An International Investigation of Intimate Partner Violence-Related Training Among Mental Health Professionals

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Acknowledgments

“At times, our light dwindles and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us.” – Albert Schweitzer

I find myself completing this thesis journey at a strange time, amid a global pandemic, when the incredible value of my supports and loved ones has never been clearer. I am now, and have ever been, deeply grateful for all the amazing people in my life who have encouraged me, stood by me, and lent me strength, so I could make it to the end of this journey.

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Content of Thesis and Contributions of Authors

The present thesis is in article format and contains four sections: a general introduction, two studies, and a general discussion. The general introduction presents the topic of the thesis, provides detailed theoretical and empirical context related to the focus of the thesis, and defines the main objectives of the thesis. The first study, *Exploring Mental Health Professionals' Experiences of Intimate Partner Violence-Related Training: Results from a Global Survey*, and the second study, *Evaluating the Relationship between Intimate Partner Violence-Related Training and Mental Health Professionals' Assessment of Relationship Problems*, have both been published in the *Journal of Interpersonal Violence*. Both are included in this thesis with permission from the journal editor. The general discussion presents a summary and integration of both studies and their findings, and discusses implications, as well as study limitations and future directions for research.

This thesis was conducted in the context of the Eleventh Revision of the Relationship Problem and Maltreatment (RPM) guidelines for the World Health Organization (WHO)'s International Classification of Diseases (ICD-11) Clinical Descriptions and Diagnostic Guidelines. This thesis does not present primary findings of the ICD-11 RPM field trial, and instead focuses on secondary analyses of data collected during the field trial. The opinions contained in this thesis are those of its authors and, except as specifically stated, are not intended to represent the official policies or positions of the World Health Organization.

The thesis author, Ms. Samantha Burns, appears as the primary author on both study manuscripts. Ms. Burns, Dr. Cary Kogan, Dr. Richard Heyman, Dr. Heather Foran, Dr. Amy Slep, Dr. Geoffrey Reed, Dr. Tecelli Dominguez-Martinez, Dr. Jean Grenier, Dr. Chihiro Matsumoto, and Dr. Tahilia Rebello formed the research team for this doctoral thesis. Ms. Burns

was responsible for the literature review and the conceptualization of the thesis and research objectives, the programming and field testing of the study survey using Qualtrics™ survey software (Provo, Utah), data cleaning and management, developing the data analysis plan and performing all analyses, interpreting results, and the writing of the thesis document itself. Ms. Burns was also consulted on the study design and participated in the development of study materials by creating questions related to IPV-related training and assisting with the review of clinical vignettes and the translation of the study into French.

Drs. Kogan, Heyman, Foran, and Slep are members of the working group tasked with revising the Relationship Problem and Maltreatment (RPM) definitions for the Eleventh Revision of the WHO's ICD Clinical Descriptions and Diagnostic Guidelines. Dr. Reed was the Senior Project Officer in the WHO Department of Mental Health and Substance Abuse and managed all activities related to development of chapters on Mental, Behavioral and Neurodevelopmental Disorders; Sleep-Wake Disorders; and Conditions related to Sexual Health for the ICD-11. Together, Drs. Kogan, Heyman, Foran, Slep, and Reed developed the materials and methodology for the larger ICD-11 RPM online field trial that formed the basis for this thesis. These authors revised ICD-10 RPM categories and developed proposed definitions of RPM for inclusion in the ICD-11. They adapted the study design used for all ICD-11 online field trials to be applicable for the evaluation of RPM categories and developed and revised clinical vignettes. They also provided important feedback on the editing of the two manuscripts included in this thesis, which focus on secondary analyses of field trial data. Dr. Kogan, thesis supervisor, provided global oversight on this project, and had an invaluable role as a consultant throughout each step of the thesis process.

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I would also like to recognize the work of Dr. Howard Andrews, who collated data collected from the English, French, Japanese, and Spanish versions of the ICD-11 RPM field trial, and of Dr. Dwayne Schindler and Dr. Jared Keeley, who shared statistical expertise that helped guide the selection of analyses for this thesis.

Summary of Thesis

Intimate partner violence (IPV), including physical, psychological, and sexual violence towards a partner, is a human rights violation that is associated with the development of a multitude of short- and long-term physical and mental health problems (WHO, 2013[1]). IPV survivors are at greater risk of developing mood, anxiety, and trauma- and stressor-related disorders (García-Moreno et al., 2005). Public health guidelines recommend screening for IPV in mental health settings (WHO, 2013[2]). However, most mental health practitioners do not routinely assess for IPV in their practice (Howard et al., 2010). Lack of training in how to assess for and respond to IPV has been identified as an important barrier for IPV assessment in mental health settings (Trevillion et al., 2016). IPV-related training has been linked to positive outcomes for clinicians, including higher ratings of perceived knowledge and confidence in addressing IPV (Forsdike et al., 2019). Yet, studies suggest that approximately one quarter to one half of mental health professionals have never received IPV-related training (Murray et al., 2016; Nyame et al., 2013). To address this gap, the WHO advanced a series of evidence-based training recommendations (WHO, 2013[2]). At present, there is a dearth of research exploring the degree to which global mental health providers' experiences of training resemble WHO guidelines. Furthermore, few studies have investigated factors that contribute to clinicians' likelihood of participating in IPV-related training, and reasons for obtaining training are not well understood. There has also been no previous research into the relationship between mental health professionals' experiences of training and their accuracy in correctly identifying IPV. The present thesis, consisting of two studies, sought to assess global mental health providers' IPV-related training experiences, including factors that influence the probability of participating in training and the relationship between training and diagnostic accuracy.

In study 1, mental health professionals' IPV-related training experiences were surveyed, and factors that may contribute to the likelihood of participating in training were explored (e.g., IPV prevalence, norms, and legislation, and professional experience with IPV). The relationship between IPV-related training and knowledge and experience of relationship problems was also examined; 321 specialized mental health professionals (psychologists and psychiatrists) from 24 countries participated in an online survey. Participants responded to a series of questions regarding the content, duration, and frequency of their IPV-related training based on WHO recommendations, and rated their level of knowledge and experience with relationship problems. Descriptive analyses showed that nearly half of participants (46.9%) had never received IPV-related training. Approximately half of those who received training (49.4%) indicated that their training followed WHO recommendations. Logistic regressions revealed that participants who were from countries with relatively better implemented laws addressing IPV and participants who encountered IPV more often in clinical practice were more likely to have received training. Furthermore, participants who received training were more likely than those without training to report higher knowledge and experience of relationship problems. Findings highlight global challenges with regards to IPV-related training. They suggest that clinicians' likelihood of participating in training is related to their clinical contact with IPV and the institutional context in which they practice.

Study 2 investigated the relationship between IPV-related training and clinicians' diagnostic accuracy in the context of relationship problems, using the same sample as study 1. Chi-square analyses evaluated relationships between IPV-related training and clinicians' performance while assessing for clinically significant relationship problems (RPM) in case-controlled vignettes across two study conditions: RPM present (i.e., when the task was to

correctly identify RPM) and RPM absent (i.e., when the task was to correctly identify that there was no RPM; normative relationship problems were presented). Results showed that participants who received IPV-related training were more likely to perform better than those without training in the RPM present condition, but not in the RPM absent condition. In the RPM present condition, participants were more likely to respond correctly when their training was more recent and more closely resembled WHO recommendations for training. In the RPM absent condition, a similar percentage of participants with training (60-78%) and without training (45-76%) misclassified normative relationship problems as clinically significant RPM. Overall, findings suggest that IPV-related training is related to improved diagnostic accuracy in the context of relationship problems. WHO recommendations for training are supported.

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General Introduction

General Introduction

Intimate partner relationships are part of the fabric of human existence. They fulfill important attachment needs and provide partners with opportunities for warmth, support, sexual excitement, and security (Heffernan et al., 2012). However, strong bonds between partners can also evoke strong emotions, and all too often, intimate relationships are characterized by instances of violence and abuse. Intimate partner violence (IPV) is defined by the World Health Organization (WHO) as "any behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (Heise & García-Moreno, 2002; Jewkes, Sen & García-Moreno, 2002; WHO, 2010). IPV includes physical violence (i.e., non-accidental acts of physical force, such as hitting, shoving, kicking, or slapping a partner), sexual violence (i.e., forced or coerced sexual acts, or sexual acts with a partner who is unable to consent), psychological abuse (i.e., non-accidental verbal or symbolic acts, such as threatening, stalking, or isolating a partner from social supports), and partner neglect (i.e., depriving a partner who is incapable of self-care of needed food, shelter, hygiene, or necessary services; Foran et al., 2013). IPV is a serious public health problem and human rights violation (WHO, 2013[1]) that contributes to a multitude of physical, psychological, and social problems worldwide, and poses a substantial burden on health systems (García-Moreno et al., 2005).

Understanding Intimate Partner Violence

IPV has been the subject of a significant body of literature over the past 50 years. Researchers from various theoretical camps have sought to understand causes and risk factors for IPV to develop interventions to prevent violence and protect survivors. Championing early research on IPV were feminist theorists, who perceived IPV to be a problem of men's violence

towards women related to societal rules that encouraged male dominance and female subordination (Bell & Naugle, 2008). This model suggested that women's violence towards male partners was solely reactionary, the result of self-defense or retaliation for abuse (Dobash & Dobash, 2004). Data collected in intervention settings (e.g., police records, courts, hospitals, and shelters) appeared to support this hypothesis, as perpetrators were mostly male. However, when family violence researchers collected and analyzed data from population-based surveys, they found evidence that contradicted the feminist view of IPV; notably, IPV was bidirectional, and women and men were equally likely to perpetrate violence in their relationships (Straus & Smith, 1990). Seeking to integrate findings from both these camps, Johnson (1995)'s research found that different types of violence were reported from different data sources (i.e., intervention *vs.* survey data). A typology of IPV was developed, describing intimate terrorism (i.e., IPV with the goal of controlling one's partner, most often reported in intervention studies) and situational couple violence (i.e., IPV that results from situational conflicts rather than issues of power and control, most often reported in survey data; Johnson 1995; 2001). IPV research has since supported Johnson (1995)'s typology and shown that intimate terrorism is more frequently perpetrated by men towards women and is more severe than situational couple violence, leading to significant fear in the relationship and greater likelihood of visiting the emergency room or seeking help from women's shelters (Graham-Kevan & Archer, 2003; Johnson, 1995; Johnson, 2001). Situational couple violence, on the other hand, is the most common form of IPV, appears to be perpetrated equally by men and women (Graham-Kevan & Archer, 2003; Johnson, 2001) and is less likely to lead to severe consequences for survivors (although serious injury may still occur; Johnson, 1995).

The Gender Paradigm

It is currently well understood that IPV occurs across all types of relationships (e.g., male-to-female, female-to-male, or bilateral violence in heterosexual relationships, and unilateral or bilateral violence in LGBTQ+ relationships). However, IPV continues to be largely defined as male-to-female violence within social institutions (e.g., the criminal justice system, IPV intervention and advocacy services) and in the research literature (Dutton & Corvo, 2006; Espinoza & Warner, 2016). This is due to the so-called gender paradigm, whereby violence towards men is viewed as less problematic and less consequential than violence towards women, despite research that points to significant negative impacts of IPV on all survivors, regardless of gender (Dutton & Nicholls, 2005; Espinoza & Warner, 2016). As a result of the gender paradigm, there is a comparative shortage of research on female-to-male IPV and IPV in LGBTQ+ relationships. Furthermore, research that exists on these topics has primarily been led in high-income, Western countries (e.g., Canada, the US, and the UK; Laskey et al., 2019), and little is known about these forms of IPV in low- and middle-income countries. Thus, while this introduction seeks to be inclusive of IPV research as it relates to women, men, and LGBTQ+ individuals across the globe, it is limited in scope for these reasons.

IPV Risk Factors

IPV, like other forms of violence, is a complex socioecological problem. There is no simple set of causes to explain why someone may perpetrate or experience violence within their relationship. IPV appears to be the result of the interplay between various risk factors at the individual, relationship, community, and societal level (Dahlberg & Krug, 2002; WHO, 2010). The WHO (2010) developed a socioecological model integrating research from biological, psychological, cultural, and gender equality perspectives that defines risk factors according to

these four spheres of influence: individual factors (i.e., biological and personal history factors), relationship factors (i.e., factors that increase risk as a result of relationships with close others, including family, peers, and intimate partners), community factors (i.e., factors related to community contexts in which close relationships are embedded), and societal factors (i.e., larger, macro-level factors such as gender inequality, cultural beliefs, social norms, and policies; Dahlberg & Krug, 2002). Risk factors are organized hierarchically in this model (from individual to societal-level factors in ascending order), with higher-level factors having a cascading influence on levels below (WHO, 2010). This illustrates how the larger sociocultural, political, and economic context in which one lives can impact personal risk for violence.

With regards to individual factors, IPV of all kinds (i.e., male-to-female violence, female-to-male violence, and violence within LGBTQ+ relationships) has been shown to be related to younger age, lower education, lower socioeconomic status, unemployment, psychological and physical health problems, substance abuse, acceptance of violence, and exposure to childhood maltreatment (intra-parental violence or abuse; Brassard et al., 2020; Caetano et al., 2008; Caron et al., 2017; Costa et al., 2016; Dugal et al., 2019; Edwards et al., 2015; Godbout et al., 2019; Gomez, 2011; Hébert et al., 2019; Shorey et al., 2011; Simmons et al., 2005; Stuart et al., 2006; Swan et al., 2008; WHO, 2010). With regards to childhood maltreatment, research suggests that abuse contributes to developing insecure romantic attachment in adulthood, which in turn increases the risk of IPV perpetration and victimization (Brassard et al., 2014; Godbout et al., 2017). Insecurely attached individuals in heterosexual and same-sex couples are more likely to use violence as a strategy to cope with relationship conflict than securely attached individuals (Gabbay & Lafontaine, 2017; Godbout et al., 2009; Péloquin et al., 2011). Furthermore, one study found that within same-sex couples, insecurely attached persons who reported low trust

and low sexual intimacy with their partner were more likely to perpetrate sexual violence (Gabbay & Lafontaine, 2020). Other studies have found that male-to-female or female-to-male physical and psychological IPV were more likely when insecurely attached individuals reported low perspective-taking (i.e., low empathy for their partners' difficulties; Lafontaine et al., 2018; Péloquin et al., 2011) or held unrealistic, perfectionistic standards for their relationships (Lafontaine et al., 2021). Individual risk factors that are unique to male-to-female violence include women's separated or divorced status and pregnancy (WHO, 2010). Risk factors that are unique to LGBTQ+ individuals include bisexual or questioning sexual orientation and transgender status (Decker et al., 2018).

Relationship-level risk factors for male-to-female IPV include educational disparity between partners (specifically women's higher educational achievement; Ackerson et al., 2008; Xu et al., 2005) and women's higher number of children (WHO, 2010). Infidelity (Dalal et al., 2009; Edwards et al., 2015; Johnson & Das, 2009; Tang & Lai, 2008; Vung & Krantz, 2009) and relationship dissatisfaction or discord (Edwards et al., 2015; Morrison et al., 2007; Stith et al., 2004; Tang & Lai, 2008) have been related to increased risk of IPV victimization and perpetration in heterosexual and LGBTQ+ couples. Furthermore, family violence research speculates that situational couple violence towards either partner in a relationship is the result of family dynamics, including the interaction between factors that cause conflict between partners (e.g., stress, disagreements about activities, sexist attitudes) and factors that contribute to the acceptance of violence as a means of resolving conflict (e.g., witnessing or being subject to intrafamily violence as a child; Straus & Smith, 1990).

Community-level risk factors for male-to-female IPV include weak community sanctions against violence (Heise & García-Moreno, 2002; Jewkes et al., 2002; WHO, 2010), and

neighborhood characteristics such as high proportion of poverty, unemployment, and households that use corporal punishment, and low proportion of women with higher education and autonomy (Ackerson et al., 2008; Heise & García-Moreno, 2002; Jewkes et al., 2002; Koenig et al., 2006; WHO, 2010). Amongst youth (aged 12 and older), a meta-analysis showed that relationships with peers (i.e., affiliation with deviant peers) was a risk factor for IPV (Hébert et al., 2019). Societal-level risk factors for male-to-female IPV include traditional, patriarchal gender norms that contribute to men's higher social status and legitimize their control over women (Branisa et al., 2014), social norms supportive of violence (García-Moreno et al., 2005; Uthman et al., 2009), and lack of or poor implementation of legislation criminalizing IPV (Branisa et al., 2014; WHO, 2010).

Unfortunately, there is a dearth of research exploring community and societal-level risk factors for female-to-male violence and IPV in LGBTQ+ relationships. However, certain authors suggest that traditional gender norms and internalized gender stereotypes contribute to a negative societal perception of male survivors of IPV (Douglas & Hines, 2011) and are significant barriers for help-seeking in men (Cheung et al., 2009; Machado et al., 2017). Thus, certain societal risk factors for male-to-female IPV may also contribute to the maintenance of IPV directed towards men. Within LGBTQ+ relationships, minority stress (i.e., stress related to being a member of a stigmatized minority group) has been identified as a risk factor for IPV (Decker et al., 2018; Edwards et al., 2015). Notably, studies have shown that bisexual and gay men and lesbian women who were more "out" (Bartholomew et al., 2008; Carvalho et al., 2011) and LGBTQ+ individuals who reported higher rates of internalized homophobia and stigma conscientiousness (both markers of negative feelings towards their orientation or gender minority status; Carvalho et al., 2011; Balsam & Szymanki, 2005) were more likely to experience IPV.

Prevalence and Impact

IPV is a serious public health problem that has severe and long-lasting effects on survivors' physical and mental health (WHO, 2013[1]). Global studies assessing the impact of male-to-female IPV have shown that ever-abused women are more likely to experience emotional distress, inability to enjoy life, depression, anxiety, post-traumatic stress disorder (PTSD), suicidal ideation, suicide attempts, memory loss, miscarriage, abdominal pain, chronic pain, and disability, compared to non-abused women (García-Moreno et al., 2005; WHO, 2013[1]). Male and LGBTQ+ IPV survivors are at risk for similar health impacts, including increased risk of physical injury, depression, anxiety, PTSD, and suicidal ideation (Decker et al., 2018; Douglas & Hines, 2011; Laskey et al., 2019). Furthermore, children exposed to IPV are more likely to experience child abuse and adverse health outcomes than children who are not witness to violence. Horton et al. (1999) reported that 40-75% of children who lived in homes where IPV was present experienced some form of abuse. Children who witnessed IPV were more likely to report poorer overall health, take prescription medications, and develop short- and long-term physical health problems (e.g., asthma and eating, sleeping, and pain complaints) compared to children who were not exposed to IPV (Artz et al., 2014). IPV exposure also negatively impacted child development and led to increased risk of children developing mental health difficulties, including aggression, externalizing problems, depression, and PTSD (Artz et al., 2014).

Costs of IPV are significant, both in terms of the physical and emotional toll it has on survivors, and the financial burden on health services. In Canada alone, it has been estimated that the annual cost attributable to violence for women's health is over six billion dollars (Varcoe et al., 2011). Prevalence statistics for Canada, based on police-reported violent crime data collected by Statistics Canada, indicate that nearly 92,000 Canadians (79% of which were women)

reported experiencing IPV in 2015 (Burczycka & Conroy, 2015). Of these, 77% reported physical violence, while the other 23% reported either sexual violence or verbal threats.

Global prevalence statistics for IPV estimate that 35% of ever-partnered women have experienced IPV (WHO, 2013[1]). The WHO's Global Status Report on Violence Prevention (WHO, 2014) collated violence-related data from 133 countries and found that prevalence of IPV (defined as male-to-female violence) was elevated in every global region (i.e., 37.7% in South-East Asia, 37% in the Eastern Mediterranean region, 36.6% in Africa, 29.8% in the Americas, 25.4% in Europe and 24.6% in the West Pacific Region). In the WHO's Multi-Country Study on Women's Health and Domestic Violence Against Women (García-Moreno et al., 2005), women from 10 nations (i.e., Peru, Bangladesh, Thailand, Brazil, Tanzania, Ethiopia, Samoa, Namibia, Serbia, and Japan) were surveyed about their experiences of IPV. Lifetime reports of physical IPV were found to be 13% in Japan, 27% in Brazil, 40-50% in Samoa, Bangladesh, Tanzania, and Ethiopia and 61% in Peru.

Although there is relatively less research on the topic, global studies exploring IPV experienced by men suggest that prevalence rates may be comparable to rates of IPV experienced by women (Costa et al., 2016; Lafontaine et al., 2018; Péloquin et al., 2011; Murray & Graves, 2012). Using data collected from 4,239 college students in 32 nations who completed the International Dating Violence Study, Murray and Graves (2012) found that on average, 25% of all men and women had physically attacked their partner over the past year. In over two-thirds of these cases, violence was bidirectional (both partners were violent; Murray & Graves, 2012). Furthermore, in a sample of 3,496 men and women from six European cities (Athens, Budapest, London, Östersund, Porto, and Stuttgart), an average of 17.4% of women and 20.8% of men reported being victims of severe psychological aggression in the past year (e.g., partner

threatened to hit or throw something at them; Costa et al., 2016). In the same study, an average of 14.1% of women and 16.2% of men reported experiencing past-year physical assault (e.g., partner kicked, bit, or punched them; Costa et al., 2016). A systematic review of 249 studies of physical violence in heterosexual relationships from Australia, Canada, New Zealand, South Africa, the UK, and the U.S. found similar prevalence rates, whereby approximately 20% of men had experienced physical IPV (Desmarais et al., 2012).

With regards to the prevalence of IPV in same-sex relationships, studies in North America have found that LGBTQ+ individuals are at higher risk of IPV than their heterosexual peers (Burczycka & Conroy, 2015; Edwards et al., 2014; Harland et al., 2018; Hutchins, 2013). A review of three studies with a combined sample of 3,690 gay, lesbian, and bisexual individuals in the U.S. and Canada found that the rate of physical violence within LGBTQ+ relationships was 37.3% (Langhinrichsen-Rohling et al., 2012). Another systematic review found that IPV prevalence rates for LGBTQ+ couples ranged widely, from 6.5-85.7% (Decker et al., 2018). The authors attributed this to methodological differences across studies, whereby research that included broader definitions of IPV (e.g., inquiring about psychological violence rather than just physical violence) reported higher prevalence rates (Decker et al., 2018).

While prevalence rates for IPV are elevated across all types of relationships, it is likely that these statistics are under representative of actual instances of IPV as they occur in the population. Notably, Ansara and Hindin (2010) studied the help-seeking behaviors of Canadian men and women and reported that prevalence rates are often compiled using statistics reported by criminal justice systems or health professionals. Although these reports come from reputable informants, many IPV survivors only self-disclose abuse to authorities when it is severe (e.g., physical or sexual violence), and therefore situations of verbal/symbolic (i.e., psychological)

abuse may go unreported (Ansara & Hindin, 2010). Furthermore, according to the WHO (García-Moreno et al., 2005), most physically abused women (55-95% of those surveyed) reported that they would not seek help from formal agencies (e.g., legal or health care) for IPV. The most common reasons women cited for not seeking help were believing that violence was normal or not serious, fearing the consequences of reporting violence (e.g., further violence, having their children taken away, or bringing shame on their household), and worrying that they would not be believed or helped by professionals (García-Moreno et al., 2005).

It is also probable that male survivors of IPV are underrepresented in prevalence statistics, since men are less likely to seek out formal assistance services and are less likely to be believed by service providers when reporting IPV (Cheung et al., 2009; Douglas & Hines, 2011; Espinoza & Warner, 2016; Machado et al., 2017). Obstacles for men's help-seeking include a lack of support services for men, worries about stigmatization (e.g., being judged or disbelieved), fear of retaliation from their partner, shame and embarrassment (e.g., concern about being viewed as weak or feminine), and denial of abuse (Tsui et al., 2010). Similarly, research suggests that LGBTQ+ individuals prefer to disclose IPV to informal supports (e.g., friends), rather than formal support services, which may also skew prevalence statistics. Obstacles for help-seeking for LGBTQ+ individuals include a lack of services tailored to the needs of LGBTQ+ survivors, distrust in providers, worries about discrimination (e.g., related to their sexual orientation or gender identity), fear of being disbelieved or not taken seriously, shame about IPV, and internalized minority stress (e.g., low self-regard related to LGBTQ+ identity; Decker et al., 2018; Edwards et al., 2015).

The Assessment of IPV in Mental Health Care Settings

Various services and institutions (e.g., the justice system, victims' services, health and mental health services) have a role to play in addressing IPV. Of interest for the present thesis, mental health services are an important point of contact for IPV survivors who present for treatment of mental symptoms related to IPV (Foran et al., 2013). IPV is common among patients in mental health settings. For example, a systematic review of IPV prevalence studies found that the median prevalence of IPV among female psychiatric outpatients was 30% (range 26-56%; Oram et al., 2013). Psychiatric symptoms are a risk factor for IPV and experiencing IPV can contribute to the development of mental health symptoms (Ehrensaft, 2008). A review of IPV victimization and mental health found that men and women living with depressive disorders, anxiety disorders, or PTSD were more likely to experience IPV than individuals living without mental health disorders (Trevillion et al., 2012). Furthermore, some research has shown that individuals living with serious mental illness (i.e., who have a recurrent or persistent mental disorder that significantly impacts their functioning) are 2-6 times more likely to experience IPV than the general population (Khalifeh & Dean, 2010; Kamperman et al., 2014; Teplin et al., 2005).

Benefits and Limitations of Assessment

Formally assessing for IPV in mental health care is important, since individuals who experience IPV are unlikely to voluntarily disclose violence to health care providers (Ansara & Hindin, 2010; Cheung et al., 2009; Decker et al., 2018; Douglas & Hines, 2011; Edwards et al., 2015; Espinoza & Warner, 2016; Machado et al., 2017; Örmon et al., 2016; Vranda et al., 2019). Mental health service users report barriers for disclosure including fear of discrimination due to their mental health status and previous negative experiences in the mental health system

(Trevillion et al., 2012). Nevertheless, survey data shows that women identify health practitioners as the professionals they most trust with disclosures of IPV (WHO, 2013[2]), and evidence suggests that direct enquiry about IPV in psychiatric settings facilitates disclosure and increases detection rates (Howard et al., 2010; Khalifeh et al., 2015). Furthermore, since children exposed to IPV are at increased risk of abuse, research has shown that improved identification of IPV in clinical settings also increases the detection of reportable child abuse issues (Holtrop et al., 2004). Thus, international guidelines published by public health organizations (e.g., the WHO [2013] and the U.K. National Institute for Health and Care Excellence [NICE, 2014]) recommend routine screening for IPV with patients who present with mental health symptoms (e.g., symptoms of depression, suicidal ideation, anxiety, PTSD, and sleep disorders). These guidelines stress that routine screening should only be introduced if clinicians are trained in how to ask about and respond to disclosures of violence, protocols are in place to provide appropriate interventions or referrals for survivors, and confidentiality can be ensured (i.e., the partner is not present; NICE, 2014; Oram et al., 2017; WHO, 2013[2]).

There are multiple benefits of identifying IPV in mental health care settings. Ellsberg and Heise (2005) noted that improved identification of IPV by global health professionals can lead to the collection of more accurate prevalence data regarding IPV. Prevalence data can be used to inform public policy and provide the impetus to invest in programs addressing IPV. Additionally, better identification of IPV can lead to an improved understanding of its risk factors and mental health consequences (e.g., effect on mood), and help to establish thresholds for clinical significance of mental health symptoms in the context of IPV (Foran et al., 2013). It is important to distinguish normal reactions to IPV from psychopathology, to inform treatment planning and offer proper care (e.g., psychosocial support vs. psychotropic medications).

Intervention studies have shown beneficial effects of clinician-led services addressing the needs of IPV survivors (Eckhardt et al., 2013; Ogbe et al., 2020). For example, cognitive behavioral therapy (CBT) was found to enhance survivors' emotional functioning and reduce the impact of negative symptoms related to IPV (Frueh et al., 2009; Johnson et al., 2011; Johnson & Zlotnick, 2006). Advocacy-based interventions (i.e., services aimed at providing survivors with information and support to access community resources, such as legal, police, housing, and financial services) contributed to improved social support and better quality of life for IPV survivors (Sullivan & Bybee, 1999). IPV advocacy in combination with psychological treatments were effective in reducing the severity of mental health symptoms and decreasing the frequency of abuse (Kiely et al., 2010; Ogbe et al., 2020). Psychotherapeutic interventions led with children exposed to IPV also showed beneficial results, including reduced PTSD symptoms (child-parent psychotherapy; Lieberman et al., 2005; Lieberman et al., 2006), reduced anxiety (trauma-focused CBT; Cohen et al., 2011), and improved mood and self-esteem (community-based group therapy; McWhirter, 2011). A meta-analysis of 21 studies examining post-intervention outcomes for IPV-exposed children found that IPV interventions (e.g., play-based therapy, child-parent psychotherapy, psychoeducation) led to significant improvements in child well-being variables (e.g., externalizing and internalizing behaviors; Romano et al., 2019).

Unfortunately, however, research suggests that IPV is often inadequately documented and addressed when it is identified in mental health settings (Howard et al., 2010; Trevillion et al., 2016). One study of Spanish psychiatric service users found that among 33 women who presented with severe, violence-related physical injury, only half had documentation of IPV in their clinical histories (Cobo et al., 2010). Furthermore, when IPV was documented, clinicians typically provided few details about the abuse and rarely reported on follow-up interventions

targeting violence (Cobo et al., 2010). Other studies have shown that mental health clinicians do not often address IPV during treatment planning (Howard et al., 2010; Trevillion et al., 2016). In a survey of 131 U.K. mental health providers, only 27% of clinicians had provided information about specialized services to IPV survivors after disclosures of violence (Nyame et al., 2013). Moreover, a review of 92 clinical files of patients who experienced abuse at a community mental health center in New Zealand found that only 33% of treatment plans mentioned the abuse, and only 22% of patients received abuse-focused therapy (Agar & Read, 2002). These findings may, in part, help to explain why higher rates of IPV detection do not always lead to improved outcomes for patients (Trevillion et al., 2016). To be effective, IPV assessment should be paired with appropriate treatment planning and referral to services that address violence and its effects on survivors' wellbeing (Howard et al., 2010; Trevillion et al., 2016).

Barriers for Assessment

Despite potential benefits of IPV assessment, particularly when paired with effective intervention, many mental health professionals do not routinely assess for IPV in their regular practice (Chang et al., 2011; Forsdike et al., 2019; Nyame et al., 2013, Örmon et al., 2016; Trevillion et al., 2016). In their systematic review of studies addressing IPV in mental health settings, Howard et al. (2010) found that only 10-30% of cases of IPV were detected in routine practice. Surveys of 100 Indian (Vranda et al., 2019) and 428 U.S. (Chang et al., 2011) mental health service users showed that over 30% of patients had never been asked about IPV by clinicians. In the U.S. study, men were less likely to have been asked than women, with 73% of male patients reporting that IPV had not been assessed (Chang et al., 2011). Furthermore, studies led in Australia (Forsdike et al., 2019), the U.K. (Nyame et al., 2013), and the U.S. (Samuelson & Campbell, 2005) identified that fewer than half of mental health professionals (44%, 39%, and

23%, respectively) inquired about IPV with patients who presented with signs and symptoms associated with partner violence. Studies show that low rates of IPV detection are not unique to mental health settings, however; physicians and nurse practitioners operating in medical settings are also unlikely to screen for IPV (Waalen et al., 2000; Williamson et al., 2004). Interestingly, a systematic review showed that while most patients were comfortable with being asked about abuse by their health care providers, many health professionals (15-95%) reported being unwilling to routinely screen for IPV (Feder et al., 2009).

Several barriers for IPV assessment exist in medical settings. These include clinicians' unhelpful attitudes towards IPV (e.g., blaming the survivor or believing that IPV is rare), discomfort asking about IPV (e.g., fear of invading the patient's privacy or insulting them), personal experiences with IPV (e.g., witnessing or surviving IPV), perceived lack of responsibility with regards to IPV (e.g., perceiving that it is a personal or family problem, rather than a public health issue), lack of confidence in addressing IPV, lack of knowledge about IPV, survivors' hesitance to disclose IPV, lack of information about effective interventions or community resources to which to refer patients, limited time to screen for IPV, lack of or inadequate clinical guidelines or office protocols related to IPV, and lack of intimate partner violence (IPV)-related training (Sprague et al., 2012; Waalen et al., 2000).

While barriers for IPV assessment are relatively less studied in mental health contexts compared with medical settings, studies suggest that mental health professionals experience similar barriers for screening (Rose et al., 2011; Trevillion et al., 2016). Notably, mental health clinicians have reported lack of knowledge and confidence regarding IPV, lack of expertise, discomfort asking about IPV (e.g., due to lack of rapport with the patient, or fear of overwhelming, traumatizing, or offending the patient), lack of perceived responsibility in

addressing IPV (e.g., believing that enquiring about IPV was not part of their role), patient's unwillingness to disclose violence, lack of time, lack of clear care referral pathways, and lack of IPV-related training as significant barriers for IPV assessment (Rose et al., 2011; Samuelson & Campbell, 2005; Trevillion et al., 2016).

Intimate Partner Violence-Related Training

Lack of training with regards to IPV (e.g., how to identify and address IPV in clinical practice) is one of the most frequently identified barriers for IPV screening across various healthcare settings (Sprague et al., 2012; Trevillion et al., 2016; Waalen et al., 2000). Mental health professionals without training reported a lack of confidence and competence in addressing IPV with patients (Rose et al., 2011). Relatedly, studies of medical and mental health professionals who received IPV-related training showed that these clinicians reported relatively fewer barriers for IPV assessment, including reduced discomfort asking about IPV (McColgan et al., 2010), improved knowledge of IPV (Campbell et al., 2001; Connor et al., 2013; Forsdike et al., 2019; Jayatilleke et al., 2015; Mason et al., 2017; McColgan et al., 2010; Rose et al., 2011; Trevillion et al., 2016; Waalen et al., 2000; Zaher et al., 2014), improved confidence in their ability to assess and intervene appropriately in situations of IPV (Hamberger et al., 2004; Harris et al., 2002; Jayatilleke et al., 2015; Rose et al., 2011), reduced unhelpful attitudes towards IPV survivors (Campbell et al., 2001; Jayatilleke et al., 2015; Mason et al., 2017), and increased perceived responsibility in addressing IPV (Jayatilleke et al., 2015; McColgan et al., 2010).

Gaps in Training

Despite potential benefits of IPV-related training, research suggests that approximately one fourth to one half of mental health professionals have never received this form of training (Campbell et al., 1999; Dolunay-Cug et al., 2017; Murray et al., 2016; Nyame et al., 2013). A

survey of 415 Illinois counselors, psychologists, and social workers found that 41% of clinicians had never received IPV-related training (Campbell et al., 1999). Similarly, a survey of 131 U.K. psychiatrists and psychiatric nurses showed that 46% of respondents had not received this form of training (Nyame et al., 2013). Another more recent study of 173 North Carolina mental health professionals (i.e., counselors, marriage and family therapists, psychiatrists, psychologists, social workers, and substance abuse specialists) found that 21.4% of participants had never been trained to address IPV (Murray et al., 2016). To date, there is limited research on mental health professionals' experiences of IPV-related training, and most studies on the topic have been conducted in a handful of Western countries. However, a study of 121 Turkish counselors, psychiatrists, psychologists, and social workers suggests that rates of training in non-Western countries may be similarly low (Dolunay-Cug et al., 2017). In this study, 23.1% of clinicians had not received any training on family or sexual violence during their undergraduate education, and over half the sample (62.8%) reported that they had not received any family violence training since completing their professional degree (Dolunay-Cug et al., 2017).

Research shows that even amongst clinicians who had received IPV-related training, experiences of training were often insufficient to meet their needs (Mason & O'Rinn, 2014; Trevillion et al., 2016). There is no standardized curriculum for IPV-related training for health professionals, and clinicians' experiences of IPV-related training may vary widely in terms of content, duration, and frequency of training (Kamimura et al., 2015; Nyame et al., 2013; Murray et al., 2016; Stover & Lent, 2014; Valpied et al., 2017). Research conducted in medical settings has shown that IPV-related training that is limited to providing basic education about IPV (e.g., risk factors, prevalence, and health impacts) contributes to improved knowledge about IPV (Waalen et al., 2000), but does not lead to improved identification or documentation of IPV

(Campbell et al., 2001; Waalen et al., 2000; Zaher et al., 2014), or better referrals to care (Coonrod et al., 2000). However, there is evidence to suggest that IPV-related training that is multicomponent (e.g., provides education on identification of IPV, clinical skills, documentation, and provision of referral) and includes experiential skill-building exercises (e.g., vignettes, role-plays, focus group discussions) improves clinicians' self-efficacy with regards to addressing IPV (Jayatilleke et al., 2015), and may increase screening and identification of IPV (Jayatilleke et al., 2015; Short et al., 2006). Furthermore, clinicians who received repeated training, compared to training that was offered only once (Buranosky et al., 2012), and more hours of training, compared to fewer (Forsdike et al., 2019), reported better outcomes including greater IPV-related knowledge and perceived self-efficacy with regards to addressing IPV. To date, most studies of IPV-related training have been conducted in medical settings, and there is a need for research conducted with mental health professionals to better understand the relationships between training and the assessment of IPV in mental health care.

Although some studies suggest that greater breadth and depth of IPV-related training can lead to improvements in health professionals' management of IPV (Jayatilleke et al., 2015; Short et al., 2006), other research appears to show that training alone is insufficient to produce lasting changes in screening and referral behaviors (Choi & An, 2016; Hamberger & Phelan, 2006; Minsky-Kelly et al., 2000; Trevillion et al., 2016; Zaher et al., 2014). Notably, two recent reviews of studies of the effectiveness of IPV-related training for improving medical service responses to IPV found that training only improved screening and referral practices when it was paired with systemic changes (e.g., implementation of referral pathways to support services for survivors, or provision of cues to remind physicians to ask about abuse such as posters in waiting rooms or checklists in medical records; Choi & An, 2016; Lo Fo Wong et al., 2006; Zaher et al.,

2014). Although relatively less research has been conducted on this subject in mental health settings, evidence suggests that mental health professionals are similarly more likely to screen for IPV when training is combined with system support responses (e.g., improved access to advocacy services for survivors; Trevillion et al., 2014).

Overall, it appears that repeated, multicomponent IPV-related training reduces barriers for IPV assessment by improving clinicians' subjective ratings of knowledge and preparedness to address IPV (Buranosky et al., 2012; Hamberger & Phelan, 2006; Forsdike et al., 2019; Jayatilleke et al., 2015; Rose et al., 2011). However, even after training, there may remain certain barriers for assessment that are related to systemic problems (e.g., insufficient time to ask about IPV, inadequate protocols related to IPV, lack of care referral pathways), which can limit clinicians' engagement in effective clinical practices with regards to IPV (Sprague et al., 2012; Trevillion et al., 2016). To improve the health service response to partner violence, it seems that in-depth IPV education should be paired with system-wide initiatives such as the provision of IPV-related guidelines, protocols, and clear referral pathways (Choi & An, 2016; Sohal et al., 2020; Trevillion et al., 2014; Trevillion et al., 2016; Waalen et al., 2000; Zaher et al., 2014).

Factors Related to Training

Few studies have explored barriers and facilitators for participating in IPV-related training, and reasons for obtaining training are not well understood. One study by Campbell et al. (1999) examined the relationship between demographic and professional experience variables and domestic violence training within a sample of 415 U.S. mental health professionals. The authors found that women (compared with men) and individuals who were more prone to encounter IPV in their regular practice (i.e., clinicians who reported working with survivors of sexual abuse or domestic violence, or who described themselves as experts on violence against

women) were more likely to have received training on domestic violence (Campbell et al., 1999). Other factors, including ethnicity, age, years of professional experience, and whether the clinician was currently seeing clients, were not significantly related to the probability of participating in training (Campbell et al., 1999). Murray et al. (2016) also explored the relationship between demographic factors (i.e., gender, years of professional experience, profession, community type [urban vs rural], and highest level of education) and IPV-related training in 173 U.S. mental health professionals and found that none of the variables predicted training. Murray et al. (2016)'s results differed from Campbell et al. (1999) with regards to the relationship between gender and IPV-related training. Overall, it appears that demographic factors may not be related to training, while the relevance of IPV to one's clinical practice may be a predictor of the likelihood of participating in IPV-related training. It seems possible that service providers' personal awareness of IPV as a public health issue is important for obtaining training.

Beyond individual-level factors, clinicians' probability of participating in IPV-related training may also be related to larger, societal-level factors, including various institutions' (e.g., educational, political, and legal) recognition of IPV as a public health problem. The commitment of these institutions to addressing IPV by creating educational programming, policies, and laws related to IPV may be of importance for training. Of note, IPV-related training is often not a mandatory component of professional training programs for mental health professionals (Kelly, 1997; Ramos, 2008), and guidelines for IPV-related training are not frequently specified in national or organizational clinical policies (García-Moreno et al., 2015; Payne et al., 2007; Stewart et al., 2015). With regards to professional training, one survey of 270 doctoral-level clinical and counseling psychology programs and 313 psychiatry residency training programs in

the U.S. found that only 26-36% of programs offered training on abuse issues related to adults (Kelly, 1997). More recently, a survey of 37 U.S. doctoral-level psychology programs found that only two programs offered a course specifically addressing IPV (Ramos, 2008), though 88% of these programs did offer some didactic training related to IPV as a part of other courses. These studies suggest that professional training programs for mental health providers may not always foster a sense of responsibility towards addressing IPV in clinical practice.

With regards to policy, a study of national IPV-related policies and clinical guidelines across 18 nations in Central and South America found that only two national policies recommended that IPV-related training be implemented during health professionals' qualification training (Stewart et al., 2015). Moreover, only half of clinical guidelines advised providing in-service IPV-related training (i.e., on-the-job training after professional qualification) that included information about IPV and how to respond to survivors, and none specified the frequency or length of training (Stewart et al., 2015). Most nations included in this study were low- to middle-income countries, and it is possible that policy gaps may reflect limited financial resources to support the development and implementation of training programs.

A lack of policy guidelines for IPV-related training is problematic, as some evidence suggests that the presence of IPV-related training policies increases the probability that clinicians will have received IPV-related training and improves screening practices (García-Moreno et al., 2015; Payne et al., 2007). Notably, a study of 114 U.S. social work agencies showed that those that had an IPV-related training policy in place were 7 times more likely to report that 25% or more of their staff had received IPV-related training in the past year, compared to agencies without any such policy (Payne et al., 2007). Furthermore, García-Moreno et al. (2015) presented a case study of the impact of the development of a national gender-based violence awareness and

prevention plan in Spain and found that a new policy recommending IPV-related training for healthcare professionals led to increased training rates and improved IPV screening practices. Spain's development of public health policies related to IPV followed the adoption of a gender-based violence law by parliament, which suggests that improvements in health policy related to IPV can be influenced by sociopolitical factors (e.g., political will to address IPV and violence against women; García-Moreno et al., 2015). Further research is required to better understand individual- and societal-level factors that may be related to clinicians' probability of participating in training.

IPV-Related Training Guidelines

In recognition of the public health importance of addressing IPV in clinical practice, the WHO developed a series of clinical and policy guidelines for responding to IPV and sexual violence against women (WHO, 2013[2]). As part of this effort, best-practice recommendations for IPV-related training for health professionals were advanced, based on a review of the available evidence. Specifically, the WHO recommended that IPV-related training be offered repeatedly, both at the pre-qualification level (e.g., in training curricula) and the professional level (e.g., in-service training), to all health professionals who are likely to encounter women in their regular practice, including mental health professionals. Training should be multicomponent and include basic knowledge about IPV (e.g., risk factors, consequences, and laws relevant to IPV) and care referral pathways (e.g., directories of existing services that may offer support to IPV survivors), as well as skill-building exercises (i.e., teaching clinicians when and how inquire about IPV, and how to respond to survivors [e.g., by offering non-judgmental support]; WHO, 2013[2]).

Whereas the WHO strongly recommends that IPV-related training be offered to health care professionals, the organization acknowledges that there is currently low-moderate research

evidence supporting these training recommendations (WHO, 2013[2]). This is a result of a shortage of research on the subject of IPV-related training, particularly in low- and middle-income countries, and reflects the need for further studies on the topic. At present, it is unclear to what degree mental health professionals' training resembles WHO recommendations, and whether clinicians with training that more closely resembles WHO guidelines are more likely to engage in better clinical practices with regards to IPV.

Context for the Current Research

The present thesis was conducted in the context of the eleventh revision of the Mental and Behavioral Disorders chapter of the WHO's International Statistical Classification of Diseases and Related Health Problems (ICD-11; WHO, 2019). The ICD is a classification system of physical disorders, mental disorders, and factors related to the consultation of health services, developed by the WHO for use by its 194 member states, including Canada (WHO, 1992). The ICD defines diseases, disorders, injuries, and other health-related conditions using specific guidelines (i.e., minimum essential features expected to be found in all cases of the disorder or condition); 75% of the world's mental health clinicians use the ICD to diagnose and code mental and behavioral disorders in clinical practice. It is considered the international standard for reporting diseases and health conditions, and as such it is used to monitor the incidence and prevalence of health-related conditions worldwide and to observe trends in the global allocation of resources (e.g., health funding; WHO, 1992).

Eleventh Revision of the WHO's ICD Clinical Descriptions and Diagnostic Guidelines

The ICD-11 for all health conditions (i.e., the Morbidity and Mortality linearization) has been in development since 2006 and was adopted by member states of the World Health Organization in 2019. This classification provides definitions for physical health conditions,

including those for mental and behavioral disorders for clinical use by all healthcare professionals. A specialized version of the ICD for mental health providers (i.e., the Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioral Disorders [CDDG]) is also under development and is expected to be published by the WHO in 2021. The CDDG provides more detailed information and guidelines for the diagnosis of mental and behavioral disorders for use by mental health specialists. As part of the revision of the ICD CDDG, the WHO's Department of Mental Health and Substance Abuse was given the responsibility of reviewing the Mental and Behavioral Disorders chapters of the ICD, including a chapter on sleep disorders and on conditions related to sexual health (International Advisory Group [IAG] for the Revision of ICD-11 Mental and Behavioural Disorders, 2011). An International Advisory Group (IAG) was formed to lead the revision of these chapters, composed of international experts from a variety of disciplines. The IAG was tasked with proposing a set of objectives for the revision of the ICD-11 and determined that a primary focus would be to increase the clinical utility of the classification, as well as update content to match with the most recent empirical evidence (IAG, 2011). Clinical utility was defined by three major components: a) the classification's value in communicating among practitioners, patients, families, and administrators; b) its use in clinical practice, including ease of use (i.e., the ability of diagnostic constructs to facilitate conceptualization and understanding of mental and behavioral disorders), goodness of fit (e.g., how well the categories fit actual patient presentations), and feasibility (i.e., the time required to use it); and c) its usefulness in informing treatment decisions (First, 2010; Keeley et al., 2016; Reed, 2010).

The IAG appointed working groups to examine specific diagnostic areas (e.g., Mood Disorders; IAG, 2011). These working groups were tasked with reviewing the current psychopathology literature, evaluating proposals for diagnostic criteria for the DSM-5 to

consider their applicability in an international context, and formulating proposals for inclusion in the ICD-11 (IAG, 2011). Although not formally part of the chapters under the purview of the Department of Mental Health and Substance Abuse, the importance of relational problems and maltreatment, including instances of IPV, as precipitating and maintaining factors to mental and behavioral disorders compelled the formation of a separate working group on the topic. Therefore, a working group was struck to review and propose changes to the 'Conditions or factors affecting health and reasons for seeking services' chapter of the ICD, used to record problems that influence a person's health, but are not illnesses or injuries themselves (WHO, 1992). Notably, categories relating to adult relationship problems (e.g., IPV) and child maltreatment (altogether called 'relationship problems and maltreatment', or RPM) were revised. The working group was composed of researchers who had previously collaborated on the development of relationship problem categories (V codes) in DSM-5 (Heyman et al., 2015; IAG, 2011).

Revising Definitions of IPV

In the most recent version of the ICD (i.e., ICD-10 [WHO, 1992]), relationship problem and maltreatment definitions contained only a single category describing IPV. This category is named 'Problems in relationship with spouse or partner' and is defined as, 'discord between partners resulting in severe or prolonged loss of control, in generalization of hostile or critical feelings, or in a persisting atmosphere of severe interpersonal violence (hitting or striking)' (WHO, 1992). The 'Problems in relationship with spouse or partner' category was tested in a field trial during the development of the ICD-10 to determine the reliability of the category (i.e., the level of clinician agreement while applying the code; WHO, 1992). Agreement was deemed sufficient (i.e., kappa coefficient of 0.64) and the category was included in the ICD. However,

problems with the ICD-10's definition of IPV have since been identified. Specifically, different forms of violence (e.g., psychological, sexual) were not operationalized, and more recent studies have found that there is low real-world agreement for the application of the category (Heyman et al., 2015; Foran et al., 2013). Notably, Heyman et al. (2015) found that clinicians' agreement about clinically significant IPV was at chance level while using ICD-10 guidelines.

To address these issues, the ICD-11 RPM working group reviewed relationship problem categories developed for DSM-5 and considered whether they were appropriate for use in international and low resource settings (Foran et al., 2013). Criteria for these categories were created following the comprehensive review of dozens of definitions of RPM found in the research literature. Researchers worked to create guidelines that were valid, reliable, and clinically useful (Foran et al., 2013). They considered well-researched typologies of IPV (e.g., Johnson and Leone [2005]'s distinction between situational violence and intimate terrorism) and strove to ensure that definitional requirements would encapsulate all forms of violence. Ultimately, the working group included descriptions of physical, psychological, and sexual violence, as well as partner neglect and relationship distress. Although relationship distress (i.e., substantial and sustained dissatisfaction with a spouse or intimate partner associated with significant disturbance in functioning) is not in itself a form of IPV, it was included since marital distress is an important risk factor for IPV (Heyman et al., 2015; WHO, 2010) and is associated with negative outcomes (e.g., increased risk for depression, anxiety, and alcohol use disorder; Foran et al., 2013; Whisman, 2007). Furthermore, in some nations, access to certain health services is contingent on patients being assigned an ICD category. Thus, inclusion of relationship distress in the CDDG may increase access to specialized care (e.g., mental health services) for patients presenting with subthreshold mental health symptoms related to relationship problems.

The proposed RPM categories underwent extensive field testing as part of the WHO ICD-11 Case-Controlled Field Trials, whereby clinicians were asked to diagnose vignettes describing typical patients presenting for services using either newly revised ICD-11 RPM categories or older ICD-10 definitions. The purpose of these field trials was to evaluate whether the reliability and clinical utility of ICD-11 categories were improved over ICD-10 (Evans et al., 2015). Field trials were conducted using a global sample of participants, drawn from the WHO's Global Clinical Practice Network (GCPN). The GCPN is a multidisciplinary and multilingual group of over 15,000 mental health practitioners (e.g., psychiatrists, psychologists, primary care clinicians, etc.), created for the purpose of investigating the proposed diagnostic guidelines for Mental and Behavioral Disorders in ICD-11 (Reed et al., 2015). GCPN members were recruited through international and national conferences in psychology, psychiatry, and related disciplines; national and regional professional associations; professional listservs; and by word of mouth. These members were from 156 member nations of the WHO and represented a diverse sampling of the world's clinicians. As of 2015, 38% of the GCPN members were from middle- or low-income countries, and 57% of members had registered in a language other than English. For the ICD-11 RPM field trial, eligible GCPN members (i.e., who were currently seeing patients or providing clinical supervision, and were fluent in the language of the study) were sent an email invitation to an online study using Qualtrics™ (Provo, Utah). The field trial was originally conducted in English, and later translated into French, Japanese, and Spanish. Results from the field trial were used to inform further revision of RPM guidelines included in the ICD-11.

The Present Thesis

Data collected in the context of the ICD-11 RPM field trial provided a unique opportunity to perform secondary analyses to investigate factors related to global mental health

professionals' clinical training and practices with regards to IPV. Due to potential benefits of IPV-related training (e.g., clinicians' self-reported improved knowledge and confidence with regards to addressing IPV after training; Rose et al., 2011; Trevillion et al., 2016), the WHO advanced a series of IPV-related training recommendations for health professionals (WHO, 2013[2]). To date, however, little is known about the degree to which clinicians' actual training experiences resemble WHO recommendations, or whether greater adherence to these guidelines is related to improved clinical practices with regards to IPV. Moreover, there is presently a dearth of research exploring factors that may be related to clinicians' likelihood of participating in IPV-related training. Some evidence suggests that institutional support for providing IPV-related training to health professionals may be related to societal factors (e.g., political will to address IPV and draft IPV legislation; García-Moreno et al., 2015). However, relationships between clinicians' likelihood of participating in IPV-related training and societal-level factors have never been tested. There is also evidence that individual-level factors related to professional practice, such as expertise with IPV survivors, effect the probability of obtaining training (Campbell et al., 1999). Further research is needed to corroborate these findings. Additionally, most research on IPV-related training has been conducted with medical professionals in high-income, Western countries, and relatively little is known about mental health professionals' experiences of IPV-related training, or the experiences of clinicians in non-Western and low- or middle-income countries. Thus, there is a need to better understand relationships between global mental health professionals' experiences of IPV-related training, including the degree to which their training resembles WHO guidelines, and their performance with regards to IPV (e.g., knowledge and identification of IPV). Research on this topic may help to improve IPV-related training recommendations for mental health clinicians worldwide.

The present thesis, composed of two studies, sought to address gaps in the literature by exploring the IPV-related training experiences of 321 specialized mental health professionals (i.e., psychiatrists and psychologists) from 24 high- and middle-income countries in Asia (Japan), Europe, and Latin America. In study 1, participants were surveyed about the content, timing (e.g., during or after professional training), and duration of their IPV-related training experiences, based on WHO recommendations, to create a global profile of training. Relationships between training (yes / no) and factors that may be related to the probability of participating in training (e.g., individual-level factors, such as demographics and professional practice variables [frequency of encountering IPV in clinical practice], and societal-level factors, such as national IPV prevalence and IPV-related norms and laws) were also investigated. This latter analysis was largely exploratory, since there is little research investigating factors that may influence clinicians' probability of participating in IPV-related training. However, based on available evidence, it was expected that professional practice variables and national IPV-related factors, but not demographic factors, would be related to the likelihood of participating in training. Finally, the relationship between clinicians' self-reported level of knowledge and experience with relationship problems (including IPV) and IPV-related training (yes / no) was evaluated. It was hypothesized that, as seen in previous studies with mental health and medical professionals (Trevillion et al., 2016; Waalen et al., 2000), clinicians who had received IPV-related training would be more likely to report greater knowledge and experience than those without training.

Study 2 sought to evaluate relationships between participants' experiences of IPV-related training, including the degree to which training resembled WHO recommendations, and their ability to accurately identify clinically significant relationship problems. Specifically,

participants used ICD-10 or ICD-11 relationship problem and maltreatment (RPM) categories to diagnose a series of case-controlled vignettes describing fictional patients presenting with mental and behavioral disorder symptoms and relationship problems. Consistent with the research literature, it was hypothesized that participants who received training would be more likely to correctly identify relationship problems than clinicians without training. Furthermore, amongst clinicians with training, it was expected that those whose training more closely resembled WHO recommendations would be more likely to correctly identify RPM. Finally, in line with the goals of the larger field trial for the revision of the ICD RPM guidelines, the use ICD-10 and ICD-11 RPM guidelines was compared within our sample. It was hypothesized that clinicians who were assigned to use newer, more operationalized ICD-11 RPM guidelines would perform better than those who were assigned to use ICD-10 guidelines.

Overall, results from these two studies will be used to develop a better picture of the state of global mental health professionals' IPV-related training experiences. They will improve the current understanding of individual and societal factors that are related to participating in training, which in turn may promote initiatives to increase clinicians' likelihood of obtaining training. Importantly, results may also inform recommendations for the development of effective IPV-related training programs for mental health providers, which could help to improve the health service response to IPV survivors.

Study 1: Exploring mental health professionals' experiences of intimate partner violence-related training: Results from a global survey

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Abstract

Intimate partner violence (IPV) is a global public health problem that has been shown to lead to serious mental health consequences. Due to its frequent co-occurrence with psychiatric disorders, it is important to assess for IPV in mental health settings to improve treatment planning and referral. However, lack of training in how to identify and respond to IPV has been identified as a barrier for assessment of IPV. The present study seeks to better understand this IPV-related training gap by assessing global mental health professionals' experiences of IPV-related training and factors that contribute to the likelihood of receiving training. Participants were French, Spanish, and Japanese-speaking psychologists and psychiatrists (N = 321) from 24 nations differing on variables related to IPV, including IPV prevalence, norms, and laws. Participants responded to an online survey asking them to describe their experiences of IPV-related training (i.e., components and hours of training), and to rate the frequency with which they encountered IPV in clinical practice and their level of knowledge and experience related to relationship problems; 53.1% of participants indicated that they had received IPV-related training. Clinicians from countries with relatively better implemented laws addressing IPV and those who encountered IPV more often in clinical practice were more likely to have received training. Participants who had received IPV-related training were more likely to report greater knowledge and experience related to relationship problems. Findings suggest that clinicians' awareness of IPV and the institutional context in which they practice is related to training. Training, in turn, is associated with subjective appraisals of knowledge and experience related to relationship problems. Increasing institutional efforts to address IPV (e.g., implementing IPV legislation) may contribute to improved practices with regards to IPV in mental health settings.

Keywords: intimate partner violence, training, mental health and violence

Exploring mental health professionals' experiences of intimate partner violence-related training: Results from a global survey

Intimate partner violence (IPV), defined by Foran et al. (2015, p. 2) as "physical, verbal/symbolic, or sexual acts that cause — or have reasonable potential to cause — harm to a partner", has been identified as a serious and widespread public health problem by the World Health Organization (WHO, 2013[1]). Global prevalence studies estimate that 35% of ever-partnered women have experienced lifetime IPV (WHO, 2013[1]). IPV survivors are at increased risk of developing significant health problems, including psychiatric disorders (Brown et al., 2009; Okuda et al., 2011; Rees et al., 2011). Women who have ever experienced IPV are more likely to experience emotional distress, depression, anxiety, post-traumatic stress disorder, eating disorders, substance use disorders, suicidal ideation, and suicide attempts compared with women who have never experienced abuse (Ishida et al., 2010; Jonas et al., 2014; Stephenson et al., 2013; WHO, 2005). Relatedly, prevalence rates for IPV are elevated in mental health settings, compared to other healthcare settings (Alhabib et al., 2010). In their systematic review of IPV prevalence studies, Oram et al. (2013) found that 16-94% of female and 18-48% of male psychiatric inpatients reported lifetime IPV. Prevalence rates ranged widely according to the type of IPV that was reported. Specifically, in U.S. surveys, 16% of female psychiatric inpatients reported sexual violence (Owens, 2007), 94% reported psychological violence (Sansone et al., 2007), and 18% of male psychiatric inpatients reported severe physical violence (Chang et al., 2011). 48% of male inpatients in a Canadian sample reported any form of IPV (Hoffman & Toner, 1988). These prevalence rates are consistent with national averages found in epidemiological surveys (e.g., the CDC's National Intimate Partner and Sexual Violence Survey [Smith et al., 2018]).

Many professional societies and public health organizations recommend that mental health professionals assess for IPV (American Psychological Association, 1994; Canadian Psychiatric Association, 2012; World Health Organization, 2013[2]; World Psychiatric Association, 2017). Research on IPV in mental health settings can lead to an improved understanding of the link between IPV and mental health problems and help to establish thresholds for clinical significance of mental health symptoms in the context of IPV (Foran et al., 2015). Furthermore, identifying IPV may help to contextualize patients' distress and improve treatment planning and/or referral to appropriate patient care pathways.

However, rates of IPV assessment in mental health clinical practice are low (Howard et al., 2010). In a survey of 216 Australian psychiatrists, only 44% of participants reported asking all new patients about experiences of IPV (Forsdike et al., 2019). Similarly, Nyame et al. (2013) found that amongst 131 U.K. mental health clinicians, only 39% reported assessing for IPV in patients who presented with symptoms associated with IPV. Samuelson and Campbell (2005) surveyed 128 psychologists in the U.S. and showed that only 23% of clinicians asked about IPV during intake interviews with patients who presented with signs and symptoms of abuse.

There are multiple barriers for IPV assessment in mental health clinical practice including discomfort asking about IPV, lack of perceived expertise, lack of confidence in addressing IPV, poor knowledge of resources for survivors, and lack of training in how to identify and respond to IPV (Hultmann et al., 2013; Forsdike et al., 2019; Nyame et al., 2013; Trevillion et al., 2016). Importantly, research examining health professionals' experiences of IPV-related training suggests that clinicians who received training were less likely to report other barriers to assessment. In studies of medical and mental health professionals, clinicians who received training reported greater comfort asking about IPV (McColgan et al., 2010), increased IPV-

related knowledge (Connor et al., 2013; Forsdike et al., 2019; Jayatilleke et al., 2015; McColgan et al., 2010; Trevillion et al., 2016), improved confidence in managing situations of IPV (Jayatilleke et al., 2015), and greater likelihood of screening for IPV (Waalen et al., 2000). One study conducted with mental health professionals found that IPV-related training combined with the implementation of referral pathways to domestic violence advocacy services led to improved identification of IPV (Trevillion et al., 2014). The WHO has stated that clinicians should receive IPV-related training as a minimum requirement for asking about IPV with patients (WHO, 2013[2]).

Despite potential benefits of IPV-related training, current research suggests that many mental health professionals have never received this form of training (Campbell et al., 1999; Dolunay-Cug et al., 2017; Nyame et al., 2013). In surveys of U.S.and U.K. mental health providers (Campbell et al., 1999; Nyame et al., 2013), nearly half of clinicians (41-46%) reported not having received any form of IPV-related training. A survey of Turkish mental health professionals showed that more than half of clinicians (62.8%) had not received training on family violence issues since completing their professional training (Dolunay-Cug et al., 2017). However, at present, studies exploring the IPV-related training experiences of mental health professionals are scarce and data has only been collected in a handful of countries. Consequently, little is known about the IPV-related training profiles of global mental health professionals.

To improve the health service response to IPV survivors, the WHO issued a series of IPV-related training recommendations for health care providers (WHO, 2013[2]). These guidelines specify that IPV-related training should be repeated (i.e., provided at both the pre-qualification and the professional level) and include multiple components. Recommended training components include didactic training (i.e., basic knowledge about IPV and local resources for

survivors), as well as experiential skill-building exercises (i.e., when and how to ask about IPV, and how to respond to survivors). To date, there has been no research assessing the degree to which mental health professionals' experiences of IPV-related training resemble WHO recommendations.

Barriers and facilitators for engaging in IPV-related training are also not well understood since few studies have explored factors that are associated with the likelihood of participating in training. Research that does exist on this topic has examined the relationship between clinician-level factors (i.e., professional practice variables and demographics) and training. Notably, Campbell et al. (1999) surveyed 415 U.S.mental health professionals and found that those with experience working with IPV survivors and those who considered themselves experts on violence against women were more likely to have received IPV-related training. Female, compared with male clinicians, were also more likely to have received training (Campbell et al., 1999). Another more recent survey of 173 U.S.clinicians showed that demographic factors, including gender, did not predict the likelihood of participating in IPV-related training (Murray et al., 2016). It appears that clinicians' likelihood of participating in training may be associated with the extent to which IPV is considered relevant to their clinical practice. Due to the high prevalence of IPV amongst psychiatric patients (Oram et al., 2013), however, all mental health professionals, and not only those who consider themselves experts on IPV, should be trained on how to identify and respond to partner violence.

Institutional barriers for participating in IPV-related training may also exist. IPV-related training is not often a mandatory component of professional training programs for mental health care providers (Kelly, 1997; Ramos, 2008), and recommendations for IPV-related training are infrequently specified in national and organizational clinical health policies (Garcia-Moreno et

al., 2015; Payne et al., 2007; Stewart et al., 2015). While there are no studies explicitly evaluating factors that may be related to institutions' commitment to providing or promoting IPV-related training, some evidence suggests that societal factors, such as political will to address IPV, may influence the public health response to partner violence (Garcia-Moreno et al., 2015). Notably, in Spain, the adoption of gender-based violence legislation led to changes in public health policy and the implementation of IPV-related training programs for health care professionals (Garcia-Moreno et al., 2015). Further research is required to better understand societal factors that may be related to clinicians' likelihood of participating in IPV-related training.

Context for the Present Research

This study was conducted in the context of developing the eleventh revision of the Mental and Behavioural Disorders chapter of the WHO's International Classification of Diseases manual (ICD-11). Throughout the revision process, proposed ICD-11 Relationship Problem and Maltreatment guidelines, including descriptions of IPV, underwent extensive field-testing with a global sample of clinicians to determine ratings of reliability and clinical utility (Reed et al., 2018). Data used in this study was collected during the internet-based field testing of proposed Relationship Problem and Maltreatment guidelines for ICD-11. See Heyman et al. (2018) for a complete description of the larger study.

Aims and Objectives

This research sought to address gaps in knowledge by assessing global mental health professionals' experiences of IPV-related training, including the degree to which their training resembled WHO recommendations. This study also sought to improve the current understanding of factors that may influence the likelihood of participating in training by evaluating

relationships between clinician-level factors (i.e., demographic variables and professional practice variables), societal factors (i.e., country context with regards to IPV, including IPV-related laws, IPV prevalence, and IPV norms), and training. It was hypothesized that professional practice variables (e.g., frequency of encountering IPV in clinical practice) and national IPV-related variables (e.g., laws, prevalence, and norms) would be related to the probability of participating in training. Concordant with the literature, it was also expected that clinicians who received IPV-related training, compared with those who did not, would report greater knowledge and experience related to relationship problems. To the authors' knowledge, this study represents the first cross-national survey of mental health professionals' IPV-related training experiences. It will help to build a global profile of clinicians' training experiences and may highlight training needs. It may also help to demystify factors that are associated with participating in training, which could serve to inform the development of programs and initiatives to promote training.

Method

Participants

Participants were drawn from the WHO's Global Clinical Practice Network (GCPN). The GCPN comprises over 15,000 mental health professionals from 156 countries recruited to participate in the field trials for ICD-11 (Reed et al., 2015). The current study was part of a larger field trial developed in English and translated into French, Spanish, and Japanese using forward and back translation. Translated versions of the study included additional questions related to participants' experiences of IPV-related training which were not included in the English study. Since IPV-related training is the subject of the present research, only data collected in French, Spanish, and Japanese were used for this study. Eligibility criteria included current provision of

mental health services or engagement in clinical supervision and proficiency or fluency in one of the three study languages. Emails to solicit participation were sent to participants who met eligibility criteria (N = 3233; French, n = 713, Spanish, n = 1498, Japanese, n = 1022), and reminder emails were sent two and four weeks later (see Appendix A for sample email invitation). Data collection lasted approximately 2 months for each sample. Participants (n = 604, 19% of total; French = 139, Spanish = 318, Japanese = 147) responded to the survey link and initiated the study. Of these, 24 reported not meeting eligibility criteria and were removed. A further 189 participants were removed due to non-completion of the study. Analyses reported in this study focused only on psychiatrists and psychologists, as these are specialized mental health professionals involved in the assessment and diagnosis of patients. Participants from other professions (n = 56) were removed. Finally, participants from regions with low response rates in the available study languages (i.e., Africa, n = 7, Eastern Mediterranean, n = 5, North America, n = 2) were removed. In total, data from 321 participants from 24 countries were used for analyses (see Table 1.1); 35.8% of participants were from middle-income countries, and the remaining were from high-income countries.

Data and Variables

Demographic information

Demographic information was collected via an online survey during participants' registration to the GCPN and again at the beginning of the current study (see Appendix B for GCPN registration survey). Participants provided information on a wide number of variables, including their gender, age, years of professional experience, profession, and country of residence. Based on their country of residence, they were classified into one of eight WHO regions (i.e., Africa, Eastern Mediterranean, Europe, North America, South America, South East Asia, West Pacific – Asia, and West Pacific – Oceania). National income data was drawn from

the World Bank database (2019).

National IPV-related variables

IPV-related norms, prevalence and laws were drawn from the Organization for Economic Cooperation and Development (OECD) Centre's Gender, Institutions and Development (GID) Database (2019), which contains 60 indicators of gender discrimination across 160 countries. For each variable included in the GID, data was compiled and classified by country using national constitutions, legal frameworks, and primary publications, reports or studies (OECD, 2014).

IPV-related norms. IPV-related norms represent the national percentage of women aged 15-49 who consider that a husband is justified in hitting his wife under certain circumstances (i.e., if his wife burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations). Among the 24 countries included in the study (see Table 1.1 footnote), the percentage of women who believed that IPV was sometimes justified ranged from 4% in Argentina to 34% in Peru (M = 12.37, SD = 4.24).

Prevalence of physical or sexual IPV. IPV prevalence is defined by the national percentage of women who have experienced lifetime physical or sexual violence in an intimate relationship. National prevalence rates of physical or sexual IPV among the 24 countries included in the study ranged from 10% in Switzerland to 64% in Bolivia (M = 24.83, SD = 13.95).

IPV-related laws. IPV-related laws represent the degree to which a country's legal framework offers protection against IPV. Laws were rated on a 5-point scale ranging from 1 ("There is specific legislation in place to address domestic violence; the law is adequate overall, and there are no reported problems of implementation") to 5 ("There is no legislation in place to address domestic violence"). Most participants were from countries where IPV-related laws existed and were well-implemented (level 1; n = 207), and none of the participants were from

regions where IPV-related laws did not exist (levels 4 and 5). Due to low response rates (less than 5% of total sample) for level 3 (“There is specific legislation in place to address domestic violence, but the law is inadequate”; *n* = 14), it was combined with level 2 (“There is specific legislation in place to address domestic violence; the law is adequate overall, but there are reported problems of implementation”; *n* = 100) to form a new category describing countries where IPV-related laws existed yet were relatively less well implemented. The final “IPV-related laws” variable comprised two categories: 1 (“well implemented laws”; N = 207) and 2 (“less well implemented laws”; *n* = 114).

Frequency of IPV in clinical practice

Participants were asked to rate how often they used relationship problem and maltreatment [RPM] categories, which describe instances of IPV, in their regular practice. Categories are alphanumeric codes found in diagnostic manuals and used to denote diagnoses and factors associated with consultation for health services. The use of RPM categories represents an additional IPV-related variable: an estimate of how often participants encounter patients with IPV in their regular practice. Specifically, they were asked, “How frequently do you use relationship problem and maltreatment codes in your practice? (i.e., ICD-10 Z codes, T codes, or Y codes; DSM-IV V codes, or DSM-5 V codes).” Participants responded using a 5-point scale, ranging from 1 (“Never”) to 5 (“Every day”). Due to a relatively low response frequency for level 5 (“Every day”; N = 15), this level was combined with a conceptually similar adjacent level (4; “A few times per week”). The final “Frequency of IPV in clinical practice” variable comprised four levels: 1 (“Never”; *n* = 77), 2 (“Once or less per month”; *n* = 114), 3 (“Once per week”; *n* = 51), and 4 (“Several times per week”; *n* = 79).

IPV-related training

Five questions were created to measure IPV-related training. The first question inquired

about participation in formal IPV-related training (i.e., “Please indicate whether, at any point during your clinical training or professional career, you have received formal training [e.g., as a part of courses, workshops, continuing education programs] about how to detect or respond to intimate partner violence, including physical and psychological abuse.”). Response options were dichotomised (i.e., Yes or No). Participants who responded ‘No’ were not shown the following questions. The second question was based on the WHO’s IPV-related training recommendations for health care professionals (2013[2]). Participants were asked to select which components, from a list, were covered in the IPV-related training they received (i.e., definitions, laws, and risk factors related to intimate partner violence; support services for survivors of intimate partner violence; how and when to inquire about intimate partner violence with patients; and how to respond to survivors of intimate partner violence). The final three questions addressed participants’ total number of hours of training. Each was a text-entry question where participants could indicate the number of hours of IPV-related training that they had received during their professional training, after completing their professional training (e.g., in-service education), and in the past five years, respectively. These questions were included because the WHO recommends that IPV-related training be offered both during pre-qualification and professional practice (WHO, 2013[2]), and since IPV-related training has been found to be more effective when it is repeated and offered over longer periods of time (Buranosky et al., 2012).

Knowledge and experience of relationship problems

Participants’ level of knowledge and experience related to couples with relationship problems, which may include IPV, was assessed using the following question: “How would you describe your level of knowledge and experience related to couples with relationship problems?” Participants were asked to respond using a scale ranging from 1 (“None”) to 5 (“A great deal”). Categories 1 (n = 15) and 5 (n = 30) had low response frequencies (i.e., less than 10% of the total

sample). To determine whether these categories could be combined with adjacent categories, two binary logistic regression models were generated which included all predictors and used categories as binary outcome variables (i.e., ‘1’ vs ‘2’ and ‘4’ vs ‘5’; Osborne, 2017). In both cases, there were no significant predictor variables, indicating that categories were sufficiently similar to be combined. Thus, category 1 (“None”) was combined with category 2 (“A little bit”) to form the variable “Low” knowledge and experience. Category 5 (“A great deal”) was combined with category 4 (“Quite a bit”) to form the variable “High” knowledge and experience. The final “Knowledge and experience of relationship problems” variable contained three categories: “Low”; $n = 73$, “Moderate”; $n = 96$, and “High”; $n = 152$.

Procedure

This study was exempted from review by the World Health Organization Research Ethics Review Committee (Protocol ID RPC569) and by the Human Subjects Committee at the University of Kansas, Lawrence Campus (HSCL #20804).

Participants received an email invitation to participate in a larger study aimed at evaluating the accuracy and consistency of clinicians’ use of proposed diagnostic guidelines related to Relationship Problem and Maltreatment (RPM) for the ICD-11 as compared to the ICD-10. Participants who agreed to participate in the study followed an individualized link to an online survey in Qualtrics™ (Provo, Utah), where they were randomly assigned to use either ICD-11 or revised ICD-10 RPM codes to rate a series of four clinical vignettes. Each vignette described a patient presenting with concerns concordant with one of four conditions of the study (i.e., IPV only, mental health symptoms only, both, or neither). See Heyman et al. (2018) for more information on the methodology of the larger RPM study. As a part of this study, participants rated their level of knowledge and experience related to couples with relationship

problems, as well as their familiarity with RPM codes (i.e., the frequency with which they use these codes). They also responded to a series of five questions regarding their IPV-related training experiences, as described above.

Results

Sample Representativeness

To determine the representativeness of the final sample, participants were compared with individuals with similar characteristics (i.e., psychologists and psychiatrists) who were invited to the study but did not participate (i.e., non-participants; $N = 2114$). Compared with non-participants, participants did not differ in terms of gender, profession, region, or proportion of participants in each language of the survey. However, participants were slightly older ($M = 49.64$, $SD = 10.99$) than non-participants ($M = 48.10$, $SD = 12.15$); $t(2447) = 2.175$, $p < .05$ and had slightly more professional experience ($M = 19.54$, $SD = 10.12$) than non-participants ($M = 18.12$, $SD = 11.00$); $t(2447) = 2.207$, $p < .05$. The final sample ($N = 321$) was also compared with individuals who initiated the study but did not complete it (i.e., non-completers; $N = 189$). Participants were similar to non-completers in terms of gender, profession, region, and proportion of participants in each language of the survey. However, participants were slightly older ($M = 49.64$, $SD = 10.99$) than non-completers ($M = 47.33$, $SD = 10.92$); $t(508) = 2.094$, $p < .05$, and had slightly more professional experience ($M = 19.54$, $SD = 10.12$) than non-completers ($M = 17.62$, $SD = 9.27$); $t(508) = 2.085$, $p < .05$.

IPV-Related Training

Table 1.2 presents frequencies and descriptive statistics for IPV-related training by predictor. A little over half the participants (53.6%, $n = 172$) responded “Yes” when asked if they had received formal training about how to detect or respond to IPV. For these participants,

IPV-related training experiences (i.e., components of training, time points at which they received training, and number of hours of training) are summarized in Table 1.3.

The WHO recommends including four components in IPV-related training protocols (i.e., basic information on IPV, local support services for survivors, how and when to inquire about IPV, and how to offer support to survivors; WHO, 2013[2]). Approximately half of participants (49.4%, *n* = 85) reported that all four components were part of their training. Thirty-one participants (18.0%) reported that their training contained only one component, most commonly basic information on IPV (*n* = 15) or how and when to inquire about IPV (*n* = 10). Twenty-nine participants (16.9%) reported two components, most often basic information on IPV combined with information about local support services (*n* = 14). Twenty-nine clinicians (16.9%) reported three components, most commonly basic information on IPV combined with how and when to inquire about IPV and how to offer support to survivors (*n* = 11). The remaining four participants (2.3%) reported that their training contained none of these recommended components.

The WHO (2013[2]) and Buranosky et al. (2012) recommend that IPV-related training occur both during and after professional training. Most participants who received training (*n* = 149; 90.9%) reported that their training had occurred at both time points. Four participants (2.4%) reported that they had only received training at the pre-qualification level and the remaining 11 participants (6.7%) noted that they only received training post-qualification. Participants reported a wide breadth of training hours, ranging from 1-500 hours of IPV-related training at each time point. To account for skewed distributions, median hours of training are reported in Table 1.3.

Binary logistic regression

Binary logistic regression was used to determine whether national IPV-related variables

(i.e., IPV-related laws, IPV-related norms, and prevalence of physical or sexual IPV) and a factor related to professional practice (i.e., frequency of IPV in clinical practice) impacted the likelihood that participants received IPV-related training. The regression model was constructed to investigate the relationship between predictors and a binary outcome variable (i.e., IPV-related training received, [Yes, No]). Demographic factors (i.e., gender, years of professional experience, profession, country income) were included as control variables. Due to multicollinearity (VIF > 5) with key predictor variables (i.e., IPV-related laws, norms, and prevalence), two demographic variables (i.e., language of survey and global region) were not included in the regression. Furthermore, age was not included in the regression due to multicollinearity (VIF > 5) with years of professional experience.

The final regression model, compared with a model that included only control variables, significantly improved the fit between model and data ($\chi^2(10, n = 321) = 117.65$, Nagelkerke $R^2 = .44$, $p < .001$). IPV-related laws ($\chi^2(1, n = 321) = 15.70$, $p < .001$) and frequency of IPV in clinical practice ($\chi^2(3, n = 321) = 7.89$, $p < .05$) made statistically significant unique contributions to the final model. Table 1.4 presents the odds ratios for a model containing only control variables (model 1) and the final regression model with predictors included (model 2). As far as IPV-related laws are concerned, participants from regions where laws are relatively better implemented were 8.84 times more likely to have received training than participants from regions where laws were less well implemented. With regards to the frequency of IPV in clinical practice, participants who reported using IPV-related categories several times per week were 3.92 times more likely to have received training than those who never used these categories. IPV-related norms and prevalence of physical or sexual IPV were not significantly related to participants' likelihood of participating in IPV-related training.

Linear regressions

Two multiple linear regressions were carried out to investigate the relationship between IPV-related variables and the number of hours of IPV-related training during professional training and after completing professional training, respectively. The effects of demographic variables were controlled for in the regression models. For both models, normal probability plots and residual versus fitted plots showed that assumptions of normality of residuals and homoscedasticity were violated. Square root transformations of the outcome variables were performed, after which the scatterplot of standardized predicted values versus standardized residuals showed that the data met assumptions of homogeneity of variance and linearity and the residuals were approximately normally distributed.

During professional training. Regression results indicated that participants who reported more frequent use of IPV-related categories were more likely to have received more hours of IPV-related training during their professional training ($\beta = .29$, $p < .01$). No other predictors were significant. A reduced regression model with only the significant predictor included was generated, and results showed that participants' use of RPM codes in their clinical practice explained 7.5% of the variance ($R^2 = .075$, $F(1,159) = 12.76$, $p < .001$).

After completing professional training. Similar to the previous model, regression results showed that participants who reported more frequent use of IPV-related categories were more likely to have received more hours of IPV-related training after completing their professional training ($\beta = .85$, $p < .05$). No other predictors were significant. Results from a reduced regression model with only the significant predictor included indicated that participants' self-rated use of RPM categories in their clinical practice explained 5.6% of the variance ($R^2 = .056$, $F(1,154) = 9.09$, $p < .01$).

Knowledge and Experience of Relationship Problems

Table 1.5 presents frequencies and descriptive statistics for each predictor by level of knowledge and experience. A multinomial logistic regression examined the relationship between participants having IPV-related training (predictor) and their level of knowledge and experience of relationship problems (outcome variable; i.e., "Low," "Moderate," or "High" knowledge/experience). "High knowledge/experience" was used as a reference category to which the other two categories were compared. The effects of all other variables (i.e., gender, years of professional experience, profession, country income, IPV-related laws, IPV-related norms, prevalence of physical or sexual IPV, and frequency of IPV in clinical practice) were controlled for in the model. Three demographic variables (i.e., language of survey, global region, and age) were not included in the analysis due to multicollinearity (VIF > 5).

The final regression model, compared with a model that included only control variables, significantly improved the fit between model and data ($\chi^2(22, N = 321) = 171.54$, Nagelkerke $R^2 = .50$, $p < .001$). Four predictors made significant unique contributions to the final model: years of professional experience ($\chi^2(2, N = 321) = 6.24$, $p < .05$), IPV-related laws ($\chi^2(2, N = 321) = 7.77$, $p < .05$), frequency of IPV in clinical practice ($\chi^2(6, N = 321) = 26.26$, $p < .001$), and experiences of IPV-related training (χ^2 $(2, N = 321) = 36.57$, $p < .001$). Table 1.6 presents the odds ratios for a model containing only control variables (model 1) and the final regression model with the predictor included (model 2). Participants who had not received training were 13.13 times more likely to report low knowledge/experience and 5.49 times more likely to report moderate knowledge/experience, compared with high knowledge/experience, than those who had received training.

Discussion

This study provides a cross-national exploration of mental health professionals' IPV-related training experiences. It expands on previous research on IPV-related training, typically conducted with participants from a single country (e.g., Campbell et al., 1999; Forsdike et al., 2019; Howard et al., 2010; Nyame et al., 2013), by assessing the training experiences of 321 mental health professionals in 24 countries across three global regions. Specifically, we used an online survey sent to members of the WHO's GCPN (Reed et al., 2015) to explore the degree to which psychologists and psychiatrists' IPV-related training experiences resembled training recommendations advanced by the WHO (2013[2]). Additionally, we assessed whether individual- and societal-level IPV-related factors (i.e., frequency of IPV in clinical practice, IPV prevalence, norms, and laws) were related to clinicians' likelihood of participating in training and whether IPV-related training was linked to self-reported knowledge about relationship problems.

Our findings are consistent with what has been reported in the literature (Campbell et al., 1999; Nyame et al., 2013), in that global mental health professionals' experiences of IPV-related training appear to be limited. Only a little over half the sample (53.6%; n = 172) reported ever participating in IPV-related training. Among these, approximately half (49.4%; n = 85) indicated that their training resembled WHO recommendations (WHO, 2013[2]) and one-third (33.8%; n = 58) noted that their training contained only one or two of the four recommended components. Participants who received training also reported a large range of hours of training (1-500), with most participants reporting between 20–40 hours. Taken together, these results suggest that the content, breadth, and depth of clinicians' IPV-related training experiences varies widely. Nearly all participants who received IPV-related training (90.9%; n = 149) reported that training occurred more than once, both during and after professional qualification training. This suggests

that clinicians who receive training once are likely to obtain further IPV-related training. This is encouraging, since multiple sources (Buranosky et al., 2012; WHO, 2013[2]) recommend that clinicians receive IPV-related training at several time points to maximize efficacy.

There are multiple benefits of IPV-related training, including improved self-reported knowledge and confidence in addressing IPV (Connor et al., 2013; Forsdike et al., 2019; Jayatilleke et al., 2015; McColgan et al., 2010; Trevillion et al., 2016) and improved identification of IPV when training is paired with system support responses (Trevillion et al., 2014). Identifying IPV in mental health settings can help clinicians contextualize patients' distress and provide referrals to appropriate care. For these reasons, it is important to gain a better understanding of factors that are associated with clinicians' likelihood of participating in IPV-related training, as this may inform the development of initiatives that support training. Results from this study show that mental health professionals who use ICD or DSM categories for IPV more regularly in their clinical practice and come from countries with relatively better implemented laws addressing IPV are more likely to have received training. Results also show that clinicians who report using IPV categories more often are more likely to have received more hours of IPV-related training.

Findings are in line with Campbell et al. (1999)'s study showing that clinicians who had experience working with IPV were more likely to have received IPV-related training. It is possible that clinicians who encounter IPV more often in clinical practice are motivated to seek out specific training to address the needs of their patients. To that effect, clinicians' awareness of IPV as a public health issue may influence the perceived relevance of IPV-related training to their practice. Alternatively, as has been seen in the literature, it is also plausible that clinicians who have received IPV-related training are more likely to assess for IPV and thereby identify it

more frequently in their practice (McColgan et al., 2010; Waalen et al., 2000).

Results also show that implementing legislation that provides consequences for IPV is associated with improved clinical practices with regards to IPV, notably increased likelihood of participating in training. It is possible that sociopolitical factors, such as political will to address IPV through legislation, may help to legitimize IPV as a serious public health problem and encourage institutions (e.g., educational institutions, the public health sector) to develop and promote IPV-related training programs. This in turn may increase clinicians' access to this form of training. On a clinician level, some research suggests that health professionals' perception of partner violence as a private family matter, rather than a public health issue, represents a barrier for IPV assessment (Colombini et al., 2013; Ribeiro, 2014). Therefore, it is also possible that better implemented laws addressing IPV may increase clinicians' personal recognition of IPV as a public health issue and inspire them to seek out training to address it in their regular practice. Interestingly, among the middle- and high-income nations included in our study, country income was not related to the probability of participating in training. It is possible that in richer nations, there are sufficient resources to promote a public health response to IPV, and other factors (e.g., political will to devote resources to addressing IPV) are more predictive of the likelihood of participating in training. There were no participants from low-income countries in our sample, and future research may help to clarify if economic constraints are related to the probability of obtaining IPV-related training.

Our findings suggest that national prevalence rates for IPV and national IPV-related norms (i.e., the cultural acceptability of IPV) were not related to clinicians' likelihood of participating in IPV-related training. It is possible that national prevalence rates do not reflect the relative frequency with which clinicians see patients presenting with IPV in their clinics,

depending on the location and nature of their practice. As such, the likelihood that clinicians will encounter IPV in their personal practice appears to be a stronger predictor of pursuing training than national prevalence rates. National IPV-related norms also do not influence clinicians' likelihood of participating in IPV-related training. However, national norms in this study were defined as the percentage of women aged 15-49 who agreed that physical intimate partner violence was acceptable under certain conditions (OECD, 2014). The OECD sample used to define these norms is not representative of the sample of clinicians found in this study (i.e., male and female clinicians aged 26-76). It seems plausible that participants' personal attitudes towards IPV may not resemble those of the OECD sample. Research has shown that clinicians' personal attitudes towards IPV predicts their likelihood of assessing for IPV. Those who hold more negative beliefs about IPV survivors (e.g., perceive survivors as responsible for the abuse) are less likely to assess for IPV in their regular practice (Sprague et al., 2012). It is conceivable that clinicians' personal attitudes towards IPV, which were not assessed, might more strongly predict their likelihood of participating in training compared to national norms.

As noted above, IPV-related training has been shown to improve clinicians' ratings of their IPV-related knowledge (Jayatilleke et al., 2015). Concordantly, results from this study show that clinicians who received IPV-related training, relative to those without training, are more likely to report greater knowledge and experience related to relationship problems. Interpretation of this result must be made with caution, however, since it is unclear whether experiences of IPV-related training increase clinicians' likelihood of reporting greater knowledge and experience of relationship problems, or as Campbell et al. (1999) suggests, whether clinicians who report greater experience with relationship problems are more likely to pursue training. Clinical experience, frequency of IPV in clinical practice, and IPV-related laws were also

significantly related to knowledge and experience of relationship problems. Clinicians with more years of experience and those who see patients with IPV more regularly (i.e., at least once per week) were more likely to report high knowledge and experience. Unsurprisingly, it seems that clinicians with greater clinical experience are more likely to provide higher ratings of their knowledge and experience with clinical issues such as relationship problems. Participants from countries with better implemented laws related to IPV, compared to less well-implemented laws, were also more likely to describe high knowledge and experience of relationship problems. As described earlier, it is possible that the implementation of IPV-related laws may validate the importance of addressing IPV in health contexts and contribute to clinicians gaining knowledge and experience related to these issues.

Limitations

The present study used a convenience sample, whereby participants were clinicians who volunteered to be members of the WHO's GCPN and chose to respond to an online survey regarding the revision of ICD-11 relationship problem and maltreatment guidelines. Only 10% of GCPN members who were sent the survey composed the final sample. Therefore, it is possible that the sample represented a self-selected group of professionals who chose to participate since they had proficiency in the assessment and treatment of patients with relationship problems and maltreatment. These participants may have been more likely to report experiences of IPV-related training than the general population. Participants were psychologists and psychiatrists only, and no other mental health professions (e.g., counselors, social workers, mental health nurses, etc.) were included. Participants were from high income (64.2%), upper-middle income (34.3%) and lower-middle-income countries (1.5%); there were no participants from low-income countries. Additionally, English data was not used in this study due to the absence of IPV-related training variables in the English version of the survey. This makes it difficult to compare study results to

previous research on IPV-related training conducted in English-speaking countries such as the USA (Campbell et al., 1999; Murray et al., 2016), the U.K. (Nyame et al., 2013), and Australia (Forsdike et al., 2019). Data for this study was collected in French, Japanese, and Spanish, and only participants from Latin America, Europe, and Japan were included in analyses. Thus, results are a snapshot of psychologists and psychiatrists' experiences in these regions and may not be representative of a broader global sample of diverse mental health professionals.

This study explores the association between national variables related to IPV and IPV-related training. It does not measure clinicians' individual attitudes towards IPV, nor the norms, prevalence, or level of implementation of IPV-related laws in participants' specific communities or regions of practice. Therefore, while results allow conjecture about the relationship between elements of national culture and clinicians' IPV-related training experiences, it is not possible to determine how individual or regional differences with regards to IPV effect training. As described earlier, IPV-related norms in this study are limited by their narrow definition (i.e., the national percentage of women aged 15-49 who indicated that physical IPV towards women as perpetrated by men was sometimes acceptable) and are perhaps not representative of clinicians' personal attitudes towards IPV. This definition also does not capture the acceptability of other forms of IPV within the population (e.g., psychological or sexual IPV, or IPV perpetrated by women towards men, or within LGBTQ+ relationships). Furthermore, social norms are complex and dynamic concepts formed by social expectations and social influence (Mackie et al., 2015), and the one-dimensional measure of norms used in this study may not accurately capture the complexity of IPV-related norms within a given country. IPV prevalence was defined as the prevalence of physical and sexual violence towards women in intimate relationships and did not include instances of psychological violence or IPV perpetrated towards men or within LGBTQ+

relationships. Thus, it is likely that prevalence rates are under-representative of IPV incidents as they are defined by the WHO (Foran et al., 2013; WHO, 2013[1]).

This study provides insights into factors that are related to participating in training (i.e., the frequency of encountering IPV in clinical practice and the level of implementation of IPV-related laws), however it does not inform us of how these factors may affect training. Clinicians were not explicitly asked about their reasons for participating in training, nor were they asked about the accessibility of IPV-related training throughout their education and career, whether training was voluntary or mandatory, or whether there were IPV-related training policies in place within the organizations in which they practiced. As such, it is only possible to speculate about potential mechanisms (e.g., IPV awareness, public health policy) by which clinical contact with IPV and IPV legislation affect the decision to engage in IPV-related training. Further research would be required to better understand clinicians' motivations for training.

Proxy variables were used in this study to represent the frequency of IPV in clinical practice and participants' level of knowledge and experience related to IPV. With regards to measuring the frequency of IPV in clinical practice, clinicians were asked to indicate the frequency with which they used IPV-related categories from diagnostic manuals (i.e., ICD or DSM) in their practice. Although it seems likely that clinicians who use these categories more often also encounter IPV more regularly, it is conceivable that some clinicians who see cases of IPV choose not to record them using diagnostic categories. There is some research to suggest that mental health professionals do not regularly document IPV when it is detected (Howard et al., 2010; Trevillion et al., 2016). Therefore, this variable may be more representative of clinicians' likelihood of using IPV categories, rather than the frequency with which they see IPV in their practice. Results may indicate that clinicians who receive IPV-related training are more

likely to document IPV. We also considered that participants' ratings of knowledge and experience relating to couples experiencing relationship problems approximated their knowledge and experience of IPV. While relationship problems encompass instances of IPV, they also represent milder forms of relational difficulties such as normative disagreements and dissatisfaction within romantic partnerships (Foran et al., 2013). Therefore, it is difficult to determine whether clinicians' self-rated level of knowledge and experience related to relationship problems is truly representative of their experience with IPV.

Future Research

This study adds to our understanding of the gaps in global mental health professionals' IPV-related training experiences. Although it appears that clinicians' training experiences do not closely follow WHO recommendations for IPV-related training (WHO, 2013[2]), there has yet to be any research assessing whether adherence to WHO training recommendations improves clinician performance in assessing for IPV. Due to institutional and financial constraints that may limit the depth and length of IPV-related training available in many settings and regions, future research may evaluate whether comprehensive training (as is recommended by the WHO) is necessary to improve clinician outcomes in assessing for IPV. Particularly, it would be important to explore whether adherence to WHO recommendations leads to improved ability to correctly identify IPV in clinical practice.

Conclusion

This study represents a snapshot of global mental health professionals' experiences of IPV-related training. Overall, it appears that training is limited across the 24 countries included in this study, and experiences of IPV-related training vary broadly. Certain factors (i.e., IPV-related laws and frequency of IPV in clinical practice) appear to increase clinicians' likelihood of participating in training, and participating in training appears to improve the likelihood that

clinicians will report greater knowledge and experience related to relationship problems. Findings suggest that clinicians' awareness of IPV (e.g., experience working with those reporting IPV) and the greater institutional context in which they practice (i.e., whether IPV-related legislation is well implemented) are related to training. Improved institutional efforts to address IPV, such as implementing legislation and IPV awareness campaigns, may improve mental health professionals' practices with regards to IPV.

Although this study only represents a subset of global mental health professionals, it includes data collected in three different languages across 24 countries and is therefore far more inclusive than previous similar research seeking to describe clinicians' experiences of IPV-related training. It highlights the global challenges with regards to IPV-related training, which may include a lack of financial resources or infrastructure to support training. Further inquiry into the utility of comprehensive training for improving IPV identification in clinical practice, compared with less in-depth training, is an important next step as it will better inform best training practices.

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Table 1.1

Demographic information (N = 321)

Variable	*n* (%)
Study Language	
Spanish	181 (56.4)
French	51 (15.9)
Japanese	89 (27.7)
WHO Global Region[1]	
Latin America	119 (37.1)
Europe	113 (35.2)
Japan	89 (27.7)
Gender	
Male	195 (60.7)
Female	126 (39.3)
Profession	
Psychiatry	173 (53.9)
Psychology	148 (46.1)
Income Level[2]	
High	206 (64.2)
Upper-middle	110 (34.3)
Lower-middle	5 (1.5)
	M (SD)
Age	49.78 (10.96)
Years of Experience	19.81 (10.06)
National Income[3]	26701.07 (16355.95)

1. Participants were from the following countries in each global region: Japan; Europe: Croatia, Cyprus, France, Poland, Portugal, Romania, Spain, and Switzerland; Latin America: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Peru, and Venezuela.

2. National income level based on the World Bank list of analytical income classification of economies. There were no participants from low-income countries.

3. Gross Domestic Product per capita in U.S. $.

Table 1.2

IPV-related training by predictor

	IPV-related training			
	Yes		No	
Variables	*n* (%)		*n* (%)	
Total	172 (53.6)		149 (46.4)	
Language of survey				
Spanish	140 (77.3)		41 (22.7)	
Japanese	10 (11.2)		79 (88.8)	
French	22 (43.1)		29 (56.9)	
WHO global region				
Latin America	98 (82.4)		21 (17.6)	
Europe	64 (56.6)		49 (43.4)	
Japan	10 (11.2)		79 (88.8)	
Gender				
Male	86 (44.1)		109 (55.9)	
Female	86 (68.3)		40 (31.7)	
Profession				
Psychiatrist	69 (39.9)		104 (60.1)	
Psychologist	104 (69.6)		45 (30.4)	
IPV-related laws				
Well implemented	148 (71.5)		59 (28.5)	
Less well implemented	24 (21.1)		90 (78.9)	
Frequency of IPV in clinical practice				
Never	22 (28.6)		55 (71.4)	
Once or less per month	54 (47.4)		60 (52.6)	
Once per week	31 (60.8)		20 (39.2)	
Several times per week	65 (82.3)		14 (17.7)	
	M	*SD*	*M*	*SD*
Age	49.09	11.75	50.57	9.94
Years of experience	19.85	10.60	19.76	9.43
National income[1]	20721.70	16735.08	33603.50	12857.44
IPV norms (%)	12.40	4.65	12.33	3.73
Prevalence of physical or sexual IPV (%)	30.19	15.43	18.88	8.94

1. Gross Domestic Product per capita in U.S. $.

Table 1.3

IPV-related training experiences

Component of training	*n* (%)		
Basic information on IPV	152 (85.4)		
Local support services for survivors	120 (67.4)		
How and when to inquire about IPV	126 (70.8)		
How to offer support to survivors	118 (66.3)		
Other	36 (20.2)		
Hours of training[1]	*n* (%)	Median	Interquartile range
During professional training	148 (88.6)	20.00	8.00-69.00
Since completing professional training	152 (92.7)	40.00	20.00-100.00
In the past five years	144 (89.4)	30.00	10.00-100.00

1. Boxplots adjusted for skewed distributions (Walker et al., 2018) were used to detect and remove outliers for each "hours of training" variable, respectively (i.e., during professional training [*n* = 5], since completing professional training [*n* = 8], and in the past five years [*n* = 11]). Outliers were only removed for analyses on "hours of training" variables and were retained for all other analyses.

Table 1.4

Binary logistic regression of IPV-related training, Models 1 (control variables only) and 2 (IPV-related variables added) (odds ratios)

	Yes training[a]					
	Model 1			Model 2		
Predictor	OR	95% CI	*SE*	OR	95% CI	*SE*
Years of experience	1.01	0.98-1.03	0.014	1.00	0.97-1.03	0.015
National income	0.95***	0.93-0.97	0.010	1.00	0.98-1.03	0.013
Gender[b] (male)	0.53*	0.30-0.95	0.296	0.53	0.28-1.01	0.327
Profession[c] (Psychiatrist)	0.41**	0.24-0.73	0.287	0.58	0.30-1.13	0.337
IPV-related laws[d] (relatively better implemented laws)				8.84**	3.01-25.96	0.550
IPV-related norms				1.16	1.01-1.32	0.070
Prevalence of physical or sexual IPV				1.01	0.98-1.05	0.020
Frequency of IPV in clinical practice[e]						
Once or less per month				1.71	0.80-3.68	0.391
Once per week				1.85	0.75-4.59	0.463
Several times per week				3.92*	1.51-10.20	0.487

Note. OR = Odds Ratio. CI = Confidence Interval. SE = Standard Error.

* $p < .05$ ** $p < .01$ *** $p < .001$.

a. Outcome variable category (n = 178). Reference group = No training (n = 143); b. Female as reference; c. Psychologist as reference; d. Relatively less well implemented laws as reference; e. Never as reference.

Table 1.5

Knowledge and experience of relationship problems by predictor

Variables	Knowledge and experience					
	Low n (%)		Moderate n (%)		High n (%)	
Language of survey						
Spanish		11 (6.1)		55 (30.4)		115 (63.5)
Japanese		49 (55.1)		29 (32.6)		11 (12.4)
French		13 (25.5)		12 (23.5)		26 (51.0)
WHO global region						
Latin America		5 (4.2)		33 (27.7)		81 68.1)
Europe		19 (16.8)		34 (30.1)		60 (53.1)
Japan		49 (55.1)		29 (32.6)		11 (12.4)
Gender						
Male		49 (25.1)		62 (31.8)		84 (43.1)
Female		24 (19.0)		34 (27.0)		68 (54.0)
Profession						
Psychiatrist		50 (28.9)		55 (31.8)		68 (39.3)
Psychologist		23 (15.5)		41 (27.7)		84 (56.8)
IPV-related laws						
Well implemented		20 (9.7)		61 (29.5)		126 (60.9)
Less well implemented		53 (46.5)		35 (30.7)		26 (22.8)
Frequency of IPV in clinical practice						
Never		37 (48.1)		19 (24.7)		21 (27.3)
Once or less per month		30 (26.3)		45 (39.5)		39 (34.2)
Once per week		5 (9.8)		12 (23.5)		34 (66.7)
Several times per week		1 (1.3)		20 (25.3)		58 (73.4)
IPV-related training						
Yes		11 (6.4)		42 (24.4)		119 (69.2)
No		62 (41.6)		54 (36.2)		33 (22.1)
	M	*SD*	*M*	*SD*	*M*	*SD*
Age	47.84	10.51	49.41	9.97	50.94	11.65
Years of experience	17.27	9.62	19.45	9.72	21.26	10.27
Income[1]	37071.90	11913.61	25725.10	12833.74	22336.80	17995.80
IPV norms (%)	12.48	3.13	12.16	3.37	12.44	5.17
Prevalence of physical or sexual IPV (%)	16.92	6.53	24.53	13.75	29.12	15.10

1. Gross Domestic Product per capita in U.S. $.

Table 1.6

Multinomial logistic regression of knowledge and experience of relationship problems, Models 1 (control variables only) and 2 (IPV-related training added) (odds ratios)

	Model 1						Model 2					
	Low knowledge and experience (*n* = 71)			Moderate knowledge and experience (*n* = 93)			Low knowledge and experience			Moderate knowledge and experience		
Predictor	OR	95% CI	SE	OR	95% CI	SE	OR	95% CI	SE	OR	95% CI	SE
Years of experience	0.96*	0.92-0.99	0.020	0.98	0.95-1.01	0.015	0.95*	0.91-0.99	0.022	0.97	0.94-1.00	0.016
National income	0.99	0.96-1.03	0.016	0.97	0.94-1.00	0.016	1.00	0.97-1.04	0.017	0.97	0.93-0.99	0.017
Gender[a] (male)	1.15	0.49-2.70	0.436	1.45	0.75-2.79	0.334	0.71	0.28-1.83	0.483	1.23	0.62-2.44	0.350
Profession[b] (Psychiatrist)	1.06	0.43-2.60	0.460	1.21	0.62-2.40	0.346	0.98	0.37-2.59	0.498	1.03	0.51-2.09	0.362
IPV-related laws[c] (relatively better implemented laws)	0.03***	0.01-0.15	0.831	0.23**	0.07-0.69	0.573	0.09**	0.02-0.54	0.897	0.39	0.13-1.19	0.573
IPV-related norms	0.71**	0.58-0.89	0.110	0.89	0.78-1.02	0.067	0.80	0.64-1.01	0.116	0.91	0.81-1.03	0.059
Prevalence of physical or sexual IPV	1.00	0.95-1.06	0.030	0.99	0.96-1.03	0.020	1.01	0.94-1.07	0.032	0.99	0.96-1.04	0.020
Frequency of IPV in clinical practice[d]												
Once or less per month	0.75	0.32-1.79	0.444	1.59	0.68-3.69	0.431	1.04	0.40-2.72	0.491	1.94	0.78-4.83	0.465
Once per week	0.15**	0.04-0.55	0.655	0.51	0.19-1.37	0.500	0.13**	0.03-0.52	0.705	0.52	0.18-1.48	0.533
Several times per week	0.04**	0.00-0.33	1.096	0.52	0.21-1.33	0.477	0.06*	0.01-0.56	1.125	0.67	0.25-1.82	0.505
Training[e] (no training)							13.13***	4.76-36.18	0.517	5.49***	2.62-11.51	0.378

Note. Reference group: High knowledge and experience (*n* = 138). OR = Odds Ratio. CI = Confidence Interval. SE = Standard Error.

* p < .05 ** p < .01 *** p < .001.

a. Female as reference; b. Psychologist as reference; c. Relatively less well implemented laws as reference; d. Never as reference; e. Yes training as reference.

Study 2: Evaluating the relationship between intimate partner violence-related training and mental health professionals' assessment of relationship problems

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Abstract

Intimate partner violence (IPV) is a serious public health problem associated with increased risk of developing mental health conditions. Assessment of IPV in mental health settings is important for appropriate treatment planning and referral; however, lack of training in how to identify and respond to IPV presents a significant barrier to assessment. To address this issue, the WHO advanced a series of evidence-based recommendations for IPV-related training programs. This study examines the relationship between mental health professionals' experiences of IPV-related training, including the degree to which their training resembles WHO training recommendations, and their accuracy in correctly identifying relationship problems. Participants were psychologists and psychiatrists (N = 321) from 24 countries who agreed to participate in an online survey in French, Japanese, or Spanish. They responded to questions regarding their IPV-related training (i.e., components and hours of training) and rated the presence or absence of clinically significant relationship problems (RPM) and mental disorders across four case vignettes. Participants who received IPV-related training, and whose training was more recent and more closely resembled WHO training recommendations, were more likely than those without training to accurately identify RPM. Clinicians regardless of IPV-related training were equally likely to misclassify normative couple issues as clinically significant RPM. Findings suggest that IPV-related training assists clinicians in making more accurate assessments of patients presenting with clinically significant relationship problems, including IPV. These data inform recommendations for IPV-related training programs and suggest that training should be repeated, multicomponent, and include experiential training exercises, and guidelines for distinguishing normative relationship problems from clinically significant RPM.

Keywords: Intimate partner violence, training, mental health, assessment, diagnostic accuracy

Evaluating the relationship between intimate partner violence-related training and mental health professionals' assessment of relationship problems

Intimate partner violence (IPV) is defined as any behavior within a relationship that causes — or has reasonable potential to cause — physical, sexual, or psychological harm to a partner (Foran et al., 2015; WHO, 2012). Globally, it is estimated that 35% of ever-partnered women have experienced lifetime IPV (WHO, 2013). IPV is associated with increased risk of developing mental health problems including depression, anxiety, posttraumatic stress disorder (PTSD), substance use disorders, and suicidal ideation (Bacchus et al., 2017; Laskey et al., 2019; Miller & McCaw, 2019; WHO, 2005). A systematic review of IPV prevalence studies conducted in psychiatric settings reported that the median prevalence of lifetime IPV was 30-33% among female patients (inpatient and outpatient) and 18-48% among male inpatients (Oram et al., 2013). Furthermore, systematic reviews suggest that women living with serious mental illness (i.e., who have a recurrent or persistent mental disorder that significantly impacts their functioning) are more than twice as likely to have experienced violence of any kind, including IPV, compared to the general population (Khalifeh & Dean, 2010; Mauritz et al., 2013).

WHO guidelines recommend that health professionals screen for IPV when assessing or treating individuals with mental health symptoms (WHO, 2013). Identification of IPV by global mental health professionals (i.e., clinicians who are involved in the assessment and treatment of individuals living with mental health symptoms) may lead to more accurate IPV prevalence data (Ellsberg & Heise, 2005), and help enhance our understanding of IPV risk factors and mental health consequences (Foran et al., 2015). Additionally, IPV assessment in mental health settings may contribute to improved case conceptualizations and referrals to care. Advocacy-based interventions have been shown to improve survivors' quality of life and perceived social support

(Sullivan & Bybee, 1999), whereas psychological treatments (e.g., cognitive behavioral therapy) have contributed to improved coping and social adjustment (Johnson & Zlotnick, 2006; McNamara et al., 2008) and decreased ratings of PTSD symptom severity (Johnson et al., 2011).

Despite the existence of best practice recommendations related to the assessment of IPV in mental health settings, IPV remains under-detected in these settings (Howard et al., 2010). Studies from Australia (Forsdike et al., 2019) and the U.K. (Nyame et al., 2013) found that more than half of mental health clinicians (56% and 61%, respectively) did not ask new patients about IPV. Additionally, a survey of U.S. mental health service users identified that 45% of women and 73% of men had never been asked about their experiences of IPV (Chang et al., 2011).

Lack of training in how to identify and respond to IPV has been identified as an important barrier for IPV assessment in mental health settings (Forsdike et al., 2019; Rose et al., 2011; Trevillion et al., 2016). Clinicians without training report lower confidence and competence in addressing the needs of patients experiencing IPV (Rose et al., 2011; Sprague et al., 2012). IPV-related training is not often a mandatory component of professional training programs (Fricchione et al., 2012; Kamimura et al., 2015). Studies from the U.S. (Campbell et al., 1999), the U.K. (Nyame et al., 2013), and across 24 countries in South America, Europe, and Asia (Burns et al., 2020) show that nearly half of mental health clinicians have never received this form of training.

IPV-related training has been linked to improved outcomes for clinicians, including increased IPV-related knowledge (Burns et al., 2020; Connor et al., 2013; Forsdike et al., 2019; Jayatilleke et al., 2015, McColgan et al., 2010; Trevillion et al., 2016), improved confidence in addressing IPV (Forsdike et al., 2019; Jayatilleke et al., 2015), and reduced unhelpful attitudes towards survivors (e.g., victim blaming; Jayatilleke et al., 2015; McColgan et al., 2010). Given

apparent benefits of IPV-related training, the WHO advanced a series of evidence-based training recommendations for health care professionals (WHO, 2013). These recommendations specify that IPV-related training should be multicomponent and offered at several time points (e.g., at the pre-qualification and professional level). Recommended training components included didactic training (e.g., basic knowledge about IPV laws, prevalence, and risk factors as well as local support services for survivors) and skill-building exercises (e.g., teaching clinicians how and when to inquire about IPV, and how to respond to survivors). There has been no previous research evaluating the relationship between mental health professionals' experiences of IPV-related training, including the degree to which their training resembles WHO training recommendations, and their accuracy in correctly identifying IPV.

Context for the Present Research

This research was conducted in the context of a larger study evaluating the clinical utility of proposed Relationship Problem and Maltreatment (RPM) guidelines, created as a part of the development of guidelines (First et al., 2015) for Mental, Behavioural and Neurodevelopmental Disorders for the Eleventh Revision of WHO's International Classification of Diseases and Related Health Problems (ICD-11), approved in May 2019 by the World Health Assembly. RPM guidelines are intended to assist clinicians with the identification and classification of clinically significant relationship problems, including IPV, that may lead people to seek health services. The larger study, created in English and later translated into French, Japanese, and Spanish, was developed to compare the use of proposed ICD-11 RPM guidelines to guidance provided in ICD-10. In ICD-10, IPV is defined using a single category (i.e., 'Problems in relationship with spouse or partner'), in which different forms of IPV (e.g., physical, psychological, or sexual IPV) are not operationalized. Proposed ICD-11 RPM guidelines were developed to improve upon ICD-10

and include definitions for different forms of RPM (i.e., relationship distress, physical violence, psychological abuse, sexual violence, and partner neglect). Heyman et al. (2018) reported the English-language results of the field trial ($N = 738$) and showed that ICD-11 RPM guidelines improved clinicians' performance over ICD-10. French, Japanese, and Spanish results have not yet been reported.

Aims and Objectives

The present study uses data collected from specialized mental health professionals (i.e., psychiatrists and psychologists) who completed the ICD-11 Relationship Problem and Maltreatment (RPM) field trial in French, Japanese, and Spanish. The primary objective of this study was to explore how global clinicians' experiences of IPV-related training were related to accuracy in distinguishing between different forms of IPV and normative relationship problems in a series of case-controlled vignettes. We hypothesized that clinicians with IPV training would be more likely to correctly identify relationship problems, including IPV, than those without training. We also hypothesized that clinicians with training that more closely resembled WHO training recommendations would perform better at identifying relationship problems. A secondary objective of this study was to assess differences in performance between the use of ICD-11 versus ICD-10 RPM guidelines within our sample. We hypothesized that, concordant with earlier findings (Heyman et al., 2018), ICD-11 guidelines would improve performance.

Method

Participants

Participants were members of the WHO's Global Clinical Practice Network (GCPN), a global network of more than 15,000 mental health professionals from 156 countries recruited to participate in the field trials for the development of the ICD-11 (Reed et al., 2015). This study

was developed in English and later translated into French, Japanese, and Spanish by bilingual mental health professionals using a forward and backward translation procedure. Questions related to participants' IPV-related training were added to translated versions of the study and were not available for the English version. Because IPV-related training is the primary focus of this study, only French, Japanese, and Spanish data were used. To be eligible for the study, participants were required to (a) currently be providing mental health services and/or clinical supervision, and (b) be proficient or fluent in one of the three study languages. GCPN members meeting these eligibility criteria ($N = 3233$; French, $n = 713$, Japanese, $n = 1022$, Spanish, $n = 1498$) were sent personalized email invitations with a secure link to the study (see Appendix A). Reminder emails were sent two and four weeks later. Data were collected over approximately two months. Participants ($n = 604$, 19% of those invited: French, $n = 139$, Japanese, $n = 147$, Spanish, $n = 318$) responded to the survey link and began the study. Participants who did not meet eligibility criteria ($n = 24$) or who did not complete the study ($n = 189$) were removed. Because the present study compared results across WHO global regions, participants from regions with response rates too low to permit this analysis were removed (i.e., Africa, $n = 7$, Eastern Mediterranean, $n = 5$, North America, $n = 2$). Finally, we were interested in examining the results concerning IPV-related training for psychologists and psychiatrists, since they are specialized mental health professionals who are involved in both the assessment and treatment of patients and who make up most of the GCPN. Thus, participants from other professions ($n = 56$) were removed. The final sample comprised 321 participants from 24 countries (see Table 2.1).

Data and Materials

Demographic Information

Participants provided basic demographic information (i.e., gender, age, years of professional experience, profession, and country of residence) during their registration to the

GCPN (see Appendix B), and again upon initiating the current study. Participants completed the study in one of three languages (i.e., French, Japanese, or Spanish) and were classified into one of the eight WHO regions and one of four national income levels (i.e., high, upper-middle, lower-middle, low) based on their country of residence. There was significant overlap among region, study language, and national income level variables. Notably, all participants from Japan completed the study in Japanese (n = 89), and all participants from Latin America completed the study in Spanish (n = 119). Participants from Europe completed the study in either Spanish (n = 62) or French (n = 51). Furthermore, all participants from Japan and almost all participants from Europe (99%) were from high-income countries, while most participants from Latin America (95%) were from middle-income countries. Because language and country income are dependent on region, only the region variable was included in analyses.

IPV-Related Training

Participants' experiences of IPV-related training were measured with five questions. The first question asked participants to respond "Yes" or "No" to the following statement: "Please indicate whether, at any point during your clinical training or professional career, you have received formal training (e.g., as a part of courses, workshops, continuing education programs) about how to detect or respond to IPV, including physical and psychological abuse." Those who selected "No" were not shown the following questions. The second question was based on the WHO's IPV-related training recommendations (WHO, 2013) and asked participants to specify which components from the following list were included in their training: (a) definitions, laws and risk factors related to IPV, (b) support services for survivors of IPV, (c) how and when to inquire about IPV with patients, and (d) how to respond to survivors of IPV. The final three questions asked participants to input the number of hours dedicated to IPV-related training at

three different time points: during their professional training, since completing their professional training, and during the past five years.

ICD Guidelines

The proposed ICD-11 Relationship Problem and Maltreatment (RPM) Clinical Descriptions or ICD-10 RPM Guidelines (WHO, 1992) were randomly assigned to participants for use when diagnosing persons described in vignettes. RPM Clinical Descriptions and Guidelines provide clinicians with a set of essential (required) features for diagnosing the presence or absence of clinically significant relationship problems. Participants were also asked to use ICD-11 diagnostic definitions for Mood disorders and Anxiety and fear-related disorders. Guidelines and clinical descriptions used in the study can be found in Appendix E.

Vignettes

Three co-authors (RH, AS, and HF) developed twelve vignettes for the study based on actual clinical cases with all identifying information removed. Vignettes depicted six male and six female adults of various ages who were in a heterosexual relationship. Information related to cultural or religious background was omitted to mitigate participant biases when evaluating the vignettes. Vignettes reflected four study conditions: I) features consistent with both a clinically significant relationship problem (RPM) and a Mental and Behavioral Disorder (MBD; both RPM and MBD present), II) features consistent with only a relationship problem (RPM present, MBD absent), III) features consistent with only an MBD (RPM absent, MBD present), and IV) features consistent with neither a relationship problem or an MBD (both RPM and MBD absent). Each vignette described a patient presenting with either the presence or absence of one of three ICD-11 RPMs (i.e., Relationship Distress with Spouse or Intimate Partner; Spouse or Partner Violence, Physical; or Spouse or Partner Abuse, Psychological), and the presence or absence of one of two MBDs (i.e., Single Episode Depressive Disorder or Generalized Anxiety Disorder).

When an RPM was absent, normative relationship problems were described; when an MBD was absent, subthreshold psychiatric symptoms were described. Two lower prevalence ICD-11 RPM categories (i.e., Spouse or Partner Violence, Sexual, and Spouse or Partner Neglect) were not included due to concerns about study length, and the ease with which these forms of violence could be identified when described in vignettes. Vignettes were validated by twelve international experts in the study of relationship problems, who diagnosed vignettes and provided feedback on their cultural applicability, to ensure that there was consensus on correct responses for vignettes and that vignette content was appropriate for a global audience. Vignettes with less than 90% agreement were revised based on rater feedback. See Appendix D for an example of a vignette used in the study.

Procedure

This study was exempted from review by the World Health Organization Research Ethics Review Committee (Protocol ID RPC569) and by the Human Subjects Committee at the University of Kansas, Lawrence Campus (HSCL #20804).

Participants were sent an email invitation to participate in the study and followed an individualized link to the survey in Qualtrics™ (Provo, USA). Participants who initiated the study were randomly assigned to view either ICD-11 or ICD-10 RPM guidelines for use throughout the study, without any explicit indication as to which ICD version they were viewing. All participants viewed ICD-11 MBD diagnostic definitions for Mood Disorders and Anxiety and Fear-related Disorders. After viewing the guidelines, participants were randomly assigned to one of six vignette comparison conditions. Comparisons were created for each vignette to have an equal probability of being presented throughout the study, and a similar probability of being presented with any of the other vignettes. Each comparison was composed of four vignettes, and

each vignette was drawn from a different study condition: I) both RPM and MBD present, II) RPM present, MBD absent III) RPM absent, MBD present, or IV) both RPM and MBD absent. Vignettes were presented in turn, with the order of presentation counterbalanced across participants. After viewing each vignette, participants were asked to select an MBD diagnosis, or no diagnosis, followed by an RPM code, or no RPM, from drop-down lists of ICD categories (i.e., ICD-11 MBD categories and ICD-10 or ICD-11 RPM codes). Participants could consult MBD definitions and RPM guidelines while making their decisions. After rating the vignette, participants were asked to review the essential features of their selected RPM code (ICD-10 or ICD-11) to determine whether each feature was present or absent in the vignette. This provided participants with an opportunity to re-assess whether the RPM code they selected met ICD definitional requirements. Participants could then choose to change their selected RPM code or MBD category. Participants completed this sequence four times, once for each vignette (see Heyman et al., 2018 for a full description of the methodology for the larger field trial). Finally, participants responded to the five questions regarding their IPV-related training experiences. A flow-chart outlining each step of the study design can be found in Appendix C.

Results

Sample Representativeness

The representativeness of our sample was determined by comparing participants who completed the survey (i.e., completers) to clinicians who were invited to the study but did not participate (non-participants), and to participants who initiated the study but did not complete it (non-completers). Completers did not differ significantly from non-participants or non-completers in terms of gender, profession, region, or proportion of participants in each survey language. However, completers had slightly more professional experience (M = 19.54, SD =

10.12) than non-participants ($M = 18.12$, $SD = 11.00$; $t(2447) = 2.207$, $p < .05$) and non-completers ($M = 17.62$, $SD = 9.27$; $t(508) = 2.085$, $p < .05$). Completers were also slightly older ($M = 49.64$, $SD = 10.99$) than non-participants ($M = 48.10$, $SD = 12.15$; $t(2447) = 2.175$, $p < .05$) and non-completers ($M = 47.33$, $SD = 10.92$; $t(508) = 2.094$, $p < .05$).

ICD-manual version

Chi-square analyses were used to compare participants' accuracy (i.e., percentage of those who diagnosed correctly versus those who did not diagnose correctly) while identifying Relationship Problems and Maltreatment (RPM) and Mental and Behavioural Disorders (MBD) in each study condition, using ICD-11 versus ICD-10 RPM guidelines. As shown in Table 2.3, the accuracy of clinicians' diagnoses was not significantly different for the ICD-11 guidelines as compared to the ICD-10 guidelines. For this reason, the two ICD conditions were collapsed for subsequent analyses.

RPM conditions

Each of the vignettes in this study depicted patients presenting with MBD symptoms that either met full definitional requirements for a diagnosis (MBD present) or were subthreshold, which included some but never all the required features of an MBD (MBD absent). Differences in performance between MBD-present and MBD-absent conditions were relevant for the purposes of the larger ICD-11 field trial (Heyman et al., 2018) but were not pertinent for the current research. Therefore, for all following analyses, conditions I (RPM present, MBD present) and II (RPM present, MBD absent) were combined to form an RPM present condition, and conditions III (RPM absent, MBD present) and IV (RPM absent, MBD absent) were combined to form an RPM absent condition. These new conditions represent two distinct assessment tasks for clinicians: identifying an RPM in the presence of harmful relationship problems (RPM present)

and identifying that there is no RPM when normal relationship problems are described (RPM absent).

Demographic Factors

Table 2.4 presents results of chi-square analyses of the relationship between categorical demographic factors (gender, profession, and region) and clinicians' accuracy (i.e., percentage of clinicians who had 0, 1, or 2 correct responses) when assessing for RPM and MBD in each RPM condition (present; absent). To account for family-wise error, the Benjamini-Hochberg procedure was applied to all analyses. Significant differences were found for region in the RPM absent condition, while assessing for both RPM and MBD. Tukey HSD post-hoc comparisons were generated to assess regional differences, and it was found that when the task was to identify the absence of relationship problems, clinicians from Japan performed significantly better than those from Europe or Latin America. When the task was to identify a mental disorder when RPM was absent, clinicians from Japan performed significantly better than those from Latin America.

Multinomial logistic regressions were run to explore the relationship between age, years of professional experience, and diagnostic accuracy. In both RPM conditions (present; absent), when the task was to diagnose RPM, there was no relationship between age or years of professional experience and accuracy. However, when the task was to diagnose an MBD, accuracy was significantly related with age and years of professional experience in both RPM conditions. When RPM was present, younger clinicians were more likely than older clinicians to have 1 or 2 correct responses while diagnosing an MBD (maximum possible is 2), compared with 0 ($\chi^2(1, N = 321) = 9.44$, $p<.01$). Also, clinicians with less experience were more likely than those with more experience to have 2 correct responses (out of a maximum of 2), compared with 0 ($\chi^2(1, N = 321) = 8.03$, $p<.05$). When RPM was absent, younger clinicians were more likely

than older clinicians to have 2 correct responses while diagnosing an MBD, compared with 1 ($\chi^2(1, N = 321) = 6.76$, $p<.05$). Also, clinicians with less experience were more likely than those with more experience to have 2 correct responses, compared with 1 ($\chi^2(1, N = 321) = 7.46$, $p<.05$).

IPV-Related Training

Chi-square analyses were performed to evaluate the relationship between IPV-related training (i.e., received training: yes or no) and accuracy (i.e., percentage who had 0, 1, or 2 correct diagnoses) when assessing for RPM and MBD in both RPM conditions (present; absent).

RPM Absent Condition

Due to significant differences in performance across global regions (Japan, Europe, and Latin America) in the RPM absent condition, chi-square analyses were conducted separately by region. As shown in Table 2.5, there were no significant differences. Across all regions, when RPM was absent, IPV-related training did not impact the likelihood of identifying the absence of RPM. As anticipated, IPV-related training also did not impact the likelihood of correctly identifying an MBD.

RPM Present Condition

Table 2.5 shows clinicians' performance when assessing for RPM and MBD when RPM is present. Results showed that clinicians with IPV-related training were significantly more likely than those without training to have more correct responses when identifying RPM. As anticipated, there was no relationship between IPV-related training and the likelihood of correctly identifying an MBD.

Elements of Training

Training factors (i.e., timing of training, number of hours, and breadth of content) were examined to determine their impact on the likelihood of accurately identifying RPM.

Timing of Training. Chi-square analyses were performed to evaluate the relationship between IPV-related training (i.e., whether clinicians had received training: yes or no) and accuracy (i.e., the percentage of clinicians who had 0, 1, or 2 correct responses) at different time points (i.e., during professional training; since completing professional training; and in the past 5 years). The Benjamini-Hochberg procedure was applied to all analyses to correct for family-wise error. Results are presented in Table 2.6 and show that clinicians who received IPV-related training after completing their professional training and in the past 5 years were significantly more likely to correctly identify RPM than clinicians without training. Clinicians who received IPV-related training during their professional training programs were not more likely than those without training to correctly identify RPM.

Hours of Training. Two multinomial logistic regressions were carried out to investigate whether the number of hours of IPV-related training (during professional training and since completing professional training, respectively) were related to clinicians' accuracy in identifying RPM (i.e., the likelihood of having 0, 1, or 2 correct responses). Boxplots adjusted for skewed distributions (Walker et al., 2018) were used to detect and remove outliers for each "number of hours of IPV-related training" variable (i.e., during professional training [n = 5], and since completing professional training [n = 8]). Multinomial regression results showed that the number of hours of training did not significantly predict the likelihood of having a greater number of correct responses, either during professional training ($\chi^2(2, n = 148) = 1.40$, $p > .05$) or after professional training ($\chi^2(2, n = 152) = 0.57$, $p > .05$).

Breadth of Training. The WHO (2013) recommends four components to be included in IPV-related training protocols (i.e., basic information on IPV, information about local support services for survivors, how and when to inquire about IPV, and how to offer support to survivors). Breadth of training was defined as the number of training components that participants reported participating in as part of their IPV-related training.

Table 2.7 presents the results of a chi-square analysis assessing the relationship between the number of training components that participants received (0-4) and their accuracy when assessing for RPM (i.e., percentage who had 0, 1, or 2 correct responses). Results showed a significant relationship between the number of training components and clinicians' accuracy. Post-hoc chi-square analyses were performed to determine what number of training components, compared with no training, were related to an increased likelihood of accurately identifying RPM. The Benjamini-Hochberg procedure was applied to all analyses to correct for family-wise error. Results identified that clinicians who received only one (χ^2 (2, n = 183) = 2.72, $p > .05$) or two components of training (χ^2 (2, n = 181) = 0.15, $p > .05$) did not perform better than those without training. However, clinicians who received three (χ^2 (2, n = 181) = 7.42, $p < .025$) or four components of training (χ^2 (2, n = 235) = 7.59, $p < .05$) performed significantly better than those without training.

Discussion

This study explored the relationship between global psychologists' and psychiatrists' IPV-related training experiences and diagnostic accuracy in the context of relationship problems and partner violence. Specifically, we hypothesized that IPV-trained clinicians with training more closely resembling WHO recommendations (WHO, 2013) would be more likely than those without training to accurately distinguish among different forms of clinically significant

Relationship Problems and Maltreatment (RPM) and normative relationship problems. This study also assessed differences in performance between the use of ICD-11 versus ICD-10 RPM guidelines within our sample.

The findings show that, across all study conditions, the use of ICD-11 guidelines did not improve participants' performance over ICD-10 for specific case vignettes. Heyman et al. (2018) reported on the English-language data and found that ICD-11 outperformed ICD-10. These authors considered participants to have correctly responded if they selected any RPM category, regardless of whether it was the one described in the vignette. This was done to increase comparability between ICD manuals. In contrast, in the current study, to measure response accuracy participants were only rated as having a correct response if they selected the specific RPM described in the vignette. Results from both studies suggest that ICD-11 guidelines assist clinicians in identifying when an RPM is present but are less helpful in making accurate distinctions between different forms of relationship problems. Further review and revision of proposed ICD-11 RPM guidelines may be needed to address this issue, prior to the planned release of the ICD-11 clinical descriptions and diagnostic guidelines in 2022. However, recommendations for the review of ICD-11 RPM guidelines falls beyond the scope of this research. Importantly, this finding highlights the need for additional training to assist clinicians in making accurate assessments of patients presenting with relationship problems, including IPV.

To determine whether clinician factors impacted performance, we assessed the relationship between five demographic variables and participants' diagnosis of RPM and MBD in two study conditions (RPM present; RPM absent). Findings showed that when the task was to correctly identify an RPM (i.e., RPM present condition), none of the demographic variables impacted performance. However, when the task was to correctly identify the absence of RPM

(i.e., RPM absent condition), significant differences in performance were found across regions. Clinicians from Europe and Latin America were more likely to misclassify normative relationship problems as clinically significant RPM, compared to participants from Japan. Cultural differences in clinical decision-making may have influenced these results. Western clinicians have been found to employ a more analytical approach to diagnosis, retaining only details that assist in making categorical judgments, whereas East Asian clinicians appear to take a more holistic approach by gathering and remembering various types of details (Nisbett et al., 2001). Vignettes were created to depict normative relationship problems with features that fell just below the threshold for an RPM. It is possible that clinicians from Europe and Latin America (i.e., Western) were more likely than Japanese clinicians to adopt an analytical approach and sought to fit subthreshold vignette features to clinical guidelines, leading to over-identification of RPM.

A second possible explanation for regional differences in performance is that certain cultural factors may impact clinicians' familiarity with diagnosing relationship problems in clinical practice. Research suggests that Japanese individuals hold more patriarchal gender norms than individuals living in Western countries (Hofstede et al., 2010; Yamawaki et al., 2009), which can contribute to the perception of IPV as a private family matter rather than a public health issue (Nagae & Dancy, 2010; Nguyen et al., 2013; Yamawaki et al., 2009). IPV survivors in Japan report feeling ashamed of disclosing violence (Nagae & Dancy, 2010; Weingourt et al., 2001), and a national survey revealed that only 6% of women who experienced IPV had disclosed this to a health professional (Cabinet Office, 2012, as cited in Umeda et al., 2017). This is a lower rate of disclosure than reported in Western countries (e.g., Canada, where 32% of IPV survivors disclosed violence to a health care worker; Mont et al., 2005). Furthermore, a

randomized control trial of IPV screening practices in Japanese antenatal care found that women were more likely to disclose IPV using a self-report questionnaire, compared with a face-to-face interview with a health provider (Kataoka et al., 2010). It is possible that these cultural factors could contribute to Japanese clinicians having less experience assessing and identifying relationship problems in their regular practice, compared with clinicians from other regions. Thus, when presented with ambiguous patient presentations, participants from Japan may have been more likely to rely on ICD guidelines to make correct diagnoses. In contrast, participants from Europe and Latin America, who may have more clinical experience with IPV, could have been more likely to apply clinical intuition instead of guidelines to diagnose vignettes, leading to over-identification of RPM.

Findings also showed that in both study conditions (i.e., RPM present; RPM absent), age and years of professional experience were related to performance when assessing for an MBD. Younger clinicians and those with less experience were more likely to correctly classify an MBD (presence or absence), compared with older clinicians and those with more experience. Research has shown that clinicians with more experience may be more likely to rely on faster intuitive judgment than slow, deliberate, analytical judgment when presented with familiar patient presentations (Schwartz & Elstein, 2009). Intuitive judgment relies on heuristics, and although it is more time-efficient, it can lead to diagnostic errors (Croskerry & Nimno, 2011). It is possible that when presented with patients describing familiar mood and anxiety symptoms, older clinicians with more experience were more likely to rely on intuitive judgment than younger clinicians with less experience, leading to misclassification of subthreshold mood and anxiety symptoms as clinical disorders.

The main findings of this study described the relationship between IPV-related training and mental health clinicians' performance when assessing for RPM across two study conditions: when RPM was present (i.e., when the task was to identify RPM and distinguish between its different forms), and when RPM was absent (i.e., when the task was to distinguish between normative relationship problems and RPM). In the RPM-absent condition, results showed that across all regions, IPV-related training was unrelated to performance. Interestingly, both clinicians with and without training appeared to have similar difficulty with correctly identifying that RPM was absent. Amongst clinicians without training, 45-76% incorrectly classified normative relationship problems as RPM on at least one occasion. Similarly, 60-78% of clinicians who had received IPV-related training made at least one classification error across the two presented vignettes. It is possible that over-identification of RPM was related to the study design, whereby clinicians were asked to assess for RPM and therefore may have been more likely to assign subclinical features to clinically significant RPM. Nonetheless, these results suggest that IPV-related training programs may benefit from including specific guidelines on how to distinguish normative relationship problems from clinically significant RPM. This is important since treatment planning may differ according to the perceived severity of relationship problems (e.g., psychosocial support vs referral to advocacy services). Furthermore, clinicians in many nations have a duty to report severe RPM (i.e., IPV) if a child is present, and accurate identification of RPM can help to ascertain appropriate thresholds for making a report.

In the RPM present condition, participants who had prior IPV-related training were more likely than those without training to accurately identify RPM. This finding suggests that IPV-related training assists mental health clinicians in making more accurate clinical decisions while assessing patients presenting with RPM. It builds on previous research citing benefits of IPV-

related training including improved knowledge and confidence with regards to addressing IPV (Forsdike et al., 2019; Jayatilleke et al., 2015) and improved IPV-related screening practices (Murray et al., 2016; Waalen et al., 2000). As hypothesized, in both the RPM-present and RPM-absent conditions, IPV-related training was not associated with clinicians' performance while identifying an MBD. This suggests that participants' superior performance while assessing for RPM is related to IPV-related training specifically, rather than their amount of overall professional training. Clinicians with more overall training would presumably have also performed better at identifying an MBD.

Mental health professionals' training experiences can vary widely. To help inform IPV-related training protocols, the current study sought to explore the relationship between performance and different components of IPV-related training based on the WHO's evidence-based training guidelines (WHO, 2013). Our findings showed that clinicians who received training in the past five years or after completing their professional training programs were more likely to accurately identify RPM than clinicians without training. Clinicians who had IPV-related training during their professional training programs, however, were not more likely than those without training to correctly identify RPM. Furthermore, the number of hours of IPV-related training was not related to performance. Overall, these results imply that the recency of IPV-related training is more important than the amount of training to improve RPM identification. In line with WHO training recommendations (WHO, 2013), this suggests that clinicians would benefit from periodic IPV-related training throughout their careers.

This study also looked at the relationship between the number of WHO-recommended IPV-related training components and performance. WHO guidelines propose that IPV-related training should include didactic components (i.e., basic information about IPV, and local support

services for survivors), and skills training components (i.e., how and when to inquire about IPV, and how to offer support to survivors; WHO, 2013). Our findings show that clinicians whose training included three or four of the recommended components were significantly more likely to correctly identify RPM than participants without training. However, participants whose training contained only one component (most commonly basic information about IPV) or two components (most commonly basic information about IPV combined with information about local support services) performed similarly to those without training. It appears that clinicians whose IPV-related training more closely resembled WHO training recommendations were more likely to perform well at identifying RPM. Because clinicians who received three or more training components necessarily participated in at least one skills training exercise (i.e., learning how and when to inquire about IPV and/or how to respond to IPV), these results suggest that training that only provides basic information about IPV, without the addition of more experiential skills training, is not enough to improve clinical decision-making in the context of RPM. IPV-related training programs should comprise a breadth of components, including experiential learning tasks. This finding in line with previous research showing that clinicians who participated in experiential IPV-related training activities, compared with didactic training, were more likely to report improved IPV-related attitudes and knowledge (Buranosky et al., 2012).

Limitations

Participants in this study were clinicians who volunteered to be members of the WHO's GCPN and responded to an invitation to participate in an online field trial for the revision of the ICD-11 relationship problem and maltreatment guidelines. Only 10% of GCPN members who were sent an invitation constituted the final sample. These clinicians may have chosen to participate because they had expertise in the assessment and treatment of patients presenting with

RPM. Furthermore, participants were psychologists and psychiatrists only, from high-income (64.2%) and middle-income countries (35.8%) across three global regions: Japan, Europe (French- and Spanish-speaking Europeans only), and Latin America. Thus, results may not be generalizable to a broader sample of global mental health professionals.

A vignette-based method was used in this study to experimentally control case presentation. Research supports the use of vignettes as a valid and reliable method for assessing clinical practice (Evans et al., 2015); however, vignettes are necessarily brief and may lack the richness of information that clinicians would collect in their regular practice. Furthermore, clinicians' assessment of RPM in real-world clinical practice may be impacted by factors (e.g., discomfort asking about IPV; Sprague et al., 2012) that are absent in a vignette-based study. Thus, this study can only provide an analogue of participants' real-world assessment of RPM. Vignettes depicted patients presenting with relatively mild RPM, which included instances of IPV (i.e., physical and psychological partner violence) that met minimum definitional requirements for an RPM, as well as relationship distress with a spouse or intimate partner. Relationship distress (i.e., substantial and sustained dissatisfaction with a partner associated with significant disturbance in functioning) is not a form of IPV; it was included because it is an important risk factor for IPV (Stith et al., 2008; WHO, 2010) and is associated with negative mental health outcomes (e.g., depression, anxiety, and alcohol use disorder; Foran et al., 2013; Whisman, 2007). Less prevalent forms of IPV (i.e., sexual partner violence and partner neglect) were not included due to concerns about survey length. As such, this study reports on the relationship between IPV-related training and clinicians' assessment of milder forms of RPM and may not be representative of clinical decision-making in the context of more severe IPV (e.g., intimate terrorism, severe physical violence, or sexual violence).

Clinicians' experiences of IPV-related training were measured using self-report data and may have been subject to bias. For example, participants could have inflated their training experiences to appear more socially desirable, or may have had difficulty accurately recalling the timing, duration, and content of their IPV-related training. Training experiences were also observed rather than experimentally manipulated, signifying that the content of training could vary widely across participants. Although we assessed for specific components of IPV-related training based on WHO training recommendations, it is possible that participants' unique training experiences included elements not captured in our survey that could have influenced performance. Moreover, participants were asked to select as many WHO-recommended training components as were included in their IPV-related training program, from a drop-down list. Although this provided information on the characteristics of clinicians' training (e.g., content and number of components), participants' responses to this question were not independent, and therefore it was not possible to compare between training components to determine which were more strongly related to performance.

Conclusion

This study evaluated the relationship between the use of ICD guidelines, IPV-related training, and global psychologists' and psychiatrists' accuracy when assessing for relationship problems, including IPV. Findings suggest that the use of descriptive ICD guidelines is not sufficient to guide clinicians in making accurate clinical decisions in the context of RPM. As such, study results will be used to assist the WHO in making improvements to proposed RPM guidelines for inclusion in the ICD-11. Results also imply that IPV-related training leads to improved diagnostic decision-making in the context of RPM. Clinicians who received IPV-related training were more likely than their counterparts to accurately distinguish between different forms of RPM and normative relationship problems. Training appeared to yield the best

results when it was delivered recently (i.e., in the past five years or since completing professional training) and contained at least three WHO-recommended training activities, including more experiential skills training exercises (e.g., how and when to inquire about IPV, and how to offer support to survivors). Overall, these findings provide empirical support for the WHO's IPV-related training guidelines (WHO, 2013). Interestingly, clinicians with and without training appeared to misclassify normative relationship problems as RPM, suggesting that IPV-related training programs should also provide guidance on how to distinguish between normative and clinically significant relationship problems.

This study provides a glance at the relationship between global mental health professionals' experiences of IPV-related training and their diagnostic accuracy when assessing for relationship problems. Results can help to inform the development of IPV-related training programs to improve clinicians' decision-making in the context of RPM. Future research may expand on these findings by experimentally manipulating clinicians' experiences of IPV-related training in real-world settings, for improved ecological validity and better specification of components for inclusion in training programs.

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Table 2.1

Demographic information (N = 321)

Variable	*n* (%)
Gender	
Male	195 (60.7)
Female	126 (39.3)
Profession	
Psychiatry	173 (53.9)
Psychology	148 (46.1)
Study Language	
Japanese	89 (27.7)
French	51 (15.9)
Spanish	181 (56.4)
WHO Global Region[1]	
Asian West Pacific	89 (27.7)
Europe	113 (35.2)
South America	119 (37.1)
Income Level[2]	
High	206 (64.2)
Upper-middle	110 (34.3)
Lower-middle	5 (1.5)
	M (SD)
Age	49.78 (10.96)
Years of Experience	19.81 (10.06)

1. Participants were from the following countries in each global region: Asian West Pacific: Japan; Europe: Croatia, Cyprus, France, Poland, Portugal, Romania, Spain, and Switzerland; South America: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Peru, and Venezuela.

2. National income level based on the World Bank list of analytical income classification of economies. There were no participants from low-income countries.

Table 2.2

Correct responses for vignettes

Condition	Vignettes	Correct ICD-11 RPM category	Correct ICD-10 RPM category	Correct ICD-11 MBD diagnosis
RPM present, MBD present	TL (female)	Relationship Distress with Spouse or Intimate Partner	Problems in relationship with spouse or partner	Single Episode Depressive Disorder
	CI (female)	Spouse or Partner Violence, Physical	Problems in relationship with spouse or partner	Single Episode Depressive Disorder
	EK (male)	Spouse or Partner Abuse, Psychological	Problems in relationship with spouse or partner	Generalized Anxiety Disorder
RPM present, MBD absent	ML (male)	Relationship Distress with Spouse or Intimate Partner	Problems in relationship with spouse or partner	None (subthreshold depression)
	MN / LD (couple, male victim)	Spouse or Partner Violence, Physical	Problems in relationship with spouse or partner	None (subthreshold depression)
	FR (female)	Spouse or Partner Abuse, Psychological	Problems in relationship with spouse or partner	None (subthreshold depression)
RPM absent, MBD present	XM (female)	None (normative relationship problems)	None (normative relationship problems)	Generalized Anxiety Disorder
	DB (female)	None	None	Single Episode Depressive Disorder
	LG (male)	None	None	Generalized Anxiety Disorder

Table 2.2 (continued)

RPM absent, MBD absent	PW (male)	None (normative relationship problems)	None (normative relationship problems)	None (subthreshold anxiety)
	HM / FM (couple, female victim)	None	None	None (subthreshold depression)
	SP (female)	None	None	None (subthreshold depression)

Note. RPM = Relationship Problems and Maltreatment. MBD = Mental and Behavioral Disorder.

Table 2.3

Accuracy of clinicians' diagnoses, by response condition and ICD version

	Condition I (RPM+, MBD+)		Condition II (RPM+, MBD-)		Condition III (RPM-, MBD+)		Condition IV (RPM-, MBD-)	
ICD version	RPM	MBD	RPM	MBD	RPM	MBD	RPM	MBD
ICD-11 (*n* = 156)	66%	72%	79%	69%	67%	78%	57%	62%
ICD-10 (*n* = 165)	75%	72%	73%	71%	66%	72%	55%	65%
Performance (χ^2)	3.08	0.004	1.43	0.27	0.06	1.13	0.20	0.30
P-value	0.08	0.95	0.23	0.60	0.81	0.29	0.59	0.65
Cramer's V	0.098	0.004	0.067	0.029	0.013	0.059	0.025	0.030

Note. RPM = Relationship Problems and Maltreatment. MBD = Mental and Behavioral Disorder. ICD = International Classification of Diseases.

Table 2.4

Accuracy of clinicians' diagnoses, by response condition and demographic variable

	RPM present						RPM absent					
	RPM			MBD			RPM			MBD		
Nb. of correct responses	0	1	2	0	1	2	0	1	2	0	1	2
Variables												
Gender												
Female (*n* = 126)	9%	29%	62%	7%	44%	49%	14%	57%	29%	16%	36%	48%
Male (*n* = 195)	8%	42%	50%	10%	38%	52%	12%	49%	39%	9%	40%	51%
Chi-square (χ^2)	5.01			1.54			3.14			3.27		
Cramer's V	0.125			0.069			0.099			0.101		
Profession												
Psychiatrist (*n* = 173)	8%	39%	53%	10%	40%	50%	13%	48%	39%	8%	39%	53%
Psychologist (*n* = 148)	9%	35%	56%	8%	40%	52%	12%	57%	31%	16%	37%	47%
Chi-square (χ^2)	0.63			0.35			2.59			5.06		
Cramer's V	0.044			0.033			0.090			0.126		
Region												
Japan (*n* = 89)	10%	45%	45%	8%	45%	47%	7%	40%	53%	7%	30%	63%
Europe (*n* = 113)	6%	36%	58%	8%	40%	52%	13%	60%	27%	10%	46%	44%
Latin America (*n* = 119)	9%	31%	60%	11%	37%	52%	17%	53%	30%	18%	36%	46%
Chi-square (χ^2)	5.98			1.87			18.90***			13.21**		
Cramer's V	0.096			0.054			0.172			0.143		

Note. RPM = Relationship Problems and Maltreatment. MBD = Mental and Behavioral Disorder.

*$p < .05$; **$p < .01$; ***$p < .001$. Statistically significant with Benjamini-Hochberg correction.

Table 2.5

Accuracy of clinicians' diagnoses by response condition, RPM condition, region, and IPV-related training

			RPM			MBD		
Nb. correct responses			0	1	2	0	1	2
RPM condition	Region	Training						
RPM absent	Japan	Yes (n = 10)	10%	50%	40%	10%	20%	70%
		No (n = 79)	6%	39%	55%	6%	32%	62%
		Chi-square (χ^2)	0.78			0.66		
		Cramer's V	0.094			0.086		
	Europe	Yes (n = 64)	14%	64%	22%	11%	48%	41%
		No (n = 49)	12%	55%	33%	8%	43%	49%
		Chi-square (χ^2)	1.65			0.85		
		Cramer's V	0.121			0.086		
	Latin America	Yes (n = 98)	15%	53%	32%	15%	39%	46%
		No (n = 21)	24%	52%	24%	29%	24%	47%
		Chi-square (χ^2)	1.10			2.81		
		Cramer's V	0.096			0.154		
RPM present	All regions combined[1]	Yes (n = 172)	8%	31%	61%	11%	36%	54%
		No (n = 149)	9%	44%	47%	7%	46%	48%
		Chi-square (χ^2)	6.21*			4.25		
		Cramer's V	0.139			0.115		

Note. RPM = Relationship Problems and Maltreatment. MBD = Mental and Behavioral Disorder.

1. Regions are combined since there are no significant differences in performance across regions in the RPM present condition (see Table 2.4).

*p < .05.

Table 2.6

Accuracy of clinicians' diagnoses when RPM is present, by timing of training

Nb. correct responses		0	1	2
Timing of training	Training			
During professional training	Yes (*n* = 149)	7%	33%	60%
	No (*n* = 149)	9%	43%	48%
	Performance (χ^2)	4.88		
	Cramer's V	0.128		
Since completing professional training	Yes (*n* = 156)	6%	32%	62%
	No (*n* = 149)	9%	43%	48%
	Performance (χ^2)	6.55*		
	Cramer's V	0.147		
In the past five years	Yes (*n* = 151)	6%	32%	62%
	No (*n* = 149)	9%	43%	48%
	Performance (χ^2)	6.48*		
	Cramer's V	0.147		

*$p < .05$. Statistically significant with Benjamini-Hochberg correction.

Table 2.7

Accuracy of clinicians' diagnoses when RPM is present, by number of training components

Nb. of correct responses	0	1	2
Nb. of training components			
0 (*n* = 153)	9%	44%	47%
1 (*n* = 30)	17%	30%	53%
2 (*n* = 28)	8%	46%	46%
3 (*n* = 28)	4%	21%	75%
4 (*n* = 82)	6%	28%	66%
Performance (χ^2)	16.46*		
Cramer's V	0.226		

*$p < .05$. Statistically significant with Benjamini-Hochberg correction.

General Discussion

General Discussion

Rationale and Overview of Studies

This thesis reports on two studies aimed at understanding global mental health professionals' experiences of IPV-related training, including factors that are related to the likelihood of having received training, and relationships between training, self-reported knowledge of relationship problems, and diagnostic accuracy in the context of relationship problems. Research has shown that although individuals presenting for mental health services are more likely to experience IPV than the general population (Khalifeh & Dean, 2010; Trevillion et al., 2012), mental health professionals rarely assess for IPV in their regular practice (Forsdike et al., 2019; Nyame et al., 2013). Lack of training in how to identify and respond to IPV is a frequently identified barrier for assessment (Trevillion et al., 2016). Research, mostly led in high-income Western countries, suggests that approximately one-quarter to one-half of mental health professionals have never received IPV-related training (Campbell et al., 1999; Murray et al., 2016; Nyame et al., 2013). Furthermore, the content, frequency, and duration of training may vary widely, and clinicians in some studies report that the training they received did not meet their practical needs (Mason & O'Rinn, 2014; Trevillion et al., 2016).

To improve the health service response to IPV survivors, the WHO advanced a series of evidence-based recommendations for IPV-related training for health care providers (WHO, 2013[2]). These guidelines specify that training should be offered repeatedly and should comprise didactic instruction (i.e., basic information about IPV; information about local support services for survivors) and experiential training components (i.e., how and when to ask about IPV; how to respond to survivors; WHO, 2013[2]). There is a dearth of research exploring the degree to which global mental health professionals' IPV-related training experiences resemble these recommendations.

Furthermore, few studies have explored factors that contribute to the likelihood of obtaining training, and reasons for low rates of IPV-related training are not well understood. Relationships between individual-level factors (i.e., demographic and professional practice variables) and training have been investigated and showed that professional experience with IPV may promote training (Campbell et al., 1999). There are no previous studies of the relationship between societal-level factors (e.g., norms, legislation) and IPV-related training. However, a case study of the development of a national IPV health policy in Spain suggested that changes in legislation and policy that increased health professionals' awareness of IPV also promoted training (García-Moreno et al., 2015).

Study 1 sought to address gaps in the literature by surveying the IPV-related training experiences of 321 psychiatrists and psychologists across 24 middle- and high-income nations in Asia, Europe, and Latin America. Data were collected in the context of a larger internet-based field trial for the development of the eleventh revision of the WHO's ICD Mental and Behavioural Disorders chapter, comparing the use of ICD-10 and revised ICD-11 Relationship Problem and Maltreatment guidelines. The field trial was developed in English and later translated into French, Japanese and Spanish; The present thesis used data collected from translated versions of the study. In Study 1, individual- and societal-level factors that may be related to the likelihood of participating in IPV-related training were investigated to help identify elements that could promote clinicians' engagement in training. Furthermore, since training has been found to improve IPV-related knowledge and confidence (Campbell et al., 2001; Forsdike et al., 2019; Hamberger et al., 2004; Jayatilleke et al., 2015; Rose et al., 2011), Study 1 also aimed to explore the relationship between training and clinicians' subjective ratings of knowledge and experience related to relationship problems.

At present, there is mixed evidence for the effectiveness of IPV-related training for improving clinical practice (e.g., screening, identification, and documentation of IPV; Trevillion et al., 2016). Some studies suggest that IPV-related training that only provides basic didactic information about IPV is insufficient to change clinicians' assessment practices (Campbell et al., 2001; Waalen et al., 2000; Zaher et al., 2014). However, training that is multicomponent and experiential has been shown to increase IPV screening rates (Jayatilleke et al., 2015). Also, clinicians may benefit more from repeated training than a single training session (Buranosky et al., 2012), and from more hours of training compared to fewer (Forsdike et al., 2019). While such research appears to support WHO recommendations for IPV-related training (WHO, 2013[2]), there have been no studies specifically examining whether training that more closely resembles WHO recommendations is related to improved identification of IPV.

Study 2 aimed to address this issue by investigating relationships between WHO-recommended elements of IPV-related training and global mental health professionals' diagnostic accuracy in the context of relationship problems. Furthermore, in line with the goals of the larger revision of the ICD Mental and Behavioural Disorders chapter, Study 2 also sought to determine whether the provision of newer ICD-11 diagnostic guidelines for relationship problems and maltreatment (RPM) would improve performance over the use of ICD-10 RPM guidelines within our French-, Japanese-, and Spanish-speaking sample. It was expected that results would be concordant with findings from the English version of the RPM field trial, in that ICD-11 would outperform ICD-10 (Heyman et al., 2018).

Overall, this thesis had three primary objectives. The first major aim was to create a profile of global mental health professionals' IPV-related training experiences, based on WHO recommendations. The second major aim was to better understand individual- and societal-level

factors that may promote clinicians' engagement in IPV-related training. Finally, the third major aim was to determine whether IPV-related training was related to better performance (i.e., improved knowledge and experience of relationship problems, and improved identification of IPV) and specify recommendations for IPV-related training programs. This general discussion will provide an overview of study findings, discuss collective implications of the two thesis studies, and present limitations and directions for future research.

Study 1: Objectives, Hypotheses, and Findings

Study 1 represented the first cross-national survey of mental health professionals' IPV-related training experiences and provided a snapshot of global clinicians' training needs. Using a sample of psychiatrists and psychologists from 24 nations across three continents, it allowed the exploration of relationships between individual- (i.e., demographic and professional experience variables) and national societal-level variables (i.e., IPV-related variables including IPV laws, norms, and prevalence, and national income), and clinicians' likelihood of obtaining training. Based on existing literature, it was hypothesized that professional experience with IPV (i.e., greater frequency of encountering IPV in clinical practice) would be related to training. Although relationships between societal-level variables and IPV-related training had never been studied, it was also surmised that national IPV-related variables would be related to training, as these may affect clinicians' perceptions of IPV as a public health issue. Study 1 also served to investigate the relationship between IPV-related training and clinicians' subjective ratings of knowledge and experience with relationship problems, with the hypothesis that training would be related to greater knowledge and experience.

Findings showed that, consistent with previous research (Campbell et al., 1999; Dolunay-Cug et al., 2017; Nyame et al., 2013), rates of IPV-related training were low. Only slightly over

half of participants (53.6%) reported that they had ever received training. Among those with training, approximately half (49.4%) obtained training that was consistent with WHO recommendations (i.e., training that was repeated and contained four components: basic information on IPV, local resources for survivors, how and when to ask about IPV, and how to offer support; WHO, 2013[2]). Approximately one-third (33.8%) of clinicians who received training indicated that their training only included one or two WHO recommended components (most commonly basic information on IPV). Participants also reported a wide range of hours of training (most reporting between 20-40 hours), showcasing the diversity of IPV-related training experiences. Findings also supported our hypothesis that clinicians who encountered IPV more frequently in their practice and who lived in countries with better implemented IPV-related laws were more likely to have received IPV-related training than their peers. However, national IPV prevalence and norms were not related to the probability of participating in training. Furthermore, as seen in the literature (Forsdike et al., 2019; Jayatilleke et al., 2015; Rose et al., 2011), clinicians who received IPV-related training were more likely to report higher ratings of knowledge and experience of relationship problems. Overall, results highlight global challenges with regards to clinicians' participation in IPV-related training. They suggest that clinicians' likelihood of participating in training is related to their clinical contact with IPV and the institutional context in which they practice.

Study 2: Objectives, Hypotheses, and Findings

Study 2 represented a first effort to test IPV-related training guidelines advanced by the WHO (WHO, 2013[2]) using a global sample, with the goal of informing future recommendations for training. Specifically, we investigated relationships between training, including the degree to which training resembled WHO recommendations, and clinicians' diagnostic accuracy while

assessing a series of case-controlled vignettes depicting patients experiencing clinically significant and normative relationship problems. It was hypothesized that clinicians who received training, and whose training more closely resembled WHO recommendations, would be more likely than clinicians without training to accurately identify clinically significant relationship problems, including IPV, and distinguish them from normative relationship problems. Study 2 also provided the opportunity to examine relationships between clinicians' use of translated ICD Relationship Problem and Maltreatment (RPM) guidelines and diagnostic accuracy. It was expected that, concordant with Heyman et al. (2018)'s findings, clinicians who were assigned to use newer ICD-11 guidelines, compared to ICD-10, would be more likely to have accurate diagnoses.

Findings showed that clinicians who received IPV-related training were more likely than those without training to accurately identify clinically significant RPM. However, clinicians with and without training performed similarly poorly when the task was to identify that RPM was not present (i.e., normative relationship problems were described). Both groups tended to misclassify normative relationship problems as clinically significant RPM. Findings also showed that, consistent with our hypothesis and the research literature (Buranosky et al., 2012; WHO, 2013[2]), IPV-related training that more closely resembled WHO recommendations was related to improved identification of RPM. Specifically, clinicians who received training that was more recent (i.e., in-service training or training in the past 5 years) and whose training comprised at least three WHO-recommended components (including at least one experiential component) were more likely to accurately identify RPM than those without training. Clinicians whose training only included one or two components did not perform better than those without training. Also, the number of hours of training was not related to performance. Recency and breadth of

training were the most important elements for improving mental health professionals' assessment of IPV. Contrary to our hypothesis, the use of ICD-11 guidelines did not increase the likelihood of correctly identifying RPM, compared to ICD-10. Overall, findings suggest that IPV-related training is related to improved diagnostic accuracy in the context of relationship problems.

Collective Implications Across the Two Studies

Taken together, the studies included in this thesis underscore the importance of IPV-related training as a potential means of improving clinicians' knowledge and confidence in addressing IPV, as well as their identification of clinically significant relationship problems. Findings lend empirical support to WHO IPV-related training guidelines (WHO, 2013[2]) that may be used to inform the development of standardized training protocols for global clinicians. Furthermore, findings highlight worldwide IPV-related training gaps and help to clarify factors that could promote clinicians' engagement in IPV-related training. This may contribute to a better understanding of clinicians' reasons for participating in training and help to develop programs and initiatives that support training, with the goal of improving the mental health service response to IPV survivors.

Congruent with the research literature (Campbell et al., 2001; Connor et al., 2013; Forsdike et al., 2019; Jayatilleke et al., 2015; Mason et al., 2017; McColgan et al., 2010; Rose et al., 2011; Trevillion et al., 2016; Waalen et al., 2000; Zaher et al., 2014), IPV-related training was found to be related to greater knowledge and clinical experience with relationship problems. Improving clinicians' knowledge of relationship problems through training is important, as it may help to reduce perceived barriers for IPV assessment in clinical practice (Rose et al., 2011; Trevillion et al., 2016). Furthermore, training that was offered more recently, had greater breadth (i.e., contained at least three different training components), and comprised at least one

experiential training component was found to improve clinicians' identification of relationship problems. These results are congruent with WHO IPV-related training guidelines and previous findings showing that training is beneficial when it is repeated (Buranosky et al., 2012) and includes experiential skill-building exercises (Buranosky et al., 2012; Jayatilleke et al., 2015; Short et al., 2006).

Training that only included one or two training components, compared to none, was insufficient to improve the likelihood of correctly identifying IPV. This is concordant with research showing that IPV-related training that only includes basic information about IPV does not change clinical practice (Campbell et al., 2001; Coonrod et al., 2000; Waalen et al., 2000; Zaher et al., 2014) and highlights the need for more comprehensive IPV-related training for mental health professionals. Clinicians with and without training misclassified normative relationship problems as clinically significant RPM. This may have been a function of the study design since clinicians were asked to assess for relationship problems in a series of vignettes and may have been prone to over-identify RPM. The tendency of participants to select a diagnoses rather than no diagnosis for subthreshold case vignettes is consistent with what has been observed in other ICD field trials with similar demand characteristics (e.g., for Mood Disorders, Obsessive Compulsive and Related Disorders, and Anxiety and Fear-Related Disorders; Kogan et al., 2021; Kogan et al., 2020; Rebello et al., 2020). Bias toward assigning a diagnosis may also be explained by vignette attributes. Notably, vignettes depicting an absence of RPM were designed to portray relationship problems that met some but not all requirements for diagnosing an RPM. These vignettes were not created to depict normative relationship problems, but rather the absence of RPM. Thus, they may not have been representative of normal relationship problems that clinicians see in their regular practice. Nevertheless, it is plausible that clinicians'

errors in identifying the absence of RPM are indicative of a difficulty distinguishing between normative and clinically significant relationship problems, in which case guidelines for making this distinction may be included in IPV-related training programs. Regional differences in performance in identifying the absence of RPM may support the importance of including this distinction in training programs. Notably, Japanese clinicians, who had markedly lower rates of IPV-related training than clinicians from Europe or South America, were significantly more likely than participants from other countries to correctly identify that RPM was absent. While this result may be explained by certain cultural factors (e.g., cultural differences in clinical decision-making (Nisbett et al., 2001) or perceptions of IPV (Nagae & Dancy, 2010)), it is also possible that participating in IPV-related training may sensitize clinicians to relationship problems and contribute to lower thresholds for detection of IPV. To avoid overdiagnosis as a potential unintended consequence of training, it would be important for training programs to emphasize differences between normal and clinically significant relationship problems.

This research was conducted in the context of the larger revision of RPM guidelines for the Mental and Behavioural Disorders chapter of the WHO's ICD-11. As part of this process, French-, Japanese-, and Spanish-speaking clinicians' diagnostic accuracy while using ICD-11 *vs* ICD-10 guidelines was compared. It was expected that, concordant with results of the English version of the RPM field trial (Heyman et al., 2018), clinicians who used ICD-11 guidelines would outperform those who used ICD-10. Contrary to our hypothesis, however, there was no relationship between ICD guidelines and diagnostic accuracy. This may be related to problems with translated versions of the ICD-11 guidelines, though review of these guidelines falls beyond the scope of this thesis. It is also possible that ICD guidelines do not provide clinicians with sufficient guidance to make accurate distinctions between different forms of IPV and relationship

problems. Notably, Heyman et al. (2018) considered participants to have responded correctly if they selected any RPM, regardless of whether it was the one described in the vignette. However, in our research, participants were required to select the specific RPM described in the vignette. Findings from these studies suggest that ICD-11 RPM guidelines may help clinicians identify when RPM is present, but do not help to distinguish between different forms of RPM. IPV-related training, alongside the use of RPM guidelines, may be required to increase mental health providers' diagnostic accuracy in the context of relationship problems.

Given the apparent usefulness of IPV-related training for improving mental health professionals' assessment of IPV, it is concerning that nearly half of the global clinicians in our sample had never received this form of training. This suggests that the IPV-related training gap reported in previous localized studies (i.e., USA, Campbell et al., 1999; Turkey, Dolunay-Cug et al., 2017; USA, Murray et al., 2016; UK, Nyame et al., 2013) is a worldwide problem. Furthermore, among participants who received training, only two-thirds (66%; 36% of total sample) reported that their training contained at least three WHO-recommended components; the number that was found to be related to improved diagnostic accuracy in this thesis. Thus, for a significant proportion of clinicians, the IPV-related training that they received may not have been sufficient to improve their identification of IPV. These results support the need for greater efforts to implement evidence-based IPV-related training programs across the globe.

A step towards developing programs and initiatives that support IPV-related training is to gain a better understanding of factors that may promote mental health providers' engagement in training. To date, few studies have sought to investigate factors that are related to the likelihood of participating in IPV-related training. Campbell et al. (1999) showed that training was related to professional experience with IPV (e.g., self-reported expertise in working with survivors of

violence). In line with these results, we found that participants who reported encountering IPV more frequently in their practice were more likely to have received IPV-related training. It appears that the perceived clinical relevance of IPV may be important for training. Notably, it is possible that clinicians who work with IPV survivors may be more aware of the relationships between IPV and mental health outcomes, which could incentivize them to seek out training to support their patients. Alternatively, it is also possible that these clinicians work in settings that specialize in treating family violence, which could have policies that promote IPV-related training. Payne et al. (2007) found that social workers who were employed by agencies with IPV-related training policies were significantly more likely to have received this form of training than their peers. Since IPV is prevalent across mental health settings (Oram et al., 2013; Trevillion et al., 2012), it would be beneficial for all professional training programs and workplaces to emphasize the public health importance of identifying IPV in mental health care, to promote training.

IPV-related training was also found to be related to the level of implementation of IPV-related laws. Participants who practiced in countries with relatively better implemented IPV legislation were more likely to have received training than clinicians from nations with less well-implemented laws. This suggests that societal context (e.g., sociopolitical will to address IPV by drafting and implementing IPV legislation) may influence mental health professionals' behaviors with regards to IPV. Some research has shown that the perception of IPV as a private family matter, rather than a public health issue, is a barrier for IPV screening (Colombini et al., 2013; Ribeiro, 2014). Sociopolitical efforts to address IPV may legitimize partner violence as a public health problem and increase clinicians' engagement in efforts to address IPV in their practice (e.g., by pursuing training). The implementation of IPV legislation may also contribute to

changes in institutional policies with regards to IPV. A Spanish case study showed that introducing legislation related to violence against women led to the development of healthcare policies that promoted IPV-related training (García-Moreno et al., 2015). It is possible that educational and healthcare organizations that operate in nations with better implemented IPV legislation are more likely to develop policies related to IPV-related training and offer this training to students and employees. Overall, societal endeavors that may increase the perceived public health importance of addressing IPV could influence institutions' decision to offer IPV-related training, and individuals' choice to pursue it.

In sum, findings from this thesis suggest that IPV-related training is important for improving mental health professionals' knowledge of IPV and IPV identification. Recommendations for training include that IPV-related training should be multicomponent, offered periodically, and comprise at least one experiential training component, as well as guidance on distinguishing between normative relationship problems and IPV. Results also suggest that global mental health professionals are unprepared to address IPV. Most participants reported that they had either never received training, or that their training only included one or two components, which was found to be insufficient to improve accurate identification of IPV. To address this training gap, institutions and organizations may need to develop policies and legislation that promote training and increase mental health professionals' personal recognition of IPV as a serious public health problem.

Limitations and Directions for Future Research

This research had several limitations. Notably, a convenience sample was used, whereby participants were clinicians who volunteered to be members of the WHO's Global Clinical Practice Network (GCPN) and who agreed to participate in an online field trial for the revision of

the ICD-11 Relationship Problem and Maltreatment (RPM) guidelines. Only 10% of GCPN members who were sent an invitation completed the survey. Although online surveys have a lower response rate than paper questionnaires when used with medical professionals (Aitken et al., 2008; Hollowell et al., 2000; McMahon et al., 2003), it was necessary to use an internet-based approach to increase the global reach of the study. As a result, participants may have represented a self-selected group of clinicians who agreed to participate since they had expertise with relationship problems and maltreatment, and therefore may have been more likely to have experience assessing for IPV, or participating in IPV-related training, than the general population of mental health professionals. While it is likely that our sample has an overrepresentation of individuals with skills in addressing IPV, it is interesting that rates of participation in IPV-related training are low, suggesting that even amongst those most likely to be exposed to training or to possess relevant skills, there may be a need for greater efforts to increase the perceived relevance of training, or its accessibility, to improve patient care. Furthermore, the sample was composed of psychologists and psychiatrists only, from high-income (64.2%), upper-middle income (34.3%), and lower-middle income (1.5%) countries. Other mental health professionals (e.g., counselors, psychotherapists, social workers, etc.) were not included, and there were no participants from low-income countries. Data for this research were collected in French, Japanese, and Spanish, and all participants were from Europe (35.2%), Japan (27.7%), or Latin America (37.1%). There were no participants from English-speaking countries. Thus, while this set of studies was far more inclusive, in terms of population reached, than previous research, findings may not be representative of the larger population of global mental health professionals.

Self-report data was used to record participants' IPV-related training experiences, their level of knowledge and experience with relationship problems, and the frequency with which

they used RPM diagnostic categories in their regular practice. Self-report data is susceptible to response bias (McGrath et al., 2010). For example, participants may have misremembered the content, timing, or duration of their IPV-related training. They might also have tried to respond in a socially desirable way by inflating their responses (e.g., endorsing greater knowledge and experience of relationship problems, or more frequent use of RPM categories). Future research may correct for these issues by using data collected from objective sources (e.g., training course outlines, patient records). A proxy variable (i.e., the frequency with which participants used ICD or DSM IPV-related categories) was used to evaluate the frequency with which participants encountered IPV in their regular practice. It was assumed that clinicians who used RPM codes more regularly were more likely to encounter IPV. However, research suggests that clinicians do not always document IPV (Howard et al., 2010; Trevillion et al., 2016). Therefore, this variable may better represent clinicians' likelihood of using classification codes for IPV, rather than the frequency with which they see IPV in their practice. Participants' experiences of IPV-related training were also observed rather than experimentally manipulated. Notably, clinicians were asked to select IPV-related training components from a drop-down list based on WHO recommendations for training. It is possible that participants' experiences of IPV-related training included elements that were not captured in our survey. Furthermore, since participants could select more than one component from the list, responses were not independent, and it was not possible to compare between training components to identify which were more strongly related to accuracy. Future research may correct for this by providing untrained clinicians with IPV-related training that isolates WHO-recommended components and comparing the effectiveness of components.

Variables describing country context with regards to IPV (i.e., national IPV prevalence, norms, and laws) were drawn from the Organization for Economic Cooperation and Development (OECD) Centre's Gender, Institutions and Development (GID) Database (2019). These variables provided a useful snapshot of societal factors related to IPV; however, they also had several limitations. First, national measures used in this research may not be representative of the IPV prevalence, norms, and level of implementation of IPV-related laws in participants' regions of practice. Participants living in rural vs urban areas within a same country may differ significantly on these variables. For example, a multi-country study on violence against women found that IPV was more prevalent in rural settings, and that women living in rural areas were more accepting of violence than women living in urban regions (WHO, 2005). Thus, whereas national variables can approximate the IPV-related context in which clinicians operate, it is possible that regional differences on these variables could affect clinicians' behaviors in ways that were not measured in this research. Second, measures of IPV prevalence and norms were limited by their narrow definitions. IPV prevalence was defined as the percentage of women who reported that they had ever experienced physical or sexual violence perpetrated by a male partner. This definition does not capture other forms of IPV including psychological violence, IPV perpetrated by women towards men, or IPV within LGBTQ+ relationships. Thus, prevalence rates were likely under representative of the actual frequency of IPV within the population. Moreover, IPV norms were defined as the percentage of women aged 15-49 who reported that it was acceptable for a man to use physical violence against his partner under certain circumstances (e.g., if she argues with him or goes out without telling him). This variable does not describe norms related to other forms of IPV and may not be representative of the perceived acceptability of partner violence in the general population (including men and older

women), or amongst the clinicians within our sample. Also, since social norms are dynamic constructs that evolve over time (Mackie et al., 2015), it is possible that the norms used in our study were not representative of actual attitudes towards IPV at the time of our research. Finally, there were no participants from nations where there was no legal framework against IPV; differences only existed between the level of implementation of IPV legislation. This suggests that efforts to create and enforce international legal standards for addressing violence against women and domestic violence are successful (Minnesota Advocates for Human Rights, 2003). However, it also signifies that there remain no data on the IPV-related training experiences of clinicians who practice in countries where laws against IPV do not exist.

A goal of this research was to better understand factors that are related to mental health professionals' likelihood of participating in IPV-related training. However, we did not assess whether training was voluntary or mandatory, nor did we directly ask participants about their reasons for obtaining training. Thus, while findings show that the frequency of encountering IPV in clinical practice and the level of implementation of IPV legislation are related to training, it is unclear how these variables may contribute to the likelihood of obtaining training. We hypothesized that these factors may increase the perceived public health importance of addressing IPV, however further research is required to investigate potential mediating variables between IPV-related training and factors significantly related to training in this thesis.

This research used a vignette-based methodology. The use of vignettes is supported as a valid and reliable method for assessing clinical performance (Evans et al., 2015). However, vignettes are brief and do not replicate all the conditions of real-world practice that may affect assessment performance. For example, in actual practice, clinicians may wish to collect additional information to inform diagnosis; they may also encounter certain personal or systemic

barriers for IPV assessment that are not present in a vignette-based study (e.g., discomfort asking about IPV, lack of time to inquire; Sprague et al., 2012; Waalen et al., 2000). As a result, this research can only approximate actual clinical practice. Vignettes also depicted relatively mild forms of RPM that met minimal detection thresholds for ICD-11 RPM categories (i.e., relationship distress, psychological abuse, and physical violence; Heyman et al., 2018). RPM that are less prevalent (i.e., sexual partner violence and partner neglect) were not included due to concerns about survey length and since these forms of violence are easier to detect when described in a vignette. Thus, only instances of situational couple violence were portrayed in vignettes (i.e., violence that resulted from situational conflicts and was not embedded in a more general pattern of control; Johnson, 1995). There were no vignettes depicting intimate terrorism (i.e., violence with the goal of controlling one's partner; Johnson, 1995). Consequently, this research helps to understand relationships between IPV-related training and clinicians' assessment of milder forms of RPM, however results may not be representative of clinicians' performance in the context of more severe IPV (e.g., intimate terrorism or sexual violence). Furthermore, vignettes used to depict normative relationship problems were developed to present subthreshold RPM (i.e., relationship problems that met some but not all of the definitional requirements for RPM), and were not based on evidence-based definitions of normal relationship problems. Thus, these vignettes may not have been representative of patients presenting with normal relationship problems in clinical practice. Finally, vignettes only depicted male or female individuals in heterosexual relationships, and information on cultural and religious background was omitted. This was done to mitigate for factors that may introduce bias while evaluating vignettes (e.g., prejudice towards certain cultural groups). However, this limited the

generalizability of results. Future research in natural settings with culturally diverse patients is required to improve the ecological validity of our findings.

Vignettes depicted male and female individuals who were experiencing clinically significant or normative relationship problems. All participants were shown two vignettes of each gender. Dependent variables for chi-square analyses were composite scores of participants' performance (i.e., diagnostic accuracy) across two vignettes in the RPM present or RPM absent conditions. Given that composite scores often included both a male and female vignette, differences in performance by patient gender were not investigated. Some studies have shown that men presenting for health services are less likely to be screened for IPV than women (Chang et al., 2011; Machado et al., 2017). Future research exploring differences in clinicians' practices (e.g., screening and identification of IPV) with gender diverse patients before and after IPV-related training would be useful to understand whether and how training may help to mitigate for this bias.

This research used a cross-national sample of clinicians from three global regions (i.e., Asia [Japan], Europe, and Latin America). However, world region was not included as a potential predictor of the likelihood of participating in IPV-related training. Region was omitted due to multicollinearity with other key variables that were expected to be related to training (i.e., IPV prevalence, norms, and laws). We selected to omit region, rather than other variables, since it lacked explanatory power; notably, various factors (e.g., cultural, economic, political) could contribute to regional differences in IPV-related training. Our research explored a few of these potential factors, however it is possible that there are other unexplored cultural variables that are related to IPV-related training. For example, research has shown that individuals who live in more patriarchal societies tend to exhibit more lenient attitudes towards men who are violent

towards their female partners (Dobash & Dobash, 1979; Haj-Yahia, 2002). Patients in these regions are less likely to report IPV to health professionals (Nagae & Dancy, 2010; Weingourt et al., 2001) and clinicians may not feel responsible for addressing IPV (Haj-Yahia, 2010; Haj-Yahia et al., 2015). These factors could contribute to lower rates of IPV-related training. While our research is the first to show that there is a relationship between societal-level factors and mental health professionals' engagement in IPV-related training, future research should expand on these findings by investigating other social, political, or cultural factors (e.g., gender norms) that may influence clinicians' participation in training.

Conclusion

In summary, thesis findings promote the use of IPV-related training for improving the mental health service response to IPV. Clinicians who received IPV-related training were more likely to report greater ratings of knowledge and experience with relationship problems, and improved identification of IPV. Identifying IPV in mental health practice is important since this can lead to referrals to appropriate care pathways (e.g., CBT or advocacy-based interventions; Frueh et al., 2009; Johnson et al., 2011; Johnson & Zlotnick, 2006; Sullivan & Bybee, 1999). Thesis results also highlighted a global training gap with regards to IPV-related training and provided potential avenues for increasing mental health practitioners' engagement in training, such as increasing sociopolitical efforts to address IPV and improving clinicians' awareness of IPV as a public health problem. Furthermore, findings supported WHO recommendations for IPV-related training (WHO, 2013[2]) and may be used to inform the development of IPV-related training programs across the globe. Overall, this thesis filled an important gap in the literature by investigating, for the first time, global mental health professionals' experiences of IPV-related training. Its insights may be used to identify avenues for further research on this topic, including

using WHO recommendations to develop IPV-related training trials with mental health professionals in naturalistic settings; Or, exploring the feasibility of implementing IPV-related training in professional training curricula or as part of in-service training across work settings and global regions.

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Appendix A

Email Invitation to Participants – English Version

RE: Invitation to Participate in an ICD-11 Internet-Based Field Study: Relationship Problems and Maltreatment

Dear ${m://FirstName} ${m://LastName}: We are pleased to invite you to participate in an Internet-Based Field Study for ICD-11 Mental and Behavioural Disorders. This particular study will focus on Relationship Problems and Maltreatment.

You are receiving this message because you are registered as a member of the World Health Organization's (WHO) Global Clinical Practice Network (GCPN), an international community of mental health and primary care professionals committed to furthering research and practice in global mental health. These studies will allow practicing health professionals to influence the development of the ICD-11 to help make it more clinically useful in global mental health and primary care settings. We are inviting you to participate in this study in English based on the responses you have provided about the languages you use in your professional life, and in which you are proficient. We anticipate that this particular study will also be conducted in French, Japanese, and Spanish. If you would prefer to participate in this study and future studies in one of these other languages, please DO NOT click on the survey link below, but rather contact me at gcpn@who.int and tell me which language you would prefer. If you are willing to participate in this study, please follow your individualized survey link below to read the informed consent statement and participate. Note that this link is unique to you and that it will expire after it is used, so please do not forward it to anyone else. You have been invited to participate in this study because you represent a part of the global community of mental health practitioners. Therefore, we ask that you participate in the study even if you do not feel that you have specific expertise in the topic of the study. We expect that this study will take approximately 45 minutes on average, but please allow up to one hour to ensure that you have time to complete the study. In addition, it is recommended that you do not attempt to participate in this study using a smartphone given the extent of the study material.

Follow this link to ${l://SurveyLink?d=participate in the study}. Or copy and paste the URL below into your internet browser: ${l://SurveyURL}

For the purposes of these studies, it is important to keep our GCPN member data as up-to-date as possible. If your contact information, institutional affiliations, or professional duties have changed since you initially registered for the GCPN, please contact me at gcpn@who.int to update your information.

We hope that you will participate in this study even if you do not feel that you have specific expertise in the topic. Your participation is important because the ICD-11 classification must be useful for both experts and non-experts in any particular area. However, if you would not like to

participate in this study but want to continue to participate in the GCPN and to receive invitations for studies on other topics, please click ${l://OptOutLink?d=here}.

If you have any questions or comments about the ICD-11 development process, if you have received this message by mistake, or if you want to be removed from the GCPN, please contact me at gcpn@who.int. Be sure to include your name and the email address at which you received the study invitation.

Thank you for your continued contributions to this important endeavor.

Kind regards,

Tahilia Rebello, PhD
Project Coordinator
Global Clinical Practice Network
Department of Mental Health and Substance Abuse
World Health Organization

Appendix B

Global Clinical Practice Network (GCPN) Registration Survey

Participant information:

Last (family) name:

First (given) name:

Institution:

Department:

Professional Address:

(Address line 2):

City:

Postal Code:

State / Province:

Email Address for Global Clinical Practice Network correspondence:

Country of residence:

Confirm Email Address:
(Please make sure that the email address you enter here is the same as the one you entered on the previous page.)

Gender:

○ Male

○ Female

Year of birth:

What languages do you most frequently use in your professional life?

Primary ☐

Secondary ☐

In which of the following languages are you proficient? For example, you have sufficient ability to be able to read and respond to a questionnaire like this one in that language. (Check all that apply.)

☐ Arabic	☐ English	☐ French	☐ Russian
☐ Chinese	☐ Portuguese	☐ German	☐ Spanish

Some field studies will be conducted in English. Please indicate your level of proficiency in English:

Low	Intermediate	Advanced	Completely Fluent
○	○	○	○

What is your clinical profession?

○ Medicine -- Specialty: ☐

○ Psychology -- Specialty: ☐

○ Nursing -- Specialty: ☐

○ Counseling

○ Social Work

○ Other (please specify): ☐

Which of the following describes your highest educational attainment?

- Pre-university
- University degree
- Medical Degree
- Post-graduate degree (e.g., medical specialty, master's degree, doctoral degree). Please specify: ______

How many years of formal professional training have you had, not including the university degree? (Note that we are referring only to years of formal training, not to years of experience. Formal training includes post-university graduate education, professional and specialty training such as internships, residencies, and postdoctoral fellowships, but does not include routine continuing professional education.)

As part of your professional training (academic and clinical), which of the following diagnostic systems for mental and behavioural disorders were you trained to use? (Check all that apply.)

- ICD-10
- ICD-9
- ICD-8
- Other; Please specify: ______
- DSM-IV
- DSM-III-R
- DSM-III
- None

Years of professional experience in your field (after completing your formal training):

What are your primary work settings at the present time? By primary work setting, we mean one where you work for about five hours or more per week. (Check all that apply.)

- ☐ General primary care setting
- ☐ Other general medical setting (including university medical center, medical school)
- ☐ Mental health services setting (including university-based facility, hospital department, outpatient clinic)
- ☐ Substance abuse specialty program
- ☐ Private clinical practice (solo or group)
- ☐ University (not in medical, mental health, or substance abuse treatment setting)
- ☐ Public health administration or government agency
- ☐ Non-governmental organization (NGO)
- ☐ Other (specify): ______
- ☐ Other (specify): ______
- ☐ Retired

Do you currently see patients as part of your regular professional activities?

- ○ Yes
- ○ No

Please indicate which of the following types of mental health services you personally provide to patients as part of your regular professional activities. (Check all that apply.)

- ☐ Diagnostic assessment of mental and behavioural disorders
- ☐ Evaluation and management of psychoactive medications
- ☐ Psychological assessment (e.g., neuropsychological evaluation, personality testing, etc.)
- ☐ Psychological (talk) therapy
- ☐ Psychoeducation
- ☐ Other (specify): [ ]
- ☐ None

Do you directly supervise the provision of health services by others? (By direct supervision, we mean that you monitor the services provided through such mechanisms as face-to-face supervision, case conferences, chart review, and that you are directly accountable for the quality of the clinical services that they provide.)

- ○ Yes
- ○ No

How many people do you supervise directly in their provision of health services?

Number of people: [ ]

Please indicate which of the following types of mental health services are provided by the people that you supervise. (Check all that apply.)

- ☐ Diagnostic assessment of mental and behavioural disorders
- ☐ Evaluation and management of psychoactive medications
- ☐ Psychological assessment (e.g., neuropsychological evaluation, personality testing, etc.)
- ☐ Psychological (talk) therapy
- ☐ Psychoeducation
- ☐ Other (specify): [ ]
- ☐ None

During a typical week, in what types of settings do you provide or supervise health services? (Check all that apply.)

Mental health services settings

- ☐ Inpatient
- ☐ Outpatient
- ☐ Residential
- ☐ Partial hospitalization
- ☐ Group private practice
- ☐ Individual private practice

Substance abuse specialty program

- ☐ Inpatient
- ☐ Outpatient
- ☐ Residential
- ☐ Partial hospitalization

General medical settings

- ☐ Hospital or other inpatient facility
- ☐ Outpatient specialty clinic
- ☐ Outpatient primary care
- ☐ Group private practice
- ☐ Individual private practice

Other settings

- ☐ Prison, jail, or other detention center
- ☐ Community-based mental health program, community or street outreach
- ☐ School-based program
- ☐ University / college mental health / counseling center
- ☐ Other (specify): [ ]

In what type of community are the service settings where you provide or supervise health services located? (If you provide services in more than one setting, check all that apply.)

- ▢Major urban center
- ▢Smaller city or town
- ▢Suburb of a major urban center
- ▢Village
- ▢Mid-size city
- ▢Rural setting

For the health services that you provide or supervise, what are the percentages in each patient age group? (Percentages should total 100.)

Children (0-12):	0	%
Adolescents (13-18):	0	%
Adults (18-65):	0	%
Elderly (65 and over):	0	%
Total	0	%

Who is most often responsible for assigning a psychiatric diagnosis to the patients whose services you provide or supervise?

- ○ I or someone under my direct supervision usually assigns the diagnosis.
- ○ Another health professional not under my supervision usually assigns the diagnosis (e.g., an attending physician).
- ○ Diagnoses are usually assigned by medical records coders.
- ○ Psychiatric diagnoses are usually not assigned.
- ○ Other (specify):

Please indicate how regularly you use the following classification systems in your clinical practice and/or supervision:

	Routinely	Often	Sometimes	Rarely	Never
ICD-10	○	○	○	○	○
ICD-9 or ICD-9-CM	○	○	○	○	○
DSM-IV or DSM-IV-TR	○	○	○	○	○
Other (specify):	○	○	○	○	○
Other (specify):	○	○	○	○	○

Do you have administrative responsibility for one or more service units that provide mental health services, even if you do not personally provide direct clinical care or supervision?

○ Yes

○ No

How many people provide mental health services in the units for which you have responsibility?

Number of people:

During a typical week, how many hours do you devote to each of the following professional activities?

0 Providing direct mental health services to patients (e.g., assessment, psychological or behavioural therapies, medication management)

0 Providing other health care services (not mental health)

0 Supervision of health services provided by others

0 Teaching

0 Research

0 Administration

0 Other (specify):

0 Other (specify):

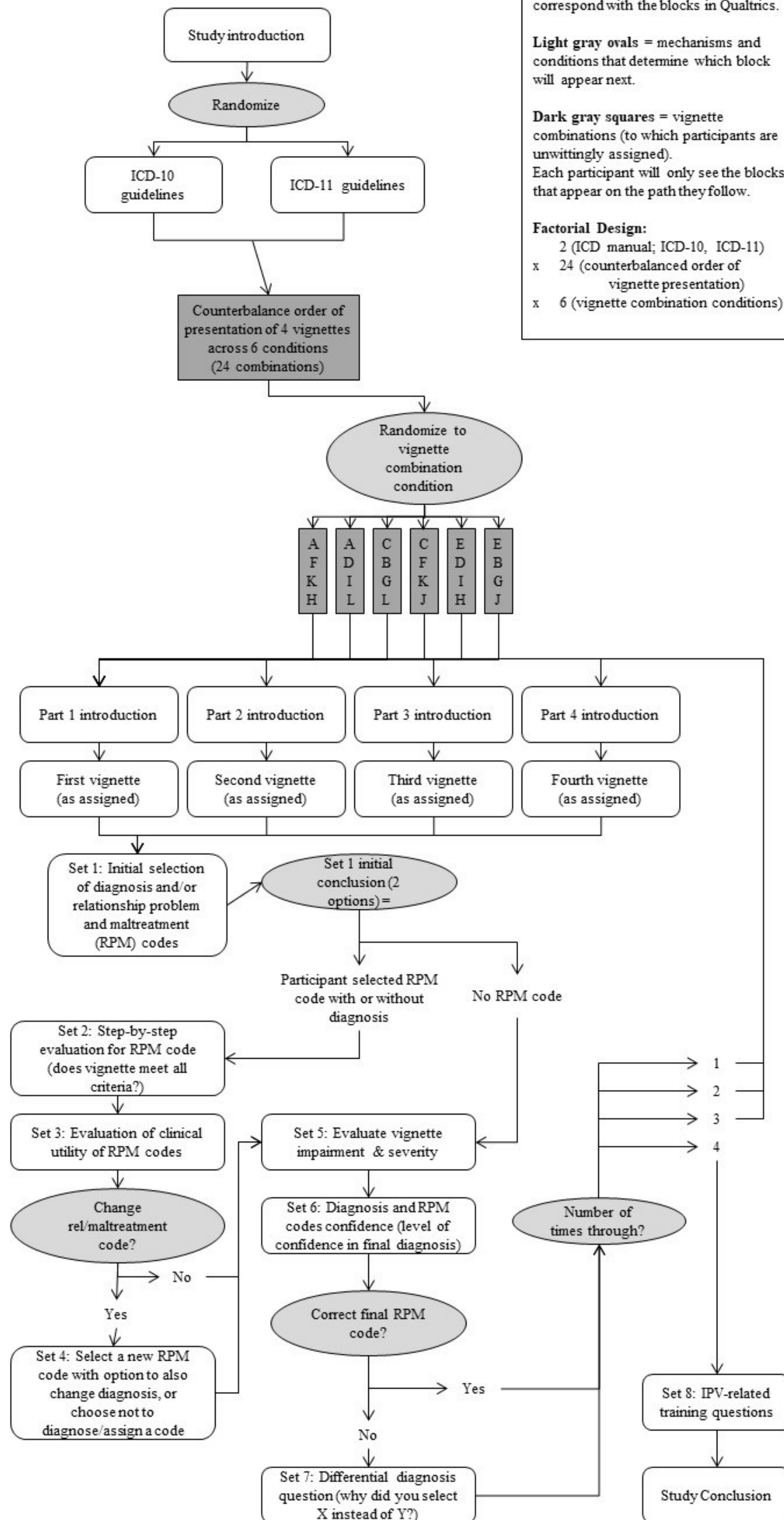
Please select up to three areas related to the ICD-10 Mental and Behavioural disorders in which you have the most knowledge and experience.

- ▢ Dementia, Delirium, and Related Disorders
- ▢ Substance-Related Disorders and Behavioural Addictions
- ▢ Schizophrenia and Related Disorders
- ▢ Mood Disorders
- ▢ Anxiety Disorders
- ▢ Stress-Related Disorders
- ▢ Obsessive-Compulsive and Related Disorders
- ▢ Somatoform Disorders
- ▢ Eating Disorders
- ▢ Sleep Disorders
- ▢ Sexual Disorders
- ▢ Personality Disorders
- ▢ Intellectual Disabilities
- ▢ Autism Spectrum Disorders
- ▢ Attention Deficit and Conduct Disorders
- ▢ Epidemiology
- ▢ Public Health
- ▢ Neuroscience
- ▢ Other (specify): ______
- ▢ Other (specify): ______

Please provide any additional comments about your work settings, interests or expertise that you feel have not been adequately addressed in this questionnaire:

Appendix C

ICD-11 Relationship Problem and Maltreatment Internet Field Trial Flowchart



Appendix D

Sample vignette (Spouse or Partner Violence, Physical and Single Episode Depressive Disorder)

Referral

CI is a 27-year-old woman who voluntarily referred herself to outpatient treatment because her "life is a mess." She works as a schoolteacher for young children.

Presenting Symptoms

CI sought treatment because for most of the past month she has felt "empty," like she is "going through the motions of life without living it." She also states that during this same period her sleep has been "terrible," given that she "normally gets, and needs, a solid 8 hours." She says that it now takes up to an hour for her to fall asleep and she ends up getting only about 5 or 6 hours of sleep a night. CI notes that although her lesson plans at work are not all that complicated, since she teaches 5-year-olds, she frequently loses her train of thought and has trouble focusing on what the children's needs are. She reports being tired all of the time, which is apparent to the interviewer who notes dark circles under CI's eyes. When asked about similar episodes in the past, she reports that she felt "very sad" for the first month after her mother died 6 years ago, but that she has never felt this bad or this same way before.

CI lives with a 26-year-old male partner. She reports being generally satisfied with the relationship, though it has its "ups and downs." She said that their arguments have gotten physical "a few times" in the past year, but "nothing more than him pushing me out of the way to leave the room or me grabbing him to try to keep him there." She said that the last time this happened (about 3 weeks ago), they were arguing in the kitchen. He tried to leave the room and she blocked his exit. He shoved her aside and her hip hit the side of the counter, leaving a bruise. When he noticed the bruise several days later, he asked how she got it. When she told him that he had done it, he apologized for hurting her but also said, "Next time, don't get in my way when I'm trying to cool off." She denied being at all fearful of him (or him being fearful of her). She reports that her true fear is that he will break up with her, stating that, "Sooner or later he will probably realize that I'm not worth staying with." CI says that many of her friends are getting married and having children, and she fears that her "dreams are slipping away."

CI also reports being quite stressed by conflict with the principal at her school.

Additional Background Information

CI was referred to a family physician for a general physical examination, which revealed her to be in good physical health. She also denied current use of alcohol, adding that she used to drink a glass of wine each evening but stopped 2 years ago because she thought it might make her more short-tempered with the children in her care at work.

Appendix E

ICD Guidelines and Descriptions

PROPOSED ICD-11 RELATIONSHIP PROBLEM AND MALTREATMENT GUIDELINES

Relationship problems and maltreatment include the following:

I. Problems in relationship with current or former spouse or partner (K)

K1 Relationship Distress with Spouse or Intimate Partner
K2 Spouse or Partner Violence, Physical
K3 Spouse or Partner Abuse, Psychological
K4 Spouse or Partner Violence, Sexual
K5 Spouse or Partner Neglect

II. Problems in relationship between child and current or former caregiver (L)

L1 Caregiver-Child Relationship Problem
L2 Child Physical Abuse
L3 Child Psychological Abuse
L4 Child Sexual Abuse
L5 Child Neglect

I. PROBLEMS IN RELATIONSHIP WITH CURRENT OR FORMER SPOUSE OR PARTNER (K)

K1 Relationship Distress with Spouse or Intimate Partner

Definition:

Substantial and sustained dissatisfaction with a spouse or intimate partner associated with significant disturbance in functioning.

Essential (Required) Features:

- Substantial and sustained dissatisfaction with the intimate relationship (for example, pervasive unhappiness with the relationship, significant thoughts of divorce/separation).
- Dissatisfaction is associated with disturbance in at least one major area of functioning such as:
    - Behaviour (for example, persistent and intense conflicts, pervasive withdrawal or neglect, lack of positive behaviours)
    - Cognition (for example, pervasive negative attributions of partner's intent)
    - Emotion (for example, persistent and intense anger, sadness, or apathy)
    - Physical health (for example, medically unexplained pain and other physical symptoms)

    - Interpersonal interaction (for example, social isolation, decreased involvement in social activities)
    - Major life role activities (for example, work, school, caregiving).

K2 Spouse or Partner Violence, Physical

Definition:

Non-accidental acts of physical force that result, or have reasonable potential to result, in physical harm to an intimate partner or that evoke significant fear in the partner.

Essential (Required) Features:

- At least one non-accidental act of physical force (for example, push/shove, scratch, slap, throw something that could hurt, punch, bite).
- Act causes (or exacerbates) at least one of the following:
    - Any physical injury
    - Significant fear
    - Reasonable potential for significant physical injury
- Act was not for physical protection of self (e.g., to ward off partner's punches) or partner (e.g., prevent partner from attempting suicide).

K3 Spouse or Partner Abuse, Psychological

Definition:

Non-accidental verbal or symbolic acts that result in significant psychological harm to an intimate partner.

Essential (Required) Features:

- Verbal or symbolic acts with the potential to cause psychological harm to the victim, for example:
    - Berating, disparaging, degrading, humiliating partner
    - Interrogating partner
    - Restricting partner's ability to come and go freely
    - Obstructing partner's access to assistance (example: police aid, legal help, protective resources, medical resources, mental health resources)
    - Threatening partner
    - Harming, or threatening to harm, people/things that partner cares about
    - Restricting partner's access to or use of economic resources
    - Isolating partner from family, friends, or social support resources
    - Stalking partner
    - Trying to make people think that s/he is crazy (or make others think that partner is crazy)
- Acts cause (or exacerbate) at least one of the following:

  - Significant fear
  - Significant psychological distress
  - Somatic symptoms that interfere with normal functioning
  - Significant self-imposed restrictions in engaging in one or more major life activities (e.g., work, education, religion, medical or mental services, contact with family members) in an attempt to avoid the recurrence of the act.

K4 Spouse or Partner Violence, Sexual

Definition:

Forced or coerced sexual acts with an intimate partner or sexual acts with an intimate partner who is unable to consent.

Essential (Required) Features:

- At least one of the following acts:
  - The use of physical force to compel participation in a sex act against the partner's will or when partner is incapable of consent (whether or not the act is completed)
  - The use of physical or emotional aggression to coerce the partner to participate in a sex act
  - Physical contact of a sexual nature (for example, kissing, fondling) that is against the expressed wishes of the partner and that causes considerable distress to the partner.

K5 Spouse or Partner Neglect

Definition:

Egregious acts or omissions that result in physical harm to a spouse or intimate partner who is incapable of self-care.

Essential (Required) Features:

- At least one egregious act or omission by an adult's caregiver that deprives an intimate partner who is incapable of self-care of needed or adequate food, shelter, hygiene, or necessary services. Examples of self-care incapacity include physical, psychological/intellectual, and cultural (inability to manage activities of rudimentary daily living due to foreign culture) limitations.
- Act or omission causes significant physical injury or reasonable potential for significant injury.

II. PROBLEMS IN RELATIONSHIP BETWEEN CHILD AND CURRENT OR FORMER CAREGIVER (L)

L1 Caregiver-Child Relationship Problem

Definition:

Substantial and sustained dissatisfaction within a caregiver-child relationship associated with significant disturbance in functioning.

Note: This disorder should be considered only within the child's primary caregiving relationships, which may include relationships with parents, grandparents, or other significant long term caregivers. The specific dyad should be identified.

Essential (Required) Features:

- Caregiver-child relationship dissatisfaction or distress occurs more days than not during the past month. Examples:
    - Pervasive sense of unhappiness with the relationship by either caregiver or child
    - For child, thoughts of running away or fantasies of having another caregiver
    - For caregiver, wishing child were totally different or not born, or thoughts of relinquishing care of the child
    - Parental alienation, that is, the child allies himself strongly with one parent (the preferred parent) and rejects a relationship with the other parent (the alienated parent) without cause. Parental alienation usually occurs in the context of high-conflict separation or divorce.
- Considering the developmental needs of the child and the socio-cultural context, dissatisfaction is associated with disturbance in at least two major areas of functioning:
    - Behaviour (for example, persistent and intense conflicts, pervasive withdrawal or neglect, lack of positive behaviours, failure to socialize child through nonexistent or poorly enforced limits, poor monitoring of child's activities and child concealment of activities, over-involvement in child's activities, child's persistent rejection, denigration, and criticism of the alienated parent without cause)
    - Cognition (for example, pervasive negative attributions of caregiver or child intent)
    - Emotion (for example, persistent and intense anger, contempt, sadness, or apathy)
    - Health (exacerbation of medical or psychological symptoms and/or significant interference with provision of medical or psychological care).

L2 Child Physical Abuse

Definition:

Non-accidental acts of physical force by a child's parent/caregiver that result, or have reasonable potential to result, in physical harm to a child or which evoke significant fear.

Essential (Required) Features:

- Confirmed or suspected non-accidental act of physical force. Examples include: hitting, slapping.
- Act causes (or exacerbates) at least one of the following:
  - Any physical injury (examples: bruises, cuts, sprains, broken bones, loss of consciousness, pain that lasts at least four hours)
  - Reasonable potential for significant physical injury
  - Significant fear.

L3 Child Psychological Abuse

Definition:

Non-accidental verbal or symbolic acts by a child's parent/caregiver that result in significant psychological harm.

Essential (Required) Features:

- Confirmed or suspected verbal or symbolic acts with the potential to cause psychological harm to the child. Examples:
  - Berating, disparaging, degrading, humiliating the child
  - Threatening child (including, but not limited to, indicating/implying future physical harm, abandonment, sexual assault)
  - Harming/abandoning – or indicating that the parent/caregiver will harm/abandon – people/things that child cares about, such as pets, property, loved ones (including exposing child to criteria-meeting or subthreshold partner maltreatment)
  - Confining child (for example, tying a child's arms or legs together; binding a child to a chair, bed, or other object; or confining a child to a small enclosed area [such as a closet])
  - Scapegoating child, i.e., blaming child for things for which he/she cannot possibly be responsible
  - Coercing the child to inflict pain on him/herself
  - Disciplining child (through physical or non-physical means) excessively (i.e., extremely high frequency or duration, though not meeting physical abuse criteria)
  - Purposefully indoctrinating child to consider a parent evil, dangerous, or not worthy of affection.
- Acts cause (or exacerbate) at least one of the following:
  - Psychological harm (for example, significant fear of abusive parent or other psychological distress)
  - Reasonable potential for significant psychological harm (for example, for developing significant psychological problems or for significant disruption of the child's physical, psychological, cognitive, or social development)
  - Stress-related somatic symptoms that interfere with normal functioning.

L4 Child Sexual Abuse

Definition:

Sexual acts involving a child that are intended to provide sexual gratification to an adult.

Essential (Required) Features:

- At least one of the following acts involving an adult and a child:
    - Physical contact of a sexual nature between child and adult. For example, vaginal or anal penetration (or attempted penetration), oral-genital or oral-anal contact, fondling (directly or through clothing)
    - Non-contact exploitation – An adult forcing, tricking, enticing, threatening, or pressuring a child to participate in acts for anyone's sexual gratification without direct physical contact between child and offender. For example, exposing child's genitals, anus, or breasts; having child masturbate or watch masturbation; having child participate in sexual activity with a third person (including child prostitution); having child pose, undress or perform in a sexual fashion (including child pornography).

L5 Child Neglect

Definition:

Confirmed or suspected egregious act or omission by a child's parent/caregiver that deprive the child of needed age-appropriate care and that result, or have reasonable potential to result, in physical or psychological harm.

Essential (Required) Features:

- At least one confirmed or suspected egregious act or omission by a child's caregiver that deprive the child of needed age-appropriate care (for example, abandonment, lack of appropriate supervision; exposure to physical hazard; failure to provide necessary education, health care, nourishment, shelter, clothing).
- Act or omission causes or exacerbates at least one of the following impacts:
    - Physical injury or reasonable potential for injury
    - Significant fear or psychological distress
    - Stress-related somatic symptoms
    - Reasonable potential for the development of a psychiatric disorder
    - Reasonable potential for significant disruption of the child's physical, psychological, cognitive, or social development.

ICD-10 RELATIONSHIP PROBLEM AND MALTREATMENT GUIDELINES

Relationship problems and maltreatment include the following:

I. Problems related to negative life events in childhood (A)

A1 Problems related to alleged sexual abuse of child by person within primary support group
A2 Problems related to alleged sexual abuse of child by person outside primary support group
A3 Problems related to alleged physical abuse of child

II. Other problems related to upbringing (B)

B1 Inadequate parental supervision and control
B2 Parental overprotection
B3 Hostility towards and scapegoating of child
B4 Emotional neglect of child
B5 Other problems related to neglect in upbringing
B6 Inappropriate parental pressure and other abnormal qualities in upbringing
B7 Problem related to upbringing, unspecified

III. Other problems related to primary support group, including family circumstances (C)

C1 Problems in relationship with spouse or partner
C2 Problems in relationship with parents or in-laws
C3 Problem related to primary support group, unspecified

I. PROBLEMS RELATED TO NEGATIVE LIFE EVENTS IN CHILDHOOD (A)

A1 Problems related to alleged sexual abuse of child by person within primary support group

Problems related to any form of physical contact or exposure between an adult member of the child's household and the child that has led to sexual arousal, whether or not the child has willingly engaged in the sexual acts (e.g. any genital contact or manipulation or deliberate exposure of breasts or genitals).

A2 Problems related to alleged sexual abuse of child by person outside primary support group

Problems related to contact or attempted contact with the child's or the other person's breasts or genitals, sexual exposure in close confrontation or attempt to undress or seduce the child, by a substantially older person outside the child's family, either on the basis of this person's position or status or against the will of the child.

A3 Problems related to alleged physical abuse of child

Problems related to incidents in which the child has been injured in the past by any adult in the household to a medically significant extent (e.g. fractures, marked bruising) or that involved abnormal forms of violence (e.g. hitting the child with hard or sharp implements, burning or tying up of the child).

II. OTHER PROBLEMS RELATED TO UPBRINGING (B)

B1 Inadequate parental supervision and control

Lack of parental knowledge of what the child is doing or where the child is; poor control; lack of concern or lack of attempted intervention when the child is in risky situations.

B2 Parental overprotection

Pattern of upbringing resulting in infantilization and prevention of independent behaviour.

B3 Hostility towards and scapegoating of child

Negative parental behaviour specifically focused on the child as an individual, persistent over time and pervasive over several child behaviours (e.g. automatically blaming the child for any problems in the household or attributing negative characteristics to the child).

B4 Emotional neglect of child

Parent talking to the child in a dismissive or insensitive way. Lack of interest in the child, of sympathy for the child's difficulties and of praise and encouragement. Irritated reaction to anxious behaviour and absence of sufficient physical comforting and emotional warmth.

B5 Other problems related to neglect in upbringing

Lack of learning and play experience

B6 Inappropriate parental pressure and other abnormal qualities of upbringing

Parents forcing the child to be different from the local norm, either sex-inappropriate (e.g. dressing a boy in girl's clothes), age-inappropriate (e.g. forcing a child to take on responsibilities above her or his own age) or otherwise inappropriate (e.g. pressing the child to engage in unwanted or too difficult activities).

B7 Problem related to upbringing, unspecified

III. OTHER PROBLEMS RELATED TO PRIMARY SUPPORT GROUP, INCLUDING FAMILY CIRCUMSTANCES (C)

C1 Problems in relationship with spouse or partner

Discord between partners resulting in severe or prolonged loss of control, in generalization of hostile or critical feelings or in a persisting atmosphere of severe interpersonal violence (hitting or striking).

C2 Problems in relationship with parents and in-laws

C3 Problem related to primary support group, unspecified

ICD-11 MENTAL AND BEHAVIOURAL DISORDER CLINICAL DESCRIPTIONS

Mental and behavioural disorders include the following:

I. Mood Disorders (R)

R1 Single Episode Depressive Disorder
R2 Recurrent Depressive Disorder
R3 Dysthymic Disorder
R4 Mixed Depressive and Anxiety Disorder
R5 Bipolar Type I Disorder
R6 Bipolar Type II Disorder
R7 Cyclothymic Disorder

II. Anxiety and Fear-Related Disorders (S)

S1 Generalized Anxiety Disorder
S2 Panic Disorder
S3 Agoraphobia
S4 Specific Phobia
S5 Social Anxiety Disorder
S6 Separation Anxiety Disorder
S7 Selective Mutism

I. MOOD DISORDERS (R)

R1 Single Episode Depressive Disorder

Single episode depressive disorder is characterized by the presence or history of one Depressive episode when there is no history of prior Depressive episodes. A Depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thought of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. There have never been any prior Manic, Hypomanic, or Mixed episodes, which would indicate the presence of a Bipolar disorder.

R2 Recurrent Depressive Disorder

Recurrent depressive disorder is characterized by a history or at least two Depressive episodes separated by at least several months without significant mood disturbance. A Depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thought of

death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. There have never been any prior Manic, Hypomanic, or Mixed episodes, which would indicate the presence of a Bipolar disorder.

R3 Dysthymic Disorder

Dysthymic disorder is characterized by a persistent depressive mood as reported by the individual (feeling down, sad) or manifested as a sign (i.e., tearful, downtrodden appearance) during more of the time than not over a period of at least 2 years. The depressed mood is accompanied by other symptoms such as diminished interest in activities, reduced energy or fatigue, difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thought of death or suicide, changes in appetite or sleep, and psychomotor agitation or retardation. Most of the time, the number or duration of symptoms is not sufficient to meet the definitional requirements of a Depressive episode. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. There have never been any prior Manic, Hypomanic, or Mixed episodes, which would indicate the presence of a Bipolar disorder.

R4 Mixed Depressive and Anxiety Disorder

Mixed depressive and anxiety disorder is characterized by symptoms of both anxiety and depression more days than not for a period of two weeks or more. Neither set of symptoms, considered separately, is sufficiently severe, numerous, or persistent to justify a diagnosis of a Depressive episode, Dysthymia or an Anxiety and fear-related disorder. Depressed mood or diminished interest in activities must be present accompanied by additional depressive symptoms as well as multiple symptoms of anxiety. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. There have never been any prior Manic, Hypomanic, or Mixed episodes, which would indicate the presence of a Bipolar disorder.

R5 Bipolar Type I Disorder

Bipolar type I disorder is an episodic mood disorder defined by the occurrence of one or more Manic or Mixed episodes. A Manic episode is an extreme mood state lasting at least one week unless shortened by a treatment intervention characterized by euphoria, irritability, or expansiveness, and by increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid or pressured speech, flight of ideas, increased self-esteem or grandiosity, decreased need for sleep, distractibility, impulsive or reckless behavior, and rapid changes among different mood states (i.e., mood lability). A Mixed episode is characterized by either a mixture or very rapid alternation between prominent manic and depressive symptoms on most days during a period of at least 2 weeks. Although the diagnosis can be made based on evidence of a single Manic or Mixed episode, typically Manic or Mixed episodes alternate with Depressive episodes over the course of the disorder.

R6 Bipolar Type II Disorder

Bipolar type II disorder is an episodic mood disorder defined by the occurrence of one or more Hypomanic episodes and at least one Depressive episode. A Hypomanic episode is a persistent mood state lasting at least several days characterized by mild elevation of mood or increased irritability and increased activity or a subjective experience increased energy, accompanied by other characteristic symptoms such as rapid speech, rapid or racing thoughts, increased self-esteem, decreased need for sleep, distractibility, and impulsive or reckless behavior. The symptoms are not severe enough to cause marked impairment in occupational functioning or in usual social activities or relationships with others, does not necessitate hospitalization, and there are no accompanying delusions or hallucinations. A Depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thought of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue.

R7 Cyclothymic Disorder

Cyclothymic disorder is characterized by a persistent instability of mood over a period of at least 2 years, involving numerous periods of hypomanic (e.g., euphoria, irritability, or expansiveness, psychomotor activation) and depressive (e.g., feeling down, diminished interest in activities, fatigue) symptoms that are present during more of the time than not. The hypomanic symptomatology may or may not be sufficiently severe or prolonged to meet the full definitional requirements of a Hypomanic episode (see Bipolar type II disorder, but there is no history of Manic or Mixed episodes (se Bipolar type I disorder). The depressive symptomatology has never been sufficiently severe or prolonged to meet the diagnostic requirements for a Depressive episode (see Bipolar type II disorder). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

II. ANXIETY AND FEAR-RELATED DISORDERS (S)

S1 Generalized Anxiety Disorder

Generalized anxiety disorder is characterized by marked symptoms of anxiety accompanied by either general apprehension (i.e., ‘free-floating anxiety’) or worry focused on multiple everyday events, most often concerning family, health, finances, and school or work, together with additional symptoms such as muscular tension or motor restlessness, sympathetic autonomic overactivity, subjective experience of nervousness, difficulty maintaining concentration, irritability, or sleep disturbance. The symptoms are present more days than not for at least several months and result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

S2 Panic Disorder

Panic disorder is characterized by recurrent unexpected panic attacks that are not restricted to particular stimuli or situations. Panic attacks are discrete episodes of intense fear or apprehension accompanied by the rapid and concurrent onset of several characteristic symptoms (e.g., palpitations or increased heart rate, sweating, trembling, shortness of breath, chest pain, dizziness or lightheadedness, chills, hot flushes, fear of imminent death). In addition, Panic disorder is characterized by persistent concern about the recurrence or significance of panic attacks, or behaviors intended to avoid their recurrence, that results in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Panic attacks can occur in the context of a variety of other disorders; their presence alone is insufficient to assign the diagnosis.

S3 Agoraphobia

Agoraphobia is characterized by marked and excessive fear or anxiety that occurs in response to multiple situations where escape might be difficult or help might not be available, such as using public transportation, being in crowds, being outside the home alone (e.g., in shops, theatres, standing in line). The individual is consistently anxious about these situations due to a sense of danger or fear of specific negative outcomes (e.g., panic attacks, other incapacitating or embarrassing physical symptoms). The situations are actively avoided, entered only under specific circumstances, or endured with intense fear or anxiety. The symptoms last for least several months, and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

S4 Specific Phobia

Specific phobia is characterized by a marked and excessive fear or anxiety that consistently occurs when exposed to one or more specific objects or situations (e.g., proximity to certain animals, heights, closed spaces, sight of blood or injury) and that is out of proportion to actual danger. The phobic objects or situations are avoided or else endured with intense fear or anxiety. Symptoms persist for at least several months and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

S5 Social Anxiety Disorder

Social anxiety disorder is characterized by marked and excessive fear or anxiety that consistently occurs in one or more social situations such as social interactions (e.g., having a conversation), being observed (e.g., eating or drinking), or performing in front of others (e.g., giving a speech). The individual is concerned that he or she will act in a way, or show anxiety symptoms, that will be negatively evaluated by others. The social situations are consistently avoided or else endured with intense fear or anxiety. The symptoms persist for at least several months and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

S6 Separation Anxiety Disorder

Separation anxiety disorder is characterized by marked and excessive fear or anxiety about separation from specific attachment figures. In children, separation anxiety typically focuses on caregivers, parents or other family members; in adults it is typically a romantic partner or children. Manifestations of separation anxiety may include thoughts of harm or untoward events befalling the attachment figure, reluctance to go to school or work, recurrent excessive distress upon separation, reluctance or refusal to sleep away from the attachment figure, and recurrent nightmares about separation. The symptoms persist for at least several months and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

S7 Selective Mutism

Selective mutism is characterized consistent selectivity in speaking, such that a child demonstrates adequate language competence in specific social situations, typically at home, but consistently fails to speak in others, typically at school. The disturbance lasts for at least one month, is not limited to the first month of school, and is of sufficient severity to interfere with educational or occupational achievement or with social communication. Failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation (e.g., a different language spoken at school than at home).