereotypes and power dynamics, extending into both clinical and academic settings.[1 2] Within healthcare, microaggressions constitute a pervasive phenomenon affecting both professionals and trainees. Recent studies indicate that 30–80% of healthcare professionals report experiencing microaggressions, while up to 87% of trainees across specialties report encountering at least one form of microaggression.[9 10] Comparable patterns of discrimination have been observed in women in other high-pressure medical fields,[11 12] including surgical training programmes, where discriminatory behaviours remain widespread.[13]

These patterns highlight not only the personal challenges faced by women in psychiatry but also the broader systemic issues embedded within healthcare systems. A report by the WHO indicates that although women constitute a substantial proportion of the global health workforce and are increasingly represented in medical education, they remain undervalued and are disproportionately excluded from senior academic, leadership and higher paid roles including within psychiatry.[14 15]

Microaggressions experienced by women psychiatrists appear to arise from a complex interplay of systemic structures, interpersonal dynamics and individual experiences. Implicit biases within clinical and academic environments shape perceptions of women's competence, authority and leadership.[16] At the same time, individual characteristics such as assertiveness, agreeableness or introversion may influence both vulnerability to microaggressions and the strategies employed to manage them. These strategies may include resistance and voice assertion, withdrawal or reframing, disengagement, internalisation, seeking support through mentorship and professional networks.[17 18] While such coping mechanisms may mitigate the immediate impact of microaggressions, persistent exposure contributes to psychologically unsafe environments, with implications for distress, burnout and professional attrition.[17 19]

Despite growing recognition of these issues, research examining microaggressions affecting women in psychiatry remains limited, with scarce evidence on specific types or protective measures. Although this article examines the lived experiences of women psychiatrists and psychologists who encounter microaggressions in professional settings, it is also important to acknowledge that men, too, may experience microaggressions within these environments. However, the nature and frequency of their experiences may vary considerably from those reported by women. To the best of our knowledge and following a review of existing literature, no original study has specifically examined the types of microaggressions experienced by women in psychiatry or developed surveys to assess them; however, a small number of studies have explored microaggressions in broader healthcare settings and among medical trainees.[12–14 20] This highlights a critical research gap and the need for the development and validation of psychiatry-specific tools to assess gender-based microaggressions. This article addresses this gap by integrating existing literature with purposefully collected lived experiences from 21 women psychiatrists, psychologists, and academic mental health professionals. In this perspective article, the term 'women in psychiatry' encompasses women working in clinical, academic, research, and educational roles across psychiatry and related mental health disciplines.

SYNTHESIS OF LIVED EXPERIENCES AND LITERATURE REVIEW OF MICROAGGRESSIONS AFFECTING WOMEN IN PSYCHIATRY

Patriarchal norms and sociocultural traditions continue to position women in subordinate roles relative to men,[21] with microaggressions emerging at multiple points across the professional life-cycle, from recruitment to everyday clinical interactions.[4 12] Evidence suggests that biases within recruitment processes may limit women's entry into competitive fields, including psychiatry.[22] From our collective perspective, the initial recruitment phase in psychiatry shapes future professional experiences, and biases introduced at this stage can have enduring effects on career progression. At the same time, women in psychiatry may encounter microaggressions throughout their professional trajectory, reinforcing inequities across different stages of their careers (figure 1). They may be seen early in career path selection and training, where women often encounter undermining comments, gendered expectations and limited access to mentorship.[20] In early-career stages, these experiences may include exclusions from research networks, biased evaluations, unequal expectations and assumptions about personal or family roles.[20 23]

As careers progress, microaggressions tend to become more institutionalised. Mid-career professionals may encounter barriers to promotion, exclusion from leadership roles and disproportionate allocation of 'invisible labour', such as administrative or supportive tasks.[24] In later career stages, microaggressions may persist in the form of diminished recognition, tokenistic inclusion or role marginalisation.[25]

Insights from our lived experiences illustrate that patients and caregivers often misidentify women psychiatrists as nurses, junior staff, assistants, subordinates or less competent personnel, reflecting entrenched gender stereotypes that undermine professional identity and authority, arguably reinforcing the notion that women are less capable of holding certain roles, regardless of their qualifications, and may hinder the realisation of their personal and professional growth. By contrast, men in clinical fields, no matter their qualifications or roles, are more consistently recognised as doctors. Such patterns may be perpetuated by both men and women, although through different mechanisms.[2] Microaggressions displayed by men often reflect traditional gender hierarchies, while those from women may stem

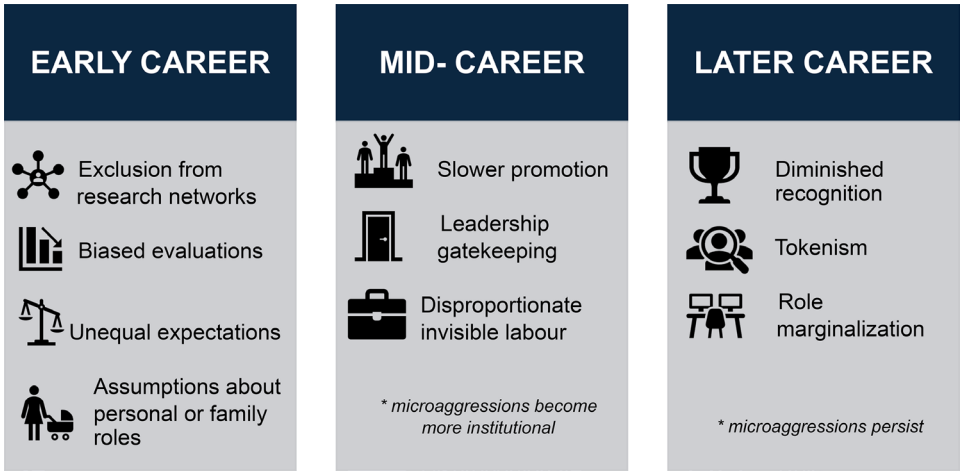

Figure 1 Image summarising common types of microaggression experiences across the career trajectory.

Table 1 Themes of microaggressions experienced by women in psychiatry (insights from the authors)

Themes	Examples	Remarks
Gender bias and stereotyping	"Find a nice man who can take care of you." "I hope you are not planning on having a child soon." "When are you going to have children?" "I honestly think women psychiatrists are better off staying home with their kids instead of trying to keep up with this job." "She is the only female here; she can take notes." "Don't you think that you are oppressed?" "That's not a woman's job."	► Assumptions about marital or parental status often imply that professional success comes at the expense of childcare responsibilities. ► Places pressure on women to conform to traditional expectations of motherhood. ► Personal judgements or discriminatory rhetoric limit women's opportunities and contributions in society.
Undermining competence and credibility	"Did you do this? Someone must have helped you." "For real, are you the psychiatrist?" "You're too young, especially as a woman to be a leader." "Your publications are not high impact enough."	► Implies that women's achievements are dependent on external support, thereby undermining their skills and accomplishments. ► Patients or colleagues may doubt a psychiatrist's competence, particularly in complex cases, despite their qualifications. ► Underestimation of the authority or responsibilities of women in positions equivalent to those held by men. These remarks and experiences affect individual confidence and perpetuate a culture in which women are discouraged from aspiring to leadership or senior academic roles.
Disrespect and boundary violations	"You look too pretty to work" "You are too pretty to be a psychiatrist." "I'm not sure you'll manage this workload with everything else you have going on."	► Inappropriate comments or insinuations about a woman's physiology and personal or sexual life in work or social settings. ► Personal boundaries are inappropriately violated, including through intrusive questions about personal relationships or life choices. ► Women's successes are attributed to male colleagues, and their achievements are framed as the result of external assistance rather than their own capabilities.
Emotional invalidation and communication barriers	"You're exaggerating the experience." "Don't be so sensitive." "She proposes adjusting the patient's medication, but the attending dismisses her and later praises a male colleague for presenting the same idea."	► Minimises women's experiences and emotions, suggesting that their feelings are not valid. ► 'Hepeating' is commonly experienced by women in psychiatry, as is the tendency to interrupt women when they are speaking, which may imply that their voices and opinions are less important than those of their male colleagues. ► Assertive communication may be perceived as being too aggressive and ambitious.
Marginalisation and limited opportunities	"I just think men should be paid more because they usually have more responsibilities." "You appear too ambitious; You have already accomplished a great deal for a woman, given your achievements."	► This disparity can begin at the hiring stage and widens with subsequent promotions. ► These remarks often undermine a woman's drive and desire to reach her full potential.

from internalised conflicts or competitive pressures.[26] In both cases, the behaviours are shaped by broader systemic gender norms rather than individual intent.[4] Ironically, women in leadership roles may, at times, inadvertently reproduce the very biases that they have experienced, reflecting the normalisation of discriminatory practices within institutional cultures.[27]

From our viewpoint, women in psychiatry within African and Arab contexts may face particularly complex challenges shaped by cultural, social and religious dynamics. These challenges are often compounded by entrenched gender stereotypes that cast doubt on women's competence and commitment to their careers, particularly when they attempt to balance professional responsibilities with familial obligations.[20] An examination of countries ranked at the lower end of the Gender Inequality Index reveals that India, along with other Asian nations, continues to grapple with pronounced gender-based discrimination.[28] Gender pay gaps persist across healthcare systems in parts of Asia and Europe, contributing to increased workload and burnout among women professionals.[19 29 30]

These intersecting barriers spanning personal, relational and systemic dimensions lead to challenging and unsafe working environments.[19 31] Adding to the complexity, discrimination often leads to older women in North America bearing a disproportionate burden of both age-related stereotypes and gender biases over time.[32]

One commonly reported form of microaggression is the expectation that women should fulfil traditional caregiving roles (table 1). This often stems from gendered assumptions about women's roles in family and childcare.[32 33] While such expectations may constrain career progress, many women also find meaning and fulfilment in these roles. Their accounts illustrate the heterogeneity of women's expectations and aspirations.[34 35] Notably, women psychiatrists worldwide often derive substantial fulfilment from aspects of life beyond clinical practice, including family relationships, personal pursuits and community engagement.[34 36]

In recent years, there has been increasing recognition of women's contributions to psychiatry. Initiatives such as '*Women's Voices in Psychiatry*'[37] and the Royal College of Psychiatrists' project '*25 Women in Psychiatry*'[38] exemplify efforts to document and celebrate the achievements and challenges faced by women in the field. Collectively, these initiatives enrich academic discourse and highlight the importance of continued advocacy, representation and structural reform within psychiatry.

CONSEQUENCES OF MICROAGGRESSIONS FACED BY WOMEN IN CLINICAL AND ACADEMIC PSYCHIATRY

Microaggressions are frequently intersectional, with gender interacting with age, ethnicity, race, religion and migration status to intensify discrimination. These experiences have both immediate and long-term detrimental effects on women psychiatrists, contributing to mental health challenges, such as isolation, burnout, impostor syndrome and stress-related diseases.[19] Microaggressions negatively affect women psychiatrists by compromising their well-being and limiting their ability to achieve personal and professional goals.[6 19] Microaggressions reduce decision-making power, undermine their sense of value

and erode confidence in professional abilities across both workplace and personal contexts.[6 20 23] Consequently, women may be less likely to share clinical insights or advocate effectively for marginalised groups, ultimately compromising patient care and health outcomes.[26 39 40] Although workplace mental health initiatives, gender-sensitisation programmes and institutional equity frameworks can offer some protection, their implementation remains inconsistent across regions and institutions.

RECOMMENDATIONS AND FUTURE DIRECTIONS

Addressing microaggressions requires a multifaceted approach that integrates advocacy, cultural change and coordinated action among clinicians, academics, patients, caregivers, policymakers and other stakeholders. Public campaigns that showcase women's contributions to psychiatry can help dismantle biases and societal barriers and inform more equitable policy development. At the regulatory level, professional bodies, accreditation agencies and licensing authorities play a critical role in embedding gender equity standards, antiharassment policies and robust reporting mechanisms within institutional governance frameworks.

Regular review and strengthening of policies aimed at addressing discrimination and promoting inclusive practices such as transparent recruitment, promotion and compensation processes are essential for ensuring equity and mitigating systemic biases. In addition, policies that support work-life balance, including subsidised childcare, flexible working arrangements and parental leave, are strongly recommended. Complementary interventions, such as structured mentorship programmes and bias awareness training, can further support equity initiatives.

Mentorship programmes that connect senior female leaders with early-career professionals can enhance career development, confidence and advancement by providing guidance on overcoming barriers, navigating promotion pathways and building professional networks.[41] Bias and anti-microaggression initiatives are most effective when embedded within sustained diversity and inclusion strategies rather than delivered as one-off sessions; such approaches have been shown to reduce the impact of racial microaggressions at work and improve well-being and retention among marginalised groups.[42]

In healthcare settings, fostering culturally safe environments and integrating indigenous perspectives into service design and delivery have been associated with improved engagement and outcomes for indigenous patients, including in psychiatric care.[43] While unconscious bias and cultural sensitivity training can increase awareness and self-reported knowledge, evidence for sustained behavioural change remains mixed. These interventions are most effective when combined with structural reforms, including policy changes, accountability mechanisms and leadership commitment, rather than implemented as stand-alone solutions.[43] Similarly, mandatory cultural competence training can enhance cultural awareness and communication skills, but its effectiveness depends on interactive, context-specific and longitudinal design, as well as integration within broader organisational reforms that address inequities in access to education, employment and healthcare.[44]

Additional pragmatic measures include amplifying diverse voices by ensuring representation of women from underrepresented regions in conferences, panels and publications. Engaging men as allies is also essential in addressing microaggressions.[45] Promoting leadership development, the use of inclusive language and community engagement collectively contribute to challenging cultural norms that perpetuate microaggressions, thereby fostering broader societal change and strengthening both professional and community environments.

A key strength of this article lies in its synthesis of diverse literature and lived experiences, providing a nuanced understanding of how microaggressions manifest across different stages of women psychiatrists' careers and cultural contexts. However, this article is limited by its reliance on narrative evidence rather than systematic data, which may introduce selection bias and limit the generalisability of its findings across different regions and professional settings.

CONCLUSIONS

This article highlights the pervasive effects of microaggressions and emphasises the need for urgent, systemic reform. It calls for equitable treatment, safe working environments and meaningful recognition of women's contributions to psychiatry. Sustainable change will require confronting bias and fostering environments in which women are supported, empowered and respected at all levels of mental healthcare, research and policy.

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