

## ORIGINAL ARTICLE

# Routine conversations about violence conducted in Swedish child health services—A mixed methods study of nurses' experiences

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## Abstract

**Aim:** To evaluate an intervention where nurses in child health care services routinely talk to and inform parents about violence.

**Methods:** The intervention included providing information during home visits and individual conversations with mothers and fathers/partners in connection with screening for parental depression. A convergent mixed-methods design was used with a documentation form for each child ( $n = 475$ ) and results from focus group interviews with nurses. Quantitative data were analysed using descriptive statistics and qualitative with manifest content analysis.

**Results:** Almost all families participated in the intervention; individual conversations were conducted with nearly all the mothers, and to a somewhat lesser extent with the fathers/partners. Initially, the nurses felt slightly uncomfortable about these conversations, but described experiencing development and professionalisation in their role of talking about violence. Parents' reactions were generally positive and they expressed appreciation for this topic being raised.

**Conclusion:** The results show that the intervention has been carried out successfully. The newborn period is a phase in which mothers and fathers are interested and receptive to knowledge and support in sensitive matters. Prerequisites for implementation were the preparation phase for the nurses, the use of routine questioning and a questionnaire as a basis for the conversations.

## KEYWORDS

child abuse, child health care, parents, prevention, violence

## 1 | INTRODUCTION

This study focuses on implementation of routine conversations about violence in a child health care context. The definition of violence in the study includes all forms of behaviour in close relationships that

involve physical, psychological or sexual violations and/or abuse. It includes violence against children, Child Abuse (CA) and violence between the adults in the family, Intimate Partner Violence (IPV)<sup>1,2</sup>

Child Abuse and IPV are global public health problems. Children who are exposed to violence from their parents or other caregivers

**Abbreviations:** CA, child abuse; CHC, child healthcare centres; CHS, child health services; CIV, conversations and information about violence; EPDS, Edinburgh postnatal scale; FG, focus groups; IPV, intimate partner violence; Md, median.

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and/or have witnessed or been indirectly exposed to IPV are both as children and adults, at an increased risk for poor mental and/or physical health.<sup>2-5</sup> In 1979, Sweden became the first country in the world to introduce legislation against the corporal punishment of children. Since then there has been a change in attitude among parents in Sweden regarding the use of violence in the upbringing of children and the prevalence of violence against children has gradually decreased, although it is still a reality in some children's lives.<sup>6,7</sup> Legislation to prohibit the corporal punishment of children has been gradually introduced in several other countries but still, in 2021, physical punishment of children is allowed in more than two thirds of the world's countries; this has consequences for how CA is viewed in different cultures. For children, IPV in the family means they experience not only the exposure of another family member to violence but also violence against themselves through the neglect of their needs for safety.<sup>5</sup> Routine conversations with parents about violence could be a way to break the shame and taboo<sup>8</sup> that surrounds exposure to violence. Children are dependent on their parents, and the parents' ability to look after and care for them affects the child's health and development. In Sweden, child health services (CHSs) are provided free of charge to all children and their parents during the child's first years of life (0–6 years). The basis for the Swedish CHS programme is one of general health promotion and the use of preventive measures; it provides, therefore, a unique opportunity to undertake preventive work and interventions.<sup>9</sup> As with other agencies that work with children, child healthcare centres (CHCs) have a legal obligation to make a report to social services if there is any suspicion that a child is being exposed to violence or maltreated in other way. The social services are responsible for investigating the child's needs for protection and support, and also offer support to the child and its parents.<sup>10</sup> Previously, it was only the mother's mental health that was addressed during visits to CHCs, but since 2018, attention has also been given to the father's mental health, life situation and parenting role.<sup>11</sup> Studies have shown that fathers, as well as mothers, have expressed interest in receiving knowledge and support concerning parenting and the early care of their child.<sup>12</sup> CHSs in Sweden have not routinely asked parents about their experience of violence, but have only done so if there has been some indication, that is, in the event of signs/signals of exposure to violence. In recent years, however, routine questions about IPV have been implemented in some CHSs.<sup>13,14</sup> Internationally, a few studies show that routine questions to mothers about IPV have been implemented in CHSs.<sup>15,16</sup> To the best of our knowledge, there are no studies within child health care in which the child's exposure has been discussed or where the father/partner has been included. However, when routine conversations have been used, studies show that both nurses and mothers emphasise that there is a need for individual conversations about IPV with both mothers and fathers.<sup>13,14</sup> The aim of this study was to evaluate an intervention where nurses working in CHS routinely provide Conversations and Information about Violence (CIV) with mothers and fathers/partners. The research questions were: To what extent were these conversations conducted and what factors impacted them from being implemented? What were

### Key Notes

- Children who are exposed to violence in their homes are at high risk for ill-health, for the sake of children, it is necessary to find new arenas for preventive work.
- An intervention with routine conversation and information (CIV) to parents within child health care services (CHS) was evaluated and also feasible.
- The results encourage continued implementation of CIV within CHS, future research should explore parents' reactions further.

the nurses' perceptions of conducting the intervention? How do the nurses' perceptions help in understanding the implementation of the intervention?

## 2 | MATERIAL AND METHODS

### 2.1 | Study design

In order to deepen and enrich the understanding of how conversations about violence can be routinely conducted in CHS with all parents, a convergent mixed methods design was chosen.<sup>17</sup> Both quantitative and qualitative data were collected. The two data sets were analysed separately, compared and integrated into an overall interpretation of the results.

### 2.2 | Definitions

#### 2.2.1 | Parents' origin

*Swedish originis* designated when one or both parents were born in Sweden.

*Foreign originis* designated when both parents were born abroad.

### 2.3 | Study group

An initial inquiry was sent via e-mail in December 2017 to nurses at all 25 CHCs in the county of Sörmland in Sweden. Six CHCs, including a total of 22 nurses, expressed interest in participating; these nurses would then form the study group. Their participation was approved by their respective head of the units. One of the CHCs discontinued participation at a later stage due to staff turnover (August 2018). The final study group consisted of a total of 20 CHS nurses from five CHCs. In the qualitative part of the study, 12 of these 20 nurses participated in focus groups (FGs). Four nurses ended their employment during the project time and their contacts with families were taken over by colleagues working in the project. These and another three nurses who

ended their employment after the project end did not participate in the FG interviews. Thirteen of the nurses signed up to participate in the FG, but one of them cancelled the same day due to illness.

## 2.4 | The research group

The study was conducted by two district nurses with long experience of clinical work in child health care including conversations on child abuse and IPV, one nurse and researcher with expertise in qualitative methods and one psychotherapist with specialised clinical experience, in training of professionals and as researcher in the field of child maltreatment, including CA and IPV.

## 2.5 | Intervention

Initially, the participating nurses received 1.5 days of training, spread over two different sessions. The themes in the training were 1) health-promoting conversations with particular focus on talking about violence, different types of violence and the short- and long-term consequences of exposure to violence; 2) individual conversations with each parent; and finally 3) information provided by social services regarding the duty to report, routines for collaboration and guidelines for responses and actions depending on the answers received and specific situations. During the project, the nurses had access to a manual including routines and support material concerning CIV and documentation as well as a list of support services and contacts, and information literature. In the manual the nurses had access to a flow chart that describes the measures to be taken based on different answers/conditions that may emerge in the conversations. This includes, for example, direct contact with the social services in the event of ongoing violence. To further ensure the safety of the nurses and of the parents who were in contact with CHSs, the county council's general guidelines concerning how to deal with threats and violence were included in the manual. The nurses were also offered the possibility of a consultation with psychologists at the CHS and/or members of the research group.

The manual stipulated three visits per family that included CIV with the parents. The times for the visits were in line with the regular Swedish CHS programme. During the home visit in the neonatal period, information was provided about violence and the consequences of violence for children's health and development. An information brochure, which had been translated into five different languages, could be handed out and there was also other written material that provided information about how violence affects children's health, and the rights and opportunities for children and parents to receive support. The second conversation including the CIV was conducted individually with the mother when the child was 6–8 weeks old and in connection with completion of the Edinburgh Postnatal Depression Scale (EPDS).<sup>11,18</sup> Conversation number three was conducted individually with the father/partner when the child was 3–5 months old and the CIV was used in connection with the

Whooley questions<sup>19</sup> that measure depression: *During the last month have you often been bothered by feeling down, depressed or hopeless?* and *During the last month, have you often been bothered by little interest or pleasure in doing things?* However, no results of EPDS and Whooley questions are included in this study.

A questionnaire form with three questions about experiences of violence was used as the basis for the CIV in the individual conversations with mothers and fathers/partners respectively. The questionnaire began with a description of what is meant by violence and information about the risks for children.

Questions:

- Have you ever in your life been exposed to violence or threats by a person close to you? As an adult or as a child?
- Are you currently afraid of your partner or any other person related to you?
- Is your child in any way exposed?

The questionnaire primarily functioned as a conversational support and answering it was voluntary. It originated from a study in Region Stockholm, where it had been translated into Swedish and adapted to a Swedish context. In turn, the questionnaire was inspired by a study by Taft et al. 2015.<sup>16</sup> In the present study the questions were also translated into four other languages.

## 2.6 | Data collection

Quantitative and qualitative data were collected separately and independently, that is, one data collection did not depend on the results of the other. However, both types of data were considered equally important.<sup>17</sup>

*The quantitative data collection* was carried out using an anonymised documentation form that the nurses filled in over a period of 6 months for each child belonging to the respective CHC born between 10 September 2018 and 10 May 2019. The documentation form, which was created by the research group, included 1) fixed response options for background factors (first-time parent or parent of several children, guardian of the child, parents' origin— Swedish or foreign— and use of an interpreter, 2) questions about the conducting of the three different parts of the intervention, including questions about measures taken as a result of the CIV, 3) open-ended questions where the nurses could answer to why the CIV was not conducted, and 4) questions regarding any subsequent continuing contact with the parents. The documentation form was filled in consecutively after each part of the intervention and included additional space for the nurses' own reflections (comments) in support of her/his memory. These comments were not used in any analyses. (See Appendix S1).

*The qualitative data collection* was performed after completion of the intervention through semi-structured interviews in two FGs (in December 2019 and January 2020). Five nurses from three units participated in the first interview and seven nurses from four units participated in the second. The length of the nurses' experience

of working within CHS varied from 2.5 to 35 years, Median (Md) 5 years. Ten of them were registered district nurses and two were registered paediatric nurses.

The interviews were held in a separate room at a research centre in the county council. The fourth author conducted the interviews as moderator and the second author was the secretary. The participants were initially informed about the roles of the moderator and secretary, respectively, and that the data collected would be treated in strict confidence and only presented at group level. In addition, it was pointed out that the aim of the FG was to produce a comprehensive picture and to highlight different perspectives. Participants were encouraged to interact with each other and discuss the questions, and were informed that the purpose of using FGs was that the interaction would help them reflect on their own perceptions of the intervention.

Four different themes were presented as interview topics: *How have you experienced routinely asking questions about violence? How have you experienced parents' reactions to questions about violence? Tell us about the experience of inviting fathers as well as mothers to an individual conversation. Has your own need for support as a member of staff been met?*

The moderator led the interview and asked clarifying questions. The secretary took care of the digital audio recording and made notes about any non-verbal communication. The FG interviews lasted for about an hour and were ended when it was perceived that the goal based on the purpose and the research questions of the study had been achieved. After each FG interview, the moderator and secretary discussed their experience of the interview and to what extent they had received relevant data concerning the topic in question.

## 2.7 | Data analysis

The two types of data were analysed separately using methodologies that are typical for each type of data.<sup>17</sup> *Quantitative analysis.* Data from the documentation forms were analysed using descriptive statistics and are mainly presented as frequencies and percentages. Differences between groups were tested with Chi<sup>2</sup> tests and a value of  $p < 0.05$  was considered statistically significant. Statistical analyses were performed using SPSS (Statistical Package for the Social Sciences) version 22.0. The answers to the open-ended questions in the documentation form were read through and compiled according to differences and similarities in content.

### 2.7.1 | Qualitative analysis

The data material from the FGs were analysed using qualitative, manifest content analysis.<sup>20</sup> The recorded interviews were transcribed verbatim by the second author. The second and fourth authors identified meaning units, and condensed and coded these. The codes were then arranged into categories and subcategories based on their similarities and differences. The third author participated in

critical discussions about both the coding and the sorting into categories/subcategories, and the analysis was completed when consensus between the authors regarding the categorisation had been reached.

### 2.7.2 | Convergent phase

All four authors participated in the final phase of the study, where results from the two different data sets were brought together and compared in order to investigate how they interacted and were related to each other.<sup>17</sup> First, content areas that represented both data sets were identified. Then the authors discussed similarities and differences until agreement over the content areas was reached. Subsequently, for each content area, quantitative results were integrated with qualitative results in order to gain a deeper understanding that would not have been possible if only one type of data had been collected.<sup>21,14</sup>

## 2.8 | Ethical considerations

An application for ethical review was sent to the Regional Ethics Review Board in Stockholm in May 2018. In accordance with Swedish legislation, the board decided that the application would not be reviewed. Instead the board issued an advisory opinion stating that there were no ethical objections to the study (dnr 2018/1149-31/5).

The participating nurses and their managers were informed of the purpose and design of the study and gave written consent to participate. The consent applied to both participation in the provision of information using the documentation form and participation in the FG interviews.

## 3 | RESULTS

Data were reported about holding conversations with and giving information about violence to parents of 475 newborn children registered per the 20 nurses in the study group. There was a higher proportion of parents of several children than first-time parents, and the majority of the parents had joint custody of the newborn. The proportion of parents of Swedish origin was slightly higher than the proportion of parents of foreign origin (Table 1). Interpreters were used in conversations with 95 (20%) of the families.

### 3.1 | The intervention

#### 3.1.1 | Quantitative data

Home visits during the neonatal period, Md 9 days, were carried out in the majority of the families and 94.2% received information about violence. Both parents participated in almost three quarters

**TABLE 1** Background factors of the families ( $n = 475$ ) presented in numbers ( $n$ ) and percentages (%)

	Responses; $n$ (missing; $n$ )	$n(\%)$
Child of first-time parents	473 (2)	197 (41.6)
Child of parents with several children		276 (58.4)
Parents with joint custody	457 (18)	426 (93.2)
Parent with sole custody		31 (6.8)
Swedish origin (one or both parents born in Sweden)	471 (4)	249 (52.9)
Foreign origin (both parents born abroad)		222 (47.1)

**TABLE 2** Participation in different parts of the intervention presented in numbers ( $n$ ) and percentages (%),  $n = 475$ 

Intervention	Responses; $n$ (missing; $n$ )	$n(\%)$
Home visits including information about violence	469 (6)	442 (94.2)
Both parents participated	469 (6)	340 (72.5)
Only mothers participated	469 (6)	128 (27.3)
Only fathers participated	469 (6)	1 (0.2)
Individual conversations with mothers including talking about violence	472 (3)	462 (97.9)
Use of both questionnaire and oral conversation	462 (10)	425 (92.0)
Individual conversations with fathers including talking about violence	468 (7)	286 (61.1)
Use of both questionnaire and oral conversation	286 (182)	269 (94.0)

of the home visits (Table 2). When compiling the answers to the open-ended questions, it emerged that information about violence had not been provided during the home visit if other people had been present or if it had not been perceived appropriate for other unspecified reasons.

Individual conversations with the mothers, including talking and information about violence, were conducted for almost all families when the child was 6 weeks old (Md). In a majority of the conversations with mothers, both the questionnaire form about experiences of violence was provided and an oral conversation about violence were conducted with 92% of the participating mothers (Table 2). Compiling the answers to the open-ended questions in the form concerning mothers who did not participate in an individual conversation revealed that the mothers had either declined, had moved, already had an ongoing contact or had low proficiency in the Swedish language.

Fathers/partners participated in individual conversations, including talking and information about violence, to a statistically significantly lower extent than mothers ( $p < 0.001$ ). In the cases where both parents participated in the home visit, the proportion of fathers/partners who also participated in individual conversations was statistically significantly higher ( $p < 0.001$ ). The conversations with fathers were conducted when the child was 4 months of age (Md). The questionnaire form about experiences of violence in combination with the oral conversations about violence were used for 94% of the participating fathers (Table 2). Compiling the answers to the open questions concerning fathers/partners who did not participate in individual conversations revealed that practical reasons for nonparticipation were given, such as work or that

the father/partner was abroad, that the nurse had never met the father/partner, or that they had been offered a conversation but had declined.

### 3.1.2 | Qualitative data

*From feeling worried to feeling secure.* Routinely talking and informing about violence was a new task for the nurses, which led to feelings of insecurity concerning the breaking of taboos, moving into the private sphere and getting to know unpleasant things. The nurses described initially feeling uncomfortable asking about the parents' experiences of violence, but that this became easier with time. There had been concern about how the parents would react when the question was asked.

The nurses further described experiencing a sense of professional development through holding the conversations. They described that it was important to find a way to deal with the parents' reactions and to develop an appropriate approach, while still following the manual for the intervention and how they often asked follow-up questions to the questionnaire to clarify what the participants perceived as violence. They felt that the parents' reactions to the conversations about violence were predominantly positive, and that negative reactions, such as: "why are you asking this question?" were encountered in only a few cases. No severe complications were reported.

*Awareness.* The nurses described having gained an in-depth awareness of the importance of talking about violence and that this is done in the best interests of the child. They felt that the conversation could also help to raise awareness among the parents.

## 3.2 | Individual conversations with mothers and with fathers/partners

### 3.2.1 | Quantitative data

Individual conversations with parents were conducted to a large extent in connection with the EPDS screening for mothers (98.3%) and in connection with the Whooley questions (98.8%) for fathers/partners. Fathers/partners of foreign origin participated to a statistically significantly lower extent in individual conversations than fathers/partners of Swedish origin ( $p < 0.001$ ). This difference was not seen among the mothers (Table 3).

### 3.2.2 | Qualitative data

*A more personal conversation with the mother and a new approach with the father/partner.* The content of the individual conversation with the mother was felt to be different when conducted as an addition to the EPDS screening. The nurses felt that the adding of questions about violence meant that the conversations became more in-depth compared to previous individual conversations with only EPDS screening. They also described that it was obvious for the women to take part in the conversations. Individual conversations with fathers/partners was a new intervention and not as natural to participate in. The nurses described that it was positive to invite the fathers/partners to an individual conversation specifically aimed at them. They also described that the combination of Whooley questions and questions about violence meant that the conversations often focused on close relationships.

## 3.3 | Further measures taken based on the conversations

### 3.3.1 | Quantitative data

Based on the completed conversations, 41 (8.6%) of all the families were offered one or more further measure. As a result of individual conversations with the mothers, 23 (4.9%) were offered continued support by the CHS, the family centre or the health care centre, and six (1.3%) of the mothers were referred to another resource within the health care or social services. As a result of individual conversations with the father/partner, a small number was offered continued support by the CHS, the family centre or referral to another

resource. Reports to social services were made for seven (1.5%) of all the children.

### 3.3.2 | Qualitative data

*Being forced to take action.* Being told about ongoing violence was challenging for the nurses. It raised awareness of the importance of not only asking questions about violence during contact with new parents but also meant that they were forced to take action in form of reports to social services. When the nurses perceived that a family needed a contact for support, it could be challenging to find an adequate resource or to get help soon enough.

## 3.4 | Feasibility

This content area was covered by qualitative data only. Three themes emerged from the qualitative analysis, that is, *Facilitating factors*; *Dilemmas*; and *Meaningfulness and gratitude*. The findings provide further understanding about the nurses' experiences of how the intervention was feasible and what was perceived as dilemmas.

### 3.4.1 | Facilitating factors

The nurses described both parents being present at the home visit as positive "then they have both been able to hear". Being able to be flexible with the times for the conversations with the father/partner facilitated the implementation. The questionnaire gave weight to the conversation and the nurses perceived that when the parents read the questions this provoked thought and reflection "when you read the questions you think about it a bit more". The fact that the questions were asked on a routine basis also facilitated the implementation. This was partly because the nurses felt more secure since no individual was being singled out, and partly because the parents did not feel singled out either. "In the beginning it was very awkward but I could reassure myself with the thought that everyone is being asked this question".

The nurses emphasised that the introduction, training days and continued support in the form of opportunities for consultation and the information folder/manual were important. Collegial support had also been of great value during the implementation. In addition, the nurses emphasised the importance of good ancillary resources, such as psychosocial support for families and professional interpreters.

	Number/proportion of Swedish origin	Number/proportion of foreign origin	p-value
Individual conversations with mother	244 (98.8%)	214 (96.8%)	0.202
Individual conversations with father/partner	171 (69.2%)	112 (51.6%)	<0.001

TABLE 3 Individual conversations and Swedish/foreign origin, presented as numbers and proportions in each group

### 3.4.2 | Dilemmas

Despite what is stated above, about interpreters as a facilitating factor, using an interpreter has not always been unproblematic. All interpreters are not perceived as sufficiently professional and families do not always feel comfortable with having an interpreter present. This means that language difficulties sometimes arise in conversations. Furthermore, the nurses described experiencing a number of other dilemmas during the implementation, for example, in relation to the families' various situations and the different views regarding the parenting roles of mothers and fathers in Sweden and in cultures from other countries. Fathers/partners participated in individual conversations to a lesser extent than mothers in both Swedish and foreign families. In families from other cultures, it is the mother who is usually solely responsible for the children and the home. It also emerged during the conversations that parents from other cultures may have different views concerning violence, and what is allowed and perhaps necessary. One nurse described it as *"foreign-born parents - who themselves do not see that they have been exposed to violence"*. Another nurse said that *"it is not just about changing culture and environment - you may not change just because you get a social security number and live in Sweden"*.

### 3.4.3 | Meaningfulness and gratitude

The nurses talked about experiencing a sense of meaningfulness through asking questions about violence in contact with new parents and described feeling grateful for having been able to participate in conversations about violence. A nurse said that *"the stories are gifts that you have received"*. They perceived that it was important to ask about being exposed to violence and expressed a desire for this to continue, both in their own unit and other units in the county council.

#### Integrated data

The integrated data show how the nurses' experiences of the intervention, qualitative data, explain and confirm what had emerged in the quantitative data. As for example the number of completed CIVs (Table 4).

## 4 | DISCUSSION

The aim of this study was to evaluate and describe an intervention where nurses in CHSs routinely talk to and inform mothers and fathers/partners about violence as a primary preventive measure. The aim of the intervention was not, therefore, to carry out a form of screening. The study is, as far as we know, the first to evaluate CIV with both parents within CHSs, and to enquire about ongoing or previous experience of violence, as an adult or as a child, and finally the child's exposure to violence.

In summary, the results show that the intervention has, to a large extent, been carried out and that it has been perceived as successful by the nurses. Almost all families have taken part in the CIV during home visits and individual conversations were conducted with nearly all the mothers, although to a lesser extent with the fathers/partners. Initially, the nurses felt slightly worried about talking about violence, but they described experiencing that they had developed and become more professional in their role of asking questions and talking about violence, and the risks of violence in a CHS context. They also described a new awareness of the importance of the conversations and that they are conducted in the long-term best interests of the child. The nurses emphasised the importance of the preparation prior to the intervention, in the form of training and the knowledge support/manual, as well as the opportunity for consultation and the collegial support they received while the work was being carried out. Previous studies have shown the need for training and support in conversation methodology in the implementation of similar interventions.<sup>13,14,22</sup> Studies on conversations with mothers about IPV have shown that there have been greater barriers among the staff than among mothers about raising the issue of violence.<sup>13,15</sup> For the implementation to be successful, a process of normalisation in several steps is required, which includes, for example, making it meaningful and reflecting on how it affects yourself and those you meet.<sup>15</sup> According to the current national recommendations, CHS should ask about violence if there is any indication, that is, when there are signs of exposure to violence.<sup>9</sup> The results of the current study show, as in previous studies, that implementation is facilitated by the fact that the question is asked routinely of everyone and that individuals are, therefore, not singled out.<sup>13,14</sup> The use of a questionnaire to introduce the issue and create space for reflection in order to later follow up with dialogue between the parent and the nurse was also a facilitating factor, which has also been seen in previous studies.<sup>13</sup> The parents' reactions to the CIV were perceived by the nurses as positive, with only a few exceptions.

Individual conversations with the mother and the father/partner were part of the intervention. The results show that the nurses felt that it was natural for mothers to participate in the individual conversations. Screening for postpartum depression has been carried out for more than 10 years through individual conversations with mothers<sup>23</sup> and, in the current intervention, the conversations have also included the CIV. The nurses described that the conversations with the mothers were more in-depth thanks to the new questions. Previously, there have been no interventions within CHSs targeted directly at fathers. The results show that the nurses felt that the fathers have previously been excluded. Since studies have shown that new fathers have an increased risk of mental ill-health in connection with childbirth,<sup>24,25</sup> individual conversations with fathers/partners about mental health are now recommended in the Swedish CHS programme. Conversations with the father/partner were introduced in connection with the intervention and included partly questions about mental health and partly the CIV. The participation of fathers/partners in the individual conversations was lower than

TABLE 4 Description of quantitative data about the intervention, qualitative data on nurses' experiences and integrated data from the two data sets

Different parts of the intervention	Share within numbers reported, Quantitative data	Nurses' perception, Qualitative data/ Quotations	Integrated data
Home visit including information about violence	94.2% 97.9% 61.1%	Generally: <b>From feeling worried to feeling secure</b> 'It was scary in the beginning – it's become easier'. 'Have large experience and then one knows if it is appropriate or not'. <b>Awareness</b> 'we want things to be as good as they can possibly be for the child'. 'Sown a seed and then they now that they can come to us' <b>Meaningfulness and gratitude</b> 'I feel grateful to have received this trust' 'We continue'	The nurses' description of professional development in these conversations, the raised awareness and experience of meaningfulness validate and deepen the understanding of the high shares of conducted parts of the intervention.
Individual conversations with mothers including CIV Individual conversations with fathers including CIV	97.9% 96.8%	<b>A more personal conversation with the mother</b> 'It was obvious for women to participate in the conversations' 'The conversations has, in a way become more personal' 'Life stories actually' 'In some cultures there is a different view of, violence against children. In their culture, it is the norm to use corporal punishment. Can we break the pattern?'	The high degree of participation of mothers in the individual conversations is confirmed by the nurses' experiences, that it was natural for mothers to come. In addition that the conversations became more personal and made visible cultural differences in perceptions of violence.
Individual conversations with mothers Mothers/foreign origin	61.1% 51.6%	<b>A new approach with the father/partner</b> 'more difficult to get the fathers to come due to work and other practical obstacles' 'In the past, it has felt strange to exclude the fathers' 'now, you could almost see them shine up' 'Fathers from other cultures are not always visible at CHS, instead it is only the mothers who come'	The nurses describe both positive experiences of inviting fathers to not only individual conversations but also practical and cultural obstacles, which confirms and explains the lower proportions of participating fathers and especially fathers born abroad.
Individual conversations with fathers/partners Fathers/foreign origin	8.6%	<b>Being forced to take action</b> 'when one find out that there is ongoing violence, then I have made a report' 'Why did I asked this question, why?' 'But they have kept coming, yes both of them' 'You want to provide someone a support contact and then it is unclear to which institution and when'	The quantitative data show that further measures have been taken, which confirms the qualitative data showing that the nurses have taken their responsibility for this even though it has been perceived as challenging and difficult.
Further measures based on CIV			

that of the mothers, but the proportion can still be seen as good in relation to goals that are realistic in a completely new initiative by CHS. Talking and informing about violence with both parents individually is important, since both parties may have experience of current or previous exposure to violence in adult relationships and/or as children. Parents of foreign origin accounted for a large proportion of participants in the study (47%) and this was higher than the proportion of parents of foreign origin in both the county (27%) and the country as a whole (26%) (Statistics Sweden). This high proportion of foreign born parents is probably due to the fact that the CHCs included in the study were located in areas with a high share of residents of foreign origin and that the families were registered on these CHCs. The results showed that almost all the families of

foreign origin took part in the intervention, which indicates a high level of confidence in Swedish CHS. This confirms a Swedish study that showed that foreign-born parents expressed satisfaction and trust in Swedish CHS, and also highlighted the importance of cultural competence among the staff and access to interpreters.<sup>26</sup> The results showed that 8.6% of the participating families were offered continued support as a result of the CIV and that the number of reports of concern to social services was higher in the study group than in previously reported figures in Sweden (1.5% in the study and 0.5% in the country according to statistics from the National Board of Health and Welfare). This indicates that the CIV creates an opportunity for children's vulnerability and families' need for support to be given greater attention.

## 4.1 | Methodological considerations

In the present study a mixed methods design was chosen. Mixed methods designs have pragmatic advantages when addressing complex research questions. The statistical analysis can provide results for response patterns while qualitative data provide the researcher with a deeper understanding of the responses. However, in order to provide reliable and valid data it is important that both quantitative and qualitative research questions are formulated, and answered.<sup>27</sup> In the present study, thus, data were collected both on the extent to which the intervention was carried out (quantitative data) and on the nurses' experiences of the intervention (qualitative data). In addition, the researchers need to have expertise in both qualitative and quantitative research approaches.<sup>27</sup> Thus, the research team included two senior researchers, one with extensive experience of quantitative research, and one with extensive experience of qualitative research. In addition the other two members of the research team had extensive knowledge and experience from the clinical field.

The results show that the use of a convergent mixed methods design enabled validation, confirmation, explanation and increased understanding of the findings from the two data sets, which provided more in-depth knowledge regarding the implementation. However, in line with Fetters, Curry and Creswell,<sup>28</sup> the integration of data were limited and possible only at the study design level, that is the data collection and data analyses were conducted in parallel, and integration was possible only during integration phase.

A limitation of the study may be that the parents themselves were not asked about how they perceived the CIV; finding a suitable method for this may be an important subject for future studies. The high proportion of parents of foreign origin means that the material is not representative of the county as a whole; this also constituted a great challenge in the implementation due to language and cultural differences. A further limitation may be that the study group consisted of nurses who registered early interest in participating and who can, therefore, be assumed to be more positive about the purpose of the study than other potential participants. Finally, a possible limitation may be the high proportion of nurses who chose to terminate their employment during or after the study period and thus did not participate in the FG interviews. However, we have no indication that this is related to the implementation, but is a part of a generally high staff turnover in the region.

Since the aim of the study was to evaluate a shared experience, that is, an intervention conducted at five different CHCs, focus groups were used for data collection.<sup>29</sup> FG interviews are seen to have both disadvantages and advantages. There is a risk that group processes control the content so that it is the smallest common denominator that characterises the content and that different perceptions do not emerge. In contrary, the interaction between the participants in a FG can help to enrich the content by highlighting different perspectives and also reminding of different parts of a phenomenon that might otherwise have been forgotten or overlooked. In conclusion, the present study found that the CHS is an

arena where it is possible to talk to all parents of newborn children and inform about violence. During this period, mothers and fathers/partners are receptive and keen to receive information that is in their child's best interests. The nurses described that facilitating factors for implementation of the conversations with parents included thorough preparation in the form of training and information; support from colleagues; opportunities for consultation and, further, the fact that the questions were asked on a routine basis and that a questionnaire gave weight to the conversation. The results encourage further implementation of CIV in CHSs in general and of individual conversations about violence and mental health with fathers/partners.

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## CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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## REFERENCES

1. World Health Organization. Preventing child maltreatment: A guide to taking action and generating evidence / World Health Organization and International Society for Prevention of Child Abuse and Neglect. World Health Organization; 2006.
2. Gilbert R, Widom CS, Browne K, Fergusson D, Webb E, Janson S. Burden and consequences of child maltreatment in high-income countries. *Lancet*. 2009;373(9657):68-81.
3. Gartland D, Conway LJ, Giallo R, et al. Intimate partner violence and child outcomes at age 10: a pregnancy cohort. *Arch Dis Child*. 2021;106(11):1066-1074.
4. Miller-Graff LE, Cater AK, Howell KH, Graham-Bermann SA. Victimization in childhood: general and specific associations with physical health problems in young adulthood. *J Psychosom Res*. 2015;79(4):265-271.
5. Holt S, Buckley H, Whelan S. The impact of exposure to domestic violence on children and young people: a review of the literature. *Child Abuse Negl*. 2008;32(8):797-810.
6. Durrant JE. Evaluating the success of Sweden's corporal punishment ban. *Child Abuse Negl*. 1999;23(5):435-448.
7. Kvist T, Dahllöf G, Svedin CG, Annerback EM. Child physical abuse, declining trend in prevalence over 10 years in Sweden. *Acta Paediatr*. 2020;109(7):1400-1408.
8. Dheensa S, Halliwell G, Daw J, Jones SK, Feder G. "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Serv Res*. 2020;20(1):129.
9. National Board of Health and Welfare. Vägledning för barnhälsovård. In: Swedish. English translation by the author: Guidelines for the Child Health Services. Socialstyrelsen; 2014.
10. National Board of Health and Welfare. SOSFS 2014:4 Föreskrifter och allmänna råd, Vård i nära relationer. 2014.
11. Rikshandboken i barnhälsovård. Barnhälsovårdens nationella program. <https://www.rikshandboken-bhv.se/metoder-riktlinjer/ensklida-foraldrasamtal/2020>. Accessed June 21, 2021.
12. Massoudi P, Wickberg B, Hwang CP. Fathers' involvement in Swedish child health care - the role of nurses' practices and attitudes. *Acta Paediatr*. 2011;100(3):396-401.

13. Almqvist K, Källström Å, Appell P, Anderzen-Carlsson A. Mothers' opinions on being asked about exposure to intimate partner violence in child healthcare centres in Sweden. *J Child Health Care*. 2018;22(2):228-237.
14. Anderzen-Carlsson A, Gillå C, Lind M, Almqvist K, Lindgren Fändriks A, Källström Å. Child healthcare nurses' experiences of asking new mothers about intimate partner violence. *J Clin Nurs*. 2018;27(13-14):2752-2762.
15. Hooker L, Small R, Humphreys C, Hegarty K, Taft A. Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial. *Implement Sci*. 2015;10:39.
16. Taft AJ, Hooker L, Humphreys C, et al. Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): a cluster randomised trial. *BMC Med*. 2015;13:150.
17. Creswell JW, Plano Clark VL. *Designing and conducting mixed methods research*. SAGE Publications; 2011.
18. Wickberg B, Hwang CP. The Edinburgh postnatal depression scale: validation on a Swedish community sample. *Acta Psychiatr Scand*. 1996;94(3):181-184.
19. Whooley MA. Screening for depression—A tale of two questions. *JAMA Intern Med*. 2016;176:436-438.
20. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24:105-112.
21. Hesse-Biber SN, Johnson B. *The Oxford handbook of multimethod and mixed methods research inquiry*. Oxford University Press; 2016.
22. Engstrom M, Hiltunen J, Wallby T, Lucas S. Child health nurses' experiences of addressing psychosocial risk factors with the families they meet. *Acta Paediatr*. 2021;110(2):574-583.
23. Wickberg B, Hwang CP. Screening for postnatal depression in a population-based Swedish sample. *Acta Psychiatr Scand*. 1997;95(1):62-66.
24. Psouni E, Agebjorn J, Linder H. Symptoms of depression in Swedish fathers in the postnatal period and development of a screening tool. *Scand J Psychol*. 2017;58(6):485-496.
25. Andersson SO, Annerback EM, Sondergaard HP, Hallqvist J, Kristiansson P. Adverse childhood experiences are associated with choice of partner, both partners' relationship and psychosocial health as reported one year after birth of a common child. A cross-sectional study. *PLoS One*. 2021;16(1):e0244696.
26. Mangrio E, Persson K. Immigrant parents' experience with the Swedish child health care system: a qualitative study. *BMC Fam Pract*. 2017;18(1):32.
27. Sadan V. Mixed methods research: a new approach. *Int J Nurs Edu*. 2014;6(1):254.
28. Fetters MD, Curry LA, Creswell JW. Achieving integration in mixed methods designs-principles and practices. *Health Serv Res*. 2013;48(6 Pt 2):2134-2156.
29. Holloway I, Galvin K. *Qualitative research in nursing and health-care*, 4th ed. John Wiley & Sons Inc; 2017.

## SUPPORTING INFORMATION

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