What is the role of the psychiatrist in the #MeToo era?

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She sat opposite me in a small side room on a psychiatric ward. It was my first psychiatric placement as a medical student. Sobbing and hyperventilating, she relayed to me the ten years of domestic violence she had suffered which culminated in her partner stabbing her. No wonder she's had a break down, I thought. On presenting the case to the (male) Consultant, he told me she probably had a personality disorder. On asking why this was he said, “no normal woman would tolerate that level of abuse”.

Five years on, as an F2 doctor, I experienced first hand what happens when you make a formal complaint against a Consultant on the grounds of sexual harassment after he repeatedly asked about my “dirty underwear”. The mortifying interviews. The sense that no one will believe you. The fear for your reputation within the hospital.

More recently, on apologising to a patient that I had not phoned him sooner, I was met with the response, “Oooh! You naughty girl. You deserve a smack”. The sexual undertone was not lost on me, and I was left reeling by the belittling experience of being described as a “girl” when I am a woman who has endured both medical training and childbirth.

As a psychiatry trainee I have met countless numbers of women (and men) who have recounted to me stories of sexual violence, sometimes in childhood, sometimes in later life. The impact of this violence seems to vary by individual, but one thing is clear: it nearly always has an impact on mental health.

I tell these intimate stories as our individual experiences always paint the backdrop to our viewpoints, whether we are conscious of this or not. And these experiences certainly influence my take on the role of the psychiatrist in the #MeToo era.

#MeToo

The #MeToo movement began in October 2017 when the phrase spread virally via social media. Coined and tweeted by actress Alyssa Milano, herself a victim of sexual harassment, the phrase would go on to trigger an international movement against sexual violence. Facebook reported that #MeToo was used by over 4.7 million men and women within 24 hours of Milano’s initial tweet (1). The movement elicited discussion about sexual harassment in multiple industries including the media, fashion industry, financial sector, politics and healthcare.

Despite its good intentions the movement has drawn criticism from both men and women. Journalist Brendan O’Neill (2) describes #MeToo as “Sexual McCarthyism” which is “more about vengeance and censorship than justice”. Some older feminists have been critical of the movement’s focus on victimhood. Discussing the movement in the The Atlantic, American writer Caitlin Flanagan claimed that women who were teenagers in the 1970s “were strong in a way that so many modern girls are weak” (3). There have also been allegations that the ownership and benefactors of the movement are predominantly white Western women and that Tarana Burke, a
black woman who originally used the phrase in 2006 on MySpace, has not been given enough credit for her attempts to raise awareness of the prevalence of sexual violence.

#MeToo and Psychiatry

The role of the psychiatrist in the #MeToo era is multifaceted.

Most obviously, perhaps, it is to demonstrate empathy towards victims of any form of sexual violence; to be prepared to listen and not be afraid to ask about past traumas; to be prepared to support a patient who wants to seek justice for previous acts of violence.

A psychiatrist should understand the potential impact of sexual violence on mental health and the correlation between sexual violence and various psychiatric conditions, such as PTSD or personality disorder. They should reflect on the role that trauma may play in a patient's presentation.

As healthcare professionals psychiatrists should be aware of the prevalence of workplace sexual harassment, both from colleagues and patients themselves. They should be prepared to support colleagues who have experienced sexual harassment.

On a broader level, a psychiatrist should have an understanding of the ways in which psychiatry has failed victims of sexual violence historically and attempt to move forward from the past.

The impact of sexual violence on mental health

Sexual violence is clearly linked to several psychiatric conditions, including depression, anxiety disorders and PTSD. Underlying psychosocial vulnerabilities, including past mental health service use, may predispose to the development of a mental disorder (4).

Despite this clear link, mental health professionals have been criticised for not routinely enquiring about previous sexual violence, perhaps because they are uncertain how to manage a disclosure (5). Other authors have argued that professionals may miss “subtle” sexual violence, such as coercion, reproductive control and forced consumption of pornography (6).

Given such a link psychiatrists have a key role in routinely and sensitively enquiring about non-recent, recent or on-going sexual violence. Mental health services should provide female-only or male-only consultations if requested. If a disclosure is made psychiatrists should be ready to support the patient in reporting both historic sexual abuse and recent sexual violence to the police and understand the steps involved in this (7). They should make themselves aware of local policies in this area as well as Safeguarding procedures if there is on-going risk.

They should also be aware of both local NHS treatments available to victims of sexual violence as well as third sector sources of support, such as the NAPAC (National Association for People Abused in Childhood) and local rape crisis centres.

Looking out for each other
Before I experienced sexual harassment from a Consultant responsible for my clinical supervision, if questioned I would have said such behaviour is rare. What I came to realise is that such behaviour can be hidden for years. Such behaviour can be excused or ignored by colleagues. Junior doctors can be too scared to complain, potentially due to the anticipated impact on their careers. Indeed had I planned to apply for surgical training in the same hospital, or had the perpetrator been a local Consultant Psychiatrist, I would probably have suffered in silence. I also grew to understand the psychological impact of workplace sexual harassment and subsequent formal investigations. Insomnia. Restlessness. Self-loathing and doubt. Fear.

Several surveys this year have revealed the sad extent of sexual harassment reported by NHS employees. In June 2019 a Unison survey of nurses, cleaners and administrative staff found that one in 12 had experienced sexual violence at work, including harassment, “upskirting” and rape. The majority of perpetrators (54%) were colleagues (8). Such harassment impacts on the safety and wellbeing of patients yet only a fraction of cases lead to disciplinary action (9).

A recent survey of 1,378 hospital doctors and GPs, commissioned by the BMA, found that one in five had experienced or witnessed sexual harassment at work, including groping, propositioning and sending explicit texts or emails. However unlike the Unison survey the perpetrators were mostly patients. The majority (56%) did not report the harassment. Respondents described feeling anxious, avoiding work and wanting to quit as a result of harassment (10).

So what role can psychiatrists play in all this? As with their patients, they should be willing to listen to and trust colleagues reporting sexual harassment, even if the accused is a senior clinician or has an good reputation in other areas. They should be aware of local formal complaint procedures and potential sources of support available, such as the Psychiatrists’ Support Service (11) or BMA welfare services (12). They should also take the risk of sexual violence into account when assessing new patients, and consider whether it is appropriate to allocate male only or female only staff based on these risks.

Rejecting the past

The link between negative sexual encounters and subsequent mental illness was noted by Sigmund Freud in 1896 when he wrote “I trace a regular parallelism… between the nature of the sexual influence and the pathological species of neurosis”. However novelist and writer Lisa Appignanesi notes “The omnipresence of what [Freud] called childhood ‘seduction’, and we now call ‘abuse’, made him suspicious. Could it be that the instigating event did not have to have taken place in the external world but needed only to be imagined?” (13)

Freud’s concept of a “fantasised sexual memory” clearly challenges the reports of sexual abuse by patients and has no role in modern psychiatry. While such attitudes may be outdated, it seems that even in more recent years psychiatrists have failed to appreciate the role that sexual trauma can have in their patient’s presentation. For example, rather than acknowledging the possibility of “Complex PTSD”, which places the onus on the external trauma, too often a trauma victim is automatically labelled as “personality disordered”, placing the onus on the victim themselves who is repeatedly told they need to “take responsibility” for their behaviour (14). Some victims will go on to endure a long cycle of malignant alienation and be denied certain interventions on the grounds of a label. And while the C-PTSD vs. EUPD debate seems beyond the scope of this essay, it is a debate that will surely continue in the #metoo era.
References


(6) Tarzia L et. al “Exploring the relationships between sexual violence, mental health and perpetrator identity: a cross-sectional Australian primary care study” BMC Public Health (2018) 18, article number 1410


(11) https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service [Accessed 13th October]


(14) "Are sexual abuse victims being diagnosed with a mental disorder they don't have?"