What do female and male psychiatrists in South Africa do?

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Objectives. (i) To document the types of intervention provided by psychiatrists in South Africa; (ii) to ascertain the diagnostic characteristics of their patients; (iii) to investigate whether there are differences in the diagnostic profiles of the patients of male and female psychiatrists; and (iv) to find out if the proportion of women psychiatrists is increasing.


Subjects. Psychiatrists registered with the South African Medical and Dental Council (SAMDC).

Outcome measures. Anonymous and confidential postal questionnaire with closed questions.

Results. The gender of 261 psychiatrists in South Africa was ascertained; of this number 195 (74.7%) completed questionnaires. Among outpatients treated by the respondents, 71.3% received medication and 9.8% assessment and evaluation only. The most common and second most common diagnoses for both outpatients and inpatients were mood and anxiety disorders respectively. Women psychiatrists had a relatively high proportion of outpatients with disorders usually first manifest in infancy, childhood or adolescence. Below the age of 50 years the proportion of women psychiatrists increased with decreasing age group.

Conclusions. The training psychiatrists receive is appropriate to the clinical services they provide. The 'feminising' of psychiatry may help to increase the relatively small amount of psychiatric effort currently devoted to children and adolescents.


In a previous paper we reported that there are only 6.4 practising psychiatrists per million population in South Africa. Furthermore, we provided data documenting the extent to which they are inaccessible to those living in certain provinces, those in rural areas, and those who are dependent on public sector mental health services. In the context of the above it is clearly important to determine whether the professional training of psychiatrists is appropriately utilised in the clinical services they provide. Psychotherapy, for example, can be provided by a range of mental health workers; it would therefore be uneconomical for a large amount of psychiatrists' time to be devoted to this intervention. Conversely, biological interventions such as pharmacotherapy can only be provided by medical practitioners. Infrequent use of biological interventions by psychiatrists would imply suboptimal application of their training.

Diagnostic characteristics of psychiatrists' patients can also indicate whether psychiatric training is being optimally utilised. This training may be necessary for effective management of psychiatric disorders with a biological component to their aetiology. However the management of patients with adjustment disorders or conditions not attributable to a mental disorder ('V-codes'), for example, is not necessarily enhanced by specialist psychiatric training.

The type of treatment provided by psychiatrists was included in a report in which the role of medical practitioners in the promotion of psychiatry and mental health in South Africa was explored. However this study was published approximately a decade ago and data were available for only 71 (32%) of the 223 psychiatrists practising in the country at the time. A recent review of private sector mental health services in the Western Cape supplied information on both the types of intervention provided by psychiatrists and the diagnoses of the patients. However, the response rate of 41% and the fact that the review was confined to psychiatrists in one province limit the extent to which these findings may be generalised. We were not able to locate other South African studies addressing these issues.

In the USA, similar data are included in periodic surveys carried out by the American Psychiatric Association. These surveys have also addressed various issues regarding the gender of psychiatrists. It has been found, for example, that female psychiatrists see more children and adolescents and fewer patients with substance abuse disorders than their male colleagues. There is also evidence that the proportion of woman psychiatrists is increasing, which has been referred to as the 'feminisation' of psychiatry. We could not locate any papers dealing with the gender of South African psychiatrists.

The database used in our previous report included additional variables that enabled us to address the issues outlined above. We therefore decided to conduct further analyses of this data set in order to address the following research questions: (i) what types of intervention do psychiatrists practising in South Africa provide? (ii) what are the diagnostic characteristics of their patients? (iii) are there differences in the diagnostic profiles of the patients of female and male psychiatrists? and (iv) is there evidence that the proportion of female psychiatrists is increasing?

Methods

The methods for this study have been presented previously. We mailed a questionnaire with a cover letter to all psychiatrists registered with the South African Medical and Dental Council (SAMDC) on 30 June 1993, to be completed and returned in an enclosed stamped, addressed envelope.
The questionnaire consisted of a series of closed questions. Although the questionnaire itself was anonymous, respondents were asked to provide their name on the outside of the return envelope to facilitate follow-up.

We sent subsequent mailings to non-responders approximately 3 and 6 months later, following which we made a concerted attempt to contact telephonically those whose replies were still outstanding. If the telephone number in the register was no longer valid we took the following additional steps: (i) looking their names up in the telephone directories for all areas in South Africa; (ii) where feasible, contacting others with the same surname in the telephone directories in the hope of identifying relatives; (iii) speaking to colleagues in all the major cities in the hope that they would have information about the non-responders; and (iv) making announcements at professional meetings. We recorded the gender of the non-responders.

We analysed the data using Epi-Info computer software and provide the 95% confidence intervals (CIs) for calculated percentages. These percentages, derived from the sample, are estimates of the true population percentages (which are unknown). An indication of how close an estimated percentage is to the true percentage is given by the CI. The 95% CI is such that there is a probability of 0.95 that the interval includes the true prevalence. We used t-tests to assess the statistical significance of differences between the frequencies of patient diagnoses for female and male psychiatrists.

Results
On 30 June 1993 there were 378 registered psychiatrists in South Africa. As reported previously, completed questionnaires were obtained from 210 (55.6%), 195 (92.9%) of whom were still practising psychiatry in South Africa. Of the 147 located non-respondents, 66 were still practising in the country, which meant that the genders of 261 psychiatrists was known for this study.

Table I indicates that 71.3% of outpatients received medication and 9.8% received assessment and evaluation only. The mean number of outpatients and inpatients seen per week were 41.5 (95% CI 38.3 - 44.7; interquartile range 16.0 - 60.0) and 14.0 (95% CI 12.1 - 16.0; interquartile range 2.0 - 20.0), respectively. The most common and second most common diagnoses for both outpatients and inpatients were mood disorders and anxiety disorders respectively (Table II).

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Outpatients (N = 179)*</th>
<th>Inpatients (N = 150)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>95% Cl</td>
</tr>
<tr>
<td>Disorders usually first manifest in infancy,</td>
<td></td>
<td></td>
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<tr>
<td>childhood or adolescence</td>
<td>10.7</td>
<td>8.7 -12.7</td>
</tr>
<tr>
<td>Organic mental disorders</td>
<td>8.4</td>
<td>7.3 - 9.4</td>
</tr>
<tr>
<td>Psychoactive substance use disorders</td>
<td>10.4</td>
<td>9.4 - 11.7</td>
</tr>
<tr>
<td>Schizophrenia, delusional disorder, psychotic disorders not elsewhere classified</td>
<td>11.4</td>
<td>9.9 - 13.0</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>40.0</td>
<td>37.8 - 42.3</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>22.1</td>
<td>20.4 - 23.8</td>
</tr>
<tr>
<td>Adjustment disorders</td>
<td>13.8</td>
<td>12.3 - 15.3</td>
</tr>
</tbody>
</table>

Female psychiatrists had a higher mean percentage of outpatients with disorders usually first manifest in infancy, childhood or adolescence than their male colleagues (20.7% v. 7.4%; t = 3.62; two-tailed P = 0.0007). There were no other significant (P < 0.10) differences between genders for any of the other diagnostic groups, either outpatient or inpatient.

Of the 261 psychiatrists for whom gender was known, 54 (20.8%) were women. Although there were more male psychiatrists in each age group, there was a trend for the proportion of female psychiatrists to be greater in the younger age groups. Below the age of 50 years the
The proportion of female psychiatrists increased with decreasing age group (Fig. 1).

**Fig. 1. Number of psychiatrists of each gender by age group.**

**Discussion**

The 55.6% response rate achieved in this study was similar to those obtained in postal surveys of paediatric surgeons (51.7%) and obstetricians and gynaecologists (62.4%) in this country. However, the validity of the trends regarding the proportion of female psychiatrists was increased because the gender of the 261 practising psychiatrists was known. We made a considerable effort to locate the remaining 5.6% of registered psychiatrists for whom we had no data. As they could not be traced it is probable that most of them are no longer practising in South Africa, which reduces the potential impact of non-response bias.

There are similarities between the outpatient interventions provided by US psychiatrists and those in the present study. For example in the USA 52% of patients were treated by means of individual psychotherapy, with 61% of this number also receiving medication. In the present study the corresponding figures are 51% and 67%, respectively. In the USA 15% were seen for assessment and evaluation only, compared with 10% in the present study. However, it would appear that a smaller percentage of patients receive medication in the USA compared with South Africa (55% v. 71.3%).

With regard to previous local studies, the majority of patients (87%) seen by psychiatrists in Visser’s sample received medication. Ensink et al. did not include behaviour therapy in their definition of psychotherapy, and did not have a category for supportive psychotherapy. Despite these differences, the percentage of cases in which psychotherapy was used in their study (47%) was very similar to the present study (51%). However, medication was used less frequently in their study (33% of cases) than in the current study (71%). This may be attributable to provincial differences in prescribing habits, since their study was confined to the Western Cape.

In their sample Ensink et al. reported the reasons for seeking treatment, as opposed to diagnoses made by the psychiatrists. However there are no obvious grounds to ascribe the difference in the proportion of patients receiving medication to dissimilar patient populations. In their study reasons for seeking treatment included depression and dysthymia (36%), personality problems (10%), psychotic disorders (8%), substance dependence (7%), and childhood and scholastic problems (7%). These reasons are compatible with the percentages of patients with each diagnosis documented in Table II. The value of comparing diagnostic profiles in the present study with those reported in the USA is reduced by the fact that in both studies the diagnoses were based on psychiatrists’ self-reports, and are thus of unknown validity and reliability. However no striking differences were evident.

In summary, the specific training of psychiatrists is necessary for the management of the 71.3% of patients who receive medication, and may also be relevant for many of the 9.8% receiving assessment and evaluation only. In addition, the majority of their outpatients and inpatients have diagnoses for which the specific training of psychiatrists is relevant in the assessment and/or treatment phases.

However, these conclusions only apply to the clinical services provided by psychiatrists, and do not imply whether the role psychiatrists currently play in mental health service delivery in general is appropriate. Indeed, as we argued in our previous paper, there are grounds for believing that they devote less time to direct clinical services and more time to activities such as training and continuing education of other mental health care providers, consultation-liaison consultation, policy development, service planning and research.

The study found an increased proportion of female psychiatrists in the younger age groups. Although the cross-sectional study design precludes definitive conclusions, this is consistent with the possibility that, as in the USA, a ‘feminisation’ of psychiatry may be taking place in South Africa. This could be explained by a combination of differential emigration of male psychiatrists, a greater number of women entering the medical profession, and a greater proportion of female medical graduates specialising in psychiatry.

Whatever its cause, this possible ‘feminisation’ would have implications for mental health service delivery in the years ahead. As mentioned above, female psychiatrists in the USA see fewer patients with substance abuse and more children and adolescents. Although there was no evidence in the present study that female psychiatrists see fewer patients with substance abuse, they did have a higher proportion of outpatients with disorders usually first manifest in infancy, childhood or adolescence. This indicates that the possible feminisation of psychiatry in South Africa may be correlated with expanding professional effort in child and adolescent psychiatry. Despite the fact that approximately 36% of the population are aged 18 years or under, only 10.7% of outpatients and 3.9% of inpatients in the present study were being treated for disorders usually first manifest in infancy, childhood or adolescence (Table II). Furthermore, there were only 21 registered child psychiatrists in 1993, of whom 15 (4.0% of all psychiatrists) were practising in South Africa. An increasing proportion of woman psychiatrists would serve to rectify this imbalance.

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REFERENCES


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