Australian Psychologists' Current Practice, Beliefs and Attitudes towards Supporting Women Survivors of Childhood Maltreatment

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Child maltreatment survivors have an increased risk of developing various mental illnesses in adulthood, which may lead survivors to access psychological services. This study explored the frequency with which Australian psychologists encounter child maltreatment survivors in their clinical practice and their attitudes and beliefs about routine screening and supporting survivors. The results showed that 81.1% of psychologists surveyed saw clients with co-morbid mental illness and child maltreatment experience on a daily or weekly basis. The majority of psychologists believed that child maltreatment was a health care issue which impacts upon mental health, routinely asked about child maltreatment experiences, and believed that screening and supporting survivors was very important. Self-reported confidence and a belief in the importance of screening and supporting survivors for child maltreatment experiences were showed to predict actual screening behaviours, whilst comfort in screening did not. Highlighting the complexity of supporting survivors, 75.4% 'agreed' or 'strongly agreed' that they would benefit from further training in screening and supporting survivors despite reporting high levels of confidence and comfort in this area. Further education to better equip psychologists to screen and respond to survivors, may therefore facilitate early intervention and provision of appropriate psychological services to survivors.

In Australia, 339,454 reports were made to local child protective agencies in 2009 regarding possible or actual child maltreatment (Australian Institute of Health and Welfare, 2010). Child maltreatment comprises of five different forms: physical abuse, sexual abuse, emotional abuse, neglect and witnessing violence (Taylor, Moore, Pezulla, Tucci, Goddard, & De Bortoli, 2008) and studies have found that specific types of child maltreatment (and its combination) are associated with different problems in adulthood. For example victims of child sexual abuse (CSA) and victims of CSA and physical child abuse (PCA) had higher posttraumatic stress symptoms compare to victims of PCA only and those who were not abused in childhood (Hetzel & McCanne, 2005). In a study on adolescents depressive symptoms were experienced more frequently by those who were exposed to both CSA and PCA, compared to those who experience PCA only and those with no abuse history (Danielson, de Arellano, Kilpatrick, Saunders, & Resnick, 2005). Child maltreatment survivors have also been documented to have a higher number of medical conditions (Chartier, Walker, & Naimark, 2007) and an increased prevalence of various mental illnesses (McLaughlin, Green, Gruber, Sampson, Zaslavsky, & Kessler, 2010) such as depression (Banyard, 1999; Bifulco & Moran, 1998; Miller, Wolff, & Scott, 2000), anxiety (Miller et al., 2000), and post-traumatic stress disorder (Foa, 2000; Miller et al., 2000).

The reason for this higher prevalence of mental illness in adult survivors of child maltreatment may be due to multiple disruptions to normal child development that

can occur as a result of child maltreatment. Child maltreatment experiences can disrupt a person's early attachment (Bowlby, 1973; Stien & Kendall, 2004). This may disrupt the formation of the sense of self, others, and the world (Bowlby, 1973; Stern, 1985; Stien & Kendall, 2004), potentially resulting in the child viewing themselves as unloved or unworthy of others' attention or disrupting the development of interpersonal skills necessary to draw on social support to help in resolving emotional distress. Neurological development as well as physical growth can also be disrupted (van der Kolk, 2003; van der Kolk, Pelcovitz, Roth, Mandel, McFarlance, & Herman, 1996). These factors may reduce the person's ability to cope in later life, affecting trust in others, inducing feelings of self-blame, and predisposing them to mental illness (Sanderson, 2006).

The importance of intervening early with child maltreatment survivors has been previously demonstrated. As a group they have higher access of primary and tertiary healthcare services (Hulme, 2000) and psychological services (Walker et al., 1999), with resultant higher healthcare costs. However, most maltreatment survivors do not seek assistance until adulthood (Sanderson, 2006), so the onus is often on clinicians to be sensitive to early signs of child maltreatment-related distress.

Research further indicates that women are more vulnerable than men to experience CSA (Finkelhor, Ormrod, Turner, & Hamsby, 2005) and were shown to have higher death rates from CSA (Taylor et al., 2008). A meta-analysis looking at prevalence of CSA around the world, reported the highest combined prevalence from 217 publications to be in Australia for women compared to men (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). When other demographic factors were controlled for, women survivors were documented to be more likely than men to acquire a mental illness in adulthood (Thompson, Kingree, & Desai, 2004) with higher prevalence rates for depression, anxiety and post-traumatic stress disorder (PTSD) following sexual violence in women (World Health Organization [WHO], 2011) compared to men. Women are also more likely to seek psychological support compared to men (WHO, 2011). Given the findings of prior studies indicating that women are more vulnerable than men to CSA and are more likely to acquire mental illness in adulthood and are more likely to seek psychological support, this study focused on psychologists' contact with women survivors.

Despite survivors' increased risk of developing mental illnesses in adulthood and their potential increased access of psychological services, there is a paucity of research into Australian psychologists' current practice, attitudes and belief in screening and supporting women survivors. There is also a lack of research exploring whether confidence in screening and supporting survivors has any predictive capacity to actual screening of clients. Past research investigating psychologists' professional practice in the area of child maltreatment often focused on the issues of mandated reporting, in particular professional ethical constraints (Walters, 1995), barriers to reporting (Beck & Ogloff, 1995), and practitioner characteristics that facilitate reporting (Renninger, Veach, & Bagdade, 2002; Waldecker, 2010) rather than exploring psychologists actual practice with survivors. This study redresses this gap by exploring the current practices, attitude and beliefs of psychologists in working with and supporting adult survivors who present for psychological services. Assessing childhood maltreatment experience of clients is extremely important for a holistic understanding of the client and for the implementation of appropriate management and therapies. Overlooking this complex issue may result in delivery of inappropriate psychological interventions that treat symptoms rather than address the underlying cause.

In addition to exploring the practices of psychologists in screening adult survivors of

child maltreatment, determining why some psychologists ask and assess for childhood maltreatment experience while others do not is also important, as this may help in developing education resources to promote better management of child maltreatment survivors. Bandura's self-efficacy theory may provide a framework for understanding psychologists' screening behaviour. The theory posits that the beliefs one holds about their ability influences the way in which they will behave (Bandura, 1986). Within the context of screening behaviour, psychologists with a higher belief about their ability to conduct screening and support identified survivors are expected to be more likely to conduct screening. It is therefore hypothesised that higher levels of confidence in conducting screening will predict actual screening behaviour, over and above other practice related factors. Beyond a demonstration of predictors of screening behaviour, a further aim of this study was to provide a preliminary insight into the current practice, beliefs, attitudes and confidence of psychologists in screening and supporting women child maltreatment survivors. A final aim was to explore the perceived training needs of Australian psychologists.

Method

Participants and Procedure

A total of 127 psychologists participated in this study by completing an electronic survey from January 2010 to June 2011. Psychologists were recruited from a recurring advert placed on the Australian Psychological Society (APS; the professional body representing psychologists in Australia) webpage. Psychologists interested in participating were given the option to contact the first author or click on the link listed on the advertisement, which took them to the secured survey hosted by Survey Methods (an online survey delivery tool). Opportunistic sampling was utilised, as only those who wished to take part would have proceeded to complete the survey. Responses were collected automatically by the online survey software. The first author collated all responses at the end of recruitment period and transferred all responses into a statistical package for analyses.

The protocol for this research project was approved by Alfred Research Ethics Committee, Monash University Human Research Ethics Committee, and Latrobe Regional Hospital Human Research Ethics Committee.

The majority of respondents were female (89%) and the average age of respondents was 45.8 years (SD = 11.4). All respondents reported an interest in mental health and 90% of respondents had undertaken additional training in mental health. More than half were private practitioners (55.1%) and most had gained their psychology training in Australia (92.4%).

Questionnaire

To our knowledge, there were no established questionnaires to ascertain the characteristics of practice, attitudes, beliefs, and confidence of health practitioners in assisting women survivors. To allow assessment of these characteristics, the Clinician Feedback Questionnaire (CFQ) was developed. The CFQ comprises 41 items and includes 6 items adapted from a British survey (Richardson, Feder, Eldridge, Chung, Coid, & Moorey, 2001) that looked at health professionals' attitudes and clinical practice with women who experience domestic violence and survivors of childhood sexual abuse. To develop the remaining CFQ items, a set of domains relating to key aspects of psychologist practice relating to treatment of adult child abuse survivors were identified from a review of the literature. These included: prevalence of clients with the comorbidity; attitudes and beliefs; confidence and perceived importance of aspects of practice; comfort with screening for abuse sub-types; perceived training needs and beliefs about screening. A pool of potential

items were developed for each domain and refined in consultation amongst the study authors to develop the final survey. As a final phase of validation, pre-testing was conducted with a sample of clinicians including a general practitioner, a psychiatrist, a neuropsychologist, and three clinical psychologists to ensure face validity, and appropriateness of items, and format. Comments received were incorporated into the finalised questionnaire. As the survey was exploratory in nature, formal psychometric testing of reliability or validity was not performed.

The final CFQ consists of 41 items:

- Six items were adapted from a British survey (Richardson et al., 2001) which looked at health professionals' attitudes and clinical practice with women who experience domestic violence and survivors of childhood sexual abuse. The term 'domestic violence/child sexual abuse' was replaced with 'child maltreatment'. Original scale anchors of 'agree, uncertain or disagree' and 'yes/no' were changed to scale anchors which ranged from 1 'strongly disagree' through to 5 'strongly agree'.
- A further four items were added asking about clinicians' attitude and beliefs using the same scale anchors
- Fourteen items explored clinicians' demographics and current practice.
- Eleven items explored the importance, confidence and comfort level in dealing with issues surrounding screening, supporting and referring survivors; scale anchors ranged from 1 'not important' through 4 'very important', 1 'not confident' through 4 'very confident', 1 'not comfortable' through 4 'very comfortable' respectively.
- The remaining items asked about: the need for further training in responding to adult women survivors of child maltreatment; who clinicians believe should be screening survivors; and perceived barriers to screening for experiences of childhood maltreatment in their practice.

Analyses

Data analyses were conducted utilising IBM SPSS Statistics 19. Descriptive analyses such as percentages and means was utilised to demonstrate cumulative responses of psychologists. To explore whether psychologists' current beliefs about importance, confidence and comfort in screening and supporting survivors predicted self-reported screening behaviour, logistic regression was used due to the skewed distribution of the dependent variable (self-reported screening behaviour).

Results

Approximately 81.1% of surveyed psychologists reported seeing women survivors with mental health issues and comorbid childhood maltreatment experiences on a daily or weekly basis (see Table 1). The majority of psychologists (66.1%) provided ongoing treatment within their practice for women survivors of childhood maltreatment hence did not need to refer clients for ongoing treatment. Practice characteristics, attitudes and beliefs of psychologists in relation to responding to the adult consequences of child maltreatment are summarised in Table 1. The total number of psychologists responding to each variable ranged from 121 to 127 as some participants did not answer some of the questions.

Ninety-four per cent of the sample 'agreed' or 'strongly agreed' that child maltreatment is a health care issue. Almost all respondents (96.8%) 'agreed' or 'strongly agreed' that child maltreatment was an issue for their clients and discussed the issues of childhood maltreatment with their clients. The majority (94.4%) also routinely asked clients about mental health issues. All but one respondent (99.2%) 'agreed' or 'strongly agreed' that the experience of childhood maltreatment impacts upon mental health;

Table 1
Psychologists' Practice Characteristics, Attitudes and Beliefs in Caring for Women Survivors of Child Maltreatment

How often do you:	Frequency (%)			
	Daily	Weekly	Monthly	Yearly
see adult female clients with mental health issues who has had childhood maltreatment experience (n = 127)	42(33.1)	61(48.0)	18(14.2)	6(4.7)
see adult female clients with childhood maltreatment experience who has mental health issues (n = 121)	37(29.1)	57(47.1)	19(15.0)	8(6.6)
refer a client with childhood maltreatment experience for ongoing treatment* (n = 127)	2(1.6)	6(4.7)	24(18.9)	11(8.7)

To what extent do you agree with the following:	Frequency (%)				
	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Child maltreatment is a health issue (n = 127)	2(1.6)	3(2.4)	3(2.4)	38(29.9)	81(63.8)
Child maltreatment **is not** a problem for women in my practice population (n = 126)	91(72.2)	31(24.6)	2(1.6)	1(0.8)	1(0.8)
I believe that women should be routinely screened for childhood maltreatment experience/(s) (n = 127)	3(2.4)	18(14.2)	40(31.5)	41(32.3)	25(19.7)
I put off talking about childhood maltreatment experience/(s) because it takes too much time (n = 127)	92(72.4)	31(24.4)	3(2.4)	0(0.0)	1(0.8)
I **do not** talk about childhood maltreatment experience/(s) because I do not know what to do (n = 127)	90(70.9)	33(26.0)	1(0.8)	1(0.8)	2(1.6)
When women disclose child maltreatment experience/(s) I give information about help available (n = 127)	3(2.4)	2(1.6)	8(6.3)	57(44.9)	57(44.9)
Experience/(s) of childhood maltreatment impacts on mental health (n = 126)	1(0.8)	0(0.0)	0(0.0)	25(19.8)	100(79.4)
I routinely ask all women about their mental health (n = 125)	3(2.4)	2(1.6)	2(1.6)	29(23.2)	89(71.2)
I routinely ask all women about their childhood maltreatment experience/(s) (n = 127)	4(3.1)	16(12.6)	8(6.3)	47(37.0)	52(40.9)
I would like specific training on child maltreatment and how to treat women survivors(n = 126)	6(4.8)	8(6.3)	17(13.5)	62(49.2)	33(26.2)

however, only 77.9% routinely asked clients about childhood maltreatment experience.

The majority of respondents believed that screening, supporting, and referring clients with childhood maltreatment experiences was 'very important' (Figure 1) and were 'very confident' in screening, supporting, and referring when necessary (Figure 2). Most were also 'very comfortable' with screening clients for all five types of childhood maltreatment (Figure 3).

Despite feeling confident and comfortable with screening, supporting, and referring women survivors when necessary, the majority of respondents would still like further training (Figure 4) on child maltreatment and its impact (75.2%), how to treat (75.4%), screen (66.1%), support (81.6%), and refer women survivors to appropriate services (57.3%).

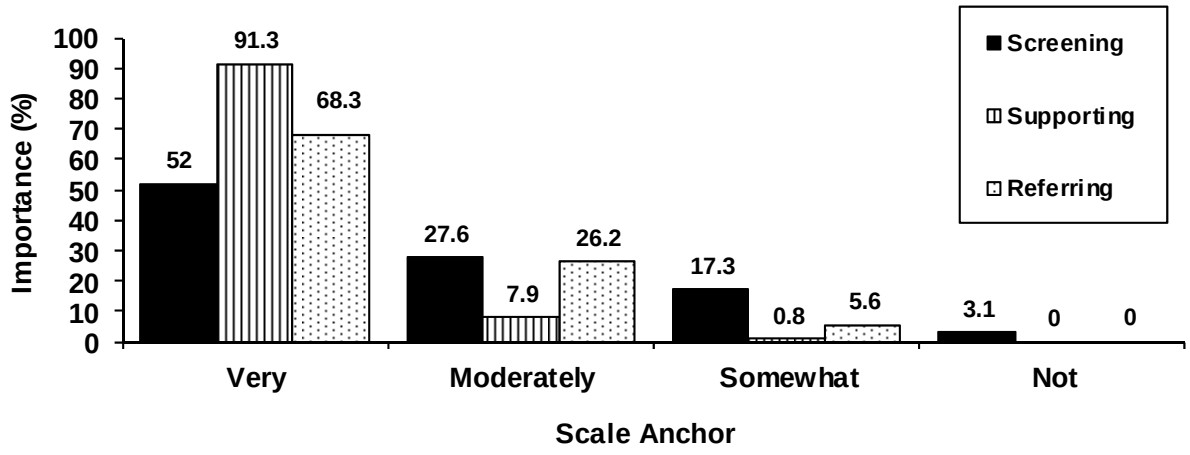

Figure 1. Importance of screening, supporting, and referring women survivors.

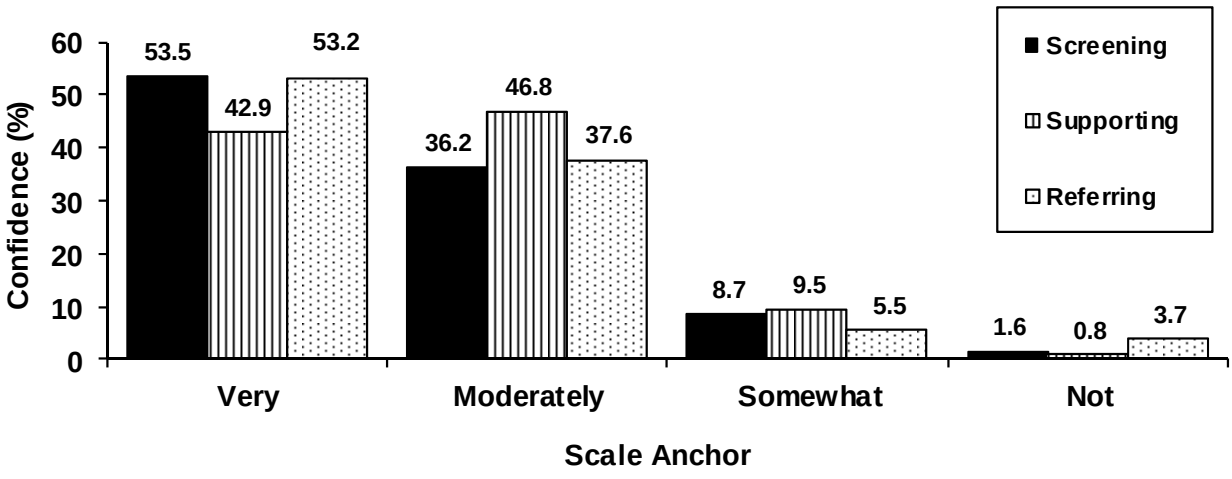

Figure 2. Confidence in screening, supporting, and referring women survivors.

Logistic regression was used to assess whether psychologists' current beliefs about importance, confidence and comfort in screening and supporting survivors impacted upon the likelihood of self-reported screening behaviour, after controlling for other predictors in the model. The choice of analysis technique was influenced by the dependent variable (self-reported screening behaviour) being significantly skewed or not normally distributed, related to the majority of participants responding that they 'agreed' or 'strongly agreed' that they routinely screened clients. To adjust for the potential impact of this skewed dependent variable it was dichotomised into 'Not Agree' (for those who responded 'strongly disagree', 'disagree' and 'uncertain) and 'Agree' (for those who responded 'agree' and 'strongly' agree. Given the similarity of psychologists' responses on their comfort in screening for the five different types of child maltreatment experiences, a composite variable Comfort

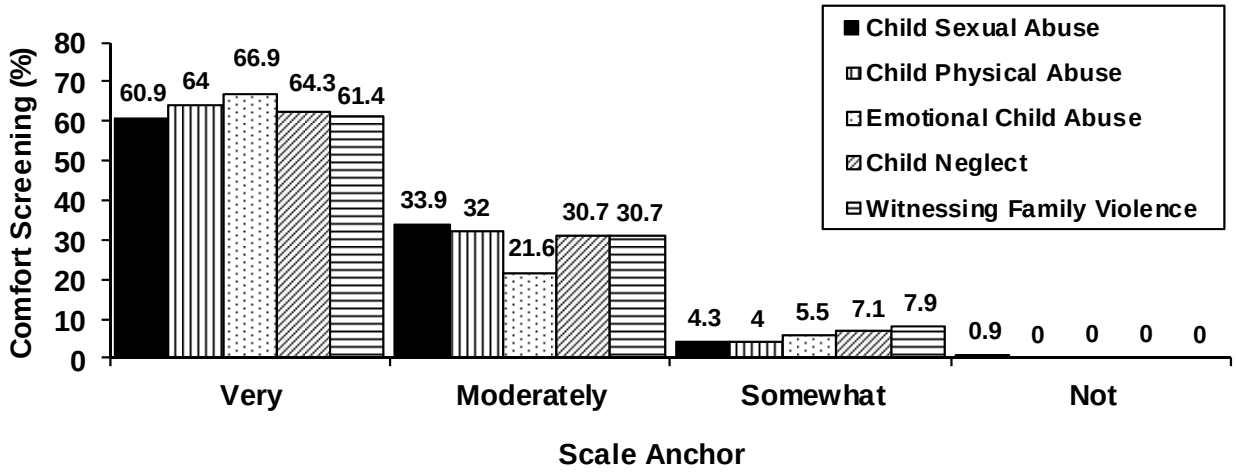

Figure 3. Comfort with screening for different types of maltreatment.

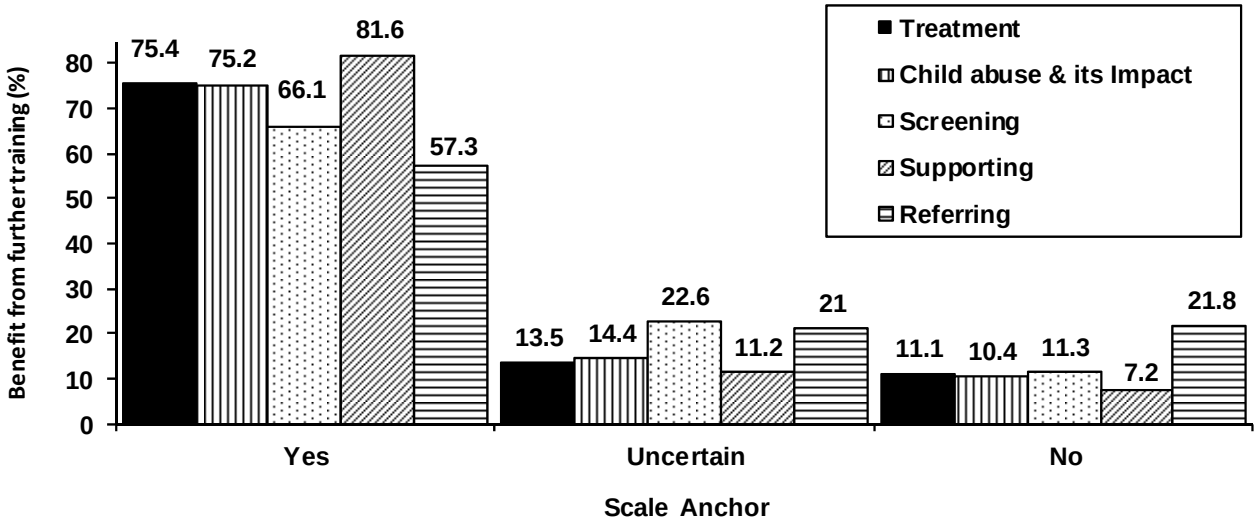

Figure 4: Need for further training

Screening for Abuse were formed from five questions to prevent collinearity between predictors biasing the regression model (Pallant, 2007). All logistic regression assumptions of sample size (minimum ratio of valid cases to independent variables of 10

Table 2
Summary of Direct Logistic Regression Analysis for Variables Predicting Psychologists Screening Behaviours

Predictor	*B*	*SE B*	Wald	*df*	e^B (Odds Ratio)	95% CI for e^B Lower	Upper
Age	-.07*	.03	4.99	1	.93	.87	.99
Gender	.55	.98	.31	1	1.73	.25	11.85
Practice Length	.06	.04	1.85	1	1.06	.98	1.15
Importance screening women for childhood maltreatment experience/(s)	1.22**	.35	11.91	1	3.39	1.70	6.78
Importance supporting women with childhood maltreatment experience/(s)	-.45	.76	.35	1	.64	.14	2.82
Confidence in screening women for childhood maltreatment experience/(s)	1.70**	.61	7.71	1	5.45	1.65	18.06
Confidence in supporting women with childhood maltreatment experience/(s)	.48	.66	.55	1	1.62	.45	5.82
Comfort with screening women for childhood maltreatment experience/(s)	.28	.60	.22	1	1.32	.41	4.26
Constant	-6.87	3.28	4.40	1	.00		

Note: CI = Confidence Interval.
Importance and confidence screening and supporting women for childhood maltreatment experience/(s) scored from 1 for 'not important' or not confident to 4 for 'very important' or 'very confident'.
Comfort screening women for childhood maltreatment experience/(s) scored from 1 for 'not comfortable' to 4 'very comfortable'.
Did not agree to routinely ask women about childhood maltreatment experience/(s) is the reference category.
*$p < .05$ **$p < .01$ ***$p < .001$

to 1) (University of Texas, 2006), multicollinearity, outliers, and independence of errors (Tabachnick & Fidell, 2001) were fulfilled.

The regression model contained eight independent variables: age, gender, practice length, importance screening and supporting women survivors, confidence screening and supporting survivors and comfort screening women survivors. The full model containing all predictors was statistically significant, $\chi 2$ (8, N = 121) = 52.86, p <.001, indicating that the model was able to distinguish between those who 'did not agree' and those who 'agreed' that they routinely asked women about childhood maltreatment experience. The model as a whole explained between 35.4% (Cox and Snell R square) and 53.5% (Nagelkerke R square) of the variance in self-reported screening behaviour, and correctly classified 86% of cases. As shown in Table 2, only age, importance, and confidence screening women for childhood maltreatment experience made a unique statistically significant contribution to the final model, with confidence screening being the strongest predictor.

Discussion

This paper explored current practices of psychologists in screening and supporting women survivors of child maltreatment. Key findings revealed that 81% percent of psychologists saw clients who presented with mental health issues and a comorbid child maltreatment experience on a daily or weekly basis. Most respondents agreed that child maltreatment was an issue for their clients and that it impacts upon client's mental health. Despite high levels of self-reported confidence and comfort in screening and assessing clients, most respondents wanted further training on the impact of child maltreatment and how to screen for and support survivors of child maltreatment.

The finding that 81% of psychologists saw clients with comorbid mental illness and child maltreatment experiences on a daily or weekly basis is consistent with the literature highlighting the significant prevalence of mental illness in child maltreatment survivors (Briere & Runtz, 1990; Chartier et al., 2007; Freeman, Collier, Parillo, & Nova Research Co, 2002; McLaughlin et al., 2010; Miller et al., 2000). This also highlighted that psychologists regularly provide care to child maltreatment survivors, and as a result must be equipped to identify and assist in treating the presenting concerns of survivors.

To help guide the development of future training, logistic regression analysis found that psychologists were more likely to routinely screen for childhood maltreatment experiences if they were more confident in conducting screening, rated the importance of screening more highly and were younger. Clinical experience alone is not sufficient to increase the likelihood of screening for maltreatment history. Comfort in screening clients for different forms of maltreatment experiences also did not significantly predict actual screening behaviour, which may indicate that psychologists who may not be comfortable screening clients for maltreatment experiences can still do so.

Despite the majority of psychologists reporting high levels of confidence and comfort in screening for and supporting survivors, most still expressed a desire for more training in this area. Given that training received by psychologists may differ, targeted and continual education and training for Australian psychologists in the area of screening and supporting survivors is warranted. This will hopefully improve screening for childhood maltreatment experiences which may contribute to current presenting problems, allowing for better treatment.

The finding that self-confidence in conducting screening was the strongest predictor of actual screening behavior was expected on the basis of Bandura's self-efficacy theory which proposes that a person's belief in their self-competence

influences whether they perform a particular task (Bandura, 1982, 1986). Provided education must therefore aim at building confidence and belief in clinicians in their ability to effectively identify and provide appropriate support to maltreatment survivors. Enhancing clinician belief about the importance of conducting screening was also suggested by study findings as a possible means of enhancing the conduct of screening. To achieve both aims, ongoing education should detail the mechanisms by which maltreatment experiences may increase the risk of and contribute to adult mental illness; how to screen (e.g., standardised measures or common screening questions); how to provide treatment for symptoms related to child maltreatment experiences; and how to refer on patients for specialist support if necessary. Psychology training programs may also wish to include screening and supporting survivors as part of core content of their training programs to equip new practitioners with the knowledge to ask and support survivors, given the prevalence of prior maltreatment experience in clients who present with mental health concerns.

Whereas the effect of self-confidence was expected, the effect of age on screening behaviour was not expected. One previous study did, however, find that younger physicians and nurses were more likely to initiate the topic of intimate partner violence with their patients (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007), but they did not explore the link between age and screening behaviour specifically. A recent study that conducted interviews with staff in the context of a program looking to enhance screening of women for partner abuse, found that a number of personal barriers to questioning were reported, including: discomfort with the question/lack of confidence to ask, fear of offending the women, and forgetting to ask (Wills, Ritchie, & Wilson, 2008). It could be speculated that with the recently increased awareness of the importance of early intervention to prevent the negative consequences of child maltreatment, training programs that younger psychologists have participated in may have provided greater coverage of how to conduct screening, resulting in higher levels of screening in younger psychologists. However, further research is required to explore this finding.

A potential limitation of this study was that 89% of respondents were female. However, the high number of female respondents in this study sample reflects the higher number of female registered psychologist (78%) in the Australian workforce during the study period (Psychology Board of Australia, 2011). Given that only 11% of respondents were male, it was not statistically meaningful to conduct a gender analysis on attitudes, beliefs and practice in relation to this issue. Future research may wish to explore gender differences on practice by utilising matched sample of female and male psychologists. The recruitment of respondents mainly via advertisement through the APS website may be a potential limitation. While this allowed for psychologists Australia wide to participate, it is likely that many psychologists did not see the advertisement or chose not to participate. There is also the possibility of selection bias against psychologists who do not access the APS website which could not be avoided. It is likely that psychologists who responded may have an interest in this area, which may have contributed to the high reported rates of confidence in screening and supporting survivors, so the extent to which this finding is reflective of the whole psychologist population in Australia is unclear. The nature of the questionnaire utilised may also be a potential limitation. Due to a lack of any previous published measures of relevance to addressing the studies' research questions, a questionnaire was developed by first author based on practice experience and a review of

the available literature and refined in consultation with other study authors. Although the final questionnaire was sent out to various practitioners to determine the face validity of the questions, it could not be tested for reliability and consistency due to the nature of the questions.

Strengths of this study were that the findings provided an insight into the current practices of 127 psychologists around Australia in screening, assessing and supporting clients who may be survivors, which has not been looked at previously. This provided information on practices of psychologists, which at times due to confidentiality and privacy may not be open knowledge to other practitioners. It also provided information on the perceived training needs of Australian psychologists in this area, which may contribute to assisting women child maltreatment survivors.

Future research is still much required to identify the reason for the discrepancies found in this study between psychologists reported confidence in conducting screening and their perceived training needs. In particular qualitative research exploring the factors that contribute to psychologists' level of confidence in supporting survivors of child maltreatment, specific training topics which psychologists might be interested in and how these specific training topics would increase their confidence levels may be helpful. Further studies may also wish to consider asking psychologists about their own childhood experience to explore whether it influence screening behaviours and to identify psychologists' views on support, treatment options and beliefs about the various types of child maltreatment.

In summary, findings confirmed that not only do Australian psychologists regularly provide care to clients with comorbid mental illness and child maltreatment experiences, but that confidence and belief about the importance of screening for child maltreatment experiences were the strongest predictors of actual screening behavior. Psychologists are also reporting that they want further training in the area of screening and supporting women who were maltreated as children. By providing further ongoing education in this area, psychologists are likely to be better equipped to identify early and provide more appropriate and holistic intervention to child maltreatment survivors.

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Acknowledgements

This research was supported by the Australian Postgraduate Award and Mental Health Postgraduate Scholarship Scheme, both from the Australian Government awarded to Ms. Adeline Lee.

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Dr. Stuart Lee is the mental health service evaluation senior research officer at the Monash Alfred Psychiatry Research Centre (MAPrc), The Alfred and Monash University. Dr Lee has conducted a number of quality

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Associate Professor Jan Coles is an academic General Practitioner who has worked in clinical medicine and general practice for 25 years. Her main area of research is sexual violence and women's health and the impact of childhood sexual violence on early mothering. She has been received a number of research grants and hosted national events such as the National Summit 2010 on women's health and sexual violence: "Happy Healthy Women: Not Just Survivors", which won the Constance Stone Award of the Victorian Medical Women's Society. She is engaged in national and international sexual violence research collaborations and is the chair and executive member of a number of research committees.

Professor Jayashri Kulkarni became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1989. She commenced her appointment as Professor of Psychiatry, The Alfred and Monash University in 2002. She founded and directs a large psychiatric research centre, the Monash Alfred Psychiatry Research Centre (MAPrc). The aim of Monash Alfred Psychiatry Research Centre is to develop new treatments, new understanding and new service deliveries for people with mental illness. It is a world leader in the translation of cutting edge neuroscience discoveries into innovative, life-changing treatments for people with mental illness. Jayashri is a passionate advocate of person-focused real world mental health research.

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