WORLD PSYCHIATRIC ASSOCIATION

ADVANCE PSYCHIATRY AND MENTAL HEALTH ACROSS THE WORLD

Intimate Partner Violence

www.wpanet.org

WHAT IS INTIMATE PARTNER VIOLENCE (IPV)?

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

- Now includes stalking and financial abuse

WHO 2013
CDC

IPV

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

PATTERNS OF IPV

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

INTERNATIONAL IPV

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

Garcia-Moreno C. 2006

IPV DURING PREGNANCY AND PERINATAL MENTAL DISORDERS IN LLMIC

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

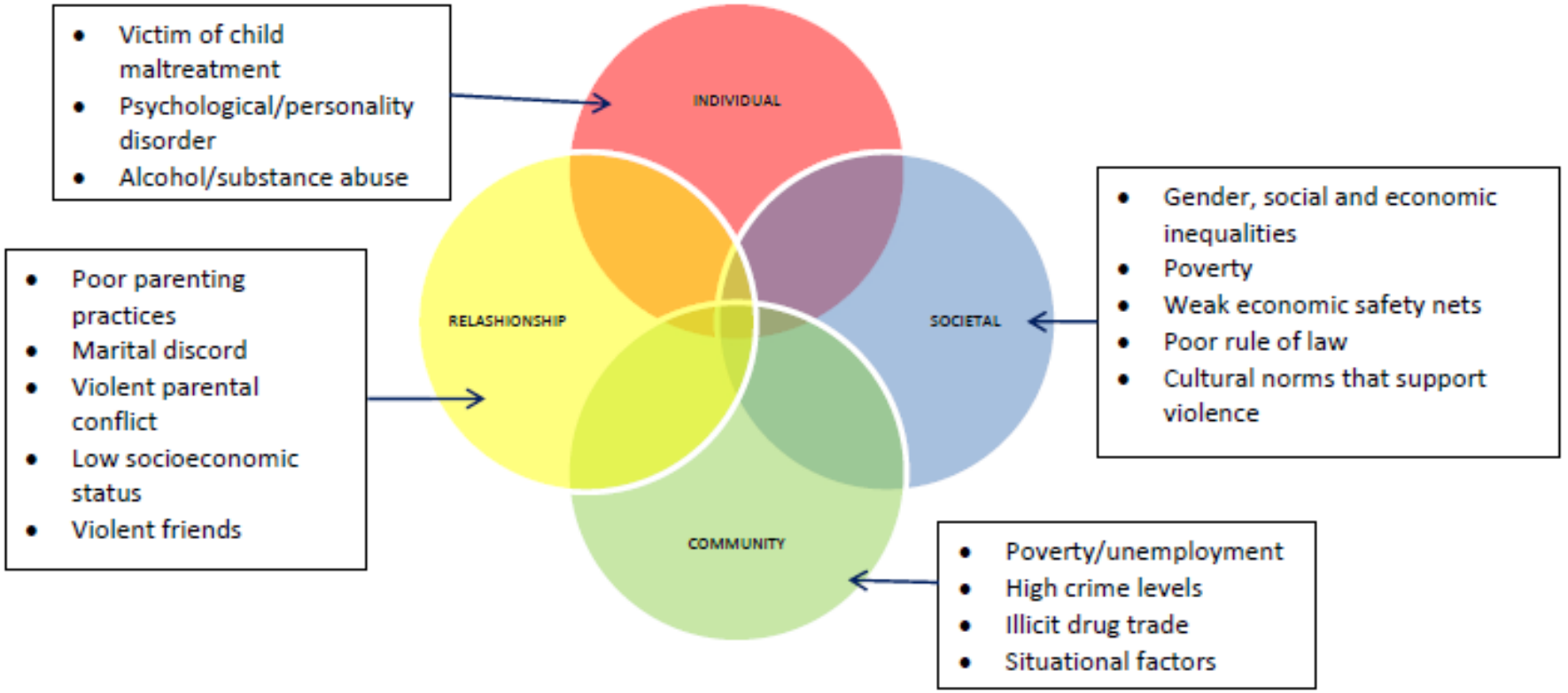
Halim N et al. Clin Psych Rev veri18;66:117-135
https://www.sciencedirect.com/science/article/pii/S0272735817302568?via%3Dihub

COVID-19 LOCKDOWN AND IPV

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

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

ECOLOGICAL MODEL OF IPV RISK FACTORS



MYTH OR FACT

"If a women is abused she can/should just leave"

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

MYTH OR FACT

"Substance abuse and stress cause battering"

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

COMMON IPV CONCERNS/MISCONCEPTIONS BY MENTAL HEALTH PROFESSIONALS

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

PHYSICAL HEALTH SEQUELAE OF IPV

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

MENTAL HEALTH SEQUELAE OF IPV

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

EFFECT OF IPV ON CHILDREN

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

PERPETRATORS

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

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

SYSTEMATIC REVIEW OF PSYCHIATRIC PATIENTS AND IPV

- 42 studies of inpatient and outpatient psychiatric patients
- Approximately 30% of men and women inpatients and outpatients had lifetime history of IPV
- Often unrecognized by HCP
- 41 studies
- Women with depressive disorders OR=2.77 IPV

  anxiety disorders OR=4.08 IPV

  PTSD OR=7.34 IPV

  compared to women without a mental disorder

Trevillion et al. 2012
Oram et al. 2013

CASE FINDING

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

CASE FINDING (cont'd)

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

TRAUMA INFORMED MODEL OF CARE

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

SIGNS OF POSSIBLE IPV

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

SOME POSSIBLE DISCLOSURE QUESTIONS

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

WHEN IPV IS DISCLOSED

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

“LIVES”

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

WHO

THERAPIST CONSIDERATIONS

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

DECISION TO LEAVE PARTNER

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

IMMEDIATE PSYCHOLOGICAL MANAGEMENT

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

PSYCHOLOGICAL GROUNDING METHODS

- Simple strategies to detach from severe emotional pain (flashbacks, anxiety etc)
- Creates a safe place to regain control over overwhelming emotions or “numbing”
- Distraction by focusing on the external world rather than inward
- Examples:

Touch the chair you are in and describe it
Repeat a safe statement “I am safe here”
Think about a soothing scene
Tap feet on the floor

IMMEDIATE PSYCHOLOGICAL MANAGEMENT

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

ADVOCACY INTERVENTIONS

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

Tirado-Munoz et al. 2014
Cochrane Review 2009

ANXIETY DISORDERS AND DEPRESSION

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

THERAPY FOR POSTTRAUMATIC STRESS DISORDER

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

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

PSYCHOLOGICAL INTERVENTIONS FOR COMMON MENTAL DISORDERS FOLLOWING IPV IN LMIC

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

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

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

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

SUBSTANCE USE DISORDERS (SUD)

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

Roberts NP et al 2015

WHO GUIDELINES

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

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

WHAT ABUSED WOMEN WANT

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

G Feder 2006

USEFUL RESOURCES

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

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

- WHO Clinical Handbook "Healthcare for Women subjected to Intimate Partner Violence and Sexual Violence"

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

- VEGA- Violence, Evidence, guidance, Action

  https://vegaproject.mcmaster.ca/

THANK YOU

WORLD PSYCHIATRIC ASSOCIATION

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