



**WORLD
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World Psychiatric Association

WPA Position Paper on Intimate Partner Violence and Sexual Violence Against Women

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Background:

Intimate partner violence (IPV) and sexual violence (SV) are global public health and human rights problem in every country of the world and cause serious physical and/or psychological harms¹. IPV and SV affect both women and men, although it is more common for men than women to perpetrate IPV and SV and women's injuries (including death) tend to be more severe than those of men². Studies have shown that one-third of patients receiving mental health services are victims of IPV or SV³. Mental health sequelae of IPV or SV include depression, anxiety, posttraumatic stress disorder, substance abuse, self-harm/suicide, low self-esteem, sexual problems and somatization⁴. Children who witness IPV are more likely to develop mental health problems and to later be involved in abusive relationships².

Definitions:

Intimate partner violence (IPV) is defined as behaviour by an intimate partner that causes physical and/or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours¹. It may be perpetrated by a current or previous partner in a heterosexual or same-sex relationship (2). Sexual violence (SV) is defined as a sexual act that is

committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; non-physically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party⁵.

Evidence:

Although IPV/SV has been reported in all countries, prevalence rates have been difficult to compare due to differential sampling and variability in definitions, with the most common variability being whether or not threats of violence and emotional or psychological violence are considered in population estimates. The World Health Organization (WHO) conducted a 10-country survey involving 24,097 women using comparable methodologies and found that 15 to 71 % of women reported lifetime physical or sexual violence by a partner, with the highest rates found in rural Ethiopia and Peru⁶. The WHO Global Status Report on Violence Prevention found one in three women has been a victim of physical and/or sexual violence by an intimate partner during her lifetime⁷ and the WHO Demographic and Health Survey of 15 countries found physical abuse during pregnancy ranged from 2 to 13.5%⁸. Same-sex IPV data are sparse but suggest that the prevalence may be even greater than in heterosexual partnerships^{2,9}.

Generally, rates are higher in rural than urban areas, most IPV/SV is not reported to police and it is also underreported in healthcare settings; consequently, the data reported in epidemiologic studies are likely gross underestimates². Thirty percent of psychiatric patients have experienced IPV or SV and most of these were not reported to mental health service providers³.

Recommendations:

As psychiatrists and other mental health professionals play vital roles as mental health care service providers, educators, researchers and policy advocates, who help shape mental health professional practice and public opinion, be it resolved that the World Psychiatric Association¹⁰:

- Approve and publish on its website this Position Paper that recognizes violence against women including IPV/SV as major determinants of mental distress and psychiatric illness in women and strongly condemn all forms of violence against women.
- Publish the WPA Curriculum on IPV/SV on the WPA website as a useful resource for education and support other programs to improve the education of practicing and training psychiatrists to recognize and treat victims of violence including IPV/SV. This education should include, as a starting point, the routine inquiry about violence and victimization in all psychiatric assessments, the recognition of the role of violence and sexual abuse in the genesis of many psychiatric illnesses and as a treatment issue.

- Promote safe, respectful, non-blaming, ambulatory and inpatient treatment programs for women victims of violence including IPV/SV.
- Support research to develop and evaluate the best treatments for women who have suffered from violence including IPV/SV, and for their children and the perpetrators.
- Support health professionals and public awareness of violence against women including IPV/SV as a critical women's mental health determinant.
- Explore opportunities for greater interprofessional collaboration (legal, social, medical, and policy makers) on an international level to prevent and ameliorate violence against women, including IPV/SV.
- Explore wide ranging psycho-educational and socio-cultural interventions designed to change the objectification of women, which is a major determinant of violence against women including IPV/SV.
- Censure public statements which seek to normalize violence against women as acceptable or a cultural norm.

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