World Psychiatry
OFFICIAL JOURNAL OF THE WORLD PSYCHIATRIC ASSOCIATION (WPA)

World Psychiatry. 2006 February; 5(1): 61–64.
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The International Consensus Statement on Women's Mental Health and the WPA Consensus Statement on Interpersonal Violence against Women

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In 1999, women's mental health leaders from Europe, Asia, Africa, North and South America and Australia began a fact finding process to determine the psychosocial, cultural and environmental factors which were most salient to women's mental health and mental illness. At the 2001 First World Congress on Women's Mental Health in Berlin, they rank ordered these factors. Discussion among women psychiatrists, psychologists, social workers, mental health nurses, policy experts, non-governmental organizations (NGOs) and consumers resulted in a published summary (1).

In 2003-2004, further discussions were held that culminated in a March 2004 roundtable at the Second World Congress on Women's Mental Health in Washington, sponsored by the International Association for Women's Mental Health. A decision was made to develop an International Consensus Statement on Women's Mental Health that described the issues and concluded with recommendations.

A Consensus Statement on Interpersonal Violence against Women was also written by the WPA Section on Women's Mental Health, and submitted to the WPA Executive Committee and Member Societies for their comments.

Work on the International Consensus Statement on Women's Mental Health was further facilitated by a WPA meeting at Metropolitan Hospital in New York City in April 2004 and a subsequent meeting hosted by the American Psychological Association in

September 2004. This International Consensus Statement on Women's Mental Health was approved by the American Psychological Association and the American Psychiatric Association by December 2004 and then rapidly approved by a number of national mental health associations, NGOs and individuals. Both the International Consensus Statement on Women's Mental Health and the Consensus Statement on Interpersonal Violence Against Women were approved by the WPA at its General Assembly in Cairo in September 2005.

We urge all WPA Member Societies to disseminate these Consensus Statements by posting them on their websites and distributing them to their members, in their journals and other written communications. Even more importantly, we urge WPA Member Societies, individual psychiatrists and other mental health workers to begin work to implement the recommendations to improve women's mental health. Please let us know how we can help (donna.stewart@uhn.on.ca).

INTERNATIONAL CONSENSUS STATEMENT ON WOMEN'S MENTAL HEALTH

Preamble

The 1995 United Nations (UN) Beijing Platform for Action states that "Women have the right to the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and wellbeing..." (2). In September 2000, UN agencies, 189 member countries of the UN, as well as multilateral and bilateral agencies unanimously endorsed the Millennium Declaration (3). The Millennium Development Goals, made up of 8 Goals and 48 Targets, are recognized as the road map for implementing the Millennium Declaration. The Goals include the achievement of universal primary education, the promotion of gender equality, reduction of child mortality, improving maternal health and combating HIV/AIDS, among others. Mental well-being of the mother is integral to the health, nutrition and educational outcomes of their children, violence against women erodes gender equality and the empowerment of women, as well as putting women at increased risk for HIV infection. It is thus imperative that women's mental health be prioritized, if the Millennium Development Goals are to be achieved.

Women's mental health must be considered within the context of women's lives and cannot be achieved without equal access to basic human rights: autonomy of the person, education, safety, economic security, property and legal rights, employment, physical health, including sexual and reproductive rights, access to health care, and adequate food, water, and shelter. Women's mental health requires the elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual orientation or religious beliefs. While both sexes benefit from the above factors and the overall rates of

mentally ill women, women with disabilities, women in institutions, ethnic minorities, sex workers, trafficked women, and other disadvantaged women, including women during armed conflict, are all disproportionately at risk for violence (7,8).

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 Association:

1. Issue a policy statement that recognizes violence against women as a major determinant of mental distress and psychiatric illness in women and strongly condemns all forms of violence against women.
2. Support programs to improve the education of practicing and training psychiatrists to recognize and treat victims of violence. 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 rape in the genesis of many psychiatric illnesses and as a treatment issue.
3. Promote safe, respectful, non-blaming, ambulatory and inpatient treatment programs for women victims of violence.
4. Support research to develop and evaluate the best treatments for women who have suffered from violence, and for their children and the perpetrators.
5. Support health professionals' and public awareness of violence against women as a critical women's mental health determinant.
6. Explore opportunities for greater interprofessional collaboration (legal, social, medical, and policy makers) on an international level to prevent and ameliorate violence against women, including violence during armed conflict.
7. 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 violence during armed conflict.
8. 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.
9. Censure public statements which seek to normalize violence against women as acceptable or a cultural norm.

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1. Stewart DE. Rondon M. Damiani G, et al. International psychosocial and systemic issues in women's mental health. *Archives of Women's Mental Health.* 2001;4:13–17.

1. Support psychological health promotion programs that encompass the life context of girls and women to include equal access to basic human rights, education and employment, the elimination of violence and discrimination and the reduction of poverty.
2. Support women's marital, sexual and reproductive choices and ensure access to safe motherhood.
3. Support public education and awareness campaigns that increase recognition and reduce the stigma of mental illness in girls and women.
4. Support safe, respectful, appropriate, gender sensitive comprehensive mental health and physical health services for girls and women across the life cycle irrespective of their economic and social status, race, nationality or ethnocultural background.
5. Support timely access to adequately skilled mental health professionals who provide quality of care consistent with best current knowledge and availability of appropriate therapy, technology or drugs and who take women's special needs into consideration.
6. Support the development and use of culturally appropriate diagnostic systems that consider the sociocultural context of women's lives, and biological differences when they are salient.
7. Support the provision of accurate information and respect choices in treatment decision making by girls and women whenever possible.
8. Support the provision of mental health care for girls and women that is free from breaches in fiduciary responsibility.
9. Support increased attention to research on girls' and women's mental health including those factors which enhance or inhibit the development of resiliency.
10. Support the provision of core training and education about gender issues for health, and mental health, professionals.
11. Support gender equality in practice and promotion within mental health services and organizations including equal opportunities for advancement and eradication of gender harassment, intimidation or unjustified discrimination on the basis of sex.

WPA CONSENSUS STATEMENT ON INTERPERSONAL VIOLENCE AGAINST WOMEN

Interpersonal violence is a critical public health challenge throughout the world that causes distress, reduced quality of life, physical and mental health consequences, and even death (4,5).

Although men, women and children may all be victims of violence, the perpetrators and consequences of violence are usually different for men and women. While men are most likely to be injured by strangers during the commission of a crime, or in war; women are most likely to be injured by their male partners or other family members; often someone they live with and love. In fact, women are more likely to be murdered by their intimate partners than by strangers. In addition, men's greater size and strength, and their more frequent use of weapons, result in more serious injuries to women from interpersonal violence between men and women (6). All these differences require special consideration for prevention, amelioration and policy for each gender, and accordingly, this consensus statement has been developed on interpersonal violence against women.

Research reveals a high prevalence of acute and chronic physical and mental health consequences of violence against women. Women who are victims of violence are more likely to suffer from depression, anxiety, post-traumatic stress disorder, borderline personality disorder, substance abuse, sexual dysfunction, low self-esteem, and psychological distress, as well as a host of acute and chronic physical disorders. Violence and abuse in early life are strong predictors of later mental illness, especially depression. Moreover, being assaulted, or witnessing an assault on family members in childhood, or adolescence, increases the risk of mental disorders, low self-esteem and subsequent involvement in abusive relationships for both men and women. Violence against women also has negative secondary effects for families, communities, society and the economy (4-9).

Violence against women takes many forms: battery, sexual assault, psychological abuse and harassment. Cultural norms, social expectations, and gender roles and relations may promote such violence against women and these social forces may determine the consequences to the woman and the response of society. Media and advertising too often portray violence against women as acceptable. Although religion may be used as a rationalization for violence against women, reference to core religious documents, such as the Bible, the Koran and the Torah, reveal in many parts that violence against women is not acceptable (4-9).

Understanding male violence against women requires an examination of the physical, legal and economic power inequality between men and women. Poor and older women,

mental illness are similar in men and women, women's unique roles in reproduction, the family and society, and their often lower socioeconomic status, necessitate special considerations for their mental health.

Even in optimal circumstances, some women will experience mental health problems and illnesses for which adequate diagnosis and treatment are essential. The identification of women's mental health problems should ideally start with women themselves who should be provided with accurate, understandable information about mental health, psychological distress, illnesses, and available services and treatments. Evaluation of mental health problems in women must consider the full context of their lives, as distress in women often has social origins and diagnoses should not be stigmatizing. The role of violence and discrimination in the genesis of mental health problems in women requires special consideration. Social and psychological services and primary care physicians should be able to undertake evaluation, diagnosis and treatment or offer referral to appropriate specialty services. Women should have access to respectful, knowledgeable mental health care in a timely fashion, in a nonstigmatizing, suitable setting within their economic means, by adequately skilled health professionals with access to appropriate treatments.

Treatment settings should be safe, and free from breaches of fiduciary trust by health care providers and staff. Women's preferences for informed medical decision making should be respected whenever possible, and the quality of care should be assessed by indicators that are consistent with best current knowledge, informed by gender- sensitive research. Women who have been sexually abused, or who have strong preferences for female health care providers, should be accommodated whenever possible. Appropriate services for adolescent, peripartum, midlife, older, immigrant, refugee, disabled and incarcerated women are essential. Acute and continuing care, supportive and rehabilitative mental health services across the life span are essential to enable mentally ill women to achieve their optimal level of functioning and well-being. Positive women's mental health benefits the health of women themselves, their families, and the general population and promotes women's participation in professions and leadership.

Recommendations

Accordingly, we recommend that professional mental health and health organizations and providers, governments, the UN system, the World Health Organization, other international health and social organizations and appropriate nongovernmental organizations integrate girls' and women's mental health as a priority in policy and program development and...

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