Violence against Women and Girls: what is the role of psychiatry?

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"Mirroring the confusion and disbelief of people whose basic assumptions are shattered suddenly by traumatic experiences, the psychiatric profession at times has embraced and been fascinated by trauma and, at other times, expressed stubborn disbelief about the relevance of patients' stories."

- Bessel Van Der Kolk

Women have traditionally, and nearly universally, been the second sex. The largest global minority across intersections of class, race, religion, and caste, women across societies have frequently been subject to coercion, control, and overt physical and sexual violence. The facts about violence against women are so well known that reiterating them feels almost trite. The scale of the problem is large enough for it to be considered a significant public health issue. One in three women globally experience at least one form of violence (1).

Scholars and administrators classify violence into various categories such as physical, sexual, financial, or emotional. In this essay, the term violence will be applied to all actions perpetrated against women and girls which diminish their safety. It is also self-evident as well as demonstrable that all forms of violence, not limited to the emotional subtype, are associated with considerable emotional distress and psychological trauma (2). Psychiatry's concern with violence against women is therefore imminently relevant. Just how this concern has played out within the discipline is the subject of this essay.

While the fact of violence against women is obvious in all societies across the world, its determinants are not always fully addressed. Ambivalent sexism, or negative and belittling attitudes towards women and girls have been known to influence violent behaviour against them (3). It is also well known that the perpetrators of violence against women are overwhelmingly male (4). It also bears to be stated that women's status as the second sex has largely meant that power has traditionally been concentrated in the hands of men. Men have been at the helm of institutions which have at best neglected, or at worst perpetuated violence against women, with sexist and discriminating attitudes fostered by wider societies in the background.

Psychiatry as an institution is unique, because on the one hand it was dominated by strong male figures with poor representation of female voices both at its inception and for most of its history. On the other hand, psychiatry has evolved to be among the most humane of medical disciplines, with ever-increasing emphasis on psycho-social determinants of il health such as violence, as well as on trauma-focussed approaches to recovery. I hope to take the reader on a journey of the complex relationship psychiatry has had with the violence women and girls experience, and what it can do to support them better.

Violence within psychiatry: a reckoning.

Medicine, psychiatry included, has never been isolated from societies in which it has thrived. It has frequently fuelled social ills including violence against women from its ivory tower. Traditional gender roles were in the past reinforced by medicine as biological norms for health. Deviations from the roles of wife and mother were pathologized, and the 'science' of early western medicine resorted to procedures such as lobectomies and oophorectomies to cure women of such illnesses (5). There is evidence to suggest that when it was a popular treatment, lobotomy was overwhelmingly performed upon female patients (6). As practice evolved to more apparently humane treatments with a heavier reliance on pharmacotherapy, women have been noted to receive a greater proportion of polypharmacy, especially with sedating agents such as Valium or Chlorpromazine (6).

Sigmund Freud, arguably the most influential early psychiatrist, was criticised in his own time by contemporaries for seemingly misogynistic theorising about women's psychology. Karen Horney, one of the few early female psychoanalysts, criticised Freud's proposed penis envy as a poor conceptualisation to explain female psychology. Alas, she was heavily criticised and ostracised by the male-dominated discipline in quite a dramatic example of entrenched misogyny at the time (7).

Any discussion of Psychiatry in the context of violence against women is incomplete without a mention of Hysteria. The Greek "wandering womb" theory of female ills was extended to any and all aspects of female health, including normal sexual behaviour (8,9). "Hysterical" women were often locked up in mental institutions without recourse to recovery in stellar displays of institutional coercive control over women's lives. On the other hand, hysteria, a problem relegated to being "only in their heads" was often a label used to dismiss genuine medical concerns in women (8,9).

Psychiatry did take a lead in addressing the issue of hysteria in women. Freud's genius was in drawing a connection between early traumatic experiences, especially experiences of childhood sexual violence and presentations of hysteria among his female patients. However, he quickly dismissed his own earlier conceptualisations and suggested that many traumatic memories reported by women weren't even real. Till as late as the nineteen seventies, women's reports of abuse were dismissed in mainstream psychiatric practice, their distress explained away as the result of their oedipal wishes coming true (10). Disbelief in women's stories about their experience of violence continues till this day to be a source of significant distress and re-traumatisation for women everywhere, and in healthcare settings has been known to adversely affect health outcomes.

Any discussion of trauma and violence in the context of psychiatric care is incomplete without covering the coercive aspects of acute mental health care. While mental health laws have evolved with time to minimise intrusion on individual freedoms, involuntary hospital admissions and restraints are still used in acute mental health settings. While some restriction on individual liberty, one hopes for the shortest possible duration, is unavoidable in the interest of safety, practitioners must remember that restrictive practices and physical restraints or seclusion are also violent acts. Patients frequently report re-traumatisation from such experiences (11). Evidence suggests that female in-patients are more likely to receive chemical restraint that males (12). Single gender wards are also not necessarily safer for female patients (13). In terms of violent incidents in medium and low secure units in the UK, it has been seen that while male patients are involved in more severe incidents, women have a greater number of other-directed as well as self-harm incidents (14). Male and female in-patients have different perceptions of therapeutic care, but because male psychiatric intensive care units are more common, the same standards of care are usually also applied to female psychiatric intensive care units (15). There is now guidance for gender-sensitive care but its implementation needs to be studied.

Healing from trauma: where we are now.

While the role of trauma now seems to dominate conversations on mental health, this was not always the case. For most of its history, psychiatry assumed constitutional weakness as the primary cause for mental ill-health. Pierre Janet was the first psychiatrist to systematically study the psychiatric impact of trauma. His assessments were close to the modern understanding of neurobiological response to trauma, but remained largely forgotten in the shadow of psychoanalysis which dominated psychiatric thought for many decades (10).

The understanding of trauma and its psychiatric implications has steadily gained deserved recognition in the last half century. It has revealed just how disproportionately violence affects

women's mental health. The world health organisation recognises gender-based violence as a significant risk factor for common mental illnesses such as anxiety and depression among women. Research also suggests that not only are women more likely to experience violence, but they are also more likely to suffer negative mental health consequences of violence. Post-traumatic stress disorder is twice as likely among women who experience traumatic events. They are also less likely to seek professional support for mental health problems (16). There may in fact be a biological component to the disproportionate impact of violence on women, mediated by their hormone profiles (17). There are other significant ways in which female psychiatric presentations differ from male ones, demonstrated in psychopathology, age of onset of symptoms, course of disease, and known risk factors (18).

This underlines the importance of a comprehensive bio-psycho-social approach is both in evaluation and therapeutic support of women victimised by violence. The bio-psycho-social model has been the foundation of modern psychiatry training since Engel first proposed it nearly half a century ago (19). However, in the relative absence of comprehensive psychotherapeutic or social care support, psychiatry in practice can often rely more heavily on biological cures. While medication has a role in controlling some symptoms that emerge from the experience of trauma, a one size fits all approach is not useful. A re-configuration of services and psychiatric training to be more trauma-focussed is warranted.

This also means that psychiatrists have a role beyond clinical practice in advocacy. Psychiatrists must advocate for a world in which violence against women is not the norm, but an unacceptable exception. They must advocate for better psychosocial supports for women who experience violence, and work together with colleagues in allied fields of psychology, social work, and law enforcement to address the scourge of violence against women. Addressing the distal factors driving violence against women is everyone's responsibility, more so for psychiatrists, who are often tasked with healing the psychological scars it leaves behind.

An equitable field: women within our ranks.

Issues of gender in relation to psychiatry cannot be fully addressed without a discussion on the representation of the genders within its own ranks. There is evidence from elsewhere in medicine demonstrating that female patients are better cared for by female physicians, who may even be preferred by female patients (20,21). While there isn't considerable evidence on mental health outcomes in relation to the gender of psychiatrists, there is some evidence indicating that people prefer same-gender psychiatrists (22).

In addition, male and female physicians have been shown to have differing perceptions of violence against women. A study by Kerssens and colleague found significant differences between male and female family physicians in their approach towards patients who have experienced violence (22). They found that female physicians unanimously considered sexual coercion as abusive and humiliating whereas their male counterparts did not. Female physicians also saw leaving an abusive partner as a process, which is reflective of the real world, whereas male physicians did not perceive leaving a relationship as a process. Female and male physicians had different approaches to managing cases of domestic violence, suggesting that physician gender is a mediating factor in the care that a victim of violence receives. Another study reports that female survivors of sexual assault report a preference for female providers (23). While standardised training for male as well as female physicians may minimise some of the differences in clinical approach, patient preference for care providers is likely to persist. This highlights the significance of equitable gender distribution among practicing psychiatrists.

In the UK, there has been an improvement in female representation among consultant psychiatrists, rising from 34% in 2004 to 45% in 2019 (24). However, the current challenges are around retention, representation among senior ranks, and pay parity of female psychiatrists. These issues need to be addressed if we are to have true parity within our ranks, because, as we have earlier seen, gender parity may well influence how well we are able to support our female patients who are survivors of violence.

In conclusion

Violence against women is an unfortunate brutality the human race still grapples with. It adversely affects women's mental health, and psychiatrists are in the position of being able to ameliorate their suffering. However, to truly understand the relationship of psychiatry with the violence women experience, we must fully understand its own relationship with women over the years since its inception. This includes the various ways in which it has minimised women's negative experiences or actively perpetrated harm. It also includes the wonderful work being done to improve trauma-informed care within the field. Lastly, if psychiatry is to support women who need its expertise, it is imperative that it becomes an equitable field for women who chose to train and work in it.

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