WORLD PSYCHIATRIC ASSOCIATION
Advance Psychiatry and Mental Health Across the World

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WPA Position Statements should contain the following:

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WPA Position Paper on Intimate Partner Violence and Sexual Violence Against Women **GA23.10.5**

Foreword :

Intimate partner violence (IPV) and sexual violence (SV) are global public health and human rights problems and cause serious physical and/or psychological harms in every country of the world. IPV and SV affect both women and men, although it is significantly more common for men than women to perpetrate IPV and SV and women's injuries (including death) tend to be more severe than those of men. Studies have shown that one-third of patients receiving mental health services are victims of IPV or SV. Mental health consequences of IPV or SV include depression, anxiety, posttraumatic stress disorder, substance abuse, self-harm/suicide, low self-esteem, sexual problems and somatization. Children who witness IPV are more likely to develop mental health problems and to later be involved in abusive relationships. Partner violence during pregnancy is known to be associated with poor pregnancy outcomes and higher rates of depression as well as self -harm. While addressing IPV and SV are important in all psychiatric settings, several barriers have been identified both for disclosure by women and enquiry by professionals. It is important for all mental health professionals including psychiatrists to be aware of the extent of the problem, the impact on clinical presentation and ways in which women facing violence can be supported.

Authors

- Donna Stewart CM, MD, FRCPC, University Professor, University of Toronto, Senior Scientist, Toronto General Hospital Research Institute, Head of Research and Academic Advancement, Centre for Mental Health, Toronto, Canada
- Prabha S Chandra MD, FRCPE, FRCPsych, FAMS, Dean of Faculty, Behavioral Sciences, Professor , Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India, President Elect- International Association for Women's Mental Health
- Josyan Madi-Skaff MD, Chair - Women's Mental Health Section - World Psychiatric Association, Commissioner - National Human Rights Commission – Lebanon, Head - Psychiatry Department - The Lebanese Hospital Geitawi - Beirut - Lebanon
- Marta Rondon MD, MSc, Instituto Nacional Materno Perinatal, Lima, International Association for Women's Mental Health, American Association of Psychiatry, International Member, Honorary Member, World Psychiatric Association, Jose De La Torre Ugarte 471 (302), Lima, Peru 15074, 511 222 1656 - 519 97905507
- Natalia Seminova PhD, Moscow Research Institute of Psychiatry – a branch of V. Serbsky National Medical Research Centre for Psychiatry and Narcology, Moscow, Russian Federation, Co-Chair, WMH Section – Russian Society of Psychiatrists, Co-Chair, Women's Mental Health Section – World Psychiatric Association
- Dr. Aida Sylla Professeur de psychiatrie, psychothérapeute, Université Cheikh Anta Diop de Dakar, BP: 5952 Dakar-Fann, Tel: +221 77 6442158

Introduction

Definitions:

Intimate partner violence (IPV) is defined as behaviour by an intimate partner that causes physical and/or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. It may be perpetrated by a current or previous partner in a heterosexual or same-sex relationship and also includes stalking. Other terms used include (1)

- Spouse abuse = wife abuse = wife battering
- Domestic or family violence (violence by anyone in the family)
- Violence against women or gender-based violence (violence based on gender)
- Interpersonal violence (between any two people)

Sexual Violence - The World Health Organization (WHO) defines sexual violence as: 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or

acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work'(2). Coercion can encompass: varying degrees of force; psychological intimidation; blackmail; or threats (of physical harm or of not obtaining a job/grade etc.). In addition, sexual violence may also take place when someone is not able to give consent – for instance, while intoxicated, drugged, asleep or mentally incapacitated (1).

What the Position Statement aims to achieve

The position statement aims to

1. Describe the relevance and importance of the influence of IPV and SV on the mental health of women.
2. Discuss what psychiatrists need to know about assessment and interventions.
3. Emphasise the need for sensitive enquiry about IPV and SV in clinical assessment and providing appropriate interventions and referrals.
4. Discuss system level changes to support women facing violence in mental health facilities.
5. Discuss collaboration and partnership opportunities for various agencies and departments and how key stakeholders can best implement the position statement itself.

Main Text

Although IPV/SV has been reported in all countries, prevalence rates have been difficult to compare due to differential sampling and variability in definitions, with the most common variability being whether or not threats of violence and emotional or psychological violence are considered in population estimates. The World Health Organization (WHO) conducted a 10-country survey involving 24,097 women using comparable methodologies and found that 15 to 71 % of women reported lifetime physical or sexual violence by a partner, with the highest rates found in rural Ethiopia and Peru(2). The WHO Global Status Report on Violence Prevention found one in three women has been a victim of physical and/or sexual violence by an intimate partner during her lifetime and the WHO Demographic and Health Survey of 15 countries found physical abuse during pregnancy ranged from 2 to 13.5% (3). Same-sex IPV data are sparse but suggest that the prevalence may be even greater than in heterosexual partnerships(4). Generally, rates are higher in rural than urban areas, most IPV/SV is not reported to police and it is also underreported in healthcare settings; consequently, the data reported in epidemiologic studies are likely gross underestimates. Thirty percent of psychiatric patients have experienced IPV or SV and most of these were not reported to mental health service providers(5).

IPV and SV are known to increase the likelihood of developing mental health problems such as anxiety, panic, depression, somatic symptoms, sleep disorders and post-traumatic stress disorders. Persons

with depression and other common and severe mental illnesses also have higher rates of experiencing IPV/SV (3).

IPV in pregnancy is not uncommon and is associated with poor pregnancy outcomes in addition to mental health consequences. A systematic review of 24 studies in low and lower-middle income countries (LLMIC) between 1997 and 2017 found the prevalence of physical IPV in pregnant and postpartum women to range from 2-35%, sexual IPV- 9-40% and psychological abuse - 22-65% (6,7). The odds of depression increased up to 7-fold following IPV depending on country and IPV type and severity. Suicidal ideation was also found to be associated with IPV both in pregnancy and the postpartum period. It is hence important to address IPV in this vulnerable period.

Violence against children and adolescents, particularly sexual violence has lasting harmful effects. Traumatic experiences, including that of witnessing physical violence against the mother, increase the risk of suffering or perpetrating violence. They increase the risk for common psychiatric symptoms and for early onset of severe mental disease, with chronic, complex presentations that are less responsive to treatment. Sexual violence is linked to academic failure and to a significant increase in suicidal ideation during pregnancy. Special efforts need to be devoted to stopping children's maltreatment, sexual violence and witnessing of IPV, in order to stop the intergenerational transmission of violence (3).

The COVID pandemic has led to an increase in all forms of gender- based violence globally, especially domestic violence (8,9). Psychiatrists need to be aware of safe ways of remote (online, telebased and use of trusted people in areas inaccessible by modern means of communication) to support women facing violence during pandemics and lockdowns. Mental health specialists need to have access to safe ways to support people suffering from violence in disaster, conflict areas and during times when in person services are unavailable (such as lockdowns) This is an area of active research, to better understand the effectiveness and the ethical considerations.

The recent Lancet Commission on IPV and Mental Health has strongly emphasised the need to address the mental health impact of violence against women in secondary mental health care(5). The commission has also discussed the need to involve people with lived experience of IPV and mental health problems in the design of services. Finally, the commission has brought attention to the fact that gender inequality and normative tolerance of violence are linked to the high prevalence of violence against women. This is a powerful argument for gender transformative interventions and advocacy as important tools in the primary prevention of violence.

Conclusion:

Mental health providers, including psychiatrists, should develop awareness and skills in identifying, supporting and treating victims of IPV/SV who comprise one third of mental health service users,

especially among women. The WPA Curriculum on IPV/SV on the WPA website is a useful resource for education, training and advice on best practice in treating victims of IPV/SV.

Summary:

IPV/SV are global causes of physical and psychological harms including depression, anxiety, posttraumatic stress disorder, substance abuse, self-harm/suicidal, sleep disorders, low self-esteem and somatization. One third of patients seeking mental health services are victims of IPV or SV which disproportionately affects girls and women. It is vital for all mental health providers, including psychiatrists to be aware of IPV/SV and their mental health sequelae, to safely identify them in clinical encounters and to intervene at multiple levels to provide the best support and treatment for victims of IPV/SV.

Recommendations for Action:

As psychiatrists and other mental health professionals play vital roles as mental health care service providers, educators, researchers and policy advocates, who help shape mental health professional practice and public opinion, be it resolved that the World Psychiatric Association:

- Approve and publish on its website this Position Paper that recognizes violence against women including IPV/SV as major determinants of mental distress and psychiatric illness in women and strongly condemn all forms of violence against women.
- Publish the WPA Curriculum on IPV/SV on the WPA website as a useful resource for education and support other programs to improve the education of practicing and training psychiatrists to recognize and treat victims of violence including IPV/SV. This education should include, as a starting point, the routine inquiry about violence and victimization in all psychiatric assessments, the recognition of the role of violence and sexual abuse in the genesis of many psychiatric illnesses and as a treatment issue.
- Promote safe, respectful, non-blaming, ambulatory and inpatient treatment programs for women victims of violence including IPV/SV. These include services for LGBTQI + groups.
- Support research to develop and evaluate the best treatments for women who have suffered from violence including IPV/SV, and for their children and the perpetrators.
- Validate measurement methods to assess IPV/SV among women with mental health problems in different cultural contexts.
- Support health professionals and develop public awareness of violence against women including IPV/SV as a critical women's mental health determinant.
- Psychiatrists including those in training need to learn about sensitive enquiry of IPV/SV as part of a mental health assessment.

- Every facility should have a referral network of multiple stakeholders so that liaison can happen if violence is identified.
- There need to be institutional policies and procedures about handling situations where IPV/SV is identified.
- Explore opportunities for greater inter-professional collaboration (legal, social, medical, and policy makers) on an international level to prevent and ameliorate violence against women, including IPV/SV.
- Explore wide ranging psycho-educational and socio-cultural interventions designed to change the objectification of women, which is a major determinant of violence against women including IPV/SV.
- Censure public statements which seek to normalize violence against women as acceptable or a cultural norm.
- Use clinical approaches that are gender sensitive, trauma informed and have user involvement.
- Have training on IPV/SV as part of postgraduate curriculum and as part of continuing medical education
- Ensure that support staff working in psychiatric clinics and facilities are also trained in trauma informed care to prevent revictimisation and psychiatrists should try and facilitate a system level response.
- In view of the system being responsive to situations such as the COVID pandemic and lockdowns, to train and develop protocols for tele support and counselling for women facing violence ensuring that the intervention is both safe and supportive and does not lead to any escalation of violence.

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