

Asking Routinely About Intimate Partner Violence in a Child and Adolescent Psychiatric Clinic: A Qualitative Study

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Abstract Among children visiting child and adolescent psychiatric clinics (CAP), the prevalence of exposure to intimate partner violence (IPV) is reported to be approximately 25 %. The extent to which CAP clinicians are aware of this violence, however, is unclear. Some researchers recommend asking about IPV at intake, both to raise disclosure rates and to ensure adequate treatment. Many clinicians are reluctant to do so as a matter of routine when there is no indication of occurrence of IPV in the family. When we interviewed 14 clinicians about their experiences using a standard questionnaire about IPV, three themes emerged: (a) *constraint* (the questions hinder the development of good relationships with patients), (b) *uncertainty* (upon reflection, screening is acknowledged as important, but somewhat deficient), and (c) *utility* (the questionnaire provides a useful framework). Our findings indicate that clinicians' negative feelings and ambivalence make the implementation of routinely asking about IPV a long process.

Keywords Intimate partner violence · Child psychiatry · Routine questions · Obstacles

Intimate partner violence (IPV) is a serious societal problem that affects a significant number of children. Population

studies find that 4–30 % of all children are affected by violence in their family, with a significant overlap between different types of violence (physical abuse 4–16 %; psychological abuse 10 %; sexual abuse 5–30 %, depending on type of abuse and gender; and intimate partner violence 10–20 %) (Gilbert et al. 2009). A recent population-based survey in Sweden found that 11 % of the children (aged 13 to 17 years reported being exposed to IPV (Annerbäck et al. 2010).

The prevalence of IPV among parents seeking help for their children at child and adolescent psychiatric clinics (CAPs) is not extensively documented; however, the few published studies suggest that the proportion of children in CAPs who experience IPV in their family ranges from 20 % to 50 % (Ford et al. 2011; McDonald et al. 2000; Olaya et al. 2010; Stewart et al. 1980). Available data from Sweden suggest that 20–30 % of children who become patients of Swedish CAPs have experienced IPV (Broberg et al. 2011; Hedtjärn et al. 2009; Jutvik 2010). It is unclear, however, to what degree violence is disclosed and if the link between violence exposure and its possible consequences for psychological symptoms is addressed. Two studies have shown that high prevalence of exposure to IPV and other types of interpersonal violence is not revealed in the contact with CAP. (Ormhaug et al. 2012; Reigstad et al. 2006).

Should Mental Health Care Professionals Routinely Ask About IPV?

There is ongoing discussion about whether or not screening for IPV should be universal within the health care system. The US Preventive Services Task Force found insufficient evidence to recommend for or against routine screening of parents or guardians for physical abuse or neglect of children, or the screening of women for intimate partner violence; and consequently does not recommend universal screening for physical abuse, neglect, or IPV (Berg et al. 2004). The authors

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do not specify the settings where these recommendations should be applicable, but health care settings are definitely important. In an update from the US Preventive Services Task Force, it is stated that potential adverse effects have minimal effects on most women and that screening instruments accurately identify women experiencing IPV (Nelson et al. 2012 #449). The National Screening Committee in Great Britain has listed 19 criteria to be met in order to recommend universal screening several of which cannot be met in the case of IPV (Hall and Elliman 2003). These criteria address the *condition* (in this case IPV) which should be adequately understood, including development from latent to declared disease. *The test* should be acceptable for the population, there should be an effective *treatment* or intervention for patients and the benefits from the *screening programme* should outweigh the physical or psychological harm (caused by the test, diagnostic procedures and treatment). Some researchers recommend screening despite lack of evidence for its positive effects and lack of the above stated criteria for screening. These researchers claim that screening for IPV is an intervention in and of itself, and should be done on that basis (Spangaro et al. 2009).

In CAPs, the prevalence of IPV is at least three times higher than in the general population. Asking routinely about IPV in CAPs, therefore, is a way to focus actively on a known problem. In line with that aim, hospital administrators in CAPs in Stockholm, Sweden now recommend that questions about family violence should be asked during intake (CAP 2010).

Why Do Clinicians Not Ask About Intimate Partner Violence?

Difficulties with routinely asking about IPV have been studied in diverse settings such as family practices (Coker et al. 2002), social services (Hazen et al. 2007), obstetrician-gynecologists (Tower 2006), physicians (Cohen et al. 1997; Jaffee et al. 2005), pediatrics (Dowd et al. 2002; Erickson et al. 2001), and other health care settings (Minsky-Kelly et al. 2005), but not within CAPs. Some reported obstacles to asking routinely about IPV include beliefs that: (a) it would do more harm than good (Dowd et al. 2002), (b) there is too little time (Erickson et al. 2001), (c) patients will be unresponsive or offended (Elliott et al. 2002), (d) asking about violence is not the job of the medical professional because violence is not a medical problem (Coker et al. 2002; Jaffee et al. 2005), and (e) IPV is not a problem among the particular group of patients (Chamberlain and Perham-Hester 2002; Erickson et al. 2001).

Discomfort and lack of confidence in intervening with IPV further influence professionals' willingness to ask about violence in the family (Cohen et al. 1997; Jonassen and Mazor 2003). Concerns about insufficient resources to support the

victims also make it difficult for professionals to ask about violence (Garimella et al. 2000), as do distrust in the service system and lack of knowledge and training (Dowd et al. 2002). In the related area of child abuse, no studies, to our knowledge, have dealt with professional resistance to asking about child abuse. However, negative views of child protection services have been reported as obstacles to report suspected child abuse among pediatricians (Vulliamy and Sullivan 2000).

At the unit where this study was conducted, the prevalence of IPV was first documented in an exploratory study (Hedtj arm et al. 2009). Clinicians, on recommendation from the hospital administration, had routinely asked verbal questions to the mother of the child about IPV for three years (2006–2009). In 2010, clinicians started to use a self-report questionnaire at intake with children aged 9 to 17 about potentially traumatic events including a question about exposure to IPV. Also, in 2010, clinicians started to administer a gender-neutral questionnaire to parents. Only the clinicians' experiences of using the questionnaire to the parents is the focus in this study. Until the start of the study only women had reported IPV.

The clinicians in this study had practiced the routine of asking about IPV for several years. A study of clinicians' willingness to ask about IPV conducted in 2007 showed that in approximately one-third of all intake interviews, clinicians choose not to ask mothers about IPV (Hedtj arm et al. 2009). Routine use of a very short three-item written questionnaire, requiring approximately 1 to 2 min to complete, was introduced in 2010 (see Table 1). Missed opportunities to ask were fairly equally distributed among the 14 clinicians in the first 77 cases, at a rate of 26 %, mainly in difficult cases (traumatized refugees, interpreter participation, child protection officers' participation, and emergencies with suicidal young people).

In spite of supports and controls for routinely asking parents/guardians about IPV in a structured manner, it seems difficult to fully implement this activity. Our interest was to investigate more thoroughly perceived difficulties in administering the questionnaire. We looked both for missed opportunities to use the questionnaire and for general difficulties in handling the issue of family violence within the CAP.

Aim of the Study

The aim of this study was to explore clinicians' experiences of routinely asking about IPV at intake in a CAP, especially cases in which they had chosen not to ask about violence. There was a special focus on difficulties—both clinicians' personal difficulties asking particular families about violence and their perceptions of general difficulties in asking about family violence.

Table 1 Instrument used in the study

Partner Violence Screening (PVS)	
1. Have you been hit, kicked, punched, or otherwise hurt by someone during your child's lifetime?	<input type="checkbox"/> Yes, during the last year <input type="checkbox"/> Yes, 1 to 3 years ago <input type="checkbox"/> Yes, 4 years ago or longer <input type="checkbox"/> No
If so, by whom?	<input type="checkbox"/> Person in current relationship <input type="checkbox"/> Person in former relationship <input type="checkbox"/> Someone else
2. Do you feel safe in your current relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is there a partner from a previous relationship who is making you feel unsafe now?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Method

Participants

Fourteen clinicians working in a CAP were interviewed. The sample consisted of five social workers, one nurse, and eight psychologists (13 women and one man). The participants had, on average, 12 years of clinical experience; and ten of the participants had been working in the clinic for the entire four years since routine questions about IPV had begun to be asked.

Background

The unit serves approximately 20,000 children in a low-income area in southwest Sweden. The clinicians had no formal education in IPV or child abuse, but there was a strong commitment in the unit, as well as administrative support, to ask routinely about violence. As part of this study, clinicians were asked to administer the Partner Violence Screening (PVS) questionnaire (MacMillan et al. 2006) in a gender-neutral screening. The PVS is a self-report questionnaire consisting of three questions about the occurrence of violence in current and former partner relations.

Clinicians were instructed to administer the PVS with both parents during intake. They were free to administer the questionnaire to individuals either privately or with other family members present. The questionnaire takes 1 to 2 min to complete. The child's exposure to different traumatic events as well as his/her reactions to these events were assessed using the child version of the Life Incidence of Traumatic Events

(LITE) questionnaire (Greenwald and Rubin 1999). LITE assesses several types of traumatic events, including IPV and physical and sexual abuse in the family as well as in the community. Clinicians' experiences of asking children about child abuse are neither reported nor discussed in this article; the instrument is presented only to add context to the interviews about IPV.

Procedure

The interviews with clinicians were performed by two of the authors who worked as psychologists at the same clinic as the participants. The research project was introduced to the staff personally by the researchers. All clinicians doing intake interviews at the clinic were interviewed, and the transcribed interviews were used as data for analysis. All those who were asked to participate accepted. Participants were told the purpose of the interview was to understand their attitudes toward, and difficulties with, routinely asking about IPV in the intake interview.

A semi-structured interview was chosen to elicit as many different experiences as possible, while ensuring that all participants were asked the same key questions to maintain focus on the routine of the clinic. The interview started with questions about specific cases where the clinician had failed to ask about IPV and continued with questions about their experiences of administering the PVS questionnaire in a gender-neutral way.

Initial questions were specific and asked why the PVS had not been administered with a particular patient. If the clinician had a large case load, not all missed opportunities to ask about violence were addressed. Other questions were more general and asked participants how they experienced asking routinely about violence; how they regarded using a standardized questionnaire (instead of a more open clinical interview); and, in particular, how they regarded the PVS questionnaire. The interviews lasted approximately 30 min each and were audio-taped and transcribed verbatim.

Data Analysis

Thematic analysis as described by Braun and Clarke (Braun and Clarke 2006) was used to analyze the data and capture the experiences, meanings, and lived reality of the participants. Quotes from the interviews that contained meaningful passages in relation to the research question were extracted using the technique of open coding. A total of 153 quotes were extracted. Two authors and an external supervisor (an associate professor expert in qualitative analysis) individually sorted approximately 30 % of the quotes into themes. Differences in themes were discussed and a general structure was agreed upon. The two authors continued reading and sorting the

remaining quotes together into subthemes that were then grouped under main themes.

Results

The themes and subthemes are presented in Table 2; quotations, explanations, and summaries further demonstrate the relations between the data and the themes. General lines of thought extracted from the quotes are introduced under each subtheme. Three themes describing the use of the questionnaire were found in the interviews: *constraint*, *uncertainty*, and *utility*. Quotes from the participants were distributed relatively evenly across subthemes (between five and nine participants are represented in each subtheme), except for the subtheme *shortcomings*, in which almost all participants are represented.

Constraint

In this theme, routine use of the questionnaire to ask about violence was generally perceived as more of an obstacle than a resource. Some of the participants said that they were unable to use the PVS in difficult cases. The theme includes negative opinions about asking routinely about family violence, marked by anxiety that use of the questionnaire could either result in *harming the patient*, or that *other things were more urgent*.

Harm to the Patient

A recurrent anxiety was the possible consequences of PVS questions for the patient and the victimized parent after the visit. The participants did not perceive asking about violence as a safe way to help the patient, and assumed that the other parent and the patient could be subjected to more, not less, violence if this theme were brought up during the intake interview. It was feared that talking about the violence, i.e.

revealing a secret, could provoke the perpetrator to use violence to punish the secret-teller after leaving the clinic.

One participant reported an actual experience of escalated violence (before the initiation of the PVS questionnaire in 2006), but most participants had no experience of harm caused by raising the subject of IPV in interviews. It was, however, a common perception that violence could escalate if it was talked about. Thus, not knowing whether questioning about IPV could cause further violence at home after the visit to the clinic presented some participants with a moral dilemma.

Participant A: “Well I had an experience several years ago when I had two parents with a history of violence, and it was mentioned during the visit, and he was a very, very aggressive man, so scary that you felt [shudders], and they started to quarrel during the visit. That mother was beaten up by him later on, because of what was said during that conversation (...) You can feel it. Things like that stay in your head. Did I cause it? Sort of—it was the situation. But yes, that is probably what you think of—a mother could have even worse trouble if it was brought out in the open—but I don’t know, it could just be imagined.”

Because they lacked control over the situation, the participants were reluctant to take responsibility for the possible consequences of asking about violence. Some participants solved this problem by arguing that the victimized parent lived in a dangerous situation where threats of violence were ubiquitous, so bringing up the problem at the clinic was a minor problem.

Participant B: “I would like to know what the reaction will be at home. Does it generate any consequences when they get home? You don’t know anything about that, so it’s quite clear that you probably need to know about that, to take the whole responsibility (...) Sometimes, maybe because you need to justify why you ask these annoying questions, I think that, all right, they already live in this tough situation, where you, if you have a wrong look in your eyes (...) then you can get

Table 2 Themes and subthemes in clinicians’ experience of asking about family violence with a routine questionnaire

Constraint $q=40$	Uncertainty $q=75$	Utility $q=38$
Harm to the patient $q=17$	Accommodation $q=24$	Facilitation of sensitive questions $q=29$
More urgent matters $q=23$	Shortcomings $q=37$	Increased clarity about the situation $q=9$
	Strong negative emotions $q=14$	

q =Number of quotes found in the interviews. Total quotes extracted from the interviews were 153

Definitions of Themes

Constraint Negative opinions about asking routinely about family violence, marked by anxiety that use of the questionnaire could either result in harming the patient, or that the questions had relatively low importance

Accommodation Appreciation of the regularity and ordered way the questionnaire facilitates asking the sensitive questions and helping clarifying the situation

Utility A positive attitude to the idea about asking routinely about IPV paired with a stance of constructive criticism to accommodate the practice or referring to personal shortcomings or attached strong negative emotions

punished at home, so then I think that they live in this context all the time.”

Concerns also arose about harm that questions about IPV could cause during the visit. These harms consisted largely of hypothetical consequences such as upsetting the parent, or making the parent feel uncomfortable. Fears of destroying the therapeutic alliance by alienating the parent or further upsetting a fragile-seeming parent were other reported reasons not to ask about IPV.

Participant C: “I think it was on that intake I did not do it [administer the questionnaire]. The mother and the father had totally opposite opinions, and I felt that the father was annoyed when I inquired about their history, if substance abuse or psychiatric illness were present in the family. He answered the questions, but the mother did not, and I think he perceived some kind of imbalance. I felt that this question [about IPV] was not possible to ask.”

Participants were asked whether it was best to separate parents at the intake interview or administer the questionnaire simultaneously to both parents. It was described as odd and inappropriate to separate the couple if both parents participated in the intake interview, because it could make suspicious parents even more suspicious. On the other hand, asking both parents at the same time was also described as problematic. The main concerns were the risk of putting a potential victim in further danger and the probability that the victim would not feel able to answer the questions freely with the potential perpetrator present.

In this subtheme all participants shared the view that the mother was the potential victim and the father the potential perpetrator. Participant E: “It becomes very difficult if the father is the perpetrator and the mother is asked to answer that type of question while he sits beside her. Not good at all.”

More Urgent Matters

The core of this subtheme is the experience that parents often have other severe problems and are so engaged in these that it is impossible for the therapist to introduce a new theme.

The following participant made a clinical judgment that it was more relevant to focus on the clinical picture, and found it preferable to skip the questionnaire at this point.

Participant F: “No, the mother did not attend at the intake. The father and the son were here alone, then at the second, or third occasion the mother attended. Even the sister attended, because she had visited the pediatrician. She was ill and I simply didn’t make it, too many other things appeared instead.”

Sometimes the complexity of the case was overwhelming. Suicidal tendencies, serious neglect, the use of an interpreter, lack of time, stress, etc., took priority over asking about violence. In some cases the patients were described as “taking

over” and the visit was described as “urgent,” “messy,” “chaotic,” and full of “conflict.”

Participant G: “I didn’t do anything about that. I met them at one intake interview, and there was an interpreter, the interpreter, it was at the summer break was by mistake only booked for an hour, so actually I didn’t prioritize this [PVS]. It was urgent; child protection services participated in an immediate, urgent apprehension, so I had to make other priorities.”

Many statements in this subtheme had in common the assertion that the use of a questionnaire was not compatible with creating a relationship and letting the patient choose focus. Some participants found it necessary to let the patient decide what to talk about during the intake interview, to “meet them where they are.” It was hard for them to introduce something that the patient had not brought up as a problem, and if the patient did not talk about violence, then the therapist preferred not to ask about it.

Participant H: “I prefer to take them into the room and ask what kind of trouble they have and let them choose focus, kind of, and then expand it on the basis of my hypotheses (...) I think I get rather troubled [by asking about violence], if in the end I have to focus on something else. In some cases it feels totally appropriate, in other cases, this is not what we have been talking about for the last hour. We have been talking about something else and I have my hypotheses of what the trouble is about, and to present something totally different [at that time], I do not like it, there is a resistance [in me].”

Uncertainty

The quotes in this theme represent a positive attitude to the idea of asking routinely about IPV, but also describe problems with the context or the preconditions. A stance of constructive criticism was found in the quotes, as opposed to the findings under the theme “Constraint”. They had to *accommodate* the practice to fit their way of working, for example by asking the questions aloud instead of using the written questionnaire or not asking about violence at all on the first visit, as prescribed, but instead waiting for the right moment to broach the topic. Personal *shortcomings*, as well as those of the questionnaire and administrative routines, were given as reasons why it was so difficult to administer the questionnaires. *Strong negative emotions* of fear, anxiety, and helplessness were also mentioned as obstacles.

Accommodation

This subtheme highlights a dilemma between the participants’ own wish to ask verbally and the administrative request to use the written PVS questionnaire. There was no reluctance to ask about violence per se; their ambivalence concerned the best way to do it.

One participant agreed on the advantage of using a questionnaire, but admitted difficulties in using this modality, compared to verbal questioning. Participant F: “I am not against using written screening on principle, but it’s harder to do it in writing than to do it verbally.”

The need to modify the written routine was also attributed to the situation.

Participant G: “I think it’s very good to have this routine, as [the manager] pointed out, if you usually do it right away, but I also think that it’s good if there is some kind of freedom, that you can be more flexible in those cases where matters are urgent, and you have a lot of social workers to deal with, and you need to prioritize to make it work.”

Shortcomings

Critiques were both self-directed and aimed towards the routine and the questionnaire. Several participants expressed ambivalence about using a structured method.

One participant acknowledged the importance of asking about violence, on the other hand, she found it very difficult to re-learn and to change old habits. Participant I: “It is difficult to re-learn. This structured way I think is very good, but I am having difficulties (...) it is a problem. I have to deal with it.”

One participant formulated concerns that the questionnaires would be perceived as a burden by the patients.

Participant B: “No, what I think is that it is important that you consider which questionnaires should be used and to minimize, but still keep the best, that you really consider this carefully. Our patients are often not motivated, so they cannot keep up with too much, before they can sense that they are being helped.”

Some participants who considered it important to ask routinely about violence but still had problems doing it found the external control represented by the mandatory questionnaires and regular monitoring helpful.

Participant A: “I think it is always great to do it [the questionnaire]. I mean that I am positive to it, still, I have had difficulties doing it; that is another thing, I think. I find it great because we are really implementing this, that we have these questionnaires, and are driven to use them.”

Strong Negative Emotions

This subtheme highlights resistance to administering the questionnaire because it evokes strong negative emotions; because the relevance of the questions are not disputed, the subtheme fit under the main theme *uncertainty*, which concerns participants’ ambivalence towards the questionnaire.

Asking about IPV could be unpleasant and frightening for the participants.

Participant A: “Then, I think that it can be unpleasant when you have fathers, where you sense already before these kind of

questions come up, who have some kind of underlying aggressiveness, that they are a bit dangerous, that they are the kind that you can be afraid of (...) then it is not that easy [to ask about violence], but it hasn’t happened to me for a very long time, so it has not been a problem.”

One participant felt anxiety, hopelessness, and a lack of control and direction when meeting families with a history of violence.

Participant J: “Anxiety [about] safety, and what are you going to do about it [the violence]? How can you help? [You feel] some kind of hopelessness. Some of these perpetrating men—I have had a few—it turns out that whatever we do, the woman and the child will not get away. It’s powerlessness, that’s what it is.”

None of the participants experienced strong negative emotions from patients in response to questions about family violence, but they did report difficulties in talking about sexual issues and violence. Violence was talked about as a sensitive issue that was difficult to handle in specific situations. Participant E: “And I wonder when the child is in the room, how that affects the mother. Does she want to answer or not? Maybe there is something she wants to keep secret.”

Utility

In this theme participants expressed appreciation of the regularity and ordered way the questionnaire allowed them to ask sensitive questions. They felt that the routine *facilitated asking the sensitive questions* and helped *clarify the situation*. The questionnaire helped them approach a difficult issue in a complicated and sometimes emotionally volatile situation. The questionnaire was described as a “lightning rod.” Participants appreciated asking both parents as an expression of gender equality and asking about violence even in cases where there was none as a means of opening the conversation to sensitive issues.

Facilitation of Sensitive Questions

The participants found that the written questionnaires made it easier to raise the issue of violence.

Putting forward the question, not on indication, but as part of a routine, helped the participant to feel comfortable approaching the issue of violence.

Participant G: “I think it becomes very clear that this is a routine. Since we are prepared with written questionnaires, this is something that we do with everybody, and it is something we consider to be serious. It is very clear both for me and the patients.”

The written form was described as helpful, and tensions were seen to relax when paper and pencil were part of the intervention. Some participants regarded the questionnaire as

a way to avoid emotional confrontation by keeping the interaction with the family more distant in the beginning.

Participant I: “But I think it is good for many patients to fill in the questionnaire, I really think so. It is highly charged to talk about it, if you have a connection, sort of, some initial relationship. That, I think, is much more charged. So I think there are advantages to using the questionnaire.”

The PVS questionnaire was regarded as a helpful instrument that allowed parents either to answer in a neutral way or to talk about their problems with violence.

Participant B: “My impression is that the reaction to the questionnaire is either totally neutral—you just administer it—or that mothers, in this case, start to talk about it, to open up and talk. So I think it is positive, the reaction is often positive.”

Some participants who found the written questionnaires preferable to asking verbally had not always been of that opinion; there had been a change over time. Participant G: “Yes, I do it in writing. I think that is good. It is almost easier than asking, or it almost feels more natural, even. I did not think so in the beginning, but now I do.”

Increased Clarity of the Situation

The systematic way of asking the questions and the fact that specific questions captured important issues were described in positive terms in this subtheme. Disclosure was found to be easier with the written questionnaire, and the history of violence was seen as important information for clinical assessment of symptoms. Using the questionnaire seemed to structure both thinking and interaction with patients.

The following participant describes a process where implementation has been worked on until she has learned to use the questionnaire. She understands the interview situation in a context of challenging emotions, but has worked through this herself.

Participant F: “No one has commented negatively on the questionnaire. I think it works very well. It is just a matter of making it work in practice. But, I have no emotional difficulties using the questionnaire.”

Concerns about approaching issues of violence in this subtheme were on the cognitive, rather than the emotional, level. In an intake interview the huge amount of information could make the participant forget to ask about family violence, but the routine made it easier to keep in mind that those questions should be asked.

Participant A: “Above all, to be sure that you really ask about it, so that it is not lost in an intake interview, where [the patient has] so much to tell, about everything, which might not be related at all [to violence], and they seek help for problems that might not be associated with trauma reactions or things like that (...) but now you check the list. That is why it is good to have this questionnaire, I think.”

The gender-neutral administration of the questionnaire was considered to be easier than restricting the questions to mothers. It was also preferred because of the general effort toward gender equality, especially in cases of true negatives. For most participants the general hypothesis was that in cases of family violence, the victim is a woman and the perpetrator is a man, but participants who appreciated gender neutrality questioned this view.

Participant B: “It is important that you screen both [parents], it becomes more normalized when this happens. This [IPV] is a common problem, and we pay attention to it—and it can occur in different ways, mothers can fight and fathers can fight.”

Summary of Results

Opinions falling under all three main themes were represented in interviews with most of the participants. Because the participants were specifically interviewed about difficulties in asking patients about their experience of violence, ambivalent experiences were dominant: *constraint* (40 quotations), *uncertainty* (75 quotations) and *utility* (38 quotations). The difficulties represented in the quotes were actual (chaotic or complex intake situations) or emotional (ambivalent feelings represented as irrational difficulties and self-reflections). The systematic way of asking patients about violence was appreciated, because it made sensitive questions easier to handle and added structure to a sensitive intake interview. In a follow-up, the prevalence of questionnaire administration 1 year after completion of this study (2011) was investigated and found to be 75 %.

Discussion

This study focused on attitudes among clinicians toward routinely asking about family violence, specifically IPV, as part of the intake interview in a CAP. Factors that discourage the clinician from asking about violence were of particular interest. The participants in this study all worked in a clinic where routinely asking about IPV had been standard practice for several years, so they had already some years of experience in the field. Before this study began, the format for inquiring about family violence had been changed from asking ad hoc verbal questions only to mothers to using a short gender-neutral questionnaire about IPV with both parents. We were interested to know what difficulties still remained in a group of dedicated clinicians after years of this practice.

Under the main theme, *constraint*, we formulated the subtheme *harm to the patient*. Participants reported being fearful of contributing to escalated violence against the patient and the victimized parent (assumed to be the mother). We have not found any published studies showing that asking about IPV

can be harmful to the victim, but this is an important aspect that needs to be addressed more thoroughly. Calculations, based on 212 PVSs collected at the unit, showed that only ten of the mothers who reported violence against herself was subject to violence within the last year, 20 reported that the violence had occurred between 1 and 3 years ago, and 54 longer than 3 years ago (Table 3). It may be that most mothers do not seek help for their child at a CAP unit until they have left the abuser. If so, the fear about escalating violence expressed by our participants may not reflect the reality of most of these families. Still, children can indeed be unsafe when visiting the perpetrator, even if the mother has left him. If children who are suffering from ongoing or recently ended violence or maltreatment are not referred to CAP, however, this is another problem that must be identified and investigated.

Clinicians worried that broaching the issue of IPV in a clinical context could put the family in a more dangerous situation, but during 4 years of experience using the PVS in this CAP no acts of violence were recorded during visits at the clinic, and no such reports were received from children or parents in subsequent visits. We found no studies documenting accelerated violence due to the mention of the issue during health care visits, but it is important that measures be taken to safeguard families in cases where assessment indicates that the perpetrator has a tendency to dangerous violence. On the other hand, it is also important not to let these rare dangerous situations prevent clinicians from approaching IPV as a matter of routine.

Some participants were anxious that the therapeutic alliance with family members could be negatively affected by asking about violence. Most studies in this area, however, show the opposite; when this question is addressed in health care settings women have generally been found to react positively (Plichta 2007). The fear of negatively affecting the alliance by asking about violence is not supported empirically. The negative attitudes seem thus to remain in the clinicians (Todahl and Walters 2009). The participants also reported that asking about violence triggered their negative emotions like fear and helplessness.

In 29 % of the intake interviews two parents accompanied the child (Table 4). The two-parent intake interview was generally seen as a problem, because the participant had to balance the potential victim's need for safety and the impossibility of keeping secret from a potential perpetrator that you are approaching the issue of IPV.

By offering the questionnaire gender-neutrally, our aim was to address the issue of family violence non-judgmentally (i.e., not assuming that the perpetrator was the father). Before knowing whether or not violence had occurred between the parents or partners, participants reported feeling anxious if both parents were present.

Table 3 Prevalence of intimate partner violence (data collected 2011)

Answer to PVS questionnaire	N	%
No	128	60
Yes, during the last year	10	4
One to 3 years ago	20	9
Four years or longer ago	54	25
Number of intakes during 12 month data collection	212	100

If family intake is the normal practice, hospital management needs to reconsider this practice and recommend additional interviews in privacy. Other relevant issues such as substance abuse, relational difficulties in the adult relationships, and psychiatric syndromes in parents might not be mentioned in the family intake, and sometimes not even in a couples visit. Private consultation is probably a safe and confidential environment, for both the clinician and the patients, if such sensitive matters should be discussed.

Some problems seemed to prioritize themselves. Under the subtheme *more urgent matters* we found that the presence of other complicated clinical problems made it difficult for the participants to ask about violence. In particularly challenging cases, it was neither possible, nor appropriate, to hand out a questionnaire about IPV at intake and therefore, it was reasonable to postpone the questionnaire until later. In other cases the clinician needed to take charge during the intake interview to assert a particular agenda. We know, however, that violence is a theme that is avoided by both clinicians and patients, so steering the interview to other topics may be used as a defense against bringing up a sensitive issue.

The main theme *uncertainty* emerged in the interviews as a struggle between disregarding or criticizing the questionnaire on the one hand, and recognizing its usefulness as resource on the other. This perspective was often related to feelings of inadequacy among the participants themselves, and the content could be summarized by the plea, "I need to be better, but I need guidance. Monitor me, help me."

The participants described the written questionnaires positively, but they also wanted to adapt the procedure to their own way of doing things—*accommodation*. It is important that the clinician should be comfortable with the

Table 4 Constellation of intake interviews

Constellation	N	%
Mother and child	91	42
Mother, father and child	63	29
Father and child	26	12
Child comes alone	17	8
Other constellations	18	9
Total number of intakes during 9 month data collection (2010)	215	100

questionnaire, but it is unclear what should be changed to accomplish this: the clinician's attitude to the questionnaire, or the actual questions and recommended way to administrate them? Although clinicians might be more comfortable with asking verbally about violence, no study has ruled out written questionnaires for IPV, and women report being more comfortable with routine written questionnaires than verbal questions about IPV (MacMillan et al. 2006). Nevertheless some intake situations described by the participants are definitely challenging. Adapting the questionnaire to the situation in a gesture of accommodation could allow the clinician to approach the concept of violence slowly.

The subtheme *shortcomings* comprises quotes showing the participants' acknowledged difficulty in changing their habits. Participants questioned their own practice, which is a positive sign in the process of learning a new practice. The routines around asking (including providing standard information to patients, using written questionnaires, and having monitoring and supportive check-ups with the researchers) were mentioned as factors that made it easier to ask the questions. Monitoring the practice of asking about violence might ease the burden of asking these routine questions. If the practice is mandatory, introduced by management, the clinician can mentally share responsibility for the reactions it generates with an external source.

Routinely asking about violence evoked *strong negative emotions*. Participants reported feeling fear and helplessness and regarding the issue as so sensitive as to be taboo. These feelings and attitudes are likely also aroused when approaching issues such as sexuality or alcohol and drugs in clinical interviews. Under the main theme *utility* we identified the subtheme *facilitation of sensitive questions*. The charged intake situation was defused by the questionnaire, which brought order to an elevated emotional situation and made it easier for both the participant and the parent to handle. Perhaps focusing on an object (i.e. the questionnaire) rather than making eye contact helps to defuse the emotional charge in the atmosphere. The use of a questionnaire also made it clear that the questions were part of the intake routine, and that they were not asked based on indication or suspicion towards this particular family.

Using the PVS questionnaire structured the collection of information and contributed to *increased clarity about the situation*. The advantage of asking open questions without a hypothesis (the inductive approach) is that you check every single case. This information makes clinicians confident in proceeding with their assessments. Clinicians know themselves well and admit that if they do not ask about IPV as a matter of routine, they will often forget to.

The estimated prevalence of IPV at this unit was known to be relatively high, indicating the importance of addressing the issue. The unit cooperated with the university in preparing a treatment study for this population. No formal training was

offered, but frequent discussions and consultations about the issue were conducted with researchers from the Department of Psychology and the study participants were assured that adequate treatment was at hand. These circumstances may all have contributed to why the participants did not worry about how to handle a disclosure of IPV, did not feel short of knowledge about the phenomena, and did not claim that the problem was either non-existent in the population or not part of their job—obstacles to inquiring about IPV that have all been reported in previous studies (Todahl and Walters 2009). Neither did any of the participants mention that mandatory reporting to the child protection office was a hindrance to their asking routinely about violence. They were aware that it was their responsibility to act in these matters.

Implications for the Practice Field

Apart from these positive findings, clinicians' feelings of anxiety or inadequacy still seem to have a great influence on their inclination to ask about IPV. It is interesting that years of training, discussions, focus groups, and administrative monitoring, as well as the clinicians' own self-proclaimed positive attitude toward asking about violence, have not been enough to make this kind of routine comfortable for the clinicians. We know of no other efforts, however, that would make the routine any easier for clinicians to follow; therefore, we think that continuing with more training, discussion, focus groups, and administrative monitoring is the only way to increase clinicians' comfort and compliance with asking routine questions about violence in the home. Our findings do point to the importance of addressing clinicians' beliefs about harming the patients as there is no indication that the questions will neither escalate the violence, nor that the patients/families are severely hurt, offended or embarrassed by asking. In some intake interviews, of course, it is neither appropriate nor possible to ask about violence. Such intakes could be when other professionals are present or in certain acute matters like suicidal evaluation.

In the two-parent interviews (29 % of all intake interviews) clinicians should add private consultations to the family intake. This is not common practice in Sweden. The dominant discourse of family therapy could explain the usual practice of seeing children and parents together in the CAP, which does not make the process of identifying family violence any easier. The sensitive character of the issue and associated safety considerations have been extensively documented, making it clear that family violence should be dealt with in privacy, which should be offered to both parents and children. Negotiating privacy sensitively might be the real challenge to clinicians approaching this issue.

Contextual factors are crucial in implementing routine inquiries about family violence. Administrative support and monitoring must be in place, and all possible support and

treatment opportunities for both adult and child victims should be identified. In the long term, specific treatment for victims and witnesses of family violence should be developed within the CAP. Adequate supervision and consultation should also be offered to clinicians identifying child victims of IPV.

If it would be easier for the clinician and more comfortable for the patients and their parents if the questions were asked at the beginning of the interview, before a relationship has begun to be established, is a question we cannot yet answer on empirical grounds. It is probably best to let the clinician choose the timing of the questionnaire, as long as it is administered at some point during the intake interview. We advocate that clinicians routinely inquire about violence, rather than on indication. The longer the patient and the clinician interact, the more difficult it may be to ask about violence without a specific indication. There is also a risk that other problems will dominate the conversation and the assessment, and then the clinician will forget or avoid asking about violence. Qualitative studies are needed to answer the question about timing for inquiring about violence.

The fear that questions about family violence at the clinic could put the patient and parent in danger of more violence has not been confirmed in this study or during the years of practice in the clinic. Neither has this consequence been documented in scientific studies. Lethal cases of IPV may explain this anxiety in clinicians. It is important to act cautiously and to make a structured danger assessment when needed, but it is not necessary to act with such extreme caution in every potential case of IPV within the CAP. Indeed, our own figures show that in most cases of IPV the mothers of patients have already moved away from the perpetrator and the violence stopped several years ago. This does not guarantee that the violence has been eliminated completely; but the immediate danger of serious or lethal violence in these cases is probably considerably diminished. Future studies should investigate if the safety of the patients is endangered when questions about IPV and child maltreatment is brought up by clinicians. Qualitative studies about clinicians' experiences with structured interviews with children are needed to reveal specific obstacles when young people are interviewed. What factors influence clinical decisions to verbally ask about family violence versus administer a written questionnaire? Do clinicians tend to change the content of written questionnaires when administered verbally? Are clinicians more experienced with at-risk families more comfortable asking about violence? Are there gender differences, e.g. do female clinicians feel more comfortable asking about violence than male clinicians?

Published studies show that the prevalence of IPV in families of patients in CAPs is 20–30 %. More studies are needed to confirm this prevalence. Findings from this study indicate that a short questionnaire facilitates asking routinely about IPV. The PVS questionnaire has been positively received by women (MacMillan et al. 2006), mothers are receptive to

being asked about family violence when visiting child health care (Dubowitz et al. 2008), and clinicians in this study responded mostly positively to implementing PVS.

In what way can our results contribute to solve problems in a clinical context regarding disclosing IPV? Implementing new practices is difficult, even if they are evidence based. A single management decision about changing ways of doing things will probably not work in this field. Education might help. Organizational support is needed. But the key issue, the clinicians' conception about IPV, is important to understand in order to overcome known obstacles. The thematic analysis helps us to identify and analyze these conceptions. Knowledge about these conceptions could help managements to identify hidden critique, fears and resistance. In our study, the research interview gave the clinicians a chance to reflect on their personal attitudes and shortcomings. The systematic collection of data and the process of giving feedback to the clinicians and the management give new ideas about how to tackle the clinical problem. The starting point of this study had a clear but narrow scope; the issue of violence should be brought up by the clinician, and we know that this is done in too few cases. Accordingly, the thematic analysis was used in a realistic manner. The analysis answered our specific and limited question. Empirical studies about prevalence of IPV in CAP and reported difficulties disclosing IPV have been the theoretical starting point for the study. In order to study clinicians' perception and construction of handling the IPV issue in a broader sense, additional theories might be helpful. In that case, other qualitative methods could be used (interpretative phenomenological analysis or discourse analysis).

Limitations of the Study

It is important to keep in mind that two of the authors were colleagues of the participants, which may have influenced both the participants' responses and the researchers' analysis of the data. Harsh critique of the routines, leadership, and research project might have been self-censored by the participants, and a critical stance to the data might have been self-censored by the researchers as colleagues of the participants. To compensate for the latter we used an external scientific supervisor expert in qualitative analyses and Associate Professor to ensure a measure of objectivity.

This study was not designed to investigate the difference between participants' attitudes towards the PVS in one versus two-parent intake interviews. As this context is hypothesized to influence the attitudes, it could be an important topic for future studies.

It might also be that the clinic studied is not representative due to the already mentioned focus on IPV, so the generalizability of the findings could be questioned. On the other hand, it is interesting that despite years of practicing identification of IPV it is in many ways still a matter that is difficult to handle,

but with practice and a good infrastructure it gets more and more doable.

Conclusion

Given the probably high prevalence of family violence among patients in CAPs we conclude that it is reasonable to ask routinely about these important life events. We recommend that both parents and children be offered assessment in privacy. Clinicians' difficulties in asking about IPV can be moderated by administrative support and monitoring. Clinicians' fear that routinely asking about family violence at intake in CAPs may in fact escalate violence is an important theme to investigate more thoroughly. This might be an unnecessary worry. In child oriented public sectors, IPV issues could be tracked by asking children about their perception or involvement in this.

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