

Article

Primary healthcare practitioners' screening practices and attitudes towards women survivors of child abuse

Adeline Lee BA (Psych) (Hons)

DPsych (Clin) Candidate, School of Psychology and Psychiatry, Monash University Australia and Senior Research Officer, Alfred Psychiatry Research Centre and Department of General Practice, Monash University, Australia

Jan Coles MBBS PhD MMed (WomenHlth) DCH GCHPE

Associate Professor, Department of General Practice, Monash University, Australia

Stuart Lee BA (Hons) DPsych

Research Fellow

Jayashri Kulkarni MBBS PhD FRANZCP

Director and Professor of Psychiatry

Monash Alfred Psychiatry Research Centre, The Alfred and Monash University, Australia

ABSTRACT

Background Child abuse survivors have an increased risk of developing various mental illnesses in adulthood, which may lead survivors to access primary healthcare services, in particular primary care mental health services.

Aim To determine the frequency with which different primary care mental health practitioners encounter child abuse survivors in their practice and differences in their views about routine screening, level of importance, confidence and comfort in screening and supporting survivors, a cross-sectional study was conducted with 186 practitioners.

Method The sample consisted of general practitioners (13.9%), psychologists (67.9%) and other professions such as psychiatrists, social workers, counsellors, psychotherapists, mental health nurses and other specific mental health practitioners (18.2%).

Results Over 91% of practitioners reported that child abuse was a healthcare issue and was a problem for women in their practice. However,

only 51.4% believed that women should be routinely screened for child abuse experiences. Significant differences among practitioner groups were found in aspects of screening and responding to survivors. General practitioners were significantly less likely to screen routinely and reported lower levels of confidence and comfort in conducting screening of survivors when compared with psychologists and other practitioners. The majority of practitioners saw it as psychologists' role to routinely screen; however, 57–82% of practitioners within each group reported that they would benefit from further training in areas relating to asking about and supporting survivors.

Conclusion Findings highlighted further education as a potential area of need to enhance the knowledge and capacity of different practitioner groups in responding to women survivors of child abuse.

Keywords: child abuse survivors, primary care practitioners, screening

Introduction

Prevalence rates of child abuse in Australia are best estimated to be between 2 and 36%.¹ Specifically, the prevalence rate of child physical abuse is estimated to be between 5 and 10%, child neglect to be between 2 and 12%, emotional abuse to be 11%, witnessing family violence to be between 12 and 23% and child sexual abuse to be between 4 and 16% for males and 7 and 36% for females.¹

A gender imbalance in the experience of some forms of child abuse (e.g. sexual abuse) has also been identified,² making women particularly vulnerable to experiencing negative consequences stemming from child abuse. One potential negative consequence that has been identified is an increased rate of mental illness in adulthood for women survivors,³ in particular depression, anxiety and post-traumatic stress disorder.⁴

Child abuse survivors may have difficulty expressing their feelings and needs because these were ignored during their abuse.⁵ Survivors may also find it difficult to trust professionals; and as such, many do not seek help until adulthood.⁵ This can result in survivors only seeking help when the symptoms of mental illness worsen, or otherwise seeking help only to address somatic symptoms due to not recognising the need to address the underlying psychological symptoms or not wanting to discuss them. Women are more likely than men to seek help from and disclose mental health problems to primary care practitioners.⁴

With 43% of women in primary care settings reporting childhood abuse and neglect histories,⁶ primary care practitioners such as general practitioners (GPs), psychologists and other mental health practitioners (psychiatrists, social workers, counsellors, psychotherapists, mental health nurses and other specific mental health practitioners) who work in primary care practices in their respective fields are likely to come into contact with women survivors. As the first step to facilitate early intervention, this research aims to explore practitioners' views, current practices and confidence in screening and supporting women survivors of child abuse. It further aims to assess whether there are differences among practitioners from different disciplines when responding to women survivors of child abuse.

To date, there has been little research exploring primary care practitioners' practices in responding to women survivors of child abuse, and no research to the authors' knowledge that specifically explores whether there are differences in primary care practitioner groups in relation to their practice in responding to women survivors. Existing literature

focused primarily on the practices and beliefs of family physicians or GPs. For example, Weinreb (2007) conducted a focus group and Weinreb *et al* (2010) a cross-sectional study in America explored GPs' practices in responding to women survivors of child abuse. Results indicated that GPs tend to not screen for child abuse and fewer perceived barriers increased the likelihood of screening.^{7,8} In the cross-sectional survey of 313 GPs, only 28.6% reported usually or always screening women patients despite 79% believing it was their role to conduct screening, citing reasons such as lack of time to ask about child abuse. GPs who reported being confident and comfortable conducting screening and those who felt screening was useful were more likely to screen patients. Number of years in practice did not relate to frequency of screening and almost 40% of respondents reported no formal training in screening patients for child abuse experiences.⁷

In a study conducted in the UK looking at GPs', practice nurses' and health visitors' attitudes and clinical practice with women survivors of child sexual abuse and domestic violence, only 10% of respondents agreed that GPs, practice nurses or health visitors should routinely ask women about child sexual abuse experiences, despite respondents considering that the adult sequelae of child sexual abuse was a healthcare issue. Most practitioners did not wish to screen for such experiences, but wanted to receive training about these issues.⁹

In another study looking at victims of child abuse and comorbid substance issues, counsellors 'often simply fail to ask' about child abuse experiences. Organisational issues such as not instructing staff to ask about child abuse and the lack of available comprehensive screening and assessment measures were reported to hinder screening.¹⁰

Given the paucity of research on screening for child abuse experiences in adult survivors, the authors draw on the literature exploring screening women for intimate partner violence (IPV). The rationale for this is that child abuse, in particular child sexual abuse, and IPV are forms of gendered violence with victims being predominately female.¹¹ Women survivors of child abuse have an increased risk of experiencing IPV^{12,13} demonstrating the complex and often intertwined nature of gendered violence.

Looking at the screening literature for women survivors, a third of women disclosed their experience of IPV to their GPs.¹⁴ Women thought it appropriate to be asked about child abuse or IPV experiences,^{10,15} reported that no harm resulted from screening and agreed with screening or being asked

routinely about abuse experiences.^{15,16} In fact, women found screening beneficial in removing stigma, gained a sense of support from the discussion and stated that it gave them an opportunity to disclose abuse, which may lead them to seek help.¹⁶ However, only 1 in 10 women were asked about IPV by their GPs.^{14,17}

Factors such as lack of time, education and training on screening survivors, lack of effective follow-up interventions and insufficient evidence to support the effectiveness of routine screening were identified as hindering routine screening in primary care practice.^{14,18} Others feared causing offence if patients were asked prior to a confidential relationship being established,¹⁹ whereas self-reported preparedness was found to increase the likelihood of routine screening by practitioners and disclosure rates.¹⁸ When clients and patients were asked directly about their child abuse experiences, disclosure rates increased.^{14,15}

A systematic review of 20 quantitative studies looking at various healthcare practitioners' screening attitudes found that the majority do not agree with screening programmes, but between 15 and 95% thought it to be acceptable.¹⁶ It was further concluded that there is insufficient evidence for universal screening in healthcare settings.^{16,20} However, these conclusions were reached because of the lack of evidence to support improved morbidity and mortality from universal screening programmes. Feder *et al* concluded that IPV 'is potentially an appropriate condition for screening' (p xii).¹⁶ Other authors urged caution in interpreting the conclusions drawn from systematic reviews due to methodological issues.²¹ In the absence of definitive evidence on universal screening, several national organisations advocate a 'diagnostic' or 'case finding' approach, which is routine inquiry when signs of abuse are present.^{22,23} Regardless of whether universal screening or a case finding approach to screening is used, rates of routine inquiry by healthcare practitioners remain low (5–10%).^{24,25} Even when practitioners thought it appropriate to screen, some thought that other professional groups should be conducting the screening.¹⁶

Given the current lack of research assessing different primary care practitioners' practices with women survivors of child abuse and that many of these practitioners will encounter survivors, this study explores these practice issues in Australian GPs, psychologists and other practitioners such as psychiatrists, social workers, counsellors, psychotherapists, mental health nurses and other specific mental health practitioners. This will enable a comparison of whether there are differences in the frequency with which each practitioner group encounters adult women survivors of child abuse, and

their ratings of importance and confidence in screening for or responding to women identified as having a child abuse experience. A final aim of this study is to explore who practitioners believe should be screening women for child abuse experiences and whether practitioners would benefit from specific training to enhance their capacity to respond to the specific needs of this vulnerable population.

Method

Participants and procedure

A total of 186 practitioners participated in this study by completing an electronic survey between January and June 2011. Participants were recruited from advertisements placed in various professional newsletters and websites such as the Division of General Practice and Australian Psychological Society and flyers in various community health centres.

Practitioners interested in participating were given the option of contacting the first author (AL) or clicking on the link listed in 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. AL collated all responses at the end of the recruitment period and transferred all responses to a statistical package for analyses.

The respondents consisted of GPs (13.9%), psychologists (67.9%) and other practitioners, such as psychiatrists, social workers, counsellors, psychotherapists and mental health nurses and other specific mental health practitioners (18.2%). The majority of respondents were female (84.9%) and the average age was 46.9 years (SD = 11.1). Mean number of years of practice for GPs was 20.7 (SD = 2.1), for psychologists was 11.4 (SD = 0.74) and for other practitioners was 11.7 (SD = 1.7). More than half were working in the private sector (54.9%) and most gained their qualifications in Australia (93.5%). Table 1 summarises the demographics and characteristics of different practitioner groups.

Questionnaire

To our knowledge, there are no established questionnaires to examine different practitioners' practices with women survivors. The Clinician Feedback Questionnaire (CFQ) was developed by the first

Table 1 Demographics and participant characteristics by practitioner group [*n* (%)]

	GPs	Psychologists	Other
Gender			
Male	11 (42.3)	13 (10.3)	4 (11.8)
Female	15 (57.7)	113 (89.7)	30 (88.2)
Undertaken additional training in mental health			
Yes	17 (65.4)	115 (90.6)	31 (94)
No	9 (34.6)	12 (9.4)	2 (6)
Current practice			
Public hospital and community health centres	3 (11.5)	23 (18.3)	14 (41.2)
Private hospital and private practice	22 (84.6)	73 (57.9)	7 (5.6)
Non-government/Not for profit organisation	0	13 (10.3)	9 (7.1)
Other (specialist services and government organisation)	1 (3.8)	17 (13.5)	4 (3.2)
Frequency of encounters with women with comorbid mental health issues and child abuse			
Daily	6 (23.1)	42 (33.1)	10 (31.3)
Weekly	8 (30.8)	61 (48)	13 (40.6)
Month	9 (34.6)	18 (14.2)	7 (21.9)
Yearly	3 (11.5)	6 (4.7)	2 (6.3)
Child abuse is a health issue			
Strongly agree/Agree	24 (96)	119 (93.7)	34 (100)
Uncertain	0	3 (2.4)	0
Disagree/Strongly disagree	1 (4)	5 (4)	0
Child abuse is a problem for women in my practice			
Strongly agree/Agree	24 (92.3)	122 (96.8)	31 (91.2)
Uncertain	1 (3.8)	2 (1.6)	3 (8.8)
Disagree/Strongly disagree	1 (3.8)	2 (1.6)	0 (8.)
Believed in routine screening for child abuse			
Strongly agree/Agree	7 (28)	66 (52)	22 (66.7)
Uncertain	14 (56)	40 (31.5)	10 (30.3)
Disagree/Strongly disagree	4 (16)	21 (16.6)	1 (3)
Routinely screen for child abuse			
Strongly agree/Agree	3 (11.5)	99 (77.9)	22 (73.3)
Uncertain	1 (3.8)	8 (6.3)	3 (10)
Disagree/Strongly disagree	22 (84.6)	20 (15.7)	5 (16.6)

author to explore these characteristics. The items on the questionnaire, which consists of a set of domains relating to key aspects of women survivors, were identified from a review of the literature. These included the prevalence of clients with mental health and child abuse experiences, 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 was developed for each domain and refined in consultation among the study authors to develop the final survey. A sample of practitioners including a GP, a psychiatrist, a neuropsychologist and three clinical psychologists were approached to review the face validity, item appropriateness and format of the CFQ. 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 (a copy of the CFQ can be obtained by contacting the corresponding author):

- Six items were adapted from a British survey⁹ which looked at health professionals' attitudes and clinical practice with women who experience domestic violence and the survivors of child sexual abuse. The term 'domestic violence/child sexual abuse' was replaced with 'child abuse'. Original scale anchors of 'agree, uncertain or disagree' and 'yes/no' were changed to scale anchors which ranged from 0 'strongly disagree' to 4 'strongly agree'. A further four items asking about practitioners' attitudes and beliefs used the same scale anchors.
- Fourteen items explored practitioners' demographics and current practice.
- Eleven items explored importance, confidence and comfort level in dealing with issues surrounding screening, supporting and referring survivors; scale anchors ranged from 0 'not important' to 3 'very important', 0 'not confident' to 3 'very confident', and 0 'not comfortable' to 3 'very comfortable', respectively.
- The remaining items asked about the need for further training in responding to adult women survivors of child abuse, who practitioners believe should be screening survivors and perceived barriers to screening for experiences of child abuse in their practice.

Analyses

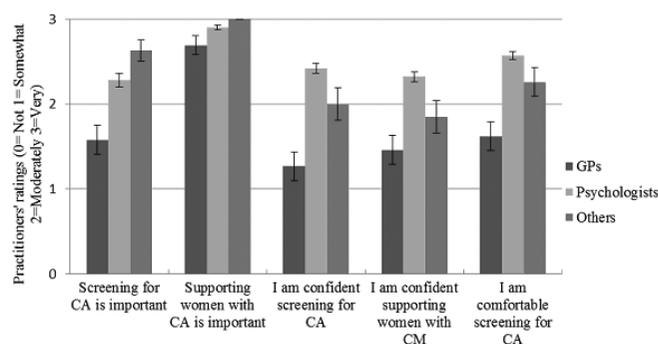
Data analyses were conducted utilising IBM SPSS Statistics 19.²⁶ Descriptive analyses such as percentages and means were utilised to demonstrate cumulative responses of practitioners. Non-parametric statistics were utilised due to the skewed distri-

bution of our sample and the ordinal scale data.²⁷ A Kruskal–Wallis test was conducted to explore between-group differences among GPs, psychologists and other health practitioners on different outcome variables such as importance and confidence with screening and supporting survivors of child abuse. Follow-up Mann–Whitney *U*-tests and effect size calculations were conducted on statistically significant results from the Kruskal–Wallis test to evaluate pairwise differences among the three groups, controlling for type I error across tests by using the Bonferroni correction.²⁷

Results

The frequencies of responses from the three practitioner groups are displayed in Table 1. Across all surveyed practitioners, 76% reported seeing women survivors with mental health issues and comorbid child abuse experiences on a daily or weekly basis. The majority of practitioners (95.1%) surveyed 'agree' or 'strongly agree' that child abuse is a health issue, 95.2% of respondents indicated that child abuse is a problem for women in their practice and 67.8% routinely screened women. Twelve per cent of GPs, 78% of psychologists and 73.3% of other professionals 'agree' or 'strongly agree' that they routinely screen women with child abuse experiences.

Figure 1 compares the mean ratings for the three practitioner groups on the importance of screening and supporting women survivors, confidence in conducting screening and supporting women survivors and comfort in screening women for child abuse experiences.



CA=Child abuse experience/(s)

Figure 1 Practitioners' ratings on importance, confidence and comfort screening and supporting women with child abuse experiences with one standard error bars.

Kruskal–Wallis tests revealed statistically significant differences among the three practitioner groups across all six variables. Bonferroni-corrected pair-wise Mann–Whitney *U*-test differences for each variable are detailed below. On conducting routine screening, GPs were significantly less likely to agree than psychologists ($P < 0.001$, $r = 0.52$) and other practitioners ($P < 0.001$, $r = 0.66$). On the importance of screening, GPs rated significantly lower than psychologists ($P < 0.001$, $r = 0.29$) and other practitioners ($P < 0.001$, $r = 0.58$). On the importance of supporting women survivors, GPs rated significantly lower than psychologists ($P = 0.009$, $r = 0.21$) and other practitioners ($P = 0.002$, $r = 0.41$). On confidence in conducting screening, GPs were significantly less confident than psychologists ($P < 0.001$, $r = 0.46$) and other practitioners ($P = 0.005$, $r = 0.37$). On confidence in supporting women, GPs were significantly less confident in supporting women survivors compared to psychologists ($P < 0.001$, $r =$

0.38), but not compared with other practitioners ($P = 0.103$, $r = 0.21$). Lastly, GPs reported significantly less comfort than psychologists ($P < 0.001$, $r = 0.44$) and other practitioners ($P = 0.005$, $r = 0.47$). Psychologists' and other practitioners' ratings on four of the six variables were not statistically significantly different. Compared with psychologists, other practitioners reported less confidence in screening ($P = 0.046$, $r = 0.16$) and less confidence in supporting women survivors ($P = 0.027$, $r = 0.18$).

All practitioners were asked to identify the health practitioners who should screen for child abuse and whether they thought they would benefit from further training in this area. Specific questions about training on child abuse and its impact upon women, the screening of women survivors, how to support women survivors and the referral of women survivors to appropriate services were asked. Table 2 and Figure 2 summarise responses from respective practitioner groups.

Table 2 Perception of which practitioner(s) should screen women for child abuse experiences (n (%))

Practitioners	GPs ($n = 26$)	Psychologists ($n = 127$)	Other ($n = 34$)
Psychiatrist	21 (80.8)	117 (92.1)	29 (85.3)
GPs	12 (46.2)	78 (61.4)	25 (73.5)
Psychologist	22 (84.6)	122 (96.1)	29 (85.3)
Social worker	12 (46.2)	102 (80.3)	29 (85.3)
Psychotherapist	18 (69.2)	101 (79.5)	27 (79.4)
Counsellors	19 (73.1)	97 (76.4)	28 (82.4)
Mental health nurse	17 (65.4)	97 (76.4)	29 (85.3)

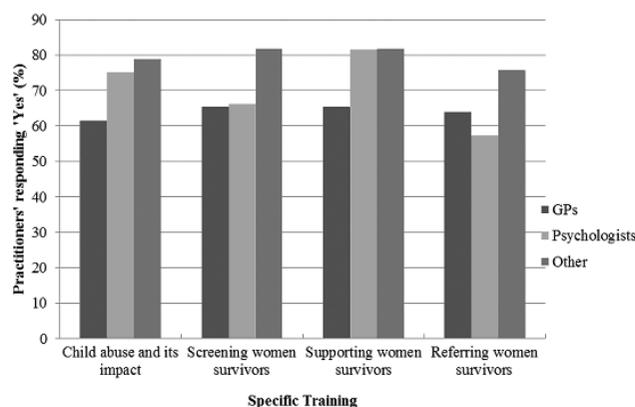


Figure 2 Perception of further training on screening, supporting and referring women survivors as well as impact of child abuse on women [n (%)]

Discussion

This study provided a description of different Australian practitioners' (GPs, psychologists and other health practitioners) practices with and views on screening and supporting women survivors of abuse. It further highlighted the differences between practitioner groups in their levels of belief regarding the importance of, confidence in and comfort with screening and supporting women survivors. The study also provided preliminary data on who the different practitioner groups thought should be conducting screening and whether practitioners saw benefit in further specific training in the area.

Consistent with past literature, we found that the majority of practitioners in all three groups (> 93%) strongly agree or agree that child abuse is a health issue.⁹ Only 12% of GPs reported routinely screening women for child abuse experiences, followed by 73% of other practitioners and 78% of psychologists. This low rate of screening for child abuse experiences by Australian GPs is consistent with past research exploring family GPs' screening of child abuse and IPV.^{9,14,24,25} An additional finding of interest was that 28% of GPs believed that routine screening of child abuse should occur, highlighting a dissociation between belief and practice for a number of GPs.

Previous research in a GP sample has shown that fewer perceived barriers (e.g. beliefs about patients as likely victims, time limitations and discomfort with screening) to screening for child abuse were associated with an increased likelihood of screening.^{7,8} Drawing on the screening literature for IPV, formal training and professional experience with abuse disclosure can also increase self-confidence, preparedness to screen and increase comfort in initiating discussions.¹⁸ Those with higher levels of confidence, less discomfort and those who felt that screening was useful were also more likely to screen patients.⁷ It is not surprising then that when exploring the level of perceived importance, confidence and comfort in screening and supporting women survivors, GPs were found to have less perceived importance, confidence and comfort in screening and supporting survivors than psychologists and other practitioners.

The differences found between responses from GPs and those from psychologists and other practitioners may be attributed to the differences in education pathways leading to the different professions. Psychologists may be more likely to be trained or encouraged to assess their clients for child abuse experiences, as 'most psychotherapeutic approaches currently in practice carry the assumption that it is important and even essential to gather a compre-

hensive trauma history in order to plan treatment' (p. 4).²⁸ Different practitioner groups may also have distinct perceived responsibilities and face practice pressures unique to their profession. For example, a general consultation time for a GP is approximately 15 minutes and often related to a specific presenting concern. By contrast, a consultation with a psychologist or other mental health practitioner is likely to be in excess of 45 minutes and may allow for more detailed exploration of factors underpinning the presenting issues. Considering that practitioners reported barriers in screening for child abuse experience such as lack of training and follow-up services,^{7,8} fear of offending clients and wanting to establish a confidential relationship prior to asking,¹⁹ the nature of consultation duration and frequency of contact with patients for mental health practitioners may facilitate screening.

The similarities between responses from psychologists and other practitioners, who consist of mental health professionals, are likely due to the similar session length and emphasis on psychotherapeutic approaches, which places importance on gathering a comprehensive trauma history. However, significant differences in levels of confidence in screening and supporting women survivors were found between other practitioners and psychologists; whereby other practitioners reported less confidence than psychologists. This difference may be due to our sample of psychologists who reported seeing more survivors on a regular basis compared with other practitioners, and are exposed to more potential disclosures, which may increase confidence in screening and supporting survivors.¹⁸

When exploring which professionals should be routinely screening for child abuse experiences, the fewest practitioners in all three groups stated that GPs should conduct screening for abuse experience. Psychologists and psychiatrists were most commonly rated by all three practitioner groups as being preferred to conduct screening. The professional groups' perceptions of which profession should be screening were consistent with the differences found in actual reported screening behaviours. This may indicate that if routine screening is to be encouraged, attitudes and perceptions of practitioners regarding their role in screening survivors will need to be enhanced.

Finally, drawing on prior literature speculating that level of confidence, perceived importance, exposure to specific training and experience in hearing disclosures are important factors in encouraging screening behaviours,¹⁸ specific education on the practitioner's role in screening and supporting women survivors is likely to be beneficial. Given that the results indicated that >55% of all practitioner groups noted that they would benefit from further training,

introducing modules on the practitioner's role in screening and in supporting women survivors and on the impacts of child abuse upon women as continuing education in the respective professions may be welcomed.

There were several potential limitations to this study. The study was cross-sectional in nature and captured the views of practitioners in Australia mainly via an advertisement on a professional society website and in newsletters. While this allowed for Australia-wide practitioners to participate, it is likely that many practitioners did not see the advertisement or chose not to participate. There is also the possibility of selection bias against practitioners who do not access the Australian Psychological Society and GP network newsletters and other websites on which the advertisement appeared, which could not be avoided. It is also likely that practitioners who have an interest in this area were more likely to complete the survey, as demonstrated in the sample size which consisted of more psychologists and few GPs. Therefore, the extent to which this finding is reflective of the different practitioner groups in Australia is unclear. The nature of the questionnaire may also be a potential limitation. Owing to a lack of any previous published measures of relevance addressing the study's research questions at the time this research was conducted, a questionnaire was developed by the first author based on practice experience and a review of the available literature and then refined in consultation with the other study authors. Although the final questionnaire was sent out to various practitioners to determine the face validity of the questions, it was exploratory in nature and not appropriate for formal validity and reliability testing.

Strengths of this study were that the findings provided an insight into the current practices of 186 practitioners around Australia in screening, assessing and supporting clients who may be child abuse survivors, which has not been looked at previously. It also allowed for a comparison of the practices of different health practitioners who may come into contact with women survivors. Further, the results of this study were consistent with prior screening literature looking at rates of routine screening and extended the literature in looking at other health practitioners' behaviours in screening women survivors of child abuse. It also highlighted the complexity in the field of screening.

In conclusion, the study provided preliminary insights into the screening practices of different health practitioners in an Australian context. It also highlighted differences in health practitioners' current levels of importance placed, confidence in and comfort with screening and supporting survivors of child abuse. In understanding the current

screening practices of practitioners, further education on how to identify women survivors in their practices, asking about and responding to disclosures of women will hopefully provide the first step to early identification and appropriate treatment intervention for this vulnerable population.

ACKNOWLEDGEMENTS

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

ETHICAL APPROVAL

The protocol for this research project has been approved by Alfred Research Ethics Committee (304/09), Monash University Human Research Ethics Committee (CF09/2776 - 2009001597) and Latrobe Regional Hospital Human Research Ethics Committee (2010-04). It conforms to the World Medical Association Declaration of Helsinki on the Ethical Principles for Medical Research Involving Human Subjects.

CONFLICTS OF INTEREST

All authors declared no conflict of interest.

REFERENCES

- 1 Price-Robertson R, Bromfield L and Vassallo S. *The Prevalence of Child Abuse and Neglect*. National Child Protection Clearinghouse: Australia, 2010.
- 2 Stoltenborgh M, van IJzendoorn M, Euser E *et al*. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreatment* 2011;16:79-101.
- 3 Thompson M, Kingree J and Desai S. Gender differences in long-term consequences of physical abuse of children: data from a nationally representative survey. *American Journal of Public Health* 2004;94: 599-604.
- 4 World Health Organization. *Gender and Women's Mental Health Gender Disparities and Mental Health: the facts* [serial on the Internet]. Available at: www.who.int/mental_health/prevention/gender_women/en.
- 5 Sanderson C. *Counselling Adult Survivors of Child Sexual Abuse* (3e). Jessica Kingsley: London, 2006.
- 6 Walker E, Gelfand A, Katon W *et al*. Adult health status of women with histories of childhood abuse and neglect. *The American Journal of Medicine* 1999; 107:332-9.
- 7 Weinreb L, Savageau, Candib LM *et al*. Screening for childhood trauma in adult primary care patients: a

- cross-sectional survey. *Primary Care Companion to the Journal of Clinical Psychiatry* 2010;12:1–18.
- 8 Weinreb L. Physicians' perceptions of adult patients' history of child abuse in family medicine settings. *Journal of the American Board of Family Medicine* 2007;20:417–19.
 - 9 Richardson J, Feder G, Eldridge S *et al.* Women who experience domestic violence and women survivors of childhood sexual abuse: a survey of health professionals' attitudes and clinical practice. *British Journal of General Practice* 2001;51:468–70.
 - 10 Department of Human Services USA. Screening and assessing adults for childhood abuse and neglect. In: Substance Abuse and Mental Health Services (ed) *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues*. Substance Abuse and Mental Health Services: Rockville, MD, 2000.
 - 11 United Nations Population Fund. *Violence Against Girls and Women*. United Nations Population Fund: New York. Available at: <http://web.unfpa.org/intercenter/violence/intro.htm> (accessed 04/04/12).
 - 12 Friesen M, Woodward L, Horwood L *et al.* Childhood exposure to sexual abuse and partnership outcomes at age 30. *Psychological Medicine* 2010;40:679–88.
 - 13 McKinney C, Caetano R, Ramisetty-Mikler S *et al.* Childhood family violence and perpetration and victimization of intimate partner violence: findings from a national population-based study of couples. *Annals of Epidemiology* 2009;19:25–32.
 - 14 Hegarty K and Taft A. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Australian and New Zealand Journal of Public Health* 2001;25:433–7.
 - 15 Burge S, Schneider F, Ivy L *et al.* Patients' advice to physicians about intervening in family conflict. *Annals of Family Medicine* 2005;3:248–54.
 - 16 Feder G, Ramsay J, Dunne D *et al.* *How Far Does Screening Women for Domestic (Partner) Violence in Different Health-Care Settings Meet Criteria for a Screening Programme? Systematic reviews of nine UK National Screening Committee criteria*. Health Technology Assessment 13, 2009.
 - 17 Bradley F. Reported frequency of domestic violence: cross sectional survey of women attending general practice. *British Medical Journal* 2002;324:271–4.
 - 18 Gutmanis I, Beynon C, Tutty L *et al.* Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health* 2007;7:1–11.
 - 19 Stenson K, Sidenvall B and Heimer G. Midwives' experiences of routine antenatal questioning relating to men's violence against women. *Midwifery* 2005;21:311–21.
 - 20 MacMillan H, Wathen C, Jamieson E *et al.* Screening for intimate partner violence in health care settings. A randomized trial. *JAMA* 2009;302:493–501.
 - 21 Jayatilleke A and Poudel K. Screening for intimate partner violence. *JAMA* 2009;302:2434.
 - 22 US Preventative Services Task Force. Screening for family and intimate partner violence: recommendation statement. *Annals of Internal Medicine* 2004;140:382.
 - 23 Wathen C and MacMillan H. Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventative Health Care. *Canadian Medical Association Journal* 2003;169:582–4.
 - 24 Thompson R, Rivara F, Thompson D *et al.* Identification and management of domestic violence – a randomized trial. *American Journal of Preventive Medicine* 2000;19:253–63.
 - 25 Elliott L, Nerney M, Jones T *et al.* Barriers to screening for domestic violence. *Journal of General Internal Medicine* 2002;17:112–16.
 - 26 SPSS Inc. *SPSS*. IBM: Chicago, 2010.
 - 27 Pallant J. Non-parametric statistics. *SPSS Survival Manual* (3e) Allen & Unwin: Australia, 2007, pp. 210–32.
 - 28 International Society for Traumatic Stress Studies. *Childhood Trauma Remembered. A report on the current scientific knowledge base and its applications*. International Society for Traumatic Stress Studies: Northbrook, IL, 1993.

ADDRESS FOR CORRESPONDENCE

Adeline Lee, Monash University, Building 1, 280 Ferntree Gully Road, Notting Hill, Vic 3168 Australia. Email: Adeline.Lee@monash.edu

Accepted October 2012

