

The World Psychiatric Association (WPA) International Competency-Based Curriculum for Mental Health Care Providers on

Intimate Partner Violence and Sexual Violence against Women

Donna E. Stewart CM, MD, FRCPC

University Professor, University of Toronto

Senior Scientist, Toronto General Hospital Research Institute

Research Head, University Health Network Centre for Mental Health

Toronto, Canada

Prabha S. Chandra MD, FRC Psych, FAMS

Professor and Head of the Department of Psychiatry,

National Institute of Mental Health and Neurosciences

Bangalore, India

Contents and Index

Sl.no	Content	Page nos.
1.	Background and Goals of this curriculum (plus abbreviations).....	4
2.	Competencies for each group – Medical Students, Psychiatry Trainees, Psychiatrists.....	5-6
	Development and Assessment of Competency.....	7-8
3.	Resource 1 - WHO Guidance: Health care for women subjected to intimate partner violence or sexual violence - A clinical handbook Clinical and policy guidelines	9-10
4.	Resource 2- Links and abstracts of key papers, books, manuals and toolkits	11
5.	Resource 3–Slides on Intimate Partner Violence and Sexual Violence	12-26
6.	Resource 4–Case Vignettes and Teaching Points	27-39
7.	Resource 5 – Video based learning vignettes	40-53
		54-55

Co-Chairs

Donna E. Stewart CM, MD, FRCPC (Canada)
University Professor, University of Toronto
Senior Scientist, Toronto General Hospital Research Institute
Research Head, University Health Network Centre for Mental Health
Toronto, Canada

Prabha S. Chandra MD, FRC Psych, FAMS (India)
Professor and Head of the Department of Psychiatry,
National Institute of Mental Health and Neurosciences
Bangalore, India

Steering Group Members

Marta B. Rondon MD, MSc (Peru)
Consultant for the Program for the Prevention and Treatment of Gender Based Violence,
National Institute for Maternal and Perinatal Health
Assistant Professor, Department of Medicine, Universidad Peruana Cayetano Heredia, Lima

Josyan Madi-Skaff MD (Lebanon)
Chair, Women's Mental Health Section, World Psychiatric Association
President, Lebanese Psychiatric Society
Head of Psychiatry Department, The Lebanese Hospital
Beirut, Lebanon

Louise M. Howard PhD, MRC Psych (United Kingdom)

NIHR Research Professor,
Professor in Women's Mental Health & Consultant Perinatal Psychiatrist
Section of Women's Mental Health, King's College
London
Harriet L. MacMillan MD, MSc, FRCPC (Canada)
Professor, Department of Psychiatry and Behavioural Neurosciences
Chedoke Health Chair in Child Psychiatry
Offord Centre for Child Studies, McMaster University
Hamilton, Ontario

Claudia Garcia Moreno MD, MSc (WHO Geneva)
Medical Officer, WHO Department of Reproductive Health and Research
WHO, Geneva, Switzerland

Alexander Butchart MA, PhD (WHO Geneva)
Co-coordinator, Prevention of Violence
Department of Injuries and Violence Prevention
WHO, Geneva, Switzerland

Mark H. van Ommeren PhD (WHO Geneva)
Scientist, WHO Department of Mental Health and Substance Abuse
WHO, Geneva, Switzerland

Educational consultants

Andrea E. Waddell MD, FRCPC (Canada)
Medical Director, Inpatient Psychiatry, University Health Network,
Assistant Professor, Department of Psychiatry, University of Toronto

Raed Hawa MD, FRCPC DABPN (Canada)
Deputy Psychiatrist in Chief, University Health Network,
Director, Undergraduate Medical Education,
Department of Psychiatry
Associate Professor, University of Toronto

1. Background and Goals of the Curriculum

Background—Violence against women (VAW) or gender-based violence (GBV) are endemic across the world and may include many forms in war and peace. This curriculum focuses on intimate partner violence (IPV) and sexual violence (SV) in women which are common abuses with serious physical and mental health consequences. Research indicates that very few women who experienced abuse/violence 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 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; skepticism about treatment effectiveness; uncertainty about appropriate referrals; patient resistance; physician discomfort with the issues; time constraints; fear of losing patients; and fear of safety of the women or oneself. If clinicians are expected to appropriately identify and respond to abused women, they must be provided with relevant education. While it is known that men may also be subject to violence from a partner or 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 violence and abuse and sustain more serious physical and mental health sequelae.

Goals—This WPA Competency-based curriculum for different levels of expertise (undergraduates, postgraduate psychiatry residents and psychiatrists) presents content of competency-based curricula that focuses on gaining skills, confidence and knowledge among these groups, using different teaching methodologies. Medical education is moving 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.

TERMINOLOGY 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 and controlling behaviours. WHO 2013
- Sexual assault (SA) or sexual violence (SV) or rape (not restricted to intimate partner)
- Spouse abuse (SA) = wife abuse = wife battering=abuse of partner of any gender
- Domestic or family violence (DV, FV) (anyone in family including children)
- Violence against women (VAW)
- Gender-based violence (GBV) violence/abuse based on gender
- Interpersonal violence (IV) (between any individual)

[MS] – graduating medical student

[PT] – pre-certification psychiatric trainee

[AE] – practicing psychiatrist with advance expertise

Intimate Partner Violence/Sexual Violence Competencies for Mental Health Care Providers

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

1. **Define physical, psychological and sexual intimate partner violence (IPV) and 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 in 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 and exposed children associated with IPV/SV. [MS, PT]
 - b. Provide education to other health care providers on the health consequences of IPV/SV [AE]
5. **Assess for presence** of IPV/SV
 - a. Enquire about IPV/SV in a supportive and safe way in 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 and follow mandatory reporting laws if applicable [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. **Have knowledge of resources** for education and supportive services in IPV/SV
 - a. Provide information to a patient or health care provider to support patients facing IPV/SV including: how to access legal aid/navigation, awareness of local laws and victim resources. [MS]
 - b. Provide specific information to a patient about the intake processes or referral pathways for services in their region.[PT]
 - c. Develop, display and disseminate educational materials for a clinical setting to support systemic response to IPV/SV. [AE]

- 8. Communicate details of assessment**
 - a. 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]
- 9. Manage IPV/SV related psychological trauma**
 - a. Provide written instructions about the initiation and monitoring of a first-line method indicated for the treatment of IPV/SV psychological trauma. [PT]
 - b. Deliver or refer for an evidence-based psychological intervention for [uncomplicated] trauma e.g., CBT with a focus on the trauma, exposure therapy, EMDR or other. [PT]
 - c. Deliver an evidence-based pharmacologic intervention for IPV/SV psychological trauma. [PT]
 - d. Supervise trainees or other providers in the provision of evidence-based interventions. [AE]
 - e. Provide comprehensive care to patients with complex needs after experiencing IPV/SV. [AE]

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

“LIVES” is the WHO Clinical Handbook for IPV or SV acronym for

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 to protect against further harm

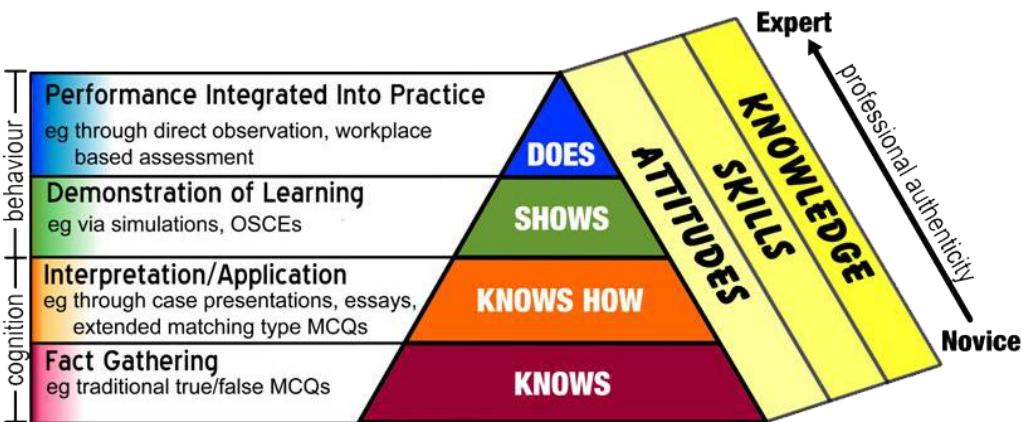
Support: help connect to services and social support

DEFINITIONS

Intimate Partner Violence (IPV): behaviour by a current or past intimate partner that causes physical, sexual or psychological harm including acts of physical aggression, sexual coercion, psychological abuse or controlling behaviours (WHO).

Sexual Violence (SV): a sexual act committed or attempted by another person without freely given consent of the victim or against someone unable to consent or refuse (CDC).

The Development of Competency



Based on work by Miller GE, *The Assessment of Clinical Skills/Competence/Performance*; Acad. Med. 1990; 65(9): 63-67
Adapted by Drs. R. Mehay & R. Burns, UK (Jan 2009)

Description of Frequently Used Assessment Methods

OSCEs= Objective Structured Clinical Examinations

MCQ= Multiple Choice Questions

Written Exam	Can include mix of multiple-choice, short-answer and essay questions
Video-Based Case	All students watch video and then complete a set of written questions
Oral Exam	Students are asked case-based questions. Focuses on oral communication.
Role Play with health care provider (HCP)	Examiner plays a health care provider and assesses clinical communication skills of student.
OSCE (Objective Structured Clinical Exam) (patient)	Examiner observes and assesses standardized patient assessment by trainee.
Practice Audit	May include chart review, direct observation, chart audits, peer review.

Recommendations for Assessment Methods for Each Competency

Medical Students

Competency #	1	2a	3a	4a	5a	6a	7a	8a
Written Exam	X	X	X					
Video-Based Case			X					X
Oral Exam				X			X	
Role Play					X	X	X	
OSCE-style					X	X	X	
Chart Audit								X

Psychiatric Trainees

Competency #	2b	3b	4a	5b	5d	6b	7b	8b	9a	9b
Written Exam	X							X	X	
Video-Based Case		X								
Oral Exam	X	X	X			X				
Role Play w/HCP		X	X	X		X	X			
OSCE (patient)			X	X	X		X			
Practice Audit				X				X	X	X

RESOURCE 1

WHO Guidance: Health care for women
subjected to intimate partner violence or
sexual violence - A clinical handbook

RESOURCE 1

- a) **World Health Organization Health Care 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 health care providers at a basic level.

When providing first-line support to a woman who has been subjected to violence, 4 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 health-care 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 4 parts:

1. Awareness about violence against women
2. First-line support for intimate partner violence and sexual assault
3. Additional clinical care after sexual assault
4. 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.

- b) 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 health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Evidence suggests that women who have been subjected to violence seek health care 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 intimate partner violence 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 health care providers.

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

- identification and clinical care for intimate partner violence
- clinical care for sexual assault
- training relating to intimate partner violence and sexual assault against women
- policy and programmatic approaches to delivering services
- mandatory 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.

RESOURCE 2

**Links And Abstracts Of Key Papers,
Books, Manuals And Toolkits**

RESOURCE 2

ARTICLES AND CHAPTERS

1. Curr Psychiatry Rep. 2016 Jan;18(1):4. doi: 10.1007/s11920-015-0644-3.

New developments in intimate partner violence and management of its mental health sequelae.

Stewart DE, Vigod S, Riazantseva E.

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.

2. CurrOpin Psychiatry. 2015 Sep;28(5):350-6

Mental health consequences of violence against women and girls.

Satyanarayana VA, Chandra PS, Vaddiparti K.

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.

3. PLoS Med. 2013;10(5):e1001439. doi: 10.1371/journal.pmed.1001439. Epub 2013 May 7.

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.

Abstract

BACKGROUND:

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

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

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.

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.

5. Glob Health Action. 2016 Feb 8;9:29890. doi: 10.3402/gha.v9.29890. eCollection 2016.

<http://www.globalhealthaction.net/index.php/gha/article/view/29890>

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.

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 services.

6. PLoS Med. 2013;10(5):e1001452. doi: 10.1371/journal.pmed.1001452. Epub 2013 May 28.

Domestic violence and perinatal mental disorders: a systematic review and meta-analysis.

Howard LM, Oram S, Galley H, Trevillion K, Feder G.

Abstract

BACKGROUND:

Domestic violence in the perinatal period is associated with adverse obstetric outcomes, but evidence is limited on its association with perinatal mental disorders. We aimed to estimate the prevalence and odds of having experienced domestic violence among women with antenatal and postnatal mental disorders (depression and anxiety disorders including post-traumatic stress disorder [PTSD], eating disorders, and psychoses).

METHODS AND FINDINGS:

We conducted a systematic review and meta-analysis (PROSPERO reference CRD42012002048). Data sources included searches of electronic databases (to 15 February 2013), hand searches, citation tracking, update of a review on victimisation and mental disorder, and expert recommendations. Included studies were peer-reviewed experimental or observational studies that reported on women aged 16 y or older, that assessed the prevalence and/or odds of having experienced domestic violence, and that assessed symptoms of perinatal mental disorder using a validated instrument. Two reviewers screened 1,125 full-text papers, extracted data, and independently appraised study quality. Odds ratios were pooled using meta-analysis. Sixty-seven papers were included. Pooled estimates from longitudinal studies suggest a 3-fold increase in the odds of high levels of depressive symptoms in the postnatal period after having experienced partner violence during pregnancy (odds ratio 3.1, 95% CI 2.7–3.6). Increased odds of having experienced domestic violence among women with high levels of depressive, anxiety, and PTSD symptoms in the antenatal and postnatal periods were consistently reported in cross-sectional studies. No studies were identified on eating disorders or puerperal psychosis. Analyses were limited because of study heterogeneity and lack of data on baseline symptoms, preventing clear findings on causal directionality.

CONCLUSIONS:

High levels of symptoms of perinatal depression, anxiety, and PTSD are significantly associated with having experienced domestic violence. High-quality evidence is now needed on how maternity and mental health services should address domestic violence and improve health outcomes for women and their infants in the perinatal period.

7. Trauma Violence Abuse. 2009 Jul;10(3):225-46. doi: 10.1177/1524838009334456. Epub 2009 May 10.

An ecological model of the impact of sexual assault on women's mental health.

Campbell R, Dworkin E, Cabral G.

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/ ecosystem 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.

8. Lancet. 2006 Oct 7;368(9543):1260-9.

Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence.

Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH; WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team.

Abstract

BACKGROUND:

Violence against women is a serious human rights abuse and public health issue. Despite growing evidence of the size of the problem, current evidence comes largely from industrialised settings, and methodological differences limit the extent to which comparisons can be made between studies. We aimed to estimate the extent of physical and sexual intimate partner violence against women in 15 sites in ten countries: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania.

METHODS:

Standardised population-based household surveys were done between 2000 and 2003. Women aged 15-49 years were interviewed and those who had ever had a male partner were asked in private about their experiences of physically and sexually violent and emotionally abusive acts.

FINDINGS:

24,097 women completed interviews, with around 1500 interviews per site. The reported lifetime prevalence of physical or sexual partner violence, or both, varied from 15% to 71%, with two sites having a prevalence of less than 25%, seven between 25% and 50%, and six between 50% and 75%. Between 4% and 54% of respondents reported physical or sexual partner violence, or both, in the past year. Men who were more controlling were more likely to be violent against their partners. In all but one setting women were at far greater risk of physical or sexual violence by a partner than from violence by other people.

INTERPRETATION:

The findings confirm that physical and sexual partner violence against women is widespread. The variation in prevalence within and between settings highlights that this violence is not inevitable, and must be addressed.

9. Reprod Health Matters. 2010 Nov;18(36):158-70. doi: 10.1016/S0968-8080(10)36533-5.

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.

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.

10. Trauma Violence Abuse. 2016 Jul;17(3):284-97. doi: 10.1177/1524838015584363.

Intimate partner violence in self-identified lesbians: a systematic review of its prevalence and correlates.

Badenes-Ribera L, Bonilla-Campos A, Frias-Navarro D, Pons-Salvador G, Monterde-I-Bort H.

Abstract

This article presents the first systematic review on intimate partner violence (IPV) in self-identified lesbians in same-sex couples. Studies published from January 1990 to December 2013 were analyzed. Of the 687 studies reviewed, 59 were preselected, of which 14 studies were selected that met the inclusion and methodological quality criteria. A summary is presented of the characteristics of the studies, the participants, the prevalence of IPV victimization and perpetration, and its correlates. All the studies were carried out in the United States and used a non-probabilistic sampling method. The majority of participants were White with a high educational level. The results indicate that all the forms of violence occur, but the most prevalent is emotional/psychological violence. The correlates positively associated with IPV are certain personality characteristics, fusion, previous IPV experience, a family history of violence, and alcohol consumption. This review finds significant limitations in the analyzed literature. Methodological recommendations are made for future studies.

11. Lancet. 2015 Apr 18;385(9977):1567-79. doi: 10.1016/S0140-6736(14)61837-7. Epub 2014 Nov 21.

The health-systems response to violence against women.

García-Moreno C, Hegarty K, d'Oliveira AF, Kozoli-McLain J, Colombini M, Feder G.

Abstract

Health systems have a crucial role in a multisector response to violence against women. Some countries have guidelines or protocols articulating this role and health-care workers are trained in some settings, but generally system development and implementation have been slow to progress. Substantial system and behavioural barriers exist, especially in low-income and middle-income countries. Violence against women was identified as a health priority in 2013 guidelines published by WHO and the 67th World Health Assembly resolution on strengthening the role of the health system in addressing violence, particularly against women and girls. In this Series paper, we review the evidence for clinical interventions and discuss components of a comprehensive health-system approach that helps health-care providers to identify and support women subjected to intimate partner or sexual violence. Five country case studies show the diversity of contexts and pathways for development of a health system response to violence against women. Although additional research is needed, strengthening of health systems can enable providers to address violence against women, including protocols, capacity building, effective coordination between agencies, and referral networks.

12. Cochrane Database Syst Rev. 2013 Dec 13;12:CD003388. doi:
10.1002/14651858.CD003388.pub4.

Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults.

Bisson JI, Roberts NP, Andrew M, Cooper R, Lewis C.

Abstract

BACKGROUND:

Post-traumatic stress disorder (PTSD) is a distressing condition, which is often treated with psychological therapies. Earlier versions of this review, and other meta-analyses, have found these to be effective, with trauma-focused treatments being more effective than non-trauma-focused treatments. This is an update of a Cochrane review first published in 2005 and updated in 2007.

OBJECTIVES:

To assess the effects of psychological therapies for the treatment of adults with chronic post-traumatic stress disorder (PTSD).

MAIN RESULTS:

We include 70 studies involving a total of 4761 participants in the review. The first primary outcome for this review was reduction in the severity of PTSD symptoms, using a standardised measure rated by a clinician. For this outcome, individual TFCBT and EMDR were more effective than waitlist/usual care (standardised mean difference (SMD) -1.62; 95% CI -2.03 to -1.21; 28 studies; n = 1256 and SMD -1.17; 95% CI -2.04 to -0.30; 6 studies; n = 183 respectively). There was no statistically significant difference between individual TFCBT, EMDR and Stress Management (SM) immediately post-treatment although there was some evidence that individual TFCBT and EMDR were superior to non-TFCBT at follow-up, and that individual TFCBT, EMDR and non-TFCBT were more effective than other therapies. Non-TFCBT was more effective than waitlist/usual care and other therapies. Other therapies were superior to waitlist/usual care control as was group TFCBT. There was some evidence of greater drop-out (the second primary outcome for this review) in active treatment groups. Many of the studies were rated as being at 'high' or 'unclear' risk of bias in multiple domains, and there was considerable unexplained heterogeneity; in addition, we assessed the quality of the evidence for each comparison as very low. As such, the findings of this review should be interpreted with caution.

AUTHORS' CONCLUSIONS:

The evidence for each of the comparisons made in this review was assessed as very low quality. This evidence showed that individual TFCBT and EMDR did better than waitlist/usual care in reducing clinician-assessed PTSD symptoms. There was evidence that individual TFCBT, EMDR and non-TFCBT are equally effective immediately post-treatment in the treatment of PTSD. There was some evidence that TFCBT and EMDR are superior to non-TFCBT between one to four months following treatment, and also that individual TFCBT, EMDR and non-TFCBT are more effective than other therapies. There was evidence of greater drop-out in active treatment groups. Although a substantial number of studies were included in the review, the conclusions are compromised by methodological issues evident in some. Sample sizes were small, and it is apparent that many of the studies were underpowered. There were limited follow-up data, which compromises conclusions regarding the long-term effects of psychological treatment.

13. AHRQ Comparative Effectiveness Reviews. Rockville (MD): Agency for Healthcare Research and Quality (US); 2013 Apr. Report No.: 13-EHC011-EF.

Psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD).

Jonas DE, Cusack K, Forneris CA, Wilkins TM, Sonis J, Middleton JC, Feltner C, Meredith D, Cavanaugh J, Brownley KA, Olmsted KR, Greenblatt A, Weil A, Gaynes BN.

Excerpt

OBJECTIVES:

To assess efficacy, comparative effectiveness, and harms of psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD).

Data sources and review methods omitted here.

RESULTS:

We included 92 trials of patients, generally with severe PTSD and mean age of 30s to 40s. High SOE supports efficacy of exposure therapy for improving PTSD symptoms (Cohen's $d = 1.27$; 95% confidence interval, -1.54 to -1.00); number needed to treat (NNT) to achieve loss of diagnosis was 2 (moderate SOE). Evidence also supports efficacy of cognitive processing therapy (CPT), cognitive therapy (CT), cognitive behavioral therapy (CBT)-mixed therapies, eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy for improving PTSD symptoms and/or achieving loss of diagnosis (moderate SOE). Effect sizes for reducing PTSD symptoms were large (e.g., 28.9- to 32.2-point reduction in Clinician-Administered PTSD Scale [CAPS]; Cohen's $d \sim -1.0$ or more compared with controls); NNTs were ≤ 4 to achieve loss of diagnosis for CPT, CT, CBT-mixed, and EMDR. Evidence supports the efficacy of fluoxetine, paroxetine, sertraline, topiramate, and venlafaxine for improving PTSD symptoms (moderate SOE); effect sizes were small or medium (e.g., 4.9- to 15.5-point reduction in CAPS compared with placebo). Evidence for paroxetine and venlafaxine also supports their efficacy for inducing remission (NNTs ~ 8 ; moderate SOE). Evidence supports paroxetine's efficacy for improving depression symptoms and functional impairment (moderate SOE) and venlafaxine's efficacy for improving depression symptoms, quality of life, and functional impairment (moderate SOE). Risperidone may help PTSD symptoms (low SOE). Network meta-analysis of 28 trials (4,817 subjects) found paroxetine and topiramate to be more effective than most medications for reducing PTSD symptoms, but analysis was based largely on indirect evidence and limited to one outcome measure (low SOE). We found insufficient head-to-head evidence comparing efficacious treatments; insufficient evidence to verify whether any treatment approaches were more effective for victims of particular trauma types or to determine comparative risks of adverse effects.

CONCLUSIONS:

Several psychological and pharmacological treatments have at least moderate SOE supporting their efficacy: exposure, CPT, CT, CBT-mixed therapies, EMDR, narrative exposure therapy, fluoxetine, paroxetine, sertraline, topiramate, and venlafaxine.

14. CHAPTERS

Psychiatry, Fourth Edition. Eds A. Tasman, J. Kay, J. A. Lieberman, M. B. First and M. B. Riba. pp2533-2548. John Wiley & Sons, Ltd, Chichester, UK, 2015. Vigod SN, Stewart DE.

Psychiatric Management of Victims of Intimate Partner and Sexual Violence. doi:
10.1002/9781118753378.ch128

15. BOOKS

1. Domestic Violence and Mental Health 1st Edition

by Louise Howard, Gene Feder, Roxanne Agnew-Davies

- **Paperback:** 112 pages
- **Publisher:** RCPsych Publications; 1 edition (May 31, 2013)
- **Language:** English
- **ISBN-10:** 1908020563
- **ISBN-13:** 978-1908020567

2. Violence against Women and Mental Health

García-Moreno, Claudia, Riecher-Rössler, Anita – Volume editors

In, Key issues in mental health, ; v. 178 ISSN 1662-4874 C

Country of Publication: Switzerland

Basel :Karger, 2013. **Language:** English

ISBN: 9783805599887 (hard cover : alk. paper)

3805599889 (hard cover : alk. paper)

9783805599894 (e-ISBN)

RESOURCE 3

Slides on

Intimate Partner Violence and

Sexual Violence

RESOURCE 3

INTIMATE PARTNER VIOLENCE (IPV) PREVALENCE, RISK FACTORS, SEQUELAE AND TREATMENT (WPA)

Donna E. Stewart CM, MD, FRCPC
University Professor

Senior Scientist
Founding Chair of Women's Health
University Health Network, University of Toronto
CANADA

WHAT IS 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 and controlling behaviours.

WHO 2013

FIVE TYPES OF IPV (CDC)

- 1) **Physical violence:** the intentional use of physical force with the potential for causing death, disability, injury, or harm.
- Includes: scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.

2) SEXUAL VIOLENCE

- (i) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed;
- (ii) an attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and
- (iii) abusive sexual contact.

3) THREATS OF PHYSICAL OR SEXUAL VIOLENCE

- threats of physical or sexual violence: words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.

4) PSYCHOLOGICAL OR EMOTIONAL VIOLENCE

- trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological or emotional violence can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources

5) STALKING

- harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property

HOW DOES IPV RELATE TO OTHER SIMILAR TERMS?

- Spouse abuse = wife abuse = wife battering
- Domestic or family violence (anyone in family)
- Violence against women or gender-based violence (based on gender)
- Interpersonal violence (between any people)
- Sexual assault or sexual violence (SV) or rape (not restricted to intimate partner)

IPV

- A human right and public health problem
- In all developed and developing countries
- Affects individuals in all walks of life
- Heterosexual or same sex relationships
- Occurs in men and women but injuries worse in women
- A way of expressing power and control over the partner

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 is 30% for women
- US National IPV/SV found lifetime IPV in 36% women and 29% men
- Leading cause nonfatal injury to US women
- Local prevalence?

ECOLOGICAL MODEL OF RISK FACTORS

- Individual
- Partner
- Family
- Community/social
- (Protective factors)

WHO

INDIVIDUAL RISK FACTORS FOR IPV

- Anyone
- Limited or different education/employment
- Young age/old age
- Lower SES (poverty)
- Hx of abuse or witness abuse as child
- Substance abuse - alcohol
- Disability: physical or psychological
- Indigenous status
- ? Same sex relationships

PARTNER FACTORS THAT INCREASE IPV

- Alcohol/drug abuse
- Need for over-control
- Hx of childhood abuse or witness abuse
- Low education level
- Negative attitudes about women
- Other sexual partners
- Unemployed

FAMILY FACTORS THAT INCREASE IPV

- Marital conflict
- Male dominance
- Low economic status
- Poor family functioning

COMMUNITY AND SOCIAL FACTORS THAT INCREASE IPV

- Gender inequality
- Lack of community cohesion/ resources
- Restrictive laws on divorce
- Restrictive laws on ownership/inheritance
- Cultural acceptance of IPV
- Media portrayal
- Role modeling for children

COMMUNITY AND SOCIAL FACTORS THAT INCREASE IPV

- Women undervalued or treated as property
- Patriarchal, laws, or religious values
- Women low social status, autonomy, power
- Low education, opportunity, SES
- Lack of policy/legal safeguards
- Women in prisons or mental health facilities
- Religion may condone

PROTECTIVE FACTORS

- Secondary education
- High SES
- Formal marriage
- Social support
- Gender equality
- Safe environments
- Good policy and services
- Monitoring and enforcement

MYTH OR FACT

- “If a women is abused she can/should just leave”
- Abused women stay in an abusive relationship for different reasons:
 1. Abuser threats to kill. Up to 50% of abused women are killed within 2 months of leaving
 2. Financially dependent on abuser

MYTH OR FACT (cont'd)

3. Strong beliefs that family must stay together
4. Societal, religious and family pressures to stay
5. Abusers repeatedly express remorse and promise to change
6. Afraid to lose their children
7. Immigration concerns that she will be deported

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 CONCERN/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: GI, MSK, H/A, QOL decrease
- Reproduction: STDs, HIV, sexual problems, miscarriage, infertility, unintended pregnancy, shorter gestation, fetal death

MENTAL HEALTH SEQUELAE OF IPV

- Emotional:
 - PTSD/complex PTSD,
 - depression, anxiety,
 - sexual problems,
 - sleep & eating disorders,
 - suicide, self harm
 - chronic pain,
 - psychosis
- Risky behaviours: substance abuse, sex

EFFECT OF IPV ON CHILDREN

- Children usually know (hear, see)
- Estimated 362 000 children in Canada
- 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"

SOCIO-ECONOMIC COSTS OF IPV

- Isolation of victims
- Inability to work/attend school
- Lost wages/education
- Unable to participate in regular activities
- Inability to care for selves or children
- 5-20% of health years of life lost (15-44 years)
- As serious cause of death/disability as cancer
- 2x medical, 8x mental health visits (USA)

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

Oram et al.
2013

SYSTEMATIC REVIEW OF PSYCHIATRIC PATIENTS AND IPV

- 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

SCREENING FOR IPV?

- Cochrane Review examined 8 studies involving 10,074 women
- Screening doubled the likelihood of identifying abused women
- Did NOT increase referral rates, re-exposure to violence, or health measure outcomes
- Authors concluded "Insufficient evidence to justify universal IPV screening in healthcare setting"
- BUT due to high prevalence in mental health settings (30%) case finding and a trauma informed model of care for all are essential

TRAUMA INFORMED MODEL OF CARE

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

SAMSA

TRAUMA INFORMED MODEL OF CARE

- KEY PRINCIPLES: safety, trustworthiness, transparency, peer support, collaboration, mutuality, empowerment, voice, choice, cultural, historical, gender issues

Substance Abuse and Mental Health Services Admin (SAMSA)

CASE FINDING

- 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!

SIGNS OF POSSIBLE IPV

- 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 DISCLOSURE QUESTIONS

- "It's important for me to understand my patient's safety in close relationships."
- "Sometimes partners or ex-partners use physical force-Is this happening to you?"
- "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?"

"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

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!

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
- 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, emergency housing
- Informal counselling and ongoing support
- Safety planning advice
- Legal and financial services
- Intensive counselling > 12 hours reduced IPV and improved QOL

Wathen and McMillan 2003
Cochrane Review 2009

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 counter transference
- Affect regulation and how to process emotions safely (without alcohol)
- Couple therapy not safe in serious abuse

ANXIETY DISORDERS AND DEPRESSION

- Common after IPV
- CBT should include traumatic exposure
- Address cognitive distortions
- Develop exposure therapy for anxiety considering trauma
- SSRI/SNRI may be useful
- Benzodiazepines only short term for severe anxiety

POST TRAUMATIC STRESS DISORDER (PTSD)

- Follows exposure to traumatic stressor
- DSM-5 lists only PTSD
- ICD-11 also includes complex PTSD
- Both PTSD and complex PTSD include re-experiencing, avoidance and sense of threat
- Complex PTSD also includes affect dysregulation, negative self-concept and interpersonal disturbances following severe or prolonged stressor

A. Maercker et al. The Lancet 2013

Bisson JI et al. 2013

POST TRAUMATIC STRESS DISORDER (PTSD)

- Studies restricted to after leaving IPV
- Most studies include victims of other violence
- Poor quality studies
- Cochrane Review shows effectiveness in IPV:
 - individual trauma-focused CBT (TFCBT)
 - Non-trauma focused CBT
 - Eye movement desensitization and reprocessing (EMDR)
 - Better than waitlist or other therapies

TRAUMA FOCUSED COGNITIVE BEHAVIOR THERAPY (TFCBT)

- Focuses on traumatic event
- Imagined or in vivo exposure treatment
- Direct challenging of maladaptive cognitions
- Related to the event or its sequelae
- Individual vs group

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

THERAPY FOR PTSD

- Exposure therapy, cognitive processing therapy, cognitive therapy, CBT, EMDR and narrative exposure therapies
- Fluoxetine, paroxetine*, sertraline, venlafaxine
- Topiramate*
- All improved PTSD to some degree
- Antipsychotics only for psychotic symptoms!
- Adrenergic inhibitors not useful

AHRQ 2013

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)

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/>

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
- May be depressed/psychotic or other mental health disorder
- May have dementia or other organic brain syndrome
- Refer appropriately to another provider/service
- Important not to increase danger to the victim!

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

SEXUAL VIOLENCE WPA CURRICULUM

Donna E. Stewart CM, MD, FRCPC
University Professor
Senior Scientist
Founding Chair of Women's Health
University Health Network, University of Toronto
CANADA

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 or work

WHO 2011

SOME TYPES OF SEXUAL VIOLENCE

- Coercive penetration of vagina, anus, mouth
- Attempted penetration of orifice
- Drug facilitated sexual violence
- Threats
- Unwanted sexual advances
- Sexual harassment
- Incest/child sexual abuse

COERCION

- Varying degrees of force
- Psychological intimidation
- Blackmail
- Threats (of physical harm, not obtaining a job/grade etc)
- Unable to give consent (drugged, intoxicated, mentally incapacitated)
- Forced to do something sexual that she finds degrading/humiliating
- Forced marriage or co-habitation

WHO 2011

PERPETRATORS

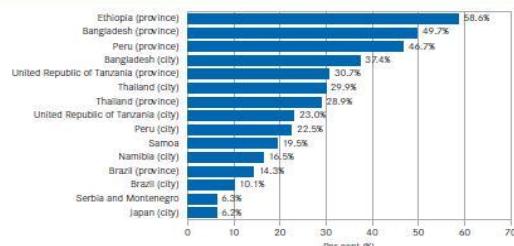
- Stranger
- Acquaintance
- Family member
- Intimate partner
- Combatants during/post conflict/war
- During humanitarian crises

PREVALENCE GREATLY UNDERREPORTED

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

PREVALENCE CAN HAPPEN ANYWHERE!

Percentage of ever-partnered women aged 15–49 years who reported sexual intimate partner violence ever, after the age of 15 years (3)



WHO 2005

RAPE MYTHS

- No really means yes
- Women love to be taken by force
- She was asking for it!
- She provoked it (dress, location)
- Women “cry rape” to punish men

WHO 2005

CHILDHOOD ABUSE

- Underreported
- Global prevalence of childhood sexual abuse 27% in girls, 14% boys
- Rates vary greatly but occurs in all countries
- Perpetrators are often known to the victim (family, neighbours, position of trust)
- Violence and harassment may occur at home, school, work
- Victimization in childhood is associated with later perpetration

WHO 2012

ECOLOGICAL MODEL OF FACTORS FOR SEXUAL VIOLENCE

- Individual: alcohol, drugs, antisocial, exposure as child, low education
- Relationship: unequal, multiple partners, infidelity
- Community: male superiority, acceptance
- Social: few community or legal sanctions

WHO 2012

HEALTH CONSEQUENCES

- Mental: depression, anxiety, PTSD, insomnia, somatization, suicide
- Behavioural: high risk, sexual dysfunction, substance abuse
- Social: isolation, shunning
- Physical: STD's, pregnancy, HIV, trauma

WHO 2012

OTHER MENTAL PRESENTATIONS

- Dissociation (zoning out)
- Cutting (self-harm)
- Eating disorders
- Anger (distance=safety)
- Relationship problems
- Distorted thinking
- Self blame/guilt/doubt

MEDICAL RESPONSE TO VICTIMS OF SEXUAL VIOLENCE

- Psychological support- immediate and follow-up
- Treat physical injuries
- Pregnancy test, emergency contraception
- Treatment and prophylaxis for STI's
- Consider prophylaxis for HIV
- Forensic examination/specimen collection
- Social and legal services
- Plan for self-care
- Enhance safety
- Document carefully!

WHO 2012

"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

PSYCHOLOGICAL MANAGEMENT

- Offer support at each meeting "LIVES"
- Use grounding techniques if necessary for extreme anxiety/dissociation
- Help strengthen positive coping methods (sleep, pleasant activity etc)
- Explore social support and encourage its use
- Psycho-education
- Demonstrate stress reduction exercises (breathing, muscle relaxation)
- Mental status exam
- Diagnosis
- Treatment: psychological, medications if needed
- Follow-up appointments for further support

WHO 2012

PTSD EVIDENCE-BASED INTERVENTIONS

- Cognitive behavioural therapy (CBT)
- Trauma focused CBT
- Interpersonal therapy (IPT)
- Eye movement desensitization and reprocessing (EMDR)
- SSRI antidepressants may be helpful

RESOURCE 4

Clinical Vignettes and Teaching Points

RESOURCE 4

Clinical Vignettes and Teaching Points

The following 12 short clinical vignettes include common factors in intimate partner violence (IPV) and sexual violence (SV) that may be seen by mental health trainees and providers. These patients were seen in the Emergency Department, Mental Health Clinic, Consultant's office, or Rural District Hospital by staff with various levels of training and expertise. The patients in these vignettes include the wife of a town major, a medical student, a woman with bipolar disorder, a suicidal patient, a survivor of armed conflict, a postpartum woman, a woman after sexual assault, a lesbian, a child exposed to IPV, and patients suffering from anxiety, depression, posttraumatic stress disorder and somatization. Each vignette is followed by some teaching points that include key information, risk factors, clinical approaches and treatment considerations which may be used to guide discussion and learning.

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 and a contusion around her right eye. She is tearful and appears fearful. Her husband reports that his wife's hand slipped while preparing a melon, causing the cut and bruise. The medical student respectfully but firmly asks the husband to move to the waiting room but he strenuously objects before leaving.

Her physical injuries are treated. The student 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 student 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 and depressed.

The student listens empathically 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. The student tells her she deserves to feel safe at home and there are things that can be recommended to help her. The student tells her about local shelters, social and mental health services and asks her if it is safe to return home today. The student 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.

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 may precede physical abuse
- Alcohol may disinhibit the perpetrator or make the victim less able to respond appropriately
- 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 it is important to develop a list of local services and how to safely contact them (electronically, phone, letter or in person)

Emergency Department Presentation after Sexual Violence

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

The psychiatric resident requested that they move to a quiet private interview room and after she was seated, offered Janet some water. The resident patiently waited a few minutes then softly said “Janet, whatever has happened to you? “After a minute of silence a tear ran down Jane’s face followed by loud sobbing. She said she had gone 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.

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). What biases might occur with Janet?
- Variable reactions to the 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
- Issues about confidentiality, respecting the woman’s wishes and reporting to authorities (when not mandated)
- Assessment of the emotional environment and support system
- What mental health interventions should you consider?
- What psychological sequelae might follow?
- Knowledge of local laws and resources
- Safety planning
- Considerations about pregnancy prevention, STI’s, Hep C, HIV and possible post exposure prophylaxis
- Next steps? Follow-up?

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 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 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 depression twice and takes some medicines, though irregularly. She says she had been reading about climate change throughout the night and left home to plant trees in the city after watching a TV program about environmental issues. She says she would like to go out and plant more trees and is unable to give you a coherent home address. Your junior colleague wonders whether she is making it all up because she does not appear agitated while describing the assault.

Teaching Points:

- Why women with severe mental illness may be at higher risk for SV
- Variable reactions to sexual violence (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
- Next steps? Follow-up?

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 take a seat in 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 her partner. She has been contemplating suicide for the past three months, since her partner slapped her because she came home late due to some urgent work. She doesn't have any friends and feels very isolated from her family. 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. She can refer her to their mental health clinic and may refer her to other services (legal, social work etc) if she feels she needs them. The doctor 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.

The psychiatrist performs a complete mental status exam and diagnoses her with depression, moderate to severe, with suicidal ideation. She refers Ms G to the follow-up mental health clinic.

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 attempt
- Lack of social/family support put women at risk of IPV
- The history of exposure to IPV in her parents is significant (intergenerational cycle of violence).
- Women with depression, suicidality or alcohol use should be referred for treatment according to current guidelines.
- The link between IPV and suicidal intent and attempt should be explicit in the chart.

Physical Presentation to a Rural Clinic of Past Sexual Violence

A 46-year rural woman presents to a rural District Hospital with chronic pain. The medical student collects information about the woman's history through a translator as the patient speaks another language. Working with the translator is difficult as the patient speaks in a monotonic whisper. 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, 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 the student 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. The student asks her gently again, and 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, one after the other, and then left in a ditch.

Teaching Points:

- Local context and risks exploring issues related to past sexual violence
- Difficulty using translators for sensitive topics
- 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

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 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. You give her written information about community resources and develop a safety plan with her. You arrange a return visit in one week to further discuss her relationship and treatment of her anxiety and depression.

Teaching Points:

- Older women may also be subject to IPV
- Partner unemployment is a risk factor for IPV
- Reasons for referral may not include 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?

Somatization and Intimate Partner Violence

Meena is a 24-year-old woman who presented to the psychiatry outpatient with episodes of fainting and appearing blank for brief spells. The family physician and neurologist have ruled out epilepsy or other causes of syncope and referred her for a mental health 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 with a frequency of at least once a week.

Meena has been married for the last 5 years and has a child who is four years old. 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 ask her if she has any injuries and check for anxiety and depressive symptoms and any suicidal thoughts or attempts. You also ask what impact this is having on her child. 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 for which she needs psychological help.

Teaching Points:

- Reasons for referral may not include IPV
- Multiple somatic complaints and dissociation maybe sometimes be signs of IPV
- Violence may be perpetrated by multiple family members
- Consider possible abuse when assessing women who live with in-laws
- Consider the emotional environment and support
- Women may 'normalise' IPV and hence feel helpless
- How would you make a safety plan for this woman?
- How would you treat her somatisation and dissociation?
- What referrals might help?
- Under what circumstances could her husband be involved- when and how?

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 out of her choice and against her parent's wishes to a man she met while working as a data entry operator. 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 give money for medication for the baby and also does not want her to go back to work. The changes in 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".

Teaching Points:

- IPV in pregnancy and the postnatal period is not uncommon
- A postpartum woman may be overburdened, vulnerable and disappointed with her baby for various reasons
- Need to assess different forms of psychological abuse and controlling behaviours- in this case, chiding her for having a girl, taking away the mobile phone
- The relationship between IPV, self-harm and suicide. How to prevent risk for self-harm?
- The need to make a safety plan immediately because of risk for self-harm
- Cultural issues related to patriarchy, sex of the child, nature of marriage and role of in-laws
- 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?
- Probable beneficial role of home visits by nurse-addressing depression, child care, the issue of the sex of the baby during pregnancy (not after childbirth)
- Effect of longer paternity leave-husband more involved with baby and baby care

Stages of Change in Disclosure of Intimate Partner Violence

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 denied any history of violence but at the end of the first interview asked “Does this include abuse from an ex-partner?” When the psychiatrist nodded, the patient said “I’ve been wondering about this, but need more time to think.” At her second appointment she was asked to discuss her previous statement and after being reassured that the information was confidential, she disclosed 3 years of psychological abuse, threats and stalking by her ex-partner.

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

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

A family doctor refers a 25-year-old woman who was raped 6 months ago by an ex-partner 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 previously well and has no psychiatric history.

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?
- Cognitive Behavioural Therapy (CBT) including a focus on the trauma (eg exposure therapy).and Eye Movement and Desensitization and Reprocessing (EMDR) are optimal.
- Selective Serotonin Reuptake Inhibitors (SSRI's)/Serotonin-Norepinephrine Reuptake Inhibitors (SNRI's) may be helpful, benzodiazepines are not
- Stress management may be helpful
- What information should the consultation report contain?

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.

Teaching Points:

- Past partners may perpetrate IPV
- IPV can occur in heterosexual and homosexual 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
- Conservative/homophobic environments may deter disclosure of IPV in same-sex partnerships

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 to stay after school for additional help. His mother took him to a pediatrician who 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 one day after injuring another child. Stephen's younger brother, Edward, began having similar difficulties. The pediatrician referred the two children to an outpatient mental health clinic.

When Stephen and Edward attended the clinic with their mother, she 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 all the time that his mom was going to be hurt while he was at school. Edward said that Stephen looked after him and got his breakfast in the morning; his mom was usually sleeping when they left for school.

Teaching Points:

- Behavioural problems including ADHD symptoms in children can be associated with exposure to intimate partner violence causing anxiety or posttraumatic stress disorder
- Importance of assessing for all types of maltreatment
- Approach to interviewing family members individually about their experiences at home
- Excessive alcohol use is a risk indicator for IPV
- 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
- Non-offending parents underestimate the likelihood that their child or children have been exposed to IPV
- Importance of addressing safety of each family member
- Need to understand care giving that each child receives in the family
- 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
- Next steps? Follow up?

RESOURCE 5

Video-Based Learning Vignettes for IPV and Mental Health

RESOURCE 5

Video- Based Learning Vignettes for IPV and Mental Health

- **Video 1-** This clinical vignette video is used with the permission of Dr Raed Hawa, Undergraduate Coordinator, Department of Psychiatry, University of Toronto, Canada
Website: <http://thehub.utoronto.ca/psychiatry/intimatepartnerviolence/>
- **Video 2 –** This clinical vignette video is used with the permission of Dr Prabha Chandra, Professor of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India. Website: <http://www.perinatalpsynimhans.org/video-resources.html>