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Perspectives on Sexual Power, #MeToo

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I am a survivor of sexual harassment and assault within a power dynamic. My specific scenario was all too typical – a male faculty member sought a sexual relationship with a female trainee. I am also an academic psychiatrist who teaches and treats women. With nearly 50% of female medical students experiencing sexual harassment [1], I am not alone. I share now how my interpretation of this experience changed over time. Shifts were both slow, as I gained clinical expertise in sexual trauma and our society began to listen to survivors with the #MeToo movement, and sudden, upon learning that he had continued to assault other women years later.

My Story

Briefly, I began working in an informal group whose daily banter included sexual commentary. As the only woman and most junior person, I deflected and ignored, attempting to fit in. Although my supervisor sometimes flirted with me, I did not think there was danger of anything more. First, everyone described him as a nice guy. By definition, nice guys do not pursue sexual relationships with either subordinates or people in committed monogamous relationships - I was both. Second, I had routinely kept relationships that started similarly platonic. Eventually, he verbally propositioned me for a sexual relationship when we were alone - I declined. Moments later, he grabbed and kissed me. I froze then yielded. Fortunately, we were not alone long, but similar incidents recurred. Before that assault, flirting back felt like an uncomfortable choice; after, nothing involving him felt like a choice. At this point, I almost abandoned my training but found a place to work that this same supervisor could not access. I avoided work-related social activities for years. I escaped without obvious visible damage to my personal life or career.

For the invisible part, gender norms blamed me and absolved him. These included that women are in charge of men's sexual interest so I could have stopped him (a lie - impossible within that power dynamic), women seek out powerful men to obtain power (a necessity given the dearth of female mentors), and men cannot always control themselves sexually (another lie – good men accept social limitations on sexuality). At the time, I accepted

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partial responsibility and protected myself with physical distance. I prioritized my safety and avoided professional social events, sacrificing the intangible benefits of networking.

Years later, I became a psychiatrist specializing in women's mental health. I heard pieces of my experiences within my patients' stories about sexual harassment and assault. Most of my patients had only heard shaming stereotypes about female sexuality. As their physician, I attempt to replace pathological beliefs by introducing new perspectives more attuned to their own experiences. This is part of cognitive behavioral therapy for sexual trauma: an event (sexual assault) activates a cognition (women control sex) that supports a pathological emotional state (shame); the emotional reaction diminishes if the belief is changed. With #MeToo raising the issue of sexual power dynamics in the workplace, I considered how beliefs I had held about our interactions derived from cultural biases about sexuality.

The terminology surrounding sexual harassment never resonated for me in this experience. I wanted the term "sexual harassment" to come with feelings of revulsion and the term "sexual assault" to generate anger inside me. Instead, I felt powerless. Thus, years later, I decided to talk to a witness, who was surprised that I had felt sexually pressured. Neither of us thought that our former supervisor intended to hurt me, and it was easier for both of us to view my experiences as an isolated accident. Another narrative was implanted: an empowered man's guilt depends more on intention than behavior. This bias is not unique to us: this defense is common in criminal investigations of domestic violence, sexual harassment and assault [2].

Months later, I learned that another woman had accused the same man of similar behavior. A lot of swear words belong here, as a new rollercoaster of emotions started. Overnight, he became a perpetrator and I was a victim. Again, these terms sounded black and white but my memories felt gray. I felt guilt about not reporting then and thought more about internal barriers. Being unable to assert myself around him felt more like a problem inside me than in him. This conceptual space is often where my patients are when we meet: unable to find an explanation for their own behaviors. Reporting then would have required answering questions about my responses to something I could not understand. Furthermore, the role of victim is egodystonic for me – changing that word to survivor helped me accept that his behaviors and my responses were consistent with sexual trauma.

As I recognized the many barriers that prevent reporting sexual misconduct, I felt an obligation to corroborate. I started calling witnesses to see if others remembered what I, ironically, had always hoped they had forgotten. First, I heard invalidation: I never had problems with him; he's too nice to hurt anyone; what I saw looked consensual; nothing serious happened so it shouldn't matter. All these statements protected him and diminished me, clearly demonstrating that the voice of one woman does not count. Most of my witnesses needed to learn that another woman made similar allegations before accepting my story. I choked back tears every time someone told me that they were sorry.

Next, I became angry as I realized how high the bar was set for validation by my peers. I had to succeed in my personal life, career, and find another survivor to achieve credibility. Yet, these interactions – dismissed as nothing important by many – had almost led me to give up

on my career, and permanently shifted its trajectory. Many women leave academic medical research entirely because of painful encounters in environments without mechanisms that ensure the safety of survivors. Career-ending retaliation is common for women who report sexual misconduct in academia [3].

Powerlessness Is Confusing

My first motivation for sharing my story is the persistent skepticism that surrounds reports of the experience of powerlessness in relation to sexual assault. My responses to his aggression felt more like a reflex than a choice. As a neuroscientist today, I know that the amygdala, a subcortical area involved in reflexive emotions and behaviors, tracks social rank and mediates social behaviors similarly for both humans and non-verbal primates [4, 5]. As a trainee, my loss of autonomy confused me: I could not understand why I yielded because I did not have words that explained my behavior. As a clinician, I have found that external validation about this confusion facilitates healing.

In listening to my patients, each survivor's immediate interpretation of their own sexual trauma seems to depend more on prior relationships than on its specific details. All the people I had been involved with previously respected me - asking and receiving consent before either emotional or physical intimacy. In response to his sexual aggression, it felt more ego-syntonic to accept his ideas about what I wanted than to consider a novel but ego-dystonic idea: what I wanted did not matter to him. Sadly, many people have not had the privilege of autonomous decision-making about their own sexuality throughout their lives. This can happen when one's sexual orientation differs from cultural norms, or if early sexual experiences involve a strong power differential as in molestation. These individuals may more quickly recognize the absence of respect and abuse of power that characterize sexual trauma. Unfortunately, these different perspectives about similar scenarios may further reduce reporting of sexual misconduct: some do not recognize assault well enough in the moment to report, and those who know it may not believe that their voices matter.

The depth of denial about sexual misconduct in academia warrants additional discussion: objective data shows an epidemic of sexual misconduct but minimal efforts are being invested in solving this problem [1]. I suspect it derives in part from powerlessness being difficult for people that have not experienced it to accept. Psychiatry frequently encounters a similar problem, as the public and even other physicians often dismiss the reality of mental illnesses, especially those described more by behaviors than emotions. Most people can imagine being unable to stop feeling sad, accepting that depression is an illness. In contrast, sexual trauma, eating disorders, and addictions are commonly portrayed as people intentionally making the wrong choices, instead of people feeling powerless to choose differently that my patients report and I experienced here. Our profession routinely bears witness to individuals whose lives have been devastated because of sexual misconduct. Psychiatrists should provide leadership within academia in support of the changes required to ensure safety for survivors.

Misogynistic Narratives

My second motivation for sharing relates to the negative impact of gender-biased sociocultural narratives on women's mental health. Mental health symptoms following sexual assault are typically related to self-blame, shame, and negative social reactions, and interventions to prevent mental health symptoms following intimate trauma need to consider both internalized and externalized social stigma [6]. Today, I attribute my resilience to the fact that not talking about this problem to witnesses in the moment prevented my confusion about feeling powerless from becoming shame. Negative biases about sexuality in women are ubiquitous, making it difficult for survivors to find someone with a viewpoint that captures their experience without shaming them.

Secondary trauma occurs when peers, clinicians, or institutions deny the reality of a victim's experience. My recent conversations with my peer witnesses illuminate the challenges in perceiving sexual misconduct in real time. Some had assumed that I wanted to trade sex for power – easier to blame the disadvantaged woman than the empowered man – and managed their own discomfort with this difficult situation by shunning me. One, now also faculty, gasped upon realizing, “You were a trainee too, how could I think it was your fault?” The assumptions that I was at fault in the moment derive from internalization of negative societal stereotypes about sexuality in women. Our cultural narratives blame women for causing sexual desire while simultaneously alleviating the responsibility of men to control their own behaviors in the presence of sexual desire [7, 8].

In contrast, positive biases about sexuality for men are also common, and their existence likely increases the inappropriate sexual behavior exhibited by empowered men. Fox recently detailed three cases in which sexual advances from former respected teachers damaged previously positive relationships with their mentees [9]. Akin to my own story, sexuality was forced into teaching relationships without securing verbal consent from the mentees. Our culture frequently celebrates the drama of relationships initiated with sexual aggression, supporting fantasies such as “powerful men can assault women into relationships”. This fantasy is a rape-myth that normalizes sexual aggression by men and subordination of women [10]. Another myth relevant to academic power dynamics is that “male mentors are father figures for trainees”. This myth also diminishes women, fixed as juveniles, and elevates men, granted authority. Both myths undermine the intellectual growth and career advancement of women. Just as in treating individuals with trauma, changing the existing inequities in academic medicine requires dismantling the sociocultural myths that unconsciously perpetuate them. Developing an awareness of the misogynistic biases pervasive in our society is a first step towards change.

Summary

My story illustrates how a power dynamic altered my own behaviors, how gender biases about sexual misconduct contribute to inequities within academia, and the importance of providing safety and validation to victims of sexual misconduct. As faculty now, I pay attention to power dynamics with trainees, colleagues and patients, recognizing that even voicing differences of opinions can be difficult from a disempowered position. The

powerlessness I experienced, freezing then yielding, can occur in any setting that does not provide safety and support for the expression of diverse and contrasting perspectives. Changing cultural norms related to power within academia requires all of us to think differently about ourselves and others continuously as we all carry implicit biases [11]. From a women's mental health perspective, all physicians should recognize that emotional pain often derives as much from sociocultural narratives that invalidate lived experiences as from the actual traumatic events. Sexual aggression from my supervisor rendered me powerless as a trainee; this common experience limits both professional successes and damages the health of women in our society.

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