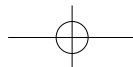


Eastern Wakefield **NHS**
Primary Care Trust





Eastern Wakefield 
Primary Care Trust

Exploring the health service response to women experiencing domestic violence in Wakefield: adopting a discursive approach

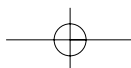
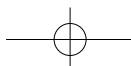
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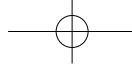
Report prepared for Eastern Wakefield Primary Care Trust



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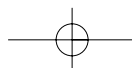
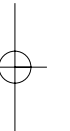
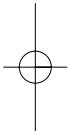


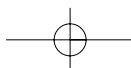
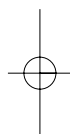
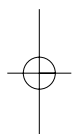
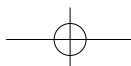


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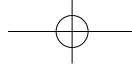
We would like to acknowledge the staff within the Eastern Wakefield Primary Care Trust for all the support and resources that they made available. In particular we acknowledge the public health team for their friendship and support through the research. We would like to offer special thanks to Val Barker, Director of Public Health, EWPCT, and Rachel Payling, Senior Public Health Manager, EWPCT, for their good humour, encouragement and support. Our thanks extend particularly to Hilary Spencer and Helen Cox, whose advice and guidance was invaluable in assisting us in developing networks with health professionals.



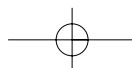
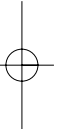


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Executive summary

This report presents the findings of a research study exploring the health service response to domestic violence within Wakefield. Recent international, national and local research has identified domestic violence as a serious health care issue resulting in a wide range of long and short term health implications for women¹ (Butler, 1995; Stark and Flitcraft, 1995, 1996; Campbell, 2002). The research highlights the changing face of domestic violence considering the implications of the recent reframing of domestic violence from a social care issue into an *integrated* health and social care issue (Glendinning, 2003). Explored is the impact of such changes for health policy makers, health professionals and women who having experienced domestic violence then access health care services in the District.

The research takes a critical approach to the medical model of care. Medicine has a very specific set of social practices that, to a large extent, determine the health service response to issues such as domestic violence (Foucault, 1979;1990; Lupton, 1997). The social practices of the medical model are argued to be initiated and maintained by what is referred to as the 'dominant medical discourse' (see for example Waitzkin and Britt, 1989, and Warshaw, 1989, 1993, 1997). The term discourse can be understood to refer to ways of talking about issues, institutions professions, etc. that then frame our everyday understandings and social practices. For example the use of the words 'patient' and 'doctor' make possible a whole set of social practices that frame the patient as in need of care and the doctor as powerful expert. Indeed, it has been shown that health professionals' responses to women presenting with health issues relating to domestic violence tend to be set within a medical framework, of for example, diagnosis and cure (Waitzkin and Britt, 1989). Yet, the causes of domestic violence are set within the social domain and thus the medical model, and its social practices, is often revealed to be highly restrictive (Warshaw, 1989, 1993, 1997).

The research, which is qualitative by design, employs a Foucauldian discursive approach (FDA) which is located within a broad movement in the social sciences often referred to as the 'turn to language' (Willig, 2001). Rather than viewing language as a means of representing or describing reality, such approaches view language as active and productive, creating different ways of viewing and living in the world (Alvesson, 2002). FDA focuses on exploring the relationship between language, the knowledges which inform it (for example the medical model) and relative power relationships. These power relationships will have implications for how health professionals perform their role and how women respond when interacting with health services.

¹ See page 13 of this report for more detailed information about the long and short term implication of domestic violence for health.

1.1 Aims

By adopting a critical approach to exploring domestic violence, this research aimed to investigate the ways in which domestic violence is understood and talked about in healthcare and the impact of this on policy makers, health professionals and women accessing services.

More specifically the research aimed to:

- gain an understanding of the discourses and practices of responding to domestic violence within the two PCTs services,
- explore the ways of being or taking action made available to policy makers, health professionals and women through those discourses,
- gain an understanding of the discourses which women draw upon to make meaning of their experience of health professionals' response to them, and
- seek to identify the ways of being or taking action that these discourses make available to women.

1.2 Methods

The research primarily takes a qualitative approach to data collection and analysis. Here the emphasis is on gaining a detailed appreciation of discursive practices – the discourses used and how these impact upon health service delivery. Therefore this language based and power/knowledge approach informed the data collection and analysis process.

There was a three stage data collection process:

- semi-structured discursive interviews with eight 'key informants' at the PCT. Participants included both policy makers and health professionals,
- a postal questionnaire was distributed to all primary care health professionals in the District², and
- in-depth, discursive interviews were undertaken with five women services users.

The interview data from women and key informants was collected through a range of different interview schedules whose development was influenced by the discursive approach, the research aims and the needs and requirements of the participants.

² It should be noted that this report does not contain the findings of the questionnaire sent to health care professionals. These findings are contained in a separate report which illustrates the level of training amongst health professionals, rates of routine and selective enquiry and likelihood of different practices of responding.

When aiming to explore the use of discourse the researcher's main task is to enable the informant to give as individual and unrestricted account of their views, perspectives and experiences of events as possible. The researcher thus tries to limit their influence over the informant's account by making decisions about how many and what type of questions may be asked of different informants at different stages of the research. The early interviews with key informants at the PCT followed a semi-structured format, aiming to elicit their views and perspectives about domestic violence within health (see appendix 1a). The interview schedule used with health professionals also followed a semi-structured format but was more flexible, enabling informants to talk about their experience of events of responding in addition to their more general views and perspectives (see appendix 1b). The final interviews, with women were of a more unstructured nature enabling the collection of in-depth experiential accounts (see appendix 1c).

The interviews were all analysed using an integrated approach to Foucauldian Discourse Analysis outlined by Willig (1999;2001). This six stage approach enables the researcher to explore the ways in which a discursive object, such as domestic violence, is being constructed within the text. The next stage is to attempt to identify the wider discourses from which these ways of talking are drawn. In the case of this research for example, framing responding to domestic violence as 'diagnosis' might be considered to arise from the wider 'medical discourse'. This is followed by an exploration of the 'functions' the different constructions of domestic violence serve. The process of analysis then extends to consider the implications these discourses have for the ways in which people can speak or act. This is where the analysis of power relationships between different ways of speaking and acting takes place. The final stage of analysis draws together the analyses from the earlier stages to explore the impact of the discourses identified for the speaker's subjectivity; that is the way in which those speaking feel, think and experience the health service response to domestic violence.

1.3 Findings

1.3.1 Impact of the medical discourse

Medicine can be understood to be a powerful institution (Foucault, 1979, 1990; Lupton, 1997). As such it holds great power, able to proclaim truth about issues in social life, such as domestic violence. This is visible in the practices of classification and diagnosis through which issues become medicalised. However, despite its power, medicine and its ways of talking about such issues represent only one way of understanding. What this research has illustrated is that some issues which have become medicalised, like domestic violence, have complex social roots which may become obscured or minimised through this process

This research showed that the medical discourse has a dominant influence on the ways in which domestic violence is understood and responded to in the District.

Whilst the dominance of the medical discourse might be expected to some degree its influence on the District's services and practices appears to be overpowering. It impacts by hiding alternate ways of understanding and responding to domestic violence which are available in the District and are identifiable in the talk of some policy makers and health professionals.

At a strategic level, the influence of the medical discourse appeared most evident in the framing of domestic violence as 'excluded' and not a 'direct' health service, being devoid of the necessary criteria for membership, that of 'targets'. Moreover, whilst domestic violence is identified as a health care issue at a national level through policy publications (DOH, 2000a, 200b) at a local level its status appears less visible and less acknowledged.

The implication of the current status of domestic violence at a local level is that some possible avenues of action for responding are unavailable. At a strategic level this would seem evident in the lack of a District policy for domestic violence and in the lack of its embeddedness in health strategy, reliant on 'champions' to fight its cause.

At a healthcare interaction level the influence of the medical discourse was conveyed through women's talk of having their experience 're-framed' by health professionals, by filtering it through the medical discourse.

The implications of the medical re-framing of women's accounts are that women experience their complex needs being reduced or minimised to a diagnosis for which a practical intervention can be prescribed. In turn this is experienced as patronising, minimising and in certain instances as making things worse.

The influence of the medical discourse was also evident in women's accounts of disclosing and talking about their experiences of violence. The debate about routine enquiry for domestic violence and the body of research literature which supports this practice indicates that women do not mind being asked by health professionals about domestic violence (Watts, 2000;2002). Moreover, a growing body of research literature suggests that women who experience domestic violence may be waiting for health professionals to ask them about domestic violence (Drake, 1982). In light of this dominant knowledge it would seem crucial to consider in more detail the relationship between telling and re-telling and the subtlety required when asking women about domestic violence.

Within this research, when questioned from the medical discourse, women experienced being 'required' to tell and in some cases tell repeatedly, a practice which they framed as distressing and to be resisted. In contrast when questioning arose outside of the medical discourse, for example through practices illustrating concern for women's wider welfare, women framed this as desirable and helpful.

1.3.2 Positive practices of responding

Positive practices of responding to domestic violence were highlighted by both women and health professionals, although these tended to arise from discourses other than medicine.

These practices of responding were framed as enabling a more effective response to women and were clearly linked to training and support which were highlighted as turning points in influencing practice.

Practices of responding informed by wider, socially and culturally available discourses, such as discourses of empowerment, respect and autonomy were also framed by women as helpful and enabling.

Amongst the key practices framed by women and health professionals as effective responses, were listening, encouraging, supporting, empathising, expressing concern for women's wider welfare and facilitating women's own action.

Women noted that practices which enabled them to take a more active role in considering possible interventions and actively engaging in decision making about health care were valued. This appears to illustrate women's requirements for empowerment within the health care interaction. This would seem to allude to the recommendation by Heath (2003:319) in the guidelines issued for responding to domestic violence by the Royal College of General Practitioners, that in order to move towards a more helpful response there needs to be an *'increasing partnership of experts' within general practice allowing empowerment of the patient*.

Figure one illustrates a comparison of the different roles and possibilities for action made available to women through alternate discourses and those made available to them through the medical discourse. The practices of responding within the medical discourse can be determined as involving action on the part of the health professional, with the accent firmly upon talking about domestic violence, in order to diagnose and provide treatment. In contrast the practices of responding informed by alternate discourses can be understood to centre on listening to women, in order to facilitate their action.

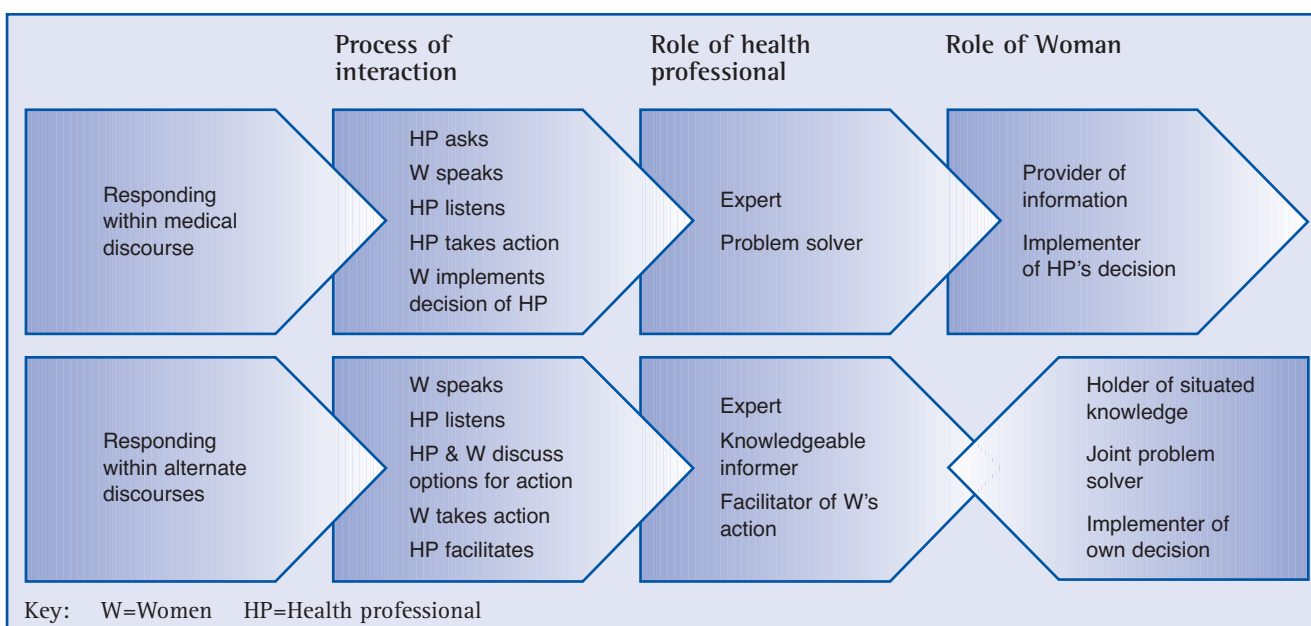


Figure 1. Comparing the roles and actions made possible through the medical discourse and alternate discourses.

The positive practices of responding identified through the research indicate that it is perhaps necessary when responding to domestic violence to move away from a more traditional medical model of 'diagnose' and 'cure'. Perhaps what is required may be more akin to the mode of operating associated with responding to chronic illness, where the role of the health professional is to empower the 'patient' to induce changes to their lifestyle or social situation in order to improve their health (Ruddy and McDaniel, 1995).

1.3.3 Implications of operating outside the medical model

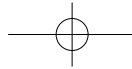
The research also highlighted the implications for health professionals of adopting the positive practices enabled by discourses other than medicine. It illustrated that these effective, but alternate, practices sometimes operate in direct conflict with those enabled through the medical discourse creating difficulties for health professionals. One example of such practices are those in which health professionals' concerns extended beyond the health care interaction and into the wider social circumstances of women's lives.

The practices of responding arising from discourses other than medicine, whilst effective, can distance health professionals from what has been termed the 'protective' function of the medical discourse (Anspach, 1988, 1987; Keller, 1985) which prevents health professionals from becoming emotionally affected by patient's lives.

The magnitude of operating outside the medical model was illustrated through discourses such as horror and warfare through which health professionals conveyed the sense of vulnerability they encounter when responding to domestic violence. These discourses offer a new context from which to view the dominant representations of health professionals in the wider research literature as 'reluctant' and 'unhelpful' (Pahl, 1995; Hopayian et al, 1983; Llewellyn et al, 1995). Indeed they suggest that within this District failure to respond is better reflected by the term of 'can't' rather than 'won't'.

A number of possibilities for addressing health professionals' vulnerabilities when responding to domestic violence were identified within the research. One such possibility would appear the provision of training and ongoing support. Health professionals themselves highlighted the importance of local training in domestic violence in enabling them to develop more positive practices of responding. This would seem significant given that this training is no longer available, having been provided through a fixed term, funding bound initiative.

The absence of ongoing support was framed by health professionals as something which contributed to their experience of being isolated and unsupported when responding to domestic violence. Arguably this signifies the partiality of the PCTs response to domestic violence. Though provision of training has made it possible for health professionals to explore new ways of representing and responding to domestic violence, the consequences of this have not been recognised through the provision of ongoing support.



A key finding arising from the research seems the need to make provision for the ongoing support and continued professional development for health professionals in relation to this change in practice.

1.3.4 Intercept, alternate discourses and women's well being

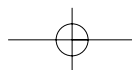
In terms of supporting women and addressing their longer term health and well being a key source of positive practices of responding, informed by discourses outside of medicine, appeared to be the Intercept counselling service.

The Intercept service and its practices of responding were framed by women as vital in enabling them to make sense of themselves as stronger and improving in well being.

A key impact of the discourses made available through Intercept appeared to be that they enabled women to speak and act in ways which were active rather than passive in responding to domestic violence. Thus, they appeared to fulfil women's apparent requirement for more empowerment within health care interactions.

In all their accounts women suggest emphatically that their construction and experience of a stronger and active self has been made available through their interactions with the Intercept counsellor. This finding would seem to highlight the necessity of recognising this as a permanent, key component of the District's services for domestic violence .

Significantly, the ways of acting and understanding oneself as 'stronger' and 'improving' were exclusive to the Intercept intervention and were often not evident in women's talk about their interactions with health care professionals. The importance of experiencing oneself as 'stronger' and 'active' is outlined in the literature which charts women's ability to overcome domestic violence (Profitt, 1996; Loseke and Cahill, 1984; Jackson and Rushton, 1982).



Background

Domestic violence is not a new phenomenon; its existence has been noted and documented since the earliest records of social history. Throughout this period of social recording, the way in which it has been characterized and understood appears to have undergone a considerable transformation. Appearing, perhaps initially, in social records as the legitimate 'chastisement' of women by their husbands, domestic violence has gradually become conceptualized as undesirable and problematic (Browne, 1987). As such it has become the focus of research which has sought to explore its social causes, implications and consequences (Mullender, 1996). Much of this research has been undertaken from what might be termed a 'feminist' framework, seeking to make visible hidden aspects of women's experience and consequently work towards advancing social justice for women (Dobash and Dobash, 1979; Yllö and Bograd, 1988). However, in recent years attention seems to have shifted to considering the implications domestic violence has for women's health; influencing a further transformation of domestic violence into a social and health care issue. As a consequence research has begun to focus upon the health service response to women experiencing domestic violence. This process would seem consistent with a concurrent UK policy shift towards integrated services for health and social care (Glendinning, 2003).

2.1 Setting the scene: the changing face of domestic violence

2.1.1 The extent and gravity of domestic violence

The hidden nature of domestic violence would appear to underlie the difficulty reported by those seeking to measure its extent (Mooney, 2000). Measurement is further complicated by the competing definitions and terminology associated with domestic violence. Definitions function to create categories for inclusion and exclusion which influence what behaviours and actions are recorded and how. Thus, the often competing and conflicting definitions employed by government departments, agencies such as the police and social services, and women's advocacy and support groups, like Refuge and Women's Aid, result in a range of estimates of prevalence which appear neither comparable nor consistent. However, what would seem in general agreement amongst researchers and policy makers is that most estimates of domestic violence are likely to be underestimates (Bazell and Gibson, 1999; Department of Health 2000). During the last decade a concerted effort has been made to attempt to uncover the extent of the phenomenon on a regional, national and international level (Ratner, 1993; Hoffman et al, 1994; Narayana, 1996; Heise, Ellsberg and Gottemoeller, 1999; Tjaden and Thoennes, 2000). A recent review of over 50 international surveys indicated that between 10 - 50% of women reported experiencing physical assault by an intimate partner³ at some point during their lifetime (Heise et al, 1999). Official prevalence figures in the United Kingdom (UK) have tended to rely on information from the British Crime Survey (BCS) which indicates that people of all genders, ages, sexual orientations,

³ An intimate partner is define as one with whom the person is having, or has had, a relationship with some stability or continuity. The relationship should also have or have had a sexual aspect such as the relationship between a husband and wife, or others generally recognised as a couple, including same sex relationships.

ethnicity and social background experience domestic violence (Home Office, 1999c). However, these figures also indicate that 74% of those identifying themselves as experiencing domestic violence are women, highlighting a gendered aspect to the risk of experiencing domestic violence which is supported by research in North America and Canada (Ratner, 1993; Bachman and Saltzman, 1995; Currie, 1998; Kurtz, 1998).

UK figures also indicate that 1 in 4 women, aged between 16 and 25, report experiencing physical assault, by a partner or current partner at some point over their lifetime and 1 in 24 women report experiencing domestic violence in the previous year (Home Office, 1999c). Further, they indicate that 57% of women who experience domestic violence will endure repeat victimisation, a figure which is unparalleled for any other criminal offence (Home Office, 2000). The extent and gravity of abuse experienced is further reflected by research which indicates that women report being assaulted 35 times, on average, before reporting such assaults to the police (Yearnshire, 1997).

Those experiencing domestic violence report enduring a wide variety of abuses. Physical violence ranges from punches, slaps and kicks, through to assault with weapons and ultimately homicide. Criminal statistics in England and Wales (Home Office, 1999a) indicate that two women are killed each week as a result of domestic violence. Emotional and psychological abuses are also reported, involving behaviours that belittle, humiliate, intimidate and restrict and control social contacts. Women also report experiencing economic abuse, which may involve preventing financial independence through restricting access to work, money or confiscating women's earnings (Watts and Zimmerman, 2002).

Thus, whilst competing constructions, definitions and forms of measurement exist to determine the phenomenon of domestic violence, it is argued here that, however defined, the phenomenon has a 'real' impact upon women in their social living, which would be detrimental to their well being.

2.1.2 Enduring impact on women's health

The implications of domestic violence for women's health have been highlighted through a vast range of research literature, both in the UK and North America. This growing body of research information has highlighted the diverse and wide ranging nature of symptoms and injuries experienced by women as a result of domestic violence which are summarised in Figure 2.⁴ Amongst these are anxiety, fatigue, dependency, depression, sleeping and eating disorders and chronic pain (Butler, 1995; Stark and Flitcraft, 1995, 1996; Campbell, 2002), in addition to physical injuries such as attempted strangulation, stabbing, burns, bruises, fractures and cuts (Bates, Redman, Brown and Hancock 1995; Stanko, Crisp, Hale and Lucraft, 1998) and abdominal and pelvic pain, headaches, gastrointestinal disorders, low birth rates and miscarriage (Parsons, Zaccaro, Wells, Stoval, Pearse and Horger, 1995; Mirlees-Black, 1995; Johnson and Sacco, 1995).

⁴ Adapted from Taket, A. et al. (2003)

Physical Health

- Injuries arising from assault (Stanko et al, 1998)
- Chronic physical health problems (Campbell 2002)

Reproductive Health

- Increased likelihood of unwanted pregnancy, miscarriage and still birth (Johnson and Sacco, 1995)

Sexual Health

- Injuries arising from rape, buggery and other sexual abuse (Bang, 1993)
- Increased risk of sexually transmitted disease and HIV (Garcia-Moreno and Watts, 2000)

Mental Health

- Higher incidence of anxiety, depression, self harm and suicide (Campbell, 2002)
- Increased likelihood of post-traumatic stress disorder (Silva et al 1997)

Figure 2. Summary of the reported effects of domestic violence upon women's health

Women also commonly report experiencing symptoms and injuries arising from sexual abuse, including rape, buggery and the insertion of objects into the anus and/or vagina (Bang, 1993). The psychological symptoms of abuse are highlighted in research which has explored its enduring impact on women's mental health. Amongst symptoms women report experiencing are flashbacks, intrusive memories, sleeplessness, concentration difficulties, fear, low self-esteem and nightmares (Women's Aid Federation of England, 1989; Mirlees-Black, 1995; Richardson and Feder, 1996; Campbell, 2002). Moreover, this research indicates that these symptoms and injuries may be experienced in any range of combinations and levels of severity. The resulting short and long term implications for health appear to have culminated in the World Health Organisation (WHO, 1997) citing domestic violence as one of the principle factors involved in gender health inequalities.

2.2 Domestic violence and recent Government responses

2.2.1 National response to domestic violence and recent government policy.

Following an initial wave of government interest in domestic violence during the 1970s and early 1980s domestic violence seemed to lose its priority within the UK policy agenda. Successive UK governments have appeared to focus predominantly on the criminal aspect of domestic violence (Harwin and Barron, 2000). It was not until the late 1990s that domestic violence began to re-emerge as a front line issue, demanding government action across a range of areas to support women experiencing abuse.

2.2.2 Initial Government responses; 'Living without Fear'

Amongst a climate of increasing pressure from lobbyists and women's advocacy groups a review was undertaken by the Women's Unit of the Cabinet Office which resulted in the publication of a booklet entitled 'Living without Fear' (Home Office, 1999d). This document appeared to acknowledge the lack of government action in responding to domestic violence, stating that '...we have been reluctant to face up to the seriousness of these crimes' (6). Outlined in the document were strategic proposals for addressing violence against women. These centred around three key goals:

- 'in the long term, to reduce crimes of violence against women and fear of violence as measured by the British Crime Survey,
- to help today's children grow up in a society where violence is not a part of family life and relationships are built on greater mutual respect, and
- within five years to see effective multi-agency partnerships operating throughout England and Wales, drawing on ...good practice...' (Living without Fear, 1999:5).

'Living without Fear' detailed how the Government intended to achieve these goals and outlined the funding to be made available. Acknowledged was the need for adequate provision of support and protection for women experiencing domestic violence, at the time and in the location in which they are required, reporting that,

'...help is still not comprehensive enough or easily accessible. In some cases women are sent up to ten different places before they get the help they need. And often how you are treated is entirely a matter of where you live.' (Living without Fear 1999:4)

Living without Fear outlined the Government's plans for achieving the long-term prevention of domestic violence, which appeared to centre upon the provision of long-term education programmes and improved multi-agency working. These policy initiatives have been acted upon resulting in increased training programmes for the police, judiciary and criminal prosecution services and the inclusion of domestic violence within the personal social citizenship and health (PSCHE) curriculum within schools. A wide range of research initiatives have also been initiated, receiving funding through the Home Office and a national network of prevention programmes has also been established through partnership between the Offending Behaviour Programmes Unit of the Home

Office and the Probation Service. Based on the Duluth model (Pense and Paymar, 1993) of domestic violence prevention this programme is known as the 'Pathfinder' initiative.

Some of the necessary funding and resources to support these aims has been provided through the Government's Crime Reduction Programme (Home Office, 1999c). A commitment was made to invest some £6 million in front line agencies dealing with domestic violence, rape and sexual assault. In addition, a commitment was made to increase funding, in stages, to Victim Support to approximately £6.3 million in part to fund a new 24 hour help-line for women. Further funding was made available at a local level, through the development of Local Strategic Partnerships between local statutory agencies, such as the police, health, local authority and crime reduction partnerships. However, the establishment of these partnerships has been lengthy and the effect of incorporating a diverse range of funders, each with their own definition, priorities, principles and ethos upon the provision of services for domestic violence has yet to be determined (James-Hanman, 2000).

2.2.3 Domestic violence and the Crime Reduction Programme

Launched by the Government in April 1999, the Crime Reduction Programme (CRP) was a fixed term, fixed funded, umbrella programme designed to gather research evidence regarding which agency interventions were most effective in reducing crime and its causes. With a budget of £250 million, over a three year term, the CRP consisted of a diverse range of individual projects each exploring some aspect of front line intervention across a range of crime related areas. One such area was the 'Reducing Violence Against Women Initiative' whose stated aim was to seek out evidence of good practice in dealing with domestic violence and rape and sexual assault by known perpetrators. The initiative, with a budget of £6.3 million, encouraged statutory and voluntary agencies and multi-agency partnerships to bid for funds to develop and implement local strategies to reduce gendered violence. By July 2000 some thirty four projects had successfully bid for money, twenty-five aimed at reducing domestic violence and nine aimed at reducing rape and sexual assault. These projects spanned a range of areas including: education and awareness raising, interventions with a multiple focus, rural based projects, civil and criminal law initiatives, projects with a minority ethnic focus, health care initiatives, prevention and protection projects, rape services, perpetrator programmes and data recording systems (Crime Reduction Programme, 2004)

However, despite this welcome commitment at a government level, to support those experiencing domestic violence, concern has been voiced regarding the adequacy of the Government's response (Bazell and Gibson, 1999). Apparent is the lack of any substantial national assessment of the cost of providing support and protection, despite independent research demonstrating that the cost of addressing domestic violence in Greater London alone amounts to some £278 million per annum (Stanko, Crisp, Hale and Lucraft, 1998). Further, given that the self imposed five year programme of intervention has reached its completion, the Home Office has still to publish key research and realise some elements of its strategy, amongst them the proposed 24 hour help line for women.

2.3 Acknowledging and responding to domestic violence as a health care issue

Throughout its documented history domestic violence appears to have been broadly understood at a policy, academic and advocacy level as a predominantly social issue. Research has been undertaken to explore and critique the response of statutory social agencies, such as the police, social services and housing (McWilliams and McKieron, 1993; Mullender, 1996). This research has highlighted the diverse and wide-ranging needs of women experiencing domestic violence, making recommendations for both improving access to services for women and improving the quality of service provision. However, in more recent years attention has begun to focus on the lack of information about domestic violence within health care agencies and the identification of health as an area of concern. North American research has lead the way in establishing the existence of domestic violence within the caseloads of health professionals, illuminating the implications of domestic violence on women's health and professional practice (Stark, 1982; Stark and Flitcraft, 1995, 1996).

2.3.1 The response of the Royal Colleges and health professionals' regulatory bodies

Despite early government initiatives heralded in 1995 by the establishment of multi-agency domestic violence forums, consisting of local representatives from the police, criminal justice, housing, health and social care agencies, health agencies appeared slow to respond (Hague, 1997). However, some of the bodies regulating health care professionals attempted to respond through the provision of guidelines for their members. The first amongst these was the Royal College of General Practitioners (RCGP) who commissioned a review of the existing research literature in order to produce guidelines for their Members Reference Book (RCGP, 1992). These guidelines were subsequently made available over the Internet and were also published (Heath, 1992; 2003). They defined the response women have historically received from general practitioners as 'poor' and indicate that domestic violence is an issue in which general practitioners can and should intervene; expressing the aim of,

'...formulat[ing] guidance in relation to the care of women who have been subjected to domestic violence and who present to general practitioners and other health workers in the UK primary health care setting.' (Heath, 2003:1)

The guidelines identify women as employing a 'calling card', characterised as an 'unimportant physical symptom' (Heath, 2003:2), which is framed as an excuse to indirectly ask for help when accessing general practitioners' assistance. Failure to respond to such a 'calling card' is constructed as collusion in maintaining the hidden nature of domestic violence. Appropriate responding is characterised within the guidelines as involving patience, understanding and the adoption of a non-judgemental approach. Additionally, the guidelines aim to raise the GPs awareness of common myths about why women stay in abusive relationships, urging them not to condemn women who do not leave. In particular, they draw upon information from women's advocacy organisations illustrating the low self-esteem and self blaming behaviours experienced by some women in relation to domestic violence (Harwin, 1997). The guidelines encourage general practitioners to consider the economic, personal and practical difficulties, which may deter or prevent women from leaving their

partner. Moreover, they provide clear advice to assist GPs in identifying women who may be experiencing domestic violence, emphasising the importance of offering reassurance to the woman through affirming confidentiality. Notably, the guidelines advocate that GPs should 'let' women tell their own story and provide practical examples for questions which might assist GPs in broaching the subject with patients (Heath, 2003:14). General practitioners are advised of the importance of developing a safety plan with women who are likely to continue to be abused and are encouraged to involve the woman in developing this strategy, thereby encouraging her 'autonomy' and 'self determination' (Heath, 2003:16). The recommendations provide detailed and practical information regarding the documentation of abuse and photographing of injuries, to enable records to be employed in any future legal proceedings. Also advocated is the importance of providing women with information about the provision of locally available domestic violence services and her legal right to be unmolested in her own home.

2.3.2 Provision of national Department of Health guidelines

However, despite the existence of such acknowledgement by health professionals' governing bodies, it was the year 2000 before the Department of Health appeared to respond to the Government's call for front line intervention from health professionals. Two resources were published: *Domestic Violence; A Resource Manual for Health Care Professionals* (DOH 2000a) and *Principles of Conduct* (DOH, 2000b). These aimed to integrate the seemingly disparate guidelines provided by the various governing bodies of differing health professions. The two documents appeared to portray domestic violence as an integrated health care issue, which transcends the traditional boundaries of agency responsibility and marked the inception of the merger between the health and social care agendas. This acceptance of domestic violence as an issue for health care providers appeared to engender a rise in UK research into the provision of health care services for those experiencing domestic violence (Richardson and Feder, 1996; Abbott and Williamson, 1999; Richardson, Feder, Eldridge, Chung, Coid and Moorey, 2001; Richardson, Coid, Petruckevitch, Chung, Moorey and Feder, 2002; Watts, Watson, Sethi, Zwi and McCarthy, 2002).

2.3.3 Concerns inherent within this changing conceptualisation of domestic violence

However, inherent within this changing conceptualisation of domestic violence are certain concerns. Not least amongst these would seem concern regarding the apparent lack of a uniformed medical approach (Llewellyn, Roden and O'Neill, 1995; Parsons et al, 1995; Warshaw, 1997). This has been linked to an outcome where key indicators to domestic violence are missed. This outcome has been related by some researchers to health professional's reported discomfort in responding to the issue (Davis, 1984; Sugg and Innui, 1992; Richardson and Feder, 1996). An attempt to overcome this through a move towards the implementation of 'routine enquiry' or 'screening' for domestic violence (DOH, 2000a) has met with resistance from many health professionals. Expressed is the reluctance to embrace what some deem a social problem, despite research evidence of the resultant health care implications (see for example British Medical Journal letters, 2002b). Researchers have

argued that this resistance may serve to impact upon women at the point of contact resulting in their misdiagnosis and health professionals' denial of women's actual experience (Kurtz, 1987; Abbott and Williamson, 1999; Williamson, 2000). A number of researchers have highlighted concern regarding what they identify as potential problems associated with the 'medicalisation' of a hitherto social issue (Stark, 1982; Reissman, 1983).

It has been argued that a danger exists in medicalising domestic violence. Its causes and interventions may become situated within an individualistic perspective and the concurrent social aspects may become obscured (Williamson, 2000). This concern has been linked to the health service response in that it is recognised that women's treatment for symptoms and injuries resulting from domestic violence takes place within an organisational structure which is argued to be permeated by social and cultural myths and stereotypes which may serve to minimise and deny women's experiences (Bograd, 1982; Kurtz, 1987). Researchers have also highlighted the potential for the social control of women made available through processes of individualisation and medicalisation (Jeffrey, 1979; Waitzkin and Britt, 1989) and linked this to the misdiagnosis of women's symptoms and injuries (Herman, 1992; Gondolf, 1998). Thus, they argue women experiencing domestic violence may be more likely to be pathologised (Herman, 1992; Gondolf, 1998). They are also more likely to be ascribed quasi-psychiatric labels (Kurtz and Stark, 1998) than to have the underlying cause of their symptoms identified.

Before exploring further the impact of medicalising domestic violence it would seem prudent to introduce the concept of 'discourse', since much of the research which explores the impact of situating domestic violence within medicine draws on this concept.

2.4 Introducing discourse: what is it and what does it do?

2.4.1 What is a discourse?

A discourse can be understood, in its simplest form as a way of talking which represent the object of the talk in a specific way. Thus, as Burr (1995) outlines a discourse is,

'A set of meanings, metaphors, representations, images, stories, statements and so on, that in some way together produce a particular version of events. It refers to a particular picture that is painted of an event (of person or class of persons), a particular way of representing it or them in a certain light'. (Burr, 1995:48)

Thus we can understand discourse as a way, or ways, of talking about something which allow us to represent it but also paint a particular picture of it at a particular point in time (Hall, 2001). At any one point in time there are therefore likely to be different discourses or ways of talking about a given phenomenon, each of which paint a different picture of it and influence how we respond to it.

The different ways of responding or taking action which are made available through discourses are referred to as 'subject positions'. A subject position refers to the 'ways of being', that is, acting and understanding oneself, made available within the discourse. For example within health two common subject positions are 'doctor' and 'patient'. In conforming to the subject position of 'patient' we are required to allow others to view and access our passive bodies. In turn the subject position of 'doctor' legitimises the powerful actions which accompany viewing or invading the bodies of others.

2.4.2 The influence of medical discourse

Medicine is argued to have its own 'discourse', that is, ways of talking which inform its practices of responding. This discourse functions to privilege some ways of understanding phenomenon and practices of responding over others (Foucault, 1980; Lupton, 1997; Waitzkin and Britt, 1989; Warshaw, 1989, 1993, 1997). Waitzkin and Britt (1989) argue that all patient presentations for health care are underlain by the social context in which their symptoms occur. Yet, they suggest the medical discourse, which informs the responding of health professionals fails to accommodate exploration of the social context. Indeed they argue that such exploration of the social context is viewed as external to what can be reasonably expected of health professionals, particularly in the case of doctors. In situations where the patient's presenting symptoms or injuries are clearly linked to social context, Waitzkin and Britt argue that health professionals' responses become influenced by their dominant beliefs about what behaviours and practices of responding are most appropriate.

One of the biggest influences on health professionals' development of these dominant beliefs is the medical discourse. Its ways of understanding health care issues and the practices of responding that the medical discourse makes available to health professionals are argued to be strengthened by their continual use (Foucault, 1980). Thus, the practices of responding to patients which are available through the specific institution of medicine and health care can be seen to regulate both the conduct of health professionals and patients. Indeed, Waitzkin and Britt argue that it is through health professionals' practices of responding that messages are conveyed to the patient. These messages they suggest are informed by health professionals' unspoken aim to 'guide' patients towards social norms, that is, socially desirable lifestyle choices. These arguments appear relevant to the response of health professionals to domestic violence, since the injuries and symptoms with which women may present arise from a social context. Further, women's inability to leave or choice to stay with an abusive partner, might be argued to transgress the social norms which Waitzkin and Britt suggest doctors aim to 'guide' their patients towards (1989:582).

Warshaw (1989, 1993, 1997) a researcher and medical doctor also problematises what she terms the bio-medical discourse in relation to responding to domestic violence. Of concern is the power of this medical discourse to re-define injuries and symptoms from their social context to a medical context. An example of this process is illustrated in figure three, opposite

Warshaw (1989) uses the example of a woman accessing health care support as a result of her husband punching her in the eye. The 'punch in the eye' becomes redefined through medical discourse as 'a blunt trauma to right eye'. This redefinition serves to remove the woman, her husband, his fist and all the other markers of social context from view.

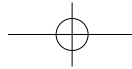
Figure 3. An example of the power of the medical discourse to redefine

As a result of this Warshaw argues the issues with which women present for treatment become reduced into categories, which can be diagnosed and successfully treated. This reflects differences in the way language is made use of to understand domestic violence at social and medical levels (Warshaw, 1989). This redefinition, she suggests, functions to distance and protect health professionals from becoming emotionally affected by women's experiences of violence and further protects them from engaging in what might be termed, more 'messy' interventions which may hold less 'certain' outcomes (Warshaw, 1993). Keller (1985) offers support for such a viewpoint, suggesting that the medical discourse plays a distinct and important part in determining the thinking and behaviour of health professionals, masking the 'protective motivation' which lies behind the supposed 'neutral' stance of western medicine. The impact of the medical discourse upon women experiencing domestic violence would therefore appear significant, since it would seem to run the risk of attempting to fit the culturally diverse and subjective experiences of women into a narrow diagnostic category, which may ignore the individual circumstances women face.

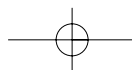
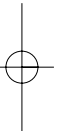
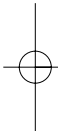
However, the medical discourse has also been argued to perform a protective function for the health professional. Anspach (1988, 1987) has argued that a key function of the discourse of the medical model is that it establishes and maintains a 'necessary' level of detachment from the patient. Thus health professionals are protected from becoming emotionally involved in the distress of the patient. In terms of domestic violence it might be argued that by reducing the problem to a distinct diagnosis which can be controlled and manipulated the health professional is able to take a seemingly practical course of action, rather than feel powerless or frustrated by the inability to change the actual cause of the problem – the woman's social situation.

2.4.3 Domestic violence, medical discourse and practices of responding in the health care interaction.

Allied to concerns regarding the limitations of medical discourse and its impact on how domestic violence is understood within health are concerns about the practices of responding it makes possible. These practices of responding are argued to determine the power relations between women and health professionals and impact upon what can be said or done, by whom and when (Willig, 1999). The impact of the medical discourse on the response health professionals afford to women experiencing domestic violence has been the subject of considerable research in North America (Warshaw, 1989, 1993, 1997; Flitcraft, Hadley, Hendricks, Matthew and McCleer, 1992; Brandt, 1997) having until recently received little attention in the United Kingdom.



Warshaw (1989) argues that medical discourse serves to move women from being active 'agents' in their own lives to 'passive' patients who fit into prescriptive categories which suggest their experiences are the same. This process involves the active reinterpretation of information about domestic violence from the context in which it has meaning for the woman into a context which is meaningful for health professionals. Of concern, within this process, is the potential perpetuation of the woman's experience of domination, since arguably this mirrors the abuse already experienced. Once again a powerful 'other', on this occasion the health professional, may invalidate, minimise and/or ignore her perception of her experience. Thus, Warshaw argues that women's difficulties are reinterpreted to accommodate a medicalised language and framework which enables health professionals to feel comfortable and positions them in control. This positioning or moving of women, she argues is further exacerbated by the discourse, or ways of talking, employed in the medical record. Here the woman's narration of the circumstance which resulted in her injuries or symptoms becomes distanced from her and reduced. Through this practice the woman is sidelined from her central position as teller and person who experienced the event and her injuries or symptoms become the object of importance.



Aims of the research

Much of the research which has sought to explore domestic violence has been undertaken in what might be termed a 'realist' framework. From such a position domestic violence is viewed as a fixed and clearly identifiable phenomenon which can be explored, measured and understood through the application of a range of scientific methods. However, taking such an approach has not enabled the possibility to explore the different ways in which domestic violence is defined and understood and the impact of this upon those who experience, respond and develop policy on domestic violence. This research therefore takes an approach which can be understood to be critical of these limitations and seeks to uncover and explore the impact of different ways of conceiving and understanding domestic violence for all those involved.

This study therefore aims to adopt a critical approach to exploring domestic violence, the ways in which it is understood and talked about in health and the impact of this upon policy makers, health professionals and women accessing services. The research will specifically aim to:

- gain an understanding of the discourses of domestic violence and their associated practices of responding within two local Primary Care Trust's services,
- explore the ways of being or taking action made available to policy makers, health professionals and women through those discourses, and
- gain an understanding of the discourses which women draw upon to make meaning of their experience of health professionals' responses to them , and
- seek to identify the ways of being or taking action, that these discourses make available to women.

Methodology

4.1 Taking a case study approach

In seeking to fulfil the aims of the research a case study approach (Stake, 1998; Reinharz, 1992) was adopted. This approach is valued in qualitative research since it allows the researcher to focus in great depth on exploring the status and significance of a given phenomenon and analysing the relationship between its different stakeholders (Reinharz, 1992). In selecting a 'case' for study the researcher must identify a 'choice of object to be studied' in relation to the phenomenon (Stake, 1998:86). In this research the 'case' identified for studying the response of health services to domestic violence was that of primary health care services in one, discreet, geographical location, Wakefield. Commensurate with the case study approach, this section of the report offers the reader an overview of the object of study.

4.1.1 Wakefield and the organisation of its health services

Wakefield covers 350sq km and is diverse in its geographical configuration consisting of a city, surrounded by nine towns and numerous small villages and outlying rural areas, two thirds of which are designated Green Belt (WMDC, 2003). The population of approximately 315,400 are predominantly of white European origin (97.7%), with almost half of the remaining 2.3% being of Pakistan origin, with fewer numbers of the population being of African Black, West Indian, Bangladeshi, and Chinese origin (WMDC, 2003).

The traditional industries upon which Wakefield has historically relied, such as coal mining, textiles and manufacturing have declined over the last twenty five years, with 19 of the areas 20 coal mining pits closing between 1981 and 1995 and a loss of 20,000 mining jobs (Foreman, Kelly and Percy-Smith, 1995). Local manufacturing industries are also in decline in many sectors, particularly textiles, foods and beverages and chemicals, where employment has been reduced over the last decade by more than 11%. (James and Bayley, 2001). The current key component of the local economy is the service industry which employs some 72% of the workforce across retails sales, hotels and catering. However, only 36% of the male workforce and 23% of the female workforce in this industry is employed full time. The remainder is employed on a part time basis, where males represent only 8% and females some 32% of the workforce (James and Bayley, 2001).

At the outset of this research local health services within Wakefield were organised through the local Health Authority, which was established in April 1996, following the merger of Wakefield's Healthcare and Family Services Authorities. In 2000, the Health Authority established two independent Primary Care Trusts (PCTs) to serve the needs of Wakefield's two regions.

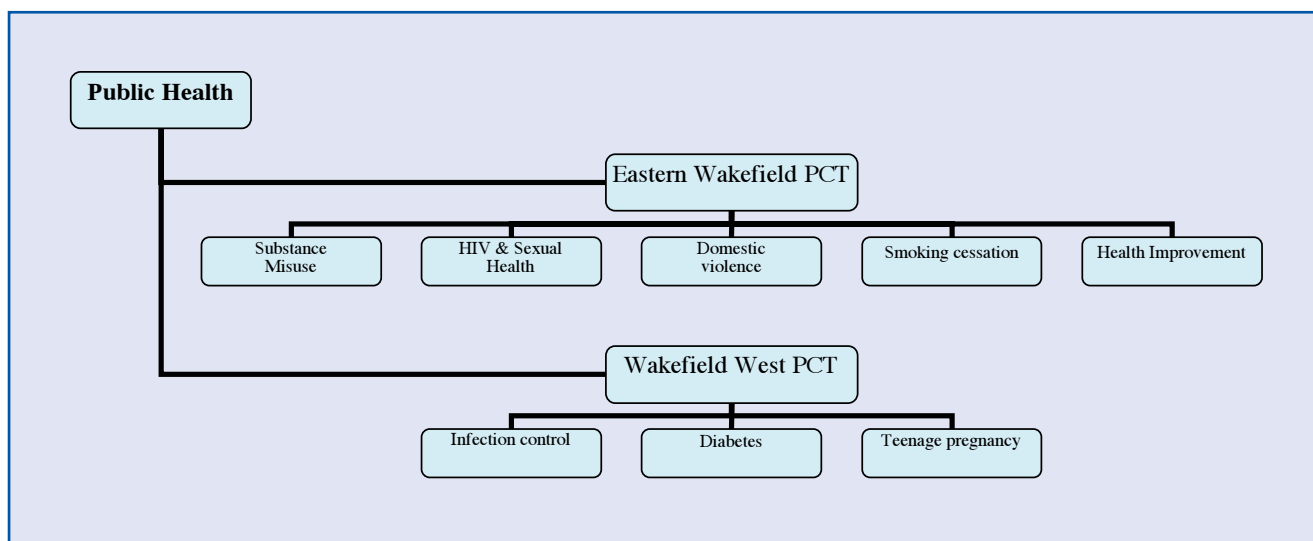


Figure 4. The current configuration of primary health care services in Wakefield

The PCTs were responsible for primary care services⁵. These complimented Wakefield’s existing Hospitals Trust established in 1997 and Community Health Trust established in 1993. In July of the same year a modernisation board, consisting of the Health Authority and all the National Health Service (NHS) organisations in Wakefield was also established and a ten year plan to modernise and improve services within the region was developed (WHA, 2000).

However, in April 2001, a national restructuring of the NHS in the UK took place. Wakefield’s Health Authority, along with the other 94 existing local health authorities in the UK, was restructured coming under the governance of one of 29 newly developed strategic health authorities across the UK. The concerns and responsibilities of these strategic health authorities were to focus on performance management and strategy within the NHS. Each of these strategic health authorities was designed to oversee a number of PCTs, which have in turn responsibility for controlling and organising health services at a district level, improving health and tackling deprivation and health inequality within their area (WHA, 2000). The Strategic Health Authority into which Wakefield falls oversees fourteen PCTs, two of which provide primary care services for Wakefield.

These two PCTs each provide primary health care services for different wards within Wakefield. The public health function of the two Trusts has been divided between the two PCTs (see Figure four). Rather than duplicate service provision, different specialist areas within Public Health have been organisationally located within the Eastern Wakefield PCT and others within Wakefield West PCT, whilst still providing services for the whole district as illustrated in Figure four. The Eastern Wakefield PCT provides district wide services for substance misuse, domestic violence, HIV and sexual health, smoking cessation, health improvement, whilst Wakefield West PCT provides services for infection control and health protection, teenage pregnancy and diabetes.

⁵ Primary care services are community based health services which form the first contact the population has with health professionals, covering services such as general practice, community and district nursing, pharmacies, dentists and midwives.

4.1.2 Recording domestic violence in Wakefield

The recording of domestic violence within Wakefield relies predominantly upon local police figures. The local Community Safety Partnership Crime and Disorder Audit 2001, demonstrated that between April 1999 and March 2001, Wakefield averaged 3,585 reported cases per year. During this period 7,170 cases of domestic violence were recorded, of which approximately 47% constituted repeat incidents within the last three months. More recent police figures recorded between December 2002 and November 2003 indicate that there were 5,302 recorded domestic violence incidents; including those perpetrated by juveniles or siblings, of which 41.3% represented repeat incidents. This would appear to represent a reduction in the repeat incidence of domestic violence within the area, which may reflect the priority status and strategy interventions initiated by local police in respect of reducing domestic violence in Wakefield. The latest figures for April to November 2003 indicate that 1121 incidents were attended by the police, 29.6% of which resulted in arrest. Of these 29.6%, 37.1% resulted in a prosecution.

4.1.3 Identifying the need for a local response

Domestic violence as an area of concern within Wakefield was first publicly identified in 1995, in the 'Report of the Director of Public Health', which highlighted the need to improve services to those experiencing domestic violence within Wakefield. This early acknowledgement⁶ of the impact of domestic violence upon health care services followed a year long district wide investigation examining the impact of domestic abuse upon women's use of local health and social care agencies (Norman, 1997). Employing semi-structured interview and survey methods to elicit information about the use of services from both agencies and women experiencing domestic violence, the research highlighted a lack of referral and knowledge across health and social care organisations within Wakefield. It illustrated that women experiencing domestic violence accessed the services of GPs for support, but that GPs reported lacking the strategies to assist women in accessing appropriate support outside the medical encounter. Further, it concluded that women who did not receive adequate support from the agencies they accessed were likely to return to abusive relationships and recommended that further research be undertaken to explore and develop protocols for the treatment and referral of both those experiencing and those perpetrating domestic violence (Norman, 1997).

Building upon this work the Health Authority, in collaboration with the local voluntary domestic violence support service, commissioned a pilot study aiming to explore more specifically the impact of domestic violence within primary health care services (Harris, 2002). The research targeted one general practice surgery within Wakefield for the period of one week. Each woman over the age of 16 attending a consultation with a doctor or nurse was issued with a short questionnaire asking about their experience of domestic abuse. Support workers were available to counsel women who having disclosed abuse required immediate support. The results of the pilot indicated that one in three of the women attending the GP surgery during that week had experienced domestic violence at some point during their lifetime. These results were employed widely across Wakefield to

⁶ This acknowledgement occurred at a time when domestic violence was still unacknowledged at a national level within the NHS and may thus be considered early.

elicit the support of a variety of local agencies: community safety partnership, police and social services, to support the Health Authority and voluntary domestic violence support agency in a joint bid for funding from the Home Office 'Crime Reduction Programme: Violence Against Women Initiative'. This bid aimed to secure funding to extend the work of the pilot study and develop screening for domestic violence in primary care.

4.1.4 'Support and Survival' Health Initiative

Following a successful bid for funding, the 'Support and Survival Health Initiative' project was implemented in January 2000 and ran until March 2002. This project aimed to reduce repeat victimisation of women experiencing domestic abuse by working with primary care health professionals to identify, document and refer for support women experiencing domestic violence. This was addressed through two phases of work beginning with an audit of women accessing of health services across Wakefield; followed by the development of a pilot programme for 'screening' or 'routinely enquiring' about domestic violence⁷. The initial audit phase of the initiative was already underway when the present research commenced and was almost complete by the time the researcher had established relationships with the team and been invited to join the steering group. However, the second, training for screening, phase of the initiative ran concurrent with the PhD, terminating 21 months prior to the present research.

The health initiative research concluded that a district wide strategy for domestic violence was required in Wakefield and recommended its inclusion on both the national and local public health agenda. In particular the findings of the research highlighted the barriers which exist in relation to women's disclosure of domestic violence to health professionals and reported that health professionals who engaged in training for screening appeared better able to assist women in overcoming such barriers. However, it also identified reluctance amongst some health professionals to the implementation of screening and highlighted the need for awareness training amongst health professionals prior to the implementation of screening training. In contrast, women appeared supportive of the practice of direct questioning about domestic violence, regardless of their own experience. Amongst its key recommendations the research identified the need for a range of support services for women experiencing domestic violence including ongoing support in addition to that available within current primary care provision. Also recommended was the need for partnership and inter-agency working in tackling domestic violence, including sharing of time and financial resources.

4.1.5 'Intercept' and the changing provision of support for women

Subsequent to the health initiative research the local voluntary domestic violence support agency, began to experience a range of difficulties which culminated in their closure during the autumn of 2003. Eastern Wakefield PCT made a successful bid to the Home Office Recovered Asset Fund on behalf of Wakefield Community Safety Partnership. The funding enabled the establishment of a service to address domestic violence,

⁷ The initial terminology employed was 'domestic violence screening'. However, consideration of the parameters for 'screening' as employed by the National Screening Committee and a review of recent publications debating the utility of 'screening' versus 'routine enquiry' resulted in a reframing of the terminology, during the lifetime of the project.

drugs and alcohol. The PCTs subsequently gave an additional resource to the project to allow it to offer support to those experiencing domestic violence where there were no drugs or alcohol links. The resulting service, 'Intercept', is a time bound project, whose Home Office funding is due to expire in October, 2005. The organisation aims to offer advice, support, and information to those affected by domestic abuse and substance misuse. Working with women and men, the agency offers individual group work and counselling for those experiencing abuse and for perpetrators. It also has a multi-agency training function in raising awareness of the links between domestic violence and substance misuse and offers advice to health professionals and practitioners in responding to issues of domestic violence. The agency is based in the Eastern Wakefield PCT and consists primarily of a manager, who also has a client caseload, four full time counsellors and an administrator. The counselling function of the service takes place in the client's own home, whilst the group work function for perpetrators takes place at the local substance misuse project premises.

4.2 Taking a discursive approach

The approach taken by this research draws on feminist research and theory (Weedon, 1987; Harding, 1987; Wetherell, 1998; Gavey, 2002), the work of Michel Foucault (1972; 1976) which explores the relationship between knowledge and power and a discursive approach to understanding language as active and productive (Willig, 1999, 2001; Davies and Harré, 1990; Gergen, 1999). Since the reader is likely to be unfamiliar with these theories we aim to provide a brief account of the ways in which they have influenced the methodology of the research.

4.2.1. Social constructionism and the changing role of language

Traditional approaches to research offer ways of understanding the individual and their social world rooted in the framework established by the natural sciences (Alvesson, 2002). This framework is based on a viewpoint of the world as real and independent, information and knowledge about which can be discovered and causal explanations established about phenomenon, events and behaviours (Lesson, 2002). In these approaches individuals are characterised as capable of being objectively explored and understood. However, in recent decades a shift has been evident towards taking a more critical approach to exploring the world, social phenomenon and individuals, this is sometimes referred to as 'postmodern'. A key aspect of postmodern approaches is the role of language (Willig, 2001). Language has historically been understood only in terms of its role in representing and describing internal states or external reality. Within postmodern approaches language is argued to be active and productive in and of itself. It is argued to create different ways of viewing the world and lived experience (Alvesson, 2002).

Language can therefore be understood to be a 'dynamic' process through which the world and our understandings of it are 'constructed' (Gergen, 1999). Moreover, there are argued to be different ways of talking, or discourses which are associated with different groups of people and different aspects of social living. For

example, there are words and phrases within medicine or education which are only used when talking within that context. These different forms of speaking are theorised to develop and extend, becoming refined and specialised resulting in the creation of new terms and words which may not be recognisable to others outside of that context. In relation to domestic violence and health, adopting such an approach offers the potential to explore the many differing conceptualisation of the phenomenon and the diversity of definition and explanation amongst the makers and implementers of health policy, health professionals, women and women's advocacy groups.

4.2.2 Knowledge, power and language

A further aspect of this critical or postmodern approach relevant to this research is the relationship of language to knowledge and power. Michel Foucault, a French philosopher (1977) argued that knowledge and power are inextricably linked to one another. To explain this he says

'...there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations...'
(Foucault, 1977:27)

Knowledge is therefore understood not only a form of power but as something which can also be employed as a form of social control (Smart, 1985). Power, in turn, is understood to influence what knowledges are applied, and when. Thus when knowledge is combined with power it is argued to have the potential to lay greater claim to the status of 'truth' (McNay 1984). In applying such thinking to the context of health and domestic violence it is likely therefore that some of the many ways of constructing domestic violence, those who experience it and those who respond to it hold greater 'power' or 'truth' status than others. Referring back to the introduction, 'medicine' and its corresponding language and knowledge base can be argued to be a powerful force whose claims are often viewed as 'unquestionable'. Moreover, health professionals through the medical discourse and its ways of talking can be understood to have the power to proclaim 'truth' to the ordinary person.

4.2.3 Powerful and less powerful knowledges

Having established that there is a relationship between power and knowledge where some discourses or ways of talking have greater power or 'truth' status than others it is also important to consider what happens to the other less powerful knowledges. Foucault (1977) calls these 'subjugated' knowledges. He identifies 'subjugated' knowledges as,

'...a whole set of knowledges that have been disqualified as inadequate to their task, or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required levels of cognition and scientificity. I also believe that it is through the emergence of these low ranking knowledges (such as that of the psychiatric patient, of the ill person, of the

nurse or the doctor – parallel and marginal as they are to the knowledge of medicine)... it is through the re-appearances of this knowledge, of these local popular knowledges, these disqualified knowledges that criticism performs its work' (Foucault, 1976:83)

In applying this to the response of health services to domestic violence it is clear that there are a range of ways of talking about and understanding domestic violence some of which will hold greater power than others. Within health, the dominant knowledge can be said to be that of medicine and therefore this form of knowledge, its ways of talking about domestic violence and its practices of responding are likely to be most powerful or influential. One of the implications of re-conceptualising domestic violence as a health, rather than a merely social care issue are that the other discourses or ways of talking about domestic are likely to be less powerful than the dominant medical approach. This has implications for women because by privileging the knowledge of medicine the situated knowledges which women hold about their own experience of violence and its impact upon their bodies may become 'subjugated' or sidelined. Adopting an approach which can account for this makes it possible to uncover the relative power of different discourses of domestic violence and the implications of these for service users and providers within the health and domestic violence arena.

4.3 Data collection

Three phases of data collection were employed drawing on different methods of gathering data

4.3.1 Phase one – interviews with key informants in the health arena

Semi structured interviewing phase - this phase employed semi structured interviews (Smith, 1995) with eight key informants within the, then, health authority and a range of health services where women may present for treatment/and or support. These participants included health professionals. The semi-structured interview schedule (see appendix 1a and 1b) was developed to facilitate three key objectives:

- to gain an understanding of the ways in which domestic violence is understood within local services,
- to identify the discourses, or ways of talking, employed by different key informants when describing responding to domestic, and
- to explore the practices of responding which are made possible through these discourses and their impact on the ways of being or acting made available to policy makers, health professionals and women experiencing domestic violence.

4.3.2 Phase two – questionnaire to health professionals

The aim of this second phase of the study was to explore the roles, perspectives and responses of health professionals to women who having experienced domestic violence accessed health care services. Specifically, phase two aimed to:

- identify the discourses, or ways of talking, employed by different health professionals when describing responding to women and when conveying their perceptions of their role and responsibility in relation to domestic violence, and
- identify and explore the practices of responding which are made possible through the use of these discourses.

In order to explore these issues a self-completed questionnaire employing a range of open ended questions, closed questions, Likert-type rating scales and semantic differential type scales was constructed⁸. This was sent through a combination of the internal mail system and external postal services to all 610 primary health care professionals registered as currently working in the Wakefield district.

4.3.3 Stage three – interviewing women about their health care experience

Generative depth interviews (Flick, 1998; Wengraf, 2001) were undertaken with five women who, having experienced domestic violence, accessed health care services; this number of participants being commensurate with the intensive, depth nature of this form of interviewing. The women were all receiving counselling support from Intercept and self selected to participate in the research. These aimed to explore how women who have encountered domestic violence make sense of their experience of the response of health professionals. Specifically it aimed to:

- gain an understanding of the discourses, or ways of talking, which women draw upon to make meaning of their experience of health professionals' responses,
- explore whether discourses identified earlier within the research at a policy making and implementation level or health professional level, were evident in women's talk about their experience,
- gain an understanding of the ways of being or taking action which are made available through those discourses and explore how women react to them, and
- explore what this may mean in terms of how women make meaning of their experience and its impact on their recovery.

Since generative discursive interviewing is a less familiar form of data collection than semi-structured interviewing and self complete questionnaire, the approach taken is outlined in more detail below.

⁸ A copy of the questionnaire and its findings will be provided in the subsidiary questionnaire report.

4.4 Generative discursive interviews

Since understanding the discourses women drew on when talking about their experience of health professionals' responses to them was a major aim of this research it was a priority to adopt an approach which enabled this to emerge. Drawing on Flick (1998) and Wengraf (2001) we prepared in advance of the interview three broad questions which aimed to generate women's talk, whilst seeking to impact as little as possible on the ways of talking they might use. The first question operated as an ice breaker and an 'invitation' to women to speak, the second and third aimed to narrow the focus slightly to experiences specifically associated with accessing health care. These questions were supplemented by feminist research principles to inform their application. Primary amongst these considerations was the research relationship we wished to develop with women. Within feminist research great emphasis is placed on minimising the unequal power differentials which have been recognised as occurring between researchers and their participants (Wilkinson and Kitzinger, 1996). These power differentials often serve to 'privilege' the knowledge and status of the researcher above those of the participant (Smith, 1987). This is particularly salient in the context of this research, since inequity in power, status and control is a dominant feature of relationships in which domestic violence occurs (Hanmer, 2000). Thus, a priority was that women's experience of participating in the research should in no way serve to replicate this dynamic. In seeking to accommodate this we aimed to adopt a more interactive approach; engendered by the creation of an atmosphere more consistent with 'informal conversation' (Taylor and Bogdan, 1984). We anticipated that this might empower women to co-define the parameters of the interview, rather than respond 'passively' to questions informed by our assumptions and definitions (Oakley, 1981). To this end, we developed an introductory section to the interview, containing a briefing (see appendix 1c). Through this we aimed to convey to women our hope that our time talking together could be as informal as possible and that rather than asking lots of questions, we would like them to focus on what they considered was important and relevant to them. This briefing also aimed to address any fears or concerns women might have about telling the 'right' story, by explaining that there were no right or wrong answers to the questions we might ask, only what was important to them.

4.5 Carrying out a Foucauldian discourse analysis

There are several different types of discourse analysis each offering the researcher different tools through which to analyse qualitative data. The choice between these different versions is generally driven by the aims of the research. The Foucauldian approach to discourse analysis focuses on the identification of the culturally and socially available discourses through which phenomenon, such as domestic violence, are understood. However, it can also enable researchers to analyse the ways of being or implications for action that these discourses make available to people in different interactions. The research has drawn upon the procedural guidelines developed by Willig (1999; 2001) which provide a six-stage approach to the analysis of discourse. The six stages, illustrated in figure 5, require an intensive and prolonged line by line and word by word engagement with the text. The first stage in this process is to explore the text aiming to identify the way, or ways, in which a discursive object, such as domestic violence, is being constructed within the text. To facilitate this, every reference to the object, both implicit and explicit must be highlighted.

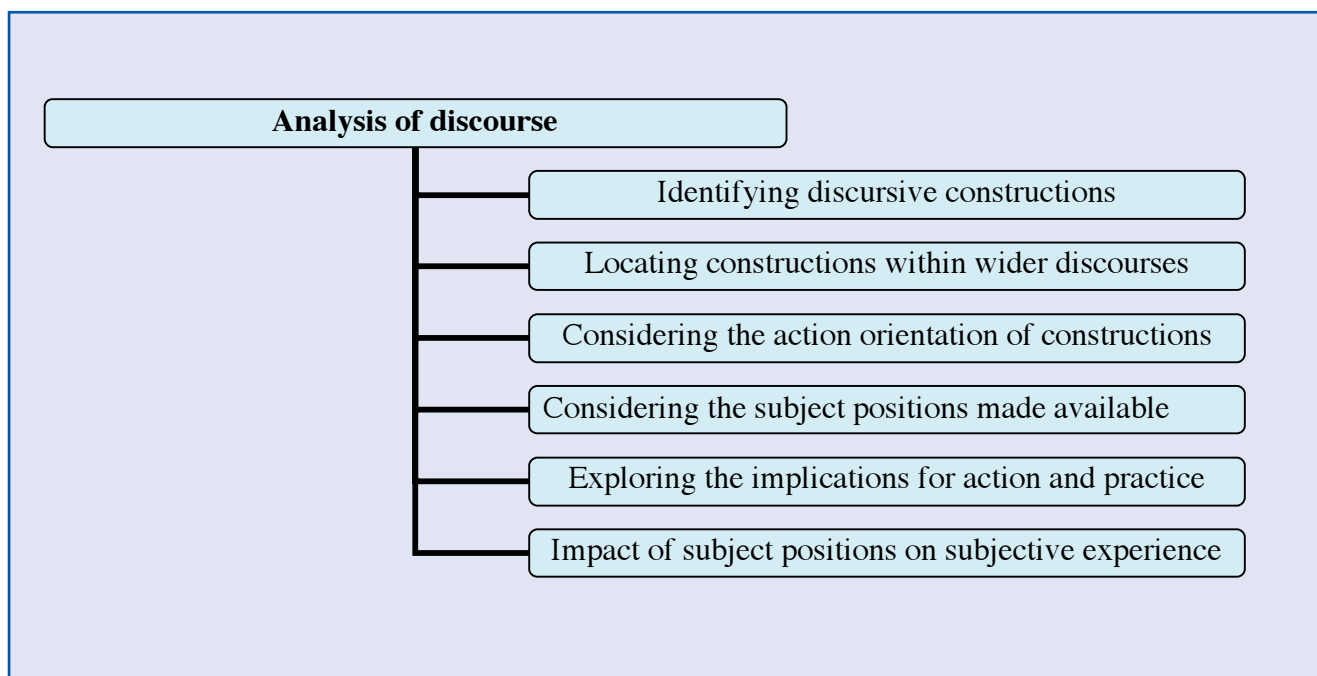


Figure 5. Six-stages within Willig's (2001) procedural guidelines for the analysis of discourse

Having identified the ways in which the discursive object or objects are constructed in the text, the next stage is to attempt to identify the wider discourses from which these ways of talking are drawn. In the case of this research for example, framing responding to domestic violence as 'diagnosis' might be considered to arise from the wider 'medical discourse'. The third stage of analysis aims to consider the 'action orientation' of the framings; that is considering what might be achieved or enabled by framing domestic violence in a particular way, at any given point in the text. In this way it is possible to explore what 'functions' the different framings of domestic violence and what relationship they bear to other, different ways of talking about domestic violence within the text.

Stages four and five of the analysis aim to analyse the implications of these different discourses of domestic violence for the ways in which people can speak or act. These stages are crucial since, within a Foucauldian discursive approach, it is also possible to identify the power relationships between the different ways of speaking and acting, and who can access these. For example, the implications of framing women who experience domestic violence within a discourse of 'victimhood' constrains women to passivity, closing down the possibility for them to speak or act as 'survivors' or 'endurers' of abuse. The final stage of analysis draws together the analyses from the earlier stages to facilitate an exploration of the impact of discourses, constructions, practices and subject positions for the speaker's subjectivity; that is the way in which those speaking feel, think and experience social phenomena and events.

Findings

The findings begin with the consideration of the effect of the medical discourse in shaping the ways in which domestic violence is understood and responded to in the District drawing on the talk of policy makers, implementers and health professionals. This talk illustrates the ineffectiveness of the medical model of responding when applied to domestic violence and is corroborated by women's talk about their experiences of accessing health care services. This is followed the consideration of the alternate discourses and practices which are evident in the talk of health professionals and policy makers. Specifically, attention is drawn to the role 'champions' have played in influencing health policy and practice and concern is expressed about the potential impact of these practices not being embedded in mainstream policy and practice.

Considered is the impact of recently available training which is constructed by health professionals as helpful in enabling them to respond outside of the medical model. However, attention is drawn to the problems this raises in terms of health professionals' perceived vulnerability which is expressed through their talk about responding to domestic violence being a 'war' in which they may experience 'horror' and become 'casualties'. The findings move on to illustrate women's experience of alternate practices which they suggest are powerful in assisting them to overcome the impact of domestic violence on their health and in their wider lives. Also highlighted are the positive practices of responding arising from ways of understanding domestic violence outside the medical model and also the difficulties of achieving these within the current system.

5.1 Exploring the influence and impact of the medical discourse on health service policy, practice and women's experience

5.1.1 Medical discourse and its influence on health service policy towards domestic violence

As might be expected the medical discourse, that is the traditional ways of talking within medicine which shape health professionals' understanding and practices of responding to patients, has a dominant influence on the ways in which domestic violence is understood and responded to in the District. However, this medical discourse appears to be overpowering, hiding other ways of understanding and responding to domestic violence, which are available in the District and identifiable in the talk of some policy makers and health professionals. For example the effect of the medical discourse seems to be visible in policy makers' and implementers' talk which paints a picture of domestic violence as historically and currently excluded from the health care agenda⁹ and contested as a health care issue. Their talk supports the research literature which indicates that historically health care services have been slow to respond to domestic violence (Hague, 1998). The talk of Sarah, a senior professional operating at a strategic level within the PCTs, illustrated this as she relayed her experience of attempting to draw attention to the exclusion of domestic violence from the health care agenda,

⁹ It should be noted that these interviews took place during the first stage of the research towards the end of 2001

'[I said] we were the worst offenders in dealing with domestic violence. I think I know now and we've talked about this, some of the reasons why we're not good at it, but we're still (.) not very good'¹⁰

Here Sarah's judgement of the PCTs response as *'still (.) not very good'* implies the historical nature of this exclusion. As her talk progresses it is suggested that this exclusion has been enabled by the framing of domestic violence as 'not a health care issue', as this extract from her talk about her historical experience of trying to get domestic violence recognised as a health care issue at an executive level within the PCTs illustrate

'I took two papers on the same day, one about domestic violence and one about rape and at the end of it one of the questions was 'very interesting, but what's it got to do with health?'

The exclusion of domestic violence was extended further in Sarah's response to my question about the '...historical context in which domestic violence became an issue for the then Health Authority', when she responded,

'It's not, (.) y' I mean I would argue that it is direct health service, other people would say it isn't, they would say (.) where's the targets, where's the national targets'.

The use of *'It's not'* followed by the pause *'(.)'*, indicates that domestic violence still holds a contested status as a health care issue within the PCTs. The remainder of her response appears to suggest that whilst Sarah may understand domestic violence as *'direct health service'* others do not share her understanding.

A further way in which domestic violence appeared excluded within the District was through talk which illustrated the ways in which its significance was minimised. In responding to my question about 'What strategies were put in place?', Sarah portrayed the lack of strategic action as arising from *'... a sort of reluctance to accept (4) the enormity of the issue'*. This apparent minimisation of domestic violence was also evident in the talk of June, who works at an implementation level within the PCTs, when she reported

'...we need the Primary Care Trust to actually (3) acknowledge the importance of domestic abuse as a health care issue'.

In exploring these ideas of exclusion and minimisation, we draw on Foucault (1979; 1977; 1976; 1972; 1963), who explored the impact of medicine and its ways of talking. Medicine, he suggests is a powerful force, in that it has the power to validate or legitimise certain experiences and discount others (Foucault, 1963). Foucault (1963) refers to this power as the medical 'gaze' which he suggests enables health professionals, and the makers of health policy, to 'see' and legitimise experience or have the power to 'overlook' and discount it. This phenomenon appeared to be evident in the ways in which local services for domestic violence are structured. Policy makers' talk appeared to paint domestic violence as something which was now 'seen' and identified as a health care issue as this quote from Sarah illustrates

¹⁰ The transcription symbols and notations evident within the quotations are based upon Parker (1992). A key for the symbols and notations are included in appendix 2.

'...it was something like 1997 when you know erm, the Health Authority had commissioned a piece of research, [names the researcher] which looked at the impact of domestic abuse on local services and they'd already said that you know domestic abuse was a very serious public health issue'.

However, the talk of health professionals suggested that domestic violence was 'unseen' and sidelined within health. This was evident in the talk of June, a former health visitor, now working at an implementation level for the PCT, when responding to a question posed about strategy and policy development within the PCTs. Her reply, which was quoted earlier in demonstrating how domestic violence appeared excluded from health, highlights that talk is not value free and illustrates that it has consequences. She says,

'...we need the Primary Care Trusts to actually (3) acknowledge the importance of domestic abuse as a health care issue and then to say, "right, this is going to be our strategy...".'

The emphasis June places on the words '*actually (3) acknowledge*' here emphasises what she suggests is the lack of acknowledgement of domestic violence as a health care issue, thus creating it as 'hidden' or 'overlooked'. Moreover, her quote here indicates that a function of overlooking domestic violence within health may be that it allows the PCTs to resist owning domestic violence as an issue. This implication is enhanced by the emphasis June places on the word 'our', which appears to accentuate the necessity of an 'owned' strategy in responding to domestic violence within health care services.

The status of domestic violence as 'overlooked' was also evident in the talk of those working at a voluntary level to provide services to women experiencing domestic violence, for example Paula, who holds a strategic position within a local domestic violence support agency says

'...y' know, as an issue erm it's always going to face resistance erm and there are people who would still prefer not to have to look at the issue...'

'...you're talking quite nasty issues which people would prefer not to look at and people would prefer not to look at their own response to it often...'

Here, Paula uses talk which suggests that domestic violence is visible to everyone, but is resisted not only at a structural level but at a personal level. Through her talk Paula implies that she is one who 'sees' and 'owns' domestic violence whilst those within statutory agencies are actively resistant to domestic violence, not passively unaware, but rather 'choosing' to ignore it at a personal and organisational level.

5.1.2 The impact of the medical discourse on health professionals' practices of responding to women experiencing domestic violence

Having established the impact of medical discourse in influencing the ways in which domestic violence is understood and responded to at a strategic level within health services in the District, the findings now move

forwards to explore its impact on health professional's practices of responding to domestic violence. Here, the research draws on the talk of health professionals which offers a window into the ways in which they understand domestic violence and respond to women who access their services in relation to it. This talk, illustrated the heavy influence of the medical discourse in structuring their response.

One prominent way of talking about responding to women experiencing domestic violence which illustrates the traditional roles made available to women through the medical discourse was to construct responding as 'fixing things'. This way of talking about responding was evident in the accounts of Louise, a general practitioner and Helen, a health visitor. Whilst their talk is in some ways different, it provides an illustration of the different roles made available to women through the practices of responding by different health professionals. In her response to my question about 'how domestic violence possibly is present within [her] work' Louise suggested,

'I wondered why she was coming and I think, now, maybe we're getting to the bottom of it, whether I can do a lot about it?'

Her talk here appears to imply that the role of general practitioners is to uncover problems, suggested by '*getting to the bottom of it*' and to attempt to 'fix' problems once identified, as indicated by the phrase '*do... about it*'. If we consider the roles this makes available to health professionals and the women they respond to we can see that this appears to afford the health professional the traditional, powerful role of 'problem solver', in relation to the woman's traditional role as 'problem to be solved'. However, Louise's talk also highlights the limitations of the role of 'problem solver' in relation to domestic violence, through her acknowledgement that there may be little she can do to solve the problems underlain by domestic violence.

These limitations are further evident in Helen's talk, in reply to my question asking her whether she could identify any changes in '*...the way that you respond to domestic violence*' which illustrates a difference between her previous and current practice

'I know it's a long time since I was a nurse, but that's our background and you go in to fix things, and I think it's actually recognising that it's not your job to fix this erm, but it's listening and guiding the woman through it, so that she takes responsibility and does it at her pace.'

Here Helen illustrates the contrast between the practices of responding afforded by the traditional medical model, namely to '*fix things*' and the practices of responding made available outside of the model, which she suggests is predicated on '*recognising that it's not your job to fix this*'. Helen goes on to illustrate that the alternate practices of responding provide women with a different role than that afforded by the traditional medical model, placing her centrally, '*...she takes responsibility ...at her pace*'. Similarly, she outlines the alternate role this practice of responding makes available to the health professional, as a supporting role, involving '*...listening and guiding...*'. Helen's talk suggests that when responding to domestic violence it is necessary to move away from a more traditional medical model of 'diagnose' and 'cure', to one which is perhaps more akin to the mode of operating associated with responding to chronic illness. There the role of the health

professional is to empower the 'patient' to induce changes to their lifestyle or social situation in order to improve their health (Ruddy and McDaniel, 1995).

5.1.3 Women's experiences of practices of responding influenced by the medical discourse

As we have already demonstrated in this section a key benefit of adopting a discursive approach to carrying out research is that it offers the potential to identify both the limitations of current practices of responding and potential alternatives. Having established the widespread influence of the medical discourse in structuring the strategic response of the makers of health policy and the practical responses of health professionals, we explore its impact on women service users. Through analysis of extracts from women's accounts we illustrate how the medical discourse and the practices of responding it makes available to health professionals appear ineffective in understanding women's experience of domestic violence. We also highlight the constraints the medical discourse imposes on women when accessing support and responding to the impact of domestic violence on their health.

One area in which the limitations of the medical model were highly visible was in women's talk of health professionals responding as 'reinterpreting' their experience. This talk would appear to provide support for the critique of the medical model proposed by Warshaw (1997, 1993, 1989)¹¹. However, it also echoes Paula's earlier talk about domestic violence being something which is resisted or overlooked at both a personal and structural level within the District, since women's talk suggested that health professionals resisted 'seeing' domestic violence by reinterpreting their experience. Thus, they suggested, a consequence of accessing health care was having one's experience of violence reinterpreted from the social context in which it occurred into a medical context. This was evident in Alima's reflections on her interaction with a male consultant in Accident and Emergency,

'He was asking me questions like, I mean I have, I've got a scar from when I had my appendix removed. He was asking me questions like that and I was actually in Pakistan when I had that removed and (.) he wanted to know when I had it removed and what happened and where I had it removed, who did it for me, which wa, I found very, very irrelevant to the fact that I had injuries from being hit.'

Here the response of the health professional appears initially constructed as one of information gathering, as indicated by *'he was asking me questions'*. However, as Alima's talk progresses and she reflects upon the questions she was asked, this response appears portrayed as inappropriate to her presenting injuries. This appears implied by her use of the word *'irrelevant'* and the ways in which this is intensified by the double use of the word *'very'*, in the line *'...which wa, I found very, very irrelevant'*. This irrelevance, Alima suggests was not a function of the practice of enquiry itself, but rather stemmed from the focus of the enquiry, which she suggests, is irrelevant to *'the fact that I had injuries from being hit'*. Thus what Alima appears to suggest here is a process whereby the focus of the interaction shifted from talk about her husband's violence and her subsequent injuries, to talk about a medical procedure and the circumstances, both social and medical, which accompanied it.

¹¹ This was discussed earlier on page 22

This extract illustrates how, when responding within the parameters of the medical model, health professionals re-interpret women's experiences of domestic violence, filtering it through the medical discourse. Whilst we have focused on Alima's experience in illustrating this issue, her comments reflect those made by the other women, illustrating that the impact of health professional's reinterpretation is that what is subsequently responded to are the symptoms manifest through domestic violence, rather than domestic violence itself. Thus women experience their complex needs being reduced or minimised to a set of symptoms and a diagnosis, for which a simple, practical intervention can be prescribed. This is illustrated further in the talk of both Alima and Susan who suggest that their experience of domestic violence was diminished through health professionals' minimisation of both the act of domestic violence itself and the injuries which may be sustained through it.

Alima first talked about health professionals' practice of responding as minimising when she returned to reflect again upon her experience with the male consultant in the casualty department. I learned in the opening part of her response that the visit occurred following a violent outburst by her husband which resulted in Alima sustaining injuries to her lower back, her neck and her head. Her talk in the extract below appears to illustrate how Alima's potential role, as the victim of a violence assault, is minimised by the health professional, and how Alima finds herself positioned as unbelievable,

'He says, it's just your word against his, something like that, and you can't really prove that it was him that hit yer, he said, something like that and I was, I was quite angry.'

Here responding-as-minimising appears constructed through the deployment of words which appear to minimise Alima's experience, thus her 'word' that she has been abused appears diminished through the consultant's use of the word 'just' implying a negative value judgement on its reliability. Moreover, minimisation appears to occur through the suggestion that Alima should be able to 'really prove' who perpetrated the abuse, again the implication being that Alima's 'word' is insufficient. This framing would seem pertinent in that it may reflect a common stereotype applied to women experiencing domestic violence, namely that they have somehow provoked or deserved the abuse (Mullender, 1996; Ptacek, 1988; Dobash and Dobash, 1984). Moreover it provides further support for Gondolf's (1998) argument that health services and those who work within them operate within a system which is rife with social and cultural myths and stereotypes.

The experience of health professionals' responding as minimising domestic violence is extended further within Alima and Susan's accounts as they reflect upon health professionals' response to the injuries they had sustained. In continuing her reflections on her encounter with the male consultant, Alima says,

'I told him that I couldn't see out of my eye and his first reaction was, 'oh your sight I come back it's just that you've been hit and you'll, you'll be okay'. I said 'well I want my sight testing and I want it checked out at the, at the hospital'; because they've got an eye department at [that] hospital, and I said 'I want to be checked out properly, and I want to know what's happened and y'know what I can, what I can do with treatment wise'. Reluctantly he sent me across. As I say he was like, I was asking him to provide this service for me where he should've been providing it anyway...'

Here Alima attempts to reflect the direct speech of the health professional to illustrate how the minimisation she has implied was directly evident in his construction of her injuries. Thus she suggests her loss of sight is minimised as *'just'* related to her having *'been hit'*. This is constructed as a temporary situation which does not warrant further attention as implied by the phrase, *'you'll be okay'*. Through the reflected talk of the consultant Alima illustrates her experience as one in which she was cast as making a fuss about nothing. Indeed her insistence that her injury required further investigation, seemingly conveyed through *'I want it checked out'*, again seems constructed as unnecessary, through her use of the word *'reluctantly'* to describe the consultant's behaviour in referring her. Here, the role Alima appears to locate herself within is one of a 'consumer of services' who has a right to be treated appropriately, as implied by the phrase *'checked out properly'*. Moreover, she indicates that she wishes to be an active agent in the process of restoring her health through the repeated phrase *'what I can, what I can do'*. However, this role would appear to be in stark contrast to the role made possible to her through the consultant's practice of responding. In minimising her injuries, the consultant's response casts Alima as troublesome, questioning his traditional role as 'expert' by making more of her injuries than is necessary and insisting on further services which he deems unnecessary. However, Alima, in her talk illustrated how she resisted this role, suggesting that she was the expert about her own body and instead taking up a role of campaigner for her own rights.

This level of analysis is important because it illustrates what options for action health professionals' practices of responding make available to women. Here the consultant's response, clearly informed by the medical discourse, asserts his role as expert and offers Alima the role of compliant patient. However, by claiming the role of expert in relation to her own body and rejecting the role of troublesome and complacent, Alima opens up her possibilities for action, resulting in the referral. In retrospect the significance of Alima's resistance is interesting since her concern about the minimisation of her injuries were well founded; as a result of the attack she is now partially sighted in one eye. This interaction highlights the tension which may operate at the health care interaction when the traditional medical subject positions of 'expert' and 'patient' are resisted and appears to illustrate women's requirements for empowerment within the health care interaction. This would seem to allude to the recommendation by Heath (2003:319) that in order to move towards a more helpful response, there needs to be 'increasing 'partnership of experts' within general practice allowing empowerment of the patient'.

Alima's experience of minimisation was not isolated and other women also shared experience of having their injuries minimised. However, in contrast they were not all able to resist the roles offered to them through practices of responding informed by the medical model. The implication of this, for these women, appeared to be that their possibilities for taking action were diminished. Susan's experience was one which illustrated this impact clearly. Like Alima, the experience she recounts occurred whilst accessing accident and emergency services following a violent attack by her husband. Her response below arose from my question 'I'd like you to think about your experiences now of when you've been to see health professionals...think about any particular events that stick in your mind as important or significant and (.) if you can talk about that for a little while',

'Well I now when (2) last time, erm (3) e 'it me and 'e were arrested before like I told you...they took, police took me ter hospital to 'ave a doctor look at me then and 'e wor right abrupt wi' me,

even though y'know 'e asked me what 'ad 'appened and I told 'im, but it seemed ter, didn't bother 'im, 'e were right, 'e didn't 'ave any (3) I were glad ter get out if y'know what I mean. 'E wa'n't (2) wa'n't nice at all. It were y'know, 'e wa' just sort o', 'oh and er, oh that's not much and this i'nt much and oh you've got a few abrasions, n' 'e just wa'n't interested.'

In this extract Susan describes the doctor's manner in responding as *'abrupt'* and this is intensified by her use of the word *'really'*. As Susan's talk progresses she offers context to this description illustrating that this response occurred in spite of the doctor's knowledge of how her injuries were sustained, implied by the phrase *'even though...e asked me what 'ad 'appened'*. Thus the abrupt response she describes can be seen not as one arising from ignorance of her situation, but one arising in spite of, or because of, such knowledge. Her suggestion of minimisation is conveyed at several points within this section of her account. Firstly, in relation to the apparent minimisation of her contextualising information, conveyed through *'it didn't seem ter, didn't bother 'im'* and secondly and perhaps most pointedly through his minimisation of her injuries. This is illustrated though the minimising word *'just'* in relation to his assessment which Susan frames in direct speech. Within this speech Susan illustrates how her injuries are minimised though his qualifications of them as *'not much', 'in't much'* and *'a few abrasions'*. Whilst we cannot provide direct evidence of the seriousness of Susan's injuries some support for her framing his assessment as dismissive would appear to be provided by the fact that Susan was brought to accident and emergency by the police who assessed her injuries as requiring medical attention.

The impact of this experience and the minimisation of Susan's injuries and experience of domestic violence however, would appear to have had profound implications for her future action in relation to protecting her health and well being, as her continuing words illustrate,

'So when I kem away from that time (2) erm, I always thought that (3) men, other men seemed to quite agree wi' women being 'it. Y'know it didn't seem to bother 'em until this time.'

Thus Susan suggests that her own perceptions of the unacceptable nature of domestic violence were influenced by the view of the health professional and generalised to all men, illustrated through *'I always thought that (3) men'*. Here the health professional's response is classified by Susan not as an isolated opinion. Rather, it is portrayed as influenced by his membership of a group, classified by sex, who condone domestic violence, implied by her words *'other men seemed to quite agree wi' women being 'it'*. Conversely, Susan appears to occupy a role, made available through this negative health care interaction, which implies she is somehow deserving of the violence she has experienced and unlikely to be successful in receiving support from male health professionals. The significance of the last three words of this extract, *'until this time'* appears understated but are powerful when juxtaposed to this framing of domestic violence as acceptable to men. What is known to Susan, but hidden from the reader, is the contextual knowledge that *'this time'* the injuries inflicted upon her were sufficient to warrant being classified as an attempt on her life. Thus, it might be argued that through these three words she may convey the exception to the general 'male' rule. Here the change in response becomes attributed to her new status, one of being almost murdered rather than merely *'it'*.

Arguably, whilst it is clear that Susan received the medical attention her injuries warranted, the practices of responding she encountered and the viewpoint of domestic violence they appeared to arise from exacerbated Susan's situation, by isolating her from seeking medical help in the future. The idea that responding to domestic violence might make things worse for women, has been cited in the wider research literature as a reason that health professionals give for not intervening further. However, women's talk appears to suggest that health professionals are in danger of making things worse through adhering to practices of responding arising from the medical discourse which serve to minimise women's experience and deter them from seeking assistance. Indeed, this may be related to the masculine origins of the medical discourse which, in conjunction with wider male discourses of women, has historically functioned to pathologise and medicalise aspects of women's everyday experiences, one such example being the re-framing of premenstrual tension as 'hysteria'. The implications of such minimisation in relation to domestic violence is evident in Alima's talk about her early experiences of accessing health care services,

'So I had five Support and Survival leaflets.... But I didn't feel that I could trust anybody, I didn't feel that anybody was gonna help me (.) because the police hadn't really been of any help to be honest with you and m, making that visit down to casualty it was just about, I felt patronised and I felt like he, he didn't understand at all. I felt like he was laughing at me, the doctor'.

Here Alima describes herself as '*patronised*' a feeling arising, she suggests, from being the butt of another's humour, implied by the phrase '*laughing at me*'. The patroniser is identified quite clearly as the health professional; '*the doctor*'. Her talk outlines her experience of the health professional as uncaring, insensitive and mocking of Alima and her situation, mirroring the way in which health professionals have been represented within the wider research literature as 'unsympathetic' (Richardson and Feder, 1996). The implications of this kind of response are however, clearly identified, '*I didn't feel that I could trust anybody*'.

5.1.4 Summary

These practices of responding, informed by the medical model, which serve to patronise women and to minimise their injuries and experience of violence, therefore appear to have implications for wider health care practice in relation to domestic violence. Moreover, they appear to provide support for the literature which characterises the response of health services as operating to minimise and deny women's everyday experience of violence (Kurtz, 1987; Abbot and Williamson, 1999; Williamson, 2000). They also appear to echo the discourse of exclusion¹² which was drawn upon by June, a former health practitioner and Sarah, a senior professional within the PCTs. June and Sarah construct domestic violence as excluded-through-minimisation from wider District and health strategies. Sarah portrays this as arising from '*a sort of reluctance to accept (4) the enormity of the issue*'. Clearly there appear parallels here between resistance to the seriousness of domestic violence at a macro policy level and at the micro level of the health care interaction.

¹² See page 35

5.2 Highlighting positive practice: the influence of alternate discourses for responding to domestic violence

What has been presented thus far within the findings is a critical consideration of the impact of the medical discourse and the policies and practices made available through it within the District. It would appear that the findings offer considerable support for previous research literature which has highlighted the ineffectiveness of the medical model when responding to domestic violence. Whilst it seems clear this discourse and its practices permeate and can be argued to be the dominant influencing force at all levels within the District's response to domestic violence, other alternative discourses were also identified. These discourses and the practices made available through them, illustrate a range of different possibilities for taking action and responding to domestic violence. This next section of the findings illustrates their impact at the level of health policy and within the health care interaction. Highlighted are the possibilities for practices of responding which are reported to be more effective and helpful to both health professionals and women, whilst also considering the implications associated with operating within these practices.

5.2.1 Exploring alternative discourses and their impact on the development of health policy

As section one of the findings illustrated the medical discourse appears to exert a strong influence on the policy response to domestic violence in the District. However, the District also appears to have made progress in advancing responses to domestic violence which appear inconsistent with this discourse, for example the Support and Survival Health Initiative project. This 'progress' appears to have been facilitated through the emergence of key people who have sought to address the power of medicine to overlook domestic violence by drawing on alternate discourses, that is, ways of understanding and responding to domestic violence which do not stem from medicine. One such way of talking is centred on 'ownership' and its implications for responding to domestic violence.

The accounts of policy makers and implementers drew on ownership talk illustrating how individual and collective ownership were both important in 'progressing' the strategic response to domestic violence. Talk about ownership of domestic violence as individual, indicated that the District's historical progress had been brought about by the intervention of 'key people' or 'champions' as June and Sarah's response to my question enquiring '...why it happened that domestic violence came to be a focus for the Health Authority?' illustrates,

'I think it's, it was about really the key individuals within the Health Authority that actually took this on as part of their agenda and were actively seeking ways how they could address this'. (June)

'I think it, I think, yeah I think I was a product champion and I kicked the issue, I thought it was an important enough public health issue to push'. (Sarah)

Through her talk, June appears to refer to historical others, as 'champions' and 'pioneers', whilst Sarah directly draws from the talk of marketing or advertising to identify herself as a 'product champion'. Through the

marketing discourse, domestic violence appears to become framed as one of many ‘products’ in the health care arena, which may or may not be successfully ‘sold’ dependent on the presence or absence of a champion. However, as her talk progresses Sarah is careful to illustrate that once the strategy has been ‘sold’, its success again relies on ‘key people’,

‘I suppose it all really focuses around the health project as far as I’m concerned, and erm (3) I mean (2) [sighs], if it hadn’t been for having some really outstanding input from [June] I think it wouldn’t have been the success it was.’

Whilst Sarah and June’s talk may suggest that they have been successful in influencing and implementing health policy in relation to domestic violence, this influence appears contingent. For example Sarah in her response to a question about ‘how domestic violence came to be a focus for the Health Authority?’ says,

‘So being able to bring some money in helps, and then you can work on it and legitimise it and show the (.) influen [unfinished]. the , the, the, y’know shapers, that it’s important...’

Here Sarah seems to suggest the position of domestic violence at a strategic level is not yet secured, as indicated by ‘then you can work on it’. In turn her own influence in moving domestic violence up the health policy agenda is contingent on acquiring external funding, which will provide legitimisation rather than contingent on any intrinsic quality of domestic violence as a health care issue itself. Thus within this talk the previous Health Authority and the PCTs have highly agentic roles, being the ‘validators’ of what counts as a health care issue. Correspondingly, others, not merely June and Sarah but all those with a ‘mandate’ for responding to domestic violence, appear to occupy the role of ‘gathering evidence’ which may legitimise their efforts and concerns. Highlighted here are the power differentials between those who can ‘validate’ and those who seek to gain ‘validation’ for domestic violence. Thus, Sarah and June’s roles appear underwritten by their distance from the power to action change other than through informing others as Sarah indicates in her response to a question about the outcomes of the Health Authority’s strategies,

‘I suppose it’s a bit ephemeral, but, but actually being able to say that you got the blessing of the Health Authority to get on with the job, and that, that w:as, y’know, that was no (.) push over.’

Moreover, such influencing appears hard won as indicated by Sarah’s use of the idiom ‘no (.) push over’.

When contextualised against the backdrop of the dominant influence of the medical discourse on the strategic response to domestic violence in the District, this talk, illustrates the vulnerable position of domestic violence within local health services. Rather than being embedded in health policy or targets, progress in responding to domestic violence appears to have been ‘sold’ and been maintained by key people. Inherent in this position is the danger that the withdrawal or absence of these people may result once again in the sidelining of domestic violence. A key finding of this research would appear therefore the need for an embedded policy response.

5.2.2 Exploring the impact of alternate discourses in influencing health professionals' practices of responding

In section 5.1.2 of the findings we illustrated how the medical discourse and the practices of responding it made available were evident in health professionals' talk about responding to women experiencing domestic violence. In this section of the report we want to illustrate some of the alternate discourses which health professionals used in explaining their practices of responding. These alternate ways of talking were drawn upon by health professionals to illustrate practices of responding which did not emerge from the medical model or medical discourse. These practices were framed as enabling a more effective response to women and were clearly linked to training which was highlighted as a turning point in influencing practice. The section begins by considering health professionals' talk about the benefits of adopting practices of responding which operate outside the medical model and draws on women's accounts which corroborate the desirability of these practices. We then progress to consider some of the less desirable implications of these practices, before identifying some of the ways in which these implications might be addressed.

It was clear that whilst different health professionals had different practices of responding to women, dependent upon the context in which the health care encounter took place, each drew on ways of talking about responding which appeared to have informed practices which were either not available through or privileged within the medical model. Moreover, these practices appeared consistent with those described by women in the wider research literature and by women in this research as helpful and empowering. This was perhaps most evident in health professionals' talk of responding as listening, encouraging, supporting, empathising and facilitating women's action. Whilst it is not possible to cover each of these in detail, we present an analysis of two, in detail; listening and facilitating women's action.

Listening appeared to be a key practice in responding. In contrast to the role of listening available through the medical model as a forerunner to the health professionals' diagnosis and action, listening was described here as a valuable response in and of itself. Helen, a health visitor, for example in responding to my question about '...how domestic violence might possibly have been present within the work that you do?' replies

'So a lot of it comes through support with them when they are feeling low [Me: Hmm.] erm, .aah and then it's listening to them, erm (2) and encouraging them to take steps...'

Note the co-operative roles made available within this talk for both women and Helen. Helen's practice of support is undertaken 'with' women, implying their joint action. Moreover, it involves placing the woman centrally by listening to her and assisting her to take action, conveyed through '*...encouraging them to take steps...*', rather than taking action for her. Caroline, a mental health nurse, similarly talks of listening to women in her reply to my question 'What is your personal view about responding to domestic violence?'

'..ensure that the person knows that there is somebody there who is going to sit and listen and not pass judgement and not go (.) and do something about it, but encourage you to look at y'know "well what can I do"...'

Significant here is Caroline's expressed lack of action following listening, implied through *'and not go (.) and do something about it'*. Also evident again is the emphasis on the woman as the taker of action and the woman as decider, illustrated through the phrase *'encourage you to look at y'know "well what can I do"...'*. These ways of talking about responding appear to privilege the less active aspects of responding for these health professionals, serving to portray responding as an event co-constructed with the women. Moreover, they appear to construct the health professionals' time and resources as available to the woman and her situation and experience as worthy of their attention.

A further way of talking about responding was to portray it as *'facilitating women's action'*. Interestingly, this talk appeared to serve different purposes for different health professionals and make available different roles for them and the women they respond to. For example, Edith, a general practitioner, employed this talk of facilitating women's action to illustrate the ways in which she will assist women to act,

'...Do you want me to, to get an appointment for you? Do you want to think about it? Do you want to come back and we'll make an appointment then or will you go home and make an appointment for yourself...?'

Thus, facilitating women's action for Edith, appears constructed in the abstract, as offering one option to women, *'referral'* and then facilitating the implementation of this via different means, each offering the woman different levels of action. Within this talk, Edith's role is one of *'provider'* of a *'solution'* and women appear to occupy the role of *'implementers'* of her *'solution'*. In contrast Helen's talk about facilitating women's action appears more concrete, for example in her response to my prompt enquiring *'What kinds of things do you think (.) fall within your remit in terms of actions for responding?'* she replies

'Erm, If she's wanting to leave, depending on the situation, erm if I was the only person available then I would arrange to meet her somewhere safe and whatever was necessary.'

Here Helen's interpretation of facilitation, whilst mitigated by the riders *'depending on the situation'* and *'if I was the only person available'*, involves a vast and seemingly unbounded range of actions involving *'whatever was necessary'*. Within this talk Helen appears to ascribe herself, somewhat reluctantly, the role of *'rescuer'* in relation to the woman whose role is *'escapee'*, needing support to make her own action successful. It is not possible to ascertain whether these different interpretations of facilitating women's action reflect personal understandings of the role of the health professional in relation to domestic violence, or arise from the differing constraints on different health professional groups. However, they serve to highlight the different possibilities for action that drawing on alternate discourses make available.

Considering the impact of these discourses, and the practices of responding they make available, is clearly an important consideration in relation to the structuring of services and their implications for training health professionals in effective responses to domestic violence. Figure six offers a comparison of the different roles and possibilities for action made available to women through these alternate discourses and those made

available through the medical discourse. The practices of responding within the medical discourse can be determined as involving action on the part of the health professional, with the accent firmly upon talking about domestic violence, in order to diagnose and provide treatment. In contrast the practices of responding informed by alternate discourses can be understood to centre on listening to women, in order to facilitate their action.

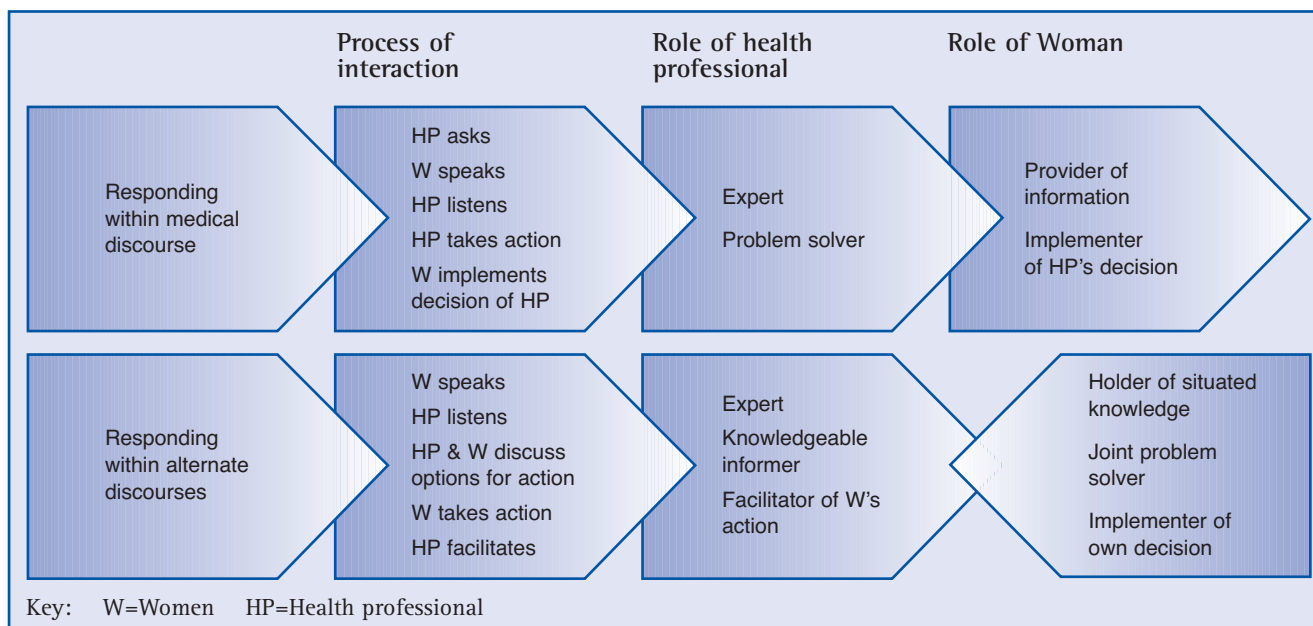


Figure 6. Comparing the roles and actions made possible through the medical discourse and alternate discourses.

Although subtle, the difference between talking and listening is significant here, as it testifies to powerful differences in the roles and possibilities for action made available to the health professional (HP) and the woman (W). In both models health professionals can be seen to occupy the role of 'expert', that is, a knowledgeable informer and source of assistance. However, when their practices of responding are informed by discourses outside of medicine, health professionals appear to make available to women very different roles than those available through the medical discourse. Indeed within practices of responding such as listening, supporting, empathising and facilitating women's action, a more powerful position appears to be made available in which the woman becomes viewed as the 'holder of situated knowledge' and experience about her situation which warrants the health professional 'listening to' and providing 'support' and 'empathy with'.

5.2.3 Good practice: women's experiences of the practices of responding arising from discourses outside of medicine.

Many of the practices of responding highlighted by health professionals as enabling them to respond more appropriately to women were corroborated within the women's accounts of their experiences. Similarly, within women's accounts these helpful and enabling practices emerged from ways of talking which were not informed by the medical discourse, appearing to reflect societal and cultural ways of talking. A key component of helpful

and enabling responses for women appeared to be the development of a knowing relationship between women and health professionals. This appeared linked to practices of responding which women constructed as enabling them to take an active role in considering possible health care interventions and actively engaging in decision making. This was perhaps best illustrated through women's talk of good practice as offering them choices.

Susan's talk reflected this when describing practices of responding which offered her a role in deciding upon the interventions she received, whereas in Alima's talk it appeared to reflect the avenues of action made available to her by health professionals. A key element in both ways of talking appeared the framing of the health professional as supportive of women's choices. Susan, in reflecting upon a health care interaction in which her medication had been reviewed, illustrates how the practice of responding which gave her choices, was very different to the practices of responding she had encountered in the past with the same practitioner,

'Like erm, she dudn't sort o' (.) just fill me prescription out or me sick note, she's started takin' time now and erm, (.) like when I went yesterday, she asked me 'ow I wa' sleeping and everything and I explained it all to 'er and then she said, she she'd increase me tablets again to 'elp me sleep on a night 'cos I'm not sleeping again. But she explained (.) .ahh what (.) erm, everything, what affect these tablets would 'ave on me and if she took me off what affect, ahh. she exp, went through everything really detailed with me and asked me if I, I wanted 'er to up the tablets or not, rather 'n' just going in saying 'oh right I'll just up your tablets.'

Here Susan's talk illustrates that the health professional enabled her to have some choice about her level of medication through the phrase [she] *asked me if I, I wanted 'er to'*. Moreover, the choice seems constructed as informed, through Susan's describing in detail the practices which led up to this offer, summing this up as going *'through everything really detailed with me'*. Susan's framing of this as a change in practice, appears implied through the word *'started'* in relation to *'taking time'*. The implication that this is current rather than previous practice is further conveyed through the contextualising words *'now'* and *'yesterday'*.

Alima's talk reflected the practice of choice in a somewhat different way, here the health professional offers possibilities and appears to resist taking action without involving Alima in the decision,

'Well, she was concerned. She, re, she said 'I'm seriously concerned, erm and', y'know, 'what do you want, what would, do you want me to do about it because I don't want to do something that you're, you're not happy with'.

In contrast to Susan's talk which appeared to relate to a single decision or choice about medication, Alima's talk appears to illustrate that she was provided with the potential for choice. Implied in the direct speech of the health professional is the possibility for action conveyed through the repeated use of the word *'do'*. Here the health professional appears to open up the possibility for action, whilst offering the choice about taking action to Alima. This appears to echo health professionals talk about facilitating women's action and provide support for this practice being valued by women. However, it should be noted that women's talk about choice appears

less concerned with directing action, as was evident in Edith's, the general practitioner's talk, and more concerned with opening up possibilities for action. Within this way of talking women occupy an agentic role in which the response of health professionals is suggested to enable them to make informed choices about medication, action and their potential effects.

Some of the practices of responding women characterised as valuable appeared to contrast with the medical model and the practices of responding it makes available. This was perhaps most evident in women's talk about good practitioners as being 'concerned for women'. This way of talking was evident across all the women's accounts and whilst its use illustrated different aspects of their experience it seemed to enable them to occupy roles within the health care interaction which were very different than those made available through the medical model.

Alima's talk, which came as a result of my prompt to tell me more about a specific encounter with her GP, outlined the concern of the health professional overtly through direct speech'

Well, she was concerned. She, re, she said 'I'm seriously concerned, erm and', y'know, 'what do you want, what would, do you want me to do about it because I don't want to do something that you're, you're not happy with'. I said, 'well, at this point will, will you not do anything about it. I don't want you to do anything I just wanted to know that if I ever need you that I, you're here to support me', and she did, she's, she was brilliant, and she said 'I am'.

Alima's response not only characterises the doctors' response as 'concerned', but emphasises this concern through the addition of the word 'seriously' and the use of direct speech, 'she said 'I'm seriously concerned'. Through this talk Alima would seem to suggest that the doctor is sensitive to the gravity of her social situation, something clearly diametrically opposed to her earlier experience with the consultant whose response she characterised as 'patronising'¹³ and 'minimising'. Here the response of the doctor appears to include Alima in the intervention process, implied through 'What do you want...me to do'. Moreover, the deferral of control for decision making to Alima is characterised not as a way that implies reluctance to take responsibility, but as one that appears to place Alima's needs at the heart of her response, conveyed through 'because I don't want to do something that you're, you're not happy with'. The characterisation of such a response as good, helpful and meeting Alima's needs appears framed through her caveat 'she did, she's, she was brilliant'. Thus, helpful responding is characterised as involving concern for Alima and placing her and her needs at the centre of any response. The role of the health professional here therefore appears very different from the role made available through traditional medical discourse and the associated practices of responding in which the health professional might be expected to decide upon the correct intervention, which the patient is then required to implement (Warshaw, 1993).

Susan's talk about the importance of the health professionals' response demonstrating concern for women offers an additional perspective. In her reflections, concern, appears to involve care and interest, not only for her health and well being, but also her wider social situation. Susan's talk about the importance of concern for women

¹³ See page 42 for Alima's earlier quotation

comes in a section of her account which occurs following my prompt 'Mmm and what, what's your experience been there [local doctor's surgery] since they've been aware of you experiencing domestic violence?'. Susan's response was lengthy and seemingly chronological, offering reflections upon her experiences from her doctor's initial response to her current experience,

'She's, y'know, she's started goin' through everything. She asked me about me' son, 'ow he's copin'. and she's remembered that and she's started asking me about 'im every time I go 'ow 'e's copin and erm (2) she asks me about 'ow things are goin' through courts 'nd like yesterday she asked me about, erm if I was 'aving a lot of stress money-wise, 'cos of the mortgage or anything like that, erm which is better wi'er, I'm being able to talk to 'er a lot better'.

Here, the characterisation of concern appears less direct than the direct speech in Alima's account and is implied through the types of questions asked by the GP. These questions appear to suggest that concern is demonstrated through operating beyond the usual limits of direct health care interventions, indicated by the phrase '*goin' through everything*'. This '*everything*' appears contextualised as the social circumstances in which Susan and her family find themselves as a result of her husband's arrest and impending prosecution. Implied within this long list of enquiries is that through her '*asking*', '*asks*' and '*asked*' the GP is demonstrating concern for Susan which she characterises as enabling her to '*talk to 'er a lot better*'. Here Susan appears characterised as a subject of interest and concern beyond the medical encounter and associated health care issues, perhaps considered as a 'whole' woman rather than a 'partial' patient. Concurrently the health professional seems characterised as thoughtful, implied through '*she's remembered that*', recognising Susan as a person not just a patient with symptoms.

As we have indicated earlier in this report¹⁴ a key function of the medical discourse is to protect health professionals from becoming too involved with aspects of the patients' lives over which they can exert little influence. However, the practices of responding which women characterised as involving 'concern' for them appeared to involve working outside of this protective framework. Their talk illustrates that this concern often extends beyond the health care interaction and considers the impact of interventions on the wider social circumstances of their lives. However, that women characterisation of these practices as helpful, enabling and desirable seems to illustrate once again the ineffectiveness of the medical discourse in enabling health professionals to respond to women in ways which assist them.

Tension between practices of responding informed by the medical discourse and those informed by alternate discourses was also apparent in women's identification of positive responding involving asking and listening. However, women did not talk of these two practices as chronological, as might be expected within the traditional medical encounter where the health professional asks, listens and diagnoses. Rather, women seemed to link the practice of health professional's asking as something that enabled their disclosure of domestic violence. The significance of asking and the potential consequences of not asking are perhaps most visible in Jo's talk when reflecting upon her initial visit to the antenatal clinic. In this first extract she indicates that by asking, the midwife opened up the opportunity for dialogue,

'I was talking like, to the, to like the midwife because I 'ad to like, ' cos I, I, I wasn't sure what I wa' going to do and she asked me why (2) and I just said, y'know I just explained what wa' goin on and she says 'its domestic violence' and then she put me in touch with (2) like erm Support and Survival and then I started understanding what I was that I was, I was dealing with and what I wa' going through'.

Here, asking appears no more than enquiring further about Jo's indecision about continuing with the pregnancy *'and she asked me why'*. It does not arise from routine enquiry or screening, but nevertheless functions to enable Jo to disclose. The significance of asking, for Jo, appears underlined by the additional information she provides in which the health professional is seemingly 'diagnosing' domestic violence, *'and she says 'its domestic violence'*. Here Jo describes herself as naïve about domestic violence and what constitutes it, whilst at the same time acknowledging that the midwife is knowledgeable. This interaction would appear to mirror the expected 'ah ha' factor common to the traditional medical subject positions of expert and patient, where the patient provides the information which the doctor interprets resulting in diagnosis. However, what appears most significant here is that the practice of 'asking' is identified as opening a gateway to understanding and referral to a support agency. This appears indicated through the word *'then'* in relation to *'I started understanding'*.

Jo's talk echoes the earlier talk of health professionals about the importance of asking as part of the effective response. It suggests that Edith's characterisation of asking as *'only opening up the possibility of talking about it'*, is in light of Jo's experience more than sufficient in enabling women to disclose domestic violence and gain access to further support. However, it would seem important to draw attention to the distinction women appeared to make between health professionals' 'asking' about domestic violence and their own experience of being 'required to tell'. This distinction appears to illustrate that it is important which discourse informs health professionals asking. Indeed women's talk illustrated that when questioned from a medical discourse, women appear to experience being required to tell and in some cases tell repeatedly. Such practices were portrayed by women as distressing and to be resisted.

5.2.4 Disclosure, telling again, and again and again.....

The difficulty associated with telling and its potential for trauma was conveyed throughout women's accounts of their health care experiences. Highlighted throughout was the distressing impact of being required to tell and tell repeatedly. The implications of this for practice appear significant in light of the developing policy and responding guidelines which aim to encourage health professionals to ask women about domestic violence (DoH, 2000; Heath, 2003). The move towards routine enquiry for domestic violence and the body of research literature which supports this move indicates that women do not mind being asked by health professionals about domestic violence (Watts, 2000; 2002). Moreover, a growing body of research literature suggests that women who experience domestic violence may be waiting for health professionals to ask them about domestic violence (Drake, 1982). In light of this dominant knowledge it would seem crucial to consider in more detail the relationship between telling and re-telling and the subtlety required when asking women about domestic violence.

Susan and Eileen's talk illustrates that the repeated requirement to tell health professionals about domestic violence was a negative and problematic aspect of accessing health care. This is conveyed in Susan's narrative about accessing health care services as a result of her husband's violent assault,

'I'm sort of 'aving, I 'ave to tell 'em again what's, and I find that upsetting 'aving to keep goin' over it and over it, cos it does make yer feel, yer feel guilty (.) embarrassed, y'know, of 'aving to keep repeating it'...

Here, the use of 'again' and 'goin' over' indicate that telling can be a repetitive enterprise. Indeed this appears intensified by the word 'keep' in relation to the 'goin' over' which Susan relates. The nature of repeated telling as negative rather than cathartic appears manifest through Susan's characterisation of it as '...upsetting...' and invoking feeling 'guilty (.) embarrassed'. Within the encounter she narrates Susan appears required to tell, implied by the repeated use of the words 'aving' and 'ave'. Moreover, she also appears placed as responsible for supplementing and or replacing each health professionals' level of information about the reason underlying her health care requirements. In contrast her talk implies that health professionals have abdicated responsibility for being informed and do not need to inform themselves of Susan's situation, because it is easier to ask her. Further weight is given to this interpretation as Susan continues,

'...but erm, (.) I went last week and that were' first time I'd seen that doctor, but I didn't 'ave t' explain to 'im what 'ad 'appened.'

Here Susan indicates that not all health care interactions require her to tell the story of how her injuries were sustained. The implication in this section of her talk is that this was because the health care professional had prepared in advance. Thus, it appears that by taking care to be informed in advance of the health care interaction, the health professional can remove the woman from the responsibility to 'explain' and thus the requirement to tell again.

In considering the implications of this way of talking for the developing movement towards implementing routine enquiry it would seem pertinent to make a distinct between re-telling and initial disclosure. Susan's talk about re-telling the story of her injuries and its negative impact upon her indicates that women who have already identified themselves as experiencing domestic violence can experience the health care interaction as a place where they are required to re-live their ordeal. Thereby reliving the concurrent emotions experienced when required to repeatedly tell their story. In terms of the practices of responding, it would appear that some health professionals are not prepared in advance of seeing clients. Consequently, women appear required to repeatedly disclose, despite the associated difficulty and trauma. By implication the health professional in this case appears either unaware of the impact of not preparing or insensitive to the impact of telling for women. However, when questioning arose from outside of the medical discourse, for example, through ways of talking which suggested that health professionals questioning was related to their concern for women, discussed earlier in this section, women appeared to portray this as desirable and helpful.

5.2.5 Listening is good practice

All the women, in reflecting upon good practice, highlighted listening as ‘good practice’. However, there were very few examples in their accounts of listening as a practice engaged in by front line health professionals. Examples of listening as a response came only when reflecting upon their experiences with counsellors through the Intercept project. One example of the importance of listening was provided by Jo as she reflected on her experiences in overcoming domestic violence. Jo talked of overcoming domestic violence as a journey, in which she indicated that she ‘... wouldn’t be as far on as what I am now if it adn’t ‘a been for Isabelle, from t’Intercept’. This prompted me to ask ‘What kind of support has she been able to give you?’, to which Jo responded,

‘She (2) she listens and erm (3) she listen to what you’ve got ter say and then, and, and, then she’ll like carry on from it and then put ‘er ‘er view from it’

In this talk Jo directly outlines the practice of responding through the phrase ‘*she listens*’. Moreover, Jo indicates that listening is the primary activity of the health professional, suggested through the follow on phrase, ‘*and then*’. Jo’s talk also indicates that it is only following the practice of listening that the health professional participates further in the interaction, implied through ‘*and then put ‘er view*’. However the difference between this practice and the practice of listening made available through the medical discourse, is that the ‘*view*’ offered here is suggested to arise out of the listening process rather than pre-existing it, as implied by Jo’s use of the phrase ‘*from it*’. Thus the health professional is suggested to offer a different perspective from which to consider one’s own understanding of an event or statement, rather than holding the correct or expert view as is perhaps more consistent with traditional medical subject positions. That listening is the predominant practice of responding in women’s interactions with Intercept counsellors may reflect the different traditions of training, methods of intervention and discourses which underlie the two professions of medicine and counselling. However, what appears clear here is that such an approach is valued by women. The potential benefits are explored more closely in the final section of the findings which looks at women’s understandings of their experiences of violence and health care responding and their impact on enabling them to develop stronger ‘selves’ which can resist domestic violence. However, in returning to this current talk, what appears afforded here to Jo is not merely space to speak, but a forum in which she is actively heard and her experience validated.

5.2.5 Summary

What we have aimed to illustrate in this section of the analysis is that the discourses women and health professionals use to convey their experience and the practices of responding made possible through those discourses illustrate the possibilities for taking action available to them. We have also aimed to illustrate that some practices of responding make available greater possibilities for women’s participation in the health care interventions suggested by health professionals. In turn, practices of responding arising from the medical discourse appear to close down these beneficial and enabling opportunities and therefore encounter women’s

resistance or passive acquiescence. These findings aim to illustrate the enormous power the medical discourse exerts over the possibilities for action available to women and health professionals in the health care interaction. Moreover, we have aimed to illustrate how women appear to draw on their previous experiences of health care interactions to either endure or actively resist unhelpful practices. Thus we suggest women are aware of, and familiar with, the traditional roles made available to them within practices of responding arising from the medical discourse. Being familiar with the role of 'object' of the health professional's scrutiny and being aware of the health professionals' role as 'expert interpreter' in prior encounters, it is unsurprising that women employ ways of speaking and responses which are consistent with this historical experience.

However, based on the interpretations presented within this research it would seem that health professionals appear ill-equipped to occupy the position of 'expert interpreter' in relation to domestic violence. Rather, a reversal of roles is evident in that the 'expert' about domestic violence, its impact upon her health and the ways in which it constrains her actions, is the woman. However, when responding from the medical discourse health professionals' practices towards women do not appear to take account of this knowledge. Indeed the ways of talking in women's accounts suggest that these practices of responding are least helpful. In contrast when responding through alternate discourses health professionals practices appear to take account of women's knowledge. These discourses appear to make available more equitable roles for the health professional and the woman, drawing on the expertise of each, in considering interventions. We suggest that this indicates that successful change in practices of responding is both desirable and possible within the District and offers hope and a foundation for future possibilities for practices of responding within the District.

5.3 Highlighting the implications for health professionals when operating outside of the medical model.

It is clear therefore that there is considerable agreement between both health professionals and women participating in this research that the practices of responding which are outlined as most helpful and enabling are those which do not emerge from the medical discourse. This section of the report moves forward to examine how health professionals account for the emergence of these alternate practices and illustrates the importance attributed to recent domestic violence training initiatives in the District. It progresses to explore the 'cost' to health professionals experienced through adopting these beneficial practices and culminates by considering what strategies may be desirable in minimising these 'costs' and supporting health professionals to continue with these beneficial practices of responding.

Clearly beneficial practices of responding arising from discourses outside of medicine appears to have implications for the health professional in that it appears to distance them from the protective mechanisms argued to be enabled by the medical discourse. Nevertheless, health professionals suggest that their experience of operating outside the protective mechanism of the medical models makes them 'vulnerable'. This is evidenced in health professionals' descriptions of responding to domestic violence as 'horror' and 'warfare'. These ways of talking about responding to domestic violence appear to provide context to representations in the wider literature of health professionals as 'reluctant' and 'unhelpful'. Indeed they appear to illustrate that failure to

respond may be related more closely with a discourse of ‘can’t’ rather than ‘won’t’. It is perhaps unsurprising then that a prominent ways of talking about domestic violence was as a ‘problem’. In line with the research literature which has sought to illustrate health care professionals’ experiences of responding to domestic violence (Davis, 1984; Sugg and Innui, 1992; Richardson and Feder, 1996) this way of talking serves to construct domestic violence as problematic for the health professional.

5.3.1 Horror and the health professional

The ‘problem’ nature of responding was illustrated variously across the interviews through the health professionals’ use of metaphors and extreme case formulations. Extreme case formulations can be understood as ways of talking which indicate the dramatic impact of an event or situation. One such example is the use of the extreme case formulation ‘horror’ by Edith, a general practitioner, to describe her past experiences of responding to domestic violence. Edith uses the term ‘horror’ in offering a comparison between her feelings about responding before undertaking training and her feelings of responding afterward

‘em (.) also that em, (.) enabled me to deal much more, more (2) confidently, so that (.) one doesn’t get the the (.) em, (2) horrors, of ‘God, no! not the half hour with that person’.

The impact of referring to responding to domestic violence as ‘horror’ can be understood by referring to the roles available within the horror genre (Tudor, 1989; Jancovich, 1994), in which the ‘victim’ is s/he who endures the horror and the ‘monster’ is s/he who does the horrifying. It might be argued that the use of ‘horror’ here serves to allow the health professional to illustrate a perceived reversal of the usual roles within the health care interaction.

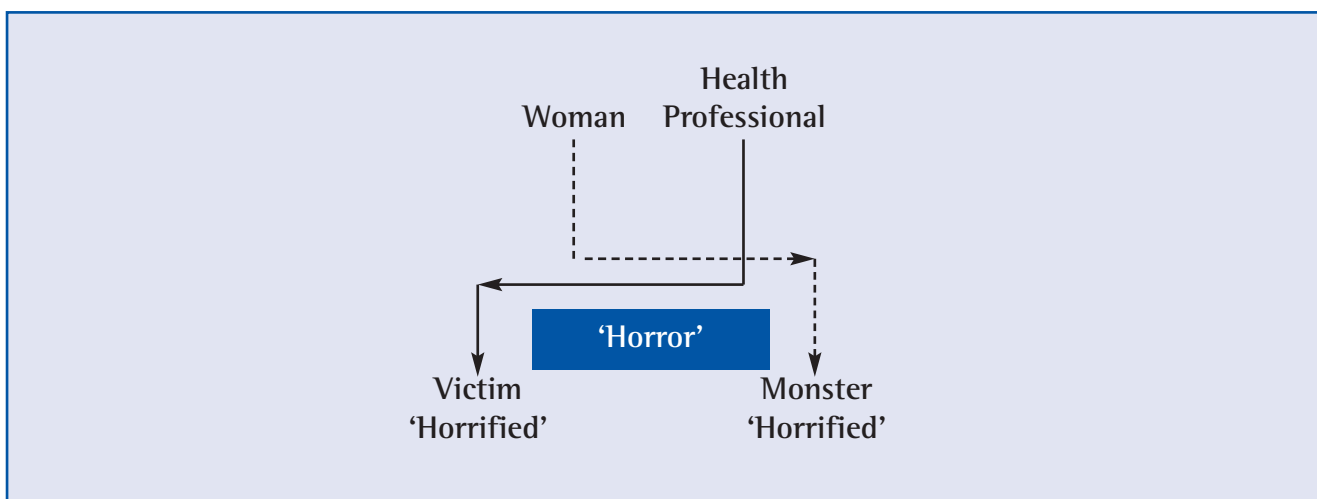


Figure 7. Positioning within the arena of ‘Horror’ and the problem discourse

Within this reversal the health professional becomes the enduror of the horror, and in need of ‘saving’ whilst the woman become the ‘horrier’ who must be ‘resisted’ or ‘avoided’, as figure 7 aims to illustrate. Moreover, this appears intensified in Edith’s extract by the evocation of ‘God, no!’, which can be understood as an appeal

for the assistance of a ‘higher power’. By using the dramatic way of talking to illustrate her experience Edith indicates the level of vulnerability she experienced when responding to domestic violence before her training.

5.3.2 Warfare and the front line

Health professionals also drew on the discourse of war to characterise their experience of responding to domestic violence. This discourse is perhaps familiar within health and is perhaps more usually employed to illustrate a unified national or international strategy aimed at tackling a specific health care issue. However, it was not employed in this way in health professionals’ talk; rather it appeared used in again illustrating health professionals’ perceived vulnerability. One of the prominent ways in which the warfare discourse was employed was in illustrating responding to domestic violence as ‘*the front line*’. This was supported by references to health professionals working ‘*on the ground*’ and without ‘*back up*’ from the PCTs, as this extract from June illustrates,

‘So down at the front line, we still have got, y’know this hardcore of professionals who are clamouring for the training...’

Figure 8 aims to illustrate the impact of this way of talking in describing the experiences of those responding to domestic violence within health services. The illustration uses both words from participants’ transcripts which are presented in italics and our own interpretations presented in normal font. In characterising responding to domestic violence as warfare, it would appear that health professionals become framed as ‘at war’ with domestic violence, fighting ‘*at the front line*’, alone and ‘at risk’. In contrast the PCT seem to be distanced from the perceived risk, the issuers of orders, not ‘*on the ground*’ but removed from the ‘*front line*’ and therefore isolated and safe. Further, it appears to indicate that the PCT are either passively unaware of what is happening at *the front line*’ or actively withholding, the required ‘*back up*’.

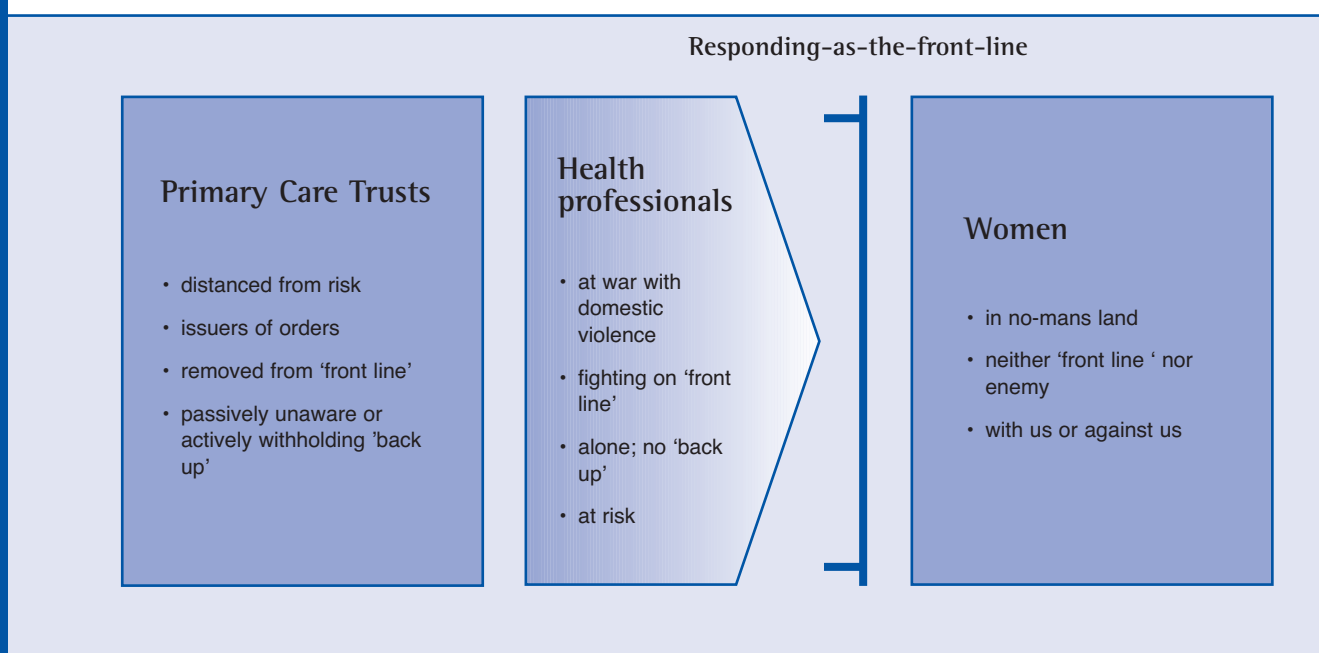


Figure 8. Illustrating the implications of characterising responding to domestic violence as ‘the-front-line’

Louise, a GP also extends the allusion to war in using the phrase 'shell-shocked' to describe her personal experience of responding to domestic violence,

'And again, it was a nice family, y'know a lot of love family, a nice family, a nice address (.) .ahh and you have to be not too shell shocked by these things and .ahh just get on with it really and give them practical advice and psychological help'.

The imagery invoked by the use of the term 'shell shocked' implies that responding to domestic violence is traumatic, akin to prolonged engagement in warfare, which it is alluded may result in psychological strain for the health professional. This imagery is significant when juxtaposed with the other descriptors in this text, 'nice', 'love', 'family' which might be interpreted as reflecting the inaccurate stereotype that some families are less likely to experience domestic abuse than others. It might be argued then that the shock factor of responding to domestic violence is more intense for the health professional in relation to some families than others. Through this imagery, Louise appears cast as a potential 'casualty' in the 'war' against domestic violence, one who cannot withdraw but must 'get on with it'. However, this way of talking about domestic violence also has implications for women who upon experiencing domestic violence then access health care services. They risk being located in 'no-man's land', neither the 'front line' nor the enemy. Moreover, this location appears precarious, since operating within a discourse of war, compliance with the health professional's direction may serve to place the woman 'on our side', whereas failure to comply, for whatever reason may risk her being placed as 'not with us, therefore against us'. This appears consistent with the research literature which suggests that being 'with us' equates with an expectation that women will follow the course of action prescribed by the health professional in order to overcome their 'illness' (Warshaw, 1989; Sugg and Innui 1991; Brown, Lent and Sas, 1993). However, this way of talking about the experience of responding to domestic violence may also leave health professionals and women at a stand-off if women are unable to assist in the recovery process in the manner prescribed by the health professional (Williamson, 1999).

5.3.3 Summary

In considering the implications which arise from health professionals' characterisation of their experience of responding to domestic violence two key issues emerged as important. Recent training, provided through the Support and Survival Health Initiative, was portrayed as something which facilitated access to alternate and more effective practices for responding. This would seem significant since this training, at least in its initial form, is no longer available; being part of a time and finance bound initiative. However, whilst the new and alternate practices of responding this training has engendered are characterised as more effective, by both health professionals and women, it appears to contribute to health professionals feeling isolated and unsupported. This might perhaps signify the partiality of the PCT response in that the training has not been followed by the provision of ongoing support and guidance. A key finding arising from the research would therefore seem to be the need to make provision for the ongoing support and development of health professionals in relation to this change in practice.

5.4 The impact of different practices of responding for women's understanding of self and recovery from domestic violence

In this final section we produce findings which illustrate what women's ways of talking tell us about their subjectivity, that is, their sense of self or awareness of who they are. This aspect of the analysis is particularly rich in illuminating the impact that different practices of responding have for the ways in which women make sense of their ability to address and attempt to overcome domestic violence at a personal level. The section begins by illustrating women's awareness of who they are as changing and changeable and how this is bound up with their experience of accessing health care services. A key facilitator, women suggest, of this change is their experience in accessing the health service support project, 'Intercept'. Highlighted throughout this section are the ways in which women draw attention to the impact of Intercept in enabling them to 'build' a stronger self, who can 'fight' domestic violence, and concurrently its impact on their health.

5.4.1 Understanding one's self across the experience of domestic violence

In talking about their experience of accessing health care services women indicate that their awareness of who they are has changed. This is conveyed through the different ways of talking women employed to express their understandings of themselves. These ways of talking suggest that rather than viewing their self as fixed and unchanging, they are aware of being different selves at different times and in different contexts. This was perhaps most visible in women's talk which compared their understandings of self across time, highlighting their understanding of who they were before domestic violence and who they had become through their experiences.

Jo's apparent comparison of past and present selves occurred towards the end of the interview, in response to my question about her experience with the Intercept counsellor, 'What kind of impact do you think this support that Isabelle has been able to give you, what kind of impact do you think that's had on you?'

'(3) I'm (2) just (3) I just feel more like me old self (.) more like me old self erm, like, erm if you'd seem me a few months ago I was in, in fact I don't think I'd a spoke without crying, in fact I wouldn't a spoke without crying erm, (2) just a lot better. I look better (2) a lot, y'know, I just, just, just looked like I 'ad this massive weight well it was, it was a massive weight on me all, y'know just really, y'know when a person just looks heavy and looks do::wn and (3) I wa' just like that and I 'ad n::o energy and I couldn't deal with things...so I've just gone back to being more like (.) me'self so (.) basically I can cope with everyday things that a normal person can cope with, that you should be able to cope with, I've gone back to bein' able to do that'.

Here Jo appears to make sense of who she is, by referring to a trinity of selves, the first of which 'old self' appears framed as 'normal', contextualised as able to 'cope with everyday things'. The in-between self, the self who experienced domestic violence, is seemingly characterised by distress, portrayed as less able to control emotion, implied through 'I don't think I'd a...' and 'in fact I wouldn't a spoke without crying'. This self appears

portrayed as burdened, implied through the imagery invoked by the phrase *'massive weight'* and the descriptors *'heavy'* and *'do::wn'*. The third self, indicated as her current self, is constructed as *'more like me old self'*. Implied here is that this is not a return to a previous self, but rather a transformed self, who can achieve the things her old self was able to achieve, signified through *'I've gone back to bein' able to do that'*. Alluded to within this talk also appears the social responsibility Jo feels, to have a 'coping' self, implied by the word *'should'* in relation to coping; *'that you should be able to cope with'*.

Alima also appeared to compare the selves she has experienced herself to be in a section of her talk which occurred towards the end of her account where she reflected upon her experience with the Intercept counsellor Isabelle,

'Everything's changed so much (4) 'nd (3) it's just, I don't know (3) realising that there was support out there made me the person that I used to be back again (.) maybe not, if not the person, made me stronger, made me stronger than what I used to be (5) and thing that he used to affect me most was that he used to think, you used to hear about, y'know, domestic violence and arranged marriages, people getting hi, women getting hit and things and I used to think 'oh that'll never happen to me, I'll never let anybody do that to me'

The opening four words of this sentence *'everything's changed so much'* appear to set the scene for the rest of her talk which, as with Jo, appears to indicate a transformation in Alima's understanding of who she is. Within this talk Alima refers to her old self as *'the person that I used to be'*. In contrast to Jo, she moves on to suggest that she has returned to this former self, implied through the phrase *'back again'*. However, she then challenges this representation, creating a distinction between that self and her current self through the phrase *'maybe not, if not the person, made me stronger'*. Implied here is that the self she currently experiences herself to be may share some elements with this former self, but is now different *'stronger than what I used to be'*. This is followed by her reflection on the old self, as someone who was aware of domestic violence but would not tolerate it herself, implied by *'I'll never let anybody do that to me'*. Thus, seemingly created is a distinction between a former self who would not tolerate domestic violence, a self who did experience domestic violence and the current self who is *'stronger'*. Here in telling her experience of selves across time Alima appears able to convey self as something improving and progressing.

5.4.2 The negative impact of the medical model for building a stronger sense of self

In contrast to women's portrayal of their current selves, supported by Intercept, as stronger, improving and progressing, were their portrayals of the impact of the medical discourse on their understandings of self. Throughout this report we have attempted to illustrate how the medical model attaches to women a specific identify which they are required to recognise and have others recognise in them. At times it was clear that women appeared to conform to these identities, for example in portraying self as a 'nervous wreck' and as 'broken'. Though these metaphors and images women appeared to illustrate the ways in which their

understanding of self had conformed to the general identity offered to service users within the medical discourse. Through this general identity women appeared to be fractured by domestic violence and either unable to fix themselves without assistance or as unfixable. This is perhaps best conveyed through Eileen's use of the metaphor 'a nervous wreck'. Eileen used the metaphor repeatedly in her account seemingly to portray self as broken down by anxiety and worry, as her response to my prompt 'How did you cope with the abuse yourself during that period of time?' appears to illustrate,

'Terrible (2), terrible (2). The, I couldn't, I, erm, really really badly (4). Well I used ter be lying in bed at night-time I was just shakin', a, from a Friday to a Monday, I was just a complete nervous wreck. I was terrified, I was, well I'm st, I'm liv, I was livin' on me nerves.'

Here the minimising word 'just' and the adjective 'complete' appear to intensify Eileen's characterisation of self as a 'nervous wreck'. They appear to suggest that Eileen is somehow 'reduced' by this anxiety; less than whatever she might have been previously. Implied is that she is now only this debilitating state of nerves and anxiety. Indeed Eileen's portrayal of her current self through this metaphor seems extended later in her account, when in reflecting she suggests,

'...cos I wa just an emotional wreck, I couldn't eat, couldn't sleep, I was just livin' off me nerves, I st, which I still do.'

Within this section of talk, the term 'nervous' is substituted for 'emotional' in relation to her portrayal of self as wreckage providing further information about the apparent 'symptoms' of such a position, 'I couldn't eat, couldn't sleep'. Moreover, Eileen portrays not only her past self but also her present selves as fractured, as implied through 'I was, well, I st, I'm...'. Thus Eileen illustrates the negative value and impact of domestic violence upon her current and previous self. Noticeably absent is any allusion to a former self prior to domestic violence, as with Jo and Alima, earlier.

This portrayal of self as wrecked or fractured is also evident in Alima's account where she refers to self as something which has broken down. Through this talk self appears characterised as something which can cease to function properly, as this extract of Alima's talk illustrates. The extract comes at a point in her talk where she is contrasting her disappointing experience with a counsellor from the District's former, voluntary, support agency and her experience with her current counsellor from the new Intercept project,

'...an::d it, it's just perfect, it's just the way (2) I, I wanted it to be with this worker [initial counsellor]. I wanted her to sort of help me through it and support me but she never did. And (3) I think, when my, when the nurse from the local surgery referred me through to Isabelle [Intercept counsellor] I was at a point of breaki, breaking down totally. Totally just givin in.'

Within this section of her talk she frames 'self' or 'identity' as something which can deteriorate, fracture and break down, as indicated through the word 'totally' which appears to operate to illustrate the finality of the

process, the potential end state, 'broken'. For Alima it appears that this end state arises when one's attempts to keep trying cease, implied by *'givin' in'*.

Arguably these ways of talking about self as broken down or a 'nervous wreck' appear allied to the identity made available to all patients' in general medical discourse. There the individual is viewed as 'not operating properly' due to the onset of 'disease' which can be 'cured' by the interventions of health professionals, through drugs, surgery and other medical practices. Within their talk here, women, whilst not identifying themselves as 'diseased', seem located as not operating properly. Through these ways of talking, it may be argued, they illustrate conformity to the identity offered within the medical discourse, portraying themselves as requiring the assistance of another who can enable their repair. Frank (1995:85) has talked about the effect of the disease model of medicine suggesting that through it the 'broken-down body' becomes the focus, the 'it' which is to be 'cured'. However, it would appear that when responding to domestic violence the, the 'it' which is to be 'cured' is not only the body, or the symptoms, but also 'I'; the self.

5.4.3 Warfare and the journey: creating alternatives to the identities offered within the medical discourse

However, there was also evidence in women's talk of their active resistance to the identity or understanding of self offered through the medical discourse. This was evident in ways of talking through which they seemed to portray themselves as active in overcoming or resisting domestic violence. Indeed women drew upon ways of talking which appear inconsistent with the seemingly passive identity which has been argued to be made available to them via medical discourse (Glass, 1995; Warshaw, 1993). These alternate ways of talking about and understanding self appeared to be drawn from a wider range of socially and culturally ways of talking (Shumway, 1989) including discourses of war, construction, journeying and strength.

Two ways of talking drawn upon by women appear to portray them as actively restoring self or resisting the impact of domestic violence upon self. These are the portrayal of self as a fighter and self as a builder. The first of these, self as fighter appears to draw upon the discourse of war, already discussed in the talk of health professionals. Jo portrays herself as a fighter in a section of her account where she appears to juxtapose herself and the perpetrator as two sides within a conflict,

'You know that it's, it's, it's not me, that it is 'im, y'know that, that it's 'im whose got the problem if, if 'e can sit in a bush fo' [laughs] twelve hours plus, when it's freezing cold and it's raining just to stare at me and watch me cum in and out of me car, then I think it's 'im who's got (2) who's got a problem and that I am strong enough and that I can beat 'im'.

Here the allusion to conflict appears metaphorical, portrayed not as one between two physical bodies but rather a battle of wills, between Jo's self and the self of the perpetrator. Indeed Jo appears to construct this conflict, through the phrase *'I can beat 'im'*, as one which can be won only by strength of self, framing herself as *'strong*

enough'. This strength does not appear physical, but rather psychological, framed as strength of self, indicated by the repeated 'I'.

In contrast Eileen's talk of self as a fighter appears a more direct framing and is a recurrent feature throughout her account. It seems to function as a mechanism through which she appears to illustrate her active resistance of domestic violence and unhelpful practices within the health care interface. This way of talking is first evident towards the end of her answer to the question with which I opened the interview. In it she reflects upon her experience of violence,

'I can wake up now hearin' his voice in me ears and (3) the thought o' the dog and nightmares o' the dog and it's horrible (3). S::o I could write a book me, I could honestly. I could...I could write a book. But I've fought through it all and I'm gonne fight now ter get me life back together again, and it's, but I'll fight and I will.

Through this talk Eileen appears to draw on the discourse of war, portraying herself as historically at war with domestic violence and currently at war with its after-effects. This seems illustrated by her direct reference to fighting domestic violence in the past; *'I've fought'* and the present and future *'I'm gonne fight now'*. Illustrated here again are the different selves Eileen is aware of being across time.

This idea of self as fighter appeared also to enable Eileen to directly resist both the role made available to her through the medical discourse and the practices of responding it made available to assist her in this fight. This is illustrated in her response to my prompt 'What was it like when you went [to the doctors]?'

'She just put me on like (2) anti-depressants and things like that which I, I don't like taking, 'cos I'm not a tablet (.) know wha' I mean. Like I'll r, read the instructions carefully and its, it frightens me again because it tells you all these things and I waint do it. It brings me back tay me, know wha' I mean, so I'm trying to do it on me own. I'm trying to (.) fight everything without any medication any at all.'

Here Eileen actively resists what might be termed the 'expected compliance' inherent within the traditional roles offered by the medical discourse. In addition she would seem also to resist the specific role or identity, often that of 'victim', ascribed to women experiencing domestic violence (Glass, 1995; Warshaw, 1993). Rather, it seems Eileen portrays herself as actively resistant, conveyed through *'I waint do it'*. This resistance appears qualified and legitimised as an informed position occurring as a result of acquired knowledge, framed through *'I'll read the instructions carefully'*. Moreover, it appears related to a fear of the potential side effects of medication, suggested by *'it frightens me again because it tells you all these things'*. Thus rather than a passive acceptance and conformity to the intervention deemed appropriate by the medical professional, Eileen would seem to portray herself as knowledgably resistant. The implications for her of such resistance appear significant though, in that they appear to leave her alone, *'on me own'*, in the fight against domestic violence. This location would appear to echo that drawn upon by June and Louise¹⁵ to frame their own place in the 'war'

¹⁵ See page 56

against domestic violence. Here, as there, it appears whilst potential allies exist; for Eileen, the health professional and for the health professional, the PCT, they are ineffective in the response and resources they offer.

A similar position of activity and resistance also appears afforded to Eileen through her talk of herself a 'builder'. Here the war discourse appears complemented by the discourse of restoration; invoking the imagery of post-war rebuilding as this extract illustrates,

'That's what I live for ma' kids and ma home, ma dad and everything, and it's got me nowhere now. I'm back er nothing [sniffs], trying to build a life back up again'.

Within this talk, Eileen would seem to portray herself as able to begin again, returning to a point before the war against domestic violence, implied through *'I'm back to er nothing.'* Here Eileen appears to portray herself as re-constructing, implied through the phrase *'trying to build a life back up again'*. The allusion is once again one of activity rather than passivity, portrayed as attempting to *'build'* something - *'a life'*, out of *'nothing'*. Arguably, the imagery evoked through this framing is one of physical as well as self reconstruction. However, theorists such as Nelson (2001) draw our attention to our ability to 'repair' identities which have been damaged by oppression through the narrating of our experience. Through this narration she suggests we are able to offer an account which may alter others' perception of us. In relation to Eileen, it might be argued, that her talk of self as builder enables Eileen to offer a perception of her self not as a victim of domestic violence but as a woman who having endured violence is reconstructing her life.

Women also appeared to resist the pull of the medical discourse and its associated practices of 'diagnosis' and 'cure', as Alima's reflections upon the efficacy of medication in addressing domestic violence appear to illustrate,

'The medicine she gave me (2) it did work (2) but I mean obviously you can't rely on medicine when you've to all, when you've got all that going on in your life and regardless of the medicine the problem that I was suffering at home, the problems I was going through and what I was experiencing, there was, there was no cure for it. The only cure was to get out of the marriage and I couldn't do that at that point, there was, there was no way out'.

Here Alima appears to resist a dominant strand of the medical discourse, that of the 'cure'. This is implied by her acknowledgement that whilst medicine might alleviate symptoms, suggested through *'it did work'*, it cannot resolve the practical issues which underlie domestic violence, conveyed through *'there was no cure'*. This inability to cure, Alima appears to attribute to the underlying cause of domestic violence, which she situates clearly within the social as *'problems'* external to the body, *'at home'* and *'in your life'*. This is not to suggest that domestic violence is portrayed within women's talk as incurable, but rather that the 'cure' is framed within the discourses of the social and the person, rather than medicine. Thus the 'cure', which Alima portrays as getting *'out of the marriage'*, seems to lie within her own gift, implied by the use of *'I'*, but constrained by social and temporal factors, indicated by *'at that point'*. Here the 'expert' who knows how to cure the problem seems

identified as not the health professional, but the woman. The health professional appears identified as one whose function is in assisting the prevention of 'break down' until the cure can taken up.

5.4.4 Negotiating the identities offered within wider discourses and social myths about domestic violence

In addition to resisting the identity afforded through the medical discourse, it was evident in women's talk that they also had to negotiate identities which are attached to women through other ways of talking, such as the discourse of citizenship (Faulks, 2000) and through dominant social and cultural myths and stereotypes about women who experience domestic violence. It appeared that women were required to negotiate these identities, not within the health care interaction, but in their attempts to rebuild their sense of who they are, post domestic violence. Arguably, this is the process which Intercept, as a service aims to support women through. Thus, in making sense of who they are in recovering from domestic violence women must negotiate the possible identities afforded to them at a societal level.

Faulks (2000) has argued that being a citizen and belonging to society involves a contract between the authority of the state and autonomous actors, in which there is a balance of rights and responsibilities. The ways of talking attached to being a good citizen, which appear to underpin much social policy, appear to portray the individual as rational, autonomous and agentic; shaping his or her own life via the choices they make (Faulks, 2000). Women appeared to draw on this way of talking when reflecting on their requirement for a socially desirable self; the self they suggest they *should* be. This is perhaps most clearly conveyed by Jo's talk about what she feels she *ought* to be. The extract below arises from my prompt for further information about her experience of the practices of midwives 'Can you tell me about what their responses were like (2) with you?'

'Aww, they've, they've all been really (.) really good, 'cos (.) you're embarrassed that you're supposed to be this confident, intelligent woman, whose, y'know totally self sufficient, y'know can, can live and manage on her own and bring a baby up on her own, to being this complete (2) and it is, it's, it's embarrassing. Erm, probably not to anybody else but you yourself, you think 'I can't believe that I've allowed somebody to do this to me. So, and then you've got the guilt and shame thing.'

Here, Jo clearly outlines the criteria of the socially desirable self, '*confident, intelligent*', '*totally self-sufficient*', '*can live and manage on her own*', '*bring a baby up on her own*'. These criteria are inferred by her talk to be a mandatory rather than voluntary requirement through the prefix '*that you're supposed to be*'. This talk would seem to reflect the balance between the rights and responsibilities of individual actors which Faulks (2000) has argued to be the criteria of citizenship (Faulks, 2000). In return for exercising the right to access services provided by the state, Jo perhaps suggests that she, as an individual actor, should also be able to conform to her responsibility to be autonomous and self sufficient. However, Jo's distance from being able to fulfil such a responsibility whilst experiencing domestic violence appears portrayed through her unfinished self

characterisation, *'to being this complete (2)'*. The impact of this perceived failure to conform to the identity of the autonomous citizen appears to invoke embarrassment, *'guilt and shame'*. Interestingly, Jo's talk about the requirement to be an autonomous citizen seems to be implied as something which is not imposed by others *'probably not to anybody else'* but something self imposed *'but you, yourself, you think'*.

However, there were also other ways of talking through which some women appeared to portray themselves as having obtained some of the elements of the good citizen identity. Such ways of talking are significant since they appear to enable women to resist some of the less desirable identities available to women through the medical discourse. For example understanding one's self as the taker of action would appear to enable women to resist roles such as 'broken' and a 'nervous wreck'. Indeed viewing self as the taker of action appeared to enable some women to adopt some of the more empowering roles available within the identity of good citizenship. One example of such a role is evident within this extract of Alima's talk

'After that, about two weeks after that I went and saw my doctor at my local surgery and she was a quite a new, fairly new doctor there and I'd been to see her before regarding y'know health issues, arthritis, high blood pressure and (.) she gave me a leaflet also to see Support and Survival. Then I contacted the domestic violence unit and I spoke to [names officer] who came out to see me. She also gave me a leaflet for Support and Survival. Erm, at work, I, I spoke to one of the girl's at work and the next day she also turned up with a leaflet for Support and Survival.'

Here Alima appears to highlight herself as the taker of action through the her continual use of 'I' in relation to disclosing abuse and accessing services, illustrated through *'I went and saw my doctor'*, *'I contacted the domestic violence unit'* and *'I spoke to one of the girls at work'*. Through this talk Alima appears able to understand herself as active in addressing her situation and thus, perhaps, fulfilling her responsibility as a citizen by pursuing all the avenues of assistance open to her to address the problem she is experiencing. In contrast, the 'others' in the text, arguably representing the state within this section of talk, the doctor and police officer, appear to be only partially fulfilling their responsibilities to support Alima. Thus it might be argued that though this talk, Alima can lay claim to a self which is made up of at least some of the elements which are required of her.

5.4.5 Building a stronger self: the vital role of the Intercept project

By exploring and offering an interpretation of women's accounts we have aimed to draw attention to the limitations and boundaries which existing discourses make available to women when recovering from domestic violence. However, we have also aimed to illustrate the ways in which women resist the identities these discourses make available to them and the alternative ways of talking through which they make sense of who they are. However, a key component of this process of change and women's ability to make sense of themselves differently, though ways of talking which allow them to adopt a stronger and improving self, is support provided by the Intercept project. The influence of Intercept counsellors in this change process was illustrated in the account of each woman and suggests that this service is a key asset in enabling women to address domestic

violence at a personal level within the District. Support for these findings is provided across women's accounts, although we can begin by exploring the impact of Intercept in Jo's talk about herself as stronger and improving. In her talk Jo portrayed self as something which can rally and recover, providing a contrast with Eileen and Alima's earlier talk of self as something which can be broken and fractured. This contrast appears to illustrate the fluidity of self within women's talk and illustrates that, with support, women can and do address the impact of domestic violence on their understanding of self and their wellbeing. This is reflected by Jo in a section of her talk where she reflects upon the support she has experienced through the Intercept project and her counsellor, Isabelle. The following extract from her talk follows my prompt 'What kind of support has she been able to give you?'

'(2) Just by (3) never lettin' me blame meself, never allowin' me ter, ter think like I did, that it, that, that it was my fault and allowin' me ter like [laughs] get me sense of humour back and, and to get stronger'.

Here Jo appears to portray herself directly as stronger than she was previously. This strength appears framed as strength of self, rather than physical strength, through the many references to 'me' and 'meself'. 'Me' and 'meself' appear here to be active, an aspect of character which can judge and blame, or which can enable Jo to resist 'blame' and 'fault'. Of further significance here are the roles which Jo and the counsellor, Isabelle, appear to occupy. Jo appears located as stronger, but only through the intervention of the counsellor. Correspondingly, the counsellor seems located as the preventor of Jo's self blame through the repeated 'never lettin' and 'never allowin'. Operating from this role it would appear that the counsellor's practices of responding involve challenging Jo's thinking about domestic violence indicating an active rather than passive response.

This portrayal of the counsellor as key to Jo's construction of self as stronger appears consolidated in her further talk of self as improving. This talk came in response to my question about key relationships within her health care experience; 'I was wondering whether there's a, any particular relationships with health professionals that you wanted to tell me about that have been significant to you?'

'Erm, (8) I don't, I wouldn't be as far on as what I am now if it 'adn't been for Isabelle from't Intercept project, erm (3) that's a definite. She's (2) she's really, really 'elped me, in fact I don't, I wouldn't like to think (2) of what I'd be like if I, y'know if I hadn't, if I hadn't o' met er. So, that's one (3) one particular, well, owt of everybody really.

Jo's portrayal of self as improving appears here through the imagery of journeying implied through the phrase 'as far on'. However, her location as 'ahead' in this improvement is directly attributed to the positive intervention of the Intercept counsellor; 'I wouldn't be as far on as what I am now if it 'adn't been for Isabelle'. Thus, within her talk, Jo is portrayed as active in moving forward away from domestic violence, whilst also portraying the counsellor as crucial in her ability to act. This appears conveyed through the intensifying effect of the repeated 'really', in 'she's really, really 'elped me'. Indeed any doubt as to the influence of the counsellor appears dispelled by the emphatic 'that's a definite'. What appears conveyed through Jo's talk about self as improving is the

crucial role played by the Intercept programme in assisting women in overcoming domestic violence. Taken together, these ways of talking illustrate powerfully that through currently available counselling services women are able to experience a self which is stronger and more active than that experienced previously.

Thus it was clear from women's talk that the 'Intercept' programme appeared to make available roles and ways understanding self which were active rather than passive in responding to domestic violence. Moreover, these roles and identities were exclusive to this intervention and were not evident in women's constructions of their interactions with health care professionals. The importance of being able to make sense of oneself in such empowering ways is outlined in the literature which explores how language has constructed women who experience domestic violence and the implications of these constructions for women's ability to overcome domestic violence (Profitt, 1996; Loseke and Cahill, 1984; Jackson and Rushton, 1982). Profitt (1996) argues that women need to experience themselves as active agents who can act and make decisions about their lives, whilst acknowledging that this action takes place within the historical and social context of power relations, such as those in health and medicine. However, in their accounts women suggest emphatically that their understanding of themselves and experience of stronger and improving selves has been made available through their interactions with the Intercept counsellor. This finding would seem to highlight the necessity to recognise and develop the District's services in this area, particularly in light of the fact that this service is currently funded as a time limited pilot project.

Summary and implications

This research has taken a very different approach to explore domestic violence and the response of health care services. In particular the research has highlighted the relationship between different ways of talking, the knowledge which underlies these and their relative power relationships. It has illustrated how in the case of domestic violence and health, medicine and the medical discourse exert a powerful and dominant influence on the ways in which domestic violence is understood. By adopting a Foucauldian discursive approach, the research has brought into view not only the discourses through which domestic violence is understood within health but also the different ways of being in, and seeing the world that these make available to women, health policy makers and health professionals. Thus, we suggest the analysis and interpretations offered convey new and alternate possibilities for considering domestic violence. Moreover, they provide the possibility to consider somewhat differently how local services might be structured and delivered. The research therefore aims to add to the considerable work that has already been achieved in Wakefield and to illustrate the implications and possibilities available to the District, its services, health professionals and women accessing services.

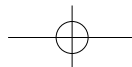
6.1 Medical discourse and its implications for ‘overlooking’ domestic violence

As we have indicated earlier in this report, medicine can be understood to be a powerful institution (Foucault, 1979, 1990; Lupton, 1997). As such it holds great power, able to proclaim truth about phenomenon in social life, such as domestic violence. This is visible in the practices of classification and diagnosis through which phenomenon become medicalised. However, despite its power, medicine and its ways of talking about phenomenon represent only one way of understanding phenomenon. What this research has illustrated is that some phenomenon which have become medicalised, like domestic violence, have complex social roots which may become obscured or minimised through this process. Indeed this research has illustrated the powerful influence medical discourse has on the ways in which the District’s services for women experiencing domestic violence are organised and developed. This is perhaps most evident in the framing of domestic violence as ‘excluded’ and not a ‘direct’ health service, being devoid of the necessary criteria for membership, that of ‘targets’. Moreover, whilst domestic violence is identified as a health care issue at a national level through policy publications (DOH, 2000a, 200b) at a local level its status appears less visible and less acknowledged. The implications of its current status, mediated by the medical discourse, is that possible avenues of action for responding are unavailable. At a strategic level this would seem evident in the lack of a District policy for domestic violence, highlighted by June and in the lack of its embeddedness in health strategy, illuminated through talk of the development of service provision as reliant on ‘champions’. At a healthcare interaction level it is conveyed through women’s talk of having their experience ‘re-framed’ by health professionals, by filtering it through the medical discourse. The implications of this re-framing are that women experience their complex needs being reduced or minimised to a diagnosis for which a practical intervention can be prescribed. In turn this is experienced as patronising, minimising and in certain instances making things worse.

6.2 The implications of newly emerging practices of responding

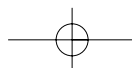
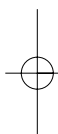
However, this research has also illuminated the possibilities made available through discourses other than medicine. These wider, socially and culturally available discourses have enabled practices of responding which women framed as helpful and enabling. Amongst these were practices which enabled women to take an active role in considering possible interventions and actively engaging in decision making. However, some of these alternate discourses appeared to operate in direct conflict with the medical discourse, creating difficulties for health professionals. One example of such practices were those in which health professionals' concerns extended beyond the health care interaction and into the wider social circumstances of women's lives. Tension was also evident between medical and alternate discourses in relation to health professionals asking about and women disclosing domestic violence. This was perhaps most notable in the distinction women made between being 'asked' and being 'required to tell'. This distinction appears to be related to the discourse from which the questioning of women arises. Thus when questioned from the medical discourse women appear to experience this as being 'required' to tell and in some cases tell repeatedly, a practice which they framed as distressing and to be resisted. In contrast when questioning arose outside of the medical discourse, for example through practices illustrating concern for women's wider welfare, women framed this as desirable and helpful. That women characterise such practices as helpful and enabling illustrates once again the ineffectiveness of the medical discourse to enable health professionals to respond to women in ways which best assist them.

However, adopting the positive practices enabled by alternate discourses is not without consequences for health professionals in that it appears to distance them from the protective functions of the medical discourse (Anspach, 1988, 1987; Keller, 1985). This is perhaps best illustrated through discourses such as horror and warfare through which health professionals convey the vulnerability they encounter when responding to domestic violence. These discourses offer a new context from which to view the dominant representations of health professionals in the wider research literature as 'reluctant' and 'unhelpful' (Pahl, 1995; Hopayian et al, 1983; Llewellyn et al 1995). Indeed they suggest that within this District, at least, failure to respond is understood in terms of 'can't' rather than 'won't'. However, the research also illuminates possibilities for addressing these vulnerabilities. One such possibility would appear the provision of training and support. Health professionals themselves highlighted the importance of local training in domestic violence in enabling them to develop more positive practices of responding. This would seem significant given that this training is not longer available, having been provided through a fixed term, funding bound initiative. Indeed the absence of support is framed by health professionals as something which contributes to their experience of being isolated and unsupported when responding to domestic violence. Arguably this signifies the partiality of the PCT's response to domestic violence. Though provision of training has made possible, for health professionals, new ways of representing and responding to domestic violence, the consequences of this have not been recognised through the provision of ongoing support. A key finding arising from the research would therefore seem the need to make provision for the ongoing support and development of health professionals in relation to this change in practice.



6.3 Intercept and the emergence of empowering discourses for women

In terms of supporting women and addressing their longer term health and well being a key source of discourses not influenced by medicine appeared to be the Intercept counselling service. Indeed the discourses which informed the practices of responding engaged in by Intercept counsellors appeared vital in enabling women to make sense of themselves as stronger and improving in well being. A key impact of these discourses appeared to be that they enabled women to speak and act in ways which were active, rather than passive, in responding to domestic violence. Moreover, these ways of being and understanding self appeared particular to this intervention and were not evident in women's talk about their interactions with health care professionals. The importance of experiencing oneself as 'stronger' and 'active' is outlined in the literature which charts women's ability to overcome domestic violence (Profitt, 1996; Loseke and Cahill, 1984; Jackson and Rushton, 1982). In all the accounts women suggest emphatically that their construction and experience of a stronger and active self has been made available through their interactions with the Intercept counsellor. This finding would seem to highlight the necessity of recognising this as a permanent, key component of the District's services.



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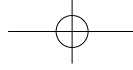
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List of Appendices

- 1a Interview schedule for participants from organisations
- 1b Interview schedule for health professionals
- 1c Briefing, consent and generative questions for interviews with women
- 2 Key to transcription symbols and notations



Appendix 1a

Interview schedule for participants from organisations

Domestic violence; women and the health service response

University of Huddersfield – Victoria Lavis (direct line) 01484 473639

Email v.lavis@hud.ac.uk

Phase one

Interview with Key informant at Contextual Level

Purpose

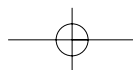
To gain an overview of the response of the Eastern & Western Wakefield PCTs to national guidelines and legislation, regarding domestic violence and the NHS.

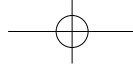
Aims of the interview

- To gain insight into the historical context in which domestic violence became an issue for what was previously Wakefield Health Authority (WHA)
- To gain detailed information about the strategic and practical consequences of the inclusion of domestic violence on the agenda of WHA
- To gain detailed information about how WHA and the newly formed Eastern and Western PCTs have responded to national guidelines and legislation regarding domestic violence and the National Health Service

Key

[P] Interviewer's prompts





Forward

Thank you for agreeing to see me today.

Firstly, I'd like to confirm a few details with you.

- Have you read the information sheet for participants, which outlines the aims of the research and the purpose of the interview?
- Do you have any questions about the information sheet or the study?
- Are you willing to participate in the research?
- Can I ask you to read the consent form, tick the boxes and sign it at the bottom
- I realise that you need to be available and that we may be interrupted, so if you get paged or have to take a call, we'll just pause the tape and start again, or I'll come back another day and finish off

Orientation

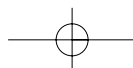
As you'll be aware from the information sheet I've approached you to participate in this interview because of the E&W PCTs overarching role as a provider, in the strategic sense, of a range of services where women who are experiencing domestic violence may present for support, assistance or treatment.

I have prepared a detailed interview schedule, which has been approved by the DREC, for use with key informants from the various services and agencies. This will provide insight into the establishment of their service its structure, aims, achievements, level and type of service, etc,

However, since the PCTs are not in active in terms of face to face delivery of services, what I'd like to talk about in this interview with you, is the strategies which determine the services offered to women experiencing DV, through the PCTs, and the context in which services arose.

To begin with, I'd like to ask you to talk about the historical context in which DV became an issue for the then WHA.

1. *How did DV first become part of the agenda of the then WHA?*
 - [P] What factors influenced its inclusion?
 - [P] How did the HA know that DV needed to be included?



2. *When* did DV become part of the focus of the HA?
3. Why do you think this happened?
[P] Were there any factors that you think facilitated its inclusion at that time?
4. Can you tell me about your input into the process?

I'd like to move on and ask you to talk about what happened on a strategic and practical level in response to the inclusion of DV on the agenda of the then WHA

5. What strategies were put in place?
[P] Were these confined only to the HA?
What other agencies/institutions did these involve?
6. How were these strategies put into action?
[P] What were the practical outcomes of these strategies?
7. Were the strategies evaluated?
[P] What was the outcome of the strategies?

The next set of questions are concerned with how WHA as was, and the new E&W PCTs have responded to national guidelines and legislation regarding DV and the NHS.

8. What impact did national guidelines and legislation regarding DV and health care provision have on the strategies of WHA as was?
9. If that is what happened what were the outcomes of that within the HA? (Effect)
10. Has the strategic and practical response changed since the development of a strategic health authority and the division of health care services into two PCTs?
[P] How have they changed? Better/worse
[P} Have you developed new ways of working?
If so, why? What are they?
11. Can you tell me about what is going on in the PCTs currently?
[P] What are the monitorable outcomes?
[P] Where do you see the outcomes going?

[P] What will happen in response to them?

12. How are the strategies and services provided by the PCTs evaluated and monitored?

[P] Internal/external

Are there specific guidelines for evaluation and monitoring? Tell me about them

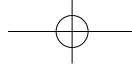
Are service providers incorporated into the process? How?

Are service users incorporated into the process? How?

Finally, I'd like to ask you if there are any aspects of the PCTs response to DV that I haven't covered, that you would like to tell me about?

Do you have any questions you would like to ask me?

Thank you for giving up your time today to talk to me.



Appendix 1b

Interview schedule for health professionals

Domestic violence; women and the health service response

University of Huddersfield – Victoria Lavis (direct line) 01484 473639

Email v.lavis@hud.ac.uk

Phase one

Interview with Key informants

Purpose

To gain an overview of the service provision for women experiencing domestic violence

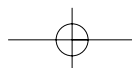
Aims of the interview

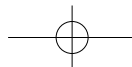
- To gain insight into the background of agencies and services already established in the area to support or treat women who experience domestic violence
- To gain detailed information about the aims, structure and achievements of such agencies
- To gain information about the level of need for such services and how service users are referred to agencies
- To gain detailed information about the type of service available to women experiencing domestic violence, in particular how these are delivered and evaluated

Key

[P] Interviewer's prompts

[N] Rephrasing of question in light of negative response to initial question





Forward

Thank you for agreeing to see me today.

Firstly, I'd like to confirm a few details with you.

- Have you read the information sheet for participants, which outlines the aims of the research and the purpose of the interview?
- Do you have any questions about the information sheet or the study?
- Are you willing to participate in the research?
- Can I ask you to read the consent form, tick the boxes and sign it at the bottom
- I realise that you may need to be available and that we may be interrupted, so if you get paged or have to take a call, we'll just pause the tape and start again, or I'll come back another day and finish off

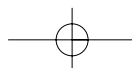
Orientation

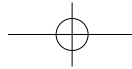
As you'll be aware from the information sheet I've approached you to participate in this interview because as a xxxxxxxxxxxx you are part of a service that offers treatment to women who experience domestic violence.

I have prepared a detailed interview schedule, which has been approved by the DREC, for use with key informants from the various services and agencies. This will provide insight into the establishment of their service its structure, aims, achievements, level and type of service, etc. However, the wording of the questions vary to reflect the type of service each participant works within

To begin with I'd like to ask you some brief questions about the service you work within and its history, in terms of providing services to women experiencing domestic violence.

1. Can you talk to me about your role and what your role is
[P] What is your role?
How long have you been working in your role?
Do you work independently or as part of a team?
Tell me about that?
2. Can you talk to me about your work and how domestic violence has possibly been present in your work?





- [P] Are you aware of domestic violence being present in your work?
When did you become aware of it?
Tell me about that?
What is your experience of it?
How does it manifest itself in your work?
- [N] If dv were to be present in your work how do you think you would become aware of it?

3. Are you aware of any training around responding to dv?

- [P] Have you attended any training?
What was your experience of it?
Are you aware of any recent initiatives around dv (policy, training, and research)?

I'd like to move on and talk to you specifically about practice in relation to domestic violence at your place of work.

4. Can you talk to me about any particular initiatives that might exist in relation to domestic violence?

- [P] Screening
Routine questioning
Referral
Training for staff
Advertising support services
- [N] If an initiative were to begin, how would you be made aware of it?

5. How do you feel the practice you are working in responds to domestic violence?

- [P] Can you tell me more about why you think that?

6. How might a woman experiencing domestic violence make this known within your practice?

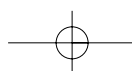
- [P] What are they ways in which a woman experiencing domestic violence could indicate this to health care workers within your practice?

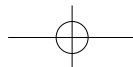
7. If a woman experiencing domestic violence made this known within your practice what would happen in response?

- [P] Tell me about the process of responding?
Recording; referring; consulting

8. Who accesses services as a result of domestic violence in your practice?

- [P] Gender; Age; Ethnicity; Social background

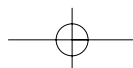
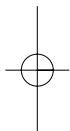


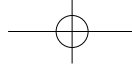


9. What do you think is the level of need for services responding to domestic violence locally?
[P] How did you come to your judgement about the level of need?
On what have you based your judgement?
- Research; own experience; shared experience amongst own profession etc.
10. In the day to day running of the practice, to what extent do you think domestic violence is monitored, in the way that other health care issues are monitored?
[P] What form does this monitoring take?
How is it similar/different to the monitoring of other HC issues?
Whose responsibility is it to monitor dv?

The next set of questions is specifically about your role as a ...

11. Are you aware of any response from your professional body in relation to providing services to those experiencing domestic violence?
[P] Policy; Guidelines; Training; Research
[N] If your professional body was to issue guidelines how would you become aware of them?
12. How does this fit in with your personal view of your role in responding to domestic violence?
[P] How is your viewpoint similar/different?
Do you share the viewpoint of professional body – Y/N - Why?
13. In the period you have been working as a have you noticed any changes in the way you think about domestic violence?
[P] What do you think about domestic violence?
Can you think of anything, which might make you change the way you think about dv?
14. Have there been any changes during the period you have been working as a in the way you respond to domestic violence?
[P] Can you tell me more about those changes?
How did they manifest themselves?
Can you think of anything, which might make you change the way you respond to dv?
[N] If you were to respond to a patient experiencing dv what would you do?
15. Can you talk to me about the effectiveness of the work you do in responding to domestic violence?
[P] What might you see as being effective?
[N] If you were to respond to dv, what might you see as being an effective response?





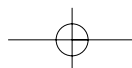
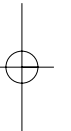
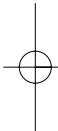
16. Is there anything, which you can identify which constrains the effectiveness of the work that you do in responding to domestic violence?

[P] Can you think of any ways in which this could be overcome?

Finally, I'd like to ask you if there are any aspects of your role, the role of your profession or the role of your practice in relation to domestic violence that I haven't covered that you would like to tell me about?

Do you have any questions you would like to ask me?

Thank you for giving up your time today to talk to me.



Appendix 1c

Briefing, consent and generative questions for phase two interviews with women

Domestic violence; the health service response

Victoria Lavis – University of Huddersfield (direct line) 01484 473639

Email v.lavis@hud.ac.uk

Interviews with women

Introductions and consent

- Introductions
- Thanks for agreeing to talk to me today
- Before we get started there are a few things I just need to check out with you.
- Have you read the participant info sheet that the INTERCEPT worker gave you?
- Do you have any questions you want to ask me about that?
- Wanted to say something more about protecting your anonymity.
- The only instance in which this could be breached would be if issues were raised around child protection
- If that were the case I'd always discuss that with the person I was interviewing first.
- Sign the form

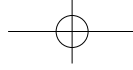
Briefing

- Thank you – talking to me today
- Hope experience pleasant and interesting for both of us

- Not sure if interviewed before? But - like our time to be as relaxed and informal as possible
- Rather than me ask lots of ?
- Like to ask you to tell me what you think is **important** and **relevant** to you about experience of accessing health services in relation to domestic violence
- Realise this may not be easy at times – if need to pause just say.
- Important thing to say at beginning
- Whilst I can never know what you have experienced, its **important** that you know that I have experienced DV myself and accessed health services
- This is one of reasons became interested in doing research and why W's experiences are such an important part of it
- Think its imp that in asking you to share your exp. I am also willing to share mine - if you like
- But imp that that does not guide or influence you – so leave it until end
- Whilst you are talking I may ask a few ? to clarify anything not sure of – imp that you say what you think is relevant
- No right or wrong answers to ? I might ask
- All imp to me is that you tell me what is **important** to you
- If you want me to repeat a ? – just ask
- Plenty of time – take pause if needed
- Probably notice me jotting notes as you talk - help me remember things I want to ask you more about later
- Hope time talking together will be interesting and helpful for both of us
- Don't want you to feel unsure or uneasy about anything
- Any questions before we start?

Generative questions

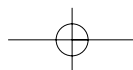
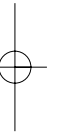
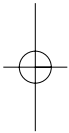
- I want to ask you to talk to me about how you think your experience of domestic violence has impacted on your health. One way to do this may be to think back to the time when the violence or abuse first started and its impact on your health at that time and then talk through your experiences from that time until today.

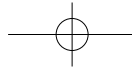


- I would like you to think back now to a time when you were experiencing violence or abuse, but hadn't accessed any health care services and tell me about how you coped with it, at this time in your life. Take your time in thinking about this time and be as detailed as you can, because what is important to you is important to me.
- I now want you to think about your experiences when you did access health services in relation to your experience of violence or abuse. You might want to think about any particular events you experienced that were important to you or had an important effect on you. I would also like you to tell me about the relationships that you experienced with health professionals and their response to you over the period of time you accessed health care services. Begin where ever you like and don't worry about jumping from things in the past to more recent things. Take your time.

Concluding

- Do you have any questions for me know?





Appendix 2

Key to transcription symbols and notations

Unsure about accuracy of transcription	<i>(put in brackets and italics like this)</i>
Material omitted	[]
Explanations	[put explanation in brackets like this]
Noise/word of assent	'hmm' 'yes' 'ah ha'
If there isn't a gap b/w speakers	= at end of 1 st speaker & = at beg of 2 nd
Pauses in speech	record duration of pause in seconds eg (6) (.) if pause is less than 1 sec
Extended sound	ye::s
Emphasis in speech	<u>underline text</u>
Intake of breath before speaking	.ahh

