WPA International Competency-Based Curriculum for Mental Health Providers on Intimate Partner Violence and Sexual Violence Against Women

Intimate partner violence (IPV) and sexual violence (SV) are public health and human rights problems worldwide which have profound effects on the health and wellbeing of individuals, families and communities[1].

The World Health Organization (WHO) defines IPV as "behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse or controlling behaviours"[2]. It may be perpetrated by a current or past intimate partner, occur in heterosexual or same-sex relationships, and include stalking. At its core it is a means to control and dominate the abused partner.

SV is defined by WHO as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"[2,3]. It includes marital, dating, stranger and acquaintance relationships, sexual slavery, forced marriage or cohabitation and wife inheritance and may occur during peace or war[2,3]. It may also take place when someone is not able to give informed consent (e.g., a child or a person who is intoxicated, drugged, asleep or physically or mentally incapacitated).

While IPV and SV can occur to both women and men, the most serious forms overwhelmingly happen to women at the hands of men[2,3].

Prevalence rates of IPV/SV varied from 15 to 71% (lifetime) or 4 to 54% (last 12 months) across a 10-country study by WHO[4]. Prevalence is greatly underreported due to guilt, shame, social stigma, inadequate social support, financial or emotional dependence on the perpetrator, or fears for safety, child custody, immigration status, or other repercussions[3]. A public health ecological model of risk factors for IPV/SV includes those related to the individual, partner, family and community (including social and cultural), which may all contribute[5].

Both IPV and SV can result in numerous physical (including death) and mental health sequelae, thereby making it imperative that health care professionals know the risk factors, how to assist disclosure and safely respond[6]. Mental health sequelae may include depression, anxiety, post-traumatic stress disorder, psychosis, self-harm, sexual problems, inability to trust others, and a host of psychosomatic conditions and risky behaviours that may be referred. Therefore, psychiatrists must be familiar with the best evidence-based short- and long-term management of IPV and SV mental health sequelae to best assist victims[6].

Evidence shows that 30% or more (depending on location and presenting symptoms) of psychiatric patients have been exposed to IPV or SV[7]. As IPV and SV are often not disclosed, or enquired about by psychiatrists, this may affect diagnosis, treatment and outcome. Needs assessments have indicated that IPV and SV are key determinants of women's mental health, but 60% of mental health professionals report that they lack adequate knowledge and want more education on these topics[8].

The WPA Action Plan for 2014-2017 developed by President D. Bhugra listed IPV and SV as priorities for a position paper and curriculum. Under the leadership of D.E. Stewart (Canada) and P.S. Chandra (India) and a Steering Group of six experts from across the globe (three from WHO), plus two educational consultants, a competency-based curriculum for medical students, psychiatric trainees and practicing psychiatrists was developed. This includes suggestions of how to test nine core competencies and their related subtopics (definitions, prevalence, misconceptions, health sequelae, assessment, psychological first aid, resources, documentation, and psychiatric management of related mental health traumas). The psychiatric management curriculum includes the initiation and monitoring of first line methods indicated for the treatment of IPV/SV psychological trauma, such as cognitive behavioural therapy with a focus on the trauma, exposure therapy, eye movement desensitization and reprocessing, pharmacological interventions and comprehensive care for complex post-traumatic stress disorder.

Different types of educational tools are employed in the curriculum to enhance knowledge, attitudinal change and skills, and thereby provide real life competencies. The curriculum links to WHO clinical and policy guidelines[9], a WHO clinical handbook[2], key paper abstracts, a list of books, manuals and toolkits, and a teaching set of powerpoints on IPV and SV. It provides twelve international case vignettes with teaching points and two video-based learning vignettes in which two senior psychiatrists each interview a woman who has experienced IPV.

A trauma-informed model of care advocated by WHO uses the acronym "LIVES", where "L" means listen (empathic and non-judgmental), "I" means inquire (about needs and concerns), "V" means validate (believe and understand the victim), "E" means enhance safety (help protect against further harm), and "S" means support (help connect to services and social support)[2].

A WPA position paper on IPV/SV was also developed by the Steering Group of experts.

The curriculum and the position paper were approved by the WPA Executive Committee in July 2016 and posted on the WPA website (www.wpanet.org). Initial response has been encouraging, with several universities, medical schools and non-governmental organizations across five continents requesting permission to

use the curriculum in whole or in part. The curriculum has been presented at several annual national psychiatric association meetings (with more planned) and has been featured in news articles. We welcome comments on the curriculum and feedback about its use at donna.stewart@uhn.ca.

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1. Stewart DE, Vigod S, Riazantseva E. Curr Psychiatry Rep 2016;18:4.
2. World Health Organization. Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. Geneva: World Health Organization, 2014.
3. World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva: World Health Organization, 2010.
4. Ellsberg M, Jansen HAFM, Heise L et al. Lancet 2008;371:1165-72.
5. World Health Organization. World report on violence and health. Geneva: World Health Organization, 2002.
6. Stewart DE, MacMillan H, Wathen N. Can J Psychiatry 2013;58:1-15.
7. Oram S, Trevillion K, Feder G et al. Br J Psychiatry 2013;202:94-9.
8. Nyame S, Howard LM, Feder G et al. J Ment Health 2013;22:536-43.
9. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization, 2013.

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