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Affective Aspects of Screening for Intimate Partner Violence: The Impact of Emotions on the Implementation of Routinely Asking Questions About Violence in Women's Health Care

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ABSTRACT

There are both facilitating and hindering factors when it comes to screening for intimate partner violence (IPV). While research indicates that health-care providers' emotions regarding screening serve as an influencing factor, there is little scholarly work that has systematically considered the role of emotions in inquiring about IPV. Addressing this research gap, the article explores the affective aspects of routinely asking questions about violence in women's health care. The findings show that emotions serve as both antecedents and consequences of routine inquiry, indicating that the role of emotions should be viewed as integral to any effort to improve screening practices for IPV.

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Women's health; intimate partner violence; routinely asking questions about IPV; emotions; emotion management

Background

Violence against women is considered a violent act against women's rights as well as a major public health issue and a threat to women's health (WHO, 2023). There are several different definitions of intimate partner violence (IPV) but the most frequently used is that of the World Health Organization (WHO), in which IPV is defined as: "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2023). WHO (2023) estimates a lifetime prevalence of one out of three women subjected to physical and/or sexual violence, the perpetrator being most often a former or current partner. In a multicountry study, Garcia-Moreno et al. (2006) highlight that 15–71% of women worldwide are affected by IPV.

Intimate Partner Violence and Its Consequences for Women's Health and Lives

It is well known that experiencing violence or living in a violent relationship has consequences for women's health and lives. Female victims of IPV are subjected to

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acute injuries as well as long-term health consequences (Stubbs & Szoeki, 2022). Unintended pregnancies, sexual dysfunction, and abdominal and pelvic pain are some of the potential consequences of IPV (Kouyoumdjian et al., 2013; Lutgendorf, 2019). Depression, anxiety, and posttraumatic stress disorders are other adverse effects impacting women's mental health (White et al., 2024). Victims of IPV are also more likely to experience somatization, which can lead to physical symptoms, such as chronic pain, but also to anxiety disorders, substance use, and suicide (Lutgendorf, 2019).

Research shows that IPV victims are frequently in contact with health-care services, yet rarely disclose that they are or have been exposed to IPV (Heron & Eisma, 2021). In a Nordic cross-sectional study, the lifetime prevalence, incidence, and consequences of physical, psychological, and sexual violence among women visiting gynecology clinics were investigated (Wijma et al., 2003). Even though the lifetime prevalence of violence was high (44–72%), only a few of the women (2–8%) had told their health-care provider (HCP) about the exposure to violence at their last visit. That few women exposed to violence were identified at the clinics was problematized as something that may have a negative impact on the care they were offered and on their health; the significance of screening for IPV was thus highlighted (Wijma et al., 2003). The importance of asking directly about IPV is confirmed in an up-to-date systematic review of 34 studies on barriers to and facilitators of disclosure by Heron and Eisma (2021). They conclude that directly asking questions about IPV facilitates victims' disclosure, and HCPs are therefore encouraged to engage in routine-based questions about IPV.

Implementing Routine-Based Questions About IPV

Despite evidence of the importance of HCPs' routine-based inquiry about IPV, screening rates have been consistently low (Alvarez et al., 2017). There is thus a need to better understand what facilitates and hinders the implementation of routine-based questions. Research on the implementation of routine-based questions about IPV is largely concerned with facilitating and hindering organizational factors (Sprague et al., 2012). In a review of studies focusing on provider-specific barriers to screening for IPV, the most frequently mentioned provider-related barriers included lack of education regarding IPV, lack of time, and lack of effective interventions. Patient-related barriers, such as patient nondisclosure and fear of offending or endangering the patient, were also often mentioned (Waalén et al., 2000).

Even though research primarily has focused on organizational or clinic-level factors, such as lack of time or training, there are studies that show that personal-level factors, such as the HCP's personal attitudes, beliefs, and perceptions regarding screening for and responding to IPV, also serve as influencing factors (Alvarez et al., 2017). Lack of comfort, self-efficacy, enculturation, and sense of responsibility or role in screening for IPV have been found to relate to lower rates of screening as well as limited responses (Grace et al., 2009; Pagels et al., 2015; Tower, 2006). In a recent qualitative meta-synthesis examining personal barriers to identification and response to IPV in health settings, three main barriers were identified (Tarzia et al., 2021). Firstly, there was an *unwillingness to interfere* as IPV was viewed as a "private matter," or as interventions were perceived as causing more harm than good. Second,

a *lack of control*, due to not being able to overrule a patient's decision to stay in an abusive relationship or return to an abusive partner, led to feelings of powerlessness, frustration, and resentment. Third, there was a *reluctance to accept the responsibility* of addressing IPV as it was perceived as a social problem rather than a health problem, or as asking about IPV was experienced as opening a "can of worms" or "Pandora's box."

Emotions as an Integral Aspect of Inquiring About IPV

The metaphor of opening Pandora's box is indeed recurrent in research about HCPs' personal attitudes, beliefs, and perceptions regarding a routine-based inquiry about IPV (Gerbert et al., 2002; Lavis et al., 2005; Spangaro et al., 2011; Sugg & Inui, 1992; Tarzia et al., 2021; Williston & Lafreniere, 2013). What significance this metaphor is given in research varies, but it is related to HCPs' perception that inquiring about IPV might lead to disclosures that cause irreversible problems and challenges for HCPs to deal with. In several studies, the use of the metaphor of opening Pandora's box is related to how feelings of fear, discomfort, and inadequacy can serve as barriers to screening for IPV (Gerbert et al., 2002; Lavis et al., 2005; Spangaro et al., 2011; Sugg & Inui, 1992; Williston & Lafreniere, 2013). However, the metaphor of opening "Pandora's box" could be seen as indicative that HCPs are both concerned with protecting themselves emotionally and professionally and protecting their patients emotionally and physically, as inquiring about IPV is perceived as entailing the risk of offending the patient and thereby threatening the HCP-patient relationship or resulting in actions on the patient's part that might further endanger her (Williston & Lafreniere, 2013).

The research presented above indicates that emotions are an integral aspect of understanding HCPs' attitudes, beliefs, and perceptions regarding screening for IPV. Moreover, responding to IPV often requires significant emotional labor (Taylor et al., 2013; Theodosius, 2008). Emotional labor signifies the management of feelings according to certain "feeling rules," that is, socially shared norms regarding what feelings are acceptable and expected in a given social situation (Hochschild, 1983). HCPs, particularly nurses, straddle contradictory norms regarding "empathetic care" and the professional obligation of "detached concern," impacting their emotion management (Hammonds & Cadge, 2014, 2). Research suggests that providing HCPs with proper training in understanding and managing emotions, for example managing frustration and relinquishing control, is of utmost importance when it comes to identifying and responding to IPV (Di Napoli et al., 2020).

Emotions in Organizations

Over the last three decades, there has been a huge surge of scholarly interest in the meaning, function, and importance of emotions in the social sciences and the humanities (Ahmed, 2014; Barbalet, 2004; Fineman, 1993; Hochschild, 2000; Kemper, 1990; Scheff, 1997). The increased scholarly interest in emotions has also involved the study of emotions in organizations (Fineman, 1993, 2007; Hochschild, 2000; Sieben & Wettergren, 2010; Theodosius, 2008). Scholars in the organization research field have

refuted the Weberian idea of the purely rational bureaucratic organization, operating *sine ira ac studio* (without anger or passion), and emphasized the numerous ways in which emotions can be seen as embedded in organizations (Fineman, 2010).

Sieben and Wettergren (2010) address the different forms in which emotion may be relevant to work in organizations by conceptualizing emotions as *antecedents of work* and as *consequences resulting from work tasks*. Emotions as antecedent to work refer to emotions as what drives us or hinders us when we approach work, for example, the joy that motivates us or the fear of or anxiety about a certain task. Emotions as consequences, on the other hand, concern emotions that emerge as a result of work, for example, shame after having failed to live up to expectations or the compassion that is evoked in the meeting with a patient. However, Sieben and Wettergren (2010) highlight that emotions are not always easily distinguished as *either* antecedents *or* consequences of work. They argue that they are best understood as emotional processes that overlap or mutually affect each other. Emotions that result from work might, for example, become integrated into or serve as an antecedent to future behavior.

Fineman (2010, p. 23) argues that a lot of the work that has been carried out regarding emotion in organizations reveals a dominant perspective on emotion as “something that occurs ‘inside’ the person, an experience or ‘competency’ that can individually or with others lead to ‘better’ or ‘worse’ leadership, change, decision making, creativity or some other organizationally related outcome.” This criticism ties into the larger critique that the increased interest of emotions in contemporary society could be viewed as an indication of a psychologization of social life. There is, however, a wide range of sociological theoretical approaches to the study of emotion (Turner & Stets, 2006). By employing a critical perspective that involves an understanding of how power circulates in and around organizations and creates certain emotion ideologies or feeling rules, Fineman (2010) suggests a shift from an individual-psychological perspective to a social-constructionist perspective on the study of emotion in organizations.

Despite there being positive aspects of a purely social-constructionist perspective on emotions, the stance in the present article is closer to Burkitt’s (2002) theorization of emotions as complexes. By making a distinction between *feelings* as pre-discursive drives and guides to action and *emotions* as the ways we articulate certain feelings through available discourse and vocabulary, Burkitt (2002) theorizes emotions as products of *both* the body *and* discourse, and as an active response to a relational context. Burkitt (2002) argues that, even though the self is central to the study of emotion, the nature of emotions is relational. Emotions do not simply arise in isolation within ourselves but in relation to others and in response to particular circumstances and situations.

Aim

Although emotions are an important part of health care, the significance of emotions is rarely recognized in health-care education and practice (McCloughen et al., 2020). In this article, we will demonstrate how a focus on the affective aspects of inquiring about IPV might contribute an important analytical perspective on how HCP respond to IPV.

With an understanding of emotions as embedded in organizations (Fineman, 2010) and as relational (Burkitt, 2002), the aim of this article is to explore the affective aspects of routinely asking questions about IPV in women's health-care services. The article is centered around the question of how emotions impact the implementation of routinely asking questions about IPV.

Materials and Methods

Design and Setting

To identify patients subjected to violence, in 2022 the Swedish government mandated that all health-care organizations must develop routines for asking patients about IPV (HSLF-FS, 2022, p. 39). The data analyzed in this article were collected within the scope of the evaluation of a pilot project concerning the implementation of routinely asking questions about IPV in women's health-care services. As a part of the evaluation study, focus-group interviews were carried out with HCPs working within an obstetric and gynecological setting in a large metropolitan area in Western Sweden.

Participants

The participants were purposively sampled based on the evaluations' overarching purpose: to explore HCPs' attitudes toward and experiences of routinely asking questions about IPV to patients seeking women's health care. Verbal information was personally given by the first author at staff meetings at the two clinics, allowing the HCP to ask questions about the study prior to deciding on participating. Written information was given to the heads of the respective departments, for further distribution to the staff. HCPs who were interested in participating in the focus-group interviews then contacted the first author by email.

A total of seven HCP participated in the two focus-group interviews, with three and four participants, respectively. The participants were divided into groups based on the clinic that they worked in. Traditionally, it has been argued that it is preferable if focus-group participants do not know each other, since preexisting relationships potentially could influence the dynamics and group discussion in a way that negatively impact the results (Smith, 1972). However, preexisting or naturally occurring groups, such as a group of people who work together, may be used when the researcher is interested in observing interactions that are similar to those that occur in everyday life (Kitzinger, 1995). As the study involved both clinic-level and personal-level facilitating and hindering factors in the implementation of routine-based questions about IPV, interactions between colleagues were deemed relevant to observe.

That focus-group members share similar backgrounds and experiences with the other group members is recommended to increase the extent to which the participants feel comfortable expressing their views (Kitzinger, 1995). The participants were demographically relatively homogenous. They were female and between 31 and 44 years old, with a mean age of 38 years. They worked as midwife, registered nurse, and physician. Their work experiences within the setting ranged from 3 to 7 years. At the time of the interviews, the participants had a little over a year's experience of routinely asking questions about IPV.

Data Collection

A semi-structured interview guide with open-ended questions was created. The interview guide was developed deductively, based on research regarding routine-based inquiry about IPV. The overarching themes were attitudes to and experiences and perceptions of routinely asking questions about violence. Questions about both clinic-level and personal-level factors that may facilitate or hinder the implementation were included. There was, moreover, a particular focus on the potentially complex situations, reactions, and emotions that a routine-based inquiry may involve. The overarching themes were broken down into 12 questions encouraging the health-care providers to speak freely about each topic, the data analyzed here were primarily shared in response to questions about experiences and perceptions of the implementation process. Both interviews were performed by the first author in January 2022 and conducted on the hospital premises at a time of the participants' convenience. The duration of the interviews was 70 and 80 minutes, respectively. They were conducted in Swedish, recorded, and transcribed. The quotations have been translated verbatim into English.

Data Analysis

Thematic analysis (TA), a systematic framework for identifying, analyzing, and interpreting patterns of meaning within qualitative data, was employed (Braun & Clarke, 2006). TA is a flexible method allowing for a wide range of applications. In this study, an abductive thematic analysis was conducted. In contrast to inductive and deductive analyses, an abductive analysis allows for an interplay between existing theories and concepts and the empirical data (Thompson, 2022). The thematic analysis was performed using Braun and Clarke (2006) six-phase guide: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining themes, and producing the results. After the initial round of coding, the first author sorted the codes into three overarching themes and 13 tentative subthemes. Both the first and the second author were involved in the remaining phases of the analysis. When reviewing and defining the themes, some of the subthemes were found to overlap and were thus included under a single heading. Other subthemes did not have enough data to support them and were thus removed. After defining the themes, nine subthemes remained. The process of developing and labeling themes was informed by the existing theoretical conceptualization of emotions as antecedents of work, emotions as consequences resulting from work tasks (Sieben & Wettergren, 2010), and emotion management strategies (Hochschild, 1983) (Table 1).

Table 1. Example of codes, subtheme, and theme.

Data extract	Coded for	Subtheme	Theme
You can tell that the mood shifts and that they are affected and sad and then you feel a little guilty for bringing it up	<ul style="list-style-type: none"> • Fear of distressing the patient • Guilt 	Questions about violence evoking emotions of sadness, distress, and guilt	Emotions as consequences of routinely asking about IPV

Ethical Considerations

The study underwent ethical review and approval by the Swedish Ethical Review Authority (reference number 2021-02954). Ethical considerations in research addressing violence against women, particularly studies involving personal experiences of violence and abuse, are paramount to ensuring that the research is conducted in an ethically sound and safe manner (WHO, 2016). Throughout the research process, the ethical defensibility of the study has been a central concern. The ethical considerations included balancing the study's potential benefits against any risks posed to participants. For health-care professionals participating in the study, involvement provided an opportunity to voice their experiences and perspectives on routinely asking about violence. This participation may contribute to enhanced knowledge, which in turn supports the implementation of routine inquiry into violence, a practice that benefits both health-care personnel and patients.

Both written and verbal information provided to participants clearly outlined contact options for those requiring support during or after their involvement in the study. Informed consent was obtained from all participants prior to the interview.

A Note on Terms

In the article, we use the concept of screening as well as the concept of routinely asking questions. According to WHO (2013), screening for violence is a systematic procedure in a wider population. The present study is, however, conducted in a smaller and specific context, and it is thus, according to Taket et al. (2003), more correct to use the label "routinely asked questions" or "routine inquiry." Another factor is that it is more common in Sweden to use the concept of "routinely asking questions" compared to "screening" when researching violence against women, as screening is defined as a method for identification of unrecognized disease in a seemingly healthy population (Engdahl & Rosenqvist, 2021). With that in mind, we are using the concept of routinely asking questions when presenting the results of the study. The concept of screening is used primarily when referring to other studies in the background section, and in the "Discussion" section.

Results

The findings regarding how emotions impacted the implementation of routinely asking questions about violence are presented under three headings consistent with the overarching themes that were generated in the analysis: emotions as antecedents of routinely asking about IPV, emotions as consequences of routinely asking about IPV, and strategies to manage emotions. See Table 2 for themes and subthemes.

Emotions as Antecedents of Routinely Asking About IPV

The emotional turn in social sciences has entailed a shift from the understanding of emotions as irrelevant to the study of organizations to emotions as an integral aspect of organizational life (Fineman, 2010). Sieben and Wettergren (2010) theorize emotions

Table 2. Themes and subthemes.

Themes		
Emotions as antecedents of routinely asking about IPV	Emotions as consequences of routinely asking about IPV	Strategies to manage emotions
Subthemes		
Apprehension before implementation	Questions about violence evoking emotions of sadness, distress, and guilt	Defining one's area of responsibility and setting boundaries
Lack of protocol producing emotions of uncertainty and discomfort		Asking and asking again
Timing—taking the patient's emotional state into account	“Strange feelings” and discomfort—emotional contagion or projected emotions? Certain situations evoking feelings of uncertainty and helplessness	Seeking support from colleagues and management

antecedent to work as emotions that drive us or hinder us when we approach different work tasks. In the focus-group interviews, several aspects arose of how emotions affected the perception of, and the approach to, the task of routinely asking about IPV.

Apprehension Before Implementation

A routine inquiry was implemented as a result of the clinics' involvement in the previously mentioned pilot project. The HCPs at the clinics first went through a training course in which they were trained in basic knowledge about identifying, routinely asking questions about, and responding to IPV in a clinical practice setting, and they were introduced to the method and material for routine inquiry. One of the most frequently expressed emotions in the initial phase of the project was apprehension. One of the informants spoke of her initial thoughts and emotions in these terms:

We will receive so much information! What are we supposed to do with it? All the life stories that you are expected to process. They [the instructors of the training course] informed us about different scenarios, about what is okay and what is not, and about what some women experience and how prevalent it is. My thoughts were: “I guess we are turning into counselors now?” (HCP#1)

The HCPs' apprehension regarding asking questions about IPV was related both to the fear of being overwhelmed by stories about violence and to the fear of transgressing professional boundaries and having to operate outside of one's professional expertise. Being introduced to a new field of knowledge and practice, with the expectation of incorporating it into one's day-to-day work, was initially perceived as intimidating. IPV was viewed as a particularly sensitive topic and a multifaceted problem requiring different fields of expertise. Even though all the participants expressed that they found facilitating disclosure and responding to IPV an important task for HCPs, apprehension regarding what this would entail and how it would impact on their working conditions was pervasive.

Lack of Protocol Producing Emotions of Uncertainty and Discomfort

Once the implementation had commenced, the HCPs at one of the clinics found that their initial apprehension decreased, while at the other clinic the apprehension largely prevailed. The participants in the focus group interview still expressed feelings of, if not apprehension, at least uncertainty and discomfort related to routinely asking about IPV. The factor described as producing most discomfort was the lack of a clear

protocol, i.e., an agreed, standardized way of how to proceed if a patient responds positively to questions about IPV.

If you receive a response where the person speaks about ongoing violence, you must be able to deal with it. You might have another patient scheduled to come within five minutes. What do you do with that response then? You're supposed to be able to refer the person to someone who can help her and take care of her and let her know where to go. I feel like we are lacking that. I don't know if there is any. (HCP#4)

There was a shared sentiment among the focus-group participants that the lack of protocol regarding how to proceed if a patient responded positively to questions about IPV impeded the implementation process. The way the HCPs spoke about the lack of protocol, and the emotions of uncertainty and discomfort that were evoked in the face of having to ask questions about IPV, was mirrored in what the HCPs at the other clinic spoke of as having decreased their initial feeling of apprehension. A clear protocol regarding how to respond and who to refer to was described as the main factor in allowing the staff to overcome the fear of asking questions about violence.

That was everybody's initial fear: "What do I do if I get a positive response?" It was super scary initially! But now we have a good protocol and great counsellors to cooperate with. (HCP#1)

While apprehension emerged as an antecedent of routinely asking questions about violence at both clinics, clinic-level organizational factors, in the form of whether the implementation was facilitated by creating a protocol for the procedure or not, appeared as crucial in determining whether these emotions prevailed. A clear protocol, detailing how to proceed in a situation where a patient responds positively, was perceived as helpful in overcoming initial feelings of fear, discomfort, and uncertainty. In contrast, a lack of such a protocol entailed the risk of hampering the implementation. Negative emotions linked to the implementation were thus not primarily a result of the individual HCP's attitude and preconceptions about routinely asking questions about IPV but were rather embedded in the specific organizational context.

Timing: Taking the Patient's Emotional State Into Account

With an understanding of emotions as relational—meaning emotions as not simply arising in isolation within ourselves but in relation to and as a response to others—it is relevant to not only address the HCPs' emotions but also the perceived emotions of the patients and how they may function as antecedents of routinely asking questions about IPV. The main way that this was addressed in the interviews was by how the participants described adhering to, or adjusting their approach in relation to, the perceived emotional state of the patient. At one of the clinics, there were both planned admissions and emergency admissions. The participants spoke of how different circumstances related to whether it was a planned admission or an emergency-care patient affected the timing, how they perceived and the way they approached routinely asking questions.

Many are rather stressed and worried when they get here. It can result in them being very anxious and agitated. I mean very contentious, and then it's really hard to ask those questions. ... That's why I really appreciate that we do it [routinely ask questions about IPV]

during the admission process. Then you have time to build trust with the patient. We meet them several times during the day, so we have the chance to gain their trust. When you have emergency-care patients, then you must attempt to build that trust quickly and often you do, but sometimes there is a clash in the personal chemistry and then you might feel like you can't, or don't want to, ask those questions. (HCP#1)

The participant touches on how the patient's emotions also can serve as an antecedent to routinely asking questions about IPV. The patient's emotional state affected how the HCPs felt and their inclination to ask the questions routinely. There was a perceived difference between the planned admissions, where there was a clear protocol regarding when to inquire and more time to build trust, and the emergency admission, where there were less favorable conditions when it came to establishing trust and no clear protocol. As a result, the emergency-care patients were rarely asked about IPV. How asking questions about IPV was perceived and how the HCP felt about implementing a routine inquiry were thus not only dependent on the larger clinical setting but also differed depending on the particular circumstance and situation in which questions were to be asked.

Emotions as Consequences of Routinely Asking About IPV

Emotions arise in response to something, they are influenced by interpersonal relationships and social situations. Apart from emotions as antecedents of routinely asking questions about IPV, several aspects regarding how emotions arose as a consequence or result of the routine inquiry emerged in the data. These aspects involved both the HCPs' and the patients' perceived emotions and how these were interrelated, actualizing the interactive nature of emotions and their at times unconscious character.

Questions About Violence Evoking Emotions of Sadness, Distress, and Guilt

Regarding emotions as a consequence or result of routinely asking questions, one concern that was brought up in the interviews pertained to how questions about violence at times were perceived as evoking emotions of sadness and distress in the patient, causing HCPs to feel both uncomfortable and guilty.

You almost want to apologize: "I'm sorry if I made you sad and distressed." You must try to sit with it, but it can be hard at times. (HCP#3)

The fear of upsetting the patient or making her sad was not spoken of as a deterrent to routinely asking questions about IPV, but as something that may cause feelings of discomfort and guilt. Having to sit with, i.e., to accept and allow for, difficult emotions that arise as a result of asking questions about IPV was a recurring theme in the interviews. Questions about violence were perceived as sensitive as they were seen as an intrusion into the private sphere, into deeply personal experiences, and as they potentially could trigger negative emotions in the patient as well as in the HCP.

“Strange Feelings” and Discomfort: Emotional Contagion or Projected Emotions?

Another aspect of emotions as consequences that emerged was that of emotional contagion and the projection of emotions as a consequence of routinely asking questions about IPV. In one of the focus-group interviews there was a consensus regarding the fact that routine inquiry about IPV involved the risk of causing “strange feelings” and discomfort. As this was elaborated on during the interview, it became clear that there was an uncertainty regarding whether this concerned emotional contagion—that the HCP’s feeling of discomfort spread to the patient—or was a case of projection, where the HCP’s own feelings of discomfort were attributed to the patient. In the following extracts, both these themes were addressed as a possibility.

You don’t really have the time to do it, and it turns into a strange situation. The whole situation feels contrived, and it creates strange feelings in the room. (HCP#4)

I feel like it alters the dynamic in the room slightly. Maybe it’s related to your own pre-conceived ideas about how that person will feel about being asked, and your own feelings about asking. However, my experience is that something alters, and it is not entirely comfortable. (HCP#5)

The participants found it hard to distinguish whether it is the HCP’s own feelings of discomfort that are projected onto the patient or if the patient actually feels uncomfortable. Another way to understand this is that the perceived discomfort experienced by the patient is a result of emotional contagion. As the HCP is uncomfortable in the situation, the patient will feel uncomfortable too. In interactions between people, emotions collide, mutually impact and bounce off each other, creating new emotional states. Just as it might be difficult at times to draw a clear line between emotions as antecedents of work tasks and emotions as consequences of work tasks, it is difficult to draw a clear line between the HCP’s emotions and the patient’s emotions. When HCP perceive questions about violence as sensitive and potentially harmful to the patient, their feeling of discomfort may be projected onto the patient.

In the quotation above, it also becomes clear how organizational factors, like the time available for each visit, impact the way the HCPs feel about routinely asking questions about IPV. The participants’ desire to facilitate disclosure of IPV was not only compromised by the fear of intruding into the private sphere of the patient but also by organizational constraints. Growing workloads and cost-reduction measures designed to streamline their work evoked feelings of frustration and ethical stress. This indicates that the personal barriers in the form of attitudes, beliefs, and perceptions regarding routinely asking questions about IPV partially were related, rather than separated from, organizational barriers.

Certain Situations Evoking Feelings of Uncertainty and Helplessness

Some of the participants spoke of having been in particular situations where there had been concerns regarding ongoing violence but where those concerns were not confirmed by the patient. In these situations, the participants spoke of being left with a sense of responsibility due to having observed something that might be an indication of ongoing violence but being unable to act on it due to the patient’s response. This left the HCP with feelings of uncertainty and helplessness.

It was an emergency-care patient: I don't remember if she was asked, but I know that we talked about it later. She was here due to pregnancy nausea, and she wanted to terminate her pregnancy but she didn't dare to tell her husband. I don't remember if she spoke Swedish, but there were a lot of concerns regarding how to make it work practically for her. (HCP#4)

You never know, maybe he [the husband] wasn't [abusing her], but it was difficult. (HCP#6)

Routinely asking questions about violence increased the awareness of violence more generally, and cases in which there was a suspicion of violence that was not confirmed were described as particularly difficult emotionally. Having observed something that had raised concern entailed a sense of responsibility. Then having to let the patient leave without knowing whether it would be safe for her to return home or not was perceived as problematic and emotionally taxing.

Strategies to Manage Emotions

Identifying and responding to women subjected to IPV can take a personal toll on HCP. As has been shown, the participants spoke of how inquiring about IPV involved not only antecedent emotions of apprehension, fear, and discomfort, but also consequences in the form of sadness, distress, worry, helplessness, and guilt. Another overarching theme that emerged in the data concerned managing these emotions. Some of the ways to manage emotions were explicitly spoken of as strategies, while others were not. The emotion management also actualized different and sometimes contradictory feeling rules, i.e., norms that dictated what feelings were acceptable in the particular organizational and social context that the HCPs operated in.

Defining One's Area of Responsibility and Setting Boundaries

Defining their area of responsibility and setting boundaries was one of the main strategies that the HCPs explicitly spoke of as a way to manage emotions.

In the beginning I know that many were worried. Will I have to deal with this and follow up? You felt a huge responsibility in relation to asking these questions. But then we had to tone it down a little. Our responsibility is to ask the questions and acknowledge it. It's not our responsibility to look into it. That's when we ask the counsellors to step in. I think it took a while before we understood where our boundaries lie. (HCP#2)

Yes, our area of responsibility. (HCP#3)

Exactly! Where our responsibility ends. Otherwise, it can turn into this huge thing. You feel like you have the world on your shoulders, and because of that you are afraid to ask. (HCP#2)

In order to handle the perceived complex and multifaceted issue of IPV, the HCP made sense of their responsibility as limited to facilitate disclosure, in this way feelings of fear were managed. The importance of setting boundaries was a recurring topic in the interviews. In one of the focus groups, this was related to a wider experience connected to the conditions for the nursing profession.

Speaking of feelings of inadequacy, it does not only concern this topic. I think that many nurses feel like they want to sort everything out for the patient, their whole life. Or not that you want to, but you feel such a sense of responsibility. (HCP#1)

Being able to define one's area of responsibility and set boundaries was spoken of as a central aspect of managing emotions, and this entailed collaborating with other professionals with different areas of expertise and responsibility. Defining one's area of responsibility enabled the HCPs to move from emotional engagement to a certain degree of emotional detachment. This emotion management strategy was described as important not only when it comes to routinely asking questions about IPV but in general, due to the complex and emotionally demanding nature of nursing. Feeling rules are hidden and invisible while still acting like pre-scripts to action. However, if we are evaluating our feelings or emotional state, a feeling rule is active. The quotations above speak of the contradiction between the professional norm of detached concern and the feeling of wanting to "sort everything out" for the patient. Even though the initial feelings of fear and anxiety were partially managed by resorting to defining one's area of responsibility and setting boundaries, there were still feelings of inadequacy that had to be managed.

Asking and Asking Again

As mentioned previously, the focus-group participants spoke of situations where the HCPs had a suspicion of ongoing violence that was not confirmed by the patient. These situations were described as particularly difficult, as they left the HCPs with feelings of uncertainty, frustration, and helplessness. One of the participants spoke of a strategy that was employed to manage these situations and the emotions that they evoked.

If their response [to the question of whether they have been subjected to IPV] is no, but there still is a concern, I often try to arrange some sort of revisit to be able to follow up on the feeling I have. Then you have to ask again, in a different way. ... Of course, you can't keep on coming up with reasons to schedule new appointments just because you're worried. If there's no positive response, you must let it go and hope that it still had some sort of impact on that woman. (HCP#4)

Coming up with reasons to schedule a new appointment, the HCP attempted to escape the feelings of worry and helplessness by acting and creating the possibility to ask the patient about IPV again. Even though this strategy was not always successful in facilitating disclosure, it alleviated some of the feelings of frustration and entailed the hope that maybe, down the line, it would make a difference.

Seeking Support from Colleagues and Management

The organizational and social contexts that the HCP worked in had particular feeling rules that dictated whether certain emotions were appropriate to express or not. To appear as professional subjects, the HCPs had to manage their emotions by suppressing fear, discomfort, and worry during interactions with patients. By being able to discuss certain situations and difficulties that arose in the process of implementing routinely asking questions about IPV with colleagues and management, the management of emotions was facilitated.

I would definitely say that there is [support from management and colleagues]. Our manager is very open to having those conversations and we can talk to each other as well ... And then there are the counsellors, we've had debriefing sessions with them in the past. (HCP#1)

The HCPs' emotion management was not simply a reactive process, it was partially strategical and linked to their goals to develop their professional identity and personal resources. The participants spoke both of informal practices and of more formal debriefing, led by experienced clinicians or by management, as central to managing emotions in a constructive way. By being able to process emotions and thoughts in relation to routinely asking questions about IPV, and by receiving support and encouragement from each other, the implementation process was facilitated.

Discussion

In this article, we have addressed the affective aspects of screening for IPV. We have argued that these aspects constitute an integral part in understanding how HCPs respond to IPV. While previous research indicates that HCP's emotions regarding screening practices serve as an influencing factor (Alvarez et al., 2017; Pagels et al., 2015; Tower, 2006; Williston & Lafreniere, 2013), there is little previous research that has systematically considered the role of emotions in inquiring about IPV. Emotions, previously viewed as incalculable, irrational, and unruly, and thus the antithesis to the idea of the purely rational bureaucratic organization, are now more or less universally recognized as essential in informing, shaping, and reflecting organizational realities (Sieben & Wettergren, 2010). Understanding the role of emotions in the functioning of health-care organizations has been demonstrated to improve effective management and create an organizational environment that supports and facilitates care (Smith & Allan, 2010).

The findings of the study show how emotions serve as an antecedent to routinely asking questions about violence. The HCPs' apprehension regarding asking questions about IPV resonates with what in other scholarly work has been spoken of as the fear of opening Pandora's box (Gerbert et al., 2002; Lavis et al., 2005; Spangaro et al., 2011; Sugg & Inui, 1992; Tarzia et al., 2021; Williston & Lafreniere, 2013). Routinely asking questions about IPV evoked concerns regarding what kind of stories of suffering and violence this could unleash, and how this would affect the HCP. The findings also show that these emotions did not emerge in isolation within the individual but were affected by the organizational context. Organizational troubles, such as time constraints and lack of protocol, became personal troubles for HCPs, impacting their willingness and ability to implement a routine inquiry. With an understanding of emotions as embedded in organizations (Sieben & Wettergren, 2010), HCPs' attitudes to and perceptions of routinely asking questions about and responding to IPV have to be understood in relation to the clinical setting and the larger organizational context. This partially troubles the categorization of hindering factors in clinic-level and personal-level barriers that is often made in research.

On a more general level, negative effects of New Public Management—such as the intensification of clinical work, entailing limited time to provide care, increased managerial control, and measures that circumscribe professional autonomy—have been shown to increase job dissatisfaction, psychological strain, and emotional labor among HCPs (Willis et al., 2016). While such negative effects were part of the organizational reality that the HCPs grappled with, the empirical data indicate that highly engaged

clinic-level management and a clear protocol can serve as a buffer against certain stressors related to implementing a routine inquiry about IPV. Even though HCPs at both clinics spoke of how feelings of apprehension emerged as an antecedent of routinely asking questions about violence, the findings indicate that a clear protocol on how to proceed in a situation when a patient responds positively served as a facilitating factor in overcoming initial feelings of fear, discomfort, and uncertainty. A lack of protocol, on the other hand, entailed the risk of hampering the implementation. These findings are corroborated by previous research in which clinic-level protocols, detailing how to screen and respond, including resources for victims, are addressed as a key facilitating factor (Allen et al., 2012; Borowsky & Ireland, 2002; Gerbert et al., 2002). While one of the clinics lacked a clear referral system for victims, the other clinic had a close collaboration with the hospital's counseling team, facilitating routinely asking about and responding to IPV. In reviewing successful screening programs, researchers have highlighted on-site availability of staff that can support victims as an important factor (O'Campo et al., 2011). Altogether, these findings show that, when there is a lack of organizational support for appropriate implementation, the work of routinely asking questions about IPV, added to an already busy clinical practice, can easily overwhelm HCPs.

Emotions did not only emerge as antecedents of routinely asking questions about IPV; the HCPs also spoke of several aspects regarding how emotions arose as a consequence or result of the routine inquiry. These aspects involved both the HCPs' and the patients' perceived emotions. Questions about violence at times evoked sadness and distress in patients, causing HCPs to feel both uncomfortable and guilty. Some of the participants spoke of having been in particular situations where there had been concerns regarding ongoing violence that were not confirmed by the patient, leaving the HCP with feelings of uncertainty and helplessness. Patients' perceived emotions, and how they influenced how routinely asking questions was experienced, was a recurring topic in the interviews. At times, the participants found it hard to distinguish whether it was their own feelings of discomfort that were projected onto the patient, or if the patient herself was feeling uncomfortable. Perceived discomfort could also be understood as a result of emotional contagion—as the HCP is uncomfortable, the patient will feel uncomfortable too. Previous research involves both conscious and subconscious emotional processes regarding inquiring about IPV (Bradbury-Jones & Taylor, 2013). Theodosius (2006) argues that it is important to understand emotions as interactive, relational, and conscious as well as unconscious. Apart from understanding how emotions are embedded in organizations, it is thus important to consider how emotions, conscious as well as unconscious, arise in relation and response to others. Research indicates that women are comfortable disclosing IPV to a HCP under the conditions that they feel safe and free from judgment (Feder et al., 2006; García-Moreno et al., 2015). A lack of positive relationship with the HCP, or the HCP appearing disinterested, could serve as a barrier against disclosure of IPV (Heron & Eisma, 2021). The interaction between the HCP and the patient, and the emotions that are evoked as a part of it, can thus, if not properly managed, impact how the care is perceived by the patient and hamper IPV disclosure.

Previous research shows that HCPs tend to find addressing issues of IPV emotionally demanding and personally challenging (Goldblatt, 2009; Henriksen et al., 2017; Sundborg

et al., 2017). Routinely asking questions about IPV entailed monitoring, evaluating, and modifying one's emotions to accomplish work-related goals (Hochschild, 1983). The emotion management strategies that the HCPs developed spoke of the somewhat contradictory feeling rules that nurses are trained to embody. Hammonds and Cadge (2014) address the fact that nurses simultaneously have to adhere to the cultural imperatives of empathetic care and the professional norms of detached concern. Straddling these potentially conflicting norms, the HCPs spoke of the importance of defining their area of responsibility and setting boundaries. This involved the struggle to achieve a balance between emotional detachment and emotional engagement. Research shows how neoliberal governance, in the form of work intensification and resource depletion in the public sector, generates conflicts between caring and efficiency demands (Selberg, 2013). In the data, self-monitoring and self-sanctioning, in not operating out of a sense of wanting to "sort everything out for the patient" but rather defining one's area of responsibility, emerged as important means in mastering the feeling rules of efficiency and detached concern. Another emotion management strategy that was addressed was to seek support from colleagues and management. The participants spoke both of informal practices and of more formal debriefing, led by experienced clinicians or by management, as central to managing emotions. While previous research indicates that HCPs develop different emotion management strategies when working with victims of IPV, there are few studies that mention any formal supervision or debrief (Bradbury-Jones & Taylor, 2013). Hayward and Tuckey (2011) argue that, despite hospitals being emotionally intense workplaces and despite the fact that working as an HCP often entails both managing one's own emotions and anticipating and influencing the emotions of others, emotion management, as a work task requiring knowledge and skills, is often obscured. Hochschild (1983) addresses that women more often are employed commercially for emotion work than men. Emotion work is traditionally seen as women's work and not treated as actual work but seen as a natural characteristic or competency of women. There are thus gendered aspects to why emotions and emotion management in relation to identifying and responding to IPV are marginalized in health-care practice and education (Smith & Allen 2010). The lack of recognition of the importance of organizational support to manage complex emotions is problematic both from a feminist and an organizational perspective, as dysfunctional emotion management strategies and emotional dissonance can have adverse effects for the individual, the group, and the organization as a whole (Smith & Allan, 2010).

Even though IPV is acknowledged as a violent act against women's rights as well as a major public health issue, the present health-care response is inadequate, and screening rates have been shown to be consistently low (Alvarez et al., 2017; Tower, 2006). Increased education and training regarding IPV has been deemed necessary in order to address perceptions and attitudes and remove barriers that hinder screening by HCPs (Sprague et al., 2012). However, in their systematic review of influencing factors on screening practices regarding IPV, Alvarez et al. (2017) conclude that training courses alone are not enough to improve screening rates. They argue that there is a need to address the multilevel factors influencing these practices. We contend that one of these factors is the affective aspects of screening for IPV. The findings of the

present study show the importance of the role of emotions being viewed as integral to any effort to improve screening practices for IPV.

Methodological Considerations

Credibility, transferability, and dependability have been addressed during the scientific process, in order to ensure rigor and achieve trustworthiness (Guba & Lincoln, 1989). The methodical description of the design and method enriched the credibility of the results. The thorough description of the setting, as well as the presentation of participants and quotations from the interviews, also contributes to the credibility of the study results. The variety of work experiences and health-care settings among the participants increases the opportunity to elucidate the research question from different aspects, which, in turn, increases transferability (Polit & Beck, 2014). To achieve dependability, an interview guide was used during the interviews.

The demographics and reflexivity of the interviewer were considered throughout the research process to ensure methodological rigor. In this study, the interviewer's professional familiarity with the subject matter likely fostered a rapport with participants, enabling them to share their experiences in greater depth. To address potential biases stemming from the researchers' prior knowledge of affective aspects of screening for violence, the analysis process was deliberately paced to allow for reflection and openness to emerging patterns in the data. By maintaining an awareness of preconceptions, the interviewer worked to minimize their influence on the findings, striving to ensure impartiality and a clear representation of the data. Even so, by acknowledging and addressing these dynamics, the study aims to provide a nuanced and credible contribution to the understanding about affective aspects of screening for intimate partner violence.

Limitations

There are several limitations to this study. The study was carried out in one region in Western Sweden. This calls for a critical reflection regarding the interpretation and transferability of findings to different contexts and countries. HCPs do not operate in a cultural and social vacuum but are influenced by broader ideologies and social norms. Over the last few decades, men's violence against women and IPV have become political issues that largely have been addressed from a feminist and public health perspective in Sweden. A recent review on practitioners' readiness to address IPV suggested that when HCPs are motivated by a broader ideological framework they may be more likely to have a commitment to addressing IPV (Hegarty et al., 2020). There is, moreover, a requirement from the Regional Council in the region in question that all HCPs must receive training regarding IPV and routine inquiry. Routinely asking questions about IPV has been implemented in a number of health-care areas in the region. There was a consensus regarding the identification of victims of IPV as an important task for the health-care system among the participants, which likely impacted their attitude and approach to the routine inquiry.

Another limitation is that, although the intention was to attract a representative sample of registered nurses, midwives, and physicians, we were mostly able to recruit nurses and midwives. All the participants were, moreover, women. The responsibility to identify and respond to IPV is often attributed to professions that are predominated by women, such as nurses and midwives. The participants' demographics in terms of gender and professional roles may be understood as a reflection of this bias. This entails that the study findings may have to be interpreted cautiously regarding their pertinence to physicians' practice. Another possible limitation is the number of participants, even though Malterud et al. (2016) highlight that a small number of informants is justified when the interviews contribute to a rich material.

Conclusion

Based on the study findings, we argue that the role of emotions should be viewed as integral to any effort to improve screening practices for IPV. Emotions serve as both antecedents and consequences of routinely asking questions about IPV and can facilitate as well as hinder the implementation. The increased scholarly interest in emotions has been criticized as an indication of a psychologization of social life. Following other social constructionist scholars, we argue that the empirical study and theorization of emotions can provide important links between different levels of social reality. The findings illustrate how emotions arise in response to the clinical setting and the organizational context. When there is a lack of organizational support for appropriate implementation, the work of routinely asking questions about IPV, added to a neoliberally governed, streamlined clinical practice, can become overwhelming. A clear protocol and a clear referral system appear to be key factors in facilitating the implementation, and creating a buffer against certain stressors, of routinely asking questions about IPV. The results also indicate that, although training is an important factor, there are multiple factors that affect the outcome of the implementation. Affective aspects of screening for IPV should be addressed in training courses. However, training courses alone do not suffice. It is crucial for healthcare managers to support their staff and provide continuous support regarding real-time challenges and barriers to routine inquiry. One such challenge concerns emotion management, a work task that tends to be implicit rather than explicit in practice. It is important to incorporate academic and practice-focused interventions for building knowledge and skills aimed at effective emotion management. One way to do this is to implement formal debriefing in the clinical setting to offer a structured environment in which to address difficulties and support adequate emotion management strategies in relation to routinely asking questions about IPV.

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Data Availability Statement

The participants of this study did not give written consent for their data to be shared publicly; supporting data is thus not available.

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