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

The #metoo movement was popularised through the Harvey Weinstein scandal in late 2017, and revealed the widespread disease that was sexual assault, harassment and violence. It gained momentum at an unprecedented rate due to the twin prongs of the Internet and globalisation. Furor over injustice was no longer restrained by geographical boundaries as it once was due to the rapid-fire speed at which news is relayed all over the world.

It seemed like the whole world was talking about #metoo except for the medical field. How is this possible? Could it be that the medical profession is untouchable as the very nature of its selflessness lends to a unified and singularly sacred space? Of course not. Its purview over the most vulnerable groups in society also allows these same patients to be exploited. Only recently, a patient gave birth in a coma, a victim of unchecked sexual assault over years. Such a scandal in this climate would lead to a reckoning of a system as a whole (see USA Gymnastics), yet medicine continues to remain unscathed, painting a false narrative of lone wolves who perpetrate these crimes.

Outwardly, it is easy to see how this came to be. A fundamental tenet of the profession is justice, to treat others without prejudice. While science rightfully shields us from the true horrors of injustice awaiting outside hospital doors, it also allows the medical field to remain oblivious to the very real social inequity that our patients suffer from. If we are to practice the biopsychosocial model we preach, then our patients are not bacteria swimming under a microscope, they are humans whose afflictions are not mutually exclusive from their socioeconomic status.

This is applicable to all medical specialties but is especially pertinent to psychiatry in the #metoo era. The role of a psychiatrist is unique in medicine as it does not fit squarely into the insular world of science. It inhabits the practices of its time more assiduously than, say, renal medicine, for nephrons are not as influenced as neuroses by beliefs and biases. The history of psychiatry reveals its masculinist foundation in structuring diagnoses around the enforcement of gender norms at the detriment of women (Chesler, 1994). Hysteria used to be a limiting label for women to explain away inconveniences, an excuse to ferret away vestiges of will and independence. And this was not limited to women, as asylums used to be a place to lock away the outskirts of community, including the LGBTQIA community whose sexuality and identity were deemed pathological (Blackbridge and Gilhooly, 1985). It is hard not to see the remnants of this in current practice, as our inherent biases will continue to slip insidiously into our interactions with patients, regardless of the Hippocratic Oath.

This can be detrimental when considering the new influx of sexual assault survivors coming forward in the aftermath of #metoo. In a literature review of healthcare-based interventions post sexual trauma by Martin et al. (Martin et al., 2007), they found that inherent biases in clinicians are even more prevalent with regards to sexual violence. Guedes et al. (Guedes, Bott and Cuca, 2002) surveyed 72 clinicians from the Dominican Republic, Peru, and Venezuela and found that 41% felt that sexual assault in adolescents are often self-provoked due to the patients’ conduct and an even larger 53% excused domestic sexual violence on the women’s behaviors. This victim-blaming is indicative of the wider and pervasive nature of
rape culture, whose influence can snake into the supposedly apolitical realm of consultation rooms. How unnerving it must be to come forward and have a 1 in 2 chance of facing an unsympathetic clinician and how devastating it must be to deal with the caustic effect of the patriarchy even in a safe place. The problem is that this issue is treated as isolated violent incidents in these women’s lives – we treat their symptoms, we administer rape kits, and we discharge them with leaflets on where to go for help. Wood and Roche (Wood and Roche, 2001) argued that we cannot remain apolitical in the face of this for they stem from a systemic, politically charged background. As psychiatrists, there lies avenues in activism, public health, education and training where we can effect change and do what is best for these patients as we took an oath we would.

The importance of being political in psychiatry flags up as the lexicon and knowledge required to engage with both victim and perpetrator is not medical but colloquial. Even now, our understanding of survivors’ experiences is limited (Jordan, 2013) due to the constraints of empathy and bystander trauma. The sheer range of types and severity of harassment can leave a clinician at a loss of words in a setting that relies heavily on the right words to be spoken. Barriers that once prevented survivors from coming forward (shame, victim blaming) are being torn down, and in its place are a language of empowerment and acceptance that have evolved past the clinician’s stock phrase of empathy: “I understand this must be hard for you”. To seem genuinely empathic, we need to have a deeper understanding of the complex net of emotions that lie behind a simple admission of victimhood. This requires a societal consciousness rather than a scientific one, and it can only be achieved by engaging with current literature and equip psychiatrists with the tools required beyond the Cambridge-Calgary framework (Denness, 2013).

As such, we cannot continue pathologising sexual assault as incidents in our patients lives that has led to convenient diagnoses. It is not a disease whose symptoms we treat with antidepressants, sedatives and 6 sessions of cognitive based therapy on the NHS. For them, it is a continuation of a systemic oppression by society and has a lasting impact. Wood and Roche (Wood and Roche, 2001) outlined an emancipatory principle approach to victims of sexual violence for social workers that emphasises the need to acknowledge the societal context this occurs in.

To quote,

Medicalising a woman’s non-physical suffering in the wake of a rape… suggests the presence of pathology, for which treatment is needed. This term labels a woman, ignoring the gender-based political nature of the interpersonal event and setting up the potential to explain other violent attacks on her in terms of her pattern.

In the practical sense, they promote easy to apply principles, by highlighting helpful evidence-based linguistic interventions that draw away from the “attack” and focuses on rebuilding the person who survived it. One of the exemplar approaches was the process of deconstructive questioning (Epston and White, 1992; Freedman M.S.W, 1996), which focuses on dismantling ingrained cultural beliefs that devalues their worth, and aid reconstruction of their life’s narrative. Sexual violence can completely alter a person’s world view and lead to permanent disturbances in their beliefs and existing relationships (Frazier, Conlon and Glaser, 2001). A victim’s personal space feels invaded which can affect readjustment to work with
one study finding productivity to suffer after rape for up to 8 months (Resick et al., 1981). By challenging the individual self-blame and guilt by placing it in a wider societal context, it allows patients to self-actualise their worth and be freed from the toxic effects of rape culture.

Rape culture consists of microaggressions that embolden a perpetrator to escalate things further. It begins with the targeting of groups who have been traditionally discriminated against, seemingly voiceless and powerless, and the objectification of these groups. It continues with the casual sexism and misogyny that degrades their worth, that maintains the patriarchy. And it solidifies until it seems very possible that you could get away with it – and more often than not, they do. Targeting of high-risk victim groups and screening for abuse is an active step forward, and this strategy can be replicated to high-risk perpetrator groups. If the risk factors of this population can be identified early, then it is entirely possible for psychiatrists to engage at an adolescent stage and weed out toxic masculinity (Coleborne, 2014) and behavior. You are not born violent, you were taught to be violent, and it is mental health professionals’ duty to help them unlearn these patterns in the interest of public health.

Moving forward, it is important that “rape culture” beliefs also be rooted out in undergraduate medical education and specialty training. The universal nature of sexual violence ensures that it presents itself from any patient, at any moment. Sexual violence is a great indicator of mental health and it is disproportionately present in the field of psychiatry, but it presents opportunistically, with any clinician the patient can trust – not solely psychiatrists. An additional strategy is for medical students to receive clinical training in actual situations versus classroom lecture formats (Alpert et al., 1998). Since 60% of medical trainees and students have reported experiencing harassment and discrimination in training (Launer, 2018), not only do we need to be taught how to sensitively deal with these topics, we should also be trained to actively question what is acceptable in the workplace. The contents of the education and training should include what words and behaviors are sexual harassment or gender bias and promoting a culture of honesty about sexual harassment or gender bias (Lee, 2018).

Additionally, the wider scope of #metoo needs to be reflected in medical practice and research. While it has raised critical questions around sexual violence, activists are keen to emphasise its intersectionality, and the multiple factors that help perpetuate it. For example, cis women are often the focus of such discussions, disregarding that women of color, prostitutes, lesbians, women with disabilities, and undocumented women tell different stories (Poore, 1995). Men and older victims fall by the wayside, diminishing their validity and furthering the narrative of shame around their assault. Consider older survivors with dementia, whose coexisting diseases render them especially vulnerable to both sexual violence and neurobiological effects of trauma on memory storage (D’Anniballe, 2012) – there still lacks clear guidance over how to deal with an unreliable narrator such as them (Bows, 2017). This affects the practitioner as we need to balance between ensuring that they feel heard and causing unnecessary anxiety by probing too hard, and more institutional support needs to be provided to handle such complex issues.

Despite our current understanding of past wrongs, psychiatry remains stagnant in its approach to mental illnesses, especially in its tackling of societal effects on a patient.
Psychiatric interventions have a two-pronged approach utilising psychology and pharmacology, and there always seems to be yet another psychotropic drug to replace an ineffective first-line drug. The efficacy of these drugs are indisputable – but why has psychiatry remained relentless in its use of diagnostic labelling and drug therapy as its primary forms of intervention (Caplan, 1984; Cosgrove, 2005) despite increasing literature on the value of social interventions in mental health (Morrow, Chappell and of Excellence for Women’s Health, 1999; Morrow, Hankivsky and Varcoe, 2004). Mental health systems are ill-equipped to deliver the kinds of services that women identify as important for recovery (counseling for childhood sexual abuse issues, women-only drop-in spaces, advocacy), which is where women’s organisations come in. The role of women’s organisations (rape crisis centres, shelters, women’s centres) in mental health is generally invisible and undervalued, and collaborative partnership models need to exist between psychiatric survivors, feminist organisations and psychiatrists and mental health professionals. State-supported mechanisms are often absent, and psychiatrists need to take a proactive and activist stance to initiate their own mechanisms to diminish the barriers to intersectional care.

There are existing movements within the medical field that are wrestling with the multifactorial issues that #metoo bring to survivor interventions. Time’s Up Healthcare promotes a safe healthcare work environment (Gold et al., 2019) and critical psychiatry is experiencing a revival, with front-line psychiatrists moving into research to critically engage with current practices (Wainberg, McKinnon and Cournos, 2019). It is clear that the specialty is willing to move forward in a constructive way, in light of our murky past – perhaps this time we will be on the right side of herstory.

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