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Studies on routine inquiry about violence victimization and alcohol consumption in youth clinics

ANNA PALM



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Abstract

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Objectives: Violence victimization is common in youth, and the association between victimization and ill-health is well established. Youth is also the period when alcohol risk drinking is most prevalent. At youth clinics in Västernorrland, Sweden, a randomized controlled intervention was conducted examining health outcomes and risk drinking after implementing routine inquiry about violence victimization and alcohol consumption.

Methods: Participants in the intervention group underwent routine inquiry about violence victimization and alcohol consumption. Victimized participants received empowering strategies and were offered further counseling. Risk drinkers received motivational interviewing (MI). All participants answered questionnaires about sociodemography and health at baseline, at 3 months and at 12 months. Of 1,445 eligible young women, 1,051 (73%) participated, with 54% of them completing the 12-month follow-up. Males were excluded from the quantitative analysis owing to the low number of male participants. Fifteen research interviews examining the experience of routine inquiry were conducted.

Results: Violence-victimized young women reported more ill health than non-victimized women did. This was especially evident for those who had been multiply victimized. There were no differences in health outcomes between the baseline and the 12-month follow-up for the intervention group and for the control group. Of the victimized women in the intervention group, 14% wanted and received further counseling. There was a significant decrease in risk drinking from baseline to follow-up, but no differences between the MI group and the controls. There was a large intra-individual mobility in the young women's drinking behavior.

In interviews, the participants described how questions about violence had helped them to process prior victimization. For some, this initiated changes such as leaving a destructive relationship or starting therapy. The participants considered risk drinking in terms of consequences and did not find unit-based guidelines useful.

Conclusion: Violence victimization, especially multiple victimization, was strongly associated with ill health in young women. Routine inquiry about violence and subsequent follow-up led to a high degree of disclosure but did not improve self-reported health. However, victimized participants described talking about prior victimization as very helpful. Participants viewed risk drinking in terms of consequences rather than in quantity or frequency of alcohol, which may render unit-based drinking guidelines less useful when addressing risk drinking in youth.

Keywords: Violence victimization, Youth, Alcohol consumption, Routine Inquiry, Screening, Youth friendly health care, Randomized controlled study, Qualitative study

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LIST OF PAPERS

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- II* Palm, A., Högberg, U., Olofsson, N., Skalkidou, A., Danielsson, I, No differences in health outcomes after routine inquiry into violence victimization in young women – A randomized controlled study in Swedish youth health centers. *Journal of Interpersonal Violence*. In press.
- III* Palm, A., Olofsson, N., Danielsson, I., Skalkidou, A., Wennberg, P., Högberg, U. (2016) Motivational Interviewing does not affect risk drinking among young women - A randomized, controlled intervention study in Swedish youth health centers. *Scandinavian journal of Public Health*, 44(6):611-8
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SVENSK SAMMANFATTNING

Bakgrund: Våldsutsatthet är vanligt i ungdomsåren och flera undersökningar har visat att våldsutsatta ungdomar har en klart sämre hälsa än jämnåriga som inte utsatts för våld. Ungdomar berättar sällan spontant om våldsutsatthet när de söker vård, men har i studier varit positiva till att sjukvårdspersonal aktivt frågar om det.

Riskabla alkoholvanor är vanligast i åldersgruppen ungdomar och unga vuxna (16–29 år). Det finns starka vetenskapliga belägg för att både våldsutsatthet och riskbruk av alkohol är kopplat till sämre hälsa hos unga. Därför rekommenderar flera professionella organisationer att hälso- och sjukvårdspersonal rutinmässigt frågar ungdomar om såväl erfarenhet av våld som alkoholkonsumtion.

Syfte: 1) Att studera effekten på unga kvinnors hälsa och riskbruk av alkohol efter införande av hälsosamtal med rutinmässiga frågor om våldsutsatthet och alkoholkonsumtion på ungdomsmottagningarna i Västernorrland. 2) Att i forskningsintervjuer undersöka hur ungdomar som fått hälsosamtal upplevde det att få frågor om våldsutsatthet och alkoholkonsumtion.

Metod: I Sverige finns det ungdomsmottagningar i nästan alla kommuner. Ungar söker ungdomsmottagningarna för råd och förskrivning av preventivmedel, testning för och behandling av sexuellt överförbara sjukdomar och även för psykiska och kroppsliga besvär.

Alla ungdomar i åldern 15–22 år som kom för ett första besök till någon av ungdomsmottagningarna i Västernorrland under 2012 tillfrågades om de ville delta i studien. Av dem som tillfrågades tackade 73 % ja och lottades då till antingen en interventions- eller en kontrollgrupp. Deltagarna i interventionsgruppen fick utöver sitt vanliga besök på ungdomsmottagningen ett hälsosamtal med strukturerade frågor om våldsutsatthet och alkoholkonsumtion. De som hade varit utsatta för någon form av våld fick stödjande samtal där barnmorskan/kuratoren bekräftade ungdomens upplevelse och betonade att våld aldrig är den utsattes fel, samt erbjudande om fortsatt samtalskontakt. Ungdomar med riskbruk av alkohol fick motiverande samtal.

Deltagarna i kontrollgruppen hade ett ”vanligt” besök på ungdomsmottagningen men fick svara på frågor om våldsutsatthet och alkoholkonsumtion i en enkät efter sitt besök. Bägge grupperna fick besvara en enkät med frågor om sociodemografi och hälsa efter sina besök. Samma enkät skickades till

samtliga deltagare efter tre och tolv månader. 15 ungdomar som varit utsatta för våld och/eller hade riskbruk av alkohol intervjuades fyra till fem månader efter att de haft hälsosamtal.

Sammanlagt deltog 1 051 unga kvinnor och 86 unga män. 65 % av dem svarade på tremånadersenkäten och 54 % på tolvmånadersenkäten.

Eftersom det var så få unga män som deltog så redovisas bara resultaten för de unga kvinnorna i de kvantitativa studierna. I forskningsintervjuerna deltog även unga män.

Resultat: Unga kvinnor som inte hade utsatts för våld skattade sin hälsa som mycket bra. Våldsutsatta unga kvinnor rapporterade däremot både sämre psykisk och fysisk hälsa än de som inte utsatts för våld. Unga kvinnor som utsatts för flera olika typer av våld var den grupp som skattade sin hälsa sämst. De unga kvinnornas självrapporterade hälsa var oförändrad vid uppföljning efter tre och tolv månader både hos de som fått hälsosamtal och hos de i kontrollgruppen. I hälsosamtalsgruppen berättade de unga kvinnorna i hög utsträckning om erfarenheter av våld när de tillfrågades. Av de våldsutsatta unga kvinnorna i hälsosamtalsgruppen önskade och fick 14 % fortsatt samtalskontakt.

I intervjuerna berättade ungdomarna att de tyckte att det var bra att personalen på ungdomsmottagningen frågade om våldsutsatthet. Flera beskrev hur frågorna om våld hjälpt dem att sätta ord på vad de varit med om och hur de i samtal med barnmorskan eller kuratorn på ungdomsmottagningen kunnat bearbeta tidigare våldsutsatthet. För en del hade hälsosamtalen haft direkta effekter så som att börja i terapi eller avsluta en destruktiv relation.

Mellan 30 och 40 % av de unga kvinnor som hade riskbruk av alkohol vid sitt besök på ungdomsmottagningen hade inte längre ett riskbruk efter tolv månader. Det var ingen skillnad i minskningen mellan dem som fått hälsosamtal med motiverande samtal och kontrollgruppen. Av de unga kvinnor som inte hade ett riskbruk av alkohol vid besöket på ungdomsmottagningen hade 20 % i både hälsosamtalsgruppen och kontrollgruppen ett riskbruk efter tolv månader. Ungdomarna som intervjuades tyckte att det var bra att personalen på ungdomsmottagningarna frågade om alkoholkonsumtion. Däremot tyckte de att frågor om hur ofta och hur många standardglas alkohol man vanligen drack var ett dåligt mått på riskbruk av alkohol. Istället betonade de att det var konsekvenserna av alkohol; om man misskötte sina studier, gjorde dumma saker när man drack etcetera, som avgjorde om ens drickande var problematiskt.

Slutsatser: Att införa ett hälsosamtal med strukturerade frågor om våldsutsatthet och alkoholkonsumtion var genomförbart inom ramen för den vanliga konsultationen på ungdomsmottagningen och mottogs positivt av ungdomar-

na. Våldsutsatthet var vanligt och unga kvinnor som varit utsatta för våld, och i synnerhet de som utsatts för flera typer av våld, hade betydligt sämre hälsa än de som inte utsatts. Frågor om våldsutsatthet förändrade inte självrapporterad hälsa vid uppföljning efter tolv månader, men ledde i hälso-samtalsgruppen till att våldsutsatta unga kvinnor kunde erbjudas uppföljande samtalskontakt vilket 14 % av dem tackade ja till. I intervjuer uppgav ungdomarna att frågor om våldsutsatthet hjälpte dem att förstå och bearbeta tidigare våldsutsatthet vilket ledde till att en del av dem bröt destruktiva relationer eller påbörjade terapi.

Andelen unga kvinnor med riskbruk av alkohol uppvisade en stor interindividuell variation under de tolv månader som studerades, men inga skillnader sågs mellan dem som fått motiverande samtal och kontrollerna. Ungdomarna själva uppgav i intervjuer att de bedömde riskbruk av alkohol utifrån konsekvenserna av drickandet och tyckte inte att mått på frekvens och antal standardglas av alkohol var bra mätare på riskbruk. För att fånga riskbruk av alkohol hos unga behövs sannolikt ett bredare angreppssätt än instrument som främst mäter konsumerad mängd alkohol.

PREFACE

In 2009, a cross-sectional study of violence victimization in 2,250 young women and 920 young men at nine youth clinics across Sweden was published (1). The study demonstrated alarming rates of reported violence victimization in youth during the prior 12 months, and many of the youth reported ongoing suffering from the victimization. One of the participating youth clinics was in Sundsvall where I was working on a regular basis as a gynecology consultant. All of us working at the youth clinic were surprised and alarmed at the numbers of victimized youth in the study, and at the realization that this was indeed the history of the youth whom we met every day at the clinic. This revelation led to many discussions among the personnel working at not only the youth clinic in Sundsvall, but also all the youth clinics in the county of Västernorrland. The discussions clarified the need to act on the greater awareness of the widespread nature of victimization in youth, and the idea of including a health dialogue containing routine inquiry about violence victimization within the youth's regular visit to youth clinics was born. The thought was to offer empowerment strategies and subsequent therapy to victimized youth, with the aim of helping them come to terms with their experiences and improving their health outcomes.

Youth is also the period when alcohol risk drinking is most frequent, and risk drinking in youth is associated with adverse health effects as well as violence. In line with this, it was also decided to include routine inquiry about alcohol consumption within the health dialogue, as well as offer subsequent motivational interviewing (MI) to those considered risk drinkers. One of my supervisors, Ingela Danielsson, who was also one of the researchers in the original study from 2009 suggested that the introduction of a health dialogue with routine inquiry about violence victimization and alcohol consumption should be done within a study. And that was the beginning of what was to become this thesis.

INTRODUCTION

The United Nations (UN) defines *youth* as individuals aged 15–24 years, including both adolescents (15–19 years) and young adults (20–24 years) (2). The reason for this rather wide definition of youth is that in the Western world, the youth period has gradually increased, and living conditions for young adults often resemble those of adolescents. The health of youth has increasingly become an important global public health concern (2). Until quite recently, it has been largely neglected because this age group has generally been perceived as healthy (2). However, in the European region, a recent report by the World Health Organization (WHO) demonstrated that among youth, mental ill health leads most notably to DALYs (disability-adjusted life years), followed by alcohol use disorders (3). Transition from youth into adulthood is a vulnerable time of life, and mental health disorders often begin during this period, potentially resulting in life course adversity (2, 4, 5). Youth is also the period in life when the risk of violence victimization is at its highest (6).

Swedish youth clinics

For more than 40 years, almost all Swedish municipalities have operated youth clinics that deliver free and accessible health care services to youth, mainly focusing on sexual and reproductive health promotion (7, 8). Today, Sweden has more than 250 youth clinics, making the country an international exception in offering comprehensive and well-established services to youth (7). For a youth clinic to qualify as certified, it has to be staffed by midwives, social workers and physicians, generally gynecologists, pediatricians or general practitioners. Youth clinics focus on teamwork and cross-professional working methods (6). Young people attend youth clinics usually until the age of 23, although age limits may vary a little across the country.

Youth clinics in Sweden strive to have high accessibility and a low threshold, to make it easy for young people to access the clinics. Usually, youth clinics are situated off the premises of ordinary health care facilities, and in contrast to those, mainly have a salutogenic and health-promoting focus (6). Youth clinics also have outreach programs, and all students in the 8th or 9th grade visit the local youth clinic with their schools in order to receive information on the available services and the location (8).

When youth come to youth clinics, it is often the first time they have sought help without their parents. Since the youth themselves seek the help, they are viewed as taking responsibility for their own life, which is seen as being a part of gradually becoming an adult. The personnel working in the clinics emphasize the importance of youth coming of their own free will and no referrals are accepted. The focus is on the young person's needs, and if the youth clinic staff cannot meet these needs, they will help the youth to obtain the right help. No one is turned away. The youth clinics adhere to non-restrictive policies and aim to have a norm-critical perspective and to ensure confidentiality (6). In ratings, youth report very high confidence in the personnel working at youth clinics in Sweden (9).

One area where the youth clinics have not been successful is gender equity. Young women account for almost 90% of the visits, with prescription of contraceptives likely being the predominant reason for the first visit (6). It is very common for young women in Sweden to attend youth clinics: 25% of all 16- to 25-year-old women reported having attended a youth clinic in the previous 3 months. However, in young men the corresponding figure was only 5% (10).

As already mentioned, youth clinics have traditionally had a focus on sexual and reproductive health issues, and these are still the reasons for most visits. However, the past decade has seen a possible increase in mental ill health in youth in Sweden, with a trend toward increased in-patient psychiatric care among youth, but with no decrease in suicide, in contrast to adults, among whom a decrease in suicide has been seen over the past decade (11). Especially among young women, self-reported mental ill health has increased (13). There is a well-known association between ill health and violence victimization (1, 12-16). This knowledge, in combination with studies reporting on the widespread experience of victimization in youth, challenges youth clinics to employ an even more comprehensive strategy.

In the youth clinics in Västernorrland, including routine inquiry about violence victimization and alcohol consumption in the form of the present study is one attempt to meet this challenge.

Definition of violence

The WHO has declared violence as a global public health problem and considers violence against young men and women a special priority (17). The WHO published the *World Report on Violence and Health* in 2002, the *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women* in 2005 and the *World Report on Violence Against Children* in 2006 (18, 20, 21). The WHO has defined violence as: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which results in or has a high like-

likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (18). This definition is intentionally broad, in order to also cover violence that does not necessarily result in death or physical harm, but may still have substantial impact on an individual’s life (Figure 1).

The WHO has also divided violence into three types:

1. Self-directed violence such as suicide ideation/attempts and self-harm
2. Interpersonal violence, meaning violence perpetrated within the family, intimate partner/dating violence, violence in schools as well as in the workplace, and random acts of violence committed by strangers
3. Collective violence, including hate crimes, and political and economic violence.

Furthermore, the WHO has stated that violence can be physical, sexual or psychological, and can involve deprivation or neglect.

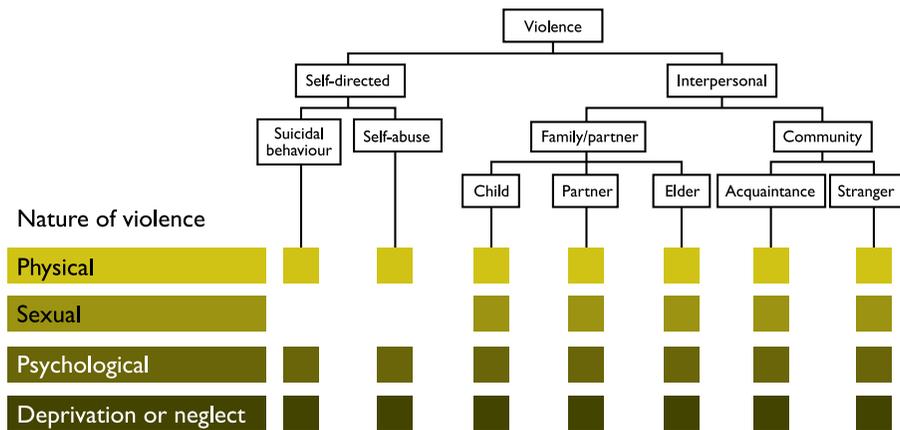


Figure 1. WHO typology of violence (Krug et al., 2002)

Measurement of violence and violence victimization

Measuring violence is difficult (18). Most countries measure homicide and suicide data, which obviously only cover the tip of the iceberg – and even these data are afflicted with errors (18). Systematic data on non-fatal outcomes are not available in most countries, and when they are, come from a number of organizations and research fields with different definitions of violence, inconsistencies in questions asked and different measured outcomes (18). Conceptualizations of violence and what even counts as violence also vary between settings and countries. Taken together, these differ-

ences often make it hard to compare data between countries, or even within the same country. The quality of studies also differs widely. That said, population-based studies using self-reports of violence victimization are considered to be the most reliable and established method when studying violence today (19, 18, 20).

Prevalence of violence victimization in youth

In existing prevalence studies, young people are invariably the group most exposed to violence victimization globally (18, 21). From an international perspective, deadly violence in youth is rare in Sweden and in most of Western Europe. In Latin America and Africa, the rates of deadly violence in youth are 10 times higher than in Western Europe (18).

Societal factors play an important role, and countries with high poverty and income inequality show higher rates of youth violence (18). The legal framework in a country, as well as its cultural norms, plays a part in if and when violence is considered an accepted way of resolving conflicts (18).

In a WHO report on physical assault victimization in youth in European countries, Sweden was one of the countries with the lowest victimization rates (22). The prevalence of child physical abuse by parents or caregivers in Sweden is among the lowest in the world. Only 13% of children reported ever being hit by parents or caregivers in a study from 2011, compared with 24% in Denmark and 25% in England in similar national mappings (23-25). National surveys concerning bullying also display low rates of bullying in Sweden compared with other European countries and the United States (26).

Prevalence of violence victimization in Swedish youth

In Sweden, three population-based surveys that include questions about violence are conducted regularly – the Swedish National Public Health Survey (Folkhälsoenkäten), the survey on living conditions (Undersökning av levnadsförhållanden (ULF)) and the Swedish Crime Survey (Nationella trygghetsundersökningen (NTU)) – all three focusing on physical violence. Reported physical violence or serious threats in women aged 16–24 years ranged between 5% and 17% in the preceding year depending on the survey. Corresponding figures for men aged 16–24 years were 11–12%.

The school survey on crime (Skolundersökningen om brott) is done every third year among 9th graders. In the survey from 2011, about 20% of girls reported violence victimization during the previous year, with 4% of them reporting more serious victimization. Corresponding figures for boys were 25% and 5%, respectively. About 10% of both girls and boys reported being

bullied sometime during the preceding year, but more girls than boys (3.2% vs. 1.6%) reported frequent bullying during that year.

In a study of 15- to 22-year-olds visiting youth clinics in Sweden, 18% of the young women and 27% of the young men reported physical violence victimization (1) within the previous year. The figures for emotional violence were 33% for young women and 18% for young men, and sexual violence was reported by 14% of women and 6% of men. There was also considerable overlap between different types of violence in the same individual (1).

The impact of violence in youth

As described earlier, youth is a period in life when the risk of violence victimization is high (1, 13, 18). The association between violence victimization and ill health in youth is well documented in a variety of defined violence exposures, such as child abuse and domestic violence (15, 27), child sexual abuse (28, 29), bullying and peer victimization (12, 30), sexual abuse (31) and intimate partner/dating violence (14, 32).

A number of possible adverse psychological outcomes and co-morbidities in youth subjected to violence victimization have been defined, such as depression (12, 16, 33); anxiety (33); symptoms of post-traumatic stress disorder (PTSD); (16, 31, 34-36); substance abuse and risk consumption of alcohol (16, 37, 38); and self-injury, suicidal ideation and suicide attempts (39). A recent meta-analysis demonstrated that bullied children and youth aged 2–19 years were at least two times more likely than their non-bullied age-mates to have somatic problems (40). Prospective longitudinal studies have also demonstrated associations between child abuse and impaired educational achievements and higher school absence rates (41-43).

The risk of developing PTSD seems to be significantly higher in youth after interpersonal violence than after other forms of traumatic events such as accidents, natural disasters or the death of a family member (34, 38, 44). Studies have demonstrated that young women are almost twice as likely as young men to develop PTSD following a significant trauma, for reasons that are not clearly understood (16, 31, 34, 36). The risk of developing PTSD also increases with repeated violence (33, 34, 37), and some researchers have suggested that exposure to different types of violence increases the risk for PTSD even more than repeated violence of the same type (33, 45).

It has been suggested that youth may be at a higher risk of developing PTSD after the experience of traumatic events than adults; this higher risk may be due to youth being a period in life with many developmental demands (31). Recently also, questions have been raised whether the standard definition of PTSD is sufficient to cover the experience of multiple and/or prolonged violence victimization that, for example, individuals experiencing

child abuse, bullying or intimate partner violence are subjected to (46). Instead, the terms *complex PTSD* or *developmental trauma disorder* have been suggested to better explain the potentially pervasive effects of violence victimization in childhood and youth (46, 47).

The processes by which violence victimization is linked to ill health are less well understood. Early lifetime victimization may contribute to insecure and disorganized attachment styles that are associated with an increased risk of ill health (48, 49). It has also been suggested that victimization may damage a person's self-concept, leading to low self-esteem and a feeling of helplessness, which might be mediators for depressive symptoms (50). Another theory is that childhood victimization may lead to alterations in the neuroendocrine stress response, which is hypothesized to increase the risk of depression and post-traumatic stress disorder, as well as physical ill health (51, 52).

However, there are also studies indicating that mental ill health increases the risk of violence victimization, and a recent study by Devries et al. has indicated a bidirectional relationship between violence victimization and depression in adult women (53). Developmental psychopathology is of course multidimensional, with ongoing interactions between protective and vulnerability factors within the child/youth, within the surroundings and among particular risk factors (54).

In addition to the ill health and suffering victimized youth are subjected to, they in turn are at an increased risk of perpetrating violence and crimes, thereby inflicting suffering and harm in others (55).

Co-occurrence of violence

Traditionally, different types of victimization have often been studied in isolation (12, 14, 15). As described in the Introduction section, research on each particular type of violence such as child abuse, child sexual abuse, dating violence and youth violence has taken place in relative isolation, with researchers in each area building up their own set of theories, empirical findings and approaches to prevention. However, more recent studies have shown that youth who experience violence in one domain often experience it in other domains as well (33, 37, 56, 57). In fact, co-occurrence of violence, even seemingly diverse and unrelated forms of violence, and experienced at different times, is rather the norm, not the exception (58). When this is the case, it is more accurate to view victimization as a chronic condition with repeated episodes of violence and not as an isolated event (33, 45).

Violence does not operate in a vacuum. In a Swedish classroom survey (Elevenkäten), the outstanding risk factor for physical abuse of a child by caregivers was violence between the adults in the family (23). The same study also showed a much greater risk of being bullied or being a bully in the children subjected to physical abuse at home. Child abuse and poor parental

supervision have been shown to be risk factors for both youth violence and adult violence in several other studies (59, 60). In addition, longitudinal studies have shown that it is not unusual for victimized children to display violent and aggressive behavior that may continue into youth and sometimes into adulthood along what has been termed a *life-course-persistent developmental pathway* (18).

Finkelhor et al. introduced the term *poly-victimization* in order to describe children who have suffered from multiple forms of violence (61). They used the Juvenile Victimization Questionnaire to determine the number and types of previous-year victimization when defining poly-victimization (61). Counting violent events in this way has turned out to be a strong predictor of subsequent victimization as well as adverse health outcomes (33). Finkelhor et al. have shown that there is significant overlap between all types of violence (62). Hence, when focusing only on a single type of victimization, the importance of poly-victimization, which may account for a considerable part of the association between the individual victimizations and adverse health outcomes, might be overlooked (33, 45, 62). Moreover, Finkelhor et al. have shown that in children, much of the perceived ill health for individual violence exposure was due to the underlying effect of poly-victimization, and that the predictive power of individual types of victimization was eliminated, or greatly reduced, when the effect of poly-victimization was taken into account (33, 45).

This important finding highlights the risk that if one type of violence is studied in isolation, the outcomes attributed to that type of violence might be overestimated, since many of the participants in the study will also be victims of other types of violence (63). In addition, many of the participants in the comparison group might themselves be victims of other types of violence and because of this have many characteristics in common with the “victim” group, thus not serving as a useful comparison group (63). Research on poly-victimization also suggests that being a victim of different types of violence has more adverse health outcomes than being a victim of repeated victimization of one type of violence (33, 45).

When focusing on the co-occurrence of violence as the norm, not an exception, it becomes evident how different forms of violence sometimes extend across time and over settings, such as from childhood to adolescence or from bullying to dating violence (33, 62, 63).

Risk factors, resilience and coping in relation to violence victimization

As mentioned earlier, different forms of violence have often been studied in isolation (12, 15, 16). The same is true in identifying risk factors and con-

ceptual models that explain the occurrence of violence (63, 64). However, there is often consistency between risk factors for different types of violence (63, 64). This is probably due to many of the vulnerabilities that make a person susceptible to one type of violence – for example, dysfunctional families and unsafe neighborhoods – also acting as risk factors for other types of violence (63, 64).

The most prominent risk factor for violence victimization is prior victimization (65, 66). Finkelhor et al. have shown that all types of violence victimization were associated with elevated risks for all other types of subsequent victimization, again pointing out the importance of a comprehensive approach when studying victimization (66). Research has suggested that early victimization can influence not only children's behavior, but also their developing personalities (67). In a study by Arata et al., a path model was developed that showed a relationship between higher degrees of self-blame and post-traumatic stress and re-victimization in women with experience of childhood sexual abuse (68). It has been suggested that post-traumatic stress symptoms might increase the risk of victimization due to dissociation and reduce the individual's capacity to engage in self-protective behaviors (69, 47).

In the past few decades, however, there has been a growing awareness that not all, not even the majority of, victimized children and youth are destined to experience lives of hardship (70-72). Masten called this the "ordinary magic," stating that the great surprise of resilience research is the ordinariness of the phenomenon (70).

In the 1970s, researchers started to draw attention to the phenomenon of resilience, which Masten has defined as "good outcomes in spite of serious threats to adaptation or development" (70). In the early studies of resilience, researchers tended to look at resilience as being a personality trait, and resilient children were referred to as hardy or invincible (73). Over time, however, researchers have come to view resilience as a developmental process, often driven by factors external to the child. Subsequent research has led to the delineation of a triad that has been shown to play important roles in the developmental of resilience: (1) personal resources such as coping skills and self-esteem, (2) family resources such as secure attachment and consistent parenting, and (3) characteristics of the wider social environment, including social support from school and peer networks (74). Resilience is a dynamic process and can grow or decline over time depending on the interaction between the individual and the environment.

Coping skills are considered an essential component in resilience (72). Coping strategies have been defined as "constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of the person" (75). In the literature, coping strategies are often referred to as being either an approach-type or an avoidance-type strategy. Several studies have found that youth

who apply approach strategies report less mental ill health than those favoring avoidance coping strategies (76, 77)

Sexual minority youth

In the past two decades, health in sexual minority youth (youth who are attracted to the same sex, engage in sexual behavior with the same sex or endorse a gay/lesbian/bisexual identity) has attracted increasing interest (78, 79). Several studies have demonstrated that sexual minority youth report higher degrees of mental ill health, violence victimization and alcohol/substance abuse than do heterosexual youth (21, 80-82). Sexual minority youth also report higher degrees of suicide ideation and suicide attempts than heterosexual youth do (83). In Sweden, the National Swedish Public Health Survey has shown that 17% of homosexual and bisexual men aged 16 to 29 years and 25% of homosexual and bisexual women in the same age have attempted to commit suicide. The corresponding figures for heterosexual young men and women are 3% and 8%, respectively (21).

To date, most research on violence victimization in sexual minority youth has focused solely on sexual orientation victimization (83, 84). Recently same-sex relationship abuse has also gained interest, although studies have been mainly done on adults and few studies have addressed adolescents and young adults (85, 86). Several studies have demonstrated an association between adverse health and violence victimization in sexual minority youth (78, 82, 83, 87, 88).

The minority stress hypothesis is sometimes used as an explanation of how the feeling of not adhering to the norm as well as experiencing discrimination and violence victimization based on sexual minority status might lead to increased ill health (89).

In the past two decades in Sweden, the recognition of equal rights for sexual minorities, such as same-sex marriage and adoption legislation, has grown, along with an increasing awareness of sexual minority issues. In the past 5 years in particular, hate crimes with homophobic motives have decreased in Sweden (90).

The association between alcohol and violence in youth

Youth are overrepresented in alcohol harm statistics and as a group they are more likely to suffer short-term negative consequences such as injuries and, as well as long-term effects including a greater likelihood of high-risk drinking in adulthood (91, 92). Studies have shown an association between alcohol consumption and youth violence (91, 93, 94). However, despite extensive research, the nature of the correlation between alcohol and violence is

not clear. Arguments for a causal relationship between alcohol and violence exist based on behavioral and pharmacological explanations (94, 95), such as alcohol increasing aggression or functioning as a situational factor, clouding judgment, reducing inhibitions and facilitating violence (96).

Some researchers have proposed that alcohol can serve as an excuse or a cultural time-out in a way that an individual might think that he or she will not be held accountable for his or her behavior when drunk (97). There is some indication that alcohol may work as an excuse for aggressive behaviour among youth in Sweden (98).

In contrast, other researchers consider the relationship between alcohol and violence to be spurious (99, 100). Those arguing for a more spurious effect emphasize the shared risk factors for excessive alcohol use and violence, as well as for other risky behaviors (99). It is known that for men, the association between alcohol drinking and violence victimization is higher than for women and higher for youth than adults (101). A Finnish study demonstrated that for girls, the linear relationship between alcohol use and violence remains in sober violence too, indicating that the association between alcohol drinking and victimization is mostly spurious (102). In boys, there seemed to be a casual rather than a spurious association between alcohol drinking and victimization (102). In a Swedish study, a trend to decreased binge drinking in youth was not accompanied by a decline in violence, strengthening the notion that the underlying mechanisms between alcohol use and violence are complex (103).

THEORETICAL FRAMEWORK

The ecological model

There are many theories for describing and understanding violence, its mechanisms and its origins. One model widely used in public health research is a multidimensional theory called the ecological model. (Figure 2) The theory was initially developed by Bronfenbrenner in 1979 as a way of describing how a child's development can be understood in light of factors internal to the individual as well as in the context of the individual's environment, from the family to economic and political structures, being seen as intersecting levels (104). The model consists of the individual (ontogenic) level, where individual factors such as personal history and experiences, education level and substance abuse are identified. The second level is the microsystem containing social relationships, such as the family situation, relations with peers and social support. On the third level (the exosystem), the community, schools, workplaces and neighborhoods are taken into account. Finally, the fourth level involves larger societal factors such as cultural norms and attitudes, and health, educational and social policies, as well as legislation. The different levels are positioned within each other, illustrating how factors on the same and different levels interact. In 1993, Belsky used the ecological model when examining the etiology of child abuse (105).

Moreover, the ecological model can be used in explaining the effects of violence over the life course. For example, experiencing violence as a child is associated with being a victim or perpetrator later in life (106). The ecological model is used by the WHO in its reports on violence as a way of understanding how different individual and contextual factors interact in the multifaceted process of violence victimization (18).



Figure 2. The ecological model (Bronfenbrenner 1986, Heise 1998)

Feminist theory and gender

At the end of the 1970s, feminist theorists began criticizing the dominating explanation of men's violence as being caused by individual factors such as personality, childhood adversities and alcohol dependency. Instead, they pointed toward the significance of gender inequalities and power differentials as reasons for violence directed toward women by men (107). The feminist movement also played an important role in drawing attention to the growing awareness of child sexual abuse in the 1970s and 1980s.

In this thesis, gender is used as relational social practice as opposed to the biological sex. The WHO has defined gender as “the result of socially constructed ideas about the behavior, actions, and roles a particular sex performs” (108). Gender is taught to individuals from the moment they are born. Like other social constructs, gender is closely monitored and reinforced by society. Connell described gender as a “multi-dimensional, historically changing structure of social relations – relations constructed in active social practice” (109). Gender is thus constructed from social positions and power hierarchies in society. This situation leads to male power creating a social structure that leads to female subordination. The conceptions of masculinity and femininity lead to continued male dominance reproduced through the socialization of both men and women (109). This means that gender differences are constructed from social positions and power hierarchies in society that result in inequality of life chances and life choices.

It is important, however, to distinguish between the social structure and individual men and women. Although men as a group benefit from this gender hierarchy in terms of, for example, money, authority and access to institutional power, it does not mean that it is always beneficial for the individual man.

There is virtually universal agreement that men commit the vast majority of homicides, sexual assaults, gang violence and robberies (110). This makes

it reasonable to examine how violence and masculinity are intertwined. Studies have also examined how violence, or the potential of violence, can be used to construct masculinity (111, 112). Franklin has suggested that violence can have several meanings for young men. It can be used individually to gain status and respect, while violence committed together with others can be used to create connectedness within the group (113). A growing body of literature suggests that memberships in social networks characterized by rape-supportive attitudes and endorsement of rape myths, as well as peers who reinforce each other's hostile talk about women, are associated with an increased risk of violence perpetration among young men (96, 114).

However, defining violence as masculine influences not only individuals' understanding of what violence is, but also their understanding of who is capable of violence. For example, men who are victims of intimate partner violence (male or female) are often reluctant to seek help for fear of not being believed or of being ridiculed (115). On the other hand, young women are generally viewed as passive victims of men's violence, which makes it difficult to see women as perpetrators. In her thesis on the perception of violence among youth, Uhnoo described how young women in some arenas view themselves, and are viewed, as passive, physically inferior and in need of men's protection, but in other arenas as equal beings and physically able to fight back or even initiate a fight just like any other young person (116). This description is in line with research on intimate partner violence in youth that has shown more similar rates of intimate partner violence among young men and women than among adults (117). That said, however, it is important to keep in mind that young women have reported more sexual victimization and fear of sustaining injury than their male counterparts have (110, 118, 119).

Integrated models

In 1998, Heise used a combination of the ecological model and feminist theory as a way of gaining understanding of men's violence against women (120). Heise found that feminist theory – that men's violence against women was a result of patriarchy – could not answer why some men were perpetrators but not all men. At the same time, individual psychological explanations such as alcohol abuse and mental illness could not explain why so much of the violence against women and girls was perpetrated by men. Heise used the ecological model in combination with feminist theory to offer an explanation of how both individual and societal factors interact. Heise's model can be used to help understand violence against both men and women, since it contains gender relations as one of the factors, but does not restrict explanations of violence to male dominance only.

In the 21st century, feminist theorists have also expanded their theories on power and control to include an intersectional perspective (121, 122). The earlier explanation of patriarchy as a moderator of power and control has stretched to include sexual orientation, ethnicity, class and other markers of identity. One of these theories is the theory of heteronormativity (123). In society today, heteronormativity is the norm (123, (124). Heteronormativity is a viewpoint that express heterosexuality as a given, instead of being one of many possibilities. It is the belief that there are two sexes, male and female, and that the sexual and marital status are most (only) natural between two people of opposite sexes (123, 124). The concept of heteronormativity privileges heterosexuality as normal and natural, and as a result, discriminates against those who do not conform to the norm, such as homosexual, bisexual, transgender and transsexual individuals. Anthropologist Gayle Rubin has described how heteronormativity creates a “sex hierarchy” in our society, where monogamous, heterosexual sex is “good sex” and other forms of sexual relations and sexual practices are “bad sex” (125).

PREVENTION OF AND INTERVENTION IN VIOLENCE VICTIMIZATION

Violence has probably always been present, but at the same time, all known societies have had some forms of rules – religious, legal or communal – that have restricted violence (18). There is also a big difference in the prevalence of violence between countries and societies (18).

The WHO has stated that in the same way that other public health efforts have been able to reduce, for example, infectious diseases, car accidents and workplace injuries, both perpetration and victimization of violence can be prevented (18).

Public health prevention of violence has traditionally been divided into three forms:

1. Primary prevention – aims to prevent the occurrence of violence
2. Secondary prevention – aims to reduce the more immediate impact of violence such as hospital care
3. Tertiary prevention – aims to soften the impact of the lasting effects of violence such as rehabilitation.

More recently, however, prevention efforts have moved to focus on the specific target group for the prevention. This new focus has resulted in three other ways of dividing prevention strategies:

1. Universal prevention strategies – designed to reach groups or the general population without regard to individual risk
2. Selective prevention strategies – targeting subgroups of the general population that are considered to be at increased risk for violence
3. Indicated prevention strategies – aimed at individuals who have already experienced violence.

Universal prevention strategies

The WHO has stated that “legislation can be a key tool in changing behavior and perceptions of cultural and social norms” (22).

In 1979, Sweden was the first country to pass a law banning all physical punishment of children by caregivers. Studies have shown that public support for physical punishment in children has changed dramatically, from 53% being in favor of corporal punishment in 1965 to 11% in 1994 (126). In 1981, 51% of parents reported having used some form of corporal punishment on their children in the past year compared with 3% of parents in 2011 (23). It is of course difficult to know how much of the shift in norms and behavior can be attributed to the passing of the law banning corporal punishment in children. Some might argue that changed attitudes in the public's minds made the passing of the law possible. However, the actual passing of the law sends a strong signal about Sweden's view on corporal punishment in children.

During the years since the ban on corporal punishment in 1979, suspicions of child abuse have been reported to the police more frequently, with substantial increases in the 1990s and 2000s. This situation led to an investigation by the Swedish National Council for Crime Prevention (*Brottsförebyggande rådet*), which came to the conclusion that the increases resulted from a greater tendency to report child abuse because of the increased awareness, with no indications of an actual increase in the abuse of children (127).

Countries differ widely in the laws applied to violent behavior (128). While almost all countries have laws criminalizing homicide, many countries lack laws protecting women from intimate partner violence, and only a few countries have laws banning corporal punishment of children (119). Moreover, even if there has been a sharp increase in countries passing laws on, for example, intimate partner violence and sexual harassment in the past decade, there is significant discrepancy in how the laws are implemented (18, 128).

In the WHO's 10-country survey of women's health and their experiences of domestic violence, the proportion of women aged 15–49 years who had suffered physical or sexual violence from an intimate male partner ranged from 15% to 71% depending on the country surveyed (19, 129). The same study investigated women's attitudes to partner violence, such as whether wife-beating was sometimes acceptable or if a wife had the right to refuse sex with her husband. Intimate partner violence was more common in countries in which the acceptance of wife-beating and a husband's right to sex was higher (19).

On the other hand, the European Union Agency for Fundamental Rights (FRA) survey on violence against women within the 28 EU countries showed that the EU countries that are ranked highest in terms of gender equality also tend to have a higher prevalence of violence against women (20). This can of course be because of violence against women being more prevalent in countries where gender equality is ranked higher. Another explanation offered by the FRA is that a greater awareness of violence against women in the society enhances the understanding and reporting of violence

(20), as was the case mentioned above with child abuse in Sweden after the passing of the ban on corporal punishment.

Selective and indicated prevention strategies

The health sector response and routine questions about violence victimization

Considering how common violence victimization is, and how closely linked victimization is to ill health, health care personnel must frequently encounter patients who are victims of violence. However, since health care personnel rarely ask about violence victimization and victims rarely disclose if not asked, this information often goes undetected (130, 131). In accordance with this, routine inquiry about intimate partner violence in adult women has been advocated for some time by professional organizations, as well as by the WHO (132, 133, 134).

Patients with experience of violence victimization may be reluctant to identify victimization as their presenting problem. Moreover, patients are often unaware that a medical problem might be associated with prior or present victimization (135). However, if victimization contributes to mental and physical ill health, interventions will not succeed without addressing the violence victimization. Studies suggest that routine inquiry by health care providers can be effective in increasing the disclosure of intimate partner violence in adult women (136-138). However, evidence also suggests that routine inquiry has only a limited effect on health outcomes and victimization rates, and the recommendation of universal screening for intimate partner violence in women remains subject to controversy (131, 137, 139).

Moreover, health care providers are often hesitant to inquire about intimate partner violence, reporting lack of training, fear of “opening Pandora’s box,” fear of offending the patient and time constraints as important barriers (137, 138). Several training programs have been developed in order to aid health care workers in increasing their ability to identify and inquire about violence victimization, as well as offer subsequent support and referral. There is some evidence that such programs may be effective (138, 140, 141). In contrast to health care providers, studies have found that adult women approve of universal screening for violence victimization in health care settings (137, 138).

Young people rarely reveal violence victimization to teachers or health professionals if not directly asked (142-146). However, existing studies have demonstrated that youth are in favor of health professionals routinely asking about violence victimization (144, 147, 148).

To date, few studies have examined routine inquiry about violence victimization in children and youth. To my knowledge, only two studies in

Sweden have been conducted on routine inquiry in health settings in Sweden. The first study examined routine inquiry of intimate partner violence in antenatal care settings and youth clinics (140). The vast majority of the women in the study were positive about health care personnel routinely asking about victimization. The other Swedish study was conducted in a child and adolescent mental health care unit, where children and parents of children were routinely asked about child abuse and intimate partner violence between parents (149). The study demonstrated that identified cases of child abuse and intimate partner violence increased from 6% to 48%. The exposure to family violence in children was estimated to be at least five-fold that of the general population (150).

In the US, routine inquiry about youth violence and dating violence has mainly been done in emergency departments with youth attending because of injuries. These studies are scarce, but have demonstrated some effects in the form of decreased re-victimization (151, 152).

There is also an ongoing discussion on whether disclosure of traumatic events per se could be beneficial (68, 153, 154). Not talking about upsetting events appears to be a health risk, theoretically because holding back or inhibiting oneself about an emotional topic is a stressor (153). Some studies on young people have shown that disclosure of victimization is likely to improve physical and psychological outcomes (68, 153, 155).

Because of the broad direct and indirect health impacts violence may have on young people's lives, the American Academy of Pediatrics (156) has advocated for routine health care inquiry into violence in youth, supported by the American College of Obstetricians and Gynecologists and the American Medical Association (132, 133). In Sweden, the Swedish National Centre for Knowledge on Men's Violence Against Women have launched similar recommendations (134), and the Swedish National Board of Health and Welfare recommend routine inquiry about violence victimization in child and adolescent mental health care settings.

Aggressive behavior and youth violence prevention

Interventions in the form of preschool enrichment programs, social development programs for schoolchildren and programs assisting youth to complete school education have been launched in order to reduce youth violence (22). Of these programs, the most promising are those targeting preschool children – for example, the Triple P Positive Parenting Program, which is also used in Sweden (157). These programs are mostly universal prevention programs, sometimes selectively targeting young children and adolescents at risk (22).

Recently, interventions at emergency departments in the form of brief interventions directed at youth attending the emergency as a result of violent

peer attacks, with the aim of reducing future violence, have been launched in the US, so far showing mixed results (151, 152, 158).

Bullying prevention

In the 1970s, the Norwegian researcher Olweus published the first study demonstrating the threat posed by bullying in schools to children's well-being and health (159). Since then, a growing body of literature has developed examining both the causes and the impacts of bullying, as well as prevention/intervention programs targeting both victims and perpetrators (160, 161). In Sweden, several anti-bullying programs are used. However, when the Swedish National Agency for Education (Skolverket) did an extensive survey of different anti-bullying programs in 39 schools in Sweden, it became evident that no school followed a strict protocol for any specific anti-bullying program, but rather mixed bits of several programs. Since it was not possible to evaluate single programs, the Swedish National Agency for Education summarized specific interventions that worked or did not work. Interventions that demonstrated an effect in reducing bullying for both girls and boys were: evaluation and follow-up; cooperative teams of school personnel such as teachers, psychologists and school nurses; students participating in the preventive anti-bullying work; education of school personnel; and specific interventions for bullies and bullied children. In girls, the systematic presence of teachers during breaks indicated lower rates of bullying, and in boys, disciplinary strategies, defined rules and programs promoting good relations among friends showed an effect. Interventions that were assessed as not having an effect on, or even potentially increasing, the rates of bullying were delivering mandatory lectures about bullying, designating students as mentors/observers and mediating between the bully and the victim (162).

Dating violence and intimate partner violence prevention

During the late 1990s dating violence/intimate partner violence and sexual abuse among youth (15- to 24-year-olds) started to attract attention. Research has made it apparent that a considerable proportion of sexual abuse in youth is committed by peers (163, 164). This factor had been mainly overlooked in older studies on sexual abuse, where the focus had been on perpetrators within the family or where an age difference of at least 5 years between the victim and the offender had been included in the definition of sexual abuse (165). Subsequent research also made it evident that youth is the group most exposed to both partner and sexual violence (18, 19).

Most prevention programs for intimate partner violence/dating violence are conducted as school-based universal prevention programs, mainly targeting high-school and college students. Evidence for these programs, when evaluated, show some effect in reducing violence (166-170). Recently, brief

interventions targeting intimate partner violence in youth have been conducted in emergency department settings in the US, with some short-term effect of reducing the number of violence events (171).

A number of programs for the primary prevention of sexual violence by non-partners have been tried. One recent Canadian study has shown some promise (172), but otherwise there is very little evidence of the programs' effectiveness (119). Evaluation studies of programs addressing rape myths and rape awareness have revealed that these programs rarely work. Educating women on self-defense is also of questionable value and might even be harmful (128).

Indicated prevention and intervention approaches with victimized youth

Studies of youth with more severe mental ill health after victimization have mostly been conducted in child psychiatric clinics. Most studied are different interventions for PTSD in victimized youth where cognitive behavioral therapy (CBT), especially trauma-focused CBT, is considered to be the treatment of first choice (173). A Swedish study also suggests that Eye Movement Desensitization and Reprocessing (EMDR) therapy may be beneficial for children with PTSD (174).

Prevention and intervention programs for alcohol risk drinking in youth

Traditionally, alcohol risk drinking prevention programs for youth have been educational, targeting youth in junior and senior high school. The idea behind the educational approach is that early and frequent information about the negative consequences of alcohol (and other drugs) will prevent or decrease alcohol consumption (175). However, several studies have shown that there is no straightforward link between an individual's attitudes to and knowledge of the negative consequences of alcohol and actual alcohol consumption (175).

Increasingly, alcohol preventive educational programs in schools have come to include so-called "life skills training," "problem solving" and "resistance training." The main rationale for this is to enhance the individual's capacity to handle pressure from peers and to make his or her own decisions, as well as to build self-esteem. To date, international evaluations have shown modest results from these prevention programs (176). No evaluation of those types of program has been conducted in Sweden.

Recently, interventions targeting youth with alcohol risk drinking have gained focus. In adults, brief interventions, mainly modeled on motivational interviewing, have shown some results in decreasing alcohol risk drinking

(177). MI with youth is less well studied, but several studies have used MI with youth with risk drinking behaviors (151, 178-180). The studies on youth have shown mixed results, and a recent Cochrane review concluded that although some of the studies found significant effects, the effect sizes were too small to be of relevance for policy or practice (181).

The need for intervention studies

The majority of prevention/intervention programs for youth addresses bullying, dating/intimate partner and or youth violence, and is designed as universal or selective prevention (22, 128). Most of these programs are school-based interventions, and little is known about interventions that extend beyond classroom-based curricula. Very few studies have addressed interventions for youth who have been or presently are victimized outside a psychiatric setting. Moreover, the vast majority of the violence prevention/intervention programs in youth have been conducted and evaluated in the US (22, 128). The US alone accounts for more than two thirds of all youth violence/intervention studies (128). Hence studies from other countries are warranted.

As mentioned earlier, different types of violence victimization have generally been studied in isolation, one type of violence at a time. The same is true for interventions for violence. Rarely is intervention for more than one type of violence addressed at the same time. It is increasingly known, however, that various types of violence often co-occur and that multiply victimized youth experience more mental ill health than singly victimized youth (33, 37, 46, 57, 58). This factor calls for a broader approach, identifying prevention/interventions that can address the multidimensional and multiple types of violence victimization among youth (64).

Since violence is a multifaceted problem, a comprehensive approach is needed on individual, relational and societal levels (64, (182).

RESEARCH AIMS

The primary aim of this thesis was to examine the effects on health outcomes and alcohol risk drinking of including routine inquiry about violence victimization and alcohol consumption in health dialogues with young women. The health dialogues were part of the ordinary consultation at youth clinics, and the aim was to measure the effects on the young women compared with controls at 12 months after the initial consultation. A further aim was to explore youth's perceptions and experiences of the health dialogues in a qualitative study.

The specific objectives of the four studies in the thesis were as follows:

- To assess self-reported ill health in young women victimized by one or more types of violence compared with non-victimized young women. Specific aims were to analyze the associations between violence victimization and symptoms of post-traumatic stress, anxiety, somatic complaints, self-injury and suicide ideation/attempts, and school absence (study I).
- To examine health outcomes in young women receiving routine inquiry about violence victimization and offered subsequent support at youth clinics compared with controls at 12-month follow-up. Secondary aims were to study re-victimization during the study period, and to examine whether and to what extent routine inquiry altered the consultation (study II).
- To examine the effectiveness of MI, targeting young women with risk drinking, as a part of a health dialogue given during a regular visit to a youth clinic in Sweden. Specific aims were to analyze if young women who received MI had reduced their alcohol consumption and binge drinking at 12-month follow-up, compared with young women with risk drinking not receiving MI (study III).
- To explore perceptions and experiences among youth who, in addition to their regular visits to Swedish youth clinics, underwent a health dialogue with structured questions about violence victimization as well as alcohol consumption (study IV).

Table 1. Overview of study designs

Study	Study design	Subjects	Study question
I	Cross-sectional study	1,051 young women aged 15–22 years at four youth clinics	Ill health in violence victimized compared with non-victimized
II	Randomized controlled intervention study	565 young women aged 15–22 years at four youth clinics	Health outcomes after routine questions about violence at 12-month follow-up compared with controls
III	Randomized controlled intervention study	565 young women aged 15–22 years at four youth clinics	Alcohol risk drinking after MI at 12-month follow-up compared with controls
IV	Qualitative study	13 young women and 2 young men aged 18–22 years at four youth clinics	Youth’s experience of being asked about violence victimization and alcohol use

METHODS

This thesis has a mixed-methods approach entailing a cross-sectional study conducted from the baseline data (study I), two randomized controlled intervention studies examining the effects of routine inquiry about violence victimization and alcohol consumption and subsequent interventions (studies II and III) and a qualitative study with research interviews (study IV). In this section, the materials, methods and procedures used for generating and analyzing the data from the four studies are described. More complete descriptions are available in each paper.

Overall study design

The quantitative part of the study design was a randomized parallel controlled intervention study. In addition to their regular visit with the midwife/social worker, the participants assigned to the intervention group underwent a health dialogue that included routine inquiry about violence victimization and alcohol consumption. Victimized participants received empowering strategies within the same visit and were offered further counseling. Risk drinkers underwent motivational interviewing (MI) within the same visit.

Participants in the control group had a regular visit to the midwife/social worker and questions about alcohol were generally not addressed. The participants in the control group completed questionnaires with the same questions about violence victimization and alcohol consumption after their visit. Both groups answered validated questions about physical and mental health and demographics in a sealed questionnaire after their visits. A questionnaire with the same questions, including questions about violence victimization and alcohol/substance use, was administered to the participants in both groups 3 months and 12 months after the baseline.

In addition to the quantitative studies a qualitative study with the objective of exploring experiences, perceptions and changes among youth after routine questions about violence victimization and alcohol risk drinking was conducted.

Study setting and data collection

The studies took place at four youth clinics situated in two mid-sized and two small towns in the county of Västernorrland, Sweden. All 15- to 22-year-olds coming for their first visit to one of the four youth clinics during the period January 1, 2012 to December 31, 2012 were consecutively asked to participate in the research, and if they agreed to participate, were randomized into the intervention or the control group. In one of the youth clinics, participants were included until June 10, 2013 owing to a lack of staff at the beginning of the study period. Exclusion criteria were severe mental disease, intellectual mental impairment or inability to understand written Swedish.

Of 1,445 eligible young women, 1,051 (73%) agreed to participate in the research, and of 132 eligible men, 86 (65%) consented to participate. Due to the low number of participating young men, only the young women's responses are reported in the quantitative studies (studies I to III). The young men's responses were included in the qualitative study (study IV).

For the randomized controlled intervention studies, randomization was stratified by sex and youth clinic, and assigned based on a computer-generated algorithm and using sealed envelopes. Randomization occurred in blocks of eight.

At their visit to the youth clinic, 84% of the youth visited a midwife and 16% visited a social worker.

The participants assigned to the intervention group underwent a health dialogue including routine inquiry about violence victimization and alcohol consumption, in addition to their regular visit with a midwife or social worker. Victimized youth received empowering strategies and were offered further counseling, and risk drinkers received MI. Those participants who had been victimized and had alcohol risk drinking were offered interventions addressing both the victimization and the risk drinking.

The participants in the control group had a regular visit with a midwife/social worker without addressing questions about violence victimization or alcohol consumption. Instead, the control group answered questions about violence victimization and alcohol consumption in a pre-structured questionnaire after the visit. Both groups answered questions about physical and mental health and demographics in a sealed questionnaire after their visits. A questionnaire with the same questions, including questions about violence victimization and alcohol/substance use, was administered to the participants in both groups by mail, e-mail or cell-phone text message 3 and 12 months after baseline. Non-responders received a second questionnaire 3 weeks later and a third questionnaire 3 weeks after this if no response had been received. Participants not answering the questionnaire after the third reminder were considered non-responders.

The young women's follow-up rate at 3 months was 685 (65%) and at 12 months was 565 (54%) – see Figure 1. The 3-month follow-up was mainly to

ensure that there were no short-term negative effects after routine questioning about violence or other short-term effects in health outcomes or alcohol risk drinking that would have disappeared at the 12-month follow-up. However, no such effects were seen, and there were no significant differences in outcomes between the 3-month and the 12-month follow-up (not shown). Thus, in this thesis only the 12-month follow-up results are presented.

In the 3-month questionnaire, the participants were asked for consent to be contacted for an interview by one of the researchers. Purposeful sampling was used. Of those who volunteered to be interviewed, 22 youth met the criteria. Six of these did not respond when contacted and one had moved abroad and declined to participate, leaving 15 youth – 13 female and 2 males aged between 18 and 22 years – who completed the interviews. Of the 15 youth participating, 13 were victims of violence and 8 had risk-drinking behavior; 6 of the participants were both victimized and risk drinkers. Eight attended or had attended an academic program in high school and seven a vocational program.

Eleven of the interviews were done at youth clinics and four via the telephone, depending on what the participant preferred. The interviews were audiotaped with the participants' consent and lasted between 20 and 45 minutes. They were transcribed verbatim by the interviewer, with pauses and expressed emotions noted in the transcript.

Measures and definitions

Violence victimization

For the purposes of this research, violence victimization was categorized as having been exposed to one type of violence (i.e. emotional, physical, sexual or family violence) or multiple victimization, defined as victimization of two or more types of violence.

Five structured questions about violence victimization were used in the health dialogue interview for the intervention group, and in the questionnaire for the control group. Four of the questions were modeled on the NorVold Abuse Questionnaire (183), but were shortened and were worded as follows: (1) "Have you ever experienced being repressed, humiliated or threatened?" (2) "Have you ever experienced physical abuse (for example, being slapped in the face, hit with fists or kicked, or having a weapon used against you)?" (3) "Have you ever experienced being touched against your will on your body or genitals, or forced to touch someone else's body or genitals, or has anybody used your body to satisfy him/herself?" and (4) "Have you ever experienced someone, against your will, putting or trying to put his penis, or something else, into your (vagina), mouth or rectum?" A final question was

added about experiencing family violence: (5) “Have you ever seen or heard a grown-up in your family hurting someone in your family?”

After each of the five questions, the participant, if victimized, was asked to mark on a visual analogue scale (VAS) how much the victimization still affected him or her. The VAS ranged from 0–10, where 0 was not at all and 10 was very much. The time frames for violence victimization were before 15 years of age, 15 years of age and above and during the last 3 months at baseline in the 3-month follow-up questionnaire, and before 15 years of age, 15 years of age and above and during the last 12 months in the 12-month follow-up questionnaires.

In the 3-month and 12-month follow-ups, a question about the perpetrator was added for each of the five questions on violence, with the first four questions worded as “By whom, mark all answers that apply to you,” and listing five possible answers: (1) “Parent, sibling or other relative,” (2) “Step-parent or mother’s or father’s partner,” (3) “Partner or ex-partner” and (4) “Friend, schoolmate or acquaintance,” and (5) “Unknown.” For the fifth question about witnessing family violence, three possible answers were listed: (1) “Parent,” (2) “Step-parent or mother’s or father’s partner” and (3) “Another adult in the family.”

Alcohol risk drinking

Alcohol risk drinking was assessed with the AUDIT alcohol consumption questions (AUDIT-C), which are the first three questions in the WHO’s Alcohol Use Disorders Identification Test (AUDIT; (184). The questions address the frequency of alcohol drinking, typical quantity of drinking and binge drinking. The AUDIT-C generates an index scoring from 0–12. The cut-off value of ≥ 5 for alcohol risk-drinking patterns was applied in this study.

Smoking and drug use

Smoking included daily or occasional smoking. Two questions about illegal substance use were taken from the Swedish National Public Health Survey (185) and worded as follows: (1) “Do you use cannabis?” and (2) “Do you use other drugs, for example, ecstasy, GHB, anabolic steroids?” The answers were measured as: no, have tried, have quit, sometimes and daily.

Physical and mental health

Questions about self-perceived health were worded from the Swedish National Public Health Survey (185). They included perceived general health, days of not feeling well due to mental or physical ill health in the past 30 days, and number of days of absence from school or work due to ill health in

the past 30 days. Six questions about somatic symptoms in the past weeks were included. The questions addressed pain in the neck/shoulders, pain in limbs, recurrent bowel troubles, headache/migraine, difficulty in sleeping and eczema/skin rashes, and were measured as: no symptoms, mild symptoms and severe symptoms.

Symptoms of depression and anxiety were measured using the Hospital Anxiety and Depression Scale (HADS) (186). Participants were considered as having depressive symptoms if they had a HADS depression score of >10 and as having anxiety symptoms if they had a HADS anxiety score of >10 .

The Swedish version of the PTSD Checklist was used to measure post-traumatic stress (PTS) symptoms (187). PTS symptoms were defined as having at least one re-experiencing symptom, three avoidance symptoms and two arousal symptoms, with item scores of ≥ 3 .

Suicide ideation/attempts and self-injury

Two questions about suicide ideation and suicide attempts during the previous 12 months were taken from the Swedish National Public Health Survey (185). From the Q90, a questionnaire used in children and adolescent surveys (188, 189), two questions about self-injury were added, worded as follows: “Have you at any time in the past 12 months considered intentionally hurting yourself, for example, by cutting or burning yourself?” and “Have you at any time in the past 12 months intentionally hurt yourself in any way?” These four questions could be answered with either yes or no.

Socio-demographics

Socio-demographic questions including gender, age, education, family structure, immigrant status, sexual orientation and social support were based on questions from the Swedish National Public Health Survey (185). In Sweden, students in upper secondary school attend either vocational or academic programs. Attending vocational programs was chosen as a proxy for low educational level. Low economic resources were defined as the inability to obtain the equivalent of 1,600 Euros in a week. Immigrant status was dichotomized into immigrants (foreign-born youth or Swedish-born youth with two foreign-born parents) and youth with one or two Swedish-born parents. Sexual orientation was dichotomized as sexual minority (homosexual/bisexual/uncertain) or heterosexual. Questions about social support based on questions in the Swedish National Public Health Survey (185) were added, worded as follows: (1) “Do you have anyone you can share your innermost feelings with and confide in?” (2) “Can you get help from another person/other persons if you have practical problems or are ill?” and (3) “Do you believe in general that one can trust most people?”

Interventions

Below follows a description of interventions used in study II and III as well as a short description of the staff education.

Interventions for violence victimization

For the participants in the intervention group who had been violence victimized, the midwife/social worker employed empowerment strategies (136, 190-192). Empowerment strategies include listening to the participant's story, taking in and accepting the participant's perceptions and feelings in a non-judgmental way, and emphasizing that violence is never the victim's fault (192). All participants with experience of victimization were offered further counseling. The midwife/social worker also addressed safety issues and contacted social authorities when considered necessary.

Intervention in alcohol risk drinking

Participants with alcohol risk drinking and/or substance use were offered motivational interviewing (MI) within the same visit. MI is a directive client-centered counseling style that focuses on enhancing motivation to change in a respectful, non-confrontational and non-judgmental way. MI emphasizes choice and responsibility, developing a discrepancy between current behavior and future goals and values, and increasing problem recognition and self-efficacy for change (193). MI has been used in several studies targeting alcohol risk drinking in youth (151, 178).

Staff education

Prior to the start of the study, all personnel working at the four youth clinics had participated in several education sessions on women's and youth's risk of violence victimization including workshops in response based practice (222), as well as in sessions targeting the management of alcohol risk drinking. At all four youth clinics, action plans were established for the personnel on how to handle victimized youth and youth with alcohol risk drinking or substance abuse.

Both midwives and social workers at the youth clinics had received approximately 30 hours of training in MI that included reading, viewing videotapes and practicing MI techniques in training sessions and role-plays led by supervisors. Midwives and social workers also received feedback from MI supervisors on one or two audiotaped MI sessions with patients at the youth clinic. Two of the researchers (AP and ID) visited all included youth

health centers every second month in order to ensure that the interventions were consistently carried out throughout the study period.

For every young woman answering routine questions about violence victimization and alcohol consumption, the midwife/social worker was trained to document if the questions led to any form of further intervention or if it altered the consultation in any way. An assessment of how much the questions about violence as well as alcohol changed the total management of the patient was performed using a four-graded scale, with the four options worded as follows: not at all, a little, quite a lot, and much. This documentation did not contain data on the identity of either the participant or the midwife/social worker.

Statistical analysis

Prevalence was calculated with 95% confidence intervals. The Student's *t*-test was used to analyze differences in parametric variables, and Pearson's Chi² or Fisher's exact tests were used to assess differences in non-parametric variables (studies I to III). The significance level used was <0.05. Crude and adjusted odds ratios with 95% confidence intervals were applied to assess possible associations between violence exposure and different mental and somatic health outcomes (study I). Confounders were chosen according to empirical evidence in the literature and significant variables in the univariate analyses (study I). To examine for possible interactions between violence victimization and economic resources on the odds ratios for different mental health outcomes, economic resources (normal/low) and violence victimization (no violence/violence) were stratified by creating a new variable with four categories (study I). Attributable risk (AR) and population attributable risk (PAR) were estimated (study I).

To detect differences within the intervention group and within the control group throughout the study period, paired *t*-tests were performed (studies II and III). Models predicting 12-month outcomes were estimated by using generalized estimating equations (GEEs; studies II and III). To adjust for initial differences between the groups, the following variables were controlled for in the violence-victimized sample: age, educational level, risk consumption of alcohol, sexual identity and perceived health at baseline (study II). The variables controlled for in the alcohol risk-drinking sample were age, educational level, violence victimization, sexual identity and perceived health at baseline (study III).

In the GEE analysis, a significant group-by-time interaction effect would indicate that the intervention condition significantly differed from the control condition over time (12 months) in the outcomes examined (studies II and III).

The data were analyzed using SPSS 20.0 for Windows (IBM, New York, NY) for all analyses.

Power analysis

In accordance with earlier studies (178), the researchers who conducted the studies described in this thesis assumed that 30% of the participants would report alcohol risk drinking. Furthermore, they assumed that 10% of youth with risk drinking receiving MI would stop risk consumption of alcohol (change in prevalence from 100% to 90%), whereas the prevalence of risk drinking in the control group would remain unchanged. In order to achieve a power of 80% at a significance level of 0.05, 500 youth would need to be included.

Of the participants, 40% were assumed to have been violence victimized. For victimized women receiving a health dialogue, it was assumed that the mean value for the VAS describing how much the violence still affected them, would decrease from 3 to 2 and be unchanged in the control group. In order to achieve a power of 80% at a significance level of 0.05, 70 youth would need to be included.

Qualitative data analysis

Qualitative inductive content analysis was used to analyze the results in study IV. Content analysis is a stepwise process of categorization based on the expressions of feelings, thoughts and actions throughout the text (194). Using manifest and latent analysis, the surface structure as well as the deep structural meaning of the transcribed interviews emerged (194, 195). All the authors of study IV discussed the preliminary categories and subcategories until consensus was reached, to ensure that the data had trustworthiness and also reflected the selected categories. When presenting the data in the Results section, I use direct quotations in order to convey the credibility of the data.

Ethical considerations

In Sweden, an ethical review by an ethics review board is mandatory when a research method is used that is aimed at influencing research participants physically or psychologically, or when there is an obvious risk of research participants potentially being harmed physically or psychologically. The ethical concerns are of course even more momentous when young people are involved. In Sweden, the general position of the Central Ethical Review Board is that consent from parents/guardians is not needed for youth over the age of 15.

When asking questions about violence victimization, researchers risk causing feelings of distress, maybe even flashbacks. On the other hand, it is important for society to gain knowledge to use in finding the best way of offering support and intervening (196). There is also a lack of data on adolescents' experiences of participating in research entailing questions and counseling on violence victimization. In existing research, youth have in general been positive about health care personnel routinely asking about violence victimization.

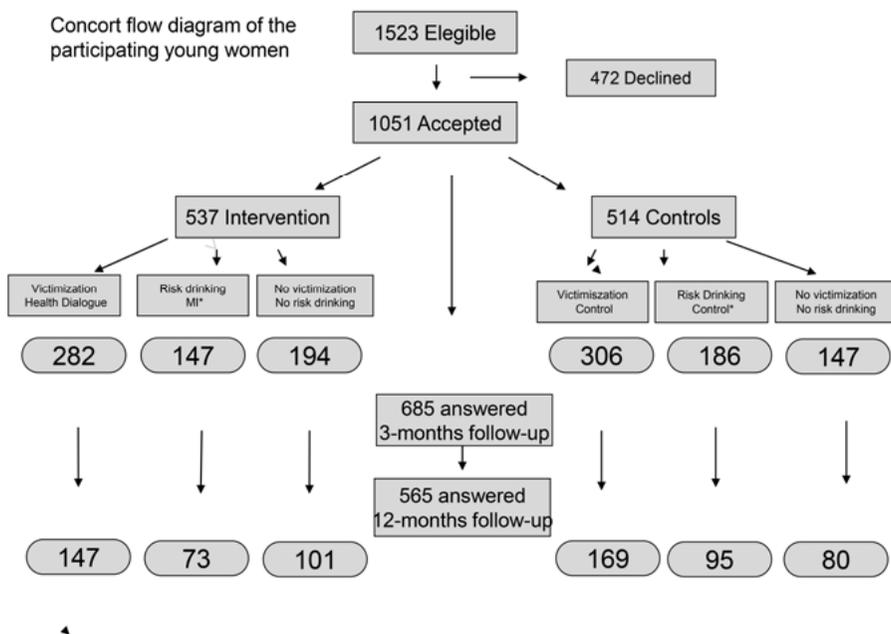
Before participating in the randomized controlled study the participants were informed verbally and in writing about the study by the midwife/social worker in a private room, and oral informed consent was obtained. Participants were informed that all answers would be anonymized before they were analyzed. All staff at the participating youth clinics was aware of the ethical implications during the study, and all participants were informed about the possibility of prompt counseling if needed. No participant used this service.

In the qualitative study, oral information concerning the study aim, voluntary participation and confidentiality was given to the participants when they were contacted for the interview and then again just before the actual interview took place. Participants were also informed that they could end the interview at any time and without explanation if they wanted to. Participants were also informed that prompt counseling was available after the interviews if needed. Due to research ethical reasons, youth under the age of 18 were excluded in the qualitative study.

All participants were assured that all information would be kept confidential, in accordance with research ethics. The study was approved by the Regional Ethical Review Board in Umeå (Dnr 2011-110-31Ö).

RESULTS

Figure 3 depicts the research process for the participants, shown as a flow diagram. The distribution of socio-demographic, social support, substance use and sexual orientation parameters at baseline for all participants by categories of no, single or multiple types of violence victimization is shown in Table 2. The distribution of socio-demographic, social support, substance use and sexual orientation parameters at baseline for the 565 women in the intervention and control groups who answered the 12-month follow-up questionnaire about violence victimization and about alcohol risk drinking is presented in Tables 3.



* In the intervention group 86 participants at baseline 51 at three months and 41 at 12 months, had both risk consumption of alcohol and violence victimization. Corresponding figures for controls were 125, 76 and 62 respectively

Figure 3

Table 2. Distribution of all participating young women at baseline according to socio-demographic status, social support, substance use and sexual orientation by categories of lifetime victimization.

	Total % (N)	Not exposed % (n)	Exposed 1 type of violence % (n)	Exposed ≥2 types of violence % (n)	p-value
Number of participants	1051	44% (461)	25% (265)	31% (325)	
Age, mean years (lowest-highest)	18.5(15-22)	18.6(15-22)	18.4(15-22)	18.5(15-22)	ns
Socio-demographics					
Upper secondary vocational school	34% (347)	30% (135)	26% (68)	45% (142)	**a
Low economic resources	18% (188)	11% (53)	16% (42)	29% (93)	**a
Foreign background	4.4% (46)	3.3% (15)	3.8% (10)	6.5% (21)	*c
Social support					
Do not have anyone to share feelings with	6.9% (71)	3.7% (17)	7.2% (19)	11% (35)	**b
Cannot get help if problems	3.0% (30)	0.7% (3)	2.6% (7)	6.2% (20)	**b
Do not trust other people in general	52% (549)	41% (190)	50% (132)	70% (227)	**a
Substance use					
Alcohol risk drinking	33% (330)	26% (122)	29% (77)	40% (131)	**a
Smoking daily or occasionally	20% (208)	10% (48)	14% (36)	38% (124)	**a
Drug use daily/sometimes	1.2% (12)	1.1% (5)	0.7% (2)	1.5% (5)	ns
Sexual orientation					
Ho-mo/bisexual/uncertain	10% (105)	3.9% (18)	9.1% (24)	19% (63)	**

**=p<0.01 between all groups

**a=p<0.01 between not victimized and victimized to 2 or more types of violence and between victimized to one type of violence and victimized to 2 or more types of violence

**b=p<0.01 between not victimized and victimized to 2 or more types of violence

*c=p<0.05 between not victimized and victimized to 2 or more types of violence

Table 3. Distribution of study participants who answered 12-month follow-up by socio-demographic, social support, substance use, sexual orientation and violence victimisation parameters and intervention/control group status.

	N	Control (n)	Intervention(n)	p<0,05
Number of participants* n	565	285	280	
Age mean years	18,2	18,3	18,2	ns
Socio-demographics				
Upper secondary vocational school	158 (28%)	91 (32%)	67 (24%)	0,04
Low economic resources	98 (17%)	50 (18%)	48 (17%)	ns
Foreign background	25 (4,4%)	20 (7%)	5 (1,8%)	0,002
Social support				
Do not have anyone to share feelings with	46 (8%)	28 (10%)	18 (6,4%)	ns
Cannot get help if problems	16 (2,8%)	9 (3,2%)	7 (2,5%)	ns
Do not trust other people in general	288 (51%)	149 (52%)	139 (50%)	ns
Substance use				
Alcohol risk drinking	172 (30%)	96 (34%)	76 (27%)	ns
Smoking daily or occasionally	109 (19%)	54 (19%)	55 (19%)	ns
Drug use daily/sometimes	4 (0,7%)	3 (0,01%)	1 (0,01%)	ns
Sexual orientation				
Homo/bisexual/uncertain	70 (12%)	36 (13%)	34 (12%)	ns
Violence victimization				
Violence victimization	318 (56%)	171 (60%)	147 (53%)	ns

Prevalence of violence victimization

At baseline, 56% of the young women reported lifetime experience of violence victimization, with 25% having suffered from one type of violence and 31% from two or more types of violence.

Violence victimization was often overlapping. Eighty-eight percent of the women exposed to physical violence, 86% of the women who had been touched sexually against their will, 99% of the women who had been victims

of sexual penetration and 87% of the women who had witnessed family violence were also victims of at least one other form of violence. In emotionally victimized young women, 60% were multiply victimized (Figure 3).

Lower socioeconomic status, risk consumption of alcohol, smoking and less social support were more common in victims of two or more types of violence than in those women exposed to one type of violence or not at all. Young women of foreign background had multiple victimization to a higher degree than women of Swedish background. Sexual minority young women reported multiple victimization twice as often as heterosexual women did.

Association between violence victimization and health outcomes

Young women who had been victims of violence met the criteria for all ill health variables to a higher degree than non-victimized women, and reported more days of perceived mental and physical ill health and more days of absence from school/work than non-victimized women. This was especially evident in multiply victimized women. When adjusted for educational level, economic resources, alcohol risk drinking and trust in others, only minor changes in health outcomes were seen (Table 4). Adjusting for sexual orientation showed increased odds ratios for suicide ideation and self-injury only, while foreign background did not change the risk.

Stratified analyses of violence victimization by economic resources showed that low economic resources did not influence health negatively for those who had not been victimized. A statistical interaction demonstrated that when violence victimization was combined with low economic resources, ill health was reinforced multiplicatively (Figure 4).

Table 4. Crude odds ratios (COR) and adjusted odds ratios (AOR) for symptoms of psychological and physical ill-health, controlling for socioeconomic status, economic resources, alcohol risk drinking and trust in others in women victimized to one or two or more types of violence

	Violence one type		Violence two or more types	
	OR	AOR	OR	AOR
Pain in shoulders/neck	1.6 (0.9-2.8)	1.6 (1.0-2.7)	2.7 (1.7-4.3)	2.4 (1.4-4.0)
Headache or migraine	3.6 (1.9-7.0)	3.9 (1.9-8.2)	6.4 (3.5-11.7)	5.1 (2.5-10.4)
Eczema or skin rashes	1.4 (0.5-3.7)	1 (0.3-3.4)	1.8 (0.7-4.3)	1.9 (0.7-5.4)
Recurrent bowel symptoms	1.9 (0.9-4.3)	2.4 (0.9-6.0)	3.8 (1.9-7.6)	5.6 (2.4-13.2)
Fatigue	2.8 (1.7-4.7)	2.5 (1.4-4.5)	5.6 (3.5-8.8)	4.6 (2.6-7.9)
Sleeping problems	3.1 (1.6-6.0)	3.1 (1.4-6.9)	8.6 (4.8-15.3)	7.7 (3.8-15.7)
Depressive symptoms	2.7 (1.1-6.7)	2.3 (0.6-8.3)	5.1 (2.3-11.4)	6.3 (2.1-19.0)
Anxiety symptoms	3.2 (2.0-5.0)	2.7 (1.6-4.6)	7.5 (4.9-11.4)	6.3 (3.9-10.2)
PTS-symptoms	5.5 (3.4-9.1)	4.8 (2.7-8.6)	15.3 (9.6-24.4)	11.8 (6.9-20.1)
Self-injury ideation	2.7 (1.6-4.4)	2.8 (1.5-5.3)	7.2 (4.6-11)	8.5 (4.8-15)
Have inflicted self-injury	2.9 (1.6-5.1)	3.3 (1.6-7.1)	6.4 (3.9-11)	9.2 (4.6-18.2)
Suicide ideation	3.2 (1.8-5.7)	4.8 (2.2-10.6)	8.6 (5.1-15)	10.8 (5.2-22.5)
Suicide attempt	1.2 (0.2-6.9)	3.4 (0.3-38)	7.9 (2.3-27)	14.6 (1.8-118.3)
>2 days absence/month (school/work)	1.5 (1.1-2.2)	1.4 (1.0-2.0)	3.4 (2.5-4.6)	2.7 (1.9-3.9)

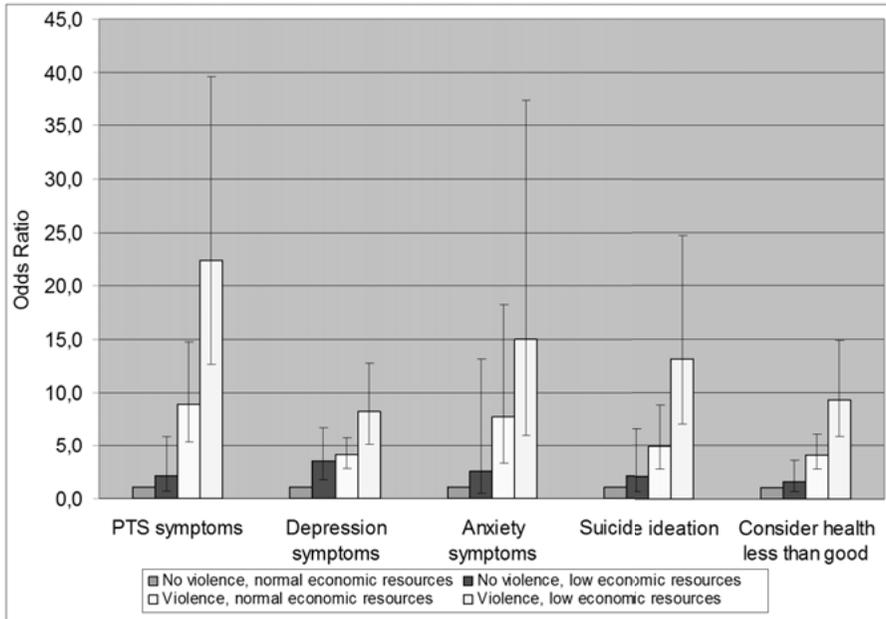


Figure 4. The interaction between violence victimisation and economic resources on OR:s for different mental health outcomes, when stratifications for economic resources and victimisation are made.

Outcomes of the intervention – violence victimization

The quantitative analyses (study III) of perceived general health, pain symptoms, days of mental or physical ill health, days away from school/work due to ill health and the VAS estimation of victimization influence showed no significant differences in victimized young women between the baseline and the 12-month follow-up, within either the control or the intervention group. Nor were there any differences between groups, and the results did not change when adjusted for age, educational level, risk consumption of alcohol, sexual identity and perceived health at baseline.

Victimization during the study period was reported by 16% in the intervention group and 12% in the control group at the 12-month follow-up, with no significant difference between the groups.

In the qualitative study (study IV), the domain “Experience of a health dialogue about violence victimization,” with two categories “Disclosure – talking about violence” and “Influence on the life situation,” as well as seven subcategories, emerged (Table 5). In these interviews, participants with experience of violence victimization described how they considered it important to talk about the victimization and that it was good to tell someone about it, even when questions about victimization brought back memories that were hard to face. It was important that somebody had listened and

acknowledged what had happened. Some described a feeling of relief after they had talked about the victimization and reported that it was good to talk to someone professional who did not know them personally.

I remember it was a relief. Really. ... And I appreciated the talk [the health dialogue] because I think it feels good to talk things through with someone who is impartial. (Participant 6)

For some participants, it was not until they were asked questions about violence victimization in the health dialogue that they conceptualized their experience as actually being an experience of violence. Being able to verbalize the experience of victimization and hearing the midwife/social worker confirm their experience helped the participants to understand what had happened.

I hadn't been exactly raped ... there wasn't any actual direct physical violence ... it was more a kind of coercive sex or whatever you call it. ... It actually made me think, that part about the sex; I hadn't really thought about it before. It was something that surfaced during the health dialogue, so that was really very good. (Participant 11)

Participants described how the questions about violence victimization in the health dialogue had sometimes made them realize how much they were still affected by the victimization, and this had encouraged them to reflect on their prior victimization.

Many of the participants described positive changes in their lives since the health dialogue. They attributed the change both to the health dialogue and/or subsequent therapy and to external conditions outside of therapy. A common description of change was attributed to altered thinking patterns regarding how to handle life in general, and with a change in thoughts about prior victimization in particular.

It is a big difference [since the time of the health dialogue], much better. I received a lot of help from the social worker; she helped me to prioritize, prioritize what made me most upset at the moment and how to solve that. To change my mind frame, kind of. (Participant 12)

What was good for me about the health dialogue was that I realized how badly that person had hurt me. I hadn't realized that before ... I thought it was normal. ... I thought it was my fault that it happened, but now I thought once more and then ... well, I've been able to let go, it feels like I've almost forgiven that person, and I think that it wasn't my fault at all. (Participant 3)

Other participants described how they had ended destructive relationships or started therapy.

I've completely broken with my ex-boyfriend, and I actually ended that relationship after doing that health dialogue. (Participant 2)

You could say that the health dialogue was a wake-up call. ... I felt that it was time to deal with it; I had to talk to someone because otherwise, otherwise it will never be ok. ... So I have started to see a social worker at the youth clinic. (Participant 7)

Participants also described how the victimization, in addition to causing emotional distress, had made them stronger. Participants said that they did not view themselves as victims but rather chose to see the victimization as a learning experience leading to personal growth.

It made me feel very bad at the time ... but it's more like I have actually gotten stronger from the experience. (Participant 13)

Table 5. Domains, Categories and Subcategories

Domains	Categories	Subcategories
Experience of a health dialogue about violence victimization	Disclosure – to talk about violence	Important to ask about violence victimization Questions about violence victimization raised mixed feelings and sometimes no feelings The health dialogue made the victimization visible To have left the victimization behind
	Influence on the life situation	The long-time impact of violence The health dialogue as a start of reflection and change Insight of one’s own ability to handle difficult situations
Experience of a health dialogue about alcohol risk drinking	One’s own alcohol consumption in black and white	Questions about alcohol was natural and sometimes led to reflection and change Normalization Insight on group pressure and expectations

Outcomes of the intervention – alcohol risk drinking

Alcohol risk drinking was reported by 27% of the young women in the MI group and 34% in the control group at baseline. All risk drinkers in the intervention group received MI.

There was a significant decrease in the number of participants with alcohol risk drinking, as well as binge drinking, from the baseline to the 12-month follow-up in both the control and the intervention group, but there were no differences between the groups. The results did not change when adjusted for educational level, violence victimization, sexual identity and perceived health at baseline. Of the participants who did not report alcohol risk drinking at baseline, 22% in the intervention group and 22% in the con-

trol group had developed alcohol risk drinking by the 12-month follow-up, with no statistical difference between the groups.

In the qualitative study (study IV), one category, “One’s own alcohol consumption in black and white”, and three subcategories emerged (Table 5).

Mostly, participants did not consider themselves as being risk drinkers, even if they were told that they exceeded current drinking guidelines. However, questions about alcohol in the health dialogue made them reflect on their alcohol consumption.

It was kind of, you kind of got it black on white when you answered the questions ... and you got [it] in writing like ... well, how much one actually drinks ... and well, it was like, damn, I drink quite a lot. (Participant 1)

Participants also reported that the health dialogue with the midwife/social worker had made them discuss their alcohol consumption with friends. However, after discussing it with friends, they usually came to the conclusion that their own drinking was not a problem. Participants applied different explanations as to why their alcohol consumption was not problematic. They generally considered their drinking as being a temporary phenomenon such as being a student.

I discussed it with my sister and girlfriends. ... We are aware that people view us as having risky drinking behavior ... but we feel it is our three [university] years now. Later, when I have an education and start working, then I won’t have those surroundings anymore. (Participant 9)

Participants defined a risk drinker according to a person’s behavior rather than to the quantity or frequency of alcohol consumption. Participants considered themselves and their friends as being responsible and able to handle alcohol, in contrast to those who could not, clearly referred to as “others.” Clear distinctions were made between participants’ personal use of alcohol and that of “others” whom they considered to be at risk because of risk drinking.

For us who can handle alcohol, there are no problems. (Participant 14)

Participants reported that although there was no overt peer pressure to drink alcohol, they often felt the expectations to drink. Participants referred to the importance of being “on the same level” as others when at a party or in a bar. That included not being sober, but equally important was to not become too intoxicated, which was also considered as ruining the fun for others. A person who did not drink at a party was generally questioned and sometimes looked upon as boring or an outsider. Drinking was described as normative and expected, and many of the social encounters evolved around alcohol.

It is hard to say no ... if you come along and don't drink, you are considered to be kind of boring. ... The few people who did not drink, they always went home early. Nobody wanted them to come, and you kind of stopped asking them ... they became outsiders. (Participant 4)

Among the participants who thought they would disappoint their friends by not drinking, some applied strategies in order to avoid drinking without being noticed.

So instead we say that it's ok, we can drive, and we drive them to the party. (Participant 5)

Altered consultation by midwives and social workers due to routine questions about violence victimization and alcohol risk drinking

In the interviews (study IV), the participants were in favor of routine inquiry at youth clinics about victimization and thought that if the personnel at the youth clinics initiated the dialogue about victimization, it would make it easier for youth to talk about their experiences. Participants also referred to the youth clinic personnel's commitment to confidentiality as an important factor in facilitating disclosure.

I think, and almost know for sure, that there are many who don't dare to open up and ask for help. Instead, many keep things to themselves – stuff that has happened – and don't dare to trust a grownup. ... So I think that it would be a great idea to offer everyone a health dialogue. (Participant 1)

In study II, the midwives and social workers reported that including routine questions about violence victimization altered the consultation quite a lot or a lot in 9% of the cases. Of those who had suffered violence victimization in the intervention group, 14% received further counseling. The social authorities were contacted about two youth. Although participants in the interviews (study IV) were positive about routine inquiry about violence, some raised the concern that youth with experience of victimization might find it uncomfortable to be asked, especially if they had not processed the victimization. However, they did not consider this a reason to refrain from asking about violence.

I have already processed my experiences ... but there are many [individuals] who have very difficult experiences, and if you haven't had time to process it, then it can be hard to bring up. ... I think it is good to ask, if there is a follow-up for those who want help. (Participant 12)

In the interviews (study IV), youth clinics were considered a natural location to inquire about alcohol consumption and questions about alcohol potentially beneficial for people who might be at significant risk of drinking too much. In study III, routine inquiry about alcohol consumption and subsequent MI for alcohol risk drinkers were reported to alter the consultation quite a lot or a lot in 5.5% of the cases. Eight percent of the young women with alcohol risk drinking had another visit with a midwife or social worker. Referral to the psychiatry ward was made for two young women.

Item response

The item non-response in the baseline questionnaire varied between 0.3% and 1.9% for the different question items. For the five questions assessing violence victimization, the item non-response varied between 0.3% and 0.5%. Corresponding figures for the 3-month follow-up questionnaire were 0.3–2.4% and 0.0–2.4% respectively and for the 12-month follow-up questionnaire were 0.2–1.6% and 0.2–0.6 % respectively.

Attrition analysis

An attrition analysis was made of the non-responders at the 12-month follow-up. The only differences between responders and non-responders at the baseline were that there were significantly more sexual minority young women and more young women who attended academic programs in upper secondary school among the responders than among the non-responders. Apart from these differences, non-responders did not differ from responders in socio-demographics, social support, health outcomes, violence victimization or alcohol risk drinking.

DISCUSSION

The main findings in this thesis were that violence victimization was strongly associated with mental ill health and post-traumatic stress symptoms in young women, and that multiple victimization strengthened these associations considerably. Routine inquiry about violence victimization and empowering strategies were feasible within ordinary consultations at youth health centers, but did not demonstrate improved health outcomes measured at the 12-month follow-up compared with controls. However, in the interviews victimized participants reported that they found talking about their victimization very helpful.

No significant differences in risk drinking between young women who received MI and controls were found. In the interviews, the participants described risk drinking in terms of consequences, not quantity or frequency, which raises questions about the AUDIT-C being an adequate screening tool among youth. Below, I discuss the findings and possible implications in further detail.

Multiple victimization common and associated with adverse health outcomes in young women

Study I demonstrated strong associations between violence victimization and mental and somatic ill health in young women. Furthermore, multiple victimization strengthened these associations considerably. Different types of victimization have often been studied in isolation (12, 14, 15). However, recent studies revealed that children and adolescents are often exposed to multiple types of victimization (33, 37, 56). In study I, single victimization was observed in 40% of emotionally victimized young women. However, victims of physical, sexual and family violence were multiple victims in 86–99% of the cases. In these cases, it may be more accurate to view multiple victimization as the norm, rather than the exception, and these cases show how different types of violence seem to extend across time and over settings.

Finkelhor et al. illustrated that the predictive power of individual types of victimization is eliminated, or greatly reduced, when the effect of poly-victimization is taken into account (33, 45). In study I, multiple violence victimization was strongly associated with mental and somatic ill health and

PTS symptoms. Finkelhor et al. used the Juvenile Victimization Questionnaire to determine the number and types of previous-year victimization when defining poly-victimization (61). We used a different definition, defining multiple victimization as lifetime victimization with two or more types of violence. However, the common denominator is probably a violent setting, whether the victimization is defined as poly-victimization or as lifetime victimization with two or more types of violence. Since most studies on multiple violence victimization are conducted on children up to the age of 17, study I contributes to the knowledge of violence victimization, and especially multiple victimization, in the age group from 15 to 22 years.

Ill health in sexual minority young women is strongly associated with high rates of violence victimization

Another important finding was that multiple victimization was seen in 60% of sexual minority women compared with 31% of all women in study 1. Earlier studies indicated that sexual minority youth suffer from mental ill health and victimization to a higher degree than heterosexual youth (81, 197). In study 1, non-victimized sexual-minority women had more suicide and self-injury ideation, but did not otherwise differ in health outcomes from non-victimized heterosexual women. Hence, high victimization rates may be an important factor in explaining the sexual minority young women's higher reported ill health.

Low socioeconomic status and associations with violence victimization and ill health

Low socioeconomic status has been considered as being linked to ill health in youth (198). In study 1, non-victimized young women with low economic resources did not differ in ill health from non-victimized young women with normal economic resources. However, in victimized young women, low economic resources displayed a multiplicative effect on ill health compared with victimized women with normal economic resources. These results are in accordance with the theory that other factors than violence alone are at play in an individual's response and resilience to victimization (33, 199, 200).

Non-victimized young women report excellent health

Reported mental ill health in young women is high, and possibly increasing (2, 11). However, non-victimized women in study I generally assessed their health as good, whereas victimized young women frequently reported mental ill health. Violence victimization thus seems to be a decisive factor in young women's mental health.

Reasons to ask youth about violence victimization in health care settings

Since violence victimization is common and the association with ill health well established, it is reasonable to believe that health care personnel frequently encounter youth who are victims of violence. However, since youth rarely disclose victimization if not directly asked, this information often goes undetected (142–146). In response to this situation, routine inquiry about and intervention for violence victimization in youth in health care settings have been advocated by several professional organizations, among them Sweden's National Centre for Knowledge on Men's Violence Against Women (134). How routine inquiry and subsequent intervention should be performed and how youth perceive such inquiry have been little studied, however.

To my knowledge, this is the first study examining routine inquiry and subsequent offered intervention for violence victimization in youth in a non-psychiatric or emergency setting.

Did routine inquiry about violence victimization affect health outcomes in young women?

Study II showed that routine inquiry and brief intervention in the form of empowering strategies were feasible within the ordinary consultation. However, they did not improve measured health outcomes nor reduce re-victimization in victimized young women compared with controls at the 12-month follow-up.

This finding leads to the question whether the intervention was non-effective or if the research instruments were too blunt to detect feelings and experiences that may still be beneficial for a participant. In the interviews (study IV), the participants reported that they found the questions about violence victimization within the health dialogue to be very helpful. They described how the health dialogue with the midwife/social worker was a factor in understanding prior and ongoing victimization, which in turn helped them create meaning and move on. Some participants explained that only when

they were asked questions about violence victimization did they realize that what had happened to them actually constituted violence. The difficulty for youth to sometimes determine what counts as violence has been described in earlier research (143).

Many of the participants in study IV experienced changes after the health dialogue. Several attributed these changes to the help they received at the youth clinic in terms of subsequently receiving therapy, learning skills to deal with stress and to alter thinking patterns, and having help in changing destructive behaviors and relationships. These aspects could be interpreted in terms of promoting a “sense of coherence” as formulated by Antonovsky (201). A sense of coherence was described by Antonovsky as a way of reflecting a person’s view of life and capacity to respond to stressful situations, including three components: comprehensibility, manageability and meaningfulness (201). In retrospect, measuring a sense of coherence in study II might have been a relevant contribution.

Several qualitative studies on adult women have also indicated that concern expressed by and support from health care providers have changed how victimized women viewed themselves and might even represent a turning point, leading to later change and healing (191, 202, 203). The same studies reported that the actual change – for example, ending an abusive relationship – might have occurred years after the disclosure to health personnel, even when the women considered the disclosure to have been a turning point. Hence it may be that the follow-up time of 12 months in study II was in fact too short.

Empowerment strategies

The reason for choosing empowerment strategies as the intervention was that its brevity made it possible to include within a regular visit to the youth clinic. Contrary to study II, an earlier study with adult women suffering from intimate partner violence demonstrated some improved health outcomes and less re-victimization after empowerment strategies were (190, 192). In study II we addressed lifetime victimization, and it may be that empowerment strategies are not suited to addressing the effects of past victimization or other types of victimization apart from intimate partner violence. It could also be that empowerment strategies are not adaptable in young women; however, in the interviews (study IV), the participants seemed to find empowerment strategies useful. It is also possible that participants who agreed to be interviewed in general viewed the health dialogue at the youth clinics more positively than those who declined to participate, and hence are not representative.

Of the victimized young women in the intervention group in study II, 14% wanted and received further counseling. This finding is in line with an

earlier Swedish study examining routine inquiry in pregnant women visiting antenatal clinics, where 13% of victimized women wanted further counseling (140). In retrospect, it would have been interesting to examine this group separately in terms of health outcomes. It was however not possible with the current study design, where all participants were promised that their answers would be anonymized before being processed.

Arguments for routine inquiry in youth clinics

Even if health outcomes do not improve in youth after routine inquiry about violence victimization and the offered counseling, there are other aspects of why routine inquiry is important in health care settings. One is that it is an opportunity for health personnel to acknowledge the youth's experience and affirm that violence is never acceptable. Studies have shown that youth often do not know where to turn when victimized and also may doubt whether their experience actually was violence victimization (143, 204). Routine inquiry about violence victimization gives youth a chance to disclose victimization, and even if they may not want or need counseling at the time, they will know where to turn should they need support later on (140, 143, 145).

Another important reason to ask about violence victimization is to be able to direct adequate support and treatment. If violence victimization has contributed to mental and physical ill health, interventions in these problems will probably not succeed without addressing the victimization (135). Both the patient and health care personal may remain unaware that the medical problems might be associated with prior or present victimization if the question is never asked (135).

A third reason for routine inquiry about violence victimization in youth is to make an accurate diagnosis. Hultman et al., who used routine inquiry about violence victimization in a child and adolescent mental health care unit, pointed out that the information gained from routine inquiry about violence was highly relevant for the clinician assessing the child's psychiatric symptoms (205). If violence victimization is not known, symptoms of stress-related trauma derived from the experience of violence can mistakenly be attributed to attention deficit hyperactivity disorder (ADHD), depression or other psychiatric disorders (205). There are also studies that have demonstrated little or no effect of treatment for bipolarity or substance use in victimized youth if the victimization is not accounted for (46).

A comprehensive view of violence victimization and the awareness of co-occurrence of violence may also make health care personnel more apt to see the whole picture. If a child or youth is bullied in school, there is an increased risk of there also being violence in the home (23). Many of the youth who report rape have experiences of other victimization as well (1). If this knowledge is not incorporated in the way health care personnel support and

care for youth in health care settings, the risk is high that they will not succeed.

How to interpret the interventions against risk drinking

Most studies of brief interventions in risk drinking among youth have taken place in hospital emergency departments or educational settings and are mainly from the US (151, 178, 181). In study III, the researchers extended prior research, studying intervention using MI in risk drinkers in a different clientele of youth, namely young women visiting youth clinics for such reasons as prescription of contraceptives, health problems or testing for sexually transmitted infections.

Study III demonstrated that risk drinking had decreased significantly in both the young women who received MI and the young women in the control group at the 12-month follow-up, but with no significant difference between groups. Of the participants who did not have risk alcohol drinking at baseline, about 20% in both the intervention and the control group had developed risk drinking by the 12-month follow-up.

Is the AUDIT-C an appropriate screening tool in youth?

In order to succeed with routine inquiry and intervention, both the screening instrument and the intervention chosen need to be effective. In practice, most alcohol screening instruments used with youth were originally developed to detect alcohol disorders in adults (206, 207). Few studies have examined the suitability of using adult alcohol screening instruments in youth, but existing studies suggest that the Alcohol Use Disorders Identification Test (AUDIT) and the AUDIT Consumption (AUDIT-C) perform well in terms of sensitivity and specificity in youth (206, 207, 208). The AUDIT-C was chosen as the screening instrument in study III because its brevity was considered an advantage in a clinical setting.

The validity of screening instruments with youth over time has been little studied. The number of young women going from being risk drinkers to non-risk drinkers and vice versa in study III indicates that risk drinking as defined using the AUDIT-C is not static in this group. Studies of alcohol risk consumption in both youth and adults with a longitudinal design in general populations are scarce. However, existing studies in adults have also shown significant intra-individual differences in alcohol dependency over time (209, 210).

In the interviews (study IV), the participants generally did not consider themselves as risk drinkers, even when told that they exceeded guidelines. The participants were aware of the possible negative effects of alcohol, but

defined risk drinking according to a person's behavior rather than to the quantity or frequency of alcohol consumption. Becoming too drunk or missing school and sports practice were indicators of the drinking being harmful. This finding is in line with the findings of earlier studies demonstrating that youth do not perceive unit-based alcohol drinking guidelines to be useful (211, 212) and find it difficult to translate their drinking into units. There is also reason to question how screening instruments using quantity and frequency account for experiences and cognitions in adolescents (213, 214). What does "a typical occasion when you are drinking" imply to an adolescent? "Typical" might change within weeks, with different friends or on different occasions. It is possible that the large intra-individual mobility in risk drinking in this study III is due in part to age variations in understanding and interpreting the questions. The AUDIT-C may not in fact be useful as a screening instrument to capture risk drinking in youth.

The youth's own views on alcohol drinking

When discussing youth and alcohol drinking, it is easy to focus only on problems, and in prevention/interventions to often focus on control. However, in the interviews (study IV), many of the youth also referred to alcohol as having positive connotations, serving as a facilitator in meeting new people and consolidating social bonds. Many of the participants also stated that youth is a time when alcohol drinking is frequent, but that this has to do with the context and will change when they begin working and start a family. Problematic drinking, on the other hand, was referred to as adverse behavior such as neglecting school or work or becoming too drunk at a party and doing things while drunk that the youth regretted afterward.

The social context in which youth drink alcohol is important to consider when developing prevention strategies. If alcohol prevention mainly focuses on the amount of alcohol consumed, there is a big risk that other factors that may be more important for future adverse effects because of alcohol drinking may be overlooked. Instead of solely using consumption-based screening instruments and prevention strategies, it may be more successful to ask about possible problematic behaviors when drinking and about mental ill health and socioeconomic problems, and to use a broader perspective when designing screening and prevention strategies.

Motivational interviewing

In study III, risk-drinking young women received only one MI session. The reason for this was that it is generally hard to motivate youth to come to booked appointments (6). Including the routine inquiry and subsequent MI

within an ordinary visit was thought of as a window of opportunity. A recent Cochrane review detected no difference in effect between different MI-based modalities and number of sessions (177).

In adults, MI has shown some results in decreasing risk drinking (177). The efficacy of MI as an intervention strategy for young risk drinkers has been addressed in several studies, but overall the results are conflicting (151, 178-180). A recent Cochrane review reported that although a number of studies found some significant effects of MI decreasing risk drinking in youth, the effect sizes were too small to be of clinical relevance (181). This finding could be said to be in line with the results in study III. However, considering the large intra-individual mobility in young women's risk drinking behavior in study III and the voices of the youth themselves in study IV, questions arise as to whether the AUDIT-C was a reliable screening instrument. And if the screening instrument was not valid, it may in fact be hard to evaluate the intervention at all. This possibility highlights the need for reliable screening tools that capture the large mobility in drinking behavior in youth before general screening and subsequent interventions can be adopted.

Interestingly, general alcohol consumption among youth in Sweden has steadily decreased since a peak in 2000, for reasons that are not clearly understood (215, 216, 217). This trend is in line with similar declines in alcohol consumption among several other Western European countries and the US (215, 217). Clearly, more research is needed to better understand the mechanisms that influence young people's alcohol consumption.

Using mixed methods

Violence victimization and risk drinking are multidimensional phenomena. Studying the implementation and possible effects of interventions directed at those affected by past victimization or who are risk drinkers is complex. In research on complex interventions, the use of mixed methods – in other words, using both quantitative and qualitative data – in the study design has been suggested to be a more fruitful approach (218).

Randomized controlled trials have become the landmark of evaluating the effects of intervention research. However, when studying more complex interventions, where the outcome does not occur at a single point but may be a process that occurs over time and where contextual factors may play an important role in the process, there may be a risk that positive outcomes not detected in the standardized scales are overlooked. Using only standardized scales or questionnaires may also limit, or exclude, new understandings and perspectives on a situation. The risk is of carrying out detailed research on what is already known, instead of expanding research to what is not yet known. When this is the situation, mixed methods may work in a comple-

mentary fashion, allowing for a triangulation that can enhance the understanding and validation of the results.

In this thesis, the use of both a quantitative and a qualitative study design led to a more complex interpretation of the results. If only a quantitative design had been used, the interpretation might well have been that routine inquiry about violence victimization and the offered support did not have any effect. However, in the interviews (study IV), the participants viewed routine inquiry about victimization very positively and described how they found the subsequent support very helpful. Similarly, if only a qualitative approach had been used, the results might well have been interpreted quite differently. In researching risk drinking, the qualitative study (study IV) added understanding to the quantitative study III in terms of how youth did not find the used measurement of risk drinking (AUDIT-C) to be very useful.

Methodological considerations

The genealogy of violence

Violence is of course not a natural category but a culturally constructed way of defining classes of experiences and events (47). This thesis rests on the assumption that the neurobiological processes underlying the acute or chronic stress of violence are the same worldwide, but the reaction to violence, the illness narratives and the medical reasoning are very different depending on the cultural context. In this thesis, violence and victimization are used in the context of the Western world, more specifically Sweden, where violence is, at least in theory, considered unacceptable unless it is committed in a socially accepted and organized form such as interventions by the police or in the boxing ring. Sweden of today is mostly a secular society where individualism is the cultural norm. This of course shapes how its people view victims and perpetrators, how they direct blame and accountability, and what they consider adequate reactions and treatment after victimization.

Ironically, the trauma of violence victimization may even be higher in a culture where violence is taboo (47). In Sweden, and probably most of the Western world today, talking about distress and stressful events is generally considered healthy and confronting emotional problems is seen as a way of coming to terms with what has happened in order to heal (153, 155). In other social contexts, however, these individualistic values may not be central in recovering from trauma. Instead, nonverbal modes of expression, silence and religious rites may be more personally or culturally appropriate (47).

No questions about perpetrators of violence

In Western society, people often link violence to one party: someone is either a victim or a perpetrator (47, 63). This way of thinking shapes people's worldview and view of themselves. It makes it easy to align with the victim and perceive the perpetrator as "the other," and it protects individuals from confronting the ordinary brutality caused by inequalities inherent in all societies (47). However, research has made it clear that youth who are victims of violence are sometimes also perpetrators of violence (18, 63). Studies have demonstrated that being a perpetrator of violence is associated with adverse health outcomes (63). The dichotomy between victim and perpetrator limits us as clinicians in understanding the whole picture of victimized individuals who are also perpetrators (63).

Before starting routine inquiry about violence victimization, the researchers discussed together with the personnel at the youth clinics if they should also ask about perpetration. At the time, the general feeling was that it would be too difficult to ask about both victimization and perpetration, and the decision was to start with routine inquiry about victimization only. In the future, questions about perpetration ideally should be included, in order to cover all aspects of violence.

Definitions and assessments of violence victimization

Terms used to represent particular types of violence victimization or associations between these types of violence victimization often differ between, and even within, different research fields. In this thesis, the focus is on interpersonal violence victimization. I have used the terms *emotional violence victimization*, *physical violence victimization*, *mild/moderate sexual violence victimization*, *penetrating/attempting to penetrate sexual violence victimization* and *witnessing family violence* in an effort to cover all types of interpersonal violence victimization.

In order to describe the co-occurrence of violence, several terms have been used in the literature. Finkelhor et al. used the term *poly-victimization* (61). However, they had a strict definition for this term that specified four or more types of violence victimization in the previous year, a definition that is not applicable in the studies in this thesis. In this thesis, the term *multiple victimization* is used for the experience of lifetime victimization from two or more types of violence. Identifying different types of violence patterns across time is also important when addressing violence victimization (18). In the studies in this thesis, lifetime victimization was assessed.

Questions about violence victimization

In study II, routine inquiry about violence victimization was integrated into the regular consultation. This made it paramount to use questions that were not too extensive and time-consuming, but at the same time permitted broad assessment of multiple forms of violence in a clinical setting. It has been shown that the wording of the questions is important. Studies have shown that using simple language in behaviorally specific questions that clearly define the type of violence that the young person is asked to report on is recommended (50, 219). In the studies in this thesis, the researchers used questions that were modeled on the NorVold Abuse Questionnaire but were less extensive than the original questionnaire (183). The NorVold questionnaire was originally validated for use with adults. However, it has been validated in a focus group session with youth, and after this used in other studies in Swedish youth clinics (220). A question about witnessing family violence, not originally in the NorVold questionnaire, was added.

A limitation in the studies in this thesis is that no specific questions on cyber/Internet violence victimization were included. However, the youth of today do not always draw strict lines between being online and being away from the keyboard, and it is possible that at least some forms of cyber-bullying/cyber-stalking violence might have been detected in the question about emotional violence victimization.

Examination of symptoms, not diagnosis

In the studies in this thesis, the researchers used the Hospital Anxiety and Depression Scale (HADS) to assess self-reported depressive and anxiety symptoms (186). The Swedish version of the PTSD Checklist was used in order to assess self-reported post-traumatic stress symptoms (187). Since there were separate questions about violence victimization, all questions about violence exposure were excluded from the checklist, thus precluding any association of a specific exposure. This differs from a clinical setting, where the diagnosis would be based on PTS symptoms in association with specific violence exposure. Hence it is important to note that the researchers did not present a measure of PTSD, depression, anxiety or any other diagnosis, but rather a measure of self-reported symptoms indicating ill health.

One objection could be that the researchers used the HADS and the PTSD Checklist, which are mainly used in adults, to attain self-reported health in a study of adolescents and young adults. However, the mean age in the quantitative studies was 18.4 years at baseline, and in the qualitative study (study IV), all the participants were above 18 years of age.

The risk of medicalization

Many individuals who have faced violence victimization withstand and heal without developing psychological problems (70). In study IV, some of the participants explained that they had already processed and recovered from the victimization at the time of the health dialogue. The participants who had processed their victimization invariably referred to support from friends and sometimes parents and health professionals as essential in their coping. This finding is in line with earlier research describing social support as a factor in resilience in victimized youth (70, 76).

An interesting finding in study IV was how participants did not view themselves as victims. Instead, they referred to themselves not only as having survived the violence, but also as being more capable and empathic than before the victimization; they had turned a traumatic event into one of meaning. Prior research in adults has demonstrated that dealing with trauma can produce positive changes, described as post-traumatic growth, but this has been little studied in youth (221). This also leads to a discussion about the term *victim*. In some of the literature, mainly concerning sexual violence victimization, the term *survivor* has been suggested to be more appropriate. I can definitely see the point in this reasoning, but since the terms *victim* and *violence victimization* are used in most of the research done in child and youth victimization, I have too used the term victim.

Study limitations

No young men in the quantitative studies

One limitation in the studies in this thesis is that the number of participating young men was low ($n = 86$), making it not meaningful to include them in the quantitative analysis. The proportion of men however, reflects the ratio between young men and young women visiting youth clinics. Increasing the number of young men visiting youth clinics has been an ongoing goal in the health care field for the last 4 decades, but with little success to date (6).

Selection bias

Of all eligible young women, 72% agreed to participate in the research. The young women who declined to participate mostly stated a lack of time as the reason, but the results may be biased by not having further information about them. The relatively high level of attrition between the baseline and the 12-month follow-up may also have caused a selection bias. The attrition analysis demonstrated no differences at baseline between completers and non-completers other than a greater number of young women with a higher educational level and a greater number of sexual minority young woman among

the completers. At baseline, sexual minority women reported more victimization than heterosexual women did, which might have influenced the results. However, attrition rates did not differ significantly between the intervention and control groups.

Another reason for the relatively high attrition level is that for two periods during the 12-month follow-up, there were severe problems with the server handling the digital questionnaires. A number of questionnaires, approximately 50–70, were not received. This could have led to random errors.

Information bias

The assessment of violence victimization as well as of health outcomes was based on self-reporting, which may have introduced some risk of under-reporting because of shame, guilt or unwillingness to disclose. There may also have been a risk of recall bias; considering the young age of the participants, however, the risk of recall bias was probably reduced. Unmeasured confounders and external variables such as the timing of victimization may also have biased the results.

The psychometric self-assessed questions in the questionnaires may also have caused information bias. The volume of missing data was low, however, with item non-response in the questionnaires varying between 0.3% and 12.4%. No imputation was done.

Confounding and mediating factors

The reason for using multivariate models in studies I, II and III was to better understand the variables associated with a history of violence victimization and ill health. The information was based on self-reported questionnaires, and the number of variables was limited. For example, no information on parental profession and education was given. Earlier research has shown that youth often do not know this information, and that therefore it is often afflicted with errors (223). It is possible, however, that the lack of this information might have affected the results. The reports of victimization may also have been influenced by the health status of the participants – in other words, earlier victimization may have been distorted when recalled through the lens of present depression or post-traumatic stress symptoms.

Performance bias

The idea of the health dialogue and the interventions was initiated and launched by the youth clinic personnel themselves, and this probably added to the adherence to the study protocol. However, the participants in both the intervention group and the control group were handled by the same midwives and social workers. This may have biased the results toward being

more susceptible to violence victimization or risk drinking, even in the control group. Simply the act of answering questions about violence victimization and alcohol consumption, even if they are in an anonymized questionnaire, might also work as a form of intervention.

External validity

The present study took place in a part of Sweden with mid-size and small towns and including rural areas. The people in the region have a lower level of postsecondary education and fewer people with foreign background than in the whole of Sweden. Hence the results in this study may not be generalizable to young women from urban and more ethnically mixed backgrounds.

A possible sampling bias could be that participants in the study were recruited in youth clinics and therefore were not representative of the population. When comparing women in the same age group answering the Swedish National Public Health Survey, participants in the present study reported less ill health (11). In an earlier study by Blom et al., past-year victimization rates do not differ between young women attending the local youth clinic and matched young women in a high-school setting (220). This is an indication that as a group, young women visiting youth clinics do not present with more ill health or a higher degree of victimization than do young women in the general population.

Transferability

In qualitative research, the transferability of a study is judged by the reader. In study IV, the results are based on 15 research interviews. In order to enhance trustworthiness, a detailed description of how the analysis was performed and quotations from the participants were included in the text (218). Transferability was promoted by being careful in describing both typical and atypical views expressed by the participants. Several of the findings were consistent with the findings of previous studies, which further strengthen transferability. Research bias may also have been unintentionally communicated to the participants, but I believe that the interviewer's awareness and experience of working with youth allowed the participants to talk freely about their experiences.

CLINICAL IMPLICATIONS AND SUGGESTIONS FOR FURTHER RESEARCH

Violence victimization is common in youth, and in this thesis victimization in young women was strongly associated with mental and somatic ill health and PTS symptoms, especially evident in those who were multiply victimized. It is crucial that health professionals working with youth are aware of these associations because if prior victimization has contributed to ill health, interventions in these problems will probably not succeed without also addressing the victimization. However, since youth rarely disclose victimization if not directly asked, this information often goes undetected. Routine inquiry about violence victimization gives youth a chance to disclose victimization and is an opportunity for health personnel to acknowledge the youth's experience and affirm that violence is never acceptable. Even if the youth may not want or need counseling at the time, they will know where to turn, should they need support later on.

Another important reason to ask about violence victimization is to be able to direct adequate support and treatment. If violence victimization is not known, stress-related trauma symptoms derived from the experience of violence can mistakenly be attributed to ADHD, depression or other psychiatric disorders. If this is the case, the focus may be unfairly directed on a problematic youth instead of on a toxic environment. Some studies have also demonstrated less effect of treatment in victimized youth if the victimization is not accounted for, but more research in this area is needed.

In the quantitative analysis in this thesis no differences were found in health outcomes in young women between the intervention and the control group. However, the youth participating in the qualitative study (study IV) reported that they found the questions about violence victimization very helpful. This leads to the question whether the instruments used to detect health outcomes were too blunt or inadequate for this age group, or if health may not be the only outcome that should be measured. In further research, it would be interesting to see if, for example, a sense of coherence might be influenced by routine inquiry about violence victimization and the offered support.

More research is needed in order to better understand what interventions youth consider helpful.

Only young women were studied in the quantitative analysis described in this thesis. More studies that include young men, and especially studies on the health of victimized young men, are needed.

A large intra-individual mobility in young women's drinking behavior was demonstrated in this thesis, but no differences in risk drinking between the MI group and the controls were found. This leads to questions about the validity of the AUDIT-C in youth over time. More longitudinal studies validating the predictability of alcohol screening instruments in youth are warranted. In the interviews in the qualitative study (study IV), youth found it difficult to translate their drinking into units and did not perceive unit-based alcohol drinking guidelines to be adequate in determining whether or not drinking habits were problematic. Instead, they viewed risk drinking in terms of the consequences of alcohol drinking.

These are important aspects to integrate into youth-friendly services such as youth clinics. If alcohol screening and prevention mainly focus on the amount of alcohol consumed, there is a big risk that other factors that may be more important for future adverse effects because of alcohol drinking may be overlooked. Instead, it might be more useful to develop instruments that capture possible problematic behaviors when drinking, mental ill health and socioeconomic problems, and to use a broader perspective when designing screening and prevention strategies for risk drinking.

Youth have great potential for life changes and for healing. Health clinics and other arenas where young people seek health care or advice is windows of opportunity for asking about violence victimization and problematic alcohol drinking and, when needed, offering intervention.

CONCLUSIONS

- Violence victimization was strongly associated with mental ill health in young women, and multiply victimized women had markedly worse health outcomes than singly victimized women. Non-victimized young women assessed their health as being good.
- Low economic resources did not influence health negatively for the non-victimized, but reinforced ill health multiplicatively for the victimized.
- Participants were in favor of routine inquiry in youth clinics about violence victimization as well as alcohol consumption.
- Routine inquiry for violence victimization and brief intervention in the form of empowering strategies were feasible within ordinary consultations at youth health centers and led to high rates of disclosure.
- In the quantitative analysis, no differences were found in violence victimization rates or health outcomes between the young women in the intervention group and the control group. However, in interviews the participants described how questions about violence helped them interpret and process prior victimization. For some, the intervention led to the possibility of initiating changes such as leaving a destructive relationship or starting therapy.
- There was a large intra-individual mobility in young women's drinking behavior, but no differences in risk drinking between the MI group and the controls were found. In interviews, participants viewed risk drinking in terms of consequences rather than in quantity or frequency of alcohol. This may render unit-based drinking guidelines less useful when addressing risk drinking in youth.

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Vi vill
fråga!

UNGDOMAR OM
ALKOHOL^{SEX} • DROGE
TOBAK • VÅLD

Loggor etc.

Välkommen till "Ungdomar om"

Några saker att tänka på

Sätt ett kryss i den eller de rutor som stämmer för dig. Så här

Ibland kanske du inte hittar något passande alternativ, ta då det alternativ som stämmer bäst

Om du råkar kryssa i fel ruta, fyll i hela rutan , sätt sedan kryss i rätt ruta

Först kommer de frågor som tas upp under Hälsosamtalet

Ska besvaras av alla

1. Blev du lottad till Hälsosamtal?

- Ja
- Nej

2. Hur tycker du att du allmänt mår?

- Mycket dåligt
- Dåligt
- Någorlunda
- Bra
- Mycket bra

3. Röker du?

- Ja, dagligen
- Ja, då och då
- Har slutat röka
- Har testat
- Har aldrig rökt

4. Vill du minska/sluta röka?

- Inte aktuellt, röker inte
- Nej
- Ja
- Vet inte

5. Snusar du?

- Ja, dagligen
- Ja, då och då
- Har slutat snusa
- Har testat
- Har aldrig snusat

6. Vill du minska/sluta snusa?

- Inte aktuellt, snusar inte
- Nej
- Ja
- Vet inte

Alkoholvanor

Kryssa för de alternativ som stämmer bäst för dig och ditt liv.

Med ”glas” menas



4 cl starksprit



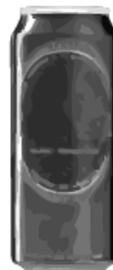
8 cl starkvin



12–15 cl vin



33 cl starköl



50 cl folköl

7. Hur ofta har druckit alkohol under de senaste sex månaderna?

- 4 ggr i veckan
- 2-3 gånger i veckan
- 2-4 gånger i månaden
- 1 gång i månaden eller mer sällan
- Har testat
- Aldrig ➡ Fortsätt direkt med fråga 10!

8. Hur många ”glas” dricker du en typisk dag när du dricker alkohol? För ”glas” se bild

- 1-2
- 3-4
- 5-6
- 7-9
- 10 eller fler
- Vet inte

9. Hur ofta dricker du sex ”glas” eller fler vid samma tillfälle t.ex. under en kväll?

- Dagligen eller nästan dagligen
- Varje vecka
- Varje månad
- Mer sällan än en gång i månaden
- Aldrig

10. Vill du minska/sluta dricka alkohol?

- Inte aktuellt, dricker inte
- Nej
- Ja
- Vet inte

11. Använder du cannabis?

- Ja dagligen
- Ja, då och då
- Har slutat
- Har testat
- Nej

12. Vill du minska/sluta använda cannabis?

- Inte aktuellt, använder inte cannabis
- Nej
- Ja
- Vet inte

13. Använder du andra droger t.ex. GHB, tabletter, anabola steroider, sniffar?

- Ja dagligen
- Ja, då och då
- Har slutat
- Har testat
- Nej

14. Vill du minska/sluta ditt bruk av andra droger?

- Inte aktuellt, använder inte andra droger
- Nej
- Ja
- Vet inte

Nu kommer några frågor om utsatthet för våld

15. Har du någon gång varit med om att någon tryckt ner dig psykiskt, mobbat eller hotat dig?

- Nej ➡️ Fortsätt med fråga 16!
- Ja

Om Ja, när hände det dig? Pricka in alla svar som stämmer för dig

- Innan du blev 15 år
- Efter du blev 15 år
- De senaste 3 månaderna

Markera på skalan hur dåligt du mår just nu av det som hänt dig!

Inte alls _____ väldigt mycket

16. Har du någon gång varit med om att någon utsatt dig för någon form av kroppsligt våld (t.ex. slag på kinden, knytnävsslag, sparkar, använt vapen).

- Nej  Fortsätt med fråga 17!
 Ja

Om Ja, när hände det dig? Pricka in alla svar som stämmer för dig

- Innan du blev 15 år
 Efter du blev 15 år
 De senaste 3 månaderna

Markera på skalan hur dåligt du mår just nu av det som hänt dig!

Inte alls _____ väldigt mycket

17. Har du någon gång varit med om att någon mot din vilja tagit på din kropp, eller ditt kön, eller tvingat dig att beröra honom/henne, eller använt din kropp för att tillfredsställa sig själv?

- Nej  Fortsätt med fråga 18!
 Ja

Om Ja, när hände det dig? Pricka in alla svar som stämmer för dig

- Innan du blev 15 år
 Efter du blev 15 år
 De senaste 3 månaderna

Markera på skalan hur dåligt du mår just nu av det som hänt dig!

Inte alls _____ väldigt mycket

18. Har du någon gång varit med om att någon mot din vilja försökt föra in, eller fört in, sin penis eller något annat i din slida, mun eller ändtarm

- Nej  Fortsätt med fråga 19!
 Ja

Om Ja, när hände det dig? Pricka in alla svar som stämmer för dig

- Innan du blev 15 år
 Efter du blev 15 år
 Sista 3 månaderna

Markera på skalan hur dåligt du mår just nu av det som hänt dig!

Inte alls _____ väldigt mycket

19. Har du någon gång sett eller hört att någon vuxen i din familj har gjort någon i familjen illa?

- Nej  Fortsätt med fråga 20!
 Ja

Om Ja, när hände det dig? Pricka in alla svar som stämmer för dig

- Innan du blev 15 år
 Efter du blev 15 år
 Sista 3 månaderna

Markera på skalan hur dåligt du mår just nu av det som hänt dig!

Inte alls _____ väldigt mycket

Slutligen några frågor om sex

20. Har du haft sex/samlag någon gång

- Ja
 Nej  Fortsätt direkt på nästa sida fråga 1.

21. Använde du/din partner något skydd mot infektioner senaste gången ni hade sex/samlag?

- Ja
 Nej
 Vet inte
 Fast partner – behövs inte

22. Använde du/din partner något skydd mot graviditet senaste gången du hade samlag?

- Ja
 Nej
 Vet inte
 Inte aktuellt – partner av samma kön

Nu fortsätter enkäten med frågor som handlar om din hälsa.

1. Hur tycker du att du allmänt mår?

- Mycket bra
- Bra
- Någorlunda
- Dåligt
- Mycket dåligt

2. Om du tänker på din kroppsliga hälsa, hur många dagar den senaste 30-dagarsperioden skulle du säga att den inte varit bra (p.g.a. sjukdom, kroppsliga besvär eller skador)?

Skriv antal dagar mellan 0 och 30.

dagar

3. Om du tänker på din psykiska hälsa, hur många dagar den senaste 30-dagarsperioden skulle du säga att den inte varit bra (till exempel p.g.a. stress, nedstämdhet eller oro)?

Skriv antal dagar mellan 0 och 30.

dagar

4. Hur många dagar den senaste 30-dagarsperioden hindrade dålig kroppslig eller psykisk hälsa dig från att göra det du vanligen gör, som att gå i skolan, arbeta eller det du brukar göra på fritiden?

Ange antal dagar mellan 0 till 30

dagar

5. Har du under de senaste veckorna känt dig stressad?

Med stress menas ett tillstånd då att man känner sig spänd, rastlös, nervös, orolig eller okoncentrerad

- Inte alls
- Lite grand
- Ganska mycket
- Våldigt mycket

**6. Har du under *de senaste veckorna* haft något/några av följande besvär eller symptom?
Sätt ett kryss på varje fråga.**

a. Värk eller smärtor i nacke, axlar eller ryggen?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

b. Värk eller smärtor i leder i t.ex. händer, fötter eller knän?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

c. Huvudvärk eller migrän?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

d. Ängslan, oro eller ångest?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

e. Trötthet?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

f. Sömnsvårigheter?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

g. Eksem eller hudutslag?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

h. Återkommande mag-tarmbesvär?

- Nej
- Ja, lätta besvär
- Ja, svåra besvär

7. Läs igenom följande påståenden och sätt ett kryss i den ruta som bäst beskriver hur Du känt Dig *den senaste veckan*. Fundera inte för länge över Dina svar utan kryssa för den ruta som Du spontant känner stämmer för Dig.

a. Jag känner mig spänd eller nervös:

- Mestadels
- Ofta
- Av och till
- Inte alls

b. Jag uppskattar fortfarande saker jag tidigare uppskattat:

- Definitivt lika mycket
- Inte lika mycket
- Endast delvis
- Nästan inte alls

c. Jag har en känsla av att något hemskt kommer att hända:

- Mycket klart och obehagligt
- Inte så starkt nu
- Betydligt svagare nu
- Inte alls

d. Jag kan skratta och se det roliga i saker och ting:

- Lika ofta som tidigare
- Inte lika ofta nu
- Betydligt mer sällan nu
- Aldrig

e. Jag bekymrar mig över saker:

- Mestadels
- Ganska ofta
- Av och till
- Någon enstaka gång

f. Jag känner mig på gott humör:

- Aldrig
- Sällan
- Ibland
- Mestadels

g. Jag kan sitta stilla och känna mig avslappnad:

- Definitivt
- Vanligtvis
- Sällan
- Aldrig

h. Allting känns trögt:

- Nästan alltid
- Ofta
- Ibland
- Aldrig

j. Jag känner mig orolig, som om jag hade "fjärilar" i magen:

- Aldrig
- Ibland
- Ganska ofta
- Våldigt ofta

k. Jag har tappat intresset för hur jag ser ut:

- Fullständigt
- Till stor del
- Delvis
- Inte alls

l. Jag känner mig väldigt rastlös:

- Våldigt ofta
- Ganska ofta
- Sällan
- Inte alls

m. Jag ser med glädje fram emot saker och ting:

- Lika mycket nu som tidigare
- Mindre än tidigare
- Mycket mindre än tidigare
- Knappast alls

n. Jag får plötsliga panikkänslor:

- Våldigt ofta
- Ganska ofta
- Sällan
- Aldrig

o. Jag kan uppskatta en god bok, ett TV- eller radioprogram:

- Ofta
- Ibland
- Sällan
- Mycket sällan

8. Har du någon gång under *de senaste 12 månaderna* funderat på att göra dig själv illa genom att till exempel bränna eller skära dig?

- nej
 ja

9. Har du någon gång under *de senaste 12 månaderna* gjort dig själv illa på något sätt?

- nej
 ja

10. Har du någon gång under *de senaste 12 månaderna* funderat på att ta ditt liv/begå självmord?

- nej
 ja

11. Har du någon gång under *de senaste 12 månaderna* försökt ta ditt liv?

- nej
 ja

II. Nu kommer flera frågor om olika problem och besvär man ibland kan få när man varit med om obehagliga upplevelser.

Läs varje fråga noggrant och markera med ett X hur mycket du varit drabbad av problemet/ problemen den senaste 30-dagars-perioden (senaste månaden).

- | | | | | | |
|------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------|------------------------------------|-----------------------------------------|-----------------------------------------|
| 1. Återkommande, plågsamma minnen, tankar eller minnesbilder av en obehaglig upplevelse? | Inte alls
<input type="checkbox"/> | Sällan
<input type="checkbox"/> | Ibland
<input type="checkbox"/> | Ganska ofta
<input type="checkbox"/> | Mycket ofta
<input type="checkbox"/> |
| 2. Återkommande, plågsamma drömmar om en obehaglig upplevelse? | Inte alls
<input type="checkbox"/> | Sällan
<input type="checkbox"/> | Ibland
<input type="checkbox"/> | Ganska ofta
<input type="checkbox"/> | Mycket ofta
<input type="checkbox"/> |
| 3. Plötsligt agerat, eller känt det som om en obehaglig upplevelse hände igen? | Inte alls
<input type="checkbox"/> | Sällan
<input type="checkbox"/> | Ibland
<input type="checkbox"/> | Ganska ofta
<input type="checkbox"/> | Mycket ofta
<input type="checkbox"/> |
| 4. Känt dig mycket upprörd över något som påmint om en obehaglig upplevelse? | Inte alls
<input type="checkbox"/> | Sällan
<input type="checkbox"/> | Ibland
<input type="checkbox"/> | Ganska ofta
<input type="checkbox"/> | Mycket ofta
<input type="checkbox"/> |

5. Fått fysiska reaktioner (som hjärtklappning, andningssvårigheter svettningar) när någonting påmint dig om en obehaglig upplevelse?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
6. Undvikit att tänka på eller tala om en obehaglig upplevelse, eller undvikit känslor som du förknippat med upplevelsen?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
7. Undvikit vissa aktiviteter eller situationer eftersom de påmint om en obehaglig händelse?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
8. Haft svårigheter att minnas viktiga delar av en obehaglig upplevelse?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
9. Haft minskat intresse för aktiviteter som du tidigare tyckt om?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
10. Känt distans till eller främlingskap inför andra människor?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
11. Känt känslomässig avtrubbning eller inte kunnat känna närhet till dina närmaste?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
12. Haft en känsla av att inte ha någon nära framtid ?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
13. Haft problem med att somna eller svårigheter med att sova sammanhängande?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>
14. Känt dig irriterad eller fått vredesutbrott?	Inte alls <input type="checkbox"/>	Sällan <input type="checkbox"/>	Ibland <input type="checkbox"/>	Ganska ofta <input type="checkbox"/>	Mycket ofta <input type="checkbox"/>

15. Haft koncentrations- svårigheter?	Inte alls	Sällan	Ibland	Ganska ofta	Mycket ofta
	<input type="checkbox"/>				
16. Varit ”hyperalert” eller på din vakt?	Inte alls	Sällan	Ibland	Ganska ofta	Mycket ofta
	<input type="checkbox"/>				
17. Känt dig ”skakis” eller lättskrämd?	Inte alls	Sällan	Ibland	Ganska ofta	Mycket ofta
	<input type="checkbox"/>				

III. Och nu några frågor om dina sociala relationer

1. Har du någon du kan dela dina innersta känslor med och anförtra dig åt?

- ja
 nej

2. Kan du få hjälp av någon/några personer om du har något problem eller mår dåligt?

Till exempel att prata med, få råd, låna saker, låna pengar

- ja
 nej

3. Tycker du att man i allmänhet kan lita på de flesta människor?

- ja
 nej

4. Har du för närvarande någon fast partner?

- ja
 nej

5. Om du plötsligt skulle hamna i en oförutsedd situation, där du på *en vecka* måste skaffa fram 15 000 kronor, skulle du klara det?

(t.ex. genom att använda sparpengar eller låna pengar av dina föräldrar eller någon kompis)

- ja
 nej

IV. Allmänna frågor

1. Vilken ungdomsmottagning besöker du?

- Sundsvall
- Härnösand
- Örnsköldsvik
- Sollefteå
- Kramfors
- Timrå
- Ånge

2. Är du tjej eller kille?

- Kille
- Tjej
- Vet inte

3. Vilken är din sexuella läggning?

- Heterosexuell
- Homosexuell
- Bisexuell
- Osäker på min sexuella läggning

4. Hur gammal är du?.....år

5. Vad har din huvudsakliga sysselsättning varit *de senaste 3 månaderna*?

Sätt ett x för det som passar bäst för dig

- Studerat på högstadiet/gymnasiet
- Studerat på universitet/högskola
- Gått annan utbildning
- Arbetat
- Arbetsökande
- Sjukskriven
- Annat

6. Om du går i gymnasiet, eller har gått i gymnasiet, vilket program går du i/gick du i?

Program:

7. Vilken gymnasieskola går du i eller har du gått i? (Om du har gått på flera olika gymnasieskolor, skriv den sista skolan)

Namn på gymnasieskolan:

8. Vem har du huvudsakligen bott tillsammans med under de senaste 3 månaderna?

Sätt ett kryss för det som passar bäst för dig

- Med båda mina föräldrar
- Mina föräldrar är skilda, jag flyttar mellan mina föräldrar
- Mina föräldrar är skilda, jag har bott mest hos en av mina föräldrar
- Hos min flickväs/pojkväs familj
- Eget boende
- Med en kompis eller flickvän/pojkvän
- Inget av alternativen stämmer för mig

9. Var är du och dina föräldrar födda? Sätt ett kryss på varje rad

Jag är född i Sverige Övriga Norden Övriga Europa Utanför Europa

Mamma är född i Sverige Övriga Norden Övriga Europa Utanför Europa

Pappa är född i Sverige Övriga Norden Övriga Europa Utanför Europa

10. Hur ser du på framtiden?

- Mycket positivt
- Ganska positivt
- Varken positivt eller negativt
- Ganska negativt
- Mycket negativt

Stort tack för ditt deltagande!

Om du känner att du vill prata med någon efter att du fyllt i enkäterna, så dra dig inte för att fråga personalen på mottagningen eller att ringa till personalen på mottagningen.

Sundsvall
Sollefteå

Timrå
Kramfors

Ånge
Örnsköldsvik

Vi kommer att skicka nya enkäter till dig om 3 och 12 månader! Vi behöver kunna nå dig för detta.

Alla uppgifter i enkäten kommer att behandlas med strikt sekretess. För att vi ska veta att det är rätt person vi kontaktar behöver vi veta ditt namn och ditt personnummer.

Så fort vi har fått in alla dina enkäter, och innan vi bearbetar svaren, kommer vi att ta bort och förstöra sista sidan på enkäten med namn och adressuppgifter, så att uppgifterna i enkäten inte kan identifieras till någon person.

Fyll i namn och personnummer

Namn.....

Födelseår mån dag nummer.....

VÄND!

***Hur vill du att vi helst kontaktar dig? Med SMS, mail eller brev?
Kryssa i minst ett alternativ***

med SMS

Vi skickar ett SMS med länkadress och lösenord till enkäten.

Fyll i ditt mobilnummer här.....

med mail

Vi skickar ett meddelande till din email med länkadress och lösenord till enkäten.

Fyll i din email adress här.....

med brev

Vi skickar ett omärkt kuvert med den nya enkäten, som du ska fylla i, och ett frankerat kuvert som du sen skickar tillbaka enkäten i.

Fyll i din adress här. Gata.....

Postnummer.....

Ort.....

***Avslutningsvis vill vi fråga dig som deltagit i Hälsosamtalet
om du kan tänka dig att bli intervjuad av någon av oss
forskare***

Vi vill få en fördjupad förståelse för hur ungdomar upplever att i Hälsosamtalet prata om bland annat sitt alkoholbruk och sina eventuella erfarenheter av utsatthet för våld för någon personal på Ungdomsmottagningen. Intervjun kommer att ta 45-60 minuter.

Vi kommer att hålla till antingen på din Ungdomsmottagning eller på Forskningsavdelningen vid Sundsvalls sjukhus.

Får vi kontakta dig för ytterligare information inför en eventuell intervju?

ja

nej

***Tack igen för ditt deltagande!
Du kommer att få en ny enkät om 3 månader***

Anna Palm

Specialistläkare

Kvinnokliniken

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Överläkare

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