Violence exposure among Swedish youth

Helena Blom
To my family with endless love

“We owe our children
- the most vulnerable citizens in any society - a life free from violence and fear”

Nelson Mandela
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ABSTRACT

Background
Violence is a global public health problem and violence among youth is a matter of high priority. Adolescence and young adulthood are important periods for the foundation of future health. Youth victimization may have serious health consequences, making it important to address the occurrence and socio-medical context for possible interventions against violence.

Aims
To analyze prevalence, risk patterns and gender differences in emotional, physical, sexual, and multiple-violence victimizations and the associations between violence victimization and sexual ill health, sexual risk behaviors and mental health in Swedish youth.

Methods
A cross sectional study using two samples, a national sample from nine youth health centers in Sweden and a population-based sample from a middle-sized Swedish city. The questionnaire included standardized instruments addressing violence exposure (NorAQ), socio-demographics, mental and sexual ill-health and sexual risk behaviors, alcohol and substance use. Proportions and crude and adjusted odds ratios with a 95% CI were calculated.

Results
A total of 2,250 young women and 920 men, aged 15-23, answered the questionnaire at the youth health centers. In upper secondary school, 1,658 women and 1,589 men, aged 15-22, answered the questionnaire.

High prevalence rates with gendered differences both in rates and in co-occurrence of different types of violence were found. Women were more often exposed to emotional violence and sexual violence than men, while men were more often physically victimized. For both women and men, violence victimization before the age of 15 was strongly associated with all types of violence victimizations during the past year.

Strong associations were found between multiple-violence victimization and poor mental health in both genders. Among the sexually experienced students, consistent associations between lifetime multiple-violence victimization and various sexual ill-health and sexual risk behaviors were found in both genders, except for non-contraceptive use.
Conclusions

High prevalence of violence victimization in youth and strong associations between victimization, especially multiple victimization, and poor mental and sexual health were found. This needs to be recognized and addressed in social and medical settings.

Key words

violence; adolescent; self-injurious behaviour; suicidal ideation; mental health; reproductive health; youth
SAMMANFATTNING PÅ SVENSKA

Bakgrund

Våld är ett internationellt och nationellt uppmärksamt folkhälsoproblem och våld bland unga är ett prioriterat område. Ungdomar och unga vuxna tillhör den grupp som är mest utsatt för våld, och detta under en viktig övergångstid i livet där händelser kan påverka framtida hälsa. Våldsutsatthet kan ha betydande konsekvenser för hälsan, och därför är det viktigt att öka kunskapen om våldsfoirekomst och dess konsekvenser hos unga.

Syfte

Syftet med den här avhandlingen var att undersöka förekomst av emotionellt, fysiskt och sexuellt våld bland unga och att studera individuella riskfaktorer för våldsutsatthet. Syftet var också att undersöka samband mellan att vara multipelt utsatt, det vill säga utsatt för två eller tre olika typer av våld, och självrapporterad sexuell och mental ohälsa samt sexuellt riskbeteende bland unga. Ytterligare ett syfte var att studera eventuella skillnader mellan kvinnor och män.

Metod

Arbetet utgår från två olika material, dels unga kvinnor och män som sökt vid nio nationellt spridda ungdomsmottagningar, från norr till söder inkluderande de tre storstadsregionerna, dels alla elever vid samtliga gymnasieskolor i en medelstor stad i Sverige. Ungdomarna deltog i en tvärsnittsstudie med en enkät inkluderande validerade frågeinstrument om våldsutsatthet, sociodemografi, alkohol, rökning, drogbruk samt sexuellt riskbeteende och sexuell och mental ohälsa. Proportioner och oddskvoter med 95 % konfidensinterval analyserades.

Resultat

I gymnasieskolan deltog 1 658 flickor och 1 589 pojkar, mellan 15 till 22 år. Av totalt 2 250 unga kvinnor och 920 unga män, 15-23 år, som sökt på ungdomsmottagningarna och svarat på enkäten, var våldsutsattheten hög, med tydliga könsskillnader. Fler unga kvinnor än män uppgav att de hade blivit utsatta för något emotionellt våld sista året (33 % respektive 18 %). Fler unga kvinnor än män hade blivit utsatta för något sexuellt våld sista året (14 % respektive 4 %), medan de unga männen uppgav i större utsträckning att de blivit utsatta för fysiskt våld sista året än de unga kvinnorna (27 % respektive 18 %). Bland de unga männen förekom fysiskt våld ofta som ensam våldsexponering, medan fysiskt våld förekom i hög grad samtidigt med emotionellt och sexuellt våld hos de unga kvinnorna. För både unga kvinnor och män förekom sexuellt våld ofta samtidigt med emotionellt och fysiskt våld. Hos både de unga kvinnorna och män var
utsatthet för våld före 15 års ålder (emotionellt, fysiskt och/eller sexuellt våld) starkt kopplat till att också ha varit våldsutsatthet de sista 12 månaderna.

Starka samband fanns mellan att någon gång varit multipelt utsatt för våld och mental ohälsa hos både kvinnliga och manliga gymnasieelever. Bland de sexuellt erfarna gymnasieeleverna, fann vi ett starkt samband mellan att ha någon gång varit multipelt utsatt för våld och sexuell ohälsa och sexuellt riskbeteende.

**Konklusion**

This thesis is based on the following papers, which will be referred to by their Roman numerals in the text.


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# ABBREVIATIONS

<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AUDIT</td>
<td>Alcohol use disorders identification test</td>
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<td>CI</td>
<td>Confidence Interval</td>
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<td>GHB</td>
<td>Gamma-hydroxybutyric acid</td>
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<td>GHQ12</td>
<td>General Health Questionnaire - 12 items</td>
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<td>NorAQ</td>
<td>NorVold Abuse Questionnaire</td>
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<td>OR</td>
<td>Odds Ratios</td>
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<td>VAS</td>
<td>Visual Analog Scale</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Personal point of departure

Ever since my years of internship as a gynecologist, I have had the opportunity to work regularly at the local youth health center and find the work most worthwhile and important. The possibilities in youth are encouraging, and adolescents are powerful agents of personal change. During my years as a medical student in the mid 1990s, I had my first orientation in the world of research and have waited for the right moment in life to continue that journey. So when I was invited to participate in this study on violence exposure and ill-health in youth, my response was given.

INTRODUCTION

Violence is a global public health problem and violence among youth is a matter of high priority. Adolescence and young adulthood are crucial periods in life and important for the foundation of future health. Violence victimization may have serious and profound health consequences, making it important to address its occurrence and socio-medical context for possible interventions against violence and its consequences.

Violence

Violence – an international perspective

In 1996, the World Health Assembly declared violence a major public health issue [1], and The World Report on Violence and Health that followed addressed the magnitude and effect of different types of violence in men, women, and children [2]. Youth violence, that is, violence perpetrated by young people and most often directed toward young people as well, is one of the most visible forms of violence and the World Health Organization (WHO) lists a range of violent acts, including physical fighting, sexual assault, bullying, and homicide, in its category of youth violence [3].

In the 2005 WHO report, The Multi-Country Study on Women’s Health and Domestic Violence against Women, intimate partner violence (IPV) was recognized as a major threat to women’s health [4, 5], with prevalence rates varying in different countries and regions. Violence against women, including both IPV and non-partner sexual violence, is a fundamental violation of women’s human rights [6]. Data from nine countries included in the WHO multi-country study demonstrated that adolescent and young women, aged 15-24 years, face a substantially higher risk of experiencing physical and sexual IPV than older women, with past-year prevalence rates ranging from eight to 57 percent [7].

In contrast to violence against women, when beginning the study for this thesis, the emphasis came to lie on areas of violence victimization in youth. Most of the studies
of the prevalence rates of emotional, physical, and sexual violence and abuse against young people had focused on studies of dating violence, mainly in the U.S. [8-13]. The definition of dating violence used in these studies was generally exposure to sexual and/or physical violence within a dating relationship, sometimes including emotional violence [8, 13]. The prevalence rates of dating violence varied significantly across studies, with one-year prevalence rates ranging from 10-20% in female high school students and 5-10% in male high school students [8, 11, 13]. The prevalence rate was often higher among the young women, but some studies reported equal or even higher prevalence among the young men [10].

The recent UNICEF report *Hidden in Plain Sight—a statistical analysis of violence against children*, from 2014, analyzes global patterns of violence against children under the age of 18 based on data drawn from 190 countries [14]. The report reveals varying prevalence rates of interpersonal violence, including different types of violence - emotional, physical, and sexual - present in many different settings (at home, in school, on the internet, and in the community), and by a wide range of perpetrators (family members, teachers, intimate partners, neighbors, strangers, other children/peers). The report puts forth that the first step in moving toward eliminating violence is the recognition that all forms of violence against children are a fundamental violation of children’s human rights [14].

**Violence - a Swedish perspective**

The Swedish Public Health Report from 2009 addressed violence in a separate chapter for the first time [15]. Young people from 16-24 were identified as particularly vulnerable, with high rates of violence victimization [15]. Three population-based, large-scale health surveys that include questions on different types of violence are conducted regularly in Sweden: Statistics Sweden’s ULF survey (*Survey on Living Conditions*), with four short questions on violence and threats; the *Swedish Crime Survey* (*Nationella Trygghetsundersökningen, NTU*), conducted by the National Council for Crime Prevention, with short questions about criminal assaults, threats, and sexual crimes; and the *National Swedish Public Health Survey*, including two questions on physical violence or threats during the past 12 months, carried out by the Public Health Agency of Sweden.

At the time of the start for this thesis (2007), Statistics Sweden’s ULF survey reported 17% of young men and 11% of young women aged 16-24 years as having been subjected to physical violence/serious threats during the past year [16], while the Swedish Crime Survey reported 5% women and 12% men aged 16-24 years as having experienced physical assault during the past year [17].

The prevalence of emotional, physical, and sexual violence in adult women had, at the time of this study, been estimated using NorVold Abuse Questionnaire (NorAQ) [18]. The NorAQ, a Nordic validated questionnaire, includes questions on exposure to emotional, physical, and sexual violence, ranging from mild to severe and during different time periods [18-22].
In 2012, the Swedish National Centre for Knowledge on Men’s Violence against Women (NCK) conducted a population-based, large-scale survey estimating prevalence rates of exposure to emotional, physical, and sexual violence and the association to adverse mental and physical health in men and women aged 18-74 years [23]. In women, 13% reported having been exposed to severe sexual violence before the age of 18, with a corresponding 4% of the men. Fourteen percent of the women reported exposure to repeated physical violence before the age of 18, and 17% of the men [23].

However, when measuring exposure to violence using the NorVold Abuse Questionnaire (NorAQ), the prevalence rates of emotional, physical, and sexual violence before the age of 18 reported by adult women and men in both a population-based and a clinical sample varied in comparison to the NCK study [24]. Methodological differences have been suggested as a cause for the discrepancy [24].

**Definitions**

The WHO defines violence in a broad sense:

*The intentional use of a physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation* (WHA 1996).

This definition takes possible consequences of violence into consideration. Furthermore, the WHO makes the distinction between different categories and types of violent behaviors. Depending on victim-perpetrator relationship, three broad categories are defined: self-directed (suicidal behaviors/self-abuse e.g. self-harm), interpersonal (family/partner and community), and collective violence (social, political, and economic violence by a large group of individuals). The types of violence reflect different violent acts, including psychological/emotional, physical, sexual, and deprivation or neglect, see Figure 1.

![Figure 1](image_url). WHO typology of violence (Krug et al., 2002).
**Conceptualization of violence**

In a recent Swedish thesis, Johanna Simmons identifies conceptual and methodological challenges in research on interpersonal violence [24]. Both the conceptualization and the operationalization of violence, i.e., the definitions of violence and the instruments used for measuring it, always need to be clearly stated, since methodological differences may cause discrepancies in prevalence rates when comparing studies [24]. In line with Simmons and our own interpretation, we have used exposed to violence, abuse, violence, and violence victimization synonymously.

**Emotional, physical, and sexual violence**

In this thesis, the conceptualization of violence focuses on interpersonal violence, i.e., violence between individuals, encompassing emotional, physical, and sexual violence, while the violence victimizations are not defined according to relationship to perpetrator, e.g. IPV or the setting. Although dating violence and IPV are important aspects of violence victimization in adolescents and young adults [7, 25], violence from others, i.e., peers, parents, and strangers, are other aspects of importance to be considered.

In youth, and primarily school-aged adolescents, bullying, often defined as exposure to negative actions (physical acts, verbal abuse, spreading of rumors) repeatedly and over time by one or several persons in the victim’s surroundings, has recently been recognized as a major health problem, often leading to long-standing psychological problems [26, 27].

To measure violence exposure as correctly as possible, the wording of the question is important. Using emotionally sensitive words like “rape” or “assault” to capture violence victimization may lead to lower prevalence rates [28]. Simple language and behaviorally specific questions that clearly define the type of incidents that the youth are being asked to report as violence victimization are recommended [18, 22, 29].

The NorVold Abuse Questionnaire (NorAQ) mentioned above includes questions on exposure to emotional, physical, and sexual violence, ranging from mild to severe and during different time periods [18-22, 30], and has been used throughout this thesis to measure exposure to emotional, physical, and sexual violence.

**The co-occurrence of violence**

There has recently been an increase in research on the co-occurrence of multiple forms of violence victimizations [31], but the terminology has varied, from, e.g., adverse childhood experiences [31] and poly-victimization [32-35] to complex trauma [31] and polytraumatization [36].

Poly-victimization, from studies of mainly children and adolescents, recognizes the variety of victimizations and the high level of multiple forms of victimizations. Studies have included 34 questions in five areas of concern: physical assault/peer
bullying, child maltreatment, sexual assault, conventional crime, and witnessing violence [34, 35, 37, 38].

The definition of poly-victimization may include reporting four or more different types of violence within the same year [34, 37], or the top 10 percent of the study sample [32, 35]. Studies indicate that exposure to multiple forms of victimization is common in children and adolescents [32, 35, 39, 40]. A longitudinal study has found that poly-victimized children and youth are at higher risk for persisting poly-victimization during childhood/adolescence [37]. Finkelhor et al. suggest that violence in some children and adolescents should be considered as living in a “violent condition” rather than experiencing isolated violent events [34].

The concept of polytraumatization takes into account both interpersonal and non-interpersonal traumatic life events (i.e., accidents and natural disasters) in the trauma-history scale [36]. For experience of violence during different time periods, i.e., in childhood and as an adult, the term re-victimization is most often used [41, 42].

In this thesis, multiple victimization is used when the young person has experienced two or more of the different types of violence (emotional, physical, and sexual) used in the NorAQ.

**Theoretical framework**

**The ecological model**

The WHO applies the ecological model as the framework for understanding the multifaceted process of interpersonal violence [2]. The ecological model recognizes that an individual’s experiences and behaviors are understood within a context of different intersectional levels, both related to child maltreatment [43] and violence against women [44]. In this thesis, the ecological model will be used as the analytical framework.

The ecological model defines four levels: a) individual level, b) relational level, c) community, and d) societal level, see figure 2.

![Figure 2. The ecological model.](image-url)
For violence victimization in youth, the individual level identifies biological and personal factors such as experience of previous violence and substance abuse. The relationship level can include interactions between the individual and the immediate context, i.e., family factors such as witnessing domestic violence, parental substance abuse, parental mental illness, and family socioeconomics. The community context represents institutions and social structures where people live, e.g., attitudes in peer groups, neighborhood, schools, and poverty. Broad social factors involved in violence can be such things as social and cultural norms regarding gender roles, endorsement of violence as a normal method to resolve conflicts, masculinity associated with dominance, and honor-based violence. Economic and political factors are also on the societal level.

**Gender**

Youth victimization has strong gender patterns [45]. Violence is not randomly distributed within the youth population, and gender is just one factor that contributes, particularly regarding physical and sexual victimization among youth [45]. In the relational theories, gender is socially constructed, multidimensional, and operating simultaneously at the different levels in the ecological model [46].

The modifying effects of gender on the associations between violence victimization and different mental health problems are demonstrated and discussed in a longitudinal study by Zona et al., where females have a heightened vulnerability to acquire depression and anxiety, while males are more prone to have conduct and neurodevelopment disorders [47], although the latter is not measured in our study. Furthermore, the gender differences may arise from different levels of violence victimization but also through interaction between biological and environmental factors [47]. It is concluded that violence victimization increases symptoms of mental ill health in both genders, but violence-victimized adolescent girls may be especially vulnerable to experiencing trauma-related symptoms, implying gender-specific pathways to psychopathology [47]. Even if no specific gender analysis will be applied to the findings of this thesis, the gendered phenomenon of violence is addressed in the patterns of violence victimization and the association to ill health.

**Socio-demographics and violence**

In the area of demographic risk factors, younger age is a risk factor for violence victimization, with high levels of exposure to violence in young people and in both young women and men [7, 15, 48]. Living in a dangerous community (e.g., violence in school or the neighborhood) is also a risk factor for violence victimization, and also poly-victimization [32, 49].

Having an unemployed parent and living alone or in other arrangements are identified as risk factors for poly-victimization [32, 35]. Aho et al. find that living with both biological parents is a protective factor that significantly reduced the risk of total victimization in 17-year-old Swedish high school students [32]. A longitudinal U.S.
A study on high school students identifies living in a single-parent household as predictive for physical violence victimization in young women, but not in young men [50]. In adult women, being single is associated with higher levels of emotional, physical, and sexual abuse [30].

Other pathways suggested for poly-victimization include living in a dangerous family and having a chaotic, multiproblem family environment [49].

The association between race, ethnicity or immigration status and violence victimization among youth is inconsistent. A study from the U.S. suggests that parents’ education and socioeconomic status may be more strongly associated with violence exposure than race [51]. In Sweden, Aho et al. finds that some isolated events are more often experienced by immigrant adolescent form Europe; although Aho et al. also finds that there is no increased risk factor in any domain for a participant who was an immigrant in the multivariate analyzes [32]. Having parents born outside of Europe seems to be protective for sexual victimization [32].

**Health risk behaviors and violence**

Alcohol is the leading substance to be used and abused among adolescents and young adults in Europe [52]. Binge drinking, a common drinking pattern in youth, is associated with a wide range of other health risk behaviors, including smoking and drug use and also violence victimization, in high school students [53].

Health risk behaviors like alcohol risk consumption or binge drinking have been shown to be associated with exposure of violence [8, 10, 11, 53], although there are studies that do not find the same clear association [54-56]. A longitudinal U.S. study finds increased heavy episode drinking and smoking in female participants, but not in the male participants, five years after exposure to teen dating violence [57]. A cross-sectional study finds that in both young adult women and men, alcohol risk use is overrepresented in violence victimized compared to non-victimized, although not for all victimizations in women [48].

Drug use, and often smoking, are more consistently associated with violence victimization [8, 50, 56, 58], although sometimes only in the young women [57]. A Swedish cross-sectional study finds an association between violence victimization (e.g., child physical abuse and forced sex) and tobacco and drug abuse in 15- and 17-year-olds, with a graded relationship in the multiple-victimized [59]. Studies on multiple forms of violence have shown that violence-victimized children and young people are more likely to take part in high-risk behaviors [34, 60]. Emotional problems in the individual that limit their ability to protect themselves and may increase risk behaviors are recognized as a risk factor for poly-victimization [49].
**Violence victimization and violence**

On the individual level in the ecological model, experience of previous violence is a factor affecting violence victimization. Although numerous studies have identified exposure to childhood physical and/or sexual abuse as significantly increasing the risk for later violence exposure in adult women [41, 42] and sometimes adult men [61] and adolescents/young adults [56, 62, 63], at the time of this study, less attention had been paid to exposure to emotional abuse during childhood. One longitudinal study suggests that victimization of any type of violence in children leads to higher vulnerability for subsequent re-victimization [37].

**Health in adolescence and young adulthood**

From a life-course perspective, adolescence is recognized as a foundation for future health, [64], and the health of young people is a global health priority [65, 66]. Health in adolescence is an interaction between previous development, the individual’s specific biological and neurocognitive development, and social-role changes during puberty, as well as social determinants that affect the uptake of health-related behaviors [64].

Several social determinants of health in youth, both structural, such as poverty and sex inequality, and proximal, such as intrafamilial violence, parental mental disorder, and substance misuse, contribute negatively to adolescent health [64]. Low socioeconomics affect adolescent health negatively [67, 68], and social determinants of health often cluster within individuals [64].

**Adverse mental health**

In a systematic analysis of the global burden of disease in youth worldwide, it has been shown that mental ill-health causes the highest cause-specific disability-adjusted life years (DALYs) [65]. For males, road traffic accidents, alcohol use, and violence also mean a high number of DALYs [65]. The transition from adolescence into adulthood is a vulnerable period during which mental disorders may begin [65, 66]. Poor mental health is also strongly related to other health problems [66]. Globally, suicide is the second leading cause of death in youth, with variations across countries and often higher in young men, while suicide attempts are more common among young women [69, 70]. The prevalence of adolescent self-harm, including intentional self-poisoning and self-injury, varies between countries, often with higher figures in the young women [69, 71, 72]. A meta analysis finds that a history of self-harm is the second strongest correlate, after suicidal ideation, to suicide attempts [73], and the association between self-harm and suicide attempt and suicidal ideation is seen in both young women and young men [69, 74, 75].
In Sweden, an increase in impaired mental well-being has been registered among 16-24 year-olds in the National Public Health Survey from 1990 and onwards irrespective of country of birth, labour market status, family structure, or parents’ socioeconomic status [76]. Significantly more young women than men report suffering from impaired mental well-being [76]. There has also been a trend during the same period of increased in-patient care for psychiatric diagnoses among youth in Sweden [76].

Sexual ill health and sexual risk behaviors

The WHO definition of sexual health includes not merely the absence of disease, but also recognises sexual reproductive rights, including pleasurable and safe sexual experiences free from coercion, discrimination, and violence [77]. Adolescent sexual development and sexual health are linked to a variety of factors, including economic and social justice, poverty, educational opportunity, human rights, and gender equity, with experiences during adolescent setting the stage for sexual health later in life [77].

Sexual ill health includes unintended pregnancy and sexually transmitted infections (STIs) [77], with sexual violence increasingly being given more attention [78]. Sexual risk behaviors, i.e., behaviors increasing the risk of contracting STIs or unplanned pregnancies, are commonly defined as early age at first intercourse, having multiple sex partners, non-use of condom or birth control, and having sex under the influence of alcohol or drugs [57, 79].

In a cross-sectional study, early age at sexual debut was associated with high risk behaviors including sexual risk behaviors as well as physical and sexual violence [79]. Sexual debut before the age of 14 is positively correlated with risky behaviors such as number of partners, drug and alcohol use [80], and poor general health compared to same-aged girls without experience of intercourse [81]. A population-based Nordic study on adult women aged 18-45 in five countries verified the median age at first intercourse as 16 [82]. In the same study, risk factors for having multiple sexual partners included a higher alcohol intake and young at first intercourse.

Many STIs, especially chlamydia, affect mostly young women and men (15-29 years) [83]. In a review article, the level of support for increased risk for STDs was identified as strong to moderate for multiple lifetime partners, younger age, concurrent STI diagnosis, and sex with a symptomatic/infected partner [84]. Low socioeconomic status is known to influence sexual ill health, even if socioeconomic status and drug/alcohol use have weaker evidence as predictors [84].
Violence victimization and ill health

In the crucial transition period from adolescence into young adulthood, violence victimization is high [15, 32, 40], and violence exposure in the life stage of adolescence may have a longitudinal relationship to negative long-term health consequences [85].

Most of the body of literature on violence victimization and adverse physical and mental health has focused on separate categories of violence exposure, for example, child sexual abuse [86], bullying [26, 71], teen dating violence/IPV in adolescents [8, 57, 58, 87], and physical violence [88]. In recent years, exposure to multiple forms of victimization and the association with trauma symptoms and mental and physical impairment are increasingly being recognized, mainly in children and adolescents [35, 36, 39, 59], and sometimes in young adults [48].

The devastating consequences of child abuse are well known. A systematic review of several reviews, encompassing 270,000 subjects, finds evidence that survivors of child sexual abuse are at risk for a wide range of medical, behavioral, psychological, and sexual disorders [86]. Child sexual abuse should be considered a general, non-specific risk factor for psychopathology, but not the only important one [86]. As for the negative long-term health consequences of child physical and emotional abuse, a meta analysis suggests a causal relationship between non-sexual child maltreatment and a range of mental disorders, suicide attempts, sexually transmitted infections, and risky sexual behaviors [89].

Violence victimization and mental ill health

Violence victimization in youth is associated with poor mental health, including anxiety/depressive symptoms [48, 90] impaired mental well-being [91], and self-harm [48, 59, 71, 90], sometimes only in the young women [90], and sometimes in both young women and men [48, 59, 71, 91]. A meta analysis finds a strong association between bullying [26] and suicidal ideation and behaviors in both young women and men.

A population-based study found poorer health in poly-victimized adolescents, with higher levels of PTSD, depressive symptoms, self-harm ideation, and poor mental health [39], although not analyzing by gender. In two Swedish studies, associations were found between multiple victimization in 15- and 17- year-olds [59] and young adults [48] and self harm. For multiple forms of victimization and adverse mental health and trauma symptoms, most of the studies involve children and adolescents [35, 36, 39, 59], sometimes young adults [48]. The association of multiple victimization and adverse mental health in children and adolescents is well established, although there is still need for studies in older adolescents and young adults, and in both young women and men.
Violence victimization and sexual ill health and sexual risk behaviors

In studies on IPV, associations have been found between exposure to primarily sexual violence and sexual risk behaviors and sexual health, mainly in young women [92, 93]. A large population-based cross-sectional survey finds that experience of non-volitional sex in young women and men is strongly associated with poor mental and physical health status, including a high number of sexual partners and ever been diagnosed with STIs [78].

In a longitudinal study, physical violence during the past 12 months had implications for increased risk of later STI [88], while a longitudinal U.S. study on teen dating violence found no association with later sexual risk behaviors [57]. Steiner et al. found that parent-family and school connectedness in adolescence may protect against subsequent STI [88]. Early age at first sex is found to be associated with physical and sexual violence [79]. Studies on the association between multiple forms of victimization and sexual ill health and sexual risk behaviors in both girls/young women and boys/young men are scarce.
AIMS

The overall aim was to address the prevalence of exposure to emotional, physical, and sexual violence, the risk pattern for violence victimization, and the associations between especially multiple victimization and sexual ill health, sexual risk behaviors, and adverse mental health in Swedish youth, and to address gender differences.

Specific aims:

Paper I To explore the prevalence and gender differences of violence victimization, the relationship to the perpetrator, and the reported current adverse effects of the violence among young men and women attending youth health centers in Sweden.

Paper II To analyze the risk pattern of violence victimization during the past 12 months by gender, socio-demographic factors, health risk behaviors and exposure to violence before the age of 15 among young men and women attending youth health centers in Sweden.

Paper III To analyze the associations between emotional, physical, and/or sexual violence, especially multiple-violence victimization, and sexual ill health and sexual risk behaviors in youth by gender, and also by socio-demographics and health risk behaviors.

Paper IV To analyze the differences in the associations between solely emotional, solely physical or solely sexual violence and multiple-violence victimization, and adverse general health and mental health including self-harm ideation, self-harm, and suicidal ideation in Swedish female and male secondary school students.
MATERIAL AND METHODS

Overall study design

A cross sectional survey was used in a primary health care/preventive community setting, including nine youth health centers in Sweden, and in a population-based setting, including all upper secondary schools in Sundsvall. The questionnaire, designed and planned by the research group and a reference group, consisted of ten questions on exposure to different types and levels of violence and 57 questions on socio-demographic factors, health risk behaviors (alcohol, smoking and drug use) and other health-related questions. The majority of the questions were validated. Before the study started, a pilot study of 100 young men and women was made and two focus group interviews were undertaken with 16-17-year-old young men and women separately. Exclusion criteria were severe medical and psychological disease, not understanding written Swedish, and mental retardation. An overview of the study populations and methods used in this thesis is given in the following sections, and in Table 1. Details may be found in the corresponding papers.

Setting and study population

Youth health centers

There are now more than 200 such youth health centers in Sweden, staffed by midwives, social workers, physicians, nurses, and sometimes psychologists. These health centers are easy accessible primary health care and preventive community resources, where young people from ages 13 to 23 (25) are eligible to attend for contraceptive advice, gynecological problems, sexually transmitted infections, social, psychological, or physical problems, and to buy subsidized condoms. More young women than men visit the centers. From the Swedish National Health Survey for the years 2006-08, it was reported that 25% of young women aged 16-25 and 5% of corresponding young men had attended a youth health center during the past three months [83]. In addition, there is an online youth health center [94].

A convenient sample of nine national representative youth health centers in Sweden was used. The centers, situated in urban and rural areas from the north to the south and including the three biggest cities, consecutively recruited youth aged 15-23 years, from February-June, 2007. Each center recruited according to its size and annual number of appointments. Anonymous self-administered questionnaires in both a paper and a computerized version were used. In total there were 4,460 eligible young men and women. Due to staff shortages, 127 men and 675 women were not approached. Of the submitted questionnaires, eight were excluded since no sex was stated. None of the participating youth health centers had a specific profile concerning violence or abuse.
**Upper secondary school**

The study population consisted of all first- to third-year students, 15 years and above, who were registered in upper secondary school and attending school on a regular basis in the city of Sundsvall. The municipality of Sundsvall, situated in mid-Sweden, has about 100,000 inhabitants. The level of those with post secondary education 3 years of more is somewhat lower than for the rest of Sweden [95].

From February to June, 2007, all five upper secondary schools were surveyed. Of 4,083 students attending school on a regular basis, 3,259 of them participated. Dropouts included students who were not in school on the day of the study. Twelve submitted questionnaires were excluded, eight since no sex was indicated, four since no answers were given. Effort was made to guarantee the reliability of the answers, including sitting in an exam set-up. After working in silence in the classroom, the students handed in the questionnaire in a sealed envelope to a member of the research team.

**Table 1. Study design and study populations included in the thesis.**

<table>
<thead>
<tr>
<th></th>
<th>Youth health centers</th>
<th>Upper secondary school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Study design</td>
<td>Cross-sectional</td>
<td>Cross-sectional</td>
</tr>
<tr>
<td>Study setting and population</td>
<td>Clinical setting</td>
<td>Clinical setting</td>
</tr>
<tr>
<td>Number</td>
<td>2,250</td>
<td>920</td>
</tr>
<tr>
<td>Response rate</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>Included in</td>
<td>Paper I</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Paper II</td>
<td>x</td>
</tr>
</tbody>
</table>

* In Paper III, only the sexually experienced students were included, 1,192 (73%) women and 1,021 (65%) men.

**Ethical considerations**

Before participating in the study, all the young men and women were informed verbally and in writing about the study. Assessments were made in specifically those under the age of 18 to see whether they understood all the information about the study. If there was any hesitation, he or she was not included. In Sweden, the position of the Central Ethical Review Board is that consent from parents/guardians is not needed for youths 15 years and older, if the person is judged capable of understanding the information and making a self-governed decision.

Prior to the study all principals, teachers, and staff at the school health services were thoroughly informed by one or two persons on the research team about the study and the ethical standpoints. The students were informed in the classroom about the study by one person on the research team before the questionnaires were handed out. All staff at the youth health centers was thoroughly informed about the ethical
standpoints, and adolescents with severe medical or psychological disease or mental retardation were excluded from participating in the study.

All questionnaires were anonymous and oral informed consent was considered sufficient. Since there was no marking, all the questionnaires were unidentifiably to the research group.

All young women and men were informed about the possibility of receiving prompt counseling related to the study if needed/wanted. After the study, five upper secondary school students and seven young men and women who had visited the youth health centers asked for counseling that was considered related to the study. Telephone numbers to different support centers were included in the written study information, and the privacy of the respondents in answering the questionnaire was recognized.

In the focus group, the young women and men expressed that it was acceptable and important to be asked about sensitive questions such as violence exposure. Other methodological studies have confirmed that young women and men find it important to gain knowledge about sensitive potential problems by actually asking the youths themselves [96], and youths visiting youth health centers have exhibited a high acceptance of answering questions about violence exposure [97]. The study was approved by the Regional Ethical Review Board at Umeå University (D no. 06-118M).

Measurements

Violence victimization (NorAQ) (Paper I-IV)

The questions on violence victimizations were taken from The NorVold Abuse Questionnaire, a validated instrument previously used in a Nordic study on women attending gynecology clinics [18, 19], a female population-based sample [30] and in both a Swedish male patient and a population-based sample [20-22]. The questionnaire contains three identically structured sections with detailed questions about experiences of emotional, physical, and sexual violence, ranging from mild to severe and during different age periods [18, 19, 21]. All questions on different types and levels of violence victimizations could be answered as yes or no for <15 years, ≥15 years, and during the past 12 months; see Table 2 for the questions.

As the questionnaire is validated for women and men from 18 years of age, formative qualitative interviews were undertaken in two focus groups of 16-17-year-old young women and men separately. Also, three teachers read the questionnaire and were interviewed about the wording of the questions and if they felt the youth might have problems understanding them. Minor changes in the wording of four of the questions were made.

In our interpretation, we used violence/violence victimization and abuse synonymously [24]. For Paper I, in the prevalence estimates, if a person had experienced several levels of violence, only the most severe level was used for each
age period, except for lifetime abuse, where a person may have been exposed to different levels of abuse but at different age periods.

Moderate and/or severe levels of emotional, physical, and sexual violence before 15 years of age were assessed as risk factors/independent variables for any emotional, physical, and sexual victimization during the past 12 months (including mild, moderate, and severe).

When analyzing violence victimization and its associations to ill health, the violence variables were constructed to include exposure before and after 15 years of age, i.e., lifetime victimization, and only moderate and/or severe levels of emotional, physical, and sexual victimizations were included. Different variables for single-type violence, that is experience of solely emotional, solely physical, and solely sexual violence victimization were constructed to include victimization to just one type of violence, even if the violence was repeated. Multiple-violence victimization variables were constructed to include at least two different types of moderate and severe lifetime violence victimizations.

Table 2. Questions about mild, moderate, and severe emotional, physical, and sexual violence victimization from the NorAQ, with minor changes of the wording for this study.

<table>
<thead>
<tr>
<th>Level of violence</th>
<th>Type of violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td></td>
</tr>
<tr>
<td>mild</td>
<td>Have you experienced anybody repeatedly trying to repress, degrade, or humiliate you?</td>
</tr>
<tr>
<td>moderate</td>
<td>Have you experienced anybody repeatedly, by threat or force, trying to limit your contacts with others or control what you may and may not do?</td>
</tr>
<tr>
<td>severe</td>
<td>Have you experienced living in fear because someone repeatedly and for a long period has threatened you or somebody close to you?</td>
</tr>
<tr>
<td>Physical</td>
<td></td>
</tr>
<tr>
<td>mild</td>
<td>Have you experienced anybody hitting you, smacking your face, or holding you firmly against your will?</td>
</tr>
<tr>
<td>moderate</td>
<td>Have you experienced anybody hitting you with his/her fist(s) or with a hard object, kicking you, pushing you violently, giving you a beating, or doing anything similar to you?</td>
</tr>
<tr>
<td>severe</td>
<td>Have you experienced anybody threatening your life by, for instance, trying to strangle you, showing you a weapon or a knife or by some other similar act?</td>
</tr>
<tr>
<td>Sexual</td>
<td></td>
</tr>
<tr>
<td>mild, no genital contact</td>
<td>Has anybody against your will touched parts of your body other than the genitals in a “sexual way” or forced you to touch other parts of his or her body in a “sexual way”?</td>
</tr>
<tr>
<td>mild, emotional</td>
<td>Have you in any other way been sexually humiliated, e.g. by against your will being forced to watch a pornographic movie or similar, or forced to show your body naked, or forced to watch when somebody else showed his/her body naked?</td>
</tr>
<tr>
<td>moderate</td>
<td>Has anybody against your will touched your genitals, used your body to satisfy him/herself sexually, or forced you to touch anybody else’s genitals?</td>
</tr>
<tr>
<td>severe</td>
<td>Has anybody against your will put or tried to put his penis, or something else, into your (vagina), mouth or rectum?</td>
</tr>
</tbody>
</table>
Current adverse effect and perpetrators (Paper I)

After each question about violence victimization during the past 12 months, the youth was invited to estimate to what extent (s)he was currently adversely affected by the experience on a visual analogue scale from 0 to 10, with 0 meaning no effects at all and 10 the most serious effects. This method has been validated in a study on physically and sexually abused gynecological patients [18]. After the questions of violence during the past 12 months, corollary questions about the perpetrator/perpetrators were also added. More than one perpetrator was possible.

Alcohol risk consumption (AUDIT–C) (Papers I-IV)

AUDIT-C, the three first questions in the WHO test AUDIT (Alcohol use disorders identification test), was used to identify young people with alcohol risk consumption [98]. Numerous studies suggest AUDIT-C to be equal, or even better, than AUDIT, for both adults and adolescents [99, 100]. The questions include how often and how much the person drinks alcohol and also covers binge drinking [101], yielding an index score from 0-12. The cut off-values of ≥5 for the young women and ≥6 for the young men were used, suitable for the youth population [100, 102, 103].

Smoking and drug use (Papers I-IV)

The questions on daily smoking and drug use (e.g. ecstasy, hash, marijuana, GHB, and anabolic steroids) over the past 12 months were drawn from the Swedish National Public Health Survey and could be answered by yes or no [104].

Sexual health and sexual risk behaviors (Paper III)

The questions on sexual health and sexual risk behaviors were formulated by the research group and a reference group, representing broad competence in youth and youth health centers. Some of the questions were tested on the focus groups. Variables were constructed for self-reported sexual ill health and sexual risk behaviors. They included (a) experience of/involvement in pregnancy, (b) non-use of contraceptives at latest intercourse, neither by the youth him/herself nor their partner, (c) ever received treatment for genital chlamydia infection, (d) first intercourse before the age of 14 years, and (e) three or more sexual partners during the past 12 months (equals to the 75th quartile).

Self-reported health (Papers III-IV)

A general health question used in the Swedish National Public Health Survey is regarded to be of outmost importance in following the health of different groups in the population. It is worded as follows: “How do you rate your general state of health?”
The answers were dichotomized into (a) “good” (including “very good”, “good” or “neither good nor poor”) and (b) poor (including “poor” or “very poor”) [104].

**GHQ12 (Paper IV)**

Impaired mental well-being was assessed using the General Health Questionnaire (GHQ 12), a much validated instrument stable to age, sex and education and used in the Swedish National Public Health Survey [104, 105]. The 12-item version covers symptoms of depression, anxiety, and self-esteem experienced in the last month. The answers are scored from 0-12 points; the cut-off point of $\geq 3$ was used in our study for impaired mental well-being [104].

**Self-inflicted harm/suicide ideation (Paper IV)**

Two questions on self-harm ideation and self-harm behavior were constructed based on Q90, a questionnaire often used in adolescent and children surveys [106, 107]. These were worded as follows: (a) “Have you at any time during the past 12 months considered harming yourself, for example, by burning or cutting yourself?” and “Have you at any time during the past 12 months harmed yourself in any way?”.

Finally one question on suicidal ideation was framed as “Have you at any time during the past 12 months considered committing suicide?” based on the question in the Swedish National Public Health Survey [104]. The answers to these three questions were either yes or no.

**Socio-demographics (Papers I-IV)**

The socio-demographic variables included place of living, attending an academic or vocational program in upper secondary school, immigrant status, and family structure. Place of living was dichotomized, according to number of inhabitants in the city of each youth health center, into big cities with more than 300,000 inhabitants and small cities with less than 300,000.

Immigrant status was dichotomized into (a) Swedish-born youth with one or two Swedish-born parents and (b) foreign- or Swedish-born youth with two foreign-born parents (immigrants). Family structure included living with (a) both biological parents, (b) one parent, and (c) living alone/with someone else.

**Statistical analyses**

SPSS software (versions 15, 19, and 20) was used for all statistical analysis and a $p$-level of $<0.05$ was considered statistically significant in all papers. Descriptive statistics were analyzed for the total sample in each paper. Student’s t-test was used to analyze differences in continuous numerical variables. For categorical variables, Pearson’s Chi² test was used for differences in frequencies and Fischer’s exact test was used in small samples. All analyses were stratified by gender. Univariate and
multivariate logistic regression analyzes were used in Papers II-IV. Crude and adjusted odds ratios were estimated.

**Study-specific analyses**

Paper I: The Mann-Whitney test was used to compare median values of the visual analogue scales.

Paper II: The first steps of the logistic regression analyses were used to examine the univariate associations between possible socio-demographic and individual risk factors and exposure to violence during the past 12 months. In the multivariate logistic regression models, a theory-driven regression approach was used. At each stage, an additional factor was added or removed to reach the best fitting model. All socio-demographic and individual risk factors proved to be significant for one or several dependent variables (violence during the past 12 months), and thus all were included in the final model, and the same model was used in both men and women. In the regression model, comparisons were made between non-exposed men and women and men and women exposed to violence during the past 12 months.

Paper III: A univariate logistic regression was used to examine associations between the outcomes for different sexual ill-health/sexual risk behaviors - (1) experience of/involvement in pregnancy, (2) ever having had treatment for chlamydia, (3) non-use of contraceptives at latest intercourse, (4) early age at first intercourse, and (5) ≥3 sexual partners during the past 12 months - and the explanatory variables for violence: lifetime solely emotional, physical, or sexual violence and multiple-violence victimization. Univariate logistic regression was also used to examine associations between the outcomes for sexual ill-health/sexual risk behaviors and socio-demographics, health risk behaviors and poor general health. In the multivariate logistic regression model the associations between the explanatory variables, including lifetime solely physical and solely sexual violence and multiple-violence, and the outcomes for sexual ill-health/sexual risk behaviors were adjusted for possible confounders. All covariates were used as confounders and included age, vocational program, family structure, immigrant status, alcohol risk consumption, daily smoking and drug use. The covariates were chosen according to the univariate logistic regression and empirical evidence in the literature. Only violence victimization variables significantly associated with any of the health outcomes in the univariate analyses were included. Age was a continuous variable in the logistic regression models.

Paper IV: A univariate logistic regression was used for analysis of associations between the dependent variables for adverse general and mental health and the independent variables for violence victimization and different socio-demographics and health risk behaviors. A multivariate logistic regression model was created to analyze the association between violence victimization and different health variables and adjust for possible confounders. The confounders were chosen according to the univariate logistic regression and empirical evidence in the literature. To analyze the
interaction between gender and violence victimization on self-harm, suicidal ideation, and impaired mental well-being (GHQ12), the material was stratified according to gender (male/female) and multiple violence victimization (no violence/multiple violence) and a new variable with four categories was created and ORs were calculated.

**Data cleaning**

Members of the research group and a data clerk entered the data and a statistician assisted in cleaning them. Controls were made for inconsistent variables. In Paper III, those who reported age at first intercourse <11 years of age, 10 women and 20 men, were excluded in the analysis.
RESULTS

Violence victimization

Prevalences

The estimated prevalence of emotional, physical and sexual violence in the national youth health centers setting are presented in Table 3.

In this material, the men were older than the women, with a mean age of 18.9 years compared to 17.9 among women. There were more male immigrants than female (19% vs. 15%). The young men had more often alcohol risk consumption than women (60% vs. 48%) and used drugs (30% vs. 15% for the women), while there was no significant difference in daily smoking (24% vs. 27%).

The prevalence of any emotional victimization during the past 12 months was 33% (CI 31-35) in the young women and 18% (CI 16-21) in the young men. In contrast, more men, 27% (CI 24-30), were physically victimized during the past 12 months compared to the women, 18% (CI 17-20). Fourteen percent (CI 12-15) of the young women had been sexually victimized over the past 12 months compared to 4.7% (CI 3.3-6) of the young men.

Perpetrators

The perpetrator of emotional and physical violence among the young women in the clinical setting was more often someone close to them (parent, partner, ex-partner) than among the men (Table 4). Strangers were more often reported as perpetrators among men than women, except for sexual violence. Strangers, friends, and schoolmates were reported by both young men and women in a large proportion of all forms of violence.

Table 3. Prevalence of emotional, physical, and sexual violence victimization during the past 12 months among youth visiting nine national youth health centers.

<table>
<thead>
<tr>
<th>Violence</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Any violence victimization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (CI)</td>
<td>n</td>
<td>% (CI)</td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>360</td>
<td>16 (15-18)**</td>
<td>221</td>
<td>9.8 (8.6-11)**</td>
</tr>
<tr>
<td>Men</td>
<td>71</td>
<td>7.7 (6.0-9.5)</td>
<td>54</td>
<td>5.9 (4.4-7.4)</td>
</tr>
<tr>
<td>Physical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>210</td>
<td>9.3 (8.1-11)**</td>
<td>133</td>
<td>5.9 (4.9-6.9)</td>
</tr>
<tr>
<td>Men</td>
<td>55</td>
<td>6.0 (4.4-7.5)</td>
<td>142</td>
<td>15 (13-18)**</td>
</tr>
<tr>
<td>Sexual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>132</td>
<td>5.9 (4.9-6.8)**</td>
<td>45</td>
<td>2.0 (1.4-2.6)</td>
</tr>
<tr>
<td>Men</td>
<td>24</td>
<td>2.6 (1.6-3.6)</td>
<td>15</td>
<td>1.6 (0.8-2.6)</td>
</tr>
</tbody>
</table>

*a If a subject experienced several levels of violence, only the most severe was registered.

*p<0.05, **p<0.01, ***p<0.001 for the difference between men and women.
Table 4. Perpetrators reported by the violence-victimized youth visiting the youth health centers. More than one perpetrator could be reported for each type of violence.

<table>
<thead>
<tr>
<th>Violence</th>
<th>Young women</th>
<th></th>
<th>Young men</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reported perpetrator (%)</td>
<td></td>
<td>Reported perpetrator (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parent</td>
<td>Partner</td>
<td>Ex-partner</td>
<td>Friend</td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>29***</td>
<td>19*</td>
<td>30***</td>
<td>56</td>
</tr>
<tr>
<td>Moderate</td>
<td>40</td>
<td>26</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Severe</td>
<td>27</td>
<td>9,3</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Physical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>27***</td>
<td>25***</td>
<td>25***</td>
<td>19</td>
</tr>
<tr>
<td>Moderate</td>
<td>21***</td>
<td>18***</td>
<td>18***</td>
<td>26</td>
</tr>
<tr>
<td>Severe</td>
<td>9,5</td>
<td>13*</td>
<td>18**</td>
<td>14</td>
</tr>
<tr>
<td>Sexual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>1,3</td>
<td>11</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td>Moderate</td>
<td>1,8</td>
<td>16</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Severe</td>
<td>0,7</td>
<td>13</td>
<td>28</td>
<td>31</td>
</tr>
</tbody>
</table>

\* Includes schoolmates and other friends.

\*p<0.05, **p<0.01, ***p<0.001 for the difference between women and men.

Comparing different settings

The prevalence rates of violence victimization in three different settings - the school setting, the national youth health centers setting, and the local youth health center setting - were analyzed in order to find differences according to setting in prevalence estimates. When comparing the prevalence rates of violence victimization in the school setting with the local youth health center, no statistically significant differences during the past 12 months were found (Table 5).

For lifetime violence victimization, the prevalence rates were significantly higher among youth visiting the local youth health center compared with the school setting, for both young women and men.
Table 5. The prevalence of violence victimizations in three different settings.

<table>
<thead>
<tr>
<th>Violence, young women</th>
<th>School setting</th>
<th>Youth health center (national)</th>
<th>Youth health center (local)</th>
<th>Age, years, mean (low-high)</th>
<th>n</th>
<th>% (CI)</th>
<th>n</th>
<th>% (CI)</th>
<th>n</th>
<th>% (CI)</th>
<th>p value c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any emotional violence past year</td>
<td>17.1 (15-21)</td>
<td>17.9 (15-23)</td>
<td>17.3 (15-22)</td>
<td>505</td>
<td>31 (29-33)</td>
<td>733</td>
<td>33 (31-35)</td>
<td>106</td>
<td>32 (27-37)</td>
<td>p=0.602</td>
<td></td>
</tr>
<tr>
<td>Any physical violence past year</td>
<td>276</td>
<td>17 (15-19)</td>
<td>406</td>
<td>18 (17-20)</td>
<td>55</td>
<td>17 (13-21)</td>
<td>p=1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any sexual violence past year</td>
<td>171</td>
<td>11 (9-13)</td>
<td>312</td>
<td>14 (12-15)</td>
<td>37</td>
<td>11 (8-14)</td>
<td>p=0.624</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Lifetime emotional violence a</td>
<td>496</td>
<td>30 (28-32)</td>
<td>756</td>
<td>34 (32-36)</td>
<td>118</td>
<td>36 (31-41)</td>
<td>p=0.043</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime physical violence a</td>
<td>321</td>
<td>19 (17-21)</td>
<td>555</td>
<td>25 (23-27)</td>
<td>83</td>
<td>25 (20-30)</td>
<td>p=0.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime sexual violence a</td>
<td>227</td>
<td>14 (12-16)</td>
<td>445</td>
<td>20 (18-22)</td>
<td>66</td>
<td>20 (16-24)</td>
<td>p=0.005</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime multiple violence b</td>
<td>279</td>
<td>22 (20-24) **</td>
<td>509</td>
<td>30 (28-32) ns</td>
<td>78</td>
<td>31 (26-36) ns</td>
<td>p=0.002</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Violence young men</th>
<th>School setting</th>
<th>Youth health center (national)</th>
<th>Youth health center (local)</th>
<th>Age, years, mean (low-high)</th>
<th>n</th>
<th>% (CI)</th>
<th>n</th>
<th>% (CI)</th>
<th>n</th>
<th>% (CI)</th>
<th>p value c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any emotional violence past year</td>
<td>17.2 (15-23)</td>
<td>18.9 (15-23)</td>
<td>18.3 (15-23)</td>
<td>256</td>
<td>16 (14-18)</td>
<td>167</td>
<td>18 (16-21)</td>
<td>28</td>
<td>20 (13-27)</td>
<td>p=0.160</td>
<td></td>
</tr>
<tr>
<td>Any physical violence past year</td>
<td>362</td>
<td>23 (21-25)</td>
<td>251</td>
<td>27 (24-30)</td>
<td>41</td>
<td>29 (22-36)</td>
<td>p=0.119</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any sexual violence past year</td>
<td>46</td>
<td>2.9 (2.1-3.7)</td>
<td>43</td>
<td>4.7 (3.3-6.0)</td>
<td>2</td>
<td>2.1 (-0.3-4.5)</td>
<td>p=1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime emotional violence a</td>
<td>311</td>
<td>20 (18-22)</td>
<td>284</td>
<td>31 (28-34)</td>
<td>47</td>
<td>33 (25-41)</td>
<td>p=0.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime physical violence a</td>
<td>542</td>
<td>34 (32-36)</td>
<td>432</td>
<td>47 (44-50)</td>
<td>65</td>
<td>46 (38-54)</td>
<td>p=0.008</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime sexual violence a</td>
<td>44</td>
<td>2.8 (2.0-3.6)</td>
<td>31</td>
<td>3.4 (2.2-4.6)</td>
<td>3</td>
<td>2.1 (-0.3-4.5)</td>
<td>p=1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime multiple violence b</td>
<td>212</td>
<td>19 (17-21)</td>
<td>217</td>
<td>35 (32-38)</td>
<td>33</td>
<td>35 (27-43)</td>
<td>p=0.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CI=confidence interval
*a*p<0.05, **p<0.01 for the difference between women and men in the same settings. Ns=non significant
a Includes moderate and severe violence victimization
b ≥2 different types of moderate/severe violence victimizations
c For the difference between youth in the school setting and the local youth health center

Co-occurrence of violence

The co-occurrence between emotional, physical, and sexual violence victimization during the past 12 months is demonstrated in Figure 3 for the youth health centers material. In Figure 4, lifetime moderate and severe violence victimizations are presented for the school material.

Physical victimization in the young men often occurred in isolation, in both materials, while emotional victimization more often occurred in isolation among the young women, in both materials. For sexual violence, the co-occurrence with emotional and physical violence was considerable for both men and women and in both materials, see Figures 3 and 4.
**Figure 3.** The number of women and men visiting youth health centers with any emotional, physical, and sexual victimization during the past 12 months and the co-occurrence of the different victimizations (proportional Venn diagram).

**Figure 4.** The number of women and men in upper secondary school with lifetime moderate/severe emotional, physical, and sexual victimization and the co-occurrence of the different victimizations (proportional Venn diagram).
**Risk patterns for violence victimization**

The risk pattern for violence victimizations over the past year was analyzed in the national youth health centers setting.

Strong associations between all violence victimizations before the age of 15 and all violence victimizations during the past year were found, with aORs varying from 1.4-2.8 in women (Table 6). In men, no association between any violence before the age of 15 and sexual violence victimization during the past year was found, nor between sexual violence before the age of 15 and any violence victimization during the past year. Since the number of sexually victimized young men overall was very low, these findings need to be interpreted with caution.

After adjusting for socio-demographics and individual risk factors, the associations between alcohol risk consumption, smoking, and drug use and the different violence victimizations during the past year varied. There was no significant association between alcohol risk consumption and emotional victimization in either men or women. On the other hand, a low association between alcohol risk consumption and sexual victimization in the young women was found, as well as a strong association with physical victimization, especially for the young men. Daily smoking and use of drugs were inconsistent in relation to all forms of victimization during the past year. No association between violence victimization and immigrant status was found, and for other demographics, there was no constant association other than lower age for both men and women. Odds for all socio-demographics and individual risk factors for the different types of violence victimization over the past year can be found in Paper II, Table 3-5.

### Table 6. Violence victimization before 15 years of age in emotionally, physically, and sexually violence-victimized youth, and the adjusted Odds Ratio (aOR) for the associations between previous and past year violence victimizations.

<table>
<thead>
<tr>
<th>Young women</th>
<th>Emotional violence, past year</th>
<th>Physical violence, past year</th>
<th>Sexual violence, past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=733</td>
<td>N=406</td>
<td>N=312</td>
<td></td>
</tr>
<tr>
<td>Violences &lt;15 y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>n</td>
<td>%</td>
<td>aOR(95% CI)</td>
</tr>
<tr>
<td></td>
<td>303</td>
<td>41</td>
<td>2.8 (2.2-3.6)</td>
</tr>
<tr>
<td>Physical</td>
<td>183</td>
<td>25</td>
<td>1.4 (1.1-1.9)</td>
</tr>
<tr>
<td>Sexual</td>
<td>119</td>
<td>16</td>
<td>2.1 (1.5-2.9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young men</th>
<th>Emotional violence, past year</th>
<th>Physical violence, past year</th>
<th>Sexual violence, past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=167</td>
<td>N=251</td>
<td>N=43</td>
<td></td>
</tr>
<tr>
<td>Violences &lt;15 y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>n</td>
<td>%</td>
<td>aOR(95% CI)</td>
</tr>
<tr>
<td></td>
<td>87</td>
<td>52</td>
<td>3.5 (2.5-5.3)</td>
</tr>
<tr>
<td>Physical</td>
<td>78</td>
<td>47</td>
<td>1.9 (1.3-2.8)</td>
</tr>
<tr>
<td>Sexual</td>
<td>5</td>
<td>3</td>
<td>0.8 (0.2-3.4)</td>
</tr>
</tbody>
</table>

<sup>b</sup> aOR=adjusted odds ratios. Adjusted for age, living area, family structure, immigrant status, alcohol risk consumption, smoking, and drug use. Significantly raised aORs in bold prints.
Violence victimizations and mental ill-health

The population-based setting was used to examine associations between violence victimization and mental ill-health, see Table 7 for descriptive characteristics.

**Table 7.** Socio-demographics, health risk behavior, general and mental health variables and violence victimizations in females and males in upper secondary schools (2007).

<table>
<thead>
<tr>
<th></th>
<th>Females N=1658</th>
<th>Males N=1589</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age, years (lowest-highest)</td>
<td>17.1 (15-21)</td>
<td>17.2 (15-23) *</td>
</tr>
<tr>
<td>Upper secondary school academic</td>
<td>878 54</td>
<td>715 46</td>
</tr>
<tr>
<td>Upper secondary school vocational</td>
<td>753 46</td>
<td>839 54***</td>
</tr>
<tr>
<td>Family structure: Living with both parents,</td>
<td>867 52</td>
<td>897 56</td>
</tr>
<tr>
<td>with one parent,</td>
<td>535 32</td>
<td>531 33</td>
</tr>
<tr>
<td>alone/with someone else</td>
<td>241 15***</td>
<td>141 9</td>
</tr>
<tr>
<td>Immigrants</td>
<td>116 7</td>
<td>109 7</td>
</tr>
<tr>
<td>Partner in the past 12 months</td>
<td>996 62***</td>
<td>682 44</td>
</tr>
<tr>
<td>Sexually experienced</td>
<td>1192 73***</td>
<td>1021 65</td>
</tr>
<tr>
<td>Alcohol risk consumption</td>
<td>644 39</td>
<td>601 38</td>
</tr>
<tr>
<td>Daily smoking</td>
<td>177 11**</td>
<td>117 7.4</td>
</tr>
<tr>
<td>Drug use</td>
<td>137 8.3</td>
<td>176 11**</td>
</tr>
<tr>
<td>Self-reported poor general health</td>
<td>86 5**</td>
<td>35 2</td>
</tr>
<tr>
<td>Self-harm ideation</td>
<td>288 17***</td>
<td>90 5.8</td>
</tr>
<tr>
<td>Self-harm behaviour</td>
<td>198 12***</td>
<td>95 6.2</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>249 15***</td>
<td>115 7.5</td>
</tr>
<tr>
<td>Impaired mental well-being (GHQ12)</td>
<td>629 38***</td>
<td>288 18</td>
</tr>
<tr>
<td>Lifetime solely emotional violence (moderate/severe)</td>
<td>237 14***</td>
<td>110 6.9</td>
</tr>
<tr>
<td>Lifetime solely physical violence (moderate/severe)</td>
<td>85 5.1</td>
<td>335 21***</td>
</tr>
<tr>
<td>Lifetime solely sexual violence (moderate/severe)</td>
<td>55 3.3***</td>
<td>9 0.6</td>
</tr>
<tr>
<td>2 or 3 types of lifetime violence (moderate/severe)</td>
<td>279 22**</td>
<td>212 19</td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.01, ***p<0.001 for the difference between women and men.

Fourteen percent of the females and 6.9% of the males were solely emotionally victimized, 5.1 respectively 21 percent were solely physically victimized and 3.3 respectively 0.6% were solely sexually victimized. More females than males were multiple victimized: 22% respectively 19%. Solely sexual violence victimization was associated with poor general health and impaired mental well-being in females only. The only single-type violence victimization with raised risk for impaired mental well-being and suicidal ideation in both females and males was emotional violence. A consistent association between multiple victimizations and poor general health, self-harm, suicidal ideation, and impaired mental well-being, was found for both women and men, see Table 8.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Single emotional violence</th>
<th>Single physical violence</th>
<th>Single sexual violence</th>
<th>Multiple violence b</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR (CI)</td>
<td>aOR (CI) a</td>
<td>OR (CI) a</td>
<td>OR (CI) a</td>
<td>OR (CI) a</td>
</tr>
<tr>
<td>Female respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor general health</td>
<td>1.3 (1.0-1.7)</td>
<td>1.1 (0.7-1.8)</td>
<td>1.1 (0.6-1.8)</td>
<td>2.4 (1.4-4.0)</td>
</tr>
<tr>
<td></td>
<td>1.2 (0.9-1.7)</td>
<td>1.1 (0.9-1.7)</td>
<td>1.1 (0.9-1.7)</td>
<td>2.3 (1.3-4.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.7 (4.3-7.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.7 (3.4-6.4)</td>
</tr>
<tr>
<td>Self harm ideation</td>
<td>1.3 (1.0-1.9)</td>
<td>0.9 (0.5-1.7)</td>
<td>0.9 (0.5-1.7)</td>
<td>1.3 (1.0-2.5)</td>
</tr>
<tr>
<td></td>
<td>1.3 (0.9-1.9)</td>
<td>0.9 (0.9-1.7)</td>
<td>1.3 (0.7-2.5)</td>
<td>1.1 (0.5-2.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6.3 (4.6-8.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.3 (3.8-7.6)</td>
</tr>
<tr>
<td>Self harm behaviour</td>
<td>1.3 (0.8-2.0)</td>
<td>1.7 (0.9-3.1)</td>
<td>0.9 (0.4-2.1)</td>
<td>0.8 (0.3-1.9)</td>
</tr>
<tr>
<td></td>
<td>1.3 (0.8-1.9)</td>
<td>1.7 (0.9-3.1)</td>
<td>0.9 (0.4-2.1)</td>
<td>0.8 (0.3-1.9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.0 (4.8-10)</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>4.9 (3.3-7.4)</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>1.6 (1.1-2.2)</td>
<td>0.8 (0.6-1.5)</td>
<td>0.8 (0.4-1.6)</td>
<td>1.4 (0.7-2.8)</td>
</tr>
<tr>
<td></td>
<td>1.5 (1.1-2.2)</td>
<td>0.8 (0.6-1.5)</td>
<td>0.8 (0.4-1.6)</td>
<td>1.2 (0.6-2.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6.4 (4.6-8.9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.0 (3.4-7.3)</td>
</tr>
<tr>
<td>Impaired mental</td>
<td>2.2 (1.6-2.8)</td>
<td>1.4 (0.9-2.2)</td>
<td>1.3 (0.8-2.1)</td>
<td>3.0 (1.7-5.2)</td>
</tr>
<tr>
<td>well-being (GHQ12)</td>
<td>2.1 (1.6-2.8)</td>
<td>1.4 (0.9-2.2)</td>
<td>1.3 (0.8-2.1)</td>
<td>2.5 (1.4-4.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.1 (2.2-4.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.7 (2.7-5.0)</td>
</tr>
<tr>
<td>Male respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor general health</td>
<td>2.8 (1.8-4.3)</td>
<td>0.9 (0.6-1.3)</td>
<td>0.8 (0.6-1.2)</td>
<td>0.7 (0.1-6.0)</td>
</tr>
<tr>
<td></td>
<td>2.8 (1.8-4.5)</td>
<td>0.9 (0.6-1.3)</td>
<td>0.8 (0.6-1.2)</td>
<td>0.7 (0.1-6.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.9 (0.1-7.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.6 (3.2-6.7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.6 (2.4-5.4)</td>
</tr>
<tr>
<td>Self harm ideation</td>
<td>2.0 (1.0-3.8)</td>
<td>0.7 (0.4-1.3)</td>
<td>0.6 (0.3-1.2)</td>
<td>2.7 (0.3-23)</td>
</tr>
<tr>
<td></td>
<td>1.8 (0.9-3.9)</td>
<td>0.7 (0.4-1.3)</td>
<td>0.6 (0.3-1.2)</td>
<td>2.7 (0.3-23)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.2 (0.3-31)</td>
</tr>
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<td></td>
<td></td>
<td></td>
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<td>7.5 (4.4-13)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.2 (2.3-7.8)</td>
</tr>
<tr>
<td>Self harm behaviour</td>
<td>1.4 (0.7-2.9)</td>
<td>1.2 (0.7-2.0)</td>
<td>1.1 (0.6-1.9)</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>1.1 (0.5-2.5)</td>
<td>1.2 (0.7-2.0)</td>
<td>1.1 (0.6-1.9)</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6.4 (3.8-11)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.1 (2.8-9.5)</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>3.2 (1.9-5.4)</td>
<td>0.9 (0.5-1.4)</td>
<td>0.8 (0.5-1.3)</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>3.3 (1.9-5.9)</td>
<td>0.9 (0.5-1.4)</td>
<td>0.8 (0.5-1.3)</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.3 (4.4-12)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6.0 (3.4-10)</td>
</tr>
<tr>
<td>Impaired mental</td>
<td>3.0 (2.0-4.5)</td>
<td>1.0 (0.7-1.3)</td>
<td>0.9 (0.6-1.2)</td>
<td>1.3 (0.3-6.2)</td>
</tr>
<tr>
<td>well-being (GHQ12)</td>
<td>3.2 (2.1-4.8)</td>
<td>1.0 (0.7-1.3)</td>
<td>0.9 (0.6-1.2)</td>
<td>1.5 (0.3-7.9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.1 (2.2-4.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.6 (1.8-3.9)</td>
</tr>
</tbody>
</table>

a aOR = adjusted odds ratios, adjusted for age, vocational program, family structure, immigrant status, hazardous alcohol consumption, daily smoking and drug use. Significant OR/aOR is in bold figures

No victimization is reference for solely one type/single violence and multiple violence (two or more different types of violence). Those victimized exclusively to mild violence are not included in the analysis.
Current adverse effects was analyzed in the national youth health centers setting in Paper 1 to describe how the experience of violence during the past year currently affected the youth. The young women reported a higher level of current adverse effects from almost all types of violence victimization during the past year compared to the young men (Table 9).

**Table 9.** Reported current adverse effects from violence victimization during the past 12 months in youth visiting youth health centers.

<table>
<thead>
<tr>
<th>Violence</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VAS median (iqr)</td>
<td>VAS median (iqr)</td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>2.7 (1.1-5.8)*****</td>
<td>1.3 (0.2-4.3)</td>
</tr>
<tr>
<td>Moderate</td>
<td>3.4 (1.1-6.3)**</td>
<td>0.8 (0.2-4.6)</td>
</tr>
<tr>
<td>Severe</td>
<td>6.3 (3.6-8.2)**</td>
<td>2.6 (0.6-6.6)</td>
</tr>
<tr>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>1.6 (0.3-4.2)**</td>
<td>0.2 (0.2-0.7)</td>
</tr>
<tr>
<td>Moderate</td>
<td>3.2 (0.7-7.2)**</td>
<td>0.3 (0.2-1.1)</td>
</tr>
<tr>
<td>Severe</td>
<td>4.8 (1.5-8.6)**</td>
<td>0.7 (0.2-2.8)</td>
</tr>
<tr>
<td>Sexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>2.4 (0.8-5.0)**</td>
<td>0.9 (0.3-3.8)</td>
</tr>
<tr>
<td>Moderate</td>
<td>5.1 (1.4-7.0)**</td>
<td>0.7 (2.2-2.7)</td>
</tr>
<tr>
<td>Severe</td>
<td>4.8 (2.0-7.8)</td>
<td>5.0 (2.5-7.6)</td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.01, ***p<0.001 for the difference between women and men, iqr=interquartile range

**Violence victimization and sexual ill-health/sexual risk behaviors**

The population-based setting was used to examine associations between violence victimization and sexual ill-health/sexual risk behaviors, see Table 10 for descriptive characteristics.

Consistent associations between multiple-violence victimization and self-reported experience of/involvement in pregnancy, early age at first intercourse, and more than three sex partners during the past year were found in both young women and men. In the young women, this applied to self-reported treatment of chlamydia infection as well, see Table 11. No significant associations between multiple-violence victimization and non-use of contraception were found in either females or males since aORs were 1.0 (0.7-1.4) for females and 0.9 (0.6-2.5) for males.
### Table 10. Socio-demographics, sexual ill health, sexual risk behaviors and violence victimization in sexually experienced upper secondary school students.

<table>
<thead>
<tr>
<th></th>
<th>Females N=1192</th>
<th>Males N=1021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean age, years (lowest-highest)</strong></td>
<td>17.3 (15-21)</td>
<td>17.4 (15-22)</td>
</tr>
<tr>
<td><strong>Age at first intercourse, yrs mean/lowest-highest)</strong></td>
<td>14.9 (12-19)</td>
<td>15.2 (12-20)**</td>
</tr>
<tr>
<td><strong>Upper secondary school, vocational programme</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>600 49</td>
<td>575 57**</td>
</tr>
<tr>
<td>Males</td>
<td>353 46</td>
<td>542 54</td>
</tr>
<tr>
<td><strong>Family structure: Living with both parents</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>546 45</td>
<td>542 45</td>
</tr>
<tr>
<td>Males</td>
<td>415 6</td>
<td>347 6</td>
</tr>
<tr>
<td><strong>Immigrants</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>219 19***</td>
<td>19 116</td>
</tr>
<tr>
<td>Males</td>
<td>75 6</td>
<td>72 7</td>
</tr>
<tr>
<td><strong>Low age at first intercourse (≤14 y)</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>436 38***</td>
<td>38 256</td>
</tr>
<tr>
<td>Males</td>
<td>152 18</td>
<td>151 28</td>
</tr>
<tr>
<td><strong>Sex-partners ≥3 past 12 months</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>218 19</td>
<td>164 18</td>
</tr>
<tr>
<td>Males</td>
<td>75 6</td>
<td>72 7</td>
</tr>
<tr>
<td><strong>Ever been pregnant</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>145 14</td>
<td>14</td>
</tr>
<tr>
<td>Males</td>
<td>72 8</td>
<td>8</td>
</tr>
<tr>
<td><strong>Non-use of contraceptives at latest intercourse</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>315 27</td>
<td>275 28</td>
</tr>
<tr>
<td>Males</td>
<td>162 14</td>
<td>108 11</td>
</tr>
<tr>
<td><strong>Treatment of genital chlamydia infection</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>129 11***</td>
<td>49 10</td>
</tr>
<tr>
<td>Males</td>
<td>78 6</td>
<td>51 5</td>
</tr>
<tr>
<td><strong>Alcohol risk consumption</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>162 14**</td>
<td>153 15**</td>
</tr>
<tr>
<td>Males</td>
<td>129 14</td>
<td>108 11</td>
</tr>
<tr>
<td><strong>Daily smoking</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>68 6***</td>
<td>25 2</td>
</tr>
<tr>
<td>Males</td>
<td>66 6</td>
<td>72 7</td>
</tr>
<tr>
<td><strong>Lifetime solely emotional violence (moderate/severe)</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>178 15***</td>
<td>82 8</td>
</tr>
<tr>
<td>Males</td>
<td>66 5</td>
<td>24 5</td>
</tr>
<tr>
<td><strong>Lifetime solely physical violence (moderate/severe)</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>64 4</td>
<td>24 9</td>
</tr>
<tr>
<td>Males</td>
<td>18 2</td>
<td>12 2</td>
</tr>
<tr>
<td><strong>Lifetime solely sexual violence (moderate/severe)</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>49 4***</td>
<td>8 1</td>
</tr>
<tr>
<td>Males</td>
<td>22 2</td>
<td>12 2</td>
</tr>
<tr>
<td><strong>≥2 types of lifetime violence (moderate/severe)</strong></td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Females</td>
<td>253 28**</td>
<td>164 24</td>
</tr>
<tr>
<td>Males</td>
<td>66 6***</td>
<td>25 2</td>
</tr>
</tbody>
</table>

*p<0.05, **p<0.01, ***p<0.001 for the difference between young women and young men.

{i} excluded 10 females and 20 males reporting age at first intercourse <11 years of age.

### Table 11. Sexual ill health and sexual risk behaviors among violence-victimized youth and the aORs for the associations between the variables for sexual ill health and risk behavior and single and multiple violence victimizations in sexually experienced young women (n=1192) and men (n=1021) in upper secondary school.

<table>
<thead>
<tr>
<th>Violence</th>
<th>First intercourse ≤14y</th>
<th>≥3 sex partners, past year</th>
<th>aOR (95% CI)b</th>
<th>aOR (95% CI)b</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime solely sexual c</td>
<td>27 6.2</td>
<td>2.1 (1.1-4.1)</td>
<td>12 5.5</td>
<td>1.2 (0.6-2.4)</td>
</tr>
<tr>
<td>Lifetime multiple d</td>
<td>133 42</td>
<td>2.2 (1.6-3.1)</td>
<td>78 47</td>
<td>2.1 (1.4-3.1)</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime solely physical c</td>
<td>72 28</td>
<td>1.2 (0.8-1.7)</td>
<td>45 27</td>
<td>1.1 (0.7-1.7)</td>
</tr>
<tr>
<td>Lifetime multiple d</td>
<td>54 33</td>
<td>1.9 (1.2-3.0)</td>
<td>41 39</td>
<td>1.7 (1.0-2.9)</td>
</tr>
<tr>
<td><strong>Violence</strong></td>
<td>Pregnancy a</td>
<td>Chlamydia infection</td>
<td>aOR (95% CI)b</td>
<td>aOR (95% CI)b</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime solely sexual c</td>
<td>6 3.6</td>
<td>0.6 (0.2-1.1)</td>
<td>10 7.8</td>
<td>2.0 (0.9-4.3)</td>
</tr>
<tr>
<td>Lifetime multiple d</td>
<td>73 56</td>
<td>2.4 (1.5-3.7)</td>
<td>46 50</td>
<td>1.8 (1.1-2.9)</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime solely physical c</td>
<td>22 32</td>
<td>1.2 (0.8-1.8)</td>
<td>12 24</td>
<td>1.0 (0.5-2.1)</td>
</tr>
<tr>
<td>Lifetime multiple d</td>
<td>18 45</td>
<td>2.1 (1.3-3.4)</td>
<td>14 44</td>
<td>1.9 (0.8-4.5)</td>
</tr>
</tbody>
</table>

a Ever experienced/been involved in pregnancy.

b aOR=adjusted odds ratio. Adjusted for age, vocational program, family structure, immigrant status, alcohol risk consumption, smoking, and drug use. Significantly raised aORs are in bold prints.

c Not single or multiple violence victimized as the referent.

d Not multiple-violence victimized as the referent.
INTERPRETATIONS AND DISCUSSION

The most important findings in this thesis are the high prevalence rates of emotional, physical, and sexual violence among Swedish youth with gendered differences, and that previous violence victimization was strongly associated with violence during the past year, and finally the strong associations between multiple violence victimization and adverse sexual and mental health outcomes in both young women and men.

Violence

The one-year prevalence of physical violence found in the first study, with prevalence rates varying between 18% for women and 27% for men, are in line with a Danish study [12]. But compared to the recent NCK study, reporting 10% of the young women, aged 18-24, having experienced sexual violence the past 12 months, and 2.9% of the young men, the estimates for sexual violence past year are higher in our study (14% in the young women vs. 4.7% in the young men) [23]. The differences in prevalence estimates are probably at least partly due to the fact that NorAQ includes also mild forms of sexual violence. Other possible reasons could be differences in drop-out rates and wording of the questions. Violence victimization varies in different countries, and also methodological differences may cause discrepancies in prevalence rates.

When comparing the findings in this study with the prevalence estimates in two clinical samples of Swedish adult men and women using the same questionnaire (NorAQ), it is obvious that young people are more violence-victimized than adults [18, 22]. In this study, the prevalence estimates of emotional, physical and sexual violence during the past 12 months in the young men are at least 10-fold higher than those for adult men [22]. For the young women, there are also almost 10-fold higher prevalence estimates for emotional and physical violence during the past 12 months compared to adult women, and even higher for sexual violence [18].

Violence is a gendered phenomenon, and the gendered differences in prevalence of violence found in our study are consistent with other studies with higher levels of sexual violence in the young women [32, 40, 71, 78, 108, 109], and higher levels of physical violence in young men [12, 71]. In our study sexual violence often co-occurred with emotional and physical violence in both young women and young men, and another study finds that sexual assault often indicates exposure to several other types of victimizations [35].

Re-victimization

When exploring risk patterns for past year violence victimization, exposure to violence before 15 years of age was found to be strongly associated with exposure to emotional, physical, and sexual violence during the past 12 months in both young men and young women, after adjusting for socio-demographics and health risk...
behaviors. These findings are in line with a longitudinal study suggesting that victimization of any type of violence in children leads to higher vulnerability for subsequent re-victimization [37]. In this thesis neither the study design nor the questionnaire were designed to answer when the violence before the age of 15 years occurred. There might differ several years between the violence victimization before 15 years of age and past year victimization. Some of the experience of violence in the youth might be a continuum from before and after 15 years of age. Several other studies have found strong association between earlier victimization and later violence victimization [41, 56, 63].

**Perpetrators**

Gendered differences concerning perpetrators were also reported in our study: the young women reported a partner, ex-partner, or parents as the perpetrator of emotional and physical violence more often than the young men, which is similar to the findings by Landstedt et al for physical violence in 17-year-old secondary school students [71]. In both young women and men strangers, friends, and schoolmates were reported as the perpetrators in a large proportion of all forms of violence. The NCK-study also found that peers to a large extent were reported as the perpetrators of physical and emotional violence under the age of 18 [23].

**Violence and mental ill-health**

The young women reported higher levels of current adverse effects, or “suffering” from past year violence experience than men, even for life threatening violence. Swahnberg et al discuss the same difference in adult women and men and implying that “suffering” may be a concept that is more difficult to associate with masculinity than femininity [22]. A strong and consistent association between multiple victimization and all the outcomes for adverse mental health was found in both young women and young men. The findings are in line with other studies in adolescents, reporting higher levels of depressive symptoms, self-harm ideation and poor mental health in poly-victimized youth compared to non-victimized youth [35, 36, 39]. In adolescents suffering from several different kinds of victimizations, a higher risk for trauma symptoms (i.e., depression, anxiety, anger, dissociation) is reported [35]. Further, a graded response of the different types of violence victimizations for poor general health, mental health problems, and self-injury is reported for both victimized adolescent boys and girls [59].

**Violence and sexual ill-health**

A consistent association between multiple victimization and sexual ill health and sexual risk behaviors, except for non-use of contraception was found in the young women. Similar associations were found for the young men, except for chlamydia infection. A Swedish cross-sectional study found a relationship between multiple victimizations during childhood and early age at first intercourse in 15- and 17-year-
olds [59]. However, in a longitudinal study, no associations between more than two different types of dating violence and sexual ill health and sexual risk behaviors were found [57]. In their study, the variables for sexual ill health and sexual risk behaviors were summed up into one score.

In a newly published meta analysis a strong association between violence and an increased risk of adolescent pregnancy in women is found, if sexual and physical violence co-occurred [110]. Also, a Swedish study of 18-year-old males found that the young men who had experienced involvement in pregnancy reported higher rates of sexual victimization than those not involved in pregnancy [107], without including multiple victimization. Earlier cross-sectional studies have demonstrated a relationship between dating violence/IPV in young women and non-use of condom/contraception, without including multiple victimization [92, 111]. Several other factors than violence victimization may be associated with the non-use of contraceptives, such as dissatisfaction with the contraceptive method [118]. However, no association between multiple victimization and non-use of contraceptives after adjusting for socio-demographic factors and health risk behaviors were found.

**Multiple victimization**

The definition of multiple violence victimization in this thesis includes two or three different types of victimizations. In comparison the definition for poly-victimization includes e.g. ≥1 violent events. Although, by including emotional, physical and sexual violence with detailed specific questions, and addressing the co-occurrence of the three types of violence, most probably several different types and areas of interpersonal violence may be conceptualized.

Studies in adult women and men, using the same questionnaire (NorAQ), find that men and women reporting having experienced more than one kind of violence from more than one kind of perpetrator was more strongly associated with self-reported symptoms of psychological ill-health than any one kind of victimization alone [24].

In studies on children and adolescents, the victimization of several types of violence and in different areas in life, may more be seen as living in a violent condition, rather than isolated events [34, 49]. Further, at the community and relational level in the ecological model, positive family resources as well as external support (e.g. school system) are important for resilience in children [112]. Poly-victimization or multiple violence victimization may influence several different areas of life and violence victimization may be present in e.g. both the family and the school context. The widespread cross-context victimization may damage the potential for resiliency, and victimization in multiple areas of life may also affect deficits in social and personal recourses that could help moderating the negative effects of victimization [35].
Violence and settings

This thesis is based on one population based material and one clinical material. When comparing the one-year prevalence of violence in the two different settings the prevalence rates do not demonstrate any significant differences between the school setting and the local youth health center. The one-year prevalence may be similar in both the population-based setting and the clinical setting.

For lifetime multiple violence victimization, higher levels was found in the local youth health center setting compared to the school setting. This indicates that there is similar one-year prevalence of violence, but in the youth visiting the clinical setting more had a history of experiencing both the moderate and severe levels of violence victimizations. None of the participating youth health centers had a specific profile concerning violence, and according to my and others experiences youth rarely seek the health care specifically for violence victimizations [113, 114]. The main reason for attending a youth health center is contraceptive advice or to test for sexually transmitted infections [115], however social and psychological problems are also reasons for attending. Unspecific symptoms such as headache, insomnia, fatigue are also common symptoms specifically among the young girls.

However, the association between multiple victimization and adverse sexual and mental health found in the school setting would most probably be the same in the youth attending youth health centers, even if prevalence of lifetime violence victimization and adverse sexual and mental health outcomes may vary.

Limitations

The study design includes some limitations. First, the study was cross-sectional, so no conclusions about causality could be made, only associations. To be able to study more than associations, a longitudinal study would be preferable. Second, as in many other surveys, our data are entirely retrospective and self-reported, with the possibility of recall bias. Even if cross-sectional retrospective surveys have their limitations, the design has often been used in studying the prevalence of different forms of violence [12, 18, 22].

When asking questions on violence victimization, there might be some hesitation due to the distress caused by the question in the participants, but young people have exhibited a high acceptance of answering questions about violence exposure [97], and low levels of upsets in [116]. The Swedish National Board of Health and Welfare now recommend screening for violence in various settings in the health care [117].

As for limitations in the study settings in the population-based material, the setting was a medium-sized city in Sweden, with a lower percentage of immigrant youth (6-7%) than in the general population of Sweden (15%), and also a somewhat lower level of post secondary education 3 years of more. Therefore, this setting may not be representative for the whole of Sweden, and the results may differ on some accounts, such as frequencies in violence victimizations, compared to Sweden as a whole [32].
Even so, the strong associations between multiple victimization and adverse health would most probably be the same.

Since not understanding written Swedish was one of the exclusion criteria, immigrant status may be underestimated. Another limitation was that neither the education nor the profession or income of the parents was measured. Low economic status of the family is associated with higher levels of violence in some studies [2, 13], and poly-victimization measured in a Swedish youth survey shows an association with parental unemployment [32].

In analyzing previous violence victimization and the association to past-year victimization, the simultaneous examination of health risk behaviors and socio-demographics provided an opportunity to compare the strengths of the relationship, even if no causality could be studied due to the cross-sectional design. A longitudinal study would have been suitable for analyzing risk factors for violence victimization.

The instrument used for measuring violence in this thesis (NorAQ), has been validated using interview as the gold standard [19, 20, 22]. Since mild physical violence in the NorAQ had low validity, only moderate and severe types of violence was included in relation to poor health outcome and association to past year victimization.

Further, a variable was constructed to include victimization of two or three of the different types of violence i.e. multiple violence victimization. The NorAQ is not designed to answer whether the young people reported the multiple victimization simultaneously or at different times. In the questionnaire the young people can report victimization of the specific type and level of violence before or after 15 years of age, or during the past 12 months and therefore lifetime victimizations may be measured.
From the results of the study and to address the different specific aims in this thesis, some conclusions are presented.

- **Violence victimization among youth is high, with gendered differences:**
  - The young women were more often exposed to emotional and sexual violence than the young men, while the young men were more often exposed to physical violence.
  - The co-occurrence of emotional, physical and sexual violence was considerable, especially when it came to sexual violence in both females and males. Physical violence in the young men often occurred in isolation, but often co-occurred with both emotional and sexual violence in the young women.
  - Schoolmates, friends, and strangers were reported by both young men and young women as perpetrators in a large proportion of all the forms of violence. In the young women, the perpetrator of emotional and physical violence was more often someone close to them, compared to the young men.
  - The young women reported a higher level of current adverse effects from past year violence victimization compared to the young men.

- **Earlier experience of violence victimization is associated with emotional, physical, and sexual victimization during the past 12 months in both genders.**
  - Exposure to emotional, physical, and sexual violence before 15 years of age was strongly associated with violence victimization during the past 12 months in both young men and women, even after adjusting for socio-demographic factors and substance use.
  - The association between alcohol risk consumption/daily smoking/drug use and violence victimization during the past 12 months was more inconsistent.

- **Multiple violence victimization (i.e. experience of 2 or 3 types of the different victimizations) in youth is strongly associated with sexual ill health, various sexual risk behaviors, and adverse mental health in both females and males.**
  - Associations between multiple victimization and experience of/involvement in pregnancy, early age at first intercourse, and ≥3 sex partners were found, after adjusting for socio-demographics and health risk behaviors. In the young women, also for treatment of genital chlamydia infection.
  - Strong and consistent associations between multiple victimization and poor general health, self-harm ideation, self-harm behaviors, suicidal ideation, and impaired mental well-being were found in both young women and young men.
Clinical implications

In the crucial and vulnerable transition period from adolescence into young adulthood, violence victimization is high. Considering the high prevalence of violence and the strong associations with adverse mental health, sexual ill health, and sexual risk behaviors, violence victimization is an important aspect of adverse health in youth. Especially multiple-victimized young people need to be recognized and addressed in medical and social settings, both as a part of sexual and reproductive health and in relation to adverse mental health.

Sexual and reproductive health care providers should be encouraged to include questions about emotional, physical and sexual violence victimization as part of normal medical history. By asking about violence, the professionals may help the victimized youth to seek further counseling by social workers, psychologists, or physicians when needed. After identifying one type of emotional, physical and sexual violence, it is important to ask about multiple violence victimization in both young women and men. The strong association between violence victimization and adverse mental health in secondary school students may indicate a public health challenge that needs to be addressed by local school health services and other youth health services. Previous violence victimization before the age of 15 was identifiable as a risk factor for current victimization in both genders, indicating that early violence intervention is of great importance.

Violence is a public health challenge and violence victimization in youth must be a matter of high priority. All persons working with young people should be aware of the disastrous effect of specifically multiple-violence victimization, and should be encouraged to ask about violence victimization with the young people. Violence is not inevitable, and needs to be addressed.

Unanswered questions and future research

For future research, a longitudinal design would be preferable, with the possibility of identifying possible mediators and moderators related to the outcome. As for the research area of violence victimization, the co-occurrence of different types of violence needs to be taken into account. For a deeper understanding of violence as a gendered phenomenon, that is the consequences for females and males, and also for other intersections related to power inequity, e.g. sexual minority youth, a qualitative research would be preferable. Further, the possibility of interventions in the health care settings of the violence victimized youths may be addressed in a prospective study.
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APPENDIX A

UNGDOMAR OCH VÄLD

VAR MED OCH ÖKA KUNSKAPEN OM HUR NI MÄR OCH HUR VÄLDET MOT ER SER UT!

Skapa anonymt på enkätsatsen.

www.fvn.se/ungdomsmottagning

Ungdomsenkäten - skolan.
Välkommen till Ungdomsenkäten

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 räkar kryssa i fel ruta, fyll i hela rutan ☐, sätt sedan kryss i rätt ruta.

- Vissa frågor har så kallade underfrågor. Dessa frågor har oftast pilar som visar hur du skall svara på frågorna. Kolla så att du inte missar någon underfråga!

- Bry dig inte om att numret på frågorna inte alltid verkar stämma. Det blir så eftersom vissa frågor är olika för tjejer och killar.

Flervalsfrågor har värden 0 eller 1
Alla idn föregis av ”F” i databasen
1. Vilken skola går du till?
☐ Barnmorska
☐ Sjuksköterska eller Undersköterska
☐ Kurator
☐ Psykolog
☐ Läkare
☐ Anm.ney inte

2. Av vilken anledning besöker du Ungdomsmottagningen/Ungdomshälsan?
   Jag skall träffa/har träffat
   ☐ Barnmorska
   ☐ Sjuksköterska eller Undersköterska
   ☐ Kurator
   ☐ Psykolog
   ☐ Läkare
   ☐ Annat

3. Hur gammal är du? ...............år

4. Är du tjej eller kille?
☐ I ej
☐ Kille

5. Vilken är din huvudsakliga sysselsättning? Du kan fylla i flera rutor
   ☐ Studerar på grundskola
   ☐ Studerar på gymnasium – yrkesförberedande program t.ex. barn o frid, el, fordon, eller omvårdnad
   ☐ Studerar på gymnasium – studieförberedande program, d.v.s. samhälle, teknik, estetiska eller naturvetenskapliga
   ☐ Studerar på gymnasium - individuellt program
   ☐ Arbetar
   ☐ Arbetslös
   ☐ Annat

6. Vem bor du huvudsakligen tillsammans med?
   ☐ Med båda mina biologiska föräldrar
   ☐ Med en av mina biologiska föräldrar med eller utan sambo
   ☐ Mina föräldrar är skilda och jag flyttar emellan dem
   ☐ Med kompis/kompisar
   ☐ Med pojk/flickvän
   ☐ Ensam
   ☐ Inget av dessa alternativ stämmer för mig

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

**Nu kommer några frågor om din hälsa.**


- [ ] Mycket bra
- [ ] Bra
- [ ] Någorlunda
- [ ] Dåligt
- [ ] Mycket dåligt


<table>
<thead>
<tr>
<th>Symptom</th>
<th>Nej</th>
<th>Ja ibland</th>
<th>Ja, ofta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Värk i rygg, nacke eller axlar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Huvudvärk eller migrän</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mag- eller tarmbesvär</td>
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</tr>
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<td>Känslan att stressad</td>
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<td></td>
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<tr>
<td>Trötthet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sjukdomshistorier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ängslan, oro eller ängest</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Har du under de senaste 3 månaderna haft besvärande menstruverk?

- [ ] Nej
- [ ] Ja, ibland
- [ ] Ja, ofta


Mycket nöjd ____________________________________ Mycket missnöjd


Mycket nöjd ____________________________________ Mycket missnöjd
Nu kommer några frågor som handlar om hur Du mår framför allt psykiskt. Sätt ett kryss på varje fråga.

13. Har du de senaste veckorna kunnat koncentrera dig på allt du gjort?
   1. Bättre än vanligt
   2. Som vanligt
   3. Sämre än vanligt
   4. Mycket sämre än vanligt

14. Har du de senaste veckorna känt att du kunnat uppskatta det du gjort om dagarna?
   1. Mer än vanligt
   2. Som vanligt
   3. Mindre än vanligt
   4. Mycket mindre än vanligt

15. Har du haft svår att sova på grund av oro de senaste veckorna?
   1. Inte alls
   2. Inte mer än vanligt
   3. Mer än vanligt
   4. Mycket mer än vanligt

16. Har du de senaste veckorna kunnat ta itu med dina problem?
   1. Bättre än vanligt
   2. Som vanligt
   3. Sämre än vanligt
   4. Mycket sämre än vanligt

17. Upptäcker du att du har gjort nytta de senaste veckorna?
   1. Mer än vanligt
   2. Som vanligt
   3. Mindre än vanligt
   4. Mycket mindre än vanligt

18. Har du ständigt de senaste veckorna känt dig olycklig och nedstämd?
   1. Inte alls
   2. Inte mer än vanligt
   3. Mer än vanligt
   4. Mycket mer än vanligt

19. Har du de senaste veckorna kunnat fatta beslut i olika frågor?
   1. Bättre än vanligt
   2. Som vanligt
   3. Sämre än vanligt
   4. Mycket sämre än vanligt

20. Har du de senaste veckorna förlorat tron på dig själv?
    1. Inte alls
    2. Inte mer än vanligt
    3. Mer än vanligt
    4. Mycket mer än vanligt

21. Har du ständigt känt dig spänd de senaste veckorna?
    1. Inte alls
    2. Inte mer än vanligt
    3. Mer än vanligt
    4. Mycket mer än vanligt

22. Har du tyckt att du varit värdelös de senaste veckorna?
    1. Inte alls
    2. Inte mer än vanligt
    3. Mer än vanligt
    4. Mycket mer än vanligt

23. Har du de senaste veckorna känt att du inte kunnat klara dina problem?
    1. Inte alls
    2. Inte mer än vanligt
    3. Mer än vanligt
    4. Mycket mer än vanligt

24. Har du på det hela taget känt dig någorunda lycklig de senaste veckorna?
    1. Mer än vanligt
    2. Som vanligt
    3. Mindre än vanligt
    4. Mycket mindre än vanligt
25. Har det hänt någon gång under de senaste 12 månaderna att du funderat på att göra dig själv illa genom att t.ex. bränna eller skärva dig?

☐ nej ▶ Gå till fråga 28!
☐ ja

26. Har du berättat det för någon?

☐ Nej ▶ Gå till fråga 28!
☐ Ja

27. För vem har du berättat det? Kryssa i alla alternativ som stämmer för dig.

☐ Föreläser
☐ Syskon
☐ Lärare
☐ Skolköterska/skolkurator/skolläkare
☐ Personal på Ungdomsmottagning/Ungdomshälsan
☐ Annan vuxen
☐ Kompis/partner
☐ Annan

28. Har det hänt någon gång under de senaste 12 månaderna att du har gjort dig själv illa på något sätt?

☐ Nej ▶ Gå till fråga 31!
☐ Ja

29. Har du berättat det för någon?

☐ Nej ▶ Gå till fråga 31!
☐ Ja

30. För vem har du berättat det? Kryssa i alla alternativ som stämmer för dig.

☐ Föreläser
☐ Syskon
☐ Lärare
☐ Skolköterska/skolkurator/skolläkare/
☐ Personal på Ungdomsmottagning/Ungdomshälsan
☐ Annan vuxen
☐ Kompis/partner
☐ Annan
31. Har det hänt någon gång att du under de senaste 12 månaderna funderat på att ta ditt liv/begå självmord?

☐ Nej  Gå till fråga 34!
☐ Ja

32. Har du berättat det för någon?

☐ Nej  Gå till fråga 34!
☐ Ja

33. För vem har du berättat det? Kryssa i alla alternativ som stämmer för dig.

☐ Föralder
☐ Syskon
☐ Lärare
☐ Skolköterska/skolkurator/skolläkare/
☐ Personal på Ungdomsmottagning/Ungdomshälsan
☐ Annan vuxen
☐ Kompis/partner
☐ Annan

Följande två frågor handlar om Dina kontakter med sjukvården de senaste 12 månaderna.

34. Har du under de senaste 12 månaderna sökt någon inom hälso- eller sjukvården?

Sätt ett kryss på varje rad!

<table>
<thead>
<tr>
<th>Personal inom skolhälsovården</th>
<th>nej</th>
<th>en gång</th>
<th>mer än en gång</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal på ungdomsmottagningen/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ungdomshälsan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal på vårdcentral</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal på sjukhusmottagning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annan personal inom vårdvän</td>
</tr>
<tr>
<td>Har du varit inlagd på sjukhus?</td>
</tr>
</tbody>
</table>

35. Har du under de senaste 12 månaderna tyckt att du behövt kontakt med någon inom sjukvården men ändå inte sökt?

☐ Nej
☐ Ja
*Nu kommer några frågor som handlar om dig och din sexualitet.*

36. Har du någon gång haft samlag?
   - [ ] Nej
   - [ ] Ja

   Gå direkt till fråga 46 nästan längst ner på sidan!

37. Hur gammal var du första gången du hade samlag? .......... år

38. Har du varit gravid någon gång?
   - [ ] Nej
   - [ ] Vet inte
   - [ ] Ja

   Gå till fråga 42!


40. Har du gjort någon tjän med barn?
   - [ ] Nej
   - [ ] Vet inte
   - [ ] Ja

   Gå till fråga 42!

41. Hur många gånger har du gjort någon tjän med barn? .......... gånger

42. Använd de eller din partner något preventivmedel vid senaste samlaget? Kryssa i alla alternativ som stämmer för dig.
   - [ ] Ja, jag
   - [ ] Ja, min partner
   - [ ] Nej, varken jag eller min partner
   - [ ] Vet inte

43. Hur många sexuella partners har du haft senaste året? .......... stycken

44. Har du någon gång fått behandling för klamydia?
   - [ ] Nej
   - [ ] Ja

   Gå till fråga 46!

45. Hur många gånger? ............... gånger

46. Har du haft någon fast partner under de senaste 12 månaderna?
   - [ ] Nej
   - [ ] Ja

47. Har du för närvarande en fast partner?
   - [ ] Nej
   - [ ] Ja
Vi vill också att Du svarar på några frågor som handlar om dina rökvanor, alkoholvanor och drogvanor. Svara så ärligt som möjligt på frågorna!

48. Röker du dagligen?
☐ Nej
☐ Ja

Alkoholvanor
Med "alkohol" menas folköl, mellanstarköl, alkoholstark cider, vin, starkvin och sprit. Besvara frågorna så noggrant och ärligt som möjligt.

Med ett "glas" menas:
- 5 cl folköl
- 3,3 cl starköl
- 10-15 cl vitt eller rött vin
- 5,8 cl starkvin
- 4 cl sprit
- tex whisky

49. Hur ofta har du druckit alkohol under de senaste 12 månaderna?
☐ 4 gånger/vecka eller mer
☐ 2-3 gånger/vecka
☐ 2-4 gånger/månad
☐ 1 gång/månad eller mer sällan
☐ Aldrig ➔ Gå till fråga 53!

50. Hur många "glas" (se exempel) dricker du en typisk dag då du dricker alkohol?
☐ 1-2
☐ 3-4
☐ 5-6
☐ 7-9
☐ 10 eller fler
☐ Vet inte

51. Hur ofta dricker du sex "glas" eller fler vid samma tillfälle?
☐ Dagligen eller nästan varje dag
☐ Varje vecka
☐ Varje månad
☐ Mer sällan än en gång i månaden
☐ Aldrig
52. Har du under de senaste 12 månaderna någon gång råkat illa ut i samband med att du varit berusad/full?

☐ Nej
☐ Ja

53. Har du under de senaste 12 månaderna någon gång prövat hasch eller marihuana?

☐ Nej
☐ Ja

54. Har du under de senaste 12 månaderna prövat någon annan drog som ecstasy, GHB eller anabola steroider?

☐ Nej
☐ Ja


OBS! Alla frågor har flera ”underfrågor”. Läs noggrant så att du inte missar någon sådan fråga.

Vänd!
55. Har du upplevt att någon flera gånger försökt trycka ned dig, förnedra eller förödmjuka dig eller kallat dig för saker som särat dig?

- Innan du blev 15 år  □ Nej □ Ja
- Efter att du blev 15 år  □ Nej □ Ja

- De senaste 12 månaderna  □ Nej → gå till fråga 56! Närsta sida □ Ja → fortsätta direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

□ Syskon  □ System  □ Bror
□ Förläder  □ Mann  □ Pappa
□ Annan vuxen  □ Kvinna  □ Man
□ Skollärare/kompis  □ Tjej  □ Kille
□ Okänd  □ Tjej/kvinna  □ Kille/man
□ Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån: 
□ F.d. partner
□ När hände det första gången? □ Medan ni var tillsammans. □ När det tagit slut

B. Har du berättat det som hänt för någon?

□ Nej → Gå till D!
□ Ja

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

□ Förläder
□ Syskon
□ Lärare
□ Skolinspektör/skollärare
□ Personal på Ungdomsmottagning/Ungdomshålsan
□ Annan vuxen
□ Kompis/partner
□ Polisen
□ Annan

D. Var du påverkad av alkohol eller någon annan drog sist gången det hände?

□ Nej □ Ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls .............................................. väldigt mycket
56. Har du upplevt att någon flera gånger under hot eller tvång försökt begränsa din kontakt med andra eller bestämma vad du får och inte får göra?

- Innan du blev 15 år
  - Nej
  - Ja

- Efter att du blev 15 år
  - Nej
  - Ja

- De senaste 12 månaderna
  - Nej, gå till fråga 57! Nista sida
  - Ja, fortsätt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förfälld
- Annan vuxen
- Skolkamrat/kompis
- Okänd
- Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån: 

- F.d. partner
- När hände det första gången?
  - Medan ni var tillsammans.
  - När det tagit slut

B. Har du berättat det som hänt för någon?

- Nej
  - Gå till D!
- Ja

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Förälder
- Syskon
- Lärare
- Skolknappskola/skolnatt/ororna/skolnät/oron
- Personl på Ungdomsmottagning/ungdomshälsan
- Annan vuxen
- Kompis/partner
- Polisen
- Annan

D. Var du påverkad av alkohol eller någon annan drog sist gången det hände?

- Nej
- Ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ............................................................................................................ världigt mycket
57. Har du varit med om att leva i skräck på grund av att någon flera gånger under en längre tid hotat att skada dig eller någon som står dig nära?

- Innan du blev 15 år
  □ Nej  □ Ja
- Efter att du blev 15 år
  □ Nej  □ Ja

- De senaste 12 månaderna
  □ Nej  gå till fråga 58! Nästa sida
  □ Ja  fortsätt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förläder
- Annan vuxen
- Skolkamrat/kompis
- Okänd
- Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån:...........

- F.d. partner
- När hände det första gången? □ Medan ni var tillsammans. □ När det tagit slut

B. Har du berättat det som hänt för någon?

□ nej  Gå till D!
□ ja

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Förläder
- Syskon
- Lärare
- Skolsköterska/skolkurator/skolläkare/
- Personal på Ungdomsmottagning/Ungdomshälsan
- Annan vuxen
- Kompis/partner
- Polisen
- Annan

D. Var du påverkad av alkohol eller någon annan drog sista gången det hände?

□ nej □ ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ........................................... väldigt mycket
58. Har du varit med om att någon slagit till dig eller givit dig en örfil eller hållit fast dig mot din vilja?

- Innan du blev 15 år
- Efter att du blev 15 år

De senaste 12 månaderna

- Nej
- Ja

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förfälder
- Annan vuxen
- Skolkamrat/kompis
- Okänd
- Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån:.........

- F.d. partner
- När hände det första gången? (Medan ni var tillsammans)
- När det tagit slut

B. Har du berättat det som hänt för någon?

- Nej
- Ja

Gå till D!

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Föräldrar
- Syskon
- Lärare
- Skolköterska/skolkurator/skolläkare/
- Personlig på Ungdomsmottagning/Ungdomshälsan
- Annan vuxen
- Kompis/partner
- Polisen
- Annan

D. Var du påverkad av alkohol eller någon annan drog sista gången det hände?

- Nej
- Ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls .............................................. Väldigt mycket
59. Har du varit med om att någon slagit dig med knytnäven eller med något hårt föremål, eller sparkat dig eller knuffat dig våldsamt eller misshandlat dig på något annat sätt?

- Innan du blev 15 år
  - Nej
  - Ja

- Efter att du blev 15 år
  - Nej
  - Ja

- De senaste 12 månaderna
  - Nej, gå till fråga 60! Nästa sida
  - Ja, fortsätt direkt nedanför

### A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förälder
- Amman vuxen
- Skolkamrat/kompis
- Okänd
- Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån:………..

- F.d. partner
  - När hände det första gången?
  - Medan ni var tillsammans.
  - När det tagit slut

### B. Har du berättat det som hänt för någon?

- Nej, gå till D!
- Ja

### C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Förälder
- Syskon
- Lärare
- Skolburs/utbildningslärares
- Person på Ungdomsmottagning/Ungdomshälsan
- Amman vuxen
- Kompis/partner
- Polisen
- Amman

### D. Var du påverkad av alkohol eller någon annan drog sista gången det hände?

- Nej
- Ja

### E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls   ____________________________ mycket
60. Har du varit med om att någon har hotat dig till livet genom att t.ex. försöka kväva dig, visa vapen, ha en kniv till hands eller något liknande?

- Innan du blev 15 år
  □ Nej  □ Ja

- Efter att du blev 15 år
  □ Nej  □ Ja

- De senaste 12 månaderna
  □ Nej, gå till fråga 61! Nissa sida 61
  □ Ja, fortsätt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förfäder
- Annan vuxen
- Skolkamrat/kompis
- Okänd
- Partner
  Hur länge hade ni varit tillsammans när det hände första gången? Antal mån:........
  □ F.d. partner
  □ När hände det första gången?  □ Medan ni var tillsammans. □ När det tagit slut

B. Har du berättat det som hänt för någon?

- Nej  ➔ Gå till D!
- Ja

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Förfäder
- Syskon
- Lärare
- Skolkåtare/kuralt/adaktare/
- Personer på Ungdomsmottagning/Ungdomshälsan
- Annan vuxen
- Kompis/partner
- Polisen
- Annan

D. Var du påverkad av alkohol eller någon annan drog sista gången det hände?

- Nej  □ Ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ............................................. väldigt mycket
61. Har någon mot din vilja rört vid din kropp på andra delar än könsorganen på ett "sexuellt sätt", eller tvingat dig att beröra andra delar av hans eller hennes kropp på ett "sexuellt sätt"?

- Innan du blev 15 år  □ Nej  □ Ja
- Efter att du blev 15 år  □ Nej  □ Ja

- De senaste 12 månaderna  □ Nej  gå till fråga 62! Nästa sida  □ Ja  fortsatt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förfälder
- Anman vuxen
- Skolkomrad/kompis
- Okänd
- Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån:………

- F.d. partner
- När hände det första gången?
- Medan ni var tillsammans.
- När det tagit slut

B. Har du berättat det som hänt för någon?

- nej  Gå till D!
- ja

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Förfälder
- Syskon
- Lärare
- Skolköterska/skolkurator/skolläkare/
- Personal på Ungdomsmottagning/Ungdomsbälsan
- Anman vuxen
- Kompis/partner
- Polisen
- Anman

D. Var du påverkad av alkohol eller någon annan drog sista gången det hände?

- nej  □ ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ...........................................väldigt mycket
62. Har du på något sätt blivit sexuellt förnedrad; t.ex. genom att du mot din vilja tvingats se porrfilm eller liknande, eller visa upp din kropp naken, eller tvingats se på när någon annan visat upp sin kropp naken?

- Innan du blev 15 år  
  □ Nej  □ Ja
- Efter att du blev 15 år  
  □ Nej  □ Ja

- De senaste 12 månaderna
  □ Nej, gå till fråga 63! Närsta sida
  □ Ja, fortsätt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon  □ sist  □ syste    □ bror
- Förälder    □ manna     □ pappa
- Annan vuxen □ kvinna    □ man
- Skolkamrat/kompis □ tjejer     □ kille
- Okänd □ tjejer/kvinnor □ kille/man
- Partner

Hur länge hade ni varit tillsammans när det hänt första gången? Antal mån:………..

- F.d. partner    □ När hände det första gången? □ Medan ni var tillsammans. □ När det tagit slut

B. Har du berättat det som hänt för någon?

□ nej  □ ja
  Gå till D!

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

□ Förälder
□ Syskon
□ Lärare
□ Skolkontakt/skolvaktar/medarbetare/
□ Personal på Ungdomsmottagning/Ungdomshall
□ Annan vuxen
□ Kompis/partner
□ Polisen
□ Annan

D. Var du påverkad av alkohol eller någon annan drog sist gången det hänte?

□ nej  □ ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ___________________________ väldigt mycket
63. Har någon mot din vilja tagit på dina könsorgan, eller använt din kropp för att tillfredsställa sig själv sexuellt eller tvingat dig att ta på någon annans könsorgan?

- Innan du blev 15 år
  - Nej
  - Ja

- Efter att du blev 15 år
  - Nej
  - Ja

- De senaste 12 månaderna
  - Nej ➜ gå till fråga 64! Nätta sida
  - Ja ➜ fortsätt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förfälter
- Mannan vuxen
- Skolkmarrat/kompis
- Okänd
- Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån:--------

- F.d. partner
- När hände det första gången?  ➜ Medan ni var tillsammans.
- När det tagit slut

B. Har du berättat det som hänt för någon?

- Nej ➜ Gå till D!
- Ja

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Förfälter
- Syskon
- Lärare
- Skolköterska/skolkurator/skolläkare/
- Personal på Ungdomsmottagning/Ungdomshälsan
- Mannan vuxen
- Kompis/partner
- Polisen
- Mannen

D. Var du påverkad av alkohol eller någon annan drog sista gången det hände?

- Nej
- Ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ........................................................................................................................................... väldigt mycket
64. Har någon mot din vilja försökt föra in, eller fört in, penis eller någonting annat i din slida, mun eller ändtarm.

- Innan du blev 15 år
  - Nej
  - Ja

- Efter att du blev 15 år
  - Nej
  - Ja

- De senaste 12 månaderna
  - Nej, gå till fråga 66! Nissa sida
  - Ja, fortsätt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

- Syskon
- Förfälder
- Annan vuxen
- Skolkamrat/kompis
- Okänd
- Partner

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån: 

- F.d. partner
  - När hände det första gången? Medan ni var tillsammans. När det tagit slut

B. Har du berättat det som hänt för någon?

- Nej, gå till D!
- Ja

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

- Förfälder
- Syskon
- Lärare
- Skolsköterska/skolkurator/skolläkare/
- Personal på Ungdomsmottagning/Ungdomshälsan
- Annan vuxen
- Kompis/partner
- Polisen
- Annan

D. Var du påverkad av alkohol eller någon annan drog sist gången det hände?

- Nej
- Ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ......................................................... väldigt mycket
65. Har någon mot din vilja försökt föra in, eller fört in, penis eller någonting annat i din mun eller ändtarm.

- Innan du blev 15 år  
  - Nej  
  - Ja

- Efter att du blev 15 år  
  - Nej  
  - Ja

- De senaste 12 månaderna  
  - Nej ➔ gå till fråga 66! Nächste Seite  
  - Ja ➔ fortsätt direkt nedanför

A. Av vem då? Kryssa i alla svar som stämmer för dig!

<table>
<thead>
<tr>
<th>Systro</th>
<th>Syster</th>
<th>Bror</th>
</tr>
</thead>
<tbody>
<tr>
<td>Förfäder</td>
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<td>Pappa</td>
</tr>
<tr>
<td>Annan vuxen</td>
<td>Kvinna</td>
<td>Man</td>
</tr>
<tr>
<td>Skolkamrat/kompis</td>
<td>Tjej</td>
<td>Kille</td>
</tr>
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<td>Okänd</td>
<td>Tjej/kvinna</td>
<td>Kille/man</td>
</tr>
<tr>
<td>Partner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hur länge hade ni varit tillsammans när det hände första gången? Antal mån:...........

- F.d. partner 
  - När hände det första gången?  
    - Nej ➔ Gå till D! 
    - Ja ➔ Medan ni var tillsammans.  
    - När det tagit slut

B. Har du berättat det som hänt för någon?

- Nej  
  - Ja ➔ Gå till D!

C. För vem har du berättat det? Kryssa i alla svar som stämmer för dig!

<table>
<thead>
<tr>
<th>Föräder</th>
<th>Systro</th>
<th>Bror</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systro</td>
<td>Mamma</td>
<td>Pappa</td>
</tr>
<tr>
<td>Lärare</td>
<td>Kvinna</td>
<td>Man</td>
</tr>
<tr>
<td>Skolböcker/skolkurator/skolläkare</td>
<td>Tjej</td>
<td>Kille</td>
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<tr>
<td>Personl på Ungdomsmottagning/Ungdomshälsan</td>
<td>Tjej/kvinna</td>
<td>Kille/man</td>
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<tr>
<td>Kompis/partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polisen</td>
<td></td>
<td></td>
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<tr>
<td>Annan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. Var du påverkad av alkohol eller någon annan drog sista gången det hände?

- Nej  
  - Ja

E. Försök att markera på skalan hur mycket du tycker att du för nuvarande lider av det som har hänt dig!

Inte alls ➔ _______  
Väldigt mycket ➔ _______
**Nu kommer ett par avslutande frågor om något helt annat.**

66. Vad gör du på fritiden? Sätt ett kryss på varje rad!

<table>
<thead>
<tr>
<th>Träffar kompisar</th>
<th>Aldrig</th>
<th>Ibland</th>
<th>Ofta</th>
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</thead>
<tbody>
<tr>
<td>Träffar pojkvän/flickvän</td>
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<td>Går på stan/fikar</td>
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<td></td>
</tr>
<tr>
<td>Läser läxor</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Läser böcker eller tidningar |        |        |      |
| Går på bio/theater/disco |        |        |      |
| Tränar på något sätt |        |        |      |
| Deltar i annan fritidsaktivitet |        |        |      |
| Umgås med dina föräldrar/syskon |        |        |      |
| Spelar på dator/chat |        |        |      |
| Ser på TV |        |        |      |
| Vilar |        |        |      |

67. Hur ser du på framtiden?

- [ ] Mycket positivt
- [ ] Ganska positivt
- [ ] Varken positivt eller negativt
- [ ] Ganska negativt
- [ ] Mycket negativt

---

**Nu har du svarat på alla frågor. Tack för din medverkan!**

Kanske har Du svarat på några frågor som berör saker som är svåra för dig. Personalen på elevhållan är van att prata med ungdomar om svåra saker. Lägg en lapp med namn och telefonnummer i lådan i väntrummet/brevlådan på elevhållan så ringer någon från mottagningen upp dig senare.

Du kan också vända dig till Ungdomsmottagningen, eller ringa något av de telefonnumren som finns på informationslappen du fått.