

WPA International Curriculum for Mental Healthcare Providers on Violence Against Women

Module 1 Intimate Partner Violence Against Women

Module 2 Sexual Violence Against Women

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1. Background and Goals of the Curriculum

BACKGROUND—Violence against women (VAW) is endemic across the world and may include many forms in peace, war and humanitarian settings. This curriculum has 2 modules: Module 1 addresses intimate partner violence (IPV) and Module 2 sexual violence (SV) in women. Both are common abuses with serious physical and mental health consequences. Research indicates that very few women who experienced abuse/violence have ever told a physician and very few physicians reported ever asking about victimization. This is also true in mental health settings. The major barriers offered by psychiatrists towards discussing these 2 common forms of abuse, intimate partner or sexual violence, include: lack of adequate training about how to ask or respond; lack of knowledge regarding prevalence of mental health impacts; risk and protective factors ; skepticism about treatment effectiveness; uncertainty about appropriate referrals; patient apprehension about disclosing; physician discomfort with the issues; time constraints; fear of offending or losing patients; and fear about safety of the women or oneself. If clinicians are expected to appropriately identify and respond to abused women, they must be provided with relevant skills and knowledge.

While it is known that men may also be subject to violence from a partner or to sexual violence, this curriculum focuses on intimate partner violence and sexual violence against women specifically as women are more likely than men to experience more severe forms of abuse and violence from an intimate partner and sustain more serious mental health and physical sequelae (including death).

GOALS- Medical education has moved from a time-based didactic format to a competency-based one in which core competency levels must be achieved before trainees move on to the next level. This WPA curriculum is intended for different levels of expertise (undergraduates [MS], postgraduate psychiatry residents [PT] and psychiatrists [AE]) and presents the content of competency-based curricula that focuses on building skills, confidence, and knowledge among these groups, using different teaching methodologies.

The competencies we list on the next 2 pages are followed by the corresponding abbreviation indicating the appropriate level of expertise of the intended learners.

TERMINOLOGY, DEFINITIONS AND ABBREVIATIONS

- Intimate Partner Violence (IPV) - behaviour by a current or previous intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, controlling behaviours, stalking and financial abuse
- Sexual assault (SA) or sexual violence (SV) or rape (not restricted to the intimate partner)
- Spouse abuse = abuse of partner of any sex, sexual orientation, or gender identity. Spousal abuse of women also = wife abuse = wife battering.
- Domestic or family violence (DV, FV) (anyone in family including children and elderly)

- Violence against women (VAW) The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."
- Gender-based violence (GBV) violence/abuse based on the gender of the victim and rooted in gender inequality
- Interpersonal violence (IV) (between any individual-not necessarily known to the abused person)

[MS] – graduating medical student

[PT] – pre-certification psychiatric trainee (resident or registrar)

[AE] – practicing psychiatrist with advance expertise

Competencies

Intimate Partner Violence/Sexual Violence Competencies for Mental Healthcare Providers

At the conclusion of training, the trainee/practitioner will be able to:

1. **Define physical, psychological and sexual intimate partner violence (IPV) and non-partner sexual violence (SV).** [MS]
2. **Discuss prevalence** of IPV/SV in their local community and patient population
 - a. Describe local prevalence (including relevant vulnerable groups). [MS]
 - b. Estimate the prevalence of IPV/SV and common at-risk groups and protective factors in one's patient population including the mentally ill. [PT]
 - c. Apply knowledge of local population to advocate effectively for services. [AE]
3. **Be aware of myths and preconceptions** in IPV/SV
 - a. Describe the common biases about IPV/SV held by the public and healthcare providers. [MS]
 - b. Identify biases that may impact one's clinical assessments.[PT]
 - c. Participate in interprofessional and intersectoral collaborations to increase public awareness and sensitivity. [AE]
4. **Have knowledge of sequelae** of IPV/SV
 - a. Describe the physical and psychological health sequelae to victims/survivors and exposed children associated with IPV/SV. [MS, PT]
 - b. Provide education to other healthcare providers on the health consequences of IPV/SV [AE]
5. **Assess for presence** of IPV/SV
 - a. Know how to enquire about IPV/SV in a supportive and safe way with a range of patients. [MS]
 - b. Obtain information about IPV/SV in a supportive and safe way from patients presenting with psychiatric complaints in a wide range of settings (including: outpatients, inpatients, ER and medically-ill) [PT]
 - c. Provide expert opinion on complex patients affected by IPV/SV. [AE]
 - d. Assess and refer if necessary, children exposed to IPV [PT,AE]
 - e. Awareness of mandatory reporting, if applicable, and/or child safeguarding requirements and processes, and ability to discuss these with the patient [PT, AE]
6. **Provide psychological first aid**
 - a. Apply the principles of psychological first-aid for IPV/SV victims ("LIVES") [MS]
 - b. Model the LIVES approach and coach other providers in applying it in clinical care [PT]
7. **Assess safety and develop a plan**
 - a. Ask the woman if it is safe to return home today [MS]
 - b. Develop a safety plan specific to her situation [MS]

8. **Have knowledge of resources** for education and supportive services in IPV/SV
 - a. Provide information to a patient or healthcare provider to support patients facing IPV/SV including: how to access shelters or legal aid, how to navigate the system, awareness of local laws and victim resources. [MS]
 - b. Provide specific information to a patient about the intake processes or referral pathways for IPV/SV services in their region and facilitate referrals personally or through involvement of a social worker or advocacy service. [PT]
 - c. Develop, display and disseminate educational materials for a clinical setting to support systemic response to IPV/SV. [AE]
9. **Communicate details** of assessment
 - a. After discussing with the patient and ensuring safety and confidentiality, accurately document the IPV/SV signs, symptoms and discussion in the medical record [MS]
 - b. Provide a feasible written care plan for a primary care provider (or referring provider) to address the identified needs of a victim of IPV/SV. [PT]
10. **Manage IPV/SV related psychological trauma**
 - a. Provide a mental health assessment including assessing for suicidality
 - b. Make a diagnosis and implement appropriate evidence-based treatment for any mental disorder
 - c. Provide written instructions about the initiation and monitoring of a first-line method indicated for the treatment of IPV/SV psychological trauma. [PT]
 - d. Deliver or refer for an evidence-based psychological intervention for IPV/SV trauma such as PTSD e.g., cognitive behavioural therapy (CBT) with a focus on the trauma, exposure therapy, eye movement desensitization and reprocessing (EMDR) or other. [PT]
 - e. Prescribe an evidence-based pharmacologic intervention if indicated for IPV/SV psychological trauma. [PT]
 - f. Supervise trainees or other providers in the provision of evidence-based interventions. [AE]
 - g. Provide comprehensive care to patients with complex needs after experiencing IPV/SV. [AE]

Note: If PT or AE psychiatrists have not been trained in competencies listed for more junior levels, please review and master material for those competencies.

“LIVES” (adapted from psychological first aid) is the WHO Clinical Handbook for IPV or SV acronym for

Listen: empathically and non-judgmentally

Inquire: about needs and concerns (emotional, physical, social practical)

Validate: show you believe and understand the victim

Enhance safety: discuss how to protect against further harm

Support: help connect to services and social support

RESOURCE 1

1. WHO Guidance: A Clinical Handbook on Women Subject to IPV or SV (2014)
2. WHO: Responding to IPV or SV against Women: Clinical and Policy Guidelines (2013)
3. VEGA: Violence, Evidence, Guidance, Action. Online Educational Resources (2020)

1. World Health Organization Healthcare for Women Subjected to Intimate Partner Violence or Sexual Violence. A clinical handbook. 2014.

Available at: <http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>. A useful clinical handbook on IPV for healthcare providers at a basic level.

When providing first-line support to a woman who has been subjected to violence, four kinds of needs deserve attention:

- Immediate emotional/psychological health needs
- Immediate physical health needs
- Ongoing safety needs
- Ongoing support and mental health needs.

There are simple ways that every healthcare provider – including those who are not specialists – can assist a woman subjected to violence. This can be very important to her health. This handbook offers easy steps and suggestions to help you provide that care. This handbook has four parts:

- Awareness about violence against women
- First-line support for IPV and sexual assault
- Additional clinical care after sexual assault
- Additional support for mental health.

There are clinical aids throughout this handbook to help you while caring for and supporting a woman who has experienced or is experiencing violence. The guidelines on which this handbook is based do not directly address young women (under age 18) or men. Nonetheless, many of the suggestions for care may be applicable to young women or to men.

“LIVES” (adapted from psychological first aid) is the WHO Clinical Handbook for IPV or SV acronym for

Listen: empathically and non-judgmentally

Inquire: about needs and concerns (emotional, physical, social practical)

Validate: show you believe and understand the victim

Enhance safety: discuss how to protect against further harm

Support: help connect to services and social support

2. **World Health Organization Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines.** WHO, Geneva.2013.

Available at:

http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf?ua=1. A useful evidence-based WHO guide for IPV national policies and clinical guidelines for the health sector. A healthcare provider is likely to be the first professional contact for survivors of IPV or sexual assault. Evidence suggests that women who have been subjected to violence seek healthcare more often than non-abused women, even if they do not disclose the associated violence. They also identify health-care providers as the professionals they would most trust with disclosure of abuse. These guidelines are an unprecedented effort to equip healthcare providers with evidence-based guidance as to how to respond to IPV and sexual violence against women. They also provide advice for policy makers, encouraging better coordination and funding of services, and greater attention to responding to sexual violence and partner violence within training programs for healthcare providers.

The guidelines are based on systematic reviews of the evidence, and cover:

- identification and clinical care for IPV
- clinical care for sexual assault
- training relating to IPV and sexual assault against women
- policy and programmatic approaches to delivering services
- mandatory (if legislated) reporting of intimate partner violence.

The guidelines aim to raise awareness of violence against women among health-care providers and policy-makers, so that they better understand the need for an appropriate health-sector response. They provide standards that can form the basis for national guidelines, and for integrating these issues into health-care provider education.

3. The **VEGA (Violence, Evidence, Guidance, Action) online educational resources** (2020) include evidence-based guidance and tools that can assist psychiatrists and psychiatric trainees in recognizing and responding safely to IPV. The resources are comprised of learning modules (e.g., care pathways, scripts, how-to videos), interactive educational scenarios and a Handbook. The VEGA online educational resources are free and available in English and French.

Creating Safety, Module 2, discusses how to create safe interactions and environments using a trauma- and violence-informed care framework.

Recognizing and Responding Safely to IPV, Module 3, discusses how to inquire about IPV, assess risk of immediate danger, respond safely, make appropriate referrals, and includes a section about children's exposure to IPV.

Visit <https://vegaproject.mcmaster.ca/>. Scroll to the bottom of the page and click "Register now" under "Registration for Individuals". After completing the simple form, you will be sent a welcome email with your username, password, and login instructions. The email should come to your inbox, but if not, please check your spam folder.

MODULE 1: INTIMATE PARTNER VIOLENCE

RESOURCE 2:

IPV SUGGESTED READING LIST

Theme Index	Reference #
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IPV among Women with Severe Mental Illness	8-9
Perinatal IPV	10-11
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Mental Disorders in Perpetrators of IPV	13
Psychological Interventions for Mental Disorders related to IPV	14-17

NOTE: PLEASE CLICK THE HYPERLINKED TITLE TO BE REDIRECTED TO THE FULL PAPER. YOUR INSTITUTIONAL LOGIN MAY BE REQUIRED, PLEASE PROCEED AS DIRECTED ON WEBSITE

1. [**INTIMATE PARTNER VIOLENCE: RECOGNIZING AND RESPONDING SAFELY.**](#)

MacMillan HL, Kimber M, Stewart DE.

JAMA. 2020;324(12):1201–1202. doi:10.1001/jama.2020.11322

Link to Podcast: <https://edhub.ama-assn.org/in-learning/audio-player/18543809>

JAMA Description

“This JAMA Insights Clinical Update reviews clinical indicators of intimate partner violence (IPV) and ways that clinicians can ask about and begin to assist individuals who experienced IPV in phased, sensitive approaches that do not encourage patients to act before they are ready or compromise their autonomy or safety.”

2. [NEW DEVELOPMENTS IN INTIMATE PARTNER VIOLENCE AND MANAGEMENT OF ITS MENTAL HEALTH SEQUELAE](#)

Stewart DE, Vigod SN, Riazantseva E

Current Psychiatry Reports. 2016; 18(4). doi: <https://doi.org/10.1007/s11920-015-0644-3>

Abstract

Intimate partner violence (IPV) is a global public health and human rights problem that causes physical, sexual and psychological harms to men and women. IPV includes physical aggression, sexual coercion, psychological abuse and/or controlling behaviours perpetrated by a current or previous intimate partner in a heterosexual or same-sex relationship. IPV affects both men and women, but women are disproportionately affected with nearly one third reporting IPV during their lifetime. Physical and sexual harms from IPV include injury, increased risk for sexually transmitted diseases, pregnancy complications and sometimes death. Psychological consequences include depression, anxiety, posttraumatic stress disorder, substance abuse, impulsivity and suicidality and non-specific physical complaints thought to be related to the traumatic nature and chronic stress of IPV. Children who witness IPV are also negatively impacted in the short and long term. This paper reviews prevalence, risk factors, adverse effects and current evidence-based mental health treatment advice for IPV victims.

3. **DOMESTIC VIOLENCE AND ABUSE: HOW TO PREVENT, ASSESS AND MANAGE THE RISK OF DOMESTIC VIOLENCE AND ABUSE IN THE CONTEXT OF THE COVID-19 PANDEMIC.**

Oxford Precision Psychiatry Lab. Last Updated: 05 October 2020.

<http://oxfordhealthbrc.nihr.ac.uk/wp-content/uploads/2020/10/9.-domestic-abuse-2c.pdf>

Excerpt

This resource contains advice specifically in the setting of COVID-19, and the additional risks posed by the circumstances and restrictions related to the pandemic. For general pre-COVID-19 resources, those for mental health professionals are available at this link, and more generally for any healthcare setting, including advice on how to identify and respond to domestic abuse, see this link. The tables were created with input and guidance from ***Professor Louise M Howard*** (Professor in Women's Mental Health and Consultant Perinatal Psychiatrist, Kings College London). We thank her for her helpful contributions and guidance.

Please read the following advice in combination with ***national UK advice on protection/self-isolation.***

During the COVID-19 pandemic and the associated restrictions, the mode of assessment and delivery of treatment in mental health has changed. Where possible, services have changed to remote contact, using telepsychiatry. This has presented new opportunities, but also challenges in some areas including risk assessment. General guidance on telepsychiatry, including risk assessment, and on mental health in children, adolescents and older people is covered in our table at ***<https://oxfordhealthbrc.nihr.ac.uk/our-work/oxppl/table-5-digital-technologies-and-telepsychiatry/>***. Domestic abuse issues related specifically to pregnancy and the perinatal period is covered in a ***dedicated table.***

4. [VIOLENCE AGAINST WOMEN DURING COVID-19 PANDEMIC.](#)

Roesch E, Amin A, Gupta J, García-Moreno C

BMJ. 2020; 369:m1712. doi: <https://doi.org/10.1136/bmj.m1712>

Excerpt

Protections for women and girls must be built into response plans:

As the covid-19 pandemic intensifies, its gendered effects have begun to gain attention. Though data are scarce, media coverage and reports from organisations that respond to violence against women reveal an alarming picture of increased reports of intimate partner violence during this outbreak, including partners using physical distancing measures to further isolate affected women from resources. In Jianli County, Hubei province of China, a police department reported a tripling of domestic violence cases in February 2020 compared with February 2019, estimating that 90% were related to the covid-19 epidemic. In the UK, a project tracking violence against women noted that deaths from domestic abuse between 23 March and 12 April had more than doubled (to 16 deaths) compared with the average rate in the previous 10 years. These reports are disturbing yet predictable. Globally, 30% of women experience physical or sexual violence by an intimate partner in their lifetime. Such violence can increase during humanitarian crises, including conflict and natural disasters. The gendered impacts of infectious disease epidemics are less understood and acknowledged. Past epidemics, including Ebola and Zika, suggest violence against women may shift in nature and scale as outbreaks affect social and economic life.

5. [MENTAL HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN AND GIRLS.](#)

Satyanarayana VA, Chandra PS, Vaddiparti K.

Curr Opin Psychiatry. 2015 Sep;28(5):350-6. doi: 10.1097/YCO.0000000000000182. PMID: 26181668.

Abstract

PURPOSE OF REVIEW:

Recent studies on mental health consequences of violence against women and girls were reviewed in a range of situations.

RECENT FINDINGS:

Although several studies continued to show cross-sectional associations between child sexual abuse (CSA) and mental health outcomes, a few prospective studies showed a robust association between CSA and depression. Studies on the impact of dating violence are still at a nascent stage and focus on antecedents of violence rather than its consequences. Women at higher risk, such as adolescents, migrants, the homeless, and women in the perinatal period have been studied and specific vulnerabilities identified. Women reporting bidirectional violence had higher rates of depression and post-traumatic stress disorder (PTSD). Cumulative violence, severity of violence, and recent violence are associated with higher morbidity. Studies among women in conflict zones have emphasized the role of different forms of sexual and physical violence on mental health.

SUMMARY:

Newer emerging areas that need more research include mental health consequences of women in conflict zones and among same sex relationships. There are also few studies on the violence experience of both older women and adolescents. The need to better delineate the psychopathology of complex manifestations of PTSD is underscored.

6. **INTIMATE PARTNER VIOLENCE AND INCIDENT DEPRESSIVE SYMPTOMS AND SUICIDE ATTEMPTS: A SYSTEMATIC REVIEW OF LONGITUDINAL STUDIES.**

Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, Astbury J, Watts CH. PLoS Med. 2013;10(5):e1001439. DOI: <https://doi.org/10.1371/journal.pmed.1001439>
Abstract

Depression and suicide are responsible for a substantial burden of disease globally. Evidence suggests that intimate partner violence (IPV) experience is associated with increased risk of depression, but also that people with mental disorders are at increased risk of violence. We aimed to investigate the extent to which IPV experience is associated with incident depression and suicide attempts, and vice versa, in both women and men.

METHODS AND FINDINGS:

We conducted a systematic review and meta-analysis of longitudinal studies published before February 1, 2013. More than 22,000 records from 20 databases were searched for studies examining physical and/or sexual intimate partner or dating violence and symptoms of depression, diagnosed major depressive disorder, dysthymia, mild depression, or suicide attempts. Random effects meta-analyses were used to generate pooled odds ratios (ORs). Sixteen studies with 36,163 participants met our inclusion criteria. All studies included female participants; four studies also included male participants. Few controlled for key potential confounders other than demographics. All but one depression study measured only depressive symptoms. For women, there was clear evidence of an association between IPV and incident depressive symptoms, with 12 of 13 studies showing a positive direction of association and 11 reaching statistical significance; pooled OR from six studies = 1.97 (95% CI 1.56-2.48, $I^2 = 50.4%$, $p(\text{heterogeneity}) = 0.073$). There was also evidence of an association in the reverse direction between depressive symptoms and incident IPV (pooled OR from four studies = 1.93, 95% CI 1.51-2.48, $I^2 = 0%$, $p = 0.481$). IPV was also associated with incident suicide attempts. For men, evidence suggested that IPV was associated with incident depressive symptoms, but there was no clear evidence of an association between IPV and suicide attempts or depression and incident IPV.

CONCLUSIONS:

In women, IPV was associated with incident depressive symptoms, and depressive symptoms with incident IPV. IPV was associated with incident suicide attempts. In men, few studies were conducted, but evidence suggested IPV was associated with incident depressive symptoms. There was no clear evidence of association with suicide attempts.

7. [DOMESTIC VIOLENCE AND MENTAL HEALTH: A CROSS-SECTIONAL SURVEY OF WOMEN SEEKING HELP FROM DOMESTIC VIOLENCE SUPPORT SERVICES.](#)

Ferrari G, Agnew-Davies R, Bailey J, Howard L, Howarth E, Peters TJ, Sardinha L, Feder GS. [Glob Health Action](#). 2016 Feb 8;9:29890. doi: 10.3402/gha.v9.29890. eCollection 2016. PMID: [26860876](#)

Abstract

BACKGROUND:

Domestic violence and abuse (DVA) are associated with increased risk of mental illness, but we know little about the mental health of female DVA survivors seeking support from domestic violence services.

OBJECTIVE:

Our goal was to characterise the demography and mental health of women who access specialist DVA services in the United Kingdom and to investigate associations between severity of abuse and measures of mental health and health state utility, accounting for important confounders and moderators.

DESIGN:

Baseline data on 260 women enrolled in a randomized controlled trial of a psychological intervention for DVA survivors were analysed. We report the prevalence of and associations between mental health status and severity of abuse at the time of recruitment. We used logistic and normal regression models for binary and continuous outcomes, respectively. The following mental health measures were used: Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM), Patient Health Questionnaire, Generalised Anxiety Disorder Assessment, and the Posttraumatic Diagnostic Scale to measure posttraumatic stress disorder (PTSD). The Composite Abuse Scale (CAS) measured abuse.

RESULTS:

Exposure to DVA was high, with a mean CAS score of 56 (SD 34). The mean CORE-OM score was 18 (SD 8) with 76% above the clinical threshold (95% confidence interval: 70-81%). Depression and anxiety levels were high, with means close to clinical thresholds, and more than three-quarters of respondents recorded PTSD scores above the clinical threshold. Symptoms of mental illness increased stepwise with increasing severity of DVA.

CONCLUSIONS:

Women DVA survivors who seek support from DVA services have recently experienced high levels of abuse, depression, anxiety, and especially PTSD. Clinicians need to be aware that patients presenting with mental health conditions or symptoms of depression or anxiety may be experiencing or have experienced DVA. The high psychological morbidity in this population means that trauma-informed psychological support is needed for survivors who seek support from DVA service.

8. **DOMESTIC AND SEXUAL VIOLENCE AGAINST PATIENTS WITH SEVERE MENTAL ILLNESS.**

Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, Osborn D, Johnson S, Howard LM.

Psychol Med. 2015 Mar;45(4):875-86. doi: 10.1017/S0033291714001962. Epub 2014 Sep 4. PMID: [25180908](#)

Abstract

BACKGROUND:

Domestic and sexual violence are significant public health problems but little is known about the extent to which men and women with severe mental illness (SMI) are at risk compared with the general population. We aimed to compare the prevalence and impact of violence against SMI patients and the general population.

METHOD:

Three hundred and three randomly recruited psychiatric patients, in contact with community services for ≥ 1 year, were interviewed using the British Crime Survey domestic/sexual violence questionnaire. Prevalence and correlates of violence in this sample were compared with those from 22 606 general population controls participating in the contemporaneous 2011/12 national crime survey.

RESULTS:

Past-year domestic violence was reported by 27% v. 9% of SMI and control women, respectively [odds ratio (OR) adjusted for socio-demographics, aOR 2.7, 95% confidence interval (CI) 1.7- 4.0], and by 13% v. 5% of SMI and control men, respectively (aOR 1.6, 95% CI 1.0-2.8). Past-year sexual violence was reported by 10% v. 2.0% of SMI and control women respectively (aOR 2.9, 95% CI 1.4-5.8). Family (non-partner) violence comprised a greater proportion of overall domestic violence among SMI than control victims (63% v. 35%, $p < 0.01$). Adulthood serious sexual assault led to attempted suicide more often among SMI than control female victims (53% v. 3.4%, $p < 0.001$).

CONCLUSIONS:

Compared to the general population, patients with SMI are at substantially increased risk of domestic and sexual violence, with a relative excess of family violence and adverse health impact following victimization. Psychiatric services, and public health and criminal justice policies, need to address domestic and sexual violence in this at-risk group.

9. [RECENT INTIMATE PARTNER VIOLENCE AMONG PEOPLE WITH CHRONIC MENTAL ILLNESS: FINDINGS FROM A NATIONAL CROSS-SECTIONAL SURVEY.](#)

Khalifeh H, Oram S, Trevillion K, Johnson S, Howard LM.

Br J Psychiatry. 2015;207(3):207-212. doi:10.1192/bjp.bp.114.144899. PMID: 26045349; PMCID: PMC4555442

Abstract

Background

People with mental illness are at increased risk of intimate partner violence (IPV) victimisation, but little is known about their risk for different forms of IPV, related health impact and help-seeking.

Aims

To estimate the odds for past-year IPV, related impact and disclosure among people with and without pre-existing chronic mental illness (CMI).

Method

We analysed data from 23 222 adult participants in the 2010/2011 British Crime Survey using multivariate logistic regression.

Results

Past-year IPV was reported by 21% and 10% of women and men with CMI, respectively. The adjusted relative odds for emotional, physical and sexual IPV among women with versus without CMI were 2.8 (CI = 1.9–4.0), 2.6 (CI = 1.6–4.3) and 5.4 (CI = 2.4–11.9), respectively. People with CMI were more likely to attempt suicide as result of IPV (aOR = 5.4, CI = 2.3–12.9), less likely to seek help from informal networks (aOR = 0.5, CI = 0.3–0.8) and more likely to seek help exclusively from health professionals (aOR = 6.9, CI = 2.6–18.3)

Conclusions

People with CMI are not only at increased risk of all forms of IPV, but they are more likely to suffer subsequent ill health and to disclose exclusively to health professionals. Therefore, health professionals play a key role in addressing IPV in this population.

10. [INTIMATE PARTNER VIOLENCE DURING PREGNANCY: ANALYSIS OF PREVALENCE DATA FROM 19 COUNTRIES.](#)

Devries KM, Kishor S, Johnson H, Stöckl H, Bacchus LJ, Garcia-Moreno C, Watts C. Reprod Health Matters. 2010 Nov;18(36):158-70. doi: 10.1016/S0968-8080(10)36533-5. PMID: 21111360

Abstract

We aimed to describe the prevalence of intimate partner violence (IPV) during pregnancy across 19 countries, and examine trends across age groups and UN regions. We conducted a secondary analysis of data from the Demographic and Health Surveys (20 surveys from 15 countries) and the International Violence Against Women Surveys (4 surveys from 4 countries) carried out between 1998 and 2007. Our data suggest that intimate partner violence during a pregnancy is a common experience. The prevalence of IPV during pregnancy ranged from approximately 2.0% in Australia, Cambodia, Denmark and the Philippines to 13.5% in Uganda among ever-pregnant, ever-partnered women; half of the surveys estimated prevalence to be between 3.9 and 8.7%. Prevalence appeared to be higher in African and Latin American countries relative to the European and Asian countries surveyed. In most settings, prevalence was relatively constant in the younger age groups (age 15-35), and then appeared to decline very slightly after age 35. Intimate partner violence during pregnancy is more common than some maternal health conditions routinely screened for in antenatal care. Global initiatives to reduce maternal mortality and improve maternal health must devote increased attention to violence against women, particularly violence during pregnancy.

11. INTIMATE PARTNER VIOLENCE DURING PREGNANCY AND PERINATAL MENTAL DISORDERS IN LOW AND LOWER MIDDLE-INCOME COUNTRIES: A SYSTEMATIC REVIEW OF LITERATURE, 1990-2017.

Halim N, Beard J, Mesic A, Patel A, Henderson D, Hibberd P.

Clin Psychol Rev. 2018;66:117-135. doi:10.1016/j.cpr.2017.11.004

Abstract

Mental health consequences of intimate partner violence (IPV) against pregnant and postpartum women are poorly understood in low and lower-middle-income countries (LLMIC). We systematically reviewed the evidence from 24 studies (1990–2017) selected via a comprehensive search strategy with 14 inclusion, exclusion, and quality-control criteria to assess the extent to which intimate partner violence during pregnancy adversely affects perinatal mental disorders among participants in 10 LLMIC across 4 economic regions. Mostly cross-sectional, studies included 61–1369 participants selected randomly (88%) or non-randomly (12%) from purposively selected 1–6 clinics or 1–50 communities. Multivariate logistic regression was most frequently used (68%) for association estimates, adjusting for 3–16 socio-demographic variables pertinent to: women; husbands; and/or households. The prevalence of physical IPV ranged 2–35% among participants; sexual IPV ranged 9–40%; and psychological IPV ranged 22–65%. The prevalence of antenatal and postnatal depression ranged 15–65% and 5–35% among participants, respectively. Suicidal ideation ranged 5–11% during pregnancy and 2–22% during the postpartum period. Study participants who had experienced IPV had 1.69–3.76 and 1.46–7.04 higher odds of antenatal and postnatal depression compared to those who had not, depending on country, and IPV type and severity. Considering the strong association between IPV and mental disorders, efforts should focus on developing IPV interventions aimed at preventing pregnancy during IPV and promoting mental health resilience among pregnancy and postpartum women in low and lower-middle-income countries.

12. DISPARITIES IN EXPOSURE TO INTIMATE PARTNER VIOLENCE AMONG TRANSGENDER/GENDER NONCONFORMING AND SEXUAL MINORITY PRIMARY CARE PATIENTS

Sarah E Valentine¹, Sarah M Peitzmeier², Dana S King³, Conall O'Cleirigh^{3,4}, Samantha M Marquez³, Cara Presley⁵, Jennifer Potter⁶

LGBT Health. 2017 Aug;4(4):260-267 doi: 10.1089/lgbt.2016.0113. Epub 2017 Jul 18.

Abstract

Purpose: We investigated the odds of intimate partner violence (IPV) among primary care patients across subgroups of transgender and gender nonconforming (TGNC) individuals relative to cisgender women, and cisgender sexual minority men and women relative to cisgender heterosexual men and women.

Methods: Participants completed an IPV screener as part of routine primary care visits at an urban community health center (N = 7572). Electronic medical record data were pooled for all patients who received the IPV screener January 1 to December 31, 2014.

Results: Overall, 3.6% of the sample reported experiencing physical or sexual IPV in the past year. Compared to cisgender women (past-year prevalence 2.7%), all TGNC subgroups reported elevated odds of physical or sexual IPV, including transgender women (past-year prevalence 12.1%; adjusted odds ratio [AOR] = 5.0, 95% confidence interval [CI] = 2.9-8.6), transgender men (6.6%; AOR = 2.4, 95% CI: 1.2-4.6), gender non-binary individuals (8.2%, AOR = 3.1, 95% CI = 1.7-5.4), and TGNC individuals who did not report their gender identity (9.1%; AOR = 3.7, 95% CI = 2.2-6.3). The prevalence of isolation-related IPV and controlling behaviors was also high in some TGNC groups.

Conclusion: Our findings support that IPV is prevalent across genders and sexual orientations. Clinical guidelines for IPV screening should be expanded to include TGNC individuals and not just cisgender women. Future research could explore the complex patterns by which individuals of different genders are at increased risk for different types of IPV, and investigate the best ways to screen TGNC patients and support TGNC survivors.

Keywords: gender nonconforming; intimate partner violence; primary care; screening; transgender.

13. [MENTAL DISORDERS AND INTIMATE PARTNER VIOLENCE PERPETRATED BY MEN TOWARDS WOMEN: A SWEDISH POPULATION-BASED LONGITUDINAL STUDY.](#)

Yu R, Nevado-Holgado AJ, Molero Y, D'Onfrio BM, Larsson H, Howard LM, Fazel S.

PLoS Medicine. 2019 Dec 17;16(12): e1002995. DOI:

<https://doi.org/10.1371/journal.pmed.1002995>

Abstract

Background: Intimate partner violence (IPV) against women is associated with a wide range of adverse outcomes. Although mental disorders have been linked to an increased risk of perpetrating IPV against women, the direction and magnitude of the association remain uncertain. In a longitudinal design, we examined the association between mental disorders and IPV perpetrated by men towards women in a population-based sample and used sibling comparisons to control for factors shared by siblings, such as genetic and early family environmental factors.

Methods and findings: Using Swedish nationwide registries, we identified men from 9 diagnostic groups over 1998–2013, with sample sizes ranging from 9,529 with autism to 88,182 with depressive disorder. We matched individuals by age and sex to general population controls (ranging from 186,017 to 1,719,318 controls), and calculated the hazard ratios of IPV against women. We also estimated the hazard ratios of IPV against women in unaffected full siblings (ranging from 4,818 to 37,885 individuals) compared with the population controls. Afterwards, we compared the hazard ratios for individuals with psychiatric diagnoses with those for siblings using the ratio of hazard ratios (RHR). In sensitivity analyses, we examined the contribution of previous IPV against women and common psychiatric comorbidities, substance use disorders and personality disorders. The average follow-up time across diagnoses ranged from 3.4 to 4.8 years. In comparison to general population controls, all psychiatric diagnoses studied except autism were associated with an increased risk of IPV against women in men, with hazard ratios ranging from 1.5 (95% CI 1.3–1.7) to 7.7 (7.2–8.3) (p -values < 0.001). In sibling analyses, we found that men with depressive disorder, anxiety disorder, alcohol use disorder, drug use disorder, attention deficit hyperactivity disorder, and personality disorders had a higher risk of IPV against women than their unaffected siblings, with RHR values ranging from 1.7 (1.3–2.1) to 4.4 (3.7–5.2) (p -values < 0.001). Sensitivity analyses showed higher risk of IPV against women in men when comorbid substance use disorders and personality disorders were present, compared to risk when these comorbidities were absent. In addition, increased IPV risk was also found in those without previous IPV against women. The absolute rates of IPV against women ranged from 0.1% to 2.1% across diagnoses over 3.4 to 4.8 years. Individuals with alcohol use disorders (1.7%, 1,406/82,731) and drug use disorders (2.1%, 1,216/57,901) had the highest rates. Our analyses were restricted to IPV leading to arrest, suggesting that the applicability of our results may be limited to more severe forms of IPV perpetration.

Conclusions: Our results indicate that most of the studied mental disorders are associated with an increased risk of perpetrating IPV towards women, and that substance use disorders, as principal or comorbid diagnoses, have the highest absolute and relative risks. The findings support the development of IPV risk identification and prevention services among men with substance use disorders as an approach to reduce the prevalence of IPV.

14. PSYCHOLOGICAL INTERVENTIONS FOR COMMON MENTAL DISORDERS IN WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE IN LOW AND MIDDLE-INCOME COUNTRIES: A SYSTEMATIC REVIEW AND META-ANALYSIS.

Keynejad RC, Hanlon C, Howard LM.

The Lancet Psychiatry. 2020 Feb;7(2):173-190. DOI: [https://doi.org/10.1016/S2215-0366\(19\)30510-3](https://doi.org/10.1016/S2215-0366(19)30510-3)

Abstract

Background: Evidence on the effectiveness of psychological interventions for women with common mental disorders (CMDs) who also experience intimate partner violence is scarce. We aimed to test our hypothesis that exposure to intimate partner violence would reduce intervention effectiveness for CMDs in low-income and middle-income countries (LMICs).

Methods :For this systematic review and meta-analysis, we searched MEDLINE, Embase, PsycINFO, Web of Knowledge, Scopus, CINAHL, LILACS, ScieELO, Cochrane, PubMed databases, trials registries, 3ie, Google Scholar, and forward and backward citations for studies published between database inception and Aug 16, 2019. All randomised controlled trials (RCTs) of psychological interventions for CMDs in LMICs which measured intimate partner violence were included, without language or date restrictions. We approached study authors to obtain unpublished aggregate subgroup data for women who did and did not report intimate partner violence. We did separate random-effects meta-analyses for anxiety, depression, post-traumatic stress disorder (PTSD), and psychological distress outcomes. Evidence from randomised controlled trials was synthesised as differences between standardised mean differences (SMDs) for change in symptoms, comparing women who did and who did not report intimate partner violence via random-effects meta-analyses. The quality of the evidence was assessed with the Cochrane risk of bias tool. This study is registered on PROSPERO, number CRD42017078611.

Findings: Of 8122 records identified, 21 were eligible and data were available for 15 RCTs, all of which had a low to moderate risk of overall bias. Anxiety (five interventions, 728 participants) showed a greater response to intervention among women reporting intimate partner violence than among those who did not (difference in standardised mean differences [dSMD] 0·31, 95% CI 0·04 to 0·57, $I^2=49\cdot4\%$). No differences in response to intervention were seen in women reporting intimate partner violence for PTSD (eight interventions, n=1436; dSMD 0·14, 95% CI -0·06 to 0·33, $I^2=42\cdot6\%$), depression (12 interventions, n=2940; 0·10, -0·04 to 0·25, $I^2=49\cdot3\%$), and psychological distress (four interventions, n=1591; 0·07, -0·05 to 0·18, $I^2=0\cdot0\%$, p=0·681).

Interpretation: Psychological interventions treat anxiety effectively in women with current or recent intimate partner violence exposure in LMICs when delivered by appropriately trained and supervised health-care staff, even when not tailored for this population or targeting intimate partner violence directly. Future research should investigate whether adapting evidence-based psychological interventions for CMDs to address intimate partner violence enhances their acceptability, feasibility, and effectiveness in LMICs.

15. [PSYCHOLOGICAL THERAPIES FOR WOMEN WHO EXPERIENCE INTIMATE PARTNER VIOLENCE.](#)

Hameed M(1), O'Doherty L(2), Gilchrist G(3), Tirado-Muñoz J(4), Taft A(5), Chondros P(1), Feder G(6), Tan M(1), Hegarty K(1)(7). doi: 10.1002/14651858.CD013017. Cochrane Database Syst Rev. 2020 Jul 1;7(7):CD013017. doi: 10.1002/14651858.CD013017.pub2.

OBJECTIVES: To assess the effectiveness of psychological therapies for women who experience IPV on the primary outcomes of depression, self-efficacy and an indicator of harm (dropouts) at six- to 12-months' follow-up, and on secondary outcomes of other mental health symptoms, anxiety, quality of life, re-exposure to IPV, safety planning and behaviours, use of healthcare and IPV services, and social support.

SEARCH METHODS: We searched the Cochrane Common Mental Disorders Controlled Trials Register (CCMDCTR), CENTRAL, MEDLINE, Embase, CINAHL, PsycINFO, and three other databases, to the end of October 2019. We also searched international trials registries to identify unpublished or ongoing trials and handsearched selected journals, reference lists of included trials and grey literature.

SELECTION CRITERIA: We included randomised controlled trials (RCTs), quasi-RCTs, cluster-RCTs and cross-over trials of psychological therapies with women aged 16 years and older who self-reported recent or lifetime experience of IPV. We included trials if women also experienced co-existing mental health diagnoses or substance abuse issues, or both. Psychological therapies included a wide range of interventions that targeted cognition, motivation and behaviour compared with usual care, no treatment, delayed or minimal interventions. We classified psychological therapies according to Cochrane Common Mental Disorders's psychological therapies list.

DATA COLLECTION AND ANALYSIS: Two review authors extracted data and undertook 'Risk of Bias' assessment. Treatment effects were compared between experimental and comparator interventions at short-term (up to six months post-baseline), medium-term (six to under 12 months, primary outcome time point), and long-term follow-up (12 months and above). We used standardised mean difference (SMD) for continuous and odds ratio (OR) for dichotomous outcomes, and used random-effects meta-analysis, due to high heterogeneity across trials.

MAIN RESULTS: We included 33 psychological trials involving 5517 women randomly assigned to experimental (2798 women, 51%) and comparator interventions (2719 women, 49%). Psychological therapies included 11 integrative therapies, nine humanistic therapies, six cognitive behavioural therapy, four third-wave cognitive behavioural therapies and three other psychologically-orientated interventions.

AUTHORS' CONCLUSIONS: There is evidence that for women who experience IPV, psychological therapies probably reduce depression and may reduce anxiety. However, we are uncertain whether psychological therapies improve other outcomes (self-efficacy, post-traumatic stress disorder, re-exposure to IPV, safety planning) and there are limited data on harm. Thus, while psychological therapies probably improve emotional health, it is unclear if women's ongoing needs for safety, support and holistic healing from complex trauma are addressed by this approach. There is a need for more interventions focused on trauma approaches and more rigorous trials (with consistent outcomes at similar follow-up time points), as we were unable to synthesise much of the research.

16. [PSYCHOLOGICAL AND PHARMACOLOGICAL TREATMENTS FOR ADULTS WITH POSTTRAUMATIC STRESS DISORDER: A SYSTEMATIC REVIEW UPDATE](#)

Hoffman V, Middleton K, Feltner C, Gaynes B, Weber R, Bann C, Viswanathan M, et al. AHRQ Publications. 2018 doi: <https://doi.org/10.23970/AHRQEPCCER207>

Excerpt: This systematic review uses current methods to update a report published in 2013 that evaluated psychological and pharmacological treatments of adults with posttraumatic stress disorder (PTSD). This review focuses on updating the earlier work, expanding the range of treatments examined, addressing earlier uncertainties, identifying ways to improve care for PTSD patients, and reducing variation in existing treatment guidelines. Treatments examined are shown in Table A. The analytic framework that guides our review is shown in Figure A.

Results/Key Findings

- We used information from 207 published articles reporting on 193 studies to answer our Key Questions (KQs).

- KQ 1 (Psychological Treatment) Findings (Table B)

- Two types of cognitive behavioral therapy (CBT) treatments had high strength of evidence (SOE) of benefit in reducing PTSD-related outcomes. These treatments included CBT-exposure and CBT-mixed treatments (CBT-mixed was a term we used to combine CBT treatments that had different types of CBT characteristics).

- Other psychological treatments with moderate SOE of benefit included cognitive processing therapy (CPT), cognitive therapy (CT), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET).

- Moderate strength of evidence favored CBT-exposure over relaxation for reducing PTSD-related outcomes.

- KQ 2 (Pharmacological Treatment) Findings (Table C)

- Moderate SOE of benefit in reduction in PTSD-related outcomes for fluoxetine, paroxetine, and venlafaxine as compared with placebo.

KQ 3 (Psychological Versus Pharmacological Treatment) Findings

- Insufficient evidence from a single study examined the comparative effectiveness of a psychological and pharmacological treatment.

- KQ 4 (Adverse Events of Treatments)

- Most studies did not describe methods used to systematically assess adverse event information.

- Insufficient evidence was found for all serious adverse event comparisons between and across psychological and pharmacological treatments.

- When looking at the treatments with at least moderate SOE of benefit, the only adverse event found to have at least moderate SOE was nausea, with venlafaxine.

- Insufficient evidence from only a few studies tested whether efficacy or effectiveness of treatments differed by patient characteristics such as type of trauma exposure, cooccurring condition, or other characteristics (KQs 1a, 2a, 3a).

- For many of our outcomes of interest and interventions of interest (including newer treatments added since our prior review), we did not identify any studies that tested them (KQs 1, 2, 3).

17. PSYCHOSOCIAL INTERVENTIONS FOR INTIMATE PARTNER VIOLENCE IN LOW AND MIDDLE INCOME COUNTRIES: A META-ANALYSIS OF RANDOMISED CONTROLLED TRIALS.

Turner DT, Riedel E, Kobeissi LH, Karyotaki E, Garcia-Moreno C, Say L, Cuijpers P. J Glob Health. 2020 Jun;10(1):010409. doi: 10.7189/jogh.10.010409. DOI: 10.7189/jogh.10.010409

BACKGROUND: Intimate partner violence (IPV) is prevalent worldwide and presents pernicious consequences for women in developing countries or humanitarian settings. We examined the efficacy of psychosocial interventions for IPV among women in low- and middle-income countries (LMICs).

METHODS: Seven databases were systematically searched for randomised controlled trials (RCTs) examining psychosocial interventions for IPV in LMICs. Thirteen RCTs were included in random-effects meta-analyses. Risk ratios (RR) and risk difference were calculated as pooled effect sizes. Risk of bias was assessed using an adapted version of the Cochrane tool accounting for cluster RCTs. Sensitivity analyses were conducted for risk of bias and design characteristics. Publication bias and heterogeneity were assessed.

RESULTS: Psychosocial interventions reduced any form of IPV by 27% at shortest (relative risk (RR) = 0.73) and 25% at longest (RR = 0.75) follow up. Physical IPV was reduced by 22% at shortest (RR = 0.78) and 27% at longest (RR = 0.73) follow up. Sexual IPV was reduced by 23% at longest follow up (RR = 0.77) but showed no significant effect at shortest follow-up. Sensitivity analyses for risk of bias led to an increase in magnitude of the effect for any form of IPV and physical IPV. The effect on sexual IPV was no longer significant. Heterogeneity was moderate to high in the majority of comparisons.

CONCLUSIONS: Psychosocial interventions may reduce the impact of IPV in humanitarian or low and middle income settings. We acknowledge heterogeneity and limited availability of RCTs demonstrating minimal risk of bias as limitations.

RESOURCE 3

Slides on

Intimate Partner Violence

WHAT IS INTIMATE PARTNER VIOLENCE (IPV)?

- Behavior by a current or previous intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours
- Now includes stalking and financial abuse

WHO 2013
CDC

IPV

- A human right and public health problem
- In all developed and developing countries
- Affects individuals in all walks of life
- Associated with poverty, lower education, indigenous and disabled women
- Heterosexual or same sex relationships
- Occurs in men and women but injuries worse in women (including death)
- A way of expressing power and control over the partner
 - (A result of men having more power than women in traditional settings)

PATTERNS OF IPV

- Situational violence: usually episodic. Less violence. Often bilateral
- Intimate partner terrorism: more severe, chronic abuse aimed at coercive control
- IPV often escalates over time with “cycle of violence”
- Violence may escalate when the victim discloses or leaves
- Harassment and stalking may follow separation

INTERNATIONAL IPV

- WHO 10 country study of 24 097 women found highest rates in rural Ethiopia and Peru
- WHO 15 country study of IPV in pregnancy ranged from 2 to 13.5%
- WHO lifetime prevalence globally is 30% for women
- Regional variations: high rates Africa, SE Asia, Middle East
- US National IPV/SV found lifetime IPV in 36% women and 29% men

Garcia-Moreno C. 2006

IPV DURING PREGNANCY AND PERINATAL MENTAL DISORDERS IN LLMIC

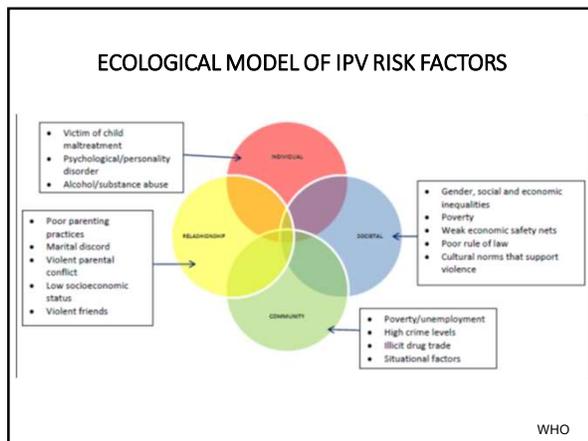
- Systematic review in low and lower-middle income countries (LLMIC)
- 24 studies (1990-2017) in 10 LLMIC countries
- Prevalence of physical IPV =2-35%, sexual IPV= 9-40%, psychological abuse =22-65% of participants
- Antenatal depression= 15-65%, postnatal depression= 5-35% following IPV
- Higher odds of depression up to 7-fold following IPV depending on country and IPV type and severity
- Suicidal ideation 5-11% during pregnancy, 2-22% postpartum following IPV

Halim N et al. Clin Psych Rev ver18;66:117-135
<https://www.sciencedirect.com/science/article/pii/S0272735817302568?via%3Dihub>

COVID-19 LOCKDOWN AND IPV

- National/international data shows an increase in IPV during COVID- 30% more than previous years
- Quarantine, social distancing, lockdown:
 - Disruption of social and protective networks
 - Forced cohabitation with perpetrator
- Increase in alcohol/drug consumption by one or both partners
- Economic stressors and uncertainty:
 - Worsening of perpetrator’s mental health
- Need for awareness and alternative services (telemedicine and services)

Roesch E et al. BMJ 2020;369:m1712. doi: 10.1136/bmj.m1712.
Bhavsar V et al. Lancet Psychiatry 2020;S2215-0366(20)30397-7. doi: 10.1016/S2215-0366(20)30397-7.
Glusay B et al. J Womens Health (Larchmt) 2020;29(10):1239-1242. doi: 10.1089/jwh.2020.8590.
<https://reliefweb.int/sites/reliefweb.int/files/resources/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf>



MYTH OR FACT

“If a women is abused she can/should just leave”

- Abused women stay for different reasons:
 - Abuser threats to kill. Up to 50% of abused women who leave are killed within 2 months of leaving
 - Stress precludes women from considering alternatives
 - Financially dependent on abuser
 - Strong beliefs that family must stay together
 - Societal, religious and family pressures to stay
 - Abusers repeatedly promise to change (cycle of violence)
 - Afraid to lose their children
 - Immigration concerns: deportation

MYTH OR FACT

“Substance abuse and stress cause battering”

- Alcohol, drug use and stress do not cause IPV
- Abusers use substance abuse and stress as excuses for violence
- However, alcohol and drug may disinhibit abusers and victims and make violence more likely
- Most people under extreme stress do not assault their partners
- Most people who drink heavily do not hit their coworkers or strangers

COMMON IPV CONCERNS/MISCONCEPTIONS BY MENTAL HEALTH PROFESSIONALS

- IPV is a social/personal/legal issue; not a mental health one
- The victim may have deserved it by behaviour, dress, location, relationship, alcohol intake
- Frustration that the woman will not leave her partner
- There is nothing useful I can do
- I feel helpless
- I don't have time for this
- The perpetrator may seek revenge on me
- How to deal with abusive partners

PHYSICAL HEALTH SEQUELAE OF IPV

- Physical:** death, fractures, contusions, lacerations, dental injuries, concussion
- Functional physical conditions:** gastrointestinal, musculoskeletal, headaches, quality of life decrease
- Reproduction:** STDs, HIV, sexual problems, miscarriage, infertility, unintended pregnancy, shorter gestation, fetal death, unsafe abortion

MENTAL HEALTH SEQUELAE OF IPV

- Emotional:**
 - depression, anxiety
 - PTSD/complex posttraumatic stress disorder
 - suicide, self harm
 - alcohol and substance use disorders
 - psychosis
 - somatization/chronic pain
 - sleep/eating disorders
 - risky behaviors

EFFECT OF IPV ON CHILDREN

- Children usually know (hear, see)
- IPV more common in families with younger than older children
- Child may also experience abuse
- May suffer psychological effects from IPV-behaviour or psychological
- Poor role modelling
- More likely to become victims or abusers as adults: “intergenerational violence”

PERPETRATORS

- May have been exposed to IPV or abuse as a child
- Family /society/beliefs condone IPV
- May need to control partner or have anger management problems
- May have a personality disorder
- May be alcoholic or have other substance use disorder
- (No intervention proven helpful to reduce IPV)
- May be depressed/anxious or other mental health disorder including psychosis, ADHD
- May have dementia or other organic brain syndrome
- Refer appropriately to another provider/service
- Important not to increase danger to the victim!

Yu R et al. PLoS Med. 2019; 16(12): e1002995

SYSTEMATIC REVIEW OF PSYCHIATRIC PATIENTS AND IPV

- 42 studies of inpatient and outpatient psychiatric patients
- Approximately 30% of men and women inpatients and outpatients had lifetime history of IPV
- Often unrecognized by HCP
- 41 studies
- Women with depressive disorders OR=2.77 IPV
anxiety disorders OR=4.08 IPV
PTSD OR=7.34 IPV
compared to women without a mental disorder

Trevillion et al. 2012
Oram et al. 2013

CASE FINDING

- Be alert to signs and symptoms of IPV
- Psychological signs/symptoms: depression, anxiety disorders (PTSD), chronic pain, eating disorders, sleep disorders, psychosomatic disorders, substance abuse, self-harm, some personality disorders (BPD), non-affective psychosis
- Inquiry about past or current IPV
- Delays in help seeking or multiple missed appointments

CASE FINDING (cont'd)

- Private, safe, supportive confidential environment (partner not present!)
- May not disclose: fear, censure, embarrassment, shame, economic dependency, worry about child custody, immigration, legal
- Family not used as translator!
- Cultural competence (female interviewer if needed)
- Essential not to increase patient's risk!

TRAUMA INFORMED MODEL OF CARE

- A program, organization or system that:
 - Realizes the widespread impact of trauma and understands potential paths to recovery. (“Survivor centred care”)
 - Recognizes the stages and symptoms of trauma in clients, family, staff and others
 - Fully integrates knowledge about trauma in policies, proceedings and practices
 - Seeks to actively resist re-traumatization

Substance Abuse and Mental Health Services Admin (SAMSA)

SIGNS OF POSSIBLE IPV

- High levels of stress, anxiety or depression
- Unexplained injuries (or unlikely explanations)
- Unexplained fear (esp. of partner)
- Social withdrawal from friends or family
- Restricted access to family finances
- Sudden absences or change in plans

SOME POSSIBLE DISCLOSURE QUESTIONS

- “How are things at home?”
- “It’s important for me to understand my patient’s safety in close relationships.”
- “Have you felt humiliated or emotionally harmed by your partner or ex-partner?”
- “Do you feel safe in your current or previous relationships?”
- “Have you ever been physically threatened or harmed by your partner or ex-partner?”
- “Have you ever been forced to have any kind of sexual activity by your partner or ex-partner?”
- “Do you feel your partner over-controls you in your relationships with family, friends or in financial matters?”

WHEN IPV IS DISCLOSED

- Validation (“Unfortunately this is common in our society.”)
- Affirmation (“Violence is unacceptable – you deserve to feel safe at home.”)
- Support (“There are things we can discuss that can help.”)
- Ask about safety and plan as needed!
- No critical remarks (“Why don’t you just leave?”)
- Respect the individual’s concerns and decisions
- Know local legislation and services
- Refer appropriately to other services
- Document carefully!

“LIVES”

- Listen: empathic and non-judgmental
- Inquire about needs and concerns (emotional, physical, social, practical)
- Validate: show you believe and understand the victim
- Enhance safety: discuss how protect against further harm
- Support: help connect to services and social support

WHO

THERAPIST CONSIDERATIONS

- Recognize connections of symptoms with trauma
- Pay attention to safety concerns
- Consider other co-morbidities
- Recognize difficulties with trust
- Don’t push her to leave
- Pay attention to countertransference
- Affect regulation and how to process emotions safely (without alcohol)
- Couple therapy not safe in serious abuse

DECISION TO LEAVE PARTNER

- Stages of change (Prochaska)
- Risk of violence increases during and following leaving
- “Do you feel safe to return home today?”
- “Do you have a safety plan?”
- “Does your partner have a weapon?”
- Referral to appropriate services (shelter, legal, advocacy, medical, mental health)
- Court protection orders may be helpful

IMMEDIATE PSYCHOLOGICAL MANAGEMENT

- Supportive psychological first aid
- Reassure victim that her reaction is understandable
- Reassure this is a safe, confidential environment
- Ask if it is safe to return home today
- Help mobilize social support
- Assist with referrals to appropriate services: locally
- Educate on effects of trauma: anxiety, hyperarousal, irritability, sleep disturbances, re-experiencing

PSYCHOLOGICAL GROUNDING METHODS

- Simple strategies to detach from severe emotional pain (flashbacks, anxiety etc)
- Creates a safe place to regain control over overwhelming emotions or “numbing”
- Distraction by focusing on the external world rather than inward
- Examples:
 - Touch the chair you are in and describe it
 - Repeat a safe statement “I am safe here”
 - Think about a soothing scene
 - Tap feet on the floor

IMMEDIATE PSYCHOLOGICAL MANAGEMENT

- Use grounding techniques and focus on present if needed
- Tech relaxation/breathing exercises
- If psychological supports do not work can use short term benzodiazepines for severe anxiety
- NO evidence for propranolol, escitalopram, temazepam, gabapentin to prevent PTSD
- Depends on patient, abuse, relationship, readiness for changes, resilience, culture
- Follow-up visit and inform family doctor

ADVOCACY INTERVENTIONS

- Facilitation for shelters, housing
- Informal counselling/ongoing support
- Safety planning, legal and financial services
- Intensive counselling > 12 hours reduced IPV and improved QOL
- Reduced physical, psychological IPV but not sexual or any IPV

Tirado-Munoz et al. 2014
Cochrane Review 2009

ANXIETY DISORDERS AND DEPRESSION

- Common after IPV
- CBT should include traumatic exposure
- Address cognitive distortions
- Exposure therapy for anxiety should consider trauma
- Serotonin reuptake inhibitors/SNRIs may be useful
- Benzodiazepines only short term for severe anxiety

THERAPY FOR POSTTRAUMATIC STRESS DISORDER

- High strength of evidence (SOE): Cognitive behavioral therapy (CBT), Exposure Therapy, Mixed CBT
- Moderate SOE: Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, Narrative Exposure Therapy, paroxetine, venlafaxine
- Low SOE: sertraline, olanzapine, risperidone, topiramate, prazosin

Hoffman et al. 2018. Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder: A Systematic Review Update.
https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/cer-207-ptsd-update-2018-rev_0.pdf

PSYCHOLOGICAL INTERVENTIONS FOR COMMON MENTAL DISORDERS FOLLOWING IPV IN LMIC

- 21 eligible papers identified (15 RCTs) (Low –mod bias). Women exposed to IPV
- Greater response in 5 interventions for anxiety in women exposed to IPV than unexposed women
- Equal response in 8 interventions for PTSD
- Equal response in 12 interventions for depression
- Equal response in 4 interventions for distress
- Studies in Africa (7), Asia (7), post conflict (4), refugee camp (1)

Keynejad R. Lancet Psychiatry 2020;2:173-190

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

- Standardized procedure to focus simultaneously on
 - a) Spontaneous associations of traumatic images, thoughts, emotions, bodily sensations and
 - b) Bilateral stimulation, usually horizontal repetitive eye movements
- It does NOT include detailed description of the event, direct challenging of beliefs or extended exposure as in CBT

SUBSTANCE USE DISORDERS (SUD)

- May antedate IPV or be a coping mechanism
- Can combine individual TFCBT for IPV with SUD therapy
- Reduces PTSD severity and SUD
- Group interventions did not work

Roberts NP et al 2015

WHO GUIDELINES

- Mobilize social support
- Coping strategies: written materials (safety)
- Appropriate referrals (legal, housing, advocacy)
- Service directory including shelters
- Services 24/7 / Hotlines
- Psychosocial support/ counseling
- Assess for mental health problems (PTSD, substance abuse, depression, anxiety, self-harm, sleep) and refer appropriately

Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines (2013)

WHAT ABUSED WOMEN WANT

- Healthcare providers to listen, believe, express concern, be non-judgmental
- Make appropriate referrals to shelter, social, physical and mental health services, legal services
- Clarify legal status “IPV is a crime in this country”
- Warn about need to report to child welfare if applicable
- Discussion about safety
- Emotional validation and support!

G Feder 2006

USEFUL RESOURCES

- Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines

<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

- WHO Clinical Handbook “Healthcare for Women subjected to Intimate Partner Violence and Sexual Violence” ★

<http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>

- VEGA- Violence, Evidence, guidance, Action

<https://vegaproject.mcmaster.ca/>

RESOURCE 4

Clinical Vignettes, Selected Teaching Points, and Quiz for IPV

The following short clinical vignettes include several factors in intimate partner violence (IPV) and sexual violence (SV) that may be seen by medical students, mental health trainees (residents) and psychiatrists. These patients were seen in various settings by staff with different levels of training and expertise. The patients come from different backgrounds and suffer from anxiety, depression, posttraumatic stress disorder and somatization. Each vignette is followed by selected teaching points which may be used by trainees to guide discussion and learning.

The vignettes are followed by a brief quiz for learners with the correct answers provided below.

Complete the quiz before accessing the answers below.

Vignette #	IPV Correct Answer
1	B
2	D
3	B
4	C
5	C
6	C
7	A
8	D

1. Emergency Department Assessment of Intimate Partner Violence

Miriam, the 28-year-old wife of the town mayor, arrives in the Emergency Department with a hand laceration. She is tearful and appears fearful. Her husband reports his wife's hand slipped while preparing a melon, causing the cut. The psychiatric trainee (resident) respectfully but firmly asks the husband to move to the waiting room but he strenuously objects before leaving.

Her physical injuries are treated. The resident then quietly asks Miriam if she feels safe here and why she is crying. Miriam asks if her conversation can be overheard and if it is confidential. She is reassured that it is safe and confidential. She continues to cry. The resident asks if she is fearful of anyone and if she feels safe at home. She reveals that her husband became violently angry when his supper was not ready and punched her in the eye. She attempted to prevent further blows by raising a knife she was using to cut a melon but he grabbed it and during the struggle her hand was cut. Miriam reports that this is the most severe episode but that he has been psychologically abusive and controlling for about 2 years, especially if he has been drinking. She reports that she feels anxious but on history and mental status exam she does not have a diagnosable mental disorder.

The resident listens quietly and tells Miriam in a supportive and kindly manner that unfortunately intimate partner physical and psychological violence is common and affects approximately one in three women during their lifetime. He tells her she deserves to feel safe at home and there are things that can be recommended to help her. He tells her about local shelters, social and mental health/counselling services and asks her if it is safe to return home today. He discusses what services she would like to access and helps with appropriate referrals including the phone number of the local shelter and other social services. He carefully documents the details of their communication in the medical records. Follow-up with the woman's family doctor is arranged with the woman's permission.

Selected Teaching Points:

- Take a history in a private place without the partner present
- Ask what caused an injury and be alert to IPV
- Psychological abuse usually precedes physical abuse
- Alcohol may disinhibit the perpetrator or make the victim less able to respond appropriately
- Consider power differentials in IPV: the husband is the town's mayor. This must be considered also in very traditional settings where men make all decisions, where there is no recognition for the contribution of women and in couples with a large age or educational gap between partners
- The importance of using the "LIVES" (Listen, Inquire, Validate, Enhance safety, Support) model in dealing with all IPV victims
- The injury and discussion should be carefully documented in the chart
- Referral to appropriate services and follow-up is important so a list of local services and how to safely contact them should be developed (electronically, phone, letter or in person)

Quiz: Please mark an X beside the **CORRECT** response below:

Alcohol use:

- A. is responsible for most IPV
- B. increases the likelihood that violence occurs
- C. has no role in the etiology of VAW
- D. is less important than the use of methamphetamine

2. Suicidal Thoughts and Intimate Partner Violence

Ms. G, a 32-year-old economist presents to the Emergency Department accompanied by her partner because she has taken a benzodiazepine overdose with apparent suicidal intent. The psychiatrist asks the patient's partner to move to the waiting area and asks the woman about her story. The patient is the head of the regional office and doing very well, except she never participates in after-office activities because of her partner's controlling behavior. She discloses that her father is an alcoholic who frequently beat her mother but was extremely deferential to her [patient]. Her parents live in another city and seldom visit her because they dislike Ms G.'s partner. She has been contemplating suicide for the past three months, since her partner slapped her because she came home late after some urgent work. She does not have any friends and feels very isolated. This violent episode is the worst incident in a long history of recrimination, questioning and insults. The psychiatrist says that her partner's behavior is not acceptable, detrimental to the woman's mental health and may be linked to her desire to die. The psychiatrist also points out that violence is extremely common and happens to women of all classes and occupations and it is not the patient's fault.

Selected Teaching Points:

- Suicidal ideation and intent in women may be linked to IPV, so exposure to IPV should be explored in women presenting with suicidal ideation or attempts
- Lack of social/family support puts women at risk of IPV
- The history of exposure to IPV in her parents is significant (intergenerational cycle of violence).
- Women with depression and/or suicidality should be referred for treatment according to current guidelines.

Quiz: Please mark an X beside the **INCORRECT** response below:

- A. Perform a complete mental status examination and make a diagnosis
- B. Explore her current suicidal ideation or plan and risk
- C. Encourage a referral for psychiatric follow up and support services
- D. Order her to be admitted involuntarily to a psychiatry unit as she took an overdose

3. Mental Health Consultations and Intimate Partner Violence

A family doctor refers Maria, age 62, to a psychiatrist for treatment of anxiety and depression. Maria changes her consultation appointment three times before attending your office. She is visibly anxious when you ask her about her intimate partner relationship. When you comment that you can see this subject seems to make her more anxious and tearful, she replies “My partner is very difficult especially since he lost his job but I am really just here for my anxiety as all meds don’t work”. You ask more about her partner and she says “I don’t want to discuss him”. You ask if she feels safe at home and she begins to cry while shaking her head “no”. She reports that her partner is verbally and sometimes physically abusive. You ask if it is safe to return home today and she reports that he is out of the country for 10 days. You tell her that family violence is illegal and everyone deserves to feel safe at home.

Selected Teaching Points:

- Older women may also be subject to IPV
- Partner unemployment/ financial difficulties is a risk factor for IPV
- Frequent changes of appointments are sometimes signs of IPV
- Reluctance or anxiety in discussing an intimate relationship may be an indication of IPV
- Safety inquiries may unmask IPV
- Safety planning is vital: how to safely keep documents, money and clothes that she can access rapidly if she needs to flee. Location of willing friends, relatives or IPV shelters in emergency situations
- Knowledge of local laws regarding restraining orders or other protective measures is vital
- How would you treat her anxiety/depression?
- What referrals might help?
- What do you document in her chart?
- What are the dangers of taking written materials home?

Quiz: Please mark with an X beside the **INCORRECT** response below:

- A. Provide written material about community services for IPV
- B. Explain that she should leave her husband as he is abusive
- C. Develop a safety plan with her
- D. Provide a follow-up visit to discuss her relationship and treatment of anxiety

4. Somatization and Intimate Partner Violence

Meena is a 24-year-old woman with episodes of fainting and appearing blank for brief spells. Her family physician and neurologist have ruled out epilepsy or other causes of syncope and referred her to the mental health clinic for a consultation. On assessment you find that she complains of fatigue and pains and aches, especially headaches. She has also experienced fainting spells for the last six months.

Meena has been married for the last 5 years and has a child, age 4. She lives with her husband, mother-in-law and a sister-in-law. On enquiry about stress, she is a little hesitant and asks if this conversation is confidential. She then reports that her mother-in-law frequently chides and harasses her about her parents not giving enough gifts in her marriage and later when the child was born. When you ask her if she gets any support from her husband, she tells you that her husband is unsupportive and often listens to his mother and scolds her on minor issues. He ridicules and humiliates her in front of relatives calling her dumb and slow and makes fun of her. In the last six months he has also started slapping her if she is late in getting him meals. When you ask her “Do you think there is some relationship between the violence and your fainting spells” – she says, “I’m not sure but my headache is more when he shouts and he has also hit me on the head several times.”

You ask her if she feels unsafe at home and she says yes but cannot leave because of social reasons. She also mentions that maybe being beaten occasionally is ‘ok’ because it happens in most marriages. You validate her feelings by saying ‘I think I understand how you must be feeling’ and show that you believe her. You then tell her that violence is not acceptable and that you do not consider it is ‘normal’ in marriages and that there are laws against intimate partner violence. You then give her leaflets that have phone numbers of help lines and shelters and mention that she can read them in the waiting area if she would rather not take them with her. You also suggest to her that there might be a relationship between her emotions and her physical symptoms including the fainting spells.

Selected Teaching Points:

- Multiple somatic complaints and dissociation maybe sometimes be signs of IPV
- Violence may be perpetrated by multiple family members, including in-laws
- Consider the emotional environment and support
- How would you make a safety plan for her?
- How would you treat her somatisation and dissociation?
- What referrals might help?
- Under what circumstances could her husband be involved- when and how?

Quiz: Please mark an X beside **INCORRECT** response below:

- A. Perform a mental status examination and make a diagnosis
- B. Inquire about suicidal ideation/plans
- C. Arrange to meet her husband and explain he must not hit her
- D. Arrange for follow up psychological and social help

5. Intimate Partner Violence in the Perinatal Period

Your obstetrician colleague has referred Anita, a new mother to you because she found her distressed during a routine postnatal consultation. You find out that Anita married against her parents' wishes to a man she met while working. You assess for depression and she reports feeling sad most of the time and has difficulty in looking after her two month-old infant. When you ask her about ideas of self-harm, she tells you hesitantly that she gets ideas of harming herself often and she has tried to hang herself using a cloth once but did not do so because she could not imagine abandoning her baby daughter whom she loves very much.

You ask her about problems at home and she mentions that her husband who was very caring while they were dating, has now become increasingly violent. He drinks often and beats her. He also prevents her from going to her maternal home and has taken away her mobile phone so that she cannot be in touch with them. This happened after her parents questioned him about his drinking and abusive behaviour. He does not want her to go back to work when she stops breast-feeding. Her husband's behaviour began during her pregnancy, but increased after the baby was born. Her mother-in-law and husband often express disappointment that the baby is a girl and cries "too much".

Selected Teaching Points:

- A postpartum woman may be overburdened, vulnerable and disappointed with her baby for various reasons
- It is important to assess for different forms of psychological abuse and controlling behaviours- in this case, chiding her for having a girl, taking away her mobile phone
- The need to make a safety plan immediately because of risk for self-harm
- How will you enhance support and encourage Anita to seek support services?
- What are the possible protective factors in her situation?
- How will you treat depression in this situation?

Quiz: Please mark an X beside the **INCORRECT** statement below:

- A. IPV in the perinatal period is not uncommon
- B. Cultural factors in perinatal IPV are important
- C. Antidepressant medication is dangerous to the baby during breastfeeding
- D. Community supports including nurse home visits may be helpful

6. Stages of Change in Disclosure of IPV by Ex-Partner

A 45-year-old woman is referred to a consultant psychiatrist for “treatment-resistant depression” after her previous psychiatrist has treated her unsuccessfully for 2 years. The woman initially denies any history of violence but at the end of the first interview asks “Does this include abuse from an ex-partner?” When the psychiatrist nods, the patient says “I’ve been wondering about this, but need more time to think.” At her second appointment she is asked to discuss her previous statement and after being reassured that the information is confidential, she discloses 3 years of psychological abuse, threats and stalking by her ex-partner.

Selected Teaching Points:

- There are stages of change to disclosing IPV: precontemplation, contemplation, determination, action, maintenance, termination
- Patients may not disclose IPV at the first visit or early interviews
- Patients may be more willing to disclose IPV/SV when they trust the psychiatrist, feel safe and are reassured about confidentiality
- Ex-partners may perpetrate IPV including stalking
- Assessing and treatment of depression/anxiety should include discussion of IPV and its association with symptoms
- Stalking has very serious psychological consequences

Quiz: Please mark an X beside the **CORRECT** statement below:

- A. Failure to disclose IPV means the woman does not want help
- B. Failure to disclose IPV suggests a personality disorder or masochism
- C. Failure to disclose IPV indicates she is not yet ready to discuss IPV
- D. Threats and stalking are not considered IPV

7. Past Same-Sex Partner and Intimate Partner Violence

Marie, a 36-year-old single woman, is referred to a psychiatrist for a 3-year history of chronic anxiety symptoms that have not responded to medications. When asked about past relationships she reports that she left a controlling and verbally abusive same-sex partner two years ago but this ex-partner still harasses her by phone at work and internet and sometimes follows her to work. Her ex-partner also threatens to post intimate photos of her on the computer. Marie works for a very conservative company and is fearful her ex-partner will disclose their past lesbian relationship.

Selected Teaching Points:

- Past partners may perpetrate IPV
- IPV can occur in heterosexual and same-sex relationships
- Harassment and stalking are forms of IPV
- Threats to disseminate intimate photographs or details of their sexual relationships by ex-partners (or current partner) without the woman's permission are a form of IPV

Quiz: Please mark an X beside the **INCORRECT** statement below:

- A. Same-sex IPV is very rare
- B. Differences in size and power are similar in same-sex and heterosexual couples who experience IPV
- C. IPV in same-sex partners can give rise to psychological sequelae
- D. Conservative/homophobic environments may deter disclosure of IPV in same-sex partnerships

8. Children Exposed to Intimate Partner Violence

Stephen, an 8-year-old boy in Grade 3, was frequently in fights at school. He had difficulty academically, but refused additional help. A pediatrician diagnosed attention deficit hyperactivity disorder (ADHD) and prescribed stimulant medication for him. Stephen's problems escalated and he was called to the principal's office after injuring another child. Stephen's younger brother, Edward, began having similar difficulties. The pediatrician referred both children to an outpatient mental health clinic.

When Stephen and Edward attended the clinic, their mother said that her partner, the children's father, worked nights and was not able to come during the day for any appointments. During an individual interview with the mother, she apologized for her partner not being able to attend the appointment, but insisted that no one try to contact him. When discussing her partner, the mother appeared subdued and had poor eye contact.

The mother was asked about relationships in the family. She reported that her partner had a temper, but that most of the time he was ok except when he had too many beers. When asked if she was ever worried about the safety of anyone in the family, she said that she was very careful to ensure that her partner was never alone with the children. When asked about her own safety, the mother said that she had been hit twice across the head and had a telephone thrown at her, but never experienced any injuries. When asked about Stephen's and Edward's exposure to problems between the parents, the mother said she made sure they never knew about the problems between her and their father.

Stephen and Edward were each interviewed individually by a child psychiatrist. Stephen refused to answer any questions initially, but when asked about any worries involving family members, said he is worried that his mom was going to be hurt while he was at school. Edward said that Stephen looked after him and got his breakfast as his mom was usually sleeping when they left for school.

Selected Teaching Points:

- Approach to interviewing family members individually about their experiences at home
- Different types of IPV are sometimes not recognized as IPV by the victim
- Asking children about their daily experiences in the family to identify problems often associated with IPV such as neglect
- Discussion about assisting the mother and the two children; priorities include not compromising her safety, but helping her to see the relationships between the children's problems and their exposure to IPV

Quiz: Please mark an X beside the **INCORRECT** statement below:

- A. Excessive alcohol use is a risk indicator for IPV
- B. ADHD in children may be associated with IPV in parents
- C. Behaviour problems in child may be associated with IPV in parents
- D. Parents usually successfully prevent their children from knowing about IPV

RESOURCE 5: VIDEO-BASED LEARNING VIGNETTES

<https://www.youtube.com/watch?v=A2ZbG6q3FbA&feature=youtu.be>

<https://www.perinatalpsynimhans.org/video-resources.html>

MODULE 2: SEXUAL VIOLENCE

RESOURCE 6:

SV SUGGESTED READING LIST

INDEX

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1. **MENTAL HEALTH CONSEQUENCES OF SEXUAL ASSAULT**

Oberoi N., Patil D., Satyanarayana V.A., In: Chandra P., Herrman H., Fisher J., Riecher-Rössler A. (eds)

Mental Health and Illness of Women, Mental Health and Illness. 2019: 1-23.

https://doi.org/10.1007/978-981-10-2369-9_24.

https://link.springer.com/referenceworkentry/10.1007%2F978-981-10-0371-4_24-1#citeas

Abstract

Sexual assault is a traumatic experience known to impact multiple domains of a person's health, including mental health. This chapter provides a comprehensive overview of the mental health consequences in sexual assault survivors as well as sheds insight into the evidence-based psychological interventions. A brief introduction provides a conceptual underpinning based on existing global literature. The common aftermath of any type of sexual assault and the substantial heterogeneity that exists in the type of assault experiences individuals go through have both been discussed, leading to a complex permutation of outcomes in the affected population. The section on intimate partner violence versus non-partner sexual violence underscores that the relationship with the perpetrator has a significant bearing on the experience and outcome of sexual assault. Specific details with regard to vulnerable populations, such as sexual minorities and people in conflict zones, have also been expounded upon, so as to emphasize that the sociocultural background of the survivors is also paramount in understanding their psychopathology. The section on mental health outcomes in adulthood of childhood sexual abuse survivors validates the fact that such assault can leave significant imprints on the individual's personality and psychological well-being. After discussing the theoretical perspectives of these mental health consequences, the chapter culminates with an update on current practices in terms of effective evidence-based interventions with this vulnerable and distressed population.

2. **SEXUAL VIOLENCE AND MENTAL HEALTH SERVICES: A CALL TO ACTION**

Hughes, E., Lucock, M., & Brooker, C.

Epidemiology and psychiatric sciences.2019; 28(6): 594-597.

doi: 10.1017/S2045796019000040

<https://pubmed.ncbi.nlm.nih.gov/30854994/>

Abstract

People who experience sexual violence are highly likely to experience psychological and/or mental health (MH) problems as a result. People who use MH services often have a history of sexual assault and are also likely to be re-victimised as an adult. Yet despite there being a very clear association, MH services are not yet performing routine enquiry, and even if they do, are not confident about how to record and manage disclosures. There is some emerging evidence that people with MH problems are exposed to sexual violence in inpatient MH settings, perpetrated by both other patients or members of staff. In this editorial, we explore the evidence to support a wider focus on sexual violence as a part of routine care, as well as some recommendations about how staff can more effectively discuss sexual issues including that of sexual victimisation.

3. **AN ECOLOGICAL MODEL OF THE IMPACT OF SEXUAL ASSAULT ON WOMEN'S MENTAL HEALTH**

Campbell, R., Dworkin, E., & Cabral, G.

Trauma, Violence, & Abuse, 2009; 10(3): 225-246.

doi.org/10.1177/1524838009334456.

<https://journals.sagepub.com/doi/abs/10.1177/1524838009334456>

Abstract

This review examines the psychological impact of adult sexual assault through an ecological theoretical perspective to understand how factors at multiple levels of the social ecology contribute to post-assault sequelae. Using Bronfenbrenner's (1979, 1986, 1995) ecological theory of human development, we examine how individual-level factors (e.g., sociodemographics, biological/genetic factors), assault characteristics (e.g., victim-offender relationship, injury, alcohol use), microsystem factors (e.g., informal support from family and friends), meso/ exosystem factors (e.g., contact with the legal, medical, and mental health systems, and rape crisis centers), macrosystem factors (e.g., societal rape myth acceptance), and chronosystem factors (e.g., sexual revictimization and history of other victimizations) affect adult sexual assault survivors' mental health outcomes (e.g., post-traumatic stress disorder, depression, suicidality, and substance use). Self-blame is conceptualized as meta-construct that stems from all levels of this ecological model. Implications for curbing and/or preventing the negative mental health effects of sexual assault are discussed.

4. **SEXUAL ASSAULT VICTIMIZATION AND PSYCHOPATHOLOGY: A REVIEW AND META-ANALYSIS**

Dworkin, E. R., Menon, S. V., Bystrynski, J., & Allen, N. E.

Clinical Psychology Review. 2017;56: 65-81.

doi: 10.1177/1524838018813198.

<https://pubmed.ncbi.nlm.nih.gov/28689071/>

Abstract

Sexual assault (SA) is a common and deleterious form of trauma. Over 40 years of research on its impact has suggested that SA has particularly severe effects on a variety of forms of psychopathology, and has highlighted unique aspects of SA as a form of trauma that contribute to these outcomes. The goal of this meta-analytic review was to synthesize the empirical literature from 1970 to 2014 (reflecting 497 effect sizes) to understand the degree to which (a) SA confers general risk for psychological dysfunction rather than specific risk for posttraumatic stress, and (b) differences in studies and samples account for variation in observed effects. Results indicate that people who have been sexually assaulted report significantly worse psychopathology than unassaulted comparisons (average Hedges' $g = 0.61$). SA was associated with increased risk for all forms of psychopathology assessed, and relatively stronger associations were observed for posttraumatic stress and suicidality. Effects endured across differences in sample demographics. The use of broader SA operationalizations (e.g., including incapacitated, coerced, or nonpenetrative SA) was not associated with differences in effects, although including attempted SA in operationalizations resulted in lower effects. Larger effects were observed in samples with more assaults involving stranger perpetrators, weapons, or physical injury. In the context of the broader literature, our findings provide evidence that experiencing SA is major risk factor for multiple forms of psychological dysfunction across populations and assault types.

5. **THE PREVALENCE OF TECHNOLOGY-FACILITATED SEXUAL VIOLENCE: A META-ANALYSIS AND SYSTEMATIC REVIEW**

Patel, U., & Roesch, R.

Trauma, Violence, & Abuse.2020: 1-16.

doi: 10.1177/1524838020958057

<https://journals.sagepub.com/doi/abs/10.1177/1524838020958057>

Abstract

The primary aim of this systematic review and meta-analysis was to examine the prevalence of technology-facilitated sexual violence (TFSV) within the adolescent and adult population regarding victimization and perpetration. In addition to the primary aim, associated health outcomes with TFSV were discussed through a qualitative lens. Specific forms of TFSV that were examined include distribution of, production of, and threats to distribute sexual material involving another individual without that person's consent via images or videos; 425 articles from MEDLINE, PsycArticles, PsycINFO, Criminal Justice Abstracts, ProQuest Dissertations & Theses, and Google Scholar were screened. Nineteen articles (comprising 20 independent samples) reporting prevalence rates of TFSV on 32,247 participants were included in this random-effects meta-analysis. Pooled prevalence of victimization results revealed that 8.8% of people have had their image or video-based sexts shared without consent, 7.2% have been threatened with sext distribution, and 17.6% have had their image taken without permission. Regarding perpetration, 12% have shared sexts beyond the intended recipient, 2.7% have threatened to share sexts, and 8.9% have nonconsensually taken an image. Moderator variables included publication year, mean participant age, proportion of female participants, and study setting, with meta-regression analyses revealing no significant predictors. Finally, a qualitative analysis of nine articles ($n = 3,990$) was conducted to assess mental health associations with TFSV victimization, revealing significant mental health impacts, including anxiety, depression, and poor coping, for victims.

6. **PHYSICAL, MENTAL AND SOCIAL CONSEQUENCES IN CIVILIANS WHO HAVE EXPERIENCED WAR-RELATED SEXUAL VIOLENCE: A SYSTEMATIC REVIEW**

Ba, I., & Bhopal, R. S.

Public Health.2017; 142: 121-135.

doi: 10.1016/j.puhe.2016.07.019.

<https://pubmed.ncbi.nlm.nih.gov/27622295/>

Abstract

Objectives: To identify the health outcomes of sexual violence on civilians in conflict zones between 1981 and 2014.

Study design: Systematic review.

Methods: For the purpose of this study, we defined sexual violence as sexual torture including, individual rape, gang rape, and sexual slavery. All types of conflicts were included (intrastate, interstate, and internationalized intrastate). Quantitative and mixed-method studies, reporting any physical, mental, and social consequences, were retrieved from Medline, Embase, Global Health, Global Health Library, WHOLIS, Popline, and Web of Sciences ($n = 3075$) and from checking reference lists and personal communications ($n = 359$). Data were analyzed using Microsoft Excel and MetaXL. Given inherent variation, the means derived from combining studies were misleading; thus, we focused on the range of values.

Results: The 20 studies were from six countries, five in Africa (18 studies), and especially in Democratic Republic of Congo (12 studies). The number of subjects varied from 63 to 20,517, with 17 studies including more than 100 subjects. Eight studies included males. Gang rape, rape, and abduction were the most commonly reported types of sexual violence. Sixteen studies provided data on physical outcomes of which the most common were pregnancy (range 3.4–46.3%), traumatic genital injuries/tears (range 2.1–28.7%), rectal and vaginal fistulae (range 9.0–40.7%), sexual problems/dysfunction (range 20.1–56.7%), and sexually transmitted diseases (range 4.6–83.6%). Mental health outcomes were reported in 14 studies, the most frequent being post-traumatic stress disorder (range 3.1–75.9%), anxiety (range 6.9–75%), and depression (range 8.8–76.5%). Eleven studies provided social outcomes, the most common being rejection by family and/or community (range of 3.5–28.5%) and spousal abandonment (range 6.1–64.7%).

Conclusions

Wartime sexual violence is highly traumatic, causing multiple, long-term negative outcomes. The number and quality of studies published does not match the significance of the problem. The findings highlight the need for care of the survivors and their relatives and raise concerns about how they and their children will be affected in the long term.

7. **MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR CONFLICT-RELATED SEXUAL VIOLENCE: PRINCIPLES AND INTERVENTIONS**
<https://apps.who.int/iris/bitstream/handle/10665/75179/WHO?sequence=1>

8. **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) OPINION ON SEXUAL ASSAULT**
<https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2019/04/sexual-assault.pdf>

Note- Though the ACOG recommends routine screening, Routine screening for sexual violence in all patients is controversial and some expert guidance instead recommends appropriate (not standardized,) sensitive questions to facilitate case-finding in patients who present with symptoms suggestive of any sexual assault.

Abstract

Sexual violence continues to be a major public health problem affecting millions of adults and children in the United States. Medical consequences of sexual assault include sexually transmitted infections; mental health conditions, including posttraumatic stress disorder; and risk of unintended pregnancy in reproductive-aged survivors of sexual assault. Obstetrician–gynaecologists and other women’s health care providers play a key role in the evaluation and management of sexual assault survivors and should screen routinely for a history of sexual assault. When sexual violence is identified, individuals should receive appropriate and timely care. A clinician who examines sexual assault survivors in the acute-care setting has a responsibility to comply with state and local statutory or policy requirements for the use of evidence-gathering kits. This document has been updated to include model screening protocols and questions, relevant guidelines from other medical associations, trauma-informed care, and additional guidance regarding acute evaluation of survivors and evidence-gathering kits.

9. **#METOO AND FEMALE PATIENTS WITH MAJOR MENTAL DISORDERS: WHAT SHOULD ACADEMIC PSYCHIATRY DO?**

Coverdale, J., Roberts, L. W., Balon, R., Beresin, E. V., Guerrero, A. P., Louie, A. K., Aggarwal, R., Morreale, M. K., & Brenner, A. M.

Academic Psychiatry.2020; 44(1): 11-15.

doi: 10.1007/s40596-019-01136-5.

<https://link.springer.com/article/10.1007/s40596-019-01136-5>

Abstract

The #MeToo movement has galvanized attention to sexual violence and to its solutions. Female patients with major mental disorders constitute an especially vulnerable population at risk of sexual violence. Women living with mental illness thoroughly deserve to be well represented in the #MeToo conversations. The article discusses the critical role of the profession of psychiatry and indeed all disciplines who care for adult women with mental illnesses, in developing comprehensive primary and secondary preventive strategies and programs.

10. **SYSTEMATIC REVIEW: EFFECTIVENESS OF PSYCHOSOCIAL INTERVENTIONS ON WELLBEING OUTCOMES FOR ADOLESCENT OR ADULT VICTIM/SURVIVORS OF RECENT RAPE OR SEXUAL ASSAULT**

Lomax, J., & Meyrick, J.

Journal of Health Psychology.2020;1-27.

doi: 10.1177/1359105320950799.

<https://journals.sagepub.com/doi/full/10.1177/1359105320950799>

Abstract

Sexual assault and rape are common forms of sexual violence/abuse. The psychological/health consequences represent significant and ongoing harm. It seems imperative that victim/survivors receive evidence-based support within first response settings. To assess what psychosocial interventions work for victim/survivors of a recent sexual assault. Twenty-seven electronic databases were systematically searched. Narrative data synthesis was used to read across studies. Reporting format follows PRISMA checklist. Ten studies were identified including range of interventions. The evidence is sparse and scientifically weak, common flaws are reviewed. There is some weak evidence for the impact of video and cognitive behavioural therapy (CBT) based interventions, especially trauma processing. There is a gap in the evidence base on psychosocial interventions for victim/survivors of sexual assault and higher quality research is required.

11. **A RANDOMIZED CONTROLLED TRIAL OF TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY FOR SEXUALLY EXPLOITED, WAR-AFFECTED CONGOLESE GIRLS**

O’Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A.

Journal of the American Academy of Child & Adolescent Psychiatry.2013; 52(4): 359-369.

doi: 10.1016/j.jaac.2013.01.013.

<https://pubmed.ncbi.nlm.nih.gov/23582867/>

Abstract

Objective: To assess the efficacy of trauma-focused cognitive behavioral therapy (TF-CBT) delivered by nonclinical facilitators in reducing posttraumatic stress, depression, and anxiety and conduct problems and increasing prosocial behavior in a group of war-affected, sexually exploited girls in a single-blind, parallel-design, randomized,+ controlled trial.

Method: Fifty-two 12- to 17-year-old, war-affected girls exposed to rape and inappropriate sexual touch in the Democratic Republic of Congo were screened for trauma, depression and anxiety, conduct problems, and prosocial behavior. They were then randomized to a 15 session, group-based, culturally modified TF-CBT (n = 24) group or a wait-list control group (n = 28). Primary analysis, by intention-to-treat, involving all randomly assigned participants occurred at pre- and postintervention and at 3-month follow-up (intervention group only).

Results: Compared to the wait list control, the TF-CBT group experienced significantly greater reductions in trauma symptoms ($F_{1,49} = 52.708, p < 0.001, \chi_p^2 = 0.518$). In addition, the TF-CBT group showed a highly significant improvement in symptoms of depression and anxiety, conduct problems, and prosocial behavior. At 3-months follow-up the effect size (Cohen’s d) for the TF-CBT group was 2.04 (trauma symptoms), 2.45 (depression and anxiety), 0.95 (conduct problems), and -1.57 (prosocial behavior).

Conclusions: A group-based, culturally modified, TF-CBT intervention delivered by nonclinically trained Congolese facilitators resulted in a large, statistically significant reduction in posttraumatic stress symptoms and psychosocial difficulties among war-affected girls exposed to rape or sexual violence. Clinical trial registration information—An RCT of TF-CBT with sexually-exploited, war-affected girls in the DRC.

12. **SUPPORTING TRANSGENDER SURVIVORS OF SEXUAL VIOLENCE: LEARNING FROM USERS' EXPERIENCES**

Rymer, S., & Cartei, V.

Critical and Radical Social Work.2015; 3(1): 155-164.

doi: 10.1332/204986015X14235562796096.

<https://www.ingentaconnect.com/content/tpp/crsw/2015/00000003/00000001/art00013>

Abstract

Transgender individuals are particularly vulnerable to sexual violence, yet many do not seek, or receive, adequate support following unwanted sexual experiences. This study explores the needs and experiences of transgender survivors when accessing sexual violence support services. The study examines the barriers that transgender survivors may face in accessing services and ways that organisations can reduce these barriers. Our findings provide valuable insights for sexual violence agencies and other providers about how to engage meaningfully with transgender survivors.

13. **SEXUAL ASSAULT SUPPORT SERVICES AND COMMUNITY SYSTEMS: UNDERSTANDING CRITICAL ISSUES AND NEEDS IN THE LGBTQ COMMUNITY**

Today, J. L., Linville, D., Bustin, A., Wheeler, J., & Gau, J.

Violence Against Women. 2009; 15(8): 952-976.

doi: 10.1177/1077801209335494.

<https://journals.sagepub.com/doi/abs/10.1177/1077801209335494>

Abstract

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals encounter social conditions that create important considerations for LGBTQ sexual assault victims. This exploratory, mixed-methods study examines the relationship between community attitudes toward LGBTQ persons and associated community responses to LGBTQ sexual assault victims. An online and paper-and-pencil survey ($n = 130$) and four focus group interviews ($n = 14$) are analyzed using frequency distributions and grounded theory methods. The central theme that emerged in focus group interviews, titled “low community awareness and support for sexual violence in the LGBTQ community,” was corroborated by survey participants. Participants' views of unique considerations for LGBTQ sexual assault victims are presented, including causal factors, consequences, and recommended strategies.

14. **PSYCHOLOGICAL AND PHARMACOLOGICAL TREATMENTS FOR ADULTS WITH POSTTRAUMATIC STRESS DISORDER: A SYSTEMATIC REVIEW UPDATE**

Forman-Hoffman, V., Middleton, J. C., Feltner, C., Gaynes, B. N., Weber, R. P., Bann, C., & Green, J.

Comparative Effectiveness Review.2018; No. 207. PMID: 30204376

<https://www.ncbi.nlm.nih.gov/books/NBK525132/>

Abstract

Objective: To assess efficacy, comparative effectiveness, and harms of psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD) and to update the original 2013 review.

Data sources: MEDLINE®, CINAHL®, Cochrane Library, Cochrane Clinical Trials Registry, PILOTS (Published International Literature on Traumatic Stress), PsycINFO®, and reference lists of published literature (May 2012–September 2017).

Review methods: Two investigators independently selected, extracted data from, and rated risk of bias of relevant studies. We conducted meta-analyses or network meta-analyses using random-effects models when we had evidence from three or more studies with low heterogeneity. We graded strength of evidence (SOE) following established Agency for Healthcare Research and Quality guidance.

Results: We included 193 randomized controlled trials (207 articles) for this review. Several psychological treatments were associated with the reduction of PTSD symptoms and loss of PTSD diagnosis compared with inactive comparators; high SOE supports efficacy of cognitive behavioral therapy (CBT)-exposure and CBT-mixed treatments, and moderate SOE supports efficacy of cognitive processing therapy (CPT), cognitive therapy (CT), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET). When directly comparing two treatments of interest, moderate SOE favors CBT-exposure over relaxation therapy.

Several pharmacological treatments reduced PTSD symptoms; moderate SOE supports the efficacy of fluoxetine, paroxetine, and venlafaxine compared with placebo. Our network meta-analysis (33 trials; N=4,817) of Clinician-Administered PTSD Scale (CAPS)-measured PTSD symptoms showed no differences in effectiveness between medications with at least moderate SOE of efficacy (fluoxetine, paroxetine, and venlafaxine) (low SOE for no difference).

Studies provided insufficient strength of evidence for serious adverse events associated with any treatments of interest. The majority of psychological studies reported no information about adverse events. Among pharmacological treatments with evidence of efficacy (moderate SOE), we found increased risk of nausea with venlafaxine compared with placebo (moderate SOE).

Our review found insufficient strength of evidence for the comparative effectiveness of any psychological versus pharmacological treatment and for differences in the efficacy or comparative effectiveness of treatments by patient characteristics (e.g., co-occurring conditions) or type, number, severity, or chronicity of trauma exposure(s). We did not find evidence for many of our outcomes of interest or interventions of interest, including the newer treatments added since our prior review.

Conclusions: Several psychological and pharmacological treatments have moderate to high SOE of efficacy for treating adults with PTSD. Future research is needed on the comparative effectiveness of treatments (including different comparisons of psychological and pharmacological treatments), differences in treatment benefits by trauma type or other patient characteristics, and adverse events associated with treatments.

15. **OUT OF THE SILENCE: TOWARDS GRASSROOTS AND TRAUMA-INFORMED SUPPORT FOR PEOPLE WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND ABUSE**

Sweeney, A., Perôt, C., Callard, F., Adenden, V., Mantovani, N., & Goldsmith, L.

Epidemiology and Psychiatric sciences.2019; 28(6): 598-602

doi: 10.1017/S2045796019000131

<https://pubmed.ncbi.nlm.nih.gov/30977461/>

Abstract

To experience sexual violence and abuse is to experience silence. This commentary explores some of the ways in which psychiatry reinforces the silencing of sexual violence survivors. We argue that current psychiatric responses to sexual violence typically constitute iatrogenic harm including through: a failure to provide services that meet survivors' needs, a failure to believe or validate disclosures; experiences of medicalisation and diagnoses which can delegitimise people's own knowledge and meaning; 'power over' relational approaches which can prevent compassionate responses and result in staff having to develop their own coping strategies; and poorly addressed and reported experiences of sexual violence within psychiatric settings. We argue that these multiple forms of silencing have arisen in part because of biomedical dominance, a lack of support and training in sexual violence for staff, inconsistent access to structured, reflective supervision, and the difficulties of facing the horror of sexual violence and abuse. We then describe community-based and grassroots responses, and consider the potential of trauma-informed approaches. Whilst this paper has a UK focus, some aspects will resonate globally, particularly given that Western psychiatry is increasingly being exported around the globe.

16. **THE ESSENCE OF HEALING FROM SEXUAL VIOLENCE: A QUALITATIVE METASYNTHESIS**

Draucker, C. B., Martsof, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P.
Research in Nursing & Health.2009; 32(4): 366-378

doi: 10.1002/nur.20333.

<https://pubmed.ncbi.nlm.nih.gov/19415681/>

Abstract

A qualitative metasynthesis was conducted to identify the essence of healing from sexual violence, as described by adults who experienced it as children or as adults. Based on the findings of 51 reports, four domains of healing were identified: (a) managing memories, (b) relating to important others, (c) seeking safety, and (c) reevaluating self. The ways of healing within each domain reflected opposing responses. The dialectical process identified for each of the four domains include, respectively: (a) calling forth memories, (b) regulating relationships with others, (c) constructing an "as-safe-as-possible" lifeworld, and (d) restoring a sense of self. These complex processes resulted in a new reality for the participants that was based on a greater sense of agency and provided a more satisfying life course.

RESOURCE 7

Slides on
Sexual Violence

Sexual Violence

DEFINING TERMS

- **Sexual violence:** 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.
- **'Coercion'** as a spectrum of acts- apart from physical force, includes psychological intimidation, blackmail or other threats (eg: Threats of physical harm, being dismissed from job).

World Report on Violence and Health, WHO, 2002

DEFINING TERMS

- The WHO multi-country study operationalized sexual violence as acts through which a woman:
 - Was physically forced to have sexual intercourse when she did not want to.
 - Had sexual intercourse when she did not want to, because she was afraid of what her partner might do.
 - Was forced to do something sexual that she found degrading or humiliating.
- **Rape** is defined as 'Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object'.
 - Includes assault involving a sexual organ including coerced contact between the mouth and penis, vulva or anus.

WHO, 2012

TYPES OF SEXUAL VIOLENCE

- Coercive penetration of vagina, anus, mouth
- Attempted coercive penetration of orifice
- Sexual violence when the woman is under influence of a substance and cannot provide consent
- Sexual violence with threats to physical safety
- Unwanted sexual advances
- Sexual harassment
- Child sexual abuse including Incest

REASONS FOR UNDER REPORTING OF SEXUAL VIOLENCE

- Inadequate support systems
- Shame and stigma
- Risk/fear of retaliation
- Risk/fear being blamed
- Risk/fear of not being believed
- Risk/fear of being socially ostracized

MYTHS RELATED TO SEXUAL VIOLENCE

1. 'No' really means 'yes'
2. Women love to be taken by force.
3. She was asking for it!
4. She provoked it (dress, location)
5. Women "cry rape" to punish men.

MYTH BUSTERS RELATED TO SEXUAL VIOLENCE

1. 'No' means 'NO'. When women say No, they actually mean it.
2. Women do not like being forced for sexual activity and experience it as traumatic.
3. She never asked for it. You just wanted to blame her for the event.
4. People get raped in diverse attires & locations. Both aspects are not causative.
5. Survivors of sexual assault are often reluctant to speak up due to stigma and for fear that they will not be believed. Speaking about sexual assault requires courage.

ECOLOGICAL MODEL OF FACTORS ASSOCIATED WITH PERPETRATION OF SEXUAL VIOLENCE

INDIVIDUAL FACTORS IN PERPETRATORS	RELATIONSHIP FACTORS	COMMUNITY FACTORS	SOCIETAL FACTORS
<ul style="list-style-type: none"> Alcohol & drug use Coercive sexual fantasies. Impulsive and antisocial behaviors Preference for impersonal sex Hostility towards women History of sexual abuse as a child Witnessing family violence as a child 	<ul style="list-style-type: none"> Perpetrator associating with sexually aggressive and delinquent peers Family environment characterized by physical violence Strongly patriarchal family environment 	<ul style="list-style-type: none"> Poverty, unemployment mediated through forms of crisis of male identity Inadequate institutional support from police and judicial system for sexual assault crimes General tolerance of sexual assault within the community. Weak community sanctions against sexual violence. 	<ul style="list-style-type: none"> Societal norms supportive of sexual violence, male superiority and sexual entitlement Weak laws related to sexual violence and low levels of conviction High levels of crime and weak/social sanctions especially in humanitarian crisis

WHO, 2002

TRAUMA INFORMED CARE

- A program, organization or system that...
- Realizes the widespread impact of trauma and...
- Understands the potential paths for recovery
- Recognizes the signs and symptoms of trauma...
- In clients, families, staff and others
- Responds by integrating knowledge about trauma...
- Intro policies, procedures and practices and
- Seeks to actively resit re-traumatization

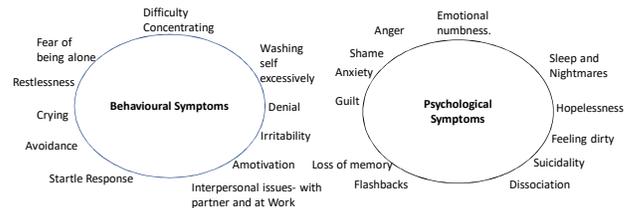
SAMHSA 2014

FIRST LEVEL (IMMEDIATE) PSYCHOLOGICAL INTERVENTIONS FOR WOMEN WHO HAVE EXPERIENCED SEXUAL VIOLENCE

- Sexual Violence especially Sexual Assault is severely traumatic and associated with immediate psychological reactions and distress.
- Sensitive and supportive counselling received at the time of first contact may determine later coping
- Validating the survivor's experiences helps to prevent self-blame and shame

FIRST LINE PSYCHOLOGICAL INTERVENTIONS

WHAT TO LOOK FOR AT THIS STAGE?



PSYCHOSOCIAL SUPPORT IN FIRST LINE INTERVENTION

- Validation and offering reassurance.
- Allowing expression of Emotions
- Gradual recounting of the experience keeping the woman's comfort and distress into account and at her own pace
- Explaining what to do during an emergency
- Conducting Risk Assessment for self harm
- Establishing no suicide and no self harm contract
- Teaching relaxation methods.
- Finding and practicing suitable grounding methods.

PREPARING FOR POLICE AND LEGAL PROCEDURES (if the woman decides to report)

- Educating the woman about ensuing legal events
- Helping to understand the legal process as aiding empowerment
- Discussing resources for support during the difficult phases in the process
- Reviewing relaxation and grounding methods that can be used if she is distressed
- Discussing possible flashbacks or anxiety during legal and police procedures

PREPARING FOR THE MEDICAL EXAMINATION

- Educating in detail about the purpose for medical examination (it is an important part of evidence if she decides to press charges).
- Discussing what constitutes the medical examination with explanation.
- Discussing expected responses of fear of touch, startle response to touch and helping using basic grounding methods.

FIRST LINE PSYCHOLOGICAL INTERVENTIONS

- Identifying the Stage of Psychological Reaction to Sexual Assault

- **The acute phase-** Starts immediately after the assault and may last for several weeks or months and may result in the complete disruption of the survivor's life.
- **The reorganization phase-** May continue for months or years, encompasses the survivor's process of reorganizing her disrupted life.
- **The restitution phase-** Rehabilitation occurs in this final stage.

Burgess & Holmstrom, 1974

FIRST LINE PSYCHOLOGICAL INTERVENTIONS

- Role of the mental health professional in first line intervention:

Acute Phase

- Physical and Psychological Safety
- Information regarding medical examination and treatment
- Information about emergency contraception and STD/HIV prophylaxis
- Sensitive Discussion about medical and forensic examination
- Education and preparation for the police report

Reorganization and Restitution Phase

- Discussing triggers of re-experiencing trauma.
- Ongoing counselling support.
- Accepting body, addressing shame.
- Discussing interpersonal issues.
- Working with family or partner

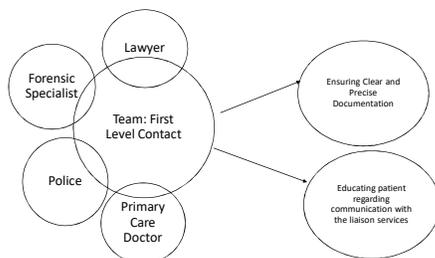
FIRST LINE PSYCHOLOGICAL INTERVENTIONS

WHEN SHOULD A WOMAN BE REFERRED TO A MENTAL HEALTH PROFESSIONAL?

- Suicidal risk or Self Harm
- Severe & persistent emotional dysregulation
- Substance use.
- PTSD and dissociative symptoms
- Past history of mental illness
- Intellectual disability and Neurodevelopmental Disorders
- Depression & anxiety symptoms.
- Psychotic Symptoms

FIRST LINE PSYCHOLOGICAL INTERVENTIONS

LIAISON WITH OTHER KEY SERVICES



FIRST LINE PSYCHOLOGICAL INTERVENTIONS

WOMEN WITH PHYSICAL OR DEVELOPMENTAL DISABILITIES AND/OR MENTAL ILLNESS

- High vulnerability to sexual violence and may have special needs.
- Difficulty in understanding the traumatic experience or reporting.
- Women reporting while in an episode of mental illness, may be 'not believed' or be dismissed casually.
- Awareness of additional help required to enable feeling safe and to communicate distress.
- Psychiatric assistance immediately after first level interventions should be arranged, if seen necessary.

LONG -TERM INTERVENTIONS FOR PSYCHOLOGICAL CONSEQUENCES OF TRAUMA FROM SEXUAL VIOLENCE

- Trauma-focused psychological intervention
- Exposure based intervention
- Interventions with moderate evidence
- Multicomponent intervention

TRAUMA-FOCUSED PSYCHOLOGICAL INTERVENTION

1. Trauma Focused Cognitive Behaviour Therapy (TF CBT)

- Evidence based intervention for adolescent and adult survivors of trauma.
- Follows a trauma informed format of CBT protocol.
- Designed to be delivered in 12 to 16 weekly sessions.
- Psycho-education, relaxation methods, in-vivo exposure, cognitive restructuring

Follette & Ruzek, 2007

EXPOSURE BASED INTERVENTION

1. Prolonged Exposure Therapy

- Exposure corrects erroneous stimulus-stimulus and stimulus-response associations and mistaken evaluations.
- 8-to-15-session protocol, typically provided in weekly or bi-weekly basis, 60-to-90 minute sessions.
- Techniques used are relaxation, psychoeducation
- Imaginal exposure progresses to In-Vivo exposure techniques.

Follette & Ruzek, 2007

INTERVENTIONS WITH MODERATE EVIDENCE

1. Cognitive Processing Therapy

- Uses methods such as Psychoeducation, Socratic questioning and Cognitive restructuring.
- ### 2. Narrative Exposure Therapy – NET
- Reprocessing, meaning-making and integration is facilitated.
- ### 3. Eye Movement Desensitization and Reprocessing
- Uses bilateral saccadic eye-movements while recounting events.
- ### 4. Antidepressants
- Venlafaxine, paroxetine, fluoxetine

Hoffman et al, 2018

MULTICOMPONENT INTERVENTIONS

- Systematic review and component network meta-analysis with 94 RCTs, for a total of 6,158 participants, were included across the primary and secondary outcomes
- Evidence for efficacy of multimodal interventions for survivors of sexual violence.
- Multicomponent interventions that include cognitive restructuring and imaginal exposure were the most effective for reducing PTSD symptoms.

Coventry et al, 2020

TRAINING PSYCHIATRISTS

- Need for training psychiatrists and residents on discussing sexual well-being and sexual violence as a health care issue.
- Primary and Secondary prevention strategies:
 - Trauma focused training of professionals
 - Developing clinically integrated teams in psychiatric settings for women reporting sexual assault
 - Awareness about community resources
 - Addressing safety, lack of financial resources and homelessness.

RESOURCE 8

Clinical Vignettes, Selected Teaching Points, and Quiz for SV

Complete the quiz before accessing the answers below.

Vignette #	SV Correct Answer
1	B
2	A
3	C
4	C
5	C

1. Emergency Department Presentation after Sexual Violence

Janet, a 23-year-old single medical student is brought to the Emergency Department by her clinical supervisor who is concerned that “Janet seemed to be in a trance and unable or unwilling to speak at rounds this morning”. The emergency physician confirms the clinical supervisor’s observations and finds no abnormality on physical exam or lab testing other than over-reaction to loud noises in the hall. He then requests a psychiatric consultation.

The psychiatric resident requests that they move to a quiet private interview room and after she is seated, offers Janet some water. The resident patiently waits a few minutes then softly says “Janet, whatever has happened to you?” After a minute of silence a tear runs down Jane’s face followed by loud sobbing. She says she went to a nightclub with classmates the previous evening to celebrate a colleague’s birthday. A half hour after her first glass of wine she began to feel dizzy and nauseated and went to the woman’s washroom in the basement. She noticed a club waiter behind her and was surprised when she approached the washroom that he quickly opened the door and roughly pushed her in, before gagging, hitting and raping her. As he fled upstairs he said “If you tell anyone, I’ll kill you”. She stumbled upstairs, staggered home, cried profusely, fell into bed and slept until the next morning. She then showered and went to morning rounds at her hospital.

Selected Teaching Points:

- This illustrates rape including physical, sexual and psychological abuse
- SV can happen to anyone. Who is at higher risk?
- Drugs and alcohol as enablers of assault (date rape drugs included).
- Variable reactions occur to trauma (trance, mute, hypervigilant, agitated, distraught etc)
- How to ask about SV in an empathic way. Discuss the “LIVES” acronym
- The importance of privacy and safety when asking
- Assessment of the emotional environment and support system
- What mental health interventions should you consider?
- Safety planning and knowledge of local laws and resources
- Considerations of pregnancy prevention, STI’s, Hep C, HIV and post exposure prophylaxis and coordination with sexual and reproductive health team for delivery of “rape kit”
- What psychological sequelae might follow? Describe psychological reactions and sequelae over time. (This is described in resource 1 in the Clinical Handbook)
- Next steps? Follow-up?

Quiz: Please mark an X beside the **INCORRECT** response below:

- A. Reassure Janet that she is now safe in the Emergency Department
- B. Notify the police of the rape and assailant’s identity
- C. Use psychological grounding and psychological first aid techniques
- D. Discuss safety planning and early psychological follow up

2. A Woman with Bipolar Disorder who has been Sexually Assaulted

You are a psychiatrist called to the emergency psychiatry service at 12:30 am to evaluate a 32-year-old woman “Yvonne” who was found in the park by the police and whom they suspect has been sexually assaulted. The medical team has already seen her, provided medical first aid and taken specimens for medico-legal documentation.

During the mental status examination, you find she is impatient and highly irritable. She tells you that her name is Mary and that she went to the park late in the evening “to plant trees to prevent climate change”. She feels that is her mission. She tells you that two men who were in the park teased her and when she protested, they sexually assaulted her. She was sitting half-naked on a park bench when the police spotted her and brought her to the Emergency Department.

She is able to give you a description of what happened but appears quite detached when giving you the details. When you ask her if she has had a psychiatric consultation in the past, she tells you that she has been hospitalised for bipolar disorder twice and irregularly takes some medications. She says she had been reading about climate change throughout the night and left home to plant trees. She is unable to give you a coherent history. Your trainee colleague wonders whether she is making it all up because she does not appear agitated while describing the assault.

Selected Teaching Points:

- Why women with severe mental illness may be at higher risk for SV
- Variable reactions to SV (trance, detached, mute, hypervigilant, agitated, distraught etc.)
- Assess legal competence in a woman with mental illness. What mental health interventions should you consider?
- What psychological sequelae might follow and how might they impact the course of her current episode of mental illness?
- Safety planning to prevent any such episode in the future
- Considerations about pregnancy prevention, STI’s, Hep C, HIV and possible post exposure prophylaxis.
- Coordination with the sexual and reproductive health team for delivery of rape kit
- Next steps? Follow-up?

Quiz: Please mark an X beside the **CORRECT** response below:

- A. Tell Yvonne that you are concerned about her and admit her to the Psychiatry Unit
- B. Explain that planting a few trees will not help climate change
- C. Heavily sedate Yvonne to help her forget the experience
- D. Tell your trainee that he is foolish and needs to study sexual violence

3. Physical Presentation to a Rural Clinic Following Past Sexual Violence

A 46-year rural woman presents to a District Hospital with chronic pain. The medical student collects information about the woman's history through a translator as the patient speaks another language. The patient makes no eye contact but gazes steadily into the distance. Except for the chronic pain she is healthy and takes no medications, including pain medications as she cannot afford them. The student asks more details about the pain. The patient cannot recall when the pain started, and can only tell you it has been "many years". It is a dull, aching pelvic pain that comes and goes randomly a few times a month. She denies any aggravating or alleviating factors. The student asks her if she is sexually active. She appears visibly upset by this question and her eyes lower to the ground.

The student allows her a few moments of silence, then notices there are now tears in the patient's eyes. The student hands her a tissue, speaks in a softer voice and asks if she is in an intimate relationship. The patient nods. The student asks her if her partner ever has made her feel unsafe, and she shakes her head: her partner is kind and gentle with her, although she is often not able to have intercourse with him. The student asks why, and she replies because it makes her "remember". The student asks her gently what it makes her remember, and she pauses. She now responds that it makes her remember when she was stopped by soldiers while she was fleeing her village during the war. She was raped by five soldiers and then left in a ditch.

Selected Teaching Points:

- Local context and risks exploring issues related to past sexual violence
- Difficulty using translators for sensitive topics (Do not use partner or family)
- Different presenting symptoms (somatization) of past sexual violence
- Chronic sequelae of past sexual violence
- Helping to identify sources of social support
- Psychological treatment –including stress reduction techniques

Quiz: Please mark an X beside the **CORRECT** response below:

- A. Prescribe a benzodiazepine to help her relax during intercourse
- B. Prescribe an analgesic for the pain
- C. Arrange a mental health clinic follow up that provides trauma-focused CBT
- D. Explain that her rapes were in the past and she is should forget them now

4. Treatment of Posttraumatic Stress Disorder after Sexual Violence (or Intimate Partner Violence)

A family doctor refers a 25-year-old woman to a community psychiatrist for intrusive memories of the assault, distressing dreams, flashbacks, avoidance of being alone, sadness, anxiety, trouble concentrating, hypervigilance and inability to work. The woman was raped 8 months ago by an ex-partner and was previously well with no psychiatric history.

Selected Teaching Points:

- What is the likely (provisional) diagnosis and what are the differential diagnoses?
- If the diagnosis is Post Traumatic Stress Disorder (PTSD), what therapy is indicated?
- What information should the consultation report contain?

Quiz: Please mark an X beside the INCORRECT statement below:

PTSD is effectively treated by:

- A. Cognitive Behavioural Therapy (CBT)
- B. Fluoxetine, paroxetine or venlafaxine
- C. Benzodiazepines
- D. Eye Movement Desensitization and Reprocessing (EMDR)

5. Dating and SV (or IPV)

Laura, age 16, is referred to the mental health clinic by her family doctor who reports that Laura “has been anxious and tearful for 6 months for no apparent reason”. Her school work is suffering.

During history taking she initially denies any stress at home, school or social life. She has been dating a young man, age 21, for 7 months. The psychiatrist comments that it seems her symptoms began a month after she started dating this boyfriend and is there a connection? She asks if her information is confidential and when reassured she admits that her boyfriend pressures her to do “sexual things” or he will post photos of her nude body on the internet where her friends and parents can see them. She is terrified, cannot sleep and feels guilty about already being “pressured” into some unwanted sexual activities.

Selected Teaching Points:

- Dating IPV/SV are not uncommon
- Internet/electronic abuse is increasing
- Wide discrepancies in age in dating couples increases vulnerability to IPV/SV
- Power differentials may increase the risk of IPV/SV

Quiz: Please mark an X beside the **CORRECT** statement:

- A. IPV or SV can only occur in a relationship that includes sexual intercourse
- B. Electronic sexual abuse cannot qualify as IPV or SV
- C. Electronic IPV and SV are increasing, especially in teens
- D. The psychiatrist should tell her parents about this