REGULATION AND RESISTANCE:

AN ANALYSIS OF THE PRACTICES OF HEALTH VISITORS AND WOMEN EXPERIENCING DOMESTIC VIOLENCE.

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SUMMARY.

The titular themes of "regulation" and "resistance" provide a conceptual and theoretical framework for this research, which examines health visiting work in relation to women experiencing domestic violence. These themes, which are threaded throughout the study, arise from the feminist poststructuralist analysis underpinning this research. This draws attention towards the issues of power and knowledge, which are key sites for this analysis of the practices of health visitors and women experiencing domestic violence.

Understanding health visiting in terms of the social regulation of mothers enables the analysis to focus upon the ambiguities and contradictions that arise from the double bind of welfare and surveillance inherent within health visiting work with women. These tensions are particularly visible in the context of domestic violence, where different understandings about male violence and abuse against women are associated with different practices. In particular, the feminist discourses about domestic violence that underpin this research and which are represented as "resistance", have made little impact upon the professional health visiting knowledge-base.

The study draws upon qualitative data from semi-structured interviews with 24 health visitors, and 16 women with young children who have experienced domestic violence. It examines the practices through which health visitors "get to know" about women's experiences of domestic violence, and the extent that they were able to offer support or protection. The women who participated in this research all faced a number of difficulties in seeking help about domestic violence. These included dilemmas about disclosing their experiences to health visitors, as well as inadequate responses once they had broken their silence. The findings suggest that an urgent response, at the policy and practice level, is required to enable health visitors to improve their practices with women experiencing domestic violence.

INTRODUCTION.

My interest in researching health visiting and domestic violence arose from my own health visiting practice experience, where my work brought me into direct contact with a number of women who were experiencing, or who had survived, violent or abusive relationships. Listening to these women's accounts, I was angered and distressed by both the severity and frequency of such violence and abuse in their lives, and concerned by my own uncertainty about responding. At the time I recognised a gap within my knowledge-base regarding the issue of domestic violence; despite having undertaken considerable professional health care training, domestic violence had never been mentioned.

There was also a tension between my own practice, informed by feminist perspectives, and that of some of my colleagues who appeared to collude with a professional discourse which disregarded women's experiences of male violence. Consequently there was considerable diversity concerning the extent to which myself, and my colleagues, were able to recognise and respond to the difficulties facing women experiencing domestic violence; differences in practice which were marked by both personal and professional constraints. Looking back on these experiences, I can recall attempting, and failing, to locate relevant literature about health visiting practice and domestic violence; however, at the time, I did not fully understand the implications of this silence. A few years later I had the opportunity to develop a theoretical perspective on practice, and this created the space for me to undertake the current study. This examination of health visiting work aims to explore this silence in relation to the issue of domestic violence, developing new insights about policy and practice, and contributing to the existing scholarship about domestic violence.

The practice focus of this research is upon health visitors work. Health visitors are general nurses who have undertaken a post-registration qualification in health visiting. They are employed by the National Health Service, working within primary health care provision. Health visiting work is focused upon the health of individuals, families and communities (Council for Education and Training of Health Visitors 1977), although they have a

particular role in relation to child health and welfare (Mayall and Foster 1989; Abbott and Sapsford 1990; Hall et al 1994).

The term "domestic violence" is used throughout this thesis. This term has shortcomings, but is intended to describe gender-specific violence within intimate adult relationships. The understandings of domestic violence which underpin this research reflect feminist work (for example, Hanmer and Maynard 1987; Kelly 1988a; Hester et al 1996). The following definition is adapted from Mooney (1993) and was used throughout this research, specifically in the context of the fieldwork interviews with health visitors.

> *Domestic violence includes threats of physical violence, physical violence which may or may not result in actual bodily harm, mental cruelty, and being forced to have sex without consent. Domestic violence usually occurs to women by men with whom they have had or are continuing to have an intimate relationship. They may not always be living together. In a few instances, domestic violence may involve a women inflicting violence on a male partner. It may also occur within same-sex relationships.*

This research understands health visiting work in terms of the social regulation of mothers, drawing attention towards the inter-relationships between power, discourses, gendered practices, and subjectivity. The term "discourse" is used in cognisance of the work of Michael Foucault (1979; 1984) and refers to structures of knowledge which shape social practices. This situates the research within a feminist post-structuralist theoretical framework (Foucault 1979; 1984; McNay 1992; Weedon 1997); this is represented and reflected in the titular themes of "regulation" and "resistance".

These titular themes of "regulation" and "resistance" are threaded throughout the study, providing a number of conceptual and analytical tools. Regulation refers to the exercise of disciplinary power beween mothers and health visitors (Foucault 1979; 1984). "Regulation" also hints at the abuse and control that men inflict over women in situations of domestic violence. However, understandings of male power which inform feminist

discourses on domestic violence are materially, and conceptually, very different to power in the Foucauldian sense.

Feminist discourses on domestic violence are substantial, representing a considerable body of scholarship which has pointed to the extent and nature of women's experiences, the inter-connections between domestic violence and children, and the failure of state agencies to adequately support and protect women, and their children. Feminist work has also acknowledged the differences, as well as the commonalities of women's, and childrens experiences of domestic violence, drawing attention to the particular issues arising through the social divisions of class, "race", age, sexuality and (dis)-ability. Such feminist work is inter-twined with practice designed to support and protect women, and their children, as well as feminist campaigns and other activities concerned with challenging male violence against women. Together, these feminist discourses, both scholarship and practice, have challenged and resisted malestream understandings, and practices, of domestic violence.

Throughout this thesis these feminist discourses are represented as "resistance". However, this discursive perspective is not intended to challenge the material reality of women's and children's experiences of domestic violence. It does however problematise the nature of knowledges, pointing towards the inter-relationships between social practices, knowledge, power and subjectivities. This provides an analytical foothold for the current study, drawing attention towards the knowledge base of health visiting. In particular, it opens the spaces to examine the extent to which feminist discourses on domestic violence have leaked into professional health visiting discourses. However, these feminist discourses are also used as "lens" through which the practices and knowledges of health visitors are filtered and examined. In this way, this thesis itself becomes part of these feminist discourses.

"Resistance" primarily refers to feminist work on domestic violence, and as such is threaded throughout this entire thesis. However, this titular theme of "resistance" also relates to other issues. For example, it refers to some of the ways in which women actively resist health visiting contact. This is analysed in terms of the possibilities of client

resistance inherent within the exercise of disciplinary power (Foucault 1979; Bloor and McIntosh 1990; May 1992a; 1992b). In the context of this study such resistance represents a partial reading of women's experiences; such activities of concealment and resistance may also be read as women's attempts to survive in complex and difficult circumstances.

Resistance is also found within health visiting work, particular amongst those workers who themselves actively resisted professional discourses about domestic violence, often providing prolonged support to women, sometimes enabling women to access protection and begin the process of survival. There is also resistance within professional discourses about the nature of health visiting. Here, professional understandings point towards a relationship-centred, and enabling activity, underpinned by models of health and health promotion. These ignore a substantial body of work which suggests that health visiting can be understood in terms of the social regulation of mothers; a reading which underpins this thesis. Thereby professional discourses are (re)-presented here as "resistance" to this narrative of gendered regulation.

These titular themes of "regulation" and "resistance" are inter-twined throughout this thesis, reflecting the theoretical perspectives which underpin this study. These are intended to reinforce, rather than deflect attention away from, the policy and practice issues arising from this study. Throughout the research the knowledge-base of health visiting work is problematised, pointing towards the urgent need for professional education and training programmes which address women's experiences of domestic violence, and take seriously issues of social diversity. This needs to be undertaken alongside an organisational and professional effort designed to ensure that health visitors are equipped to provide a safe and effective response to women, and children, experiencing domestic violence. Such initiatives include addressing issues such as worker supervision and safety, as well as developing practice guidelines within the context of inter-agency work. Thus, the thesis intertwines these everyday practice issues, within an overall theoretical framework, thereby contributing towards existing scholarship about agency responses to domestic violence.

Throughout this thesis the following terms are used:

The term "Black" is used to refer to all those who suffer discrimination and racism because of their skin colour.

The term "Asian" refers to all those who have an ethnic and cultural heritage which originates from the Indian sub-continent. It refers to people from India, Pakistan, Bangladesh or Asian communities in Africa. It does not necessarily depict their place of birth or nationality.

SECTION A: ESTABLISHING THE CONTEXT.

The notions of "regulation" and "resistance" provide the theoretical tools for analysing health visiting work with mothers experiencing domestic violence. "Regulation" and "resistance" enables the exercise of power between mothers and health visitors to be examined, which viewed through the lens of feminist poststructuralism also embraces analyses of discourse and knowledge. This argument is presented in the three chapters of this section which together establish the theoretical framework and "story-line" for the overall thesis.

Chapter 1 aims to review the existing understandings concerning health visiting work with mothers experiencing domestic violence. A discursive perspective is adopted which introduces feminist discourses about domestic violence, tracing the extent to which they have permeated the knowledge and practice base of health visiting. Although this is largely marked by silences and omissions, there are a number of emerging discourses, notably those pointing to the impact of domestic violence upon health and upon children, which may inform future health visiting practices.

By embracing both social policy and sociological analyses of health visiting work with mothers, drawing upon feminist and historical work, chapter 2 establishes that health visiting is constituted in terms of the social regulation of mothers.

Chapter 3 addresses the analyses of power which are embedded in the preceding review. It introduces the ideas of Foucault concerning disciplinary power (Foucault 1979), and reviews their use in sociological studies of nursing and health care practice. In attempting to address the tensions and discontinuities between feminists and the ideas of Michel Foucault, this chapter ensures that the central argument of "regulation" and "resistance" is not disguising a contradictory view of power. Moreover, it establishes and promotes the theoretical framework of feminist poststructuralism.

CHAPTER ONE.

TRACING THE DOMESTIC VIOLENCE DISCOURSES.

INTRODUCTION.

The theoretical approach which underpins this thesis incorporates a discursive perspective. This is adopted in the opening chapter in order to examine the knowledges and practices concerning domestic violence (Foucault 1979; 1984; 1988; Weedon 1997). Focusing upon discourses in this way draws attention towards the inter-connections between knowledge and practice, enabling a textured analysis to develop concerning health visiting work with women experiencing domestic violence.

This chapter traces the domestic violence discourses which inform this study. These include feminist discourses, as well as those which draw attention to the impact of domestic violence upon children, and upon health. In contrast, the discourses of domestic violence are difficult to trace within health visiting, suggesting there has been little attention paid to this issue in professional knowledge and practice.

This review commences with feminist work which has consistently challenged and resisted male violence against women. These feminist discourses provide a number of analytical and conceptual themes for this study. They have also ensured that domestic violence is now more widely recognised as a policy and practice issue (Hester and Radford, L. 1996; Mullender 1996). Nevertheless, there remain considerable hurdles before the issue of domestic violence is fully recognised and addressed, particularly in the context of agency practices. This is illustrated in the analysis of the domestic violence discourses within professional health visiting, which are marked by a near silence. Even though Pahl suggested as early as 1982 that health visitors were "front line workers" in relation to identifying and supporting women experiencing domestic violence (Pahl 1982),

as this review illustrates, there has been little subsequent work focusing upon this group. Indeed, despite the gendered nature of health visiting work (Graham 1979; Davies 1988; Abbott and Sapsford 1990; Edwards, J. 1998) feminist discourses on domestic violence have made little impact upon health visiting. However, the growing awareness about domestic violence and children (Abrahams 1994; Mullender and Morley 1994), and as a health care issue (Scottish Needs Assessment Programme 1997; British Medical Association 1998), as well as the emphasis upon inter-agency working (Victim Support 1992; Home Office 1995; Hague et al 1996a), all suggest that domestic violence is a relevant policy and practice issue for health visitors. It is argued that together these emerging discourses will create a space in which health visiting work in relation to domestic violence will develop.

FEMINISM AND DOMESTIC VIOLENCE: THEMES AND PERSPECTIVES.

Challenging male violence and abuse against women has been an important and enduring feature of feminist activity. This has occured both in practice, such as feminist activities directed at the establishment of women's refuges and support groups, as well as in the academy, where feminist scholarship has pointed, for instance, towards the extent and range of women's experiences of abuse, and the difficulties they face in seeking support. This has resulted in a comprehensive body of feminist work regarding domestic violence (Dobash and Dobash 1979; Binney et al 1981; Borkowski et al 1983; Homer et al 1984; Pahl 1985; Hanmer and Maynard 1987; Kelly 1988a; Yllo and Bograd 1988; Gordon 1989; Hanmer et al 1989; Mama 1989a; Dobash and Dobash 1992; Hague and Malos 1993; Kirkwood 1993; McWilliams and McKiernan 1993; Lupton and Gillespie 1994; Tayside Women and Violence Group 1994; Dominy and Radford, L.. 1996; Fawcett et al 1996; Hague and Wilson 1996; Hester et al 1996; Rai and Thiara 1997). Much of this work has been undertaken from a radical feminist perspective, which is underpinned by understandings of male power and the associated patriarchal structures which constrain women's lives, both in the public and private domain.

In reviewing this feminist work, the following section highlights a number of inter-connected issues which are pertinent for the current study. These include language use, theoretical understandings, the extent and nature of domestic violence, and the provision of support.

The Issue of Language.

Language is an important site in feminist struggles concerning domestic violence. This is reflected most clearly in the debates which have problematised the term "domestic violence", pointing to the ways in which it ignores gendered power relationships, and privileges notions of both physical violence and private spaces. For example, feminist concern with the term "violence" reflects understandings that women's experiences of domestic violence involves a range of abuses, including emotional and sexual abuse, and threatening behaviour, and does not just constitute physical assaults and violent behaviour (Kelly 1988a; Kirkwood 1993; Mooney 1993). The term "domestic" implies a relationship occuring within the domestic sphere, and excludes intimate relationships which do not involve co-habitation. This is problematised by the diversity of family structures (Mama 1989a), as well as women's experiences of continued violence after leaving relationships (Binney et al 1981; Pahl 1985; Mooney 1993; Hester and Radford, L. 1996). Moreover, the term "domestic violence" masks its gendered nature, in which women are usually the victims and men the perpetrators (Dobash and Dobash 1979; Kelly 1988a; Mooney 1993; Abrahams 1994). For these reasons some feminists have adopted other terms which make the gendered and intimate nature of domestic violence more visible; these include, for instance, the term "violence against women from known men" (Leeds Inter-Agency Project 1996).

Notwithstanding these concerns, the term "domestic violence" is used throughout this study. This is largely a pragmatic decision, and one that reflects other feminist work which acknowledges these difficulties but recognises it to be a commonly used term (Hague and Malos 1993; McWilliams and McKiernan 1993; Mooney 1993; Mullender 1996).

Alongside these debates about terminology are differences in the definitions which are used. A review of the feminist literature reveals a number of definitions, displaying various degrees of commonality and difference (Victim Support 1992; Hague and Malos 1993; McWilliams and McKiernan 1993; Mooney 1993; Dominy and Radford, L. 1996; Women's Aid Federation of England 1996a). The definition of domestic violence used in this research was chosen to reflect a number of key themes in feminist work, and is outlined in the "Introduction" to this thesis.

As well as the concern with definitional issues, there are many other examples where feminists have struggled with language. For example, terms such as "survivors of domestic violence" are used in order to highlight the coping and survival strategies of women, rather than focusing upon their status as victims (Hoff 1990; Kirkwood 1993). This focus upon language is much more than a semantic exercise, however. This is because language, not only influences the ways women come to understand and name their experiences (Kelly 1998a; 1998b; Kelly and Radford, J. 1991), it also informs the wider knowledge base about domestic violence. In particular, differing definitions of domestic violence have had implications for establishing prevalance rates (Mooney 1993).

Such concerns about language usage in the context of domestic violence are closely inter-connected with other issues arising from feminist discourses, reflecting key themes in feminist scholarship. In particular the concern to make visible the gendered nature of violence and abuse mirrors feminist theoretical perspectives which understand domestic violence in the context of gendered power relations.

Domestic Violence and Gendered Power.

Feminist analyses of domestic violence have been underpinned by understandings of gendered power relations. Through privileging notions of both gender and power, feminist have made visible the structural context in which violence and abuse occurs,

problematizing the control and power exercised by men over women (Pence and Paymar 1986; Pence 1987; Kelly 1988a). As Kelly (1988a) has pointed out:

> "Feminist theory stresses that the patriarchal structure of the family legitimises violence by men, and that male authority within the family is supported by social arrangements outside the family. Men have power within the family before they use violence" (Kelly 1988a, p. 71).

This approach has been exemplified in the work of the Duluth Abuse Intervention Project (Pence and Paymar 1986; Pence 1987), a long established North American based project which aims to support women survivors of domestic violence and challenge male perpetrators. Understanding that male abuse is underpinned by power and control, has led to the development of the "Power and Control Wheel" (Pence and Paymar 1986; Pence 1987), which illustrates the range of behaviours and tactics used by men to exert power and control over women. This approach has influenced a number of feminist support and training initiatives in this country (Leeds Inter-Agency Project 1996, p. 27; Sheffield Domestic Violence Forum 1997).

Feminist analyses which emphasise both gender and power directly challenge malestream understandings of domestic violence, particularly the family violence theorists (Steinmetz and Strauss 1974; Gayford 1976; Strauss et al 1980; Strauss and Hotaling 1980; Pizzey and Shapiro 1982; Gelles 1987; Browne and Herbert 1997). These have often drawn upon individually focused explanations, suggesting violence and abuse can be attributed to the perpetrator or victim having psychological problems (Gayford 1976; Walker 1979; Pizzey and Shapiro 1982). Other explanations have drawn upon social learning theory to propose a "cycle of violence" (Steinmetz and Strauss 1974; Strauss et al 1980). Some family violence theorists do recognise the importance of social structural factors, such as poverty, unemployment and poor housing (Strauss and Hotaling 1980; Gelles 1987). However, these analyses are disputed by feminist work which has argued that domestic violence cuts across issues of class and structural inequality (Dobash and Dobash 1979; Pahl 1985; Kelly 1988a; Mooney 1993).

Understanding women's abuse of men represents a key site of difference between feminists and family violence theorists. The issue of women's violence was first raised following a large scale survey of over 2,000 couples in North America, using an instrument to meaure relationship violence known as the Conflict Tactics Scale (Strauss et al 1980). This self-report questionnaire ignored the context in which abuse occured, and the severity of the behaviours involved, merely counting individual violent acts (Saunders 1988; Nazroo 1995). The results pointed towards similiar results for both husbands and wives, suggesting that "mutual fighting" was a feature of many relationships. In contrast, in understanding women's use of violence, feminists have pointed towards the context in which such violence takes place, which is often provoked as a result of experiencing long term violence and abuse themselves, and often in self-defence (Hague and Malos 1993, p. 16; Kelly 1996). These understandings of women's use of inter-personal violence have taken into account the wider societal context of gendered power relations. It has also enabled feminists to address the issue of violence within lesbian relationships (Kelly 1991; 1996).

Understandings of diversity are important developments in second wave feminism. This allows analyses which take into account the similiarities and differences between women, paying particular attention to the social divisions of race, class, sexuality, age and (dis)-ability. These considerations of diversity have impacted upon feminist analyses of domestic violence. For example, the growing awareness of domestic violence experienced in lesbian relationships (Kelly 1991; 1996; Lie and Gentlewarrier 1991; Burstow 1992, p. 167-171), by older women (Whittaker 1996), Black women (Guru 1986; Mama 1989a; Southall Black Sisters 1993; Bhatti-Sinclair 1994; Bowstead et al 1995; Rai and Thiara 1997), and women with (dis)-abilities (Cosgrove and McLeod 1995; McCarthy 1996; Hendey and Pascall 1998) point towards the need for feminist perspectives on domestic violence to incorporate understandings of the similiarities and differences between women, within the overall framework of gendered power relations. This distinguishes feminist perspectives from others, such as family violence theorists.

The issues of language use and theoretical understandings are central to feminist discourses on domestic violence. As such they are threaded throughout a range of applied feminist work which has focused upon the extent and nature of domestic violence, and the provision of support; these are reviewed in the following sections.

The Extent and Nature of Domestic Violence.

Feminist work has made visible the extent and nature of women's experiences of domestic violence (Dobash and Dobash 1979; Binney et al 1981; Kelly 1988a; Mama 1989a; McGibbon et al 1989; Mooney 1993; McWilliams and McKiernan 1994; Rai and Thiara 1997). This has been achieved through intertwining a range of conceptual, methodological and analytical approaches, underpinned by feminist experiences of supporting women and children experiencing domestic violence. Central to this work has been understandings that domestic violence is based upon the abuse of gendered power within personal relationships.

This feminist scholarship has challenged notions which privilege understandings of domestic violence as physical violence, making visible women's experiences of emotional and sexual abuse, and threats of violence (Dobash and Dobash 1979; Kelly 1988a; Mooney 1993). This has led Kelly (1988a) to suggest the notion of a "continuum" as a means to ensure inclusion of the range and diversity of women's experiences of abuse and violence. This has also incorporated understandings of the scope of abusive acts experienced by women, as well as the context in which these occur. Moreover, feminist work has examined Black women's experiences of domestic violence, pointing towards the compounding effects of racism, and the problems raised by issues such as immigration status and language (Mama 1989a; Southall Black Sisters 1993; Bhatti-Sinclair 1994; Bowstead et al 1995; Rai and Thiara 1997). Other work has highlighted the additional difficulties faced by women with disabilities and learning difficulties who experience domestic violence; such experiences of abuse may often be inter-connected with the provision of care, which compounds the power and control of male perpetrators

over women, creating extra problems in relation to help-seeking (Williams 1992; Cosgrove and McLeod 1995; McCarthy 1996; Hendey and Pascall 1998).

Feminists have challenged dominant understandings that domestic violence is an uncommon event. This has often been based on official statistics, such as crime records, where it has been both under-reported and under-recorded. For example, Dobash and Dobash (1979) found that only 2 per cent of the women they interviewed had reported an assault to the police. Moreover, this has been exarcebated by the absence of any national survey work on gender specific violence. Central to this challenge has been a range of feminist research which has established that domestic violence is a common occurrence in women's lives, and is experienced by women across all sections of the community (Hanmer and Saunders 1983; Mama 1989a; McGibbon et al 1989; Mooney 1993; Dominy and Radford, L. 1996; Stanko et al 1998). This work has involved a range of methodologies in order to encourage women to report their experiences, often undertaking specifically focused local surveys which have uncovered high prevalence rates for domestic violence. It has also addressed a number of methodological issues such as the value of using self-complete questionnaires, the need for sensitive interviewing, and the constraints and opportunities associated with different definitional and language approaches.

A striking feature of this work is the broad similiarity in the reported prevalence rates. For example, a survey undertaken by Mooney (1993), which involved collecting data from 571 women living in North London, found that one in eight women had experienced physical violence during the past twelve months (Mooney 1993). These findings are similar to the results of the study reported by Stanko et al (1998), which aimed to estimate the prevalence of domestic violence amongst women in a G.P. surgery waiting room. This found that 1 in 9 women (11 per cent of 129) reported experiencing physical abuse serious enough to require medical attention in the last year. Their findings also suggest that 60 per cent of the women who responded had experienced some sort of abuse at some time in their life. Similarly McGibbon et al (1989) found that 27 per cent (75) of the 281 women they surveyed reported experiencing repeated verbal or physical threats from

a male partner, 18 per cent (47) reported they had been beaten by their partners, and 13 per cent (37) reported being forced to have sex. Although these prevalence rates are not restricted to the past twelve months, they suggest that between one in four and one in eight women have experienced some form of abuse and violence from a male partner. A survey undertaken of 484 women in a suburban shopping centre found that 31 per cent had experienced domestic violence from a known man at some time in their lives (Dominy and Radford, L 1996).

These studies have also established that domestic violence is experienced by women across the social divisions of race, class, age and (dis)-ability. For example, in the north London survey of 571 women reported by Mooney (1993) the prevalence rates for women experiencing domestic violence according to class, age and ethnicity were analysed. This illustrates that all groups of women had experienced domestic violence at some time in their lives, although some differences between groups were identified. For example, professional women reported lower prevalence rates of domestic violence compared to lower middle class and working class women. These differences probably reflect the different circumstances influencing women's ability to leave unsatisfactory relationships, before they become violent. As Mooney (1993, p. 41) suggests this includes access to resources, particularly an independent income, as well as differing rates of childbearing; these features make it more difficult for women to alter their domestic circumstances independently of men. The occurrence of domestic violence amongst middle class women has important practice implications. As Pahl (1985, p. 81) has observed, middle class women may be less likely to use refuge services, because of the availability of other resources, but they do use support and advice services as much as other women.

The extent of domestic violence experienced by Black women is highlighted by Mooney (1993, p. 43) who found broadly similiar rates for women experiencing domestic violence across ethnic groups. This probably reflects the attention to diversity incorporated throughout the research design which ensured appropriately trained and socially diverse interviewers conducted the work. Mama (1989a) reports the most extensive study regarding Black women's experiences of domestic violence, focusing upon the

compounding difficulties exacerbated by racism, uncertain immigration status and language difference. This work is not, however, a prevalence study.

Domestic violence occurs to women across all age groups, although there appears to be higher rates for women of child bearing age. This may reflect the differing experiences and understandings of older women who are often reluctant to name their experiences (Mooney 1993, p. 42-43). However, as Whittaker (1996) has suggested, older women's experiences of domestic violence are often categorised as elder abuse, thus masking the situation.

The extent of domestic violence amongst women of child bearing age is particularly pertinent for the current study. Mooney (1993, p. 42) identified higher prevalence rates of domestic violence experienced by women between the ages of 16 and 44 years old. Other work provides age-related data which suggest that domestic violence occurs predominantly to women of child bearing age. For example, in a North American study, McLeer and Anwar (1989) found that 33 per cent (101 out of 298) of women aged between 18 and 40 years attending an emergency department did so because they were seeking medical help in relation to domestic violence. These figures are supported by feminist experiences of supporting women and children escaping domestic violence; for example, women aged between 19 and 35 years of age represented 66 per cent of women using refuge services during the year 1996/1997 (Women's Aid Federation of England 1998).

There are no studies which have separetely examined the extent of domestic violence experienced by mothers. However, existing feminist knowledge which draws the links between domestic violence, children, and pregnancy (reviewed in later sections of this chapter) suggests that pregnancy and motherhood are times when women may first experience domestic violence, or may be times when existing violence and abuse escalates in frequency or severity (Abrahams 1994; McWilliams and McKiernan 1993; Gazmararian et al 1996; Bewley et al 1997; Mezey and Bewley 1997). For example, in the study reported by Abrahams (1994), it was found that 71 per cent of the 108 women who responded had children when the violence began; the remaining 29 per cent went on to

have children while they still in the violent relationship (see figure 1:1). Moreover, violence began at a time when the children were predominantly of pre-school age.

Figure 1:1. Number and Ages of Children when the Violence Began (Abrahams 1994, p. 23).

No. of Children.	%	Mean Ages of Children.
None	29	-
One	38	1.6
Two	21	4.6, 2.1.
Three	9	5.2, 3.3, 1.4.
Four	3	9.3, 6.7, 4.0, 3.0.
	100% (101 responses).	

Further evidence of this overlap is gained from the study reported by Stanko et al (1998, p. 24). The results of their survey aiming to estimate the extent of domestic violence found that more than one in three women with children had experienced serious violence and abuse during the past year. Their sample also included 24 pregnant women, finding that nine of these had experienced domestic violence during the past year (Stanko et al 1998, p. 24).

Moreover, feminist research which takes account of women's experiences has enabled the reasons why women fail to report, or minimise their experiences of male violence, to be better understood (Stanko 1985; Kelly 1988a; Kelly and Radford, J. 1991). Kelly and Radford, J. (1991) have pointed towards women's reluctance to name their experiences either because they continue to fear for their own safety, or because they have learnt to define their experiences as unimportant. Kelly (1988a) has suggested that women "forget" their experiences as a coping strategy, while Stanko (1985) has argued that the prevailing moral discourse about gendered roles ensures that women remain silent about negative experiences.

Establishing the extent and nature of domestic violence is also intertwined with feminist work which has challenged attempts to trivialise women's experiences of domestic violence, pointing to the serious and criminal nature of this activity. Even though these findings may reflect a degree of under-reporting, analysis of the 1992 British Crime Survey

suggested that domestic violence accounted for 46 per cent of all violent incidents against women (Mirrlees-Black 1995, p. 2). Considerable work has focused upon the responses of the legal and criminal justice system, which has systematically treated women's experiences of domestic violence differently than assaults caused by strangers (Radford, J. 1987; Edwards, S. 1989; Hanmer et al 1989; Smart 1989; Kennedy 1992; Hester and Radford, L. 1996).

Thus, feminist work has established the extent and nature of domestic violence. This has taken seriously women's experiences, and established high prevalence rates regardless of social structural differences. These feminist discourses represent a considerable challenge to dominant malestream understandings of domestic violence.

Help-seeking.

A number of studies have examined women's experiences of help-seeking, pointing towards the problematic and patriarchal nature of state responses to women experiencing domestic violence (Maguire 1988; Mama 1989b; Morley 1993). These studies have focused, for example, upon the responses of the criminal justice and court welfare system (Radford, J. 1987; Edwards, S. 1989; Hanmer et al 1989; Hester and Radford, L. 1996; Hester et al 1997), housing (Malos and Hague 1993; Charles, 1994), and social services (Leonard and McLeod 1980; Maynard 1985; Mullender 1996; Humphreys 1997), as well as a number of multi-agency studies (Binney et al 1981; Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993; Tayside Women and Violence Group 1994; Dominy and Radford, L. 1996). There has been little attention paid in the literature to the responses of health visiting, which has an uncertain identity in much of this research.

These studies suggest that the responses women receive are marked by diversity, with some workers providing appropriate support and information. However, the overall picture suggests that women's experiences of help seeking are often handled inappropriately. Dobash and Dobash (1979) have identified women's help-seeking, illustrating that

requests for help increase over time, with a gradual shift towards formal sources of help. Their results which suggest that women often make multiple contacts with agencies before accessing support or protection, are reflected in more recent work (McGibbon et al 1989; Dominy and Radford, L. 1996). The key themes suggest a low awareness about the extent and nature of domestic violence, and a poor understanding about appropriate support and protection. These attitudes are underpinned by a lack of training about domestic violence (Kingston et al 1995); this reinforces prevailing patriarchal discourses which suggest that domestic violence is an uncommon and private event.

These studies suggest that, even though all women face a number of difficulties accessing services in relation to domestic violence, the problems are particularly marked for Black and Asian women (Guru 1986; Mama 1989a; 1989b; Southall Black Sisters 1993; Bhatti-Sinclair 1994; Imam 1994; Bowstead et al 1995; Rai and Thiara 1997). For example, as part of a multi-agency study undertaken in the south east of England, Black women's experiences of help-seeking together with the agency practices in responding to ethnic minority women, were examined (Dominy and Radford, L.. 1996, p. 30-34). In particular, agency responses were marked by discrimination in policy and practice, lack of understanding of cultural and religious needs and lack of access to translation services for women requiring this support (Dominy and Radford, L. 1996, p. 31). These themes have been consistently identified in previous work (Mama 1989a; 1989b; Southall Black Sisters 1993; Bhatti-Sinclair 1994; Imam 1994; Bowstead et al 1995; Rai and Thiara 1997). The particular difficulties facing women from minority groups, such as travelling communities, lesbian women, and dis-abled women, have begun to be acknowledged, but there remains considerable room for further work, in terms of both research and practice (Bell et al 1989; Kelly 1991; Hall 1992; Cosgrove and McLeod 1995; Kelly 1996; Hendey and Pascall 1998). The commonalities and differences amongst women seeking help about domestic violence are aptly illustrated by Stanko et al (1998, appendix 3.), who draw upon the records of a range of statutory and voluntary sector agencies in Hackney, North London, in order to illustrate the issues of social diversity.

The difficulty mothers face in getting support has been highlighted by Abrahams (1994). The findings suggests that women took on average between one and two years to tell about their experiences. The barriers they faced in seeking outside help included feeling guilty and embarrassed, and not knowing who to turn to for help. A major reason for concealing the violence was fear that their children would be taken away from them, which was reported by 74 per cent (out of 58) of women.

These studies which have examined women's help-seeking represent the tip of the iceberg in terms of the problem of domestic violence. Feminists have suggested that many women remain silent about their experiences of domestic violence, consequently never seeking any support or protection. For example, McGibbon et al (1989, p. 27) found that 32 per cent (43 out of 133) of women experiencing domestic violence had never told anyone of their experiences. A similar figure was reported by Mooney (1993, p. 60) who found that 45 per cent of women experiencing domestic violence in the last twelve months had remained silent.

This feminist scholarship which has focused upon the provision of support and protection, recognising the difficulties women face in living with, and leaving, violent relationships, has been underpinned by feminist practice. This has involved the development of women's refuges which provide support and protection to women and children experiencing domestic violence (Dobash and Dobash 1992; Women's Aid Federation of England 1998). These services continue to be widely used; recent figures report that during the year 1995/6, 54,500 women and children found shelter in a local women's aid refuge, and a further 145,000 contacted the organisation for advice and support (Women's Aid Federation of England 1998). These services continue to be marred by a shortfall in funding and provision of places.

However, such developments reflect the successes of women in resisting and breaking silences about male violence against women. This feminist activity is undertaken against a backdrop of inadequate and un-coordinated state responses to domestic violence (Maguire 1988; Morley 1993), a situation which is further aggravated by the contradictions within the existing legislative and policy framework (Hester and Radford, L. 1996). Even

though recent policy and practice initiatives have seen the establishment of inter-agency working (Victim Support 1992; Home Office 1995), feminists have been concerned that such forums may not ensure that women and children receive appropriate support or protection (Hague et al 1996a).

Thus, there is a considerable body of feminist work, both in the academy and in practice, which has been concerned with the provision of support and protection to women experiencing domestic violence. This has pointed towards the difficulties women face in achieving support from a range of agencies, as well as the extra problems experienced by different groups of women.

Summary.

Breaking silences is a central theme threaded throughout feminist work on domestic violence. This has been achieved by taking seriously women's experiences of male violence, and developing analyses which challenge existing malestream understandings.

Thus, feminist work has focused upon the nature and extent of domestic violence (Dobash and Dobash 1979; Stanko 1985; Hanmer and Maynard 1987; Kelly 1988a; Mama 1989a; McGibbon et al 1989; Mooney 1993; Hester et al 1996; Fawcett et al 1996; Rai and Thiara 1997) establishing that it is a frequent event in many women's lives, and one that occurs across social divisions of class and race. It has challenged understandings that domestic violence is a "private" event, pointing to the criminal nature of such violence. Feminists have also demonstrated how domestic violence has been "silenced" within institutions and agencies (Hanmer et al 1989; Hester and Radford, L. 1996; Mullender 1996), as well as examining the problems women face in their efforts to seek support (Binney et al 1981; Pahl 1985; Stanko 1985; Hanmer and Maynard 1987; Kelly 1988a; Dobash and Dobash 1992). Moreover, this scholarship has been inter-twined with feminist practice which supports women, and children, experiencing domestic

violence. Taken together, this feminist work can be constituted as "resistance", because of the ways it has broken silences, and challenged malestream knowledges and practices.

In contrast to representing feminist work as "resistance", Featherstone and Trinder (1997) have suggested that radical feminism has now become the dominant discourse regarding domestic violence. However, the continued difficulties facing women experiencing male violence suggest otherwise. This can be seen, for instance, in the criminal justice system, where, even though feminist activity has had some impact, women's experiences of domestic violence and abuse continue to be understood within a malestream culture (Smart 1989; Kennedy 1992; Hester and Radford, L. 1996). In the context of a study which also draws upon the ideas of Foucault (1979; 1984) it is more appropriate to suggest that these resistant feminist discourses represent "subjugated knowledges" (Foucault 1980b; Cain 1993). Moreover, attempts to trace domestic violence discourses within the professional knowledge base of health visiting reveals a near silence, further challenging the argument of Featherstone and Trinder (1997).

A Domestic Violence Discourse In Health Visiting?

The discursive perspectives adopted throughout this thesis draw attention to how a set of knowledges and practices are constituted (Foucault 1979; 1984; 1988; Weedon 1997). This has been demonstrated in the preceeding section which has focused upon feminist discourses on domestic violence; these represent a coherent and comphrehensive body of work with clear inter-connections between knowledge and practice. Constructing such radical feminist perspectives as discursive has already been suggested in the argument of Featherstone and Trinder (1997), although they go on to argue that they now represent the dominant discourse. The shortcomings of their argument is illustrated by examining the professional discourses of health visiting which reveals a near silence about domestic violence.

The following review focuses upon the professional literature, searching for references to domestic violence and abuse. There is very little material available (Orr 1986; Chalmers 1991; 1992; 1994; Strelley Nursing Development Unit 1993; McLelland 1995; Frost 1997), and currently no work which substantially addresses the practice issues arising for health visitors in relation to domestic violence experienced by women. The silence within the professional literature is further supported by focusing upon the analyses of health visiting responses within wider multi-agency studies (Binney et al 1981; Pahl 1982; 1985; Borkowski et al 1983; Homer et al 1984; McWilliams and McKiernan 1993; Tayside Women and Violence Group 1994; Dominy and Radford, L. 1996). These suggest that health visitors have a very mixed practice in relation to either recognising domestic violence amongst women, or providing appropriate support or protection. Often the contribution of health visiting is barely mentioned in contrast to other agencies such as social work or medicine. However, the studies reviewed are often more than ten years old, and may not reflect current practice.

Examining the Professional Literature.

In a paper which argues that health visiting work should be informed by a feminist perspective, Orr (1986) recognises domestic violence as a practice issue. Posing the question "how does a feminist approach help us in our work with female victims of violence?", Orr considers two main issues. Firstly, she argues that feminism " .... helps us to recognise that violence is a misuse of power and that its main victims are children, the elderly and women" (Orr 1986, p. 84). Secondly she addresses the issue of recognition for health visitors, arguing that feminism, by considering domestic violence to be a major problem for women, enables practitioners to identify domestic violence as an important issue, and a legitimate concern for health visitors (Orr 1986, p. 84-86). This has been achieved by a group of health visitors working in Nottingham, who identified domestic violence as an issue of central concern for their practice. By establishing local links with Women's Aid, they developed a "baby drop-in clinic" which incorporated advice and

support from legal advice workers with expertise in domestic violence (Strelley Nursing Development Unit 1993).

Domestic violence is mentioned as a practice issue in a study which aimed to identify the processes of health visitors' work with families (Chalmers 1991; 1992; 1994). The research is based upon qualitative interview data from 45 experienced practitioners who were asked to discuss their work, talking about cases where they considered their interventions had a positive impact and those where they thought they had little impact. Reading Chalmers' work, it is clear that at least one of her research participants discussed domestic violence as a practice issue, and her use of a grounded theory methodology necessitates that this "data bit" is incorporated into the analysis and discussion (Glaser and Strauss 1967). Thus, domestic violence is mentioned in the context of health visitors work with men (Chalmers 1992), and in relation to dealing with difficult situations (Chalmers 1994).

Children living in refuges usually receive health visiting services (Department of Health 1996; Hague et al 1996b). This is often driven by concern to ensure their inclusion within child health surveillance programmes (Department of Health 1996, p. 33), and is an area of health visiting work which has received very little attention. However, McClelland (1995) has described her role providing health visiting services to both women and children living in a women's refuge. Written from a public health perspective, McLelland (1995) points to the range of health problems experienced by these women. She also draws attention towards the important role health visitors can play in their everyday practice.

> "I am aware from my own work of the supportive role health visitors can and do play. I hear comments from the women that it was information from their health visitor that gave them choices, sometimes transport to leave, someone to listen to and believe, somewhere for an hour's respite" (McLelland 1995, p. 10).

Health visitors' vulnerability when dealing with domestic violence in their work has been highlighted by Frost (1997). This study was conducted in two health trusts in the south east of England. It involved a questionnaire sent to 134 health visitors which aimed to

identify their training needs, as well as interviews with 24 health visitors about their practice experiences of dealing with domestic violence. There is no discussion of the extent to which domestic violence is an aspect of health visitors work, but the results suggest that it is not an uncommon issue. In this paper Frost (1997) focuses upon the vulnerability of workers which emerged as a key theme, reflected in terms of their feelings of safety when undertaking home visiting to families, their lack of training about domestic violence, and their need for support from colleagues and managers. The report provides little detail about the nature and content of training experiences. However, the overall results are concerning, with only 34 per cent (n=37) out of the 107 health visitors who responded to the survey reporting they had ever received any form of training about domestic violence.

Such lack of training is also reflected in research conducted by Kingston et al (1995), which found that domestic violence was included in the curriculum of only 60 per cent of nursing colleges replying to their survey (28 out of the 48 schools of nursing which responded). Even though this work was not concerned with specialised post-basic training programmes such as health visiting, these results suggest that few nurses are learning about domestic violence during their pre-registration educational programmes. The study reported by Borkowski et al (1983) found that the majority of health visitors interviewed (69 per cent) had no knowledge of the law relating to women experiencing violent relationships.

Health Visiting and Multi-Agency Responses.

A number of studies have focused upon agency responses to domestic violence (Binney et al 1981; Borkowski et al 1983; Homer et al 1984; Pahl 1985; Mama 1989a; McGibbon et al 1989; McWilliams and McKiernan 1993; Tayside Women and Violence Group 1994; Dominy and Radford, L. 1996). When health visiting has been identified as a helping agency within these studies, it has received much less attention than other agencies such as social services, housing and police. This reflects the small numbers of women seeking

help from health visitors, as well as the often inadequate responses of health visitors to domestic violence. For example, in their study of 636 women living in refuges, Binney et al (1981) found that 23 per cent (146) of the women they interviewed had contacted a health visitor for help; this contact was found to be helpful in 55 per cent of cases. As health visitors were one of the least frequently contacted agencies, the report contains little discussion about their work. A similar study reported by Homer et al (1984) found that only 15 (18 per cent) of the 80 women they interviewed had asked a health visitor for help. Little detail is given, but the study suggests that these women turned to health visitors because they wanted someone to talk to, as well as requesting information and advice. More recent work by McWilliams and McKiernan (1993) showed similar results; from a sample of 56 women, only 25 (45 per cent) reported that they had made contact with a health visitor in relation to domestic violence.

In contrast, the study reported by McGibbon et al (1989) found that only 3 per cent of the total sample of 133 women who reported experiencing some form of abuse from a male partner, had approached a health visitor for help. Out of these 5 women who reported they had contacted a health visitor for help, 4 reported they received helpful responses. However, it is difficult to draw conclusions from these studies, because they often lack detail about whether the women involved have pre-school children, a factor which makes them much more likely to have access to the health visiting service.

This issue is addressed in the study reported by Pahl (1982; 1985). This examined the experiences of 42 women who had escaped domestic violence, finding that only 29 per cent of them had talked to their health visitor about their husbands violent behaviour. As most of these women were mothers of young children, Pahl comments upon their reluctance to disclose domestic violence, pointing out that most of these women had a health visitor calling at the house during the time the violence was taking place. However, for those women who did disclose their experiences of domestic violence to a health visitor, the responses they received were mixed. Helpful responses included the provision of practical advice and information, as well as overall support. The understanding of health visitors regarding domestic violence was important, and Pahl notes that women

appreciated health visitors who " .... made an effort to understand the woman's position as she saw it" (Pahl 1982, p.529).

In contrast Pahl identified a number of unhelpful responses, which suggested that health visitors often failed to understand women's experiences of domestic violence. Thus, they focused upon the welfare of children rather than addressing women's safety and support; they reinforced ideas that women may be responsible for the violence and abuse they experienced; and they offered inappropriate advice focusing upon reconciliation, rather than supporting women to challenge the violence. Pahl (1985) also pointed to the suspicion of men towards welfare workers, suggesting that they blocked contact between women and health visitors. Despite such problems, Pahl (1985) considers health visitors have a unique position as front line workers in relation to women experiencing domestic violence. This is underpinned by an awareness that domestic violence is a frequent issue in the lives of women who are pregnant or who have small children.

The study reported by Borkowski et al (1983) involved asking 45 health visitors to complete a form recording the numbers of known or suspected cases of marital violence on their caseload. The reported results of this exercise indicate that 1.8 per cent of the average health visitor caseload fell into this category (also expressed as 1 in 56 women). This suggests that health visitors are under-estimating or unaware of the levels of domestic violence; more recent feminist work indicates prevalence rates of between 1 in 4, and 1 in 10 relationships (McGibbon et al 1989; Mooney 1993; Stanko et al 1998).

In another multi-agency study health visitors were asked to estimate the number of abused women they had contact with during a twelve month period (Tayside Women and Violence Group 1994). The results of the survey, which was completed by 58 health visitors, are displayed in Figure 1:2.

Figure 1:2. Health Visitors Estimates of the Number of Abused Women Making Contact in 12 Month Period (Tayside Women and Violence Group 1994, p. 68).

No. of Health Visitors.	No. of abused women making first contact in 1 year.
35.	1-5.
14.	6-10.
5.	11-25.
2.	26-50.
0.	51-75.
1.	76-100.
1.	101-150.

As can be seen, the majority of health visitors reported very little contact with women experiencing domestic violence; however, a minority reported high levels of contact. Such contrasting results makes it difficult to draw conclusions. This study also found that out of 20 women interviewed, only 5 had contact with health visitors, ".... and talked about, or wanted to talk about abuse with them" (Tayside Women and Violence Group 1994, p. 69). When health visitors are mentioned in other studies concerned with agency practices in relation to domestic violence, the multi-agency nature of the research often means that it is difficult to extrapolate with any certainty the contribution of health visiting (Dominy and Radford, L. 1996).

The contribution of health visitors to inter-agency domestic violence forums is noted by Hague et al (1996a). This recognises the presence and involvement of health visitors within many inter-agency forums, contrasting this with the often notable absences of other health care professionals. However, as the authors observe, health visitors often participate in inter-agency forums because of a personal interest, and although this is valued the absence of a representative with an organisational remit to develop agency practice is regretted (Hague et al 1996a, p. 57).

Summary.

This examination of the professional health visiting literature is suggestive of a silence about the issue of domestic violence. This silence is also reflected in the studies of multi-agency responses to domestic violence; these suggest that health visiting work is marked by a mixed and uncertain response to women experiencing domestic violence. Most of this work was undertaken over 10 years ago, and the changing context of both agency practice and awareness of domestic violence must be considered. It is therefore difficult to draw conclusions from the previous research. However, it is useful for mapping out an initial picture of health visiting responses. In particular, the absences and silences regarding the issue of domestic violence within health visiting work suggest that feminist discourses have not informed the professional discourses which underpin health visiting practices. There are, however, a number of other emerging issues which may influence the knowledge base of health visiting. In particular, work which has drawn attention towards the impact of domestic violence upon children, and upon health, are likely to be associated with policy and practice implications for health visiting. These are reviewed in the following sections.

DOMESTIC VIOLENCE AND CHILDREN.

The emerging discourses about domestic violence and children build upon, and reflect, a long-standing feminist concern. These have established the inter-connections between child abuse and woman abuse, the adverse impact upon children living with or witnessing domestic violence, and the need for appropriate responses to both children, and their mothers, in the context of domestic violence. Understanding these issues is however marked by complexity, and particular attention is needed to ensure the differences, as well as the commonalities, between children, and children's experiences are taken into account (Imam 1994; Kelly 1994; Morley and Mullender 1994; Hendessi 1997). These include, for instance, the differences between children, particularly age, gender and race,

as well as their different understandings of the abuse experienced by their mothers (Kelly 1994). It is also necessary to consider the different contexts in which domestic violence occurs, as well as acknowledging the impact of other adverse circumstances, such as poverty and racism. Work focusing upon children's accounts of their experience is particularly important (Higgins 1994; Saunders 1995). However, as Kelly (1994) has pointed out, there is little research currently available which takes a child-centred perspective in order to examine children's understandings of, and involvement with, the domestic violence experienced by their mothers. However, despite these complexities, the evidence suggests that domestic violence is problematic for children, highlighting the need for an urgent response at the policy, practice and research level.

The previous section has examined the existing silences about domestic violence within health visiting, suggesting that feminist discourses have had little impact upon professional knowledge or practice. Domestic violence in relation to children, however, represents an important site for health visiting work to develop, and as such is an area of research that is likely to impact upon the professional knowledge base and practice of health visitors. This section aims to outline the existing work on domestic violence and children, identifying a number of key themes. These include children's experiences of domestic violence, its impact upon children, and professional responses.

Children's Experiences of Domestic Violence.

Children's experiences of domestic violence include living in households where domestic violence takes place, witnessing or overhearing their mothers being abused, and being directly abused themselves. These experiences are diverse and cumulative, and it is difficult to establish their range and extent with certainty. However, despite these complexities there is a sizeable body of work concerned with children's experiences of domestic violence (Bowker et al 1988; Stark and Flitcraft 1988; Jaffe et al 1990; Hughes 1992; Abrahams 1994; Imam 1994; O'Hara 1994; Farmer and Owen 1995; Gibbons et al

1995; Saunders 1995; Brandon and Lewis 1996; Hester and Radford, L 1996; Hendessi 1997; Humphreys 1997; Rai and Thiara 1997).

A number of studies have pointed towards the extent that children may overhear or witness their mothers being abused (Dobash and Dobash 1984; Davis and Carlson 1987; Jaffe et al 1990; Hilton 1992; Hughes 1992; Abrahams 1994; Kolbo et al 1996; Hendessi 1997).The study reported by Abrahams (1994), which is based upon the results of a survey completed by 108 women attending family centres, found that 86 mothers believed their children had become aware of the violence they were experiencing. Of these, 73 per cent reported that their children witnessed the violence, 62 per cent overheard one or more attacks, and 99 per cent said their children had seen them crying and upset because of the violence. This study also found that one in ten mothers had been sexually abused in front of their children. Hughes (1992) states that 90 per cent of incidents of domestic violence took place when a child was in the same or next room, and similar results have been reported in other research and direct work with children (Jaffe et al 1990; Hague et al 1996b; Women's Aid Federation of England 1996b; Hendessi 1997).

In addition to witnessing domestic violence, there is considerable evidence suggesting that many children experience being abused themselves (Hilberman and Munson 1977; Davis and Carlson 1987; Bowker et al 1988; Stark and Flitcraft 1988; Hooper 1992; Abrahams 1994; Debbonaire 1994; 1995; O'Hara 1994; Farmer and Owen 1995; Gibbons et al 1995; Brandon and Lewis 1996; Hague et al 1996b; Ross 1996; Mullender et al 1998). This link has been established both by examining situations where children are known to have been abused, as well as studies which have focused upon the children of mothers who are experiencing domestic violence.

For example, a North American study (Bowker et al 1988) found that 70 per cent (543 women) of the 775 mothers in a volunteer sample of "battered women" reported that the wife beater had also abused their children. This abuse included slapping their children in 41 per cent of cases, and kicking, hitting or punching them in 16 per cent of cases. Another North American study examined the medical records of 116 mothers of children where child abuse was known or suspected in order to identify the levels of domestic

violence (Stark and Flitcraft 1988). The researchers used a classification screen designed to identify abuse, and found 52 women (45 per cent) with a trauma history indicative of battering, and another 6 women (5 per cent) with a history that suggested marital conflict.

More recent work undertaken in this country has further established an overlap between domestic violence and child abuse. For example, Farmer and Owen (1995) found that domestic violence featured in 52 per cent of their intensive sample of 44 children registered as a result of child protection case conferences. Gibbons et al (1995) examined the social work records for 1888 families in which children were referred to the child protection system, finding that domestic violence was recorded for 27 per cent of these families. A study reported by Brandon and Lewis (1996) found that, out of a total sample of 105 children described as "maltreated or neglected", 49 (46 per cent) were regularly witnessing domestic violence.

The study reported by Hester and Radford, L. (1996) which examined the processes of child contact, found that 21 of the 53 women living in England reported that their male partner has also inflicted physical or sexual violence upon their children. Moreover, their work points towards the ongoing nature of both child abuse, and woman abuse. Similarly Abrahams (1994) found that 27 per cent of the mothers reported that the children had been hit or abused by the violent man. The seriousness of the overlap between domestic violence and child abuse has been highlighted by O'Hara (1994), who has pointed to the links between those cases of child abuse which have the worst outcome, notably child deaths, and the presence of domestic violence. These links are further confirmed by direct work with children, particularly in the context of refuges which frequently provide children with a safe environment and the associated opportunity to disclose their experiences of physical and sexual abuse (Debbonaire 1994; 1995; Hague et al 1996b; Women's Aid Federation Of England 1996b; Mullender et al 1998).

Feminist work has also pointed towards the inter-connections between woman abuse and child abuse, highlighting how these different behaviours intersect as men exert their power and control over both women and children. This may be experienced in a number of ways, but can include women or children being forced to directly participate in the abuse of the

other, or to undertake certain actions in order to prevent further abuse of the other (Kelly 1994). Hooper (1992), for example, has highlighted the inter-connections between woman abuse and child sexual abuse, suggesting that the ongoing violence and abuse directed towards women provided the context for men to sexually abuse their children. Moreover, Hooper (1992) points out that the sexual abuse of children was often intended as a further abuse of their mothers.

Thus, children's experiences of domestic violence are diverse and complex. At this stage there is need for further work to disentangle these different experiences, and develop further understandings. However, despite these shortcomings, the current knowledge base suggests that children do experience domestic violence in a number of ways; the impact of domestic violence upon children is examined in the following section.

The Impact of Domestic Violence Upon Children.

There is overwhelming evidence to suggest that domestic violence has an adverse impact upon children (Hilberman and Munson 1977; Davis and Carlson 1987; Jaffe et al 1990; Holden and Ritchie 1991; Hilton 1992; Hughes 1992; Abrahams 1994; Morley and Mullender 1994; Saunders 1995; Hague et al 1996b). However, the extent and nature of this impact is marked by considerable diversity and complexity, reflecting the differences between children, as well as their different experiences and understandings of domestic violence. There has been little research which has focused upon children's understandings. Despite such complexities, current understandings suggest considerable cause for concern.

Many of the studies which have attempted to examine the impact of domestic violence upon children have been undertaken in North America and Canada, often from a psychological perspective (Hilberman and Munson 1977; Davis and Carlson 1987; Jaffe et al 1990; Holden and Ritchie 1991; Hilton 1992; Hughes 1992). Even though these studies suggest cause for concern, they have been subjected to criticism due to a range of

methodological, and conceptual issues (Fantuzzo and Lindquist 1989; Morley and Mullender 1994). For example, these studies have often been undertaken amongst children living in refuges or women's shelters, and this further complicates the difficulties in disentangling the impact of domestic violence, from other events such as leaving home. Moreover, little attention has been paid to the differences between children. A review of this work is beyond the scope of this discussion. However, it is useful to highlight the range of issues which have been identified for pre-school children, and these include behavioural responses, such as sleep problems, bedwetting, and physical symptoms including headaches, stomach aches, and diarrhoea (Hilberman and Munson 1977).

A number of studies which have focused largely upon women's experiences have noted the impacts of domestic violence upon children (Hilberman and Munson 1977; Mama 1989a; Abrahams 1994; Hester and Radford, L. 1996). For example, Abrahams (1994) has suggested that witnessing violence and sexual abuse has an adverse impact upon children. Her study found a range of emotional responses, such as being frightened, "clingy", quiet or withdrawn, to being angry and aggressive; many children had started bed wetting problems, which mothers thought was a response related to the domestic violence. The studies by Hester and Radford, L. (1996) and Mama (1989a) also provide evidence that children were effected by the domestic violence. A range of work has also drawn attention to the damaging consequences to unborn children when women are abused during pregnancy (Council of Scientific Affairs 1992; McFarlane 1992; Hague et al 1996b).

In considering children's responses to domestic violence, it is often difficult to disentangle the effects of domestic violence from other aspects of children's lives. For example, for many children, experiencing domestic violence may be associated with the considerable disruption which occurs through leaving their homes, and moving to refuges. This often involves leaving neighbourhoods, friends, pets and extended families (Debbonaire 1994; 1995; Saunders 1995; Hague et al 1996b; Mullender et al 1998), and for Black children this may also involve increased exposure to racism (Imam 1994; Rai and Thiara 1997). Moreover, for many children, leaving a violent home may also involve a change in

economic resources, and many children may experience poverty and poor housing as a result of domestic violence (Hague and Malos 1994).

Women's experiences of domestic violence may have negative impacts upon their parenting, and this has further implications for children (Holden and Ritchie 1991; Abrahams 1994; Kelly 1994; Hester and Radford, L. 1996; Hester et al 1998). For example, many of the mothers who participated in the study undertaken by Abrahams (1994) felt that their experiences of domestic violence had an adverse effect on them as mothers. This often arose from a loss of self-confidence, as well as from feeling exhausted and physically ill as a result of the violence and abuse they had experienced. Moreover, as Kelly (1994) has pointed out, domestic violence provides an adverse context for bringing up children. This relates to the social and economic circumstances in which parenting takes place, as well as issues relating to the emotional and physical well being of the mother. Often woman abuse commences, or escalates in pregnancy or early parenthood, and many women conceive children as a result of marital rape or enforced pregnancy (Kelly 1994). As a result, many mothers experience additional difficulties in relation to their children, often aggravated by children's emotional and behavioural responses towards the domestic violence. Overall, this provides a difficult context for mother-child relationships to develop. In contrast, there appears to have been little work documenting the parenting skills of violent and abusive fathers. The study reported by Holden and Ritchie (1991), which relied upon mothers reports of parenting, suggests that violent men are less involved with their children, and that their ".... irritability appears to spill over into fathering" (Holden and Ritchie 1991, p. 325). This has also been highlighted in the context of child contact, where it was found that men had little interest or concern for the care of their children (Hester and Radford, L. 1996).

Children and Domestic Violence: Professional Responses.

The growing interest in domestic violence and children highlights a set of concerns about the provision of appropriate support and protection. This has been a long term aspect of feminist work with women and children, which has been enhanced in recent years with the development of specific child focused work (Debbonaire 1994; 1995; Higgins 1994; Hague et al 1996b; Mullender et al 1998). This is underpinned by understandings that it is necessary to ensure the safety and empowerment of women, alongside child-centred work (Ball 1996, p. 12). It has also attempted to address the particular needs of different children, taking into account issues such as race, class, gender and (dis)-ability (Imam 1994; Rai and Thiara 1997). In contrast, professional responses have been problematic, often failing to support or protect women or children (Maynard 1985; Farmer and Owen 1995; 1998; Lloyd, S. 1995; Mullender 1996; Humphreys 1997; 1998; Stanley 1997).

Such inadequate responses have been particularly visible in relation to child protection work, where professional responses have often been associated with inappropriate and ineffective interventions. In particular, the failure to acknowledge or recognise domestic violence despite ongoing child protection interventions has been highlighted (Farmer and Owen 1995; Humphreys 1997; 1998). For example, in their study of child protection interventions, Farmer and Owen (1995) followed up an intensive sample of 44 newly registered children, reporting that although domestic violence was known about in 12 cases, they became aware of another 11 cases where it had not been revealed to social workers. Furthermore, in relation to information sharing at initial child protection case conferences, they point out that domestic violence was only reported in 27 (out of 120) cases, "....despite the fact that it was present across the full range of households and categories of abuse in the study" (Farmer and Owen 1995 p. 138). However, in those instances when domestic violence was known about, either at the initial child protection conference, or during the subsequent interventions, this was not always addressed. As they point out, in a number of cases,

> ".... domestic violence featured significantly but was not dealt with either in relation to the power imbalance within the family, the risks to the mother and children, or in relation to its relevance to whether the mother was able to protect the children. .... It was if these two manifestations of violent behaviour, domestic violence and abuse to children were regarded as quite unrelated despite the increasing research evidence which demonstrates the connection between them" (Farmer and Owen 1995, p. 224).

The study reported by Humphreys (1998) involved a documentary analysis of child protection files, as well as interviews with social workers involved in 32 families where domestic violence was known about. The results point to the ways in which the abuse and violence experienced by women was generally ignored, unnamed, or minimised. However, Humphreys (1998) also identified a contrasting trend in which the issue of domestic violence was occasionally addressed in a confrontational manner. This involved, for example, an expectation that women separate from their violent partners, even though they lacked the resources or support to enable them to undertake this safely. These interventions are part of the wider context of child welfare work, which as Milner (1993) amongst others has demonstrated is deeply gendered (Maynard 1985; Milner 1993; Farmer and Owen 1995; 1998; O'Hagan and Dillenburger 1995; Thoburn et al 1995).

The growing interest in the issue of domestic violence and children has been associated with a number of policy and practice initiatives designed to improve professional responses (Ball 1996; Hester et al 1998). These include, for example, training materials (Hester et al 1998), and improved inter-agency working, including closer associations between the work of Area Child Protection Committees and Domestic Violence Forums (Hague et al 1996a). Despite the success of child support work in North America (Mullender 1994; 1996, p. 159-163), such work has been slow to develop in this country. The main provision of support continues to be from the refuge movement which provides support to children living with and escaping domestic violence (Debbonaire 1994; Higgins 1994; Hague et al 1996b; Rai and Thiara 1997; Mullender et al 1998).

Summary.

The growing interest in the impact of domestic violence upon children and the overlap with child abuse reflects a long-standing feminist concern with supporting children experiencing domestic violence. The research evidence is complex and incomplete, but the overall picture suggests that experiencing domestic violence has an adverse impact upon children. It also points to the ways in which male violence and abuse directed towards women, also involves children, either as witnesses or victims.

Health visiting work is constituted in terms of child health and welfare (Mayall and Foster 1989; Abbott and Sapsford 1990; Hall et al 1994). Thus, the emerging discourses about domestic violence and children represent an important point at which professional attention will be drawn towards the issue of domestic violence. This is likely to have a major impact upon policy and practice in the context of health visiting.

DOMESTIC VIOLENCE AND HEALTH.

There is a growing interest in the issue of domestic violence and health, both in terms of its impact upon women's health, and as a health care issue. The majority of this work has been undertaken in the U.S.A., Canada and Australia, although there has been recent interest in the U.K. context (Bewley et al 1997; Scottish Needs Assessment Programme 1997; British Medical Association 1998). This builds upon a long-standing feminist concern which has recognised the adverse impact of domestic violence upon women's health, and the inadequate responses of health care agencies (Dobash and Dobash 1979; Kelly 1988a; Mama 1989a; Pahl 1995; Stark and Flitcraft 1996; Stanko et al 1998).

The medical interest in domestic violence and health has primarily involved epidemiological studies documenting the extent of domestic violence, and its implications for the use of health care. The cumulative results of such work suggests considerable cause for concern. However, it is marked by definitional and methodological differences,

which reflect feminist perspectives about the processes of researching women's experiences of violence and abuse (Mooney 1993; Kelly et al 1994). Understanding the impact of domestic violence upon a woman's health is also marked by complexity, not only because of the extensive and insidious nature of male violence and abuse, but also because there are many different perspectives for understanding health and disease. Of particular interest in the current context is a range of feminist work which points to the gendered nature of health and health care (Miles 1991; Roberts 1992; Graham 1993a; Oakley 1993; Wilkinson and Kitzinger 1994; Busfield 1996). Despite these tensions and discontinuities between feminist and medical discourses, the emergence of the latter is important because, in constructing domestic violence as a health issue, it contributes towards the further breaking of silences about male violence towards women. Moreover, the emerging discourses about domestic violence and health are highly relevant to health visiting work, and are discussed in this section.

The Impact of Domestic Violence Upon Health.

The impact of domestic violence upon a woman's health has been made visible by feminist research which has pointed towards the short and long term problems experienced by women in violent and abusive relationships (Dobash and Dobash 1979; Binney et al 1981; Pahl 1985; Kelly 1988a; Mooney 1993; Stanko et al 1998). These include a range of injuries, (dis)-abilities and illnesses caused by physical, sexual and emotional violence and abuse, which may be life-threatening, together with the emotional and psychological consequences of being abused and controlled. In understanding women's experiences of male violence, feminists have pointed to the range of coping strategies women have used in order to survive, as well as the processes which lead to self-abuse.

The literature examining the health implications of domestic violence is extensive (Stark et al 1979; Haber 1985; Jaffe et al 1986; Andrews and Brown 1988; Council of Scientific Affairs 1992; Plichta 1992; Muelleman et al 1996; Plichta and Abraham 1996; Abbott

1997). It includes epidemiological studies, focusing upon the health and illness experiences of women known to have suffered domestic violence, as well as studies which aim to uncover the extent of domestic violence amongst groups of women already receiving medical treatment for a range of medical and psychological conditions. Establishing the prevalence of domestic violence, and causal links with disease and injuries is problematic, often further aggravated by the methodological and definitional approaches underpinning these studies (Gazmararian et al 1996). However, the cumulative evidence suggests there is considerable cause for concern, pointing to a wide range of acute and chronic physical and mental health problems. These include immediate physical injuries, which are often multiple, such as bruises, cuts, broken bones, burns and wounds, and longer term damage such as scars, damage to joints, loss of hearing and vision, and long term chronic pain. The damaging emotional impact of domestic violence, particularly the high rates of depression and stress related illness has been well documented (Hilberman and Munson 1977; Stark et al 1979; Jaffe et al 1986; Jacobson and Richardson 1987; Andrews and Brown 1988; Mullen et al 1988).

For example, in an analysis of the case records of 481 women attending for emergency care at a US hospital, Stark et al (1979) found that 1 in 4 "battered women" had attempted suicide at least once. Their findings establish that self abuse, attempted suicide and deteriorating mental health follow on from the experience of violence, and are not preconditions for abuse and violence. Similar high rates of depression and stress related illness have been found in other research studies. A Canadian study reported by Jaffe et al (1986) compared the emotional and physical health problems of 56 women who had escaped domestic violence and were living in women's shelters, with a convenience sample of 89 women who did not report such experiences; the two groups were matched for family income, ages of children, and length of relationship. The researchers found that women experiencing domestic violence had significantly more somatic complaints, a higher level of anxiety and more reported symptoms of depression. Andrews and Brown (1988) report an interview based study undertaken with 286 working class mothers living in North London. The researchers found that women who had ever been in a violent relationship were twice as likely to be depressed and had lower self-esteem, than those

women in the study who did not report a history of marital violence. Mullen et al (1988) also found that sexual and physical abuse had an adverse impact on women's mental health. The survey reported by Abrahams (1994) found that 76 per cent of the 105 mothers who responded, considered they were depressed.

Domestic violence also impacts upon a woman's overall health through the practices of men who restrict and curtail her access to health care. This occurs across the range of services, but has been reported in the context of antenatal care (McFarlane et al 1992; McWilliams and McKiernan 1993).

There has been considerable attention paid to the issue of domestic violence and pregnancy (Helton et al 1987; Helton and Snodgrass 1987; Bullock and McFarlane 1989; McFarlane et al 1992; Newberger et al 1992; Gielen et al 1994; Parker et al 1994; Webster et al 1996; Gazmararian et al 1996; Bewley et al 1997; Mezey and Bewley 1997). A number of studies suggest that domestic violence escalates during pregnancy. For example, McFarlane et al (1992) found that 60 per cent (out of 117) of abused women reported two or more episodes of violence during pregnancy. In another study (Helton et al 1987; Helton and Snodgrass 1987), 79 per cent of women (19 out of 24) reported experiencing multiple abuse injuries during their current pregnancy. Of particular relevance for health visitors is the findings that domestic violence increases during the post-natal period. For example, Gielen et al (1994) found that moderate or severe violence was reported by 25 per cent of women (out of 275) during the post-natal period, compared with 19 per cent during the pregnancy. Helton et al (1987) also report that 29 per cent (7 out of 24) of women identified as experiencing physical abuse during pregnancy, reported that their experience of this increased after pregnancy.

Moreover, experiencing domestic violence during pregnancy is associated with poorer obstetric outcomes. Research into women's experiences of male violence has consistently found women reporting miscarriages, preterm labour, and bleeding during pregnancy associated with physical violence (Hilberman and Munson 1977, p. 462; Binney et al 1981, p. 4; Kelly 1988a, p. 209; McWilliams and McKiernan 1993, p. 34-35; Mooney 1993, p. 36; Hanmer 1998, p. 133-4). Stark et al (1979) suggested that women

experiencing physical abuse had a higher rate of miscarriages, while Andrews and Brown (1988) found that, out of the 286 women they interviewed, those experiencing domestic violence were more than twice as likely as other women, to have experienced a miscarriage or stillbirth (Andrews and Brown 1988, p. 311). Even though there is growing interest in researching the links between domestic violence and obstetric outcomes, it is a complex area, and claims of direct causal links may not stand up to scrutiny. For example, some researchers have suggested a link between physical abuse during pregnancy and low birth weight infants (Bullock and McFarlane 1989; Parker et al 1994). However, this is difficult to establish, largely because of the need to control for a range of socio-economic variables, and other health damaging occurrences such as substance abuse. For example, a study reported by Webster et al (1996) failed to establish a direct link between physical abuse during pregnancy and low birth weight babies. However, their findings did support the view that women experiencing abuse had a significantly poorer health status than non-abused women, measured by higher rates of smoking, drug use and evidence of depression, as well as poor obstetric histories. They suggested that the poor health status of these women was linked to their experience of domestic violence, and that this contributed towards poorer overall neonatal outcomes including birth weight.

This argument is important because it highlights the need to avoid conflating complex socio-economic variables which impact upon women's health. Despite a lack of feminist work examining the impact of domestic violence upon women's health, wider debates about women and health shed light on these complexities. For example, Graham (1993b) has demonstrated how women's smoking patterns need to be understood in the context of their everyday lives taking into account social structural perspectives. Others have pointed to the difficulties in using social class as a measure when examining women's health status (Arber 1990). If such arguments are applied in the context of domestic violence the evidence from epidemiological studies more limited. Understanding the impact of domestic violence upon a woman's health requires careful analysis of the complex ways in which women's lives, and therefore their health, are constrained.

Domestic Violence as a Health Care Issue.

The growing interest in the impact of domestic violence upon health, is also associated with developments designed to address how this issue is dealt with in health care settings (Plichta 1992; Warshaw 1994). The majority of this work has developed outside this country, particularly in the USA, Canada, and Australia, but the issue is beginning to receive attention within the U.K. (Richardson and Feder 1996; Bewley et al 1997; British Medical Association 1998). These developments are outlined in relation to particular health care settings, as well as reviewing the nursing contribution to this work.

There has been considerable interest in addressing the issue of domestic violence within emergency care settings, focusing upon the need to recognise this issue, and improve the responses of medical and nursing staff to women accessing these services (McLeer and Anwar 1989; McLeer et al 1989; Hadley 1992; Campbell et al 1994; Grunfeld et al 1994; Ingram 1994; Jezierski 1994; Snyder 1994; Mortlock 1996; Olson et al 1996; Waller et al 1996; Roberts et al 1997; Varvaro and Gesmond 1997). Attention has focused upon the need for training programmes, as well as studies evaluating the introduction of protocols and guidelines for detecting and responding to women experiencing domestic violence. The important inter-connections between training and the use of protocols has also been highlighted (McLeer et al 1989; Hadley 1992). In the context of North America, Hadley (1992) has described the ongoing support and presence of a hospital based advocacy programme, known as "Womankind", which provides a service for women seeking hospital based health care as a result of domestic violence. In describing this development Hadley (1992) points towards the importance of maintaining a continued profile for domestic violence within an emergency health care setting.

Addressing domestic violence in an emergency setting has received less attention in the United Kingdom. However, the issue has been raised for nurses by Ingram (1994) and Mortlock (1996), but from very different perspectives. Ingram (1994) adopts a woman-centred approach, advocating practice and policy which builds upon understandings of women's experiences of male violence, and the prevailing silence which surrounds this

issue. In contrast, Mortlock (1996) advocates a more nurse-centred approach, drawing upon psychological and communication theories, rather than attempting to understand women's experiences; thus once again reflecting the silence within the nursing knowledge base regarding domestic violence.

The research interest in domestic violence and pregnancy has also led to an increased awareness of the need to improve responses to women using maternity care services (Bohn 1990; Bewley and Gibbs 1991; McFarlane 1992; Newberger et al 1992; Bewley et al 1997; Mezey and Bewley 1997; Royal College of Midwives 1997). For example, Bohn (1990) reviews the evidence concerning the extent of domestic violence during pregnancy, and its associated adverse outcomes, urging nurse-midwives to address this issue in their everyday practice. Within the UK context, Bewley and Gibbs (1991) have reviewed the evidence, suggesting there is a need for a more pro-active response from British midwives; recent developments indicate that has begun to be addressed (Bewley et al 1997; Royal College of Midwives 1997).

An interest in domestic violence in the context of primary health care is beginning to emerge, although this has focused largely upon medical rather than nursing issues (Heath 1992; Sugg and Inui 1992; Richardson and Feder 1996; Mezey et al 1998). For example, Richardson and Feder (1996) have pointed to the reluctance of GPs and other primary health care workers to recognise and support women experiencing domestic violence. There is also a growing interest in constructing domestic violence as a public health issue (Department of Health 1997; Scottish Needs Assessment Programme 1997; British Medical Association 1998). For example, work undertaken in Scotland (Scottish Needs Assessment Programme 1997) has pointed to the need to develop a broad strategy in order to fully support women and children experiencing domestic violence. These perspectives are supported by recent developments in health policy (Department of Health 1998) which have redrawn the boundaries of public health, and enabled domestic violence to be constructed as a public health issue (Department of Health 1997; British Medical Association 1998). Moreover, recent work undertaken in north London has

pointed to the economic costs of domestic violence suggesting an annual cost to the health service of £189 million in Greater London alone (Stanko et al 1998).

Within this developing body of work, there are some incongruities concerning the relative contributions of medicine and nursing. This may reflect the differing access to academic scholarship and knowledge production between these two disciplines, which is underpinned by wider gendered divisions concerning professional health care work (Davies 1995). The reluctance of nursing to address the issue of domestic violence has been addressed by Hoff (1991), who suggests that even though nurses have themselves been an oppressed group struggling for professional recognition, they have only had a marginal involvement with wider societal issues, particularly those associated with the women's movement. However, despite this early reluctance, the issue of domestic violence has begun to be extensively addressed in the context of North American nursing practice. There is now a growing literature embracing nursing research, training and education programmes concerned with the issue of domestic violence (Sampselle 1992; Mandt 1993; Davidhizar and Newman-Giger 1996; Ross et al 1998; Sword et al 1998). In contrast, this issue has currently received very little attention within U.K. nursing research, policy or practice (Kingston and Penhale 1995), although wider developments in relation to inter-agency work, alongside the North American experience, may be associated with future changes.

Summary.

Feminist research and epidemiological studies have made visible the adverse impact of domestic violence upon health. These studies have illustrated the short and long term effects of experiencing domestic violence upon a women's physical and mental health. They also point to the increased incidence of domestic violence during pregnancy, and suggest that this is associated with a number of adverse obstetric outcomes. The evidence is complex, but the overall picture illustrates that women experiencing domestic violence also experience poorer health. This may be caused directly by the violence and

abuse, and may be further aggravated by the practices of abusive men restricting women's access to health care. In addition, women may respond to the abuse they are experiencing in ways which may further neglect or damage their health.

Alongside this research lies an increased awareness and interest about responding to domestic violence in health care settings. The majority of this work has taken place outside the U.K., but there is a growing awareness in this country. Attention has focused largely upon training issues, and the development of policies and guidelines to improve practice responses. Considerable work has been undertaken in the context of certain health care settings, particularly emergency departments, and maternity care, although domestic violence is becoming increasingly recognised as an issue to be addressed within primary, and public, health care. The contribution of nursing to research, education and practice developments in north America is particularly marked, and can be contrasted to the silence about domestic violence within British nursing.

CONCLUSION.

Adopting a discursive perspective has illustrated the extensive existing knowledge and practices regarding feminist work in relation to domestic violence. By acknowledging the abuses of male power which underpin domestic violence, feminists have undertaken both research and practice to challenge male violence. This has included the provision of support and protection to women, and their children, and extensive campaign work; it has also included the development of a considerable body of feminist scholarship which has taken seriously women's experiences of male violence, and the difficulties they face in achieving support or protection. These feminist discourses have underpinned some recent developments, particularly the emerging interest in the impact of domestic violence upon children, the recognition of domestic violence as a health care issue, and the push to develop inter-agency work.

Despite this considerable body of work, the issue of domestic violence has received very little attention within the professional health visiting knowledge base. Although the potential role of health visitors has been recognised (Pahl 1982; 1985), the results of previous multi-agency studies have provided little detail about health visiting work in relation to women and domestic violence. However it is argued that the emerging discourses about the impact of domestic violence upon children, and upon health, will bring greater professional attention to this issue, creating the space for future developments.

CHAPTER TWO.

HEALTH VISITING: THE SOCIAL REGULATION OF MOTHERS.

INTRODUCTION.

The historical and contemporary narratives of health visiting are complex and contradictory, and suggest an ambiguous and contested knowledge and practice. Often the tensions within health visiting practice have been problematised by modernist binary thinking, and this has led to a set of dualisms through which health visiting work is understood. These include, for instance, the tensions between individual and community focused approaches to health (Twinn 1991), and the boundaries of "public" and "private" which health visiting work crosses (Stacey 1981; Mayall 1993). Such tensions have ensured that the search for professional certainty remains elusive (Robinson, J. 1985; Abbott and Sapsford 1990; Robinson, K. 1992). Despite the absence of such a professional meta-narrative, however, health visiting continues to enjoy state sponsorship.

The argument presented here suggests that health visiting is constituted upon a set of practices concerned with the social regulation of mothers. It draws upon particular discourses to offer a fragmented and partial narrative of health visiting. These include historical and feminist analyses which point to the development of health visiting work as a state sponsored agency, undertaken largely by women, and focused upon mothers. This relationship between state and family is understood as a form of social regulation (Dingwall 1977a; Donzelot 1979; Dingwall and Eekelaar 1988; Abbott and Sapsford 1990; Parton 1991; Dingwall and Robinson, K. 1993); the gendered nature of this is apparent in both historical and contemporary analyses (Graham 1979; Smart 1992; Burman 1994; Edwards, J. 1998). In contrast, prevailing professional discourses focus attention upon notions of health, and stress the development of good relationships with clients. They are also silent about social diversity, and do not acknowledge or address issues such as

gender, race, class, (dis)-ability and sexuality. These professional discourses are presented as resistance to the narrative of gendered regulation, thus reflecting the titular themes of the thesis. The discussion commences with a historical analysis of health visiting work.

THROUGH THE LENS OF HISTORY.

The development of health visiting alongside political concerns about maternal and infant welfare has been documented by feminist historians (Davin 1978; Lewis 1980a, 1980b; Dwork 1987; Davies 1988), as well as historians of health visiting (Clark 1973; Dingwall 1977a; LLoyd, P. 1986; While 1987; Dingwall et al 1988). Their collective scholarship points to the processes by which health visiting became established as a state sponsored agency concerned with the social regulation of mothers (Smart 1996). The following discussion addresses three key themes that emerge from this work. These include the rise of maternalism, the establishment of occupational roles for women, and the regulatory relationship that developed between health visitors and their clients. Together these represent important analytical and conceptual themes concerning the early development of health visiting.

The Discovery of Mothers.

The early history of health visiting and the emergence in the late nineteenth century of social policy discourses about motherhood are closely inter-connected. These developments also intersect with wider gendered debates about the "public" and the "private", particularly in the context of women's roles inside the home and beyond. It is in this context that feminist historians have focused upon the set of policies associated with the rise of maternalism (Davin 1978; Lewis 1980a; 1980b; Dwork 1987; Smart 1992; 1996).

This focus on motherhood is itself inter-linked with a broader set of economic and social changes. These include imperial concerns, which were particularly marked following the Boer War, about the available workforce for the industrial processes and military requirements (Davin 1978). This drew attention towards the health and fitness of the population, a theme reinforced by the growing discourse of social eugenics. These developments led to an unprecedented interest with infant health; of particular concern was the falling birth rate amongst the middle classes, together with the high infant mortality rates and poor infant health amongst the working classes. For instance, the issue of high levels of infant mortality was identified as a key concern by the 1904 Inter Departmental Committee on "physical deterioration"; and it became an ongoing concern of the Medical Officers of Health, leading to the establishment of National Conferences on Infant Mortality in 1906 and 1908. This growing concern with infant mortality is usually portrayed as a reaction to a social problem, but Armstrong (1986) has argued otherwise suggesting it is a socially constructed notion. As he observes.

> "By the early twentieth century, therefore, infant mortality, which three decades earlier had not even existed as an analytical framework, had become the point on which was articulated the conceptualisation of the social, the surveillance of the new welfare schemes, the analysis of home life and hygiene and the evaluation of motherhood" (Armstrong 1986, p. 213-214).

This discovery of infant mortality was however pivotal to the set of public health measures which were adopted at the time. These reflected current understandings about the causes of infant deaths, focusing particularly upon infant diarrhoea which was considered to be caused by poor hygiene practices in the home. Thus attention turned towards the role of mothers, and public health measures were adopted which attempted to improve the practices of "mothering". These included Schools for Mothers, the infant welfare centres and the health visiting service; these focused upon issues such as child rearing, infant feeding practices, and control of domestic dirt. These measures emphasised the importance of "good mothering" (Smart 1996), and were underpinned by the notion of

maternalism. This elevated the role of mothers to one of sole responsibility for the welfare of infants.

While there was no doubt that the health and welfare of women and children could be improved (Llewellyn-Davies 1978), this focus upon maternalism has been questioned (Davin 1978; Lewis 1980a; 1980b). As Lewis (1980a) has observed, ".... the questionable jump in the argument of medical officers concerned with the problem of infant mortality was from the existence of dirt to women's responsibility for it" (Lewis 1980a, p. 468). In a critical analysis of these social policy developments, Lewis (1980a; 1980b) has pointed to the individual and gendered nature of these developments, which focused attention upon mothers, and largely ignored wider environmental and social causes of ill health. There was considerable evidence that poor infant and maternal health was associated with insanitary living conditions and poverty. As she has pointed out, given the structural constraints upon mothers it is difficult to see how individually focused solutions which stressed maternal education could be effective. There were also tensions between the demands of women and the particular set of infant and maternal welfare services which were developed. In particular, Lewis (1980b) suggests that a number of issues identified by women themselves, such as demands for contraceptives or practical help within the home following childbirth, were ignored.

However, as Smart (1992; 1996) has pointed out, these social and political developments which focused concerns about infant welfare upon mothers are central to the practices of social regulation. Smart (1992) has drawn upon the ideas of Foucault (1979; 1984), suggesting that motherhood has been constructed and regulated.

> ".... the discourses of law, combined with medicine and social science, brought into being a problematic feminine subject, who, at the moment of her constitution, self evidently required regulation. In other words she always required some sort of surveillance, regulation, or tutelage" (Smart 1992, p. 30-31).

Central to such regulation is the role of state agencies who, since the mid nineteenth century, have been concerned with the welfare of children carried out through the surveillance of mothers.

This policy emphasis upon maternal and infant welfare represented a key moment in the development of health visiting, which became established as a state sponsored agency (Dingwall 1977a). However, the emergence of health visiting was intertwined with broader struggles for occupational roles for women in public health (Lloyd, P. 1986; Davies 1988).

A Suitable Job for a Woman.

The early history of health visiting is complex and there are difficulties in establishing a coherent narrative (Clark 1973; Lloyd, P. 1986; While 1987; Davies 1988; Dingwall et al 1988; McLelland 1996; Maxwell 1997). This is largely because health visiting developed on a local basis, often subject to considerable variation in terms of personnel, funding and role. However, a common thread running throughout this early development was public health, which itself became a site for wider struggles concerning occupational roles for women (Dingwall 1977a; Lloyd, P. 1986; Davies 1988).

Historical accounts of health visiting have tended to provide generalised perspectives regarding the development of the profession. This is particularly apparent in relation to the historical narrative of public health, which continues to inform current practice (Burke 1990; Symonds 1993). McLelland (1996) has decried this reliance upon what she refers to as "a mythological history of health visiting" (McLelland 1996, p. 267), pointing to the need for further historically and locally specific research in order to examine the similarities and differences in these early developments. Despite this diversity, however, there are well established links between the origins of health visiting and public health work; even though these emerged differently across the country. Many of these developments were associated with the early Sanitary Reform Associations such as the one established in 1862 in Manchester and Salford. Other developments were more directly linked with the

public health remit of the local authorities; in these instances health visiting enjoyed the support of the Medical Officers of Health (Lloyd, P. 1986), a model probably exemplified by the work of Dr Bostock Hill in Warwickshire. However, different models of public health work emerged, depending upon local conditions and funding, although they often originated from the work of voluntary and missionary societies.

The diversity of these early developments is reflected in the range of employment practices. Some of the early arrangements involved the employment of a paid working class woman who was supervised by an unpaid middle class "lady". However, as the schemes developed, and enjoyed the support of the Medical Officers of Health, the personnel involved became increasingly professionalised. Indeed, some of the early health visitors held a range of qualifications, including medical degrees, nursing certificates, and Sanitary Inspection qualifications. This effectively excluded employment of working class women who were unlikely to have qualifications. The issue of qualifications contributed to some of the occupational struggles in which women were engaged, particularly the struggles between Sanitary Inspectors and health visitors (Davies 1988; Dingwall et al 1988).

The local differences and similarities between the Sanitary Inspectors and the early health visitors has not yet been fully documented, although the overlap and tensions have been highlighted (Davies 1988; Dingwall et al 1988). Davies (1988) has demonstrated how such occupational roles became delineated in terms of both gender and class. Women workers found themselves undertaking roles which focused upon the sphere of home and motherhood, while men concentrated upon the public world of factories, workplaces and abattoirs. These latter sites were considered to be unsuitable for women. This reflected notions of "public" and "private" domains which dominated contemporary understandings of the appropriate roles for men and women. Indeed Davies (1988, p. 50) has drawn attention towards the male horror at "petticoats trailing in blood" which recurred throughout this debate.

In analysing these public health struggles, Davies (1988) has drawn attention to the relationship between the women health visitors and the mothers who were the focus of

their concern. This was based upon the concept of health visitors being the "mothers friend", using a terminology of friendship and stressing the special personal qualities of the women who were employed as health visitors. However she argues that by accepting this health visitors were,

> ".... accepting much of the argument about women's special virtues, virtues which stemmed from their position in the private domain and which made their position in the public domain alongside men altogether problematic" (Davies 1988, p. 58).

The struggles concerning the establishment of appropriate occupational roles for women led to health visitors undertaking work which focused almost exclusively on the private spheres of women and motherhood, with a corresponding exclusion from the more public spheres of public health work. Davies (1988) has argued that this struggle between Sanitary Inspectors and health visitors, ".... confirmed health visiting as women's work and helped to set the parameters in which public health work in the community was to develop" (Davies 1988, p. 58).

This perspective is reinforced by work which has examined the relationship between early health visiting and the Medical Officers of Health (Lloyd, P. 1986). Again this relationship was delineated in terms of gender, even though the early health visitors enjoyed medical support rather than medical dominance. However, as Lloyd (1986) has pointed out, ".... this was premised upon a sexual division of labour in which women's work in community health care was associated with the provision of a service to women (Lloyd, P. 1986, p. 4). Thus, the early development of health visiting was intertwined with the establishment of occupational roles for women in public and community health care. This struggle was developed along lines of gender as well as class, and involved health visitors relationships with male Sanitary Inspectors and Medical Officers of Health, as well as the relationships with women Sanitary Inspectors.

Despite these struggles for occupational roles, and the diversity of early developments, by 1914 health visiting was firmly established and enjoyed state sponsorship. Dingwall (1977a) has suggested that this occurred because the political importance of maternal

and infant welfare conveniently coincided with the interests of an available occupational group. He considers that health visiting was a specific solution to a specific problem, and one which was of sufficient national political importance to warrant a State collectivist response. Hence the early health visiting service, which had developed from philanthropy and public health, was reshaped into its modern form with its emphasis upon maternal and child welfare.

Health Visiting As "Regulation".

A number of historical analyses of health visiting have pointed towards its development as a form of social regulation (Dingwall and Eekelaar 1988; Abbott and Sapsford 1990; Maxwell 1997). However, there are some differences regarding the language which is used to describe these practices. For example, Dingwall and Eekelaar (1988) have drawn largely upon the work of Donzelot (1979) using the term "tutelage" to describe health visiting intervention into family life. Others, such as Maxwell (1997) and Abbott and Sapsford (1990) have adopted broader linguistic terms, referring to such intervention as "regulation", "surveillance" and "policing". All of these analyses have developed from broadly Foucaldian theoretical perspectives, which have focused upon the regulation of the population by the "psy"-professions (Foucault 1979; 1984; Rose 1985).

The historical analysis undertaken by Maxwell (1997) suggests that health visiting developed as a form of social regulation. She has pointed to the legislative framework which ensured that health visitors had universal access to families with young children, highlighting the importance of the Notification of Births Act (1907) which created the social and legal basis for such regulation. The notion of health visitor as "mothers friend" (Davies 1988) promoted an informality about such contact, and served to disguise the actual nature of the state intervention which was being undertaken. Dingwall and Eekelaar (1988) consider the apparent informality of this relationship is an exemplary representation of the form of regulation described by Donzelot (1979) as "tutelage". This is a technique for ensuring surveillance and control over the private spaces of family life, in a

manner which is non-coercive and does not provoke collective resistance; it relies upon informality and friendship. Dingwall and Eekelaar (1988) point to the double bind in this type of intervention strategy.

> "....families with no guilty secrets had no motive for refusing surveillance. If surveillance were refused, then guilt might be inferred and parents' character damaged to a degree that could legitimate coercion. If unreported needs were discovered, parental character might be retrospectively discredited and private areas opened to compulsory intervention" (Dingwall and Eekelaar 1988, p. 353).

In their analysis of such regulation, Dingwall and Eekelaar (1988) point to the gendered nature of this type of intervention which is focused upon women within the family. However, they consider this to be a double-edged sword, arguing that the development of this alliance between the state and women challenges patriarchal control within the family. As they point out ".... the obstacle to the public regulation of family life was not so much *parental* authority as *paternal* authority" (Dingwall and Eekelaar 1988, p. 353, original italics). This changed with the elevation of maternalism, which itself built upon notions of separate spheres. Thus the discovery of mothers, and the construction of their role within the private domain of the home as specifically feminine, opened new opportunities for state intervention in families, and challenged the issue of men's control over family life. For women, however, this represented an opportunity and a challenge. As they state.

> "Tutelage took up women's complaints about the imbalance of power within families .... to offer external existence in their struggle against patriarchal assumptions. In return, however, women were expected to comply with externally-created standards of private behaviour. The barrier around the family was breached by the woman's invitation to enter" (Dingwall and Eekelaar 1988, p. 353).

This analysis is interesting because it points towards the complexity inherent within the tutelary relationship. By problematizing simplistic analyses which emphasise regulation as "power over", and stress the gendered power relations exemplified by tutelage, Dingwall

and Eekelaar (1988) offer a perspective which has salience in understanding current practice.

Summary.

The early history of health visiting provides a wealth of analytical and conceptual material regarding the development of women's work in the private and public domains. In particular, it draws attention to the political concerns about infant welfare which focused attention upon "mothers", as well as the struggles concerning the establishment of appropriate occupational roles for women. These developments challenge patriarchal assumptions concerning women's position, both in the home and the workplace, and are central to feminist analyses of health visiting work. They also illustrate the processes through which health visiting became established as a state sponsored agency involved in the social regulation of mothers. It is this legacy of gendered regulation that continues to inform contemporary health visiting practice.

CONTEMPORARY HEALTH VISITING: THE GENDERED REGULATION OF MOTHERS?

The themes of gendered regulation which emerge from historical scholarship can be traced in contemporary health visiting practice. Feminist and sociological analyses suggest that health visiting continues to be constituted as a form of social regulation of mothers. These themes are examined in this section, which focuses upon the extent to which health visiting consists of gendered practices, and continues to undertake a regulatory role. However, even though the themes of gendered regulation of mothers continue to be visible in contemporary practices, such narratives are resisted within the prevailing professional discourses; these are discussed in the final section of this chapter.

Gendered Practices.

Feminist analyses have made visible the gendered nature of contemporary health and social welfare, identifying the assumptions about women's public and private roles regarding the family and the provision of care (Finch and Groves 1983; Graham 1984; 1993a). Health visiting is part of this welfare provision, and reflects such assumptions. This is particularly evident in relation to health visiting work focused upon children's health and welfare, as such activity continues to be targeted at mothers (Mayall and Foster 1989; Abbott and Sapsford 1990; Mayall 1990; Mayall 1993; Bowes and Domokos 1998; Edwards, J. 1998). This is apparent in the findings of the study reported by Mayall and Foster (1989), which is based upon interviews with health visitors regarding their work with families with young children (see also Mayall 1990; 1993). The predominant view expressed by the participating health visitors reflected a child-centred approach to their work, but one which specifically targeted mothers who were deemed to be wholly responsible for caring for their children. This reflects earlier work by Graham (1979) who has illustrated how health care discourses about parenting disguise a concern with mothers.

The gendered nature of health visiting work which focuses upon mothers also incorporates an exclusion of men (Mayall and Foster 1989; Mayall 1990; Mayall 1993; Edwards, J. 1998). Edwards (1998), for example, has pointed towards the practices through which men are excluded and made absent from health visiting work. Paradoxically, this occurs alongside a rhetoric which ignores gendered notions of parenting, and acknowledges the important role fathers can play (Edwards, J. 1998; Williams 1998).

In an analysis of the relationships between parents and health care staff, Mayall (1993) suggests men are excluded because health visitors embrace a traditional view of the family and gender roles, preferring to direct their work through mothers. She also points to variations in child care practices between families, which caused some health visitors to be unsure about targeting fathers. This co-exists alongside an unwillingness amongst

some men to have any contact with workers such as health visitors, illustrating that men also undertake practices designed to exclude themselves from such contact. Moreover, Mayall (1993) suggests that many of the health visitors had good reason to feel some reluctance regarding their interactions with men, noting that a third of those who participated had experienced some form of rejection or hostility from fathers during a home visit. Her analysis also points to the ways in which wider societal assumptions regarding gendered roles impact upon the execution of these practices between parents and health care staff. Addressing the gendered practices of health visiting work in this way enables understandings of these micro-practices and how they are embedded within contemporary health and welfare policies.

Health visiting work in the context of child health care involves assessment of children, the protection of children, and the education of mothers (Mayall 1990). All of these further demonstrate the specific gendered nature of health visiting practices. An example of this is child health surveillance, which constitutes an important aspect of child health work (Hall et al 1994). This is underpinned by developmental psychology, which, as Burman (1994) has pointed out, is itself constituted as a form of regulation of mothers.

> "It is the adequacy of mothering that developmental psychology is called upon to regulate and legislate upon, and the continuity with which this issue crops up across the range of topics in developmental psychology is a manifestation of the widespread and routine subjection of women to the developmental psychological gaze. .... in many respects mothers have replaced children as the primary focus for developmental psychological investigation, reflecting wider themes of regulation ...." (Burman 1994, p. 3-4).

The gendered nature of health visiting practice is also apparent in relation to child protection. Professional perspectives about health visiting work regarding child protection are reviewed by Appleton (1994a; 1994b; 1996), who by focusing upon the concept of "vulnerable families" reveals how health visiting discourses have ignored the gendered dimension of their work. The exclusion of fathers as actors in relation to child protection is also highlighted in the findings of the study undertaken by Mayall and Foster (1989). Here,

health visitors accounts of child abuse focus solely upon women's actions, and exclude any consideration of male violence.

> "Whilst they were ready with explanations of women's behaviour, and with programmes of intervention into women's lives, their accounts suggest an unwillingness both to confront men's behaviour and to intervene with them. Thus men and fathers were excluded as objects of concern, either as sufferers .... or as perpetrators" (Mayall 1990, p. 319).

These insights into the gendered nature of health visiting practice reflect wider concerns about child welfare work, which focuses upon women, and renders men invisible (Hooper 1990; 1992; Milner 1993; Farmer and Owen 1998). Milner (1993) has analysed the practices of social workers demonstrating how, even when men are perpetrators of abuse and violence against children, the gaze of much of social work falls upon women and renders men invisible. The gendered nature of health visiting practice is also visible in the context of health promotion practices which are concerned with motherhood, and parenting skills (Graham 1979; David 1985; Mayall and Foster 1989; Oakley 1992; Edwards, J. 1995; Edwards, J. 1998). As Graham (1979) has pointed out, the language of "parenting" embraced by child health policies is underpinned by assumptions regarding the role and responsibility of mothers. In these discourses mothers are constructed as carers of children within traditional patriarchal family structures.

This continuing focus upon mothers is however problematised in relation to understanding how health visitors address women's own health and welfare. For as Abbott and Sapsford (1990) have observed.

> "Health visitors continue to work with a stock of knowledge that demands a particular role of the mother - that of caring full time for her children. The health needs of mothers, when they conflict with those of her children, are seen as less important, if they are considered at all" (Abbott and Sapsford 1990, p. 132).

The practices which simultaneously focus upon mothers, but fail to address their health needs as women has been highlighted in a study by Hennessy (1986), who considers it is

"....extraordinary that health visitors should be found wanting by not picking up more responsibility for mothers' health care" (Hennessy 1986, p. 96). She has suggested that the educational and organisational context of health visitors work may restrict their ability to recognise and provide support for women's emotional health needs, particularly mothers experiencing post-natal depression (Hennessy 1986). However, feminists have pointed towards the contradictions in the way women's experiences of post-natal depression are understood (Nicolson 1990; Busfield 1996) suggesting these reflect wider patriarchal discourses of motherhood (Phoenix and Woollett 1991; Smart 1992; 1996).

Understanding how motherhood has been constructed in patriarchal discourses has been the focus of considerable work (Phoenix and Woollett 1991; Smart 1992; 1996). For example, Smart (1996) has argued that the normalising discourses of motherhood lead to the production and regulation of both "good" and "bad" mothers. Adopting a discursive perspective enables the gendered practices of health visiting to be further understood. As Abbott and Sapsford (1990) have pointed out,

> "Health visitors played a role in creating and identifying the "inadequate mother". They then became involved in programmes of reform to transform her behaviour so that she became an adequate, a "good enough" mother" (Abbott and Sapsford 1990, p. 144).

The impact of prevailing discourses about "good enough mothering" are particularly salient for certain groups of mothers who may be constructed as "other", such as mothers with disabilities (Thomas 1997), Black mothers (Phoenix 1990) or lone mothers (Smart 1996).

Despite the gendered nature of health visiting work, professional discourses remain largely silent about the issue of gender. Even though Orr (1986) has advocated adopting feminist perspectives within health visiting practice, there is little evidence of this in the professional literature (Rolls 1992). This is in direct contrast to social work theory and practice, where feminist discourses can be more easily traced (Dominelli and McLeod 1989; Wise 1990; White, V. 1995; Cavanagh and Cree 1996). Moreover, despite evidence

that materialist perspectives are becoming more prominent within health visiting work (Blackburn 1996), there is little consideration of other social divisions such as race, age, sexuality and dis-ability. When such issues are considered they are usually constructed as "other", and not incorporated within an overall holistic framework. Again this can be contrasted to social work discourses where social divisions perspectives which underpin anti-discriminatory practices are more easily discerned (see for example, Ahmed et al 1986; Ahmad 1990; Langan and Day 1992; Ahmed 1994; Mullender 1996).

"Regulation" within Contemporary Practice.

Analyses of contemporary practice suggest that health visiting continues to fulfil a role concerned with social regulation (Dingwall 1977a; 1977c; Abbott and Sapsford 1990; Dingwall and Robinson, K. 1993). This argument is supported by a number of analyses of other health and social welfare agencies, including social work and psychology (Rose 1985; Parton 1991; Burman 1994; Smart 1996; White, S. 1996). These studies share a similar theoretical perspective (Donzelot 1979; Foucault 1979; 1984) but as already mentioned, embrace a diversity of terms to describe the practices of regulation.

The term tutelage has been used extensively by Dingwall (1977a; 1977c; Dingwall and Eekelaar 1988; Dingwall and Robinson, K. 1993), who considers this to be an appropriate tool for analysing the health visiting role in liberal societies. This work has spanned both historical analysis as well as that of contemporary practice, creating a body of scholarship which analyses health visiting as a state agency intervening in the private spaces of family life in terms of tutelage (Donzelot 1979). For example, this framework is used in the context of an argument supporting the continuation of home visiting as an integral part of contemporary health visiting practice (Dingwall and Robinson, K. 1993). Pointing out that health visitors do not have power to force entry into a family home, they consider the theory of tutelage,

> "....provides that a refusal of access to the health visitor may cause the family to be treated as disreputable and consequently referred to other agencies, like the police or child protective services, who do have access to such powers" (Dingwall and Robinson, K. 1993, p. 167-168).

Similarly, both Maxwell (1997) and Abbott and Sapsford (1990) argue that contemporary health visiting practice continues to be constituted in terms of social regulation. This is because of its universal access to families with pre-school children, alongside its developing role within the inter-agency environment, particularly regarding the protection of children. In a critical analysis of such practices, Abbott and Sapsford (1990) have pointed to the middle-class and patriarchal assumptions embraced within the health visiting knowledge base, which includes concerns about emotional as well as physical health, and serves to ensure that the burden of child care continues to fall upon women.

Understanding health visiting as social regulation is borne out by the findings of two studies which examined mothers' perceptions regarding health visiting work (McIntosh 1987; Mayall and Foster 1989). These suggest that mothers experienced health visiting as a non-coercive form of social control, concerned with "policing" their child care. In the study reported by Mayall and Foster (1989) many of the mothers felt that the health visitors role involved inspecting homes to detect child abuse; their acceptance of such surveillance was noted as a necessary but not always welcome function. As Mayall (1990) observes,

> ".... mothers are asked to make their child care practices visible, and to submit to monitoring and modification of their practices. .... mothers are conscious of what is being proposed, and to some extent imposed, and offer resistance when they see the need" (Mayall 1990, p. 326).

Mayall (1990) has also highlighted the greater surveillance experienced by certain groups, particularly working class and Black mothers (Mayall 1990, p. 236). Similarly, the majority of the mothers who participated in the study of client satisfaction undertaken by McIntosh (1987; 1993) understood the health visiting role in terms of social control. The results of

this study have been further analysed in order to examine the power relations between mothers and health visitors (Bloor and McIntosh 1990); this analysis draws upon the work of Foucault (1979; 1984), and is reviewed in chapter 3 of this thesis.

The theme of regulation is pursued by Parton (1991) to provide a conceptual and theoretical framework for analysing policy and practice developments regarding child protection and welfare work (Donzelot 1979; Foucault 1979; 1984). Even though his analysis is primarily concerned with social work, and the particular set of practices and discourses occurring during the 1980's leading to the Children's Act (1989), it is pertinent to the work of agencies such as health visiting who have an enduring role in child welfare and child protection work. However, feminists have highlighted the gendered nature of such social regulation developed by health and social welfare agencies, pointing out the ways in which "governing the family" is focused upon women (Hooper 1992; Milner 1993).

Summary.

Understanding health visiting work as being concerned with the social regulation of mothers is borne out by analyses of contemporary practices (Graham 1979; Mayall and Foster 1989; Edwards, J. 1998). This suggests that health visiting work continues to be underpinned by gendered notions of parenting, drawing attention to the way in which practitioners focus upon mothers. This is supported by the willingness of women to maintain their involvement in such services, in contrast to men who often engage in practices of exclusion. In establishing this argument, the relationship between mothers and health visitors has been examined, drawing upon work which focuses upon the power relations inherent in such practices (Donzelot 1979; Foucault 1979; Dingwall and Eekelaar 1988; Abbott and Sapsford 1990); this points to the relationship of regulation. Such analyses highlight the "double-edged sword" of surveillance and welfare (Nettleton 1992, p. 149), which is clearly demonstrated by the ambiguities and contradictions of health visiting work with mothers.

The argument that health visiting is constituted as the social regulation of mothers has built upon sociological and feminist approaches to the study of health care. This disrupts and challenges professional perspectives about health visiting, which are addressed within the next section.

RESISTING THE NARRATIVE OF GENDERED REGULATION?

Professional discourses of health visiting do not engage with the issues of gender or power. While this may reflect the disciplinary roots of the health visiting knowledge base, which has drawn upon medical rather than sociological discourses, it may also represent a professional resistance to the narratives of gendered regulation. The following discussion focuses upon the ways in which these professional discourses engage with ideas about health and health promotion, and the fostering of good relationships with clients, as well as highlighting the absence of perspectives which acknowledge and address issues of social diversity. Together these illustrate alternative discursive constructions of health visiting work.

Health Visiting and the Promotion of Health.

Resistance to the narrative of gendered regulation permeates professional discourses about the origins and development of health visiting. These emphasise its role in public health (Burke 1990; Symonds 1993) while omitting the gendered and individualised nature of such work. Moreover, as Craig (1998) has pointed out, the current focus upon public health work masks wider ambiguities about the nature of the health visiting role. Despite these ambiguities, notions of health continue to inform and drive health visiting practice. This is seen for example in the "principles of health visiting" (Council for Education and Training of Health Visitors 1977), which include the search for health needs and the facilitation of health enhancing activities. Their status as professional discourses have

been endorsed by Robinson (1985) who has suggested that these represent "the official version of the theoretical basis for practice" (Robinson, J. 1985, p. 70). Moreover, a recent re-examination has endorsed their continued relevance for contemporary practice (Twinn and Cowley 1992).

Health promotion and public health models and theories, often focusing upon health behaviour change at the individual or societal level, are widely utilised within health visiting. For example, health promotion models (Beattie 1991) form the basis of Twinn's (1991) paper exploring different approaches within health visiting work. They also inform different aspects of health visiting work, including community development (Dalziel 1992), public health initiatives (Strelley Nursing Development Unit 1993), and child health surveillance (Hall et al 1994). The notions of health underpinning health visiting have been problematised by Robinson, K. (1992). She has suggested that reliance upon such an abstract concept contributes to professional uncertainty, particularly given the diversity of peoples experiences and awareness of health (Blaxter and Peterson 1982; Cornwell 1984). However, Cowley (1995a) has suggested that the concept of "health-as-process" provides a stabilising strategy for the competing and contradictory perspectives regarding health within health visiting work. Her analysis suggests that this embraces ".... holistic notions of health as a dynamic, continuing process, as potential, as a resource, as a personal individual experience and as situated in a socio-cultural context" (Cowley 1995a, p. 439).

Despite such diversity, it is clear that notions of health inform the professional discourses of health visiting. They also underpin the organisational and educational context for health visiting practice. For example, health visitors continue to be trained and employed by the publicly funded health service, and develop their role following mandatory training as general nurses. Moreover, the notion of "health" is embedded in the name of "health visitor", suggesting an *a prior* concern with this issue.

A Focus Upon Professional-Client Relationships.

The contrasts between understanding health visiting as regulating women, and the prevailing professional discourses are particularly marked in debates about professional-client relationships, which emphasise empowerment and non-hierarchical approaches (Orr 1980; Robinson, J. 1982; Chalmers 1991; De La Cuesta 1994; Machen 1996; Bowes and Domokos 1998). Even though promoting an apparent equality, such perspectives serve to mask the differences between professionals and clients, as well as those between clients. It is here that understandings about social divisions, such as those arising from race, gender, class, (dis)-ability, sexuality, and age are largely absent. Moreover, as Gilbert (1995) has pointed out, there is an incongruence within such perspectives which stress empowerment but simultaneously lack any analytics of power.

Despite these shortcomings, the development of professional relationships with clients has been the focus of a number of empirical studies (Chalmers 1991; De La Cuesta 1994). Guided by grounded theory approaches, these studies have offered a normative rather than critical analysis, displaying the absence of theoretical understandings of power, whether structural or post-structural (Gilbert 1995). Viewing these studies through the lens of regulation provides a particularly interesting perspective on professional subjectivity. For example, Chalmers (1991, p. 37) discusses possible avenues for the client to take when there is a difficult relationship, highlighting that clients may passively accept or actively reject health visiting services. Even though this can be read as advocating the possibilities of client resistance identified by Bloor and McIntosh (1990), and which are embedded within the power relations between clients and health visitors, such an analysis is not suggested by Chalmers (1991). Similarly De La Cuesta (1994), describing the mediating aspect of relationships, acknowledges the dual function of health visiting, "both controlling and serving clients", and suggests this leads to a "dual role, ... that of policing and that of education" (De La Cuesta 1994, p. 455). Drawing upon the notion of health visitor as "mothers friend" (Davies 1988), she suggests that this led to tensions when health visitors needed to privilege their professional identity (De La Cuesta

1994). However, her analysis is marked by its lack of attention to both gender and power relations.

A number of accounts of practice resist the narratives of gendered regulation. This can be illustrated in the work of Machen (1996) who reports the results of a small study concerned with exploring the relevance of health visiting to first time mothers. Her analysis stresses the effectiveness, acceptability, relevance and empowering aspects of health visiting work. While the results of her research suggest a high degree of satisfaction with health visiting amongst the mothers she interviewed, her analysis draws upon a set of binary assumptions. Thus, while many of the mothers enjoyed the supportive, and informal contact they had with health visitors, this leads Machen (1996) to refute previous critiques which suggested that health visiting practice was also concerned with surveillance (McIntosh 1987; Mayall and Foster 1989). Such resistance can also be identified in the work of Cowley (1995b).

This professional reluctance to understand health visiting work in terms of social regulation or tutelage has already been noted (Abbott and Sapsford 1990; Maxwell 1997). As Maxwell (1997) has pointed out, "....(i)dentification of health visitors with the social policing role is not fully acknowledged by practitioners" (Maxwell 1997, p. 237). Similarly, Abbott and Sapsford (1990) have also drawn attention towards professional resistance to understanding their role in this way, suggesting that health visitors display little concern regarding the ambiguity of their non-judgmental stance. They argue that it,

> ".... is because they are not themselves aware of the ways in which they police the family: they accept as "truth" the discourses that inform their practice and therefore fail to recognise the ways in which they are used to shape the behaviour of their clients" (Abbott and Sapsford 1990, p. 148).

Indeed, the notion of health visitors being a "mothers friend" (Davies 1988) serves to mask the nature of the relationship which is being forged, stressing the informal and voluntary nature of the intervention, which is itself an important aspect of this type of social regulation.

This professional reluctance to acknowledge the policing aspects of health visiting work is evident in the study reported by Appleton (1996). As part of a wider study examining health visiting work with vulnerable families, Appleton (1996) points to a "reluctant monitoring role" expressed by 22 (44 per cent) of the 50 health visitors who responded to her survey (1996, p. 917). In describing health visiting work in this context, Appleton (1996) provides little information or discussion about this aspect of their work, in comparison to her discussion of other activities such as the provision of support, or referrals to other agencies. The ambiguities and contradictions that child protection involvement poses for health visitors has already been highlighted by Taylor and Tilley (1989), but there has been little professional discussion regarding this social policing role.

Addressing Diversity.

Alongside this resistance to the narrative of gendered regulation, lies a number of silences concerning the issue of gender and other social divisions such as age, race, class, sexuality and (dis)-ability. Indeed, it is difficult to identify any consideration of social diversity within health visiting professional discourses. Orr (1986) is one of the few writers to adopt a perspective which acknowledges social divisions, although her work focuses primarily upon gender, and is concerned with adopting feminist perspectives. The absence of other gender-based analyses has been highlighted by Rolls (1992). In a study which focuses upon the maternity services, Marshall (1992) has pointed towards the lack of social divisions perspectives within health visiting work, highlighting particularly the contradictions between their discourses of individualised care and their discourses of cultural differences; the latter are underpinned by stereotyped understandings of the needs of certain social groups, which in the case of her study, was focused upon Asian mothers. Marshall (1992) points out the "lack of synthesis of a *gender, socio-economic class* and *race* discourse with that of *individualised* care" (Marshall 1992, p. 222. original italics), concluding that there is an urgent need for policy and training initiatives in order to improves these services.

The recent interest in poverty which underpins some health visiting work, focuses attention towards materialist perspectives (Blackburn 1996). However, there is little evidence in the professional literature suggesting health visiting concern with social diversity, or anti-discriminatory practice.

Despite this lack of attention to diversity, health visitors have often highlighted the particular health care issues facing certain socially excluded groups (see for example, Lee and Goodburn 1993; Hutchinson and Gutteridge 1995; Anderson 1997; Collier and Avila 1997). While such initiatives may direct resources to certain special groups constructed as "other", the absence of attention to diversity within mainstream professional discourses suggest ongoing discriminatory practice. In the context of health visiting work this has never been examined directly. However, there is a wealth of work highlighting the problems experienced by minority groups regarding health and social welfare; for example, Black women (Phoenix 1990; Douglas 1992) women with disabilities (Thomas 1997), parents with learning difficulties (Booth and Booth 1994), and lone mothers (Smart 1996).

A recent study (Bowes and Domokos 1998) which highlighted the enabling aspects of health visiting work with Asian women, suggested that this was directed towards social inclusion. However, the authors acknowledged that health visiting work was undertaken in the context of institutional racism, and underpinned by a lack of training and education regarding diversity. Although focused upon nurse education more generally, Gerrish et al (1996) have highlighted the inadequacies of preparing students for meeting the needs of a multi-cultural society, addressing directly the ways in which issue of "race" has been excluded from the professional education agendas. This can be contrasted to the high profile of anti-discriminatory perspectives within social work theory and practice (Ahmed et al 1986; Dominelli and McLeod 1989; Ahmad 1990; Wise 1990; Langan and Day 1992; Ahmed 1994; White, V. 1995; Cavanagh and Cree 1996; Mullender 1996).

Summary.

The argument developed in this section has pointed towards some key themes threaded throughout the prevailing professional perspectives upon health visiting work. This has focused upon notions of health and health promotion, and relationship-based care. It has also illustrated how such perspectives co-exist alongside a lack of attention to gender and other social divisions, such as class, race and (dis)-ability. The difficulty in articulating such professional perspectives is acknowledged, particularly when addressing issues which may be marked by "silence". In this context, however, my personal understandings of professional perspectives have informed the process of developing the argument presented within this section.

This analysis of the professional discourses of health visiting work has suggested that the subjectivity of practitioners is not shaped by understandings that their work is concerned with the social regulation of mothers. It has presented an alternative reading, which illustrates some of the differences between professional and sociological approaches to health care. These professional discourses have been presented as resistance to the narrative of gendered regulation, in order to illustrate these differences, and further reflect the titular themes of this thesis.

CONCLUSION.

An analysis of historical and contemporary narratives has illustrated the argument that health visiting is constituted as the social regulation of mothers. Historical analysis has demonstrated that a combination of both imperial and philanthropic concerns focused upon the issues of child health and the concept of maternalism. At the same time, a different set of struggles regarding occupational roles ensured that women were assigned to the private spheres of home visiting. Drawing upon Foucault's ideas regarding the way "psy" professions regulate the population illustrates how early health visiting became established as a form of social regulation (Donzelot 1979). Its specific focus upon

mothers, articulated by the concept of "health visitor as mothers friend" (Davies 1988) marks the gendered nature of such regulation, which is a continued feature of contemporary practice.

Despite such feminist, historical and sociological scholarship to support the theme of gendered regulation, this is not reflected by contemporary professional discourses. Instead, their emphasis upon health, and non-judgmental relationships serves to disguise the gendered regulation inherent within health visiting work. In this way, professional discourses are considered as resistance to the narrative of gendered regulation.

CHAPTER THREE.

ESTABLISHING THE THEORETICAL PERSPECTIVES.

INTRODUCTION.

The themes of "regulation" and "resistance" which are central to this thesis have developed from the particular understandings of power and discourse embedded within feminist poststructuralism (Foucault 1979; 1984; McNay 1992; Weedon 1997). These theoretical perspectives are reviewed within this chapter, which discusses their application within the current study.

The chapter commences by presenting the conceptualisation of disciplinary power within the writings of Michel Foucault (1979; 1980a; 1980b 1984). This provides an analytical framework for understanding health visiting work. Alongside these understandings of power, the notion of discourse provides a means to analyse how feminist knowledges have permeated professional understandings about domestic violence. The work of Foucault has had a major disruptive impact upon the social sciences, providing new ways of theorising, as well as being extensively critiqued. The subsequent sections draw attention towards those arguments which intersect with the current project. This includes reviewing how the ideas of Foucault have been utilised within sociological studies of nursing and health care practice. This is followed by a consideration of some of the key themes arising in the debate by feminists, which has both contested, and utilised, Foucault's work. These arguments are presented in order to contextualise the overall feminist post-structuralist perspectives which underpin this study.

FOUCAULT'S IDEAS ON POWER.

The notion of power is threaded throughout the many writings of Michel Foucault (1976; 1979; 1980a; 1980b; 1980c; 1982; 1984; 1988; 1990; 1991). Within this work he has provided a reconceptualisation of power, drawing attention towards its exercise, its productive effects, and the inter-relationships between power and knowledge. These ideas about power have both disrupted, and been disrupted by, social science scholarship, leading to extensive debate and critique (Dews 1987; Hartsock 1990). This has included attending to the slippage within Foucault's work; for example, his earlier work focused upon disciplinary power and institutions, but the emphasis shifted somewhat in later work which was more concerned with "the self", and governmentality (McNay 1992; Fox 1998). However, as many writers, and Foucault himself acknowledged, the value of this work lies in the analytical tools it provides (Foucault 1980c, p. 145; Armstrong 1997).

In the context of the current study, the notion of disciplinary power contributes to the analytical framework for understanding the practices arising in health visiting work with mothers. This section presents the ideas of Foucault concerning disciplinary power, along with some related concepts such as the "clinical gaze". It also addresses the issue of discourse which is a key notion within his overall work, as well as pointing towards the possibilities of resistance incorporated within this conceptualisation of power. Together, these ideas underpin the theoretical framework for the current study.

The notion of disciplinary power is central to Foucault's work. This is a modern technique of power, found in its exercise and possessed by everyone. Disciplinary power is threaded throughout many of Foucault's writings, but is most clearly exemplified in his work on prisons (Foucault 1979). Here he uses the prison design of Jeremy Bentham's "Panoptican" to illustrate the exercise of disciplinary power, and to contrast it with the force and violence associated with sovereign power. Foucault demonstrates the exercise of disciplinary power in the context of modern prisons, identifying the techniques of hierarchical observation, normalising judgement, and examination (Foucault 1979, p. 170). Although presented in the context of a study about prisons, such an analysis is also

applied to "disciplinary society", drawing attention to the "micro-practices". Thus, the exercise of disciplinary power is also undertaken by the "psy" professions who, through the development of "regimes of truth", are able to observe, regulate and produce the subjects and objects of their gaze (Foucault 1976; 1979; 1984).

The exercise of disciplinary power incorporates three instruments; hierarchical observation, normalising judgement, and examination (Foucault 1979, p. 170). In the context of the Panoptican the notion of hierarchical observation refers to the architectural design which allows the prisoners to be observed. Such hierarchical observation also applies to other spaces, such as schools and hospitals, which enable a similar surveillance. However, Foucault incorporates within his analysis understandings that hierarchical observation reaches far beyond issues of mere architectural design. Thus, in the context of health visiting work, mothering takes place in a productive space which is subject to surveillance.

Alongside the instrument of hierarchical observation lies the technique of "normalising judgement". Foucault describes this as having five aspects, all of which contribute to the overall purpose of assessing and comparing the actions of individuals with others (Foucault 1979, p. 182-183). As he points out, this normalising judgement ".... compares, differentiates, hierarchizes, homogenizes, excludes. In short, it *normalizes*" (Foucault, 1979, p. 183. original italics). This normalizing judgement is central to the exercise of disciplinary power, and readily visible within health visiting work with mothers which is underpinned by notions of "good enough mothering" (Abbott and Sapsford 1990; Burman 1994; Smart 1996).

The third technique, "the examination", combines hierarchical observation and normalising judgement. Foucault was interested in the disciplinary regimes of medicine, and in earlier work which traced the emergence of modern medicine, he referred to the "gaze" (Foucault 1976, p. 89). This drew attention towards the inter-relationships between the body and medical knowledge. The exercise of surveillance in the clinical gaze constituted a power relationship within the therapeutic encounter. As Foucault (1976, p. 89) pointed out, "....it was no longer the gaze of any observer, but that of a doctor supported and justified by an

institution, that of a doctor endowed with the power of decision and intervention" (Foucault 1976, p. 89). The exercise of power and "the body" are enduring themes throughout Foucault's writings (Foucault 1984; 1988; 1990) and have been extensively developed by sociologists. For example, Nettleton (1991; 1992) has applied the disciplinary practices of examination, incorporating "the gaze", to the study of dentistry (Nettleton 1992, p. 119-120). These disciplinary practices can also be identified within health visiting work, particularly in relation to child health surveillance programmes (Rose 1989; Burman 1994; Hall et al 1994).

The notion of disciplinary power has two dimensions. This is described as "bio-power", and it refers to the exercise of power in relation to individual bodies, as well as its exercise at the level of the body of the population (Foucault 1984). In the context of health care practice, these different dimensions can be illustrated by the medical encounter (Silverman 1987; May 1992a; 1992b; Nettleton 1992), and the practices of public health (Lupton 1995). Although not previously theorised in this way, the notion of "bio-power" (Foucault 1984) is exemplified by the practices of health visiting, which operates at both an individual and a collective level (Council for Education and Training of Health Visitors 1977).

In later work Foucault (1984) further developed his thinking about disciplinary power, suggesting that Benthamite observational surveillance has been extended to patients and clients to monitor their own behaviour and to confess their activities to responsible professionals. In this context the ecclesiastical concept of "pastoral care" is drawn upon as illustrating the appropriate scheme for this analysis of power relations. His later work also develops ideas about "technologies of the self" (Foucault 1988; 1990) focusing upon the practices of self-regulation; here, the emphasis turns to the discursive production of subjectivities (Foucault 1988; 1990). Subjectivity can be understood as the sense of self (Foucault 1984; 1988). In this study, the discourses of motherhood, and the discourses of male violence have powerful effects, producing and shaping the subjectivities and practices of health visitors and mothers.

The notion of discourse is a key theme running throughout Foucault's work, and inextricably linked with power. Indeed, he considers that power cannot be considered in isolation to discourse, using the term "power/knowledge" to stress these inter-connections. As he points out, "....discourse transmits and produces power (Foucault 1984, p. 101). Thus, discourses are "regimes of truth", bodies of knowledge which have powerful effects. As Ramazanoglu (1993) explains, discourses are ".... historically variable ways of specifying knowledge and truth - what it is possible to speak of at a given moment" (Ramazanoglu 1993, p. 19). In contrast, Foucault (1980b) also refers to "subjugated knowledges" (Foucault 1980b, p. 81-82). These are described as "....a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated" (Foucault 1980b, p. 82). In Foucault's view, such knowledges are important, functioning as criticism to the prevailing dominant discourses (Foucault 1980b, p. 82). There are a number of examples in this study of "subjugated knowledges"; for example, feminist work on domestic violence (reviewed in chapter one), and health visiting knowledges about domestic violence (see chapter five).

The understandings of power represented within Foucault's work is conceptualised very differently to modernist notions of power, which he describes as "sovereign power" (Foucault 1979). This can be understood as "power over" (Smart 1988, p. 2), and incorporates power experienced as force, domination or violence. In contrast, disciplinary power permeates throughout society, and is exercised. As he points out.

> "Power must be analysed as something which circulates .... It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. .... In other words, individuals are the vehicles of power, not its points of application" (Foucault 1980b, p. 98).

Integral to such analyses of power lies the possibilities of resistance. As Foucault points out, " .... where there is power there is resistance .... . These points of resistance are

present everywhere in the power network" (Foucault 1984, p. 95). However, analyses of resistance are not developed within Foucault's work, although he does indicate such possibilities, suggesting that resistance can be analysed in "tactical and strategic terms" (Foucault 1980a, p. 163). One of the few sociological analyses to examine resistance to disciplinary power is the study reported by Bloor and McIntosh (1990) which focused upon health visiting work with mothers. This study concentrated upon the local exercise of power, undertaking ascending, rather than descending analyses, as a means of understanding the wider web of power relations (Foucault 1980b).

As the writings of Foucault are extensive, covering a range of subjects and approaches, it is difficult to embrace here anything more than the key themes. For these reasons, this discussion has concentrated upon disciplinary power, acknowledging the interplay with notions of both discourse and subjectivity. This provides a means for understanding the inter-connections between social practices, power, knowledge and subjectivity, and underpins the theoretical framework for this research (Foucault 1976; 1979; 1984; 1988; McNay 1992; Weedon 1997). These ideas are used as a way of thinking about health visiting work with mothers in relation to domestic violence; and in common with many previous studies, the ideas of Foucault about disciplinary power are used here as a "tool-kit" to develop analyses and understandings (Foucault 1980c, p. 145). Indeed, the ideas of Foucault have been extensively used by sociologists to develop understandings and analyses across a range of issues. As Armstrong (1997) has observed, there are many readings of Foucault and many uses of his work. Of particular relevance for this study about health visiting practice is the use of Foucault's ideas within sociological analyses of health care practice which are reviewed below.

FOUCAULT: NURSING KNOWLEDGE AND PRACTICES.

The ideas of Michel Foucault (1976; 1979; 1984) have been extensively used in sociological analyses of nursing (Armstrong 1983a; Bloor and McIntosh 1990; Lawler 1991; May 1992a; May 1992b; Street 1992; Cheek and Rudge 1994; Henderson 1994; Heartfield 1996; Porter 1996a; 1996b; Price and Cheek 1996; Traynor 1996; Lawler 1997) and health care (Armstrong 1983b; Silverman 1987; Daly 1989; Nettleton 1992; Jones and Porter 1994; Lupton 1995; McKie 1995; Peterson and Bunton 1997). The attraction of Foucault's ideas to nursing arises from a central concern in his writings with power and knowledge. These are also key concerns of nursing, which has struggled to establish professional status and a unique knowledge base for nursing work, which developed as a gendered caring role, dominated by medical knowledge and practices (Davies 1995; Rafferty 1996). As Cheek and Rudge (1994) have observed,

> "With respect to nursing, Foucaldian analyses can illuminate the mechanisms and techniques used by nursing to legitimate its own knowledge claims and the various, often competing discourses embedded in nursing knowledge" (Cheek and Rudge 1994, p. 585).

Thus the work of Foucault has been widely used in a number of sociological studies of nursing. For example, in an early study, Armstrong (1983a) focused upon nursing educational literature to illustrate the changing relationships between nurses and their patients. In tracing the extension of nursing interest, from a limited physical focus to a concern with the "social" aspects of patient's lives and well-being, Armstrong employed the notion of a clinical gaze (Foucault 1976) to demonstrate an increase in nursing power. The examination of nursing practices surrounding the management of the body undertaken by Lawler (1991) has incorporated a Foucauldian analysis. Street (1992) analysed the competing discourses available to nursing, illustrating how tensions between medical-technical discourses and caring discourses construct the subjectivities of nurses.

In the context of intensive care nursing, Henderson (1994) has suggested that knowledge about the patient becomes inscribed in the documentation, arguing that this both

constitutes and limits the nurse-patient relationship. Using the nursing care records, Heartfield (1996) has demonstrated the power relations between patients and nurses, pointing to the construction of patients as fragmented bodies, and the invisibility of nursing work within this formal documentation. Price and Cheek (1996) have used a post-structuralist framework to analyse the discursive construction of pain, illustrating the inter-relationships between this and the nursing practices of pain management. Traynor (1996) used discourse analysis of nursing texts on research, education, professionalisation and nursing theories in order to demonstrate the changing ways in which nursing has grappled with wider power relations.

A key theme in much of the work exploring interactions and practices in health care settings has been concerned with the nature of disciplinary power, and the mechanisms of surveillance and normalisation (Foucault 1979). This corpus of work extends across a wide range of health care settings and practices including for example, dentistry (Nettleton 1991; 1992), echocardiography (Daly 1989), cervical screening (McKie 1995) and medical-client interactions (Silverman 1987); there has been less attention to disciplinary power in the context of nursing research (Bloor and McIntosh 1990; May 1992a; 1992b; Porter 1996a). However, health visiting has been the focus of the study reported by Bloor and McIntosh (1990), who have drawn attention towards the exercise of disciplinary power in professional client relationships.

> "The professional-client relationship is always a power relationship, and even in the process of professional-client *contest* the two parties are locked into a disciplinary relationship" (Bloor and McIntosh 1990, p. 180, original italics).

Bloor and McIntosh (1990) identified a central ambiguity in health visiting work arising from their role which incorporates both supporting, and policing, families. This underpins their argument that health visiting is constituted as a form of surveillance. In their analysis Bloor and McIntosh (1990) have closely engaged with the ideas of Foucault regarding the exercise of power and the possibilities of resistance. They suggest that the mothers involved in their study undertook a range of forms of resistance to health visiting, which was ".... a reaction to the perceived social control function of health visiting" (Bloor and

McIntosh 1990, p. 169-170). This included women challenging the legitimacy of health visiting claims to professional expertise regarding mothering, which they considered a lay skill. Other examples included non-compliance with health visiting advice, avoidance of health visiting, and concealment. The latter involved concealing from the health visitor practices such as early weaning. This analysis (Bloor and McIntosh 1990) draws upon the results of a study of client satisfaction of health visiting, based upon interview data from 80 first time mothers (McIntosh 1987). However, the authors indicate that the possibilities for applying a Foucaldian analysis, particularly in respect of resistance, only became apparent after the studies were completed. As they point out.

> "Prior to Foucault's work, the central importance of surveillance as a technique of power was hardly appreciated; it may be that the role of the obverse of surveillance - concealment - has been similarly unappreciated as a technique of resistance" (Bloor and McIntosh 1990, p. 159).

A similar analysis of resistance has been developed by May (1992a; 1992b), who has used the ideas of Foucault to shed light upon the practices of clinical nurses involved in caring for terminally ill patients. His work demonstrates how patients are both subject and object of the therapeutic gaze. It also problematises the philosophy underpinning "new nursing" (Salvage 1985; Walsh and Ford 1989), pointing out that these nursing practices, which now encroach upon a "discourse of the social" (Silverman 1987, p. 191) can be understood in terms of the exercise of disciplinary power (Foucault 1976; 1979). However, his analysis stresses the possibilities of client resistance pointing out that,

> " .... as the subject of enquiries about her private qualities and biography, the patient is able to resist medical power through remaining silent" (May 1992a, p. 485).

While offering an analysis focusing upon disciplinary power, May (1992a; 1992b) stresses the productive aspects of this, and the possibilities of client resistance. In a study of dentistry, Nettleton (1991; 1992) applies Foucault's work on disciplinary power (Foucault 1979) to a specific set of health care practices, focusing upon the mechanisms of

surveillance and normalisation within modern day dental care. What is particularly interesting about this study in the current context, is how Nettleton describes and illustrates the operation of disciplinary power which discursively produces mothers as dental agents (Nettleton 1991).

The analyses offered by Bloor and McIntosh (1990) and May (1992a; 1992b) have been challenged by Porter (1996a; 1996b; Porter 1997; Cheek and Porter 1997) who objects to the applications of Foucault's ideas about disciplinary power to nursing work. For example, Porter (1996a) compares the power of nurses with those of British soldiers serving in Northern Ireland. His analysis, however, fails to distinguish between Foucault's conceptions of disciplinary power, and the type of power vested in the army which is predicated upon violence and force. As White, S. (1997) has argued, the conflation of these very different aspects of "power" represents a misreading of Foucault's work.

Thus, there is a considerable body of work within the sociology of health and illness literature, which has developed from and been influenced by the work of Foucault (1976; 1979; 1984). These have included a number of studies of nursing work (Armstrong 1983a; Bloor and McIntosh 1990; Lawler 1991; May 1992a; May 1992b; Street 1992; Henderson 1994; Heartfield 1996; Price and Cheek 1996; Traynor 1996; Lawler 1997). However, these have focused primarily upon hospital-based nursing, and with the exception of Bloor and McIntosh (1990), nursing activities that lie beyond the institutional spaces of the hospital have received little attention. These have however been addressed within studies of social welfare (Donzelot 1979; Dingwall and Eekelaar 1988; Parton 1991).

This thesis draws upon Foucault's ideas of disciplinary power (Foucault 1976; 1979; 1984; 1988) which have been applied and developed in other studies of nursing, health visiting and social welfare (Donzelot 1979; Dingwall and Eekelaar 1988; Bloor and McIntosh 1990; Parton 1991; May 1992a; 1992b; Nettleton 1992), using them as analytical tools to develop further understandings about health visiting work with mothers. However, this study is also concerned with the issue of domestic violence, and how this is constituted within health visiting work with women. Most importantly, this research is underpinned by feminist discourses about domestic violence, attempting to view and understand health

visiting work through this feminist lens. This therefore raises the question about the inter-sections between feminist perspectives, and the ideas of Foucault; these issues are addressed in the following section.

FEMINIST PERSPECTIVES AND FOUCAULT: INTER-SECTIONS AND TENSIONS.

This study utilises some of the ideas of Foucault (1976; 1979; 1984; 1988) within a project informed by feminist perspectives. The inter-sections between these differing positions enables a productive analysis, as well as making visible a number of tensions which are encountered during the process. These inter-sections and tensions are not unique to this study, however, and have been widely debated in a range of work which has attempted to incorporate the ideas of Foucault within a feminist project (Diamond and Quinby 1988; Hekman 1990; Nicholson 1990; Barrett 1991; Sawicki 1991; McNay 1992; Ramazanoglu 1993; Cooper 1994; Weedon 1997). The key themes which emerge from this debate include concerns about the nature of power, and the implications that notions of subjectivity have for women's agency; these concerns go to the heart of feminist emancipatory politics, and are addressed in this section.

Feminism is a broad term which relates to a set of theoretical and practical strategies concerned with explaining and challenging women's oppressions. Such oppressions are understood to be a result, not only of gender, but also race, class, (dis)-ability and age, leading to a diversity, as well as a commonality, of women's experiences and situations. Feminism is essentially an emancipatory project, and in challenging women's oppressions, the issue of power is central. The differences in understanding and analysing the nature of power underpins some of the tensions feminists have with Foucault's work. This often arises, however, from the differing contexts in which the term is used. This point is made by Smart (1988) in a discussion of power and child custody. Here she suggests that the ideas of Foucault provide valuable ways of theorising about power relations, especially in relation to those groups, such as women, who had

previously always been depicted as being without power. However, she argues that this does not mean the end to oppressive or forceful power relations. As she points out,

> "This new formulation of power, which has been stressed in particular by Foucault .... does not exclude the old notion of power altogether. It remains possible to see power used in negative contexts" (Smart 1988, p. 2).

Her examples of "power over" include the issue of legal rights, as well as the power of parents over children (Smart 1988, p. 2). This is an important point in the current study, where power is a central concept, but one which may be understood, analysed and experienced in different ways across the research. For example, in relation to domestic violence, feminist analyses understand power in terms of the abuse of male power against women. This is very different, in both theoretical and practical terms, to the regulatory role of health visitors exercising power in relation to mothers. It is suggested that while disciplinary power provides a useful theoretical tool for the analysis of practices between mothers and health visitors, the vestiges of male power as exemplified by domestic violence are more fittingly described in terms of the force and violence described by Foucault as sovereign power. This is aptly illustrated by Porter (1996a) who mistakes these different understandings of power, comparing the very different exercise of power between nurses and patients, with the power exercised by soldiers. The latter is underpinned by state force and may involve resorting to violence (White, S. 1997).

Many feminists have found the conceptualisation of power within Foucault's work deeply problematic arguing that his perspectives are contrary to feminist emancipatory politics (Hartsock 1990; Soper 1993). Soper (1993) for example, makes the following point.

> "Feminism is about contesting the multiple forms of power responsible for female subordination. But though Foucault everywhere refers us to power, he has very little to tell us about its nature and sources other than to inform us that it is an effect of discursive formations which are themselves theorised as the effect of power" (Soper 1993, p. 47-48).

Feminists have pointed to the multiple forms of power, for example, socio-economic inequalities and male violence which have led to women's oppression, warning against analyses of power which deflect attention from the material realities of women's subordination. Such concerns lie at the heart of feminist tensions with Foucault's analytics of power. However, they also lie at the heart of central tensions within feminist theory itself. In particular, early feminist debates about women's oppression were marked by understandings grounded in biological differences. This has been challenged by those who argued against the heterogeneity of women's experience, particularly by Black women and working class women who were excluded from much early feminism which was built upon the experiences of white middle class women (hooks 1990). This has led feminists to incorporate an awareness of both commonality and difference. However, as Ramazanoglu (1993) points out, this has important implications for feminist understandings and theorising about power.

> "This is not because of any intellectual fragility of feminist thinkers, but because close examination of the diversity of women's experiences poses immensely difficult problems of explanation which have not been adequately tackled by existing social theories, including Foucault's. The tensions between Foucault and feminism bring out fundamental problems of explaining power relations which social theory has failed to resolve" (Ramazanoglu 1993, p. 5).

Developing theoretical understandings of power and power relations which engage with the differences and commonalities of women's lives, and oppressions, and which allows for the possibilities of change, remains a key concern of feminists. As such it represents a key point of inter-section between feminist and post-structuralist theories. Some advocates of feminist poststructuralism have pointed towards the value of these theories for addressing difference (Butler 1990; Weedon 1997). For example, Weedon (1997) has suggested "....(t)he strength of the poststructuralist theories .... is that they offer a set of theoretical tools which can help feminists to understand power relations of class, gender and race in ways that enable change" (Weedon 1997, p. 180). Despite the

acknowledgements of commonality and difference within feminist perspectives, there remains difficulties in addressing these issues within a single theoretical framework.

In the context of the current study, a number of heurestic devices are used in order to address these tensions concerning power. This includes an understanding that the relationships between health visitors and mothers is constituted as disciplinary power. This is very different to the understandings of power which underpin feminist discourses on domestic violence; these are predicated upon notions of male power over women, and children, more accurately described as force, domination and abuse. Moreover, the feminist perspectives which underpin these domestic violence discourses acknowledge the commonalities and differences in womens lives and experiences, paying particular attention to the social divisions of "race", class, (dis)-ability, age and sexuality.

Despite the tensions between Foucault's work and feminists, his ideas have been used productively (Bartky 1988; Bordo 1988; Smart 1989; Sawicki 1991; Bell 1993; Rhedding-Jones 1997; Shildrick 1997). In particular, disciplinary power has been used by a number of feminists for developing understandings about the local and complex techniques of power (Bartky 1988; Bordo 1988; Sawicki 1991). For example, Bartky (1988) points to the everyday disciplinary practices with which women engage, such as exercise, diet, fashion and make up, arguing that these can be seen as examples of how women's bodies are "rendered docile". Her account illustrates not only the ways in which femininity is constructed in contemporary society, but also points to the ways in which women themselves are subjugated within this discourse, producing themselves as fit, healthy and attractive women as demanded by codes of sexuality which are embedded within patriarchy. These ideas have also been used by Bordo (1988) in relation to the issue of anorexia nervosa. Sawicki (1991) also used Foucault's ideas on power in her analysis of the new reproductive technologies, pointing out,

> ".... there are significant political advantages to adopting Foucault's disciplinary model of power for a feminist critique of new reproductive technologies. Operating with a model of the social field as a field of struggle consisting of multiple centres of power confronting multiple centres of resistance prompts us to look for the

> diverse relationships that women occupy in relation to these technologies, and for the many intersecting subject positions constituting the social field" (Sawicki 1991, p. 86-87).

In advocating the value of Foucault's analysis, Sawicki is explicitly rejecting some radical feminist accounts which posit the new reproductive technologies as another step in the take over of women's bodies as a result of patriarchal medicalisation. Instead, Sawicki suggests that women have a much more complex relationship with the new reproductive technologies. Such complexities arise because of the competing discourses surrounding childbirth and motherhood, some of which arise from feminism while others do not. Her analysis also draws upon Foucault's ideas about resistance.

Like power, the issue of resistance is also of importance to feminism, where theory and practice has challenged women's oppression. This is particularly apparent in the context of male violence against women, where feminist activism has resisted and challenged male violence through the provision of support and refuge services, feminist campaigns, and feminist research (Hanmer and Maynard 1987; Kelly 1988a; Fawcett et al 1996; Hester et al 1996; Mullender 1996). This work has challenged existing malestream understandings of male violence against women, whilst also providing a means to both highlight and develop women's strategies of resistance.

The notion of resistance implicit within Foucault's writings on power (Foucault 1980a, p. 163; 1984, p. 95) has been problematised by some feminists (Hartsock 1990; Soper 1993). This has often been because of a discomfort with poststructuralist theories of subjectivity, which appear to challenge women's agency. However, this has been disputed by a number of feminist poststructuralist writers (Henriques et al 1984; Hollway 1989; Hekman 1990; Weedon 1997). The term "subjectivity" can be understood as our sense of self, how we understand ourselves; subjectivity, however, is always produced in relation to discourse. As Henriques et al (1984) have pointed out, ".... the subject itself is the effect of a production, caught in the mutually constitutive web of social practices, discourses and subjectivity" (Henriques et al 1984, p. 117). The notion of subjectivity should be

understood as partly a development against the Enlightenment concept of "the individual", which posits the possibility of a rational and autonomous being.

A key aspect of subjectivity is the ways in which it allows for multiple subject positions, which because they are discursively produced, are contradictory and in conflict with each other. As Weedon (1997) points out, ".... (a) more positive and politically useful reading of poststructuralist theories of subjectivity would see it as socially constructed and contradictory rather than essential and unified" (Weedon 1997, p. 176). Post-structuralist theories have been used, for example, to examine the production of subjectivities of Black women in post-colonial Britain (Mama 1995). This analysis illustrates the utility of these approaches, providing a dynamic and nuanced account which challenges prevailing psychological discourses which are both raced and gendered.

The idea of "fractured subjectivities" is important to this thesis enabling understandings of difference as well as commonality amongst the participants. This recognises that they are subject to multiple oppressions, such as class, race and (dis)-ability, but also that they occupy multiple subject positions. This argument also points to the inter-relationships between discourse and subjectivity, offering opportunities for resistance. Hekman (1990), for example, considers that ".... in Foucault's conception the constituted subject is a subject that resists" (Hekman 1990, p. 73). Similarly Weedon (1997) has argued,

> "Although the subject in poststructuralism is socially constructed in discursive practices, she none the less exists as a thinking, feeling subject and social agent, capable of resistance and innovations produced out of the clash between contradictory subject positions and practices. She is also a subject able to reflect upon the discursive relations which constitute her and the society in which she lives, and able to choose from the options available" (Weedon 1997, p. 121).

Overall, Foucault's work has led to considerable debate amongst feminists (Diamond and Quinby 1988; Hekman 1990; Nicholson 1990; Barrett 1991; Sawicki 1991; McNay 1992; Ramazanoglu 1993; Cooper 1994; Weedon 1997). The terms of the debate, however, should be understood as part of a continuing dialogue within social theory, rather than a

reactive strategy on the part of feminists. As Soper (1993) has suggested, feminism opened up the discursive space for Foucault's work. Similarly, Ramazanoglu (1993) points out, ".... feminist knowledge poses a considerable challenge to the validity of his work" (Ramazanoglu 1993, p. 3). However, much of this debate, either directly or indirectly, has been concerned with the implications of his reconceptualisation of power for feminism, as well as the failure to consider gender in his writings. As Ramazanoglu (1993) points out,

> "Feminists are up against Foucault in the sense that his work .... invites us to think differently about the nature of knowledge and power, and questions in particular the ways in which women have thought about men having power over women" (Ramazanoglu 1993, p. 4).

In the context of the current study, these debates about power are highly important, and represent a key point of inter-section and conflict between feminist discourses on domestic violence, and understandings of health visiting work with women.

THE FEMINIST POSTSTRUCTURALIST FRAMEWORK.

Feminist poststructuralist theories (Foucault 1979; 1984; McNay 1992; 1994; Weedon 1997) have been found useful to this research because they enable analyses of the gendered nature of power relations between mothers and health visitors, acknowledging the complex and local nature of power, and the possibilities of resistance. This is an important issue in the current context, which seeks to examine the power relations between a group of mothers who are already oppressed as a result of male violence, and a statutory agency concerned primarily with the health and welfare of young children. In this context, it is foreground that the ways in which power is exercised and experienced will be marked by complexities and nuances. Moreover, the research also focuses upon the extent to which feminist discourses about domestic violence have informed the professional knowledge base of health visiting. Understanding this is enhanced by adopting feminist post-structuralist perspectives which draw attention towards the inter-

relationships between knowledge, social practices, power and subjectivity (Foucault 1979; 1984; McNay 1992; 1994; Weedon 1997).

In drawing upon the ideas of Foucault, the continual contestation and tension between his work and that of feminists is recognised. However, these ideas are not presented as a challenge to feminist work on male violence (Hanmer and Maynard 1987; Kelly 1988a; Hester et al 1996; Mullender 1996). These feminist knowledges, which have made visible women's experiences of male violence, as well as pointing to the additional problems mothers face in relation to their contact with state agencies such as health visiting, are represented as discursive (chapter one). This is not intended to deconstruct their "truth", but rather to construct them as representing resistance to the prevailing patriarchal discourses concerning domestic violence. Adopting this discursive perspective also enables the analysis to focus upon the extent to which such feminist discourses on domestic violence have permeated the professional knowledge base of health visiting. Moreover, feminist poststructuralist theories of power, drawing upon the ideas of Foucault (1979; 1984) draw attention towards the practices of regulation inherent in health visiting work with mothers. This provides analytical tools for exploring some of the complexities and contradictions within health visiting practice.

Finally, as Weedon (1997) has advocated, feminist post-structuralist perspectives are able to inform work designed to promote the feminist emancipatory project. Thus, this research has been undertaken with a commitment to improving understandings and consequently improving the service offered to mothers and children who are experiencing domestic violence. It is within this context that feminist poststructuralism is being deployed, as a theoretical tool to develop analyses and understandings about the gender power relations arising from the practices between health visitors and mothers.

CONCLUSION.

In examining the practices undertaken by mothers and health visitors in the context of domestic violence, the notion of power is a central theoretical and practical concern. This study draws upon Foucault's notion of disciplinary power (Foucault 1976; 1979; 1984; 1988; 1990) using these ideas as analytical tools to develop further understandings about health visiting work with mothers. These ideas have informed a number of other studies of nursing, health visiting and social welfare (Donzelot 1979; Dingwall and Eekelaar 1988; Bloor and McIntosh 1990; Parton 1991; May 1992a; 1992b; Nettleton 1992). This research is also concerned with domestic violence, and here feminist discourses draw attention towards the issue of power (Hanmer and Maynard 1987; Kelly 1988a; Hester et al 1996; Mullender 1996). Thus, in developing understandings of power, this chapter looks towards a number of debates within contemporary feminist theory, particularly the inter-sections and tensions between these feminist perspectives and the ideas of Foucault (Diamond and Quinby 1988; Hekman 1990; Nicholson 1990; Barrett 1991; Sawicki 1991; McNay 1992; Ramazanoglu 1993; Cooper 1994; Weedon 1997). These represent some key issues in current social theory (Ramazanoglu 1993).

Thus, the theoretical perspectives underpinning this research reflect these complex issues. The study draws upon the ideas of Foucault to develop the analyses and understandings of health visiting work with women, paying particular attention to the issues of power and discourse. It also draws upon feminist understandings of domestic violence, which focus upon the abuse of male power (Kelly 1988a; Hester et al 1996), and uses these discourses as a means to filter and understand health visiting work with women experiencing domestic violence. In considering how these issues impact upon women, as workers, mothers, and researchers, it also incorporates understandings of diversity, pointing towards the commonality, as well as the differences between women. The interplay between these competing positions allows for a complex analysis of health visiting work with women experiencing domestic violence. This is undertaken by examining the practices of regulation and resistance, the titular themes of this thesis.

SECTION B: THE RESEARCH PRACTICES.

In focusing upon the theory and practice of the research, chapter 4 is sub-divided into two separate sections. It commences with a discussion of the methodological issues which underpin this research study. As the practices of writing, reflection and analysis are complex and intertwined, the methodological discussion focuses upon developing a feminist poststructuralist analysis of this research process. This is achieved by problematising the notions of power and knowledge, which are threaded throughout the research, and developing an analysis which draws upon feminist poststructuralist perspectives. The themes of "regulation" and "resistance" are used as analytical tools for developing this discussion. This is followed by a section concerned with describing the practices of conducting the research. This focuses primarily upon the data collection methods which were used.

CHAPTER 4.

THE THEORY AND PRACTICES OF THE RESEARCH.

INTRODUCTION.

Feminist poststructuralist perspectives provide the lens for analysing the practices between health visitors and mothers experiencing domestic violence (McNay 1992; Weedon 1997). The ideas of Foucault (1979; 1984) focus attention upon the exercise of disciplinary power, allowing the nuances of resistance and regulation, as well as the discursive constructions of male violence and motherhood to be examined. The research is underpinned by feminist understandings and knowledges; it looks towards and builds upon previous feminist work about domestic violence (Kelly 1988a; Mullender and Morley 1994; Hester et al 1996); it foregrounds issues of gender as well as other aspects of difference including class and race; and it uses feminist analyses in the overall interpretation. It is also focused upon practice, and one of the aims of the study is to inform future improvements in service provision for women and children experiencing domestic violence. Feminist poststructuralist perspectives provide the lens for understanding the literature and situating the ideas of the thesis; they are also central to the methodology underpinning this research process.

A REFLEXIVE ACCOUNT OF THE RESEARCH PRACTICES.

Articulating and (re)-presenting the inter-relationships between theory and practice in the context of undertaking social research is a complex project. When such research is undertaken and viewed through the lens of feminist poststructuralism, such complexities become both magnified and more fragmented. This occurs in a number of ways, but of particular interest in the current context is the shattering of dualisms between the process

and content of the research, and the partial and contradictory nature of writing and (re)-presentation. These present both difficulties and opportunities for "writing methodology".

I have presented my methodological discussion as a reflexive account (Harding 1987; Stanley and Wise 1993), tracing the subjectivities and positioning of myself as the researcher. Throughout the study, my identity and experiences as a woman, a health visitor and a researcher are intermingled and inscribed upon the research process. Viewing the research through a feminist poststructuralist lens has led me to understand these as "fractured subjectivities", challenging prior notions of a fixed identity, and this has provided a means to face the complexity of the relationships between myself and the research (Rhedding-Jones 1997).

Writing myself in, in this manner, problematizes a number of issues about the theory and practice of research. These are addressed in relation to the overriding themes of this thesis. There is not an exact fit with my thematic interest in the issue of regulation and resistance, but they do relate to overarching themes about power and knowledge.

Interviews: The Exercise of Power?

Understandings and analyses of power permeate throughout this thesis, not only in terms of the focus of the study, but also in the practices of the research. This is particularly apparent in relation to undertaking interviews, which was the data collection method used in this study.

Qualitative interviews are a popular method in social research, especially when exploring sensitive issues (Lee 1993), or areas where there is little *a priori* knowledge. Although not wishing to conflate feminist methodologies with qualitative interviews (for a critique of this see Jayaratne 1993; Kelly et al 1994), they have formed a cornerstone of feminist research practices (Oakley 1981; Finch 1984; Kelly et al 1992). Indeed, Silverman (1993) has commented upon the popularity of interviews as a research method, suggesting this reflects our experiences of living in an "interview society" (Silverman 1993, p. 19).

Interviews were chosen as the data collection method for this study in preference to other techniques, such as participant observation, or documentary analysis of health visiting records. These were considered inappropriate for examining this particular issue, largely because it is marked by silence and uncertainty. This suggests that it is unlikely that methods such as participant observation or documentary analysis would have enabled the practices of health visitors and women experiencing domestic violence to be examined. Interviews were also a method I had practical familiarity with, not only in the context of previous research, but they were also central to my work as a health visitor, where part of my role was to elicit information from clients, usually women, about intimate details of their lives and that of their children and family. It is only in retrospect that my subjectivity as a health visitor, engaged in a "discourse of the social" (Silverman 1987, p. 191), shaped my approach to this study.

The considerable interest about power relations in the interview situation has been largely spearheaded by feminist researchers, who have focused much of their discussions upon the practices of interviewing women (Oakley 1981; Finch 1984; Ribbens 1989; Edwards, R. 1990; Cotterill 1992). While initially focusing upon gender, perspectives which acknowledge diversity have moved this debate forward (Edwards, R. 1990; Cotterill 1992; Reay 1996). For example, Edwards (1990) has pointed towards the tensions she faced in her research in relation to the negotiation of access and the process of undertaking interviews with Black women, suggesting that it was important to address the differences of race and ethnicity, rather than presuming commonality arising from shared gender.

This tendency to concentrate upon the relationships between the feminist researcher and the women she interviews has been problematized by Glucksmann (1994), who has suggested that the research process itself is being presented as a form of political practice.

> "The amount of angst suffered and enormous efforts expended in the attempt to create an egalitarian and reciprocal relation within the research process would seem to imply that there is some perfect model of researcher/researched relation

to be achieved and that if we succeed, then this counts as being or acting feminist" (Glucksmann 1994, p. 150-151).

Glucksmann (1994, p. 151) argues that this search for "feminism in the research situation" while ostensibly to be valued, may take precedence over the wider context of the research practice, particularly the purposes of the research. This leads her to suggest that reflexivity should embrace consideration of the relationships between feminist research and political practice.

My research practice was informed by feminist debates about interviewing women, and cognisant of the nature of power in social research. There was, however, some incongruity between my own work and these positions, which both intersect with, and ignore, some of the issues which arose for me in this study. To some extent this reflects the particular focus of this research which is concerned with agency practices and how these intersect with, and ignore, aspects of women's lives. Although there is a gendered dimension to such agency practices, and while this research focused predominantly upon interviewing women as workers and mothers (the sample included two male health visitors), it can be contrasted with many accounts of power in feminist research which have been concerned with directly researching aspects of women's lives. Indeed, Kelly et al (1994) have pointed to the problematic nature of this alignment, demonstrating how their own feminist work has often involved an agency or institutional focus.

In interviewing health visitors, my identity as a health visitor appeared to allow me access to those who participated, but also served to locate me as someone who had a shared occupational position. In such circumstances, despite stressing my role as a research student, and ensuring that my contact with those I interviewed embraced the boundaries of the academy, it was my occupational identity which remained important. Despite my efforts to stress my difference, I was perceived as an insider. In conducting these interviews, I had an uneasy feeling that those health visitors who participated presumed that my shared occupational identity would ensure that any power I held in relation to undertaking this research would be used such that health visiting practices would be conveyed "in a good light". Even though I presented my interest in this research partly as

a response to the professional silence about domestic violence, a point which was addressed during the interviews along with other challenging questions, my potential role as writer of critique was not questioned.

Interviewing mothers was largely focused upon their views and experiences of health visitors. Even though I presented myself as a woman who supported feminist work on domestic violence, revealing my identity as a health visitor placed constraints on the interviews and resulted in a complex exercise of power. This can be illustrated in the problems I encountered in accessing women willing to participate in the study. Whilst this may have signalled their resistance, it also led me to nurture any opportunities I developed in which women were willing to be interviewed. Being in a situation where I felt somewhat dependent upon women's willingness to participate in my research project appeared to alter the balance of power. This can be contrasted to my experiences interviewing health visitors, where I encountered no difficulties in accessing willing participants, such that the landscape of power between myself and the health visitors I interviewed was certainly more even, at least in relation to access and participation. Another aspect of this power relationship between myself and the women I interviewed originated from their negative experiences of health visiting in relation to domestic violence. In these instances, many of the women appeared to have considerable expectations regarding my ability to ensure improvements in future health visiting practice, thereby locating me as powerful.

The reflexive analysis of the power which was embedded within my research practices is significantly challenged when viewing research through a feminist post-structuralist lens. There is some irony in that, despite undertaking research through a lens which focused my attention upon the exercise of power specifically upon the practices of regulation and resistance, my initial understandings of power in the context of the practices of research was centred upon understandings of power as a commodity. This modernist conception of power is embedded in many accounts of feminist methodologies, which have often focused upon the power inequalities between researchers and participants. This can be contrasted to poststructuralist analyses which focus upon power relations embedded within discourses of power/knowledge (Foucault 1979; 1984; 1988).

It is through the processes of reflection, together with further engagement with sociological analyses in the writing up of research, which Birch (1998, p. 173) refers to as "being here", that has enabled me to locate this paradox, and explore the practices of the research using a similar approach. These are examined in the following discussion which illustrates how the exercise of power was inscribed upon the practices of the research.

Research as "Regulation" and "Resistance".

The ideas of Foucault have impacted throughout the social sciences, enabling the development of new insights and perspectives about power (in relation to nursing, see Lawler 1991; May 1992a; 1992b; Porter 1996a). Despite this impact, there has been surprisingly little discussion about the way his work has disrupted ideas about power within the research process itself. It has been raised by Nettleton (1992) in the introduction to her work on dentistry, who points out that her research "....contributes to, and is a consequence of, disciplinary power" (Nettleton 1992, p. viii).

> ".... The research in practice, which involved the generation of theory and the collection of empirical data, constituted another dimension of the discourse associated with dentistry. As a sociologist looking at dentistry I was an agent of surveillance" (Nettleton 1992, p. ix).

A similar point is made by Bloor and McIntosh (1990) who, after describing their own research method, make the following observation.

> "We would add, parenthetically, that we have not missed the irony that our own research methods entailed the surveillance of our research subjects" (Bloor and McIntosh 1990, p. 162).

The issue has been raised by Fitzgerald (1996) who uses the example of public health research into illicit drug users, suggesting such research practices should be understood as "a gaze of power" (Foucault 1976; 1979).

Applying the analytical tools used throughout this thesis, which regarded the exercise of power in terms of regulation and resistance, to the research itself, enabled the development of further insights about such practices. Such understandings of power suggested that research itself was concerned with regulation and resistance. Moreover, my practice experience and my research identity implicated myself in this network of power relations, both regulating mothers, and resisting dominant discourses and practices. These parallels between health visiting work with women, particularly when examined through the lens of disciplinary practices, and the practices of research, thread themselves throughout the study. The parallel is identifiable in terms of the practices of interviewing, which are reproduced in this study, but which are an integral aspect of health visiting work. As Silverman (1993) points out,

> ".... there is a broader, societal context in which methods are located and deployed. .... such activities as observation and interviewing are not unique to social researchers. For instance, as Foucault (1979) has noted, the observation of the prisoner has been at the heart of modern prison reform, while the method of questioning used in the interview reproduces many of the features of the Catholic confessional or the psycho-analytic consultation. Its pervasiveness is reflected by the centrality of the interview study in so much contemporary social research (Silverman 1993, p. 19).

Such parallels highlight the shifting boundaries between the theory and practices of this research. An example is the interpretation of the practices of health visitors undertaking "interview" approaches with women as part of their everyday work. A feminist poststructuralist lens enabled me to identify their micro-practices of "getting to know", and to interpret these using notions of pastoral power (Foucault 1984). Parallels between the practices of health visitors and researchers were also illustrated in relation to dealing with difficult or painful issues. This has been a concern of feminists who have pointed to the problems involved in researching aspects of women's lives (Kelly 1984; Cotterill 1992). Interestingly, my initial readings of these accounts resonated with my experiences as a health visitor.

Reflecting upon my work as a health visitor, I was able to recall numerous examples of uncovering painful and difficult issues in the processes of "interviewing" women, a part of my work which I later came to understand in terms of the exercise of pastoral power (Foucault 1984). As a researcher, my expectations pointed towards a repeat of such feelings during the interviews with women who had experienced domestic violence, and I prepared myself for dealing with this issue, both in the context of undertaking the interviews and in terms of the impact this might have upon myself as a researcher (Kelly 1984; Moran-Ellis 1996; Stanko 1997). In the event, even though the content of the interviews with mothers recognised their experiences of male violence and abuse, exploring this was not the focus of my work. During the interviews a few women chose to talk about their experiences of male violence, or described these experiences as they were intertwined with their contacts with outside agencies such as health visitors. And while I encountered some difficulties in dealing with women's experiences of male violence, this issue did not occur in the measure to which I had expected it to do so.

In contrast, the interviews with health visitors contained lengthy and harrowing descriptions of women's experiences of male violence and abuse, which I found surprisingly difficult to deal with. These health visitors appeared to be using the interview situation to pour out the considerable pain and distress they experienced in their work. Comments such as ".... nobody has ever asked me about this before", abound in my fieldwork notes, resonating with parallel accounts of feminist research into women's lives (Oakley 1981; Finch 1984). My reactions to this was puzzling, not only because it was unexpected but also because it co-existed with a paradox in the data, namely the silences and lack of awareness about domestic violence amongst health visitors. The data was suggesting that, on the one hand, health visitors had an everyday working contact with women experiencing domestic violence, while it also suggested there was a silence about this issue in their work. This reflects debates about the public and the private (Stacey 1981; Ribbens and Edwards, R. 1998), illustrating some of the paradoxes about health visiting work.

The focus of the research has been upon the role and practices of health visitors, problematizing these in order to develop sociological analyses. It has also examined the private and personal aspects of women's lives through the lens of health visiting work. In many senses this also represents the silent and hidden areas of health visiting work; those aspects which have been hidden from public knowledge and have not been part of the official professional discourses. In retrospect I have come to understand that my research is part of the discourses about health visiting and domestic violence, as the practices of the research have focused upon the subjugated knowledges of health visitors (Foucault 1980b; Cain 1993).

Sociological analyses of health visiting work have been concerned with its spatial location as well as theorising about its role and practices. Mayall (1993) has suggested that the relationship between mothers and health visitors occurs in the "intermediate domain", a space between the public and private worlds. While this and similar arguments have been largely concerned with analysing the impact of such work upon mothers and families in the wider context of societal regulation, there has been little analysis focusing upon such practices from the perspectives of workers. Again, this had implications for the interpretation, for using the lens of feminist poststructuralism, I drew upon the notion of pastoral power (Foucault 1984) to illustrate this.

Despite little usage of the term "resistance", the feminist literature is increasingly addressing the possibilities of resistance amongst the researched. Cotterill (1992) refers to the reticence of some of the women she interviewed, pointing to their tendency to not always talk freely and openly, their reluctance to agree to second interviews, and their concerns regarding confidentiality. Whilst these women participated in the research, Cotterill (1992) suggests that they were resistant to the researcher accessing their private accounts, focusing instead upon public accounts of their lives (Cornwell 1984). Issues of both resistance and silence have also been recognised by Mauthner, M. (1998) and Miller (1998) who, reflecting upon their own research practices, refer to the ways in which women whom they interviewed remained silent or were resistant to involvement in their research. This theme is taken further by Miller (1998) who, in the context of a longitudinal

study about the transitions to motherhood, refers to her own practices of silencing, when as a researcher answering a woman's questions during the antenatal interview, she subscribed to public discourses about pain during childbirth.

Reflecting upon the practices of the research, using a feminist poststructuralist lens, enabled me to understand some of the ways in which my subjectivities were shaped and developed. These impact upon, and reflect, the practices of the research which is reported in this thesis. Of particular interest in the current context is the processes through which my own subjectivity as a researcher, shaped and informed by my experiences of postgraduate study, were inscribed by the academic discourses of social research. When contrasted with the subjectivities of research participants, whose practices are unlikely to be informed by these academic discourses, the exercise of power within social research, such as that which is being reported here, is particularly illuminated.

The above discussion has attempted to illustrate some of the ways in which the exercise of power was inscribed upon the practices of the research. This has focused largely upon the conduct of interviews. However, the discussion has begun to consider the practices of interpretation of interview data. As this represents another key site for the exercise of power, it is examined in the following section.

Power and Knowledge in the Interpretation Process.

The practices of interpretation are an important part of the research process. However, in the context of qualitative data analysis, they are often difficult to explain and make visible (Bryman and Burgess 1994; Coffey and Atkinson 1996). Doing so is important, because interpretation is not only a site of power, but one which reflects wider epistemological concerns, particularly in the context of interview based research (Melia 1997; Miller and Glassner 1997). This has been addressed by Silverman (1993) who points out,

> "Only by following misleading correspondence theories of truth could it ever have occurred to researchers to treat interview statements as only potentially accurate or distorted reports of reality" (Silverman 1993, p. 114).

Silverman (1993) is critical of sociological perspectives which have suggested misleading polarities between the form and content of interview data. Instead, he considers that interview data should be treated as both situated and textual pointing out that, ".... (e)verything depends on the status which we accord to the data gathered in such interviews" (Silverman 1993, p. 106).

Interpretation intersects with, and is part of, the wider issues of power, reflexivity, and knowledge, and has been addressed by feminist researchers (Holland and Ramazanoglu 1994; Birch 1998; Mauthner, N. and Doucet 1998). In a detailed chapter describing the processes whereby a team of feminist researchers interpreted interview data collected as part of a study examining young peoples sexuality, Holland and Ramazanoglu (1994) made the following observation.

> "Feminists have had to accept that there is no technique of analysis or methodological logic that can neutralise the social nature of interpretation. We cannot read meaning in interview texts, allowing them to propose their own meanings, without also reading meaning into them, as we make sense of their meanings. Feminist researchers can only try to explain the grounds on which selective interpretations have been made by making explicit the processes of decision-making which produces the interpretation, and the logic of method upon which these decisions are based. This entails acknowledging complexity and contradiction which may go beyond the interpreters own experience, and recognising the possibility of silences and absences in their data" (Holland and Ramazanoglu 1994, p. 133).

Writing about the processes of interpretation is challenging. There are a number of difficulties in representing complex analytical processes in written form, which may themselves be mediated through the process of textual reproduction. There are also

challenges posed by temporality, given the ongoing nature of analysis. However, the completed form of the account, in this case a submitted thesis, will inscribe boundaries, distinguishing this interpretation from that which may be contained in any possible future texts (for a discussion of intertextuality see Fox 1995).

The processes involved in data handling, interpretation and writing are complex and multi-faceted. The processes of data analysis in which I engaged is multi-layered, and ongoing throughout the research. As Coffey and Atkinson (1996) have illustrated, there are many ways of interpreting data and writing research reports. Nevertheless, it is possible to identify the analytical decisions which were taken, and to relate these to epistemological understandings.

Certain activities related to data analysis are more visible, and perhaps therefore easier to identify and describe. This includes the processes of coding the transcribed interviews, which involved marking off segments of data according to a range of categories. Such categories included both those with which I had an identified prior interest, as well as those ideas which emerged throughout the interviews and analysis. It is possible to identify a number of areas with which I had an interest before undertaking the interviews. These include the extent to which health visitors had received training about domestic violence, their contact with men, and the extent to which they are concerned about the welfare of children in situations of domestic violence. Other aspects of the resultant analysis arose directly from the data, even though they reflected the theoretical framework. An example of this concerns theorising about resistance, which was a recurrent theme in the interviews with mothers. This was not as a result of a particular focused question or prompt, but occurred spontaneously, as many of the women talked about their practices of concealment and resistance. Although arising directly from the data, the notion of resistance is inherent within Foucaults' ideas about disciplinary power, and has been directly addressed in relation to health visiting (Bloor and McIntosh 1990). This is also illustrated by the development of the ideas around the micro-practices of the health visitors regarding the issue of "getting to know" about domestic violence. This arose as part of the general interest in their awareness of domestic violence, using the

concepts of the "gaze" and "pastoral power" (Foucault 1976; 1979; 1984) as analytical tools which arose directly from the data. The practice of using themes arising from the data to develop theoretical insights has been described as analytical induction (Glaser and Strauss 1967; Strauss 1987). This is reflected in the analysis which involves a complex interplay between data and theory.

The practices of interpretation are also concerned with power relations between the research and researched. Glucksmann (1994) has argued that there is always a difference between the researcher and those who are researched in relation to the knowledge which is being produced, suggesting that inequalities in knowledge between researcher and researched should be considered as a social division, similar to those of class, race, gender and (dis)-ability. Cotterill and Letherby (1993) acknowledge that the final shift of power between researcher and researched is with the former, as it is she who walks away with the data, writes and publishes about it.

Summary.

Viewing the research through the lens of feminist poststructuralism draws attention to the issues of power and knowledge which are intertwined throughout the research process. Feminist discourses have made visible these issues in relation to social research, particularly interviewing. However, much of this work has been based upon modernist notions of power, which has focused primarily upon power inequalities. In contrast, the methodological discussion presented here has built upon poststructuralist understandings of power, looking particularly towards how power is exercised within research relationships. This has drawn attention towards the discourses of social research, and the subjectivities of myself as researcher. It has also scrutinised aspects of the interpretation process, focusing upon the relationships between power and knowledge within social research. The overall discussion has drawn attention to the notions of "regulation" and "resistance", which are threaded throughout these research practices.

THE RESEARCH METHODS.

This study is a feminist poststructuralist analysis of the practices between health visitors and women experiencing domestic violence. It is based upon semi-structured interviews with 24 health visitors and 16 women survivors of domestic violence. In discussing the processes involved in this research, the focus here is largely upon methods.

Research Aims.

In the early stages of the research, it was helpful to develop a set of aims to guide the development of this project. These were informed by my understandings of the existing knowledge base, my practice experience and interests. These initial aims are outlined below:

1. To explore the views and experiences of women survivors of domestic violence in relation to the practices of health visitors.

2. To explore the practices of health visitors in relation to women experiencing domestic violence.

3. To identify and explore commonality and diversity within health visiting practices in relation to domestic violence.

4. To apply feminist perspectives to the examination of health visiting practices in relation to domestic violence.

5. To inform future policy and practice development of health visiting services in relation to women experiencing domestic violence.

The Fieldwork Site.

The fieldwork for this research was undertaken in a large northern city. The local N.H.S. Trust provides health visiting services across the entire city, which being a large multi-cultural city with a diverse population, ensures that the health visitors have contact with women from a wide range of social groupings, particularly in relation to race and class. Despite living locally, I had not previously worked as a health visitor in this city, and had minimal prior knowledge of the organisation or personnel of the city NHS Trust. Across the city there is a wide range of statutory and voluntary service provision. This includes three refuges for women escaping domestic violence, including a refuge for Asian women, and three community-based domestic violence projects. There is also a well established city-wide multi-agency Domestic Violence Forum. These services are valuable resources for the context of the research and the processes of accessing participants.

The research was conducted in two different parts, which focused separately upon women survivors of domestic violence, and health visitors. The research methods associated with these phases are discussed separately in the following sections.

The Health Visitors.

a): Negotiating Access.

Negotiating access to the health visitors who participated in this research study was a straightforward process. Following an explanatory letter outlining my research to the Director of Community Nursing Services, who was identified as the formal gatekeeper, I was invited to a meeting to further discuss my plans. At this meeting a number of issues were raised, including the purpose of my research, professional relevance of the study, and the ethical concerns relating to consent and confidentiality. The Director of Community Nursing was supportive of my study, and enabled me access to the health visitors employed by the N.H.S. Trust. This meeting resulted in an invitation to attend a

professional meeting organised by the health visiting staff, to discuss my research and make arrangements for conducting the interviews. For this research study, Ethics Committee approval was not required.

b): Sampling.

In order to examine the practices of health visitors in relation to women experiencing domestic violence, it was important to include within my research sample some health visitors who were interested in this issue. Such a convenience sample was attained as a result of my attendance at the meeting discussed above, during which fourteen health visitors expressed their interest in participating in this study. This initial convenience sample was supplemented by a process of purposive sampling. This was undertaken to ensure the inclusion of key informants; as a result, two health visitors who worked closely with women's refuges were identified and invited to participate. Another aim of purposive sampling was to ensure that the sample of health visitors was diverse. This led to the inclusion of a further eight health visitors, according to geographical area of practice, race, age, sex and experience.

c): The Interviews.

After the health visitors have been contacted and agreed to be interviewed, arrangements were made regarding the time and location for the interviews. These all took place during the health visitors normal working hours, and at their clinic base, in a convenient and quiet room. A total of 24 semi-structured interviews were undertaken with health visitors during the period October 1996 to April 1997, chosen by a combination of purposive and convenience sampling. Prior to commencing each interview the health visitors were asked to read and sign a Consent Form (attached as Appendix A), agreeing to the interview, and for audiotaping. Each interview was recorded using a portable tape-recorder, and afterwards transcribed verbatim by myself. The transcription notation used throughout the research is attached as Appendix B. (adapted from Potter and Wetherell 1987).

The interviews with the health visitors lasted between 40 and 90 minutes. Following each interview, the participating health visitors were asked to complete a data sheet to collect

demographic details. This is attached as Appendix C. During the interviews I asked health visitors to talk about their practice experience of women and domestic violence, exploring some of the dilemmas and concerns this raises for them in their overall work. The interview schedule developed from a combination of my own personal practice experience, as well as building upon issues highlighted in previous research. The interview guide used with the health visitors is attached as Appendix D. Throughout this thesis all the health visitors names have been changed to preserve anonymity.

d): The Health Visitors.

At the time the fieldwork was talking place for this research, the community health Trust employed 138 health visitors, based at 58 health centres or GP surgeries across the city. Overall, a total of 24 health visitors participated in this study (representing 17 per cent of employed health visitors). These included health visitors from 19 different practice locations (32 per cent of total), reflecting a degree of geographical diversity. Amongst those who participated were two male health visitors (out of four employed by the trust), and three Black health visitors (out of six employed by the trust). The latter were contacted by a process of snowball sampling, by which all the Black and Asian health visitors employed by the Trust at the time of the research were approached and invited to participate. The age of the health visitors who participated is illustrated in Figure 4:1.

Figure 4:1. Age of Health Visitors.

Age Range.	Number.	%.
31-40 years.	10.	41.6%
41-50 years.	10.	41.6%
51-60 years.	3.	12.5%
TOTAL.	**23***	**100%**

*The total is 23 as one health visitor did not answer this question.

The health visitors who participated in the research had a range of practice experience. The majority (16) had been working as health visitors for more than ten years, although 2 had recently qualified and had been practising for less than twelve months. The results are displayed in Figure 4:2.

Figure 4:2. Health Visitors Practice Experience.

Length of Health Visiting Experience.	Number.	%.
Less than 12 months.	2	8.3%
1-3 years.	-	-
3-5 years.	1	4.2%
5-10 years.	5	20.8%
More than 10 years.	16	66.7%
TOTAL.	**24**	**100%**

Overall, the health visitors had considerable practice experience, but this had often involved working in different posts. Figure 4:3. provides information about the length of time health visitors had been working in their current post.

Figure 4:3. Length of Time in Current Health Visiting Post.

Length of Time in Current Post.	Number.	%.
Less than 12 months.	4	16.6%
1-3 years.	7	29.2%
3-5 years.	7	29.2%
5-10 years.	5	20.8%
More than 10 years.	1	4.2%
TOTAL.	**24**	**100%**

The majority (15) of those who participated were employed on a part-time basis. The average weekly hours was 30.4 hours, and 18.5 hours was the least worked by all those who participated. The remaining nine health visitors were employed full-time. The majority were generic health visitors, employed to provide a range of services across the community. However, the sample included three Community Practice Teachers, and two others had specialist posts providing health visiting services to homeless families, and travellers. All the health visitors who provided services for the city wide refuges were included in this sample.

The Women.

a): Negotiating Access and Sampling.

The process of making contact with women willing to participate in this research was associated with a number of difficulties. This included choosing and accessing an appropriate sample of women, taking into account ethical, safety and practical considerations. For these reasons it was not possible to select women directly from the health visitors caseloads, and no attempts were made to match the women who participated in the study with the health visitors who were interviewed. Alternative strategies, such as placing an advert in a health clinic or GP surgery inviting women to participate in the study, were also rejected for similar reasons.

All the women were contacted through their involvement with organisations providing support to women experiencing domestic violence, such as Women's Aid, refuge groups, and community support projects. This means that the women who participated in this study represent a particular sub-sample of those who experience domestic violence, in that they had all named their experiences and taken steps to get help or escape the situation.

Although sixteen interviews were undertaken with a convenience sample of women, accessing those willing to participate was a complex and lengthy process. Negotiating access to women willing to participate in this study commenced with an initial approach to the Children's Worker at the Women's Aid Federation of England (W.A.F.E.), outlining my study aims. At this time, a number of policy developments were highlighting the importance of developing the work of other agencies regarding domestic violence (Victim Support 1992; Home Office 1995), and this paved the way for my research to be supported. This involved practical support in terms of an introductory letter which was sent on my behalf to 2 local women's refuges, linked to W.A.F.E.. In both instances this was followed up by a telephone call from myself. However, the processes of negotiating access were complex.

For example, one of the refuges provided services for Black and Asian women, and my contact with the workers there paved the way for immediate access to women. Following my initial contact, the refuge workers approached on my behalf one woman who volunteered to participate; and over the following months, I was put into contact with another two women. In contrast, although the workers at the other refuge were supportive of my research, they only put me directly into contact with one woman. However, they did put me into contact with other organisations across the city who supported women experiencing domestic violence; this included another refuge, and three community based domestic violence projects. These other contacts were extremely useful, and enabled me to access a further 9 women willing to participate in my research. In addition, my supervisor put me into contact with another refuge group elsewhere in the country, and through the support of the outreach worker I was put into contact with a further 3 women who were willing to be interviewed. Throughout this process I developed a working contact with the co-ordinator of the city-wide Domestic Violence Forum, who supported my research.

Thus, negotiating access to women willing to participate in my research was an ongoing process, and one which involved considerable groundwork. It involved producing written information, and supplying posters, interview reply slips, stamped addressed envelopes, and telephone numbers to enable the workers to promote my research, and to make it as easy as possible for women to contact me. Looking back at my notes which recorded the meetings, letters, and phone calls I had with the refuge workers and the staff of the domestic violence projects, this contact was considerable, time consuming, and lengthy. In comparison to the health visitors where the interviews were completed over 7 months, my attempts to interview women took 12 months. This process involved a degree of gate-keeping, with the workers selecting women they considered to be appropriate to participate. For example, in one refuge this involved only asking women who had been rehoused but who maintained contact through outreach work.

It was also likely that for a number of reasons women decided they did not wish to participate in this research. To portray this as resistance reflects the benefits of theoretical

hindsight. At the time, I was concerned that it reflected a more general difficulty in achieving consumer views. It may also have been a reflection of the silences of health visiting in the context of domestic violence, suggesting that women literally had nothing to say about health visiting practice. Unlike previous agency studies about domestic violence (Binney et al 1981; Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996), my research was focused solely upon health visiting services, which does not have a specific role in relation to domestic violence. This may mean that for women escaping domestic violence, health visiting is not a very significant service, particularly given that health visiting contact is often concentrated upon women with very young children. Moreover it is very difficult for any researchers to acquire accurate views about a service, particularly if they are not satisfied. Such reticence is likely to be magnified in situations such as those experienced by women escaping domestic violence, in that they may still be in receipt of a service and therefore not willing to criticise or complain. In addition, they may have negative experiences relating to statutory child care issues, making them unwilling to participate.

The decision to offer a nominal gratuity of £5 to those women willing to be interviewed greatly increased the uptake. This was "backdated" to the three women who participated initially. Following the introduction of this gratuity in June 1997, a further thirteen women agreed to participate over a six week period. In total, sixteen women were interviewed for this research during the period from November 1996-July 1997.

b): Conducting the Interviews.

The processes of contacting women willing to participate and conducting the interviews varied according to the circumstances of the women concerned. These are displayed in Figure 4:4.

Figure 4:4. Location of Interviews with Women.

Location of Interview.	Number.
Refuge or Office.	9
Home.	6
Other.	1
TOTAL.	**16.**

Eight interviews were audio-taped, and notes taken during the other eight interviews. All the women who allowed a tape recorder to be used were offered a copy of their transcript, but only four women took up this offer. Following the return of their transcripts, I telephoned these women in order to provide an opportunity to discuss them; they were often upset to read about their experiences, and appreciated the opportunity to talk.

Prior to commencing each interview the women were asked to read and sign a consent form agreeing to be interviewed and for audiotaping. This is attached as Appendix E. The interviews varied in length, some lasted about twenty minutes, while a few took nearly two hours. The interview schedules were developed with the aim of focusing upon the issues of concern to the researcher, while also allowing scope for the participants to describe their experiences, practices and perspectives. The interview guide used with the women is attached as Appendix F.

In interviewing women for this research, the aim was to clarify their experiences and perspectives concerning their relationships with health visitors. Although acknowledging the interest of this in general terms, the focus of this research was specifically upon the ways in which this developed around the issue of domestic violence. The content and focus of the interviews purposely did not explore women's experiences of domestic violence, as this was not the aim of this study.

c): Introducing the Women.

The 16 mothers who were interviewed for this research are introduced below. All their names have been altered in order to protect their anonymity, and unless indicated, the interview was tape-recorded and fully transcribed. The transcrption notation is attached as Appendix B. (adapted from Potter and Wetherell 1987).

Aimee *has two children, a daughter aged 10 years old, and a son aged 3 years old. She has now been rehoused after escaping domestic violence, but continues to receive support from a local Women's Aid group. I met with Aimee at her home. During the interview I took notes which were written up immediately afterwards. Aimee originates from south east Asia, and speaks good English.*

Alex *is a White woman who has three children, aged 6 years, 3 years and 2 years old. She experienced domestic violence for about two years from the father of her youngest two children. She has now left the relationship, but continues to experience harassment and abuse from him. Alex receives some support from a local domestic violence project. Notes were taken during the interview, and written up afterwards.*

Angela *has three children, a son aged 19 years, a son aged 12 years, and a 14 month old daughter. Angela had experienced domestic violence in a previous relationship, and during the last two years from the father of her baby. She has recently escaped domestic violence, and spent several weeks staying in a women's refuge, before being rehoused. She continues to be supported by an outreach worker. My interview with Angela took place at her home.*

Anita *is a Black woman, in her early thirties. Anita had three children, a daughter aged 15 years old, a 15 months old daughter, and a son who died as a cot death when he was 5 months old. Anita had experienced continued abuse over a 15 year period from the father of her oldest daughter. I interviewed Anita while she was staying at a women's refuge. Notes were taken during the interview and written up afterwards.*

Barbara *is a White woman who escaped from a violent husband about four years ago, and has been rehoused in a different area. After leaving him she continued to experience considerable harassment and abuse from her ex-husband. Barbara has two sons, aged 7 and 5 years old, and is currently in a new relationship. She is now involved with a local domestic violence project.*

Claire *is a White woman who has now escaped domestic violence and is bringing up her two sons, who are 4 years old and 2 years old, as a lone parent. Claire is involved with a local domestic violence project. Notes were taken during the interview, and written up immediately afterwards.*

Janet *was interviewed in her own home, where she now lives having been rehoused after escaping domestic violence. Janet had spent several weeks staying in a women's refuge, and she continues to have support from a refuge outreach worker. Janet is a White woman who has two daughters who are 6 years old and 4 years old.*

Maggie *is a White woman who has a son who is now 7 years old. She has lived in her current home for about four years, having moved away from another city to escape a violent partner. Maggie is receiving support from a local domestic violence project. Maggie has continued to experience violence from her ex-partner, especially during child contact. I interviewed Maggie at her home.*

Meera *is an Asian woman from Pakistan. She has a twelve month old son. I interviewed Meera at the refuge where she had been staying for several months, after escaping from a violent husband. Meera has lived in the UK for about six years and now speaks English as a second language. The interview was undertaken in English, and Urdu, and translation was done from another member of the refuge. Notes were taken during the interview and written up immediately afterwards.*

Moira *is a White woman who has three children, a 10 year old son, and daughters aged 6 and 3 years old. Moira had experienced domestic violence from her husband over many years. I interviewed Moira while she was staying at a women's refuge.*

Nikita *was interviewed at a women's refuge, where she had been staying for a few days in order to escape her violent husband. Nikita is an Asian woman, she was born in this country, and she speaks both Urdu and English. Nikita has three daughters who are 4*

years old, 3 years old and 1 year old. Notes were taken during the interview, and written up immediately afterwards.

***Paula** is a White woman with a five month old baby. Paula had been staying at a refuge since her son was six weeks old in order to escape a violent boyfriend. I interviewed Paula while she was staying at a women's refuge.*

***Ruth** was interviewed in her own home, where she now lives having been rehoused after escaping domestic violence. Ruth had spent several weeks staying in a women's refuge, and she continues to have support from a refuge outreach worker. Ruth is a White woman who has four children, two daughters who are 9 years old and 8 years old, and two sons aged 4 years and 2 years old. Ruth had experienced violence and abuse from her husband for over nine years.*

***Valerie** was interviewed while staying at a women's refuge, where she had been staying for a few days, having escaped a violent partner. Valerie is a White woman with four children who are aged 9 years, 6 years, 2 years, and a 9 week old baby. Notes were taken during the interview, and written up immediately afterwards.*

***Yasmin** came to this country from Pakistan about eight years ago for an arranged marriage. She has two sons aged 7 years and 6 years old. When Yasmin was living with her husband and his family she experienced considerable abuse and violence. Yasmin has now left this relationship and has been rehoused to another area of the country. She continues to receive support from an Asian Women's Refuge.*

***Zoe** is a White woman who has two sons, now aged 11 years, and 8 years old. Zoe has now escaped from domestic violence, and is a lone parent, but in the past she has experienced two extremely violent relationships. She left the last relationship when her oldest son was 6 years old. This interview was undertaken with Zoe at the offices of a local domestic violence project where she now works as a volunteer. Notes were taken during the interview, and typed up immediately afterwards.*

SECTION C: THE FINDINGS.

Understanding health visiting as the social regulation of mothers provides the conceptual and theoretical framework for the analysis and presentation of the findings of the research. These are presented in the following three chapters (5, 6 and 7).

Chapter 5 focuses upon the practices through which health visitors "get to know" about women's experiences of domestic violence. This is concerned with examining the knowledge base which informs health visiting practice, specifically exploring the extent to which feminist discourses have permeated professional understandings. Viewing health visiting work as a form of social regulation draws attention towards the exercise of power within the professional-client relationship; the notions of "pastoral power" and the "gaze" (Foucault 1976; 1984) are used as analytical tools to examine the practices through which health visitors "get to know" about domestic violence.

Chapter 6 focuses upon the perspective of the mothers, who all faced a number of difficulties in seeking help about domestic violence. This included dilemmas about disclosing their experiences to health visitors, as well as inadequate responses once they had broken their silence. Their practices of help seeking are presented and analysed within the overall framework which understands health visiting as a form of social regulation.

Chapter 7 returns to the health visitors interview data, examining their responses to domestic violence. The results suggest a mixed practice regarding their provision of support and protection to women and their children. In particular, health visitors responses often involve reframing a woman's experience of domestic violence as a child welfare concern. This often results in an increased scrutiny of mothering rather than providing any practical support or protection. The gendered nature of this social regulation of mothers is further supported by the silences regarding men within health visiting practices.

The framework for presenting these results deliberately places chapter 6 which discusses the women's experiences in between the two lengthier chapters (5 and 7) focusing upon health visiting practices. This has been adopted in order to reflect the struggles faced by many mothers in seeking help from health visitors. It also reflects the themes of "regulation and resistance" which are intertwined throughout this thesis.

CHAPTER 5.

"GETTING TO KNOW ABOUT DOMESTIC VIOLENCE".

INTRODUCTION.

An analysis that understands health visiting as the social regulation of mothers draws attention towards the discourses and power relations upon which such practices are constituted. This provides a useful set of analytical tools for understanding health visiting work with mothers. In the current context, concerned with the set of practices undertaken by health visitors and women experiencing domestic violence, adopting a feminist poststructuralist framework (Foucault 1979; 1984; Weedon 1997) is particularly productive. This is because it provides a means of analysing the knowledge-base and the micro-practices of health visiting, thus advancing understandings about their work in relation to domestic violence. As the earlier review has illustrated (chapter two), previous studies about domestic violence and agency responses have provided little detail about health visiting work (Binney et al 1981; Borkowski et al 1983; Pahl 1985); there has also been a lack of attention to domestic violence within the professional literature (Orr 1986; Frost 1997). Thus a focus upon both power and discourse provides the theoretical framework for developing this analysis.

This chapter is concerned with examining health visitors' knowledge regarding domestic violence. Although recognising the interconnections between power and discourse within Foucault's overall framework, expressed as power/knowledge (Foucault 1979; 1980a; 1980b; 1984), the analysis commences by using these concepts in related, but separate, ways. Thus, the first section is concerned to examine the overall knowledge of health visitors regarding the issue of domestic violence. Using a number of conceptual themes from feminist work as analytical tools, it focuses upon the extent to which feminist discourses about domestic violence have permeated the professional knowledge base of

health visiting. The data suggests a mixed picture, and the analytical tools used enables this diversity amongst health visitors to be examined.

This is followed by an examination of the micro-practices of health visiting work with mothers. This focuses upon both how health visitors "get to know", and do not "get to know", about domestic violence. The analysis concentrates upon the knowledge base that informs their practices, as well as the exercise of power inherent within such regulation which enables mothers to conceal their experiences of domestic violence.

TRACING THE DOMESTIC VIOLENCE DISCOURSES.

An analysis that views health visiting work through the lens of social regulation draws attention to the micro-practices, and the power/knowledge upon which these practices are constituted. In the context of their work with mothers experiencing domestic violence, examining the health visiting knowledge base that underpins this practice provides a useful means for developing an understanding of this work. This section draws upon both quantitative and qualitative data from the interviews with health visitors in order to examine these discourses. In describing the extent of their awareness of domestic violence, the health visitors' discussions were marked by considerable complexity. In order to make sense of the multiple meanings which arose in the interview data, a number of conceptual themes arising from feminist discourses about domestic violence are used as analytical tools to guide the discussion. It commences by examining health visiting knowledge regarding the extent and nature of domestic violence.

When health visiting has been considered as part of agency studies, the findings have suggested that they under-estimate the extent of domestic violence experienced by women (Borkowski et al 1983; Tayside Women and Violence Group 1994). For example, Borkowski et al (1983) found that health visitors considered that only 1 in 56 women on their caseload were experiencing this problem. These figures are very different to feminist scholarship, which points to much higher levels of woman abuse (Hanmer and Saunders

1984; McGibbon et al 1989; Mooney 1993; Stanko et al 1998). Clearly, health visitors awareness of the extent of domestic violence represents a key site for examining the extent to which feminist perspectives have been absorbed into the professional or personal discourses of health visitors.

A definition which built upon feminist understandings of the range of abusive behaviours experienced by women (Mooney 1993) was introduced at the beginning of the interviews in order to establish the understandings held by myself regarding domestic violence (see introduction). Using this as a framework, health visitors were asked to estimate the numbers of women from their caseload they knew, or suspected, were experiencing domestic violence. These estimates are displayed in Figure 5.1.

All the health visitors had some knowledge of women experiencing domestic violence. However, there were considerable differences in the estimates they gave regarding the levels of domestic violence amongst mothers with children on their caseloads. A third of the health visitors reported that they knew, or suspected, domestic violence was an issue for only five women, or less. These low figures reflect the under-estimation which has been found in previous studies (Borkowski et al 1983; Tayside Women and Violence Group 1994). In contrast, a few health visitors identified high levels of domestic violence giving figures of 50 plus women. They also commented upon the complexities involved in attempting to quantify women's experiences in this way. Such differences amongst health visitors have also been highlighted in the results of the study undertaken by Tayside Women and Violence Group (1994); they report that although the majority of participants were aware of very low levels, citing less than 5 women, one participant said she was aware of over 100 women experiencing domestic violence during the past year.

Figure 5.1:

Estimated Levels of Domestic Violence on Health Visitors' Caseloads.

	Estimated Nos. on Caseload (Known Or Suspected).	Caseload Size.	Comments.
Daisy.	100+. At least half of all women seen.	230+	H.V. with Specialist Post.
Maeve.	Daily contact.	N/A	H. V. with Specialist Post.
Grace.	50 known. More suspected.	200.	
Vicky.	25% plus of caseload.	160-200.*	
Sanji.	12-20 with physical violence. More emotional abuse etc.	350 under 5's.	Current post under 1 year. Referred to previous caseload.
Irene.	18 plus.	220.	
Marian.	High levels.	200.*	Unable to quantify.
Chris.	Unable to quantify.	300.*	Aware of several situations.
Michelle	12-18 women	300.	
Pamela.	High levels.	200 *.	Unable to quantify.
Kay.	15-20 women.	270.	
Emma	12 women.	250.	
Rebecca	8 women.	225	
Theresa	None currently. 5+ women survivors.	300 *.	
Tina.	5 known. 6 more suspected.	300 under 5's	
Natasha	3 known. More suspected.	250*	Current post under 1 year.
Joe.	4 women.	200-250.*	Current post under 1 year.
Poppy.	3 or 4 women.	180*.	
Jenny,	3 known. No others suspected.	250 under-5's.	
Isobel	2 women.	150.*	Current post under 1 year.
Beverley	2 women.	250*.	
Melissa.	2 women.	300*	
Mary	1 woman.	300 *.	
Lorraine	None identified on current caseload.	200.*	Referred to previous work.

Caseload Size: Refers to approximate number of families on health visiting caseload. Those marked with an asterix are estimates. Caseload sizes vary depending upon a number of factors including geographical area, and number of hours worked.

Comments: All of the health visitors had been in their current post for more than one year, unless indicated.

This exercise required the health visitors to reflect upon their practice experience as domestic violence is not routinely recorded either in their professional records, or as part of their population-focused profiling activities. These estimates represent a crude measure of health visitors' awareness of domestic violence, and do not take into account other issues such as women's practices of concealment. Despite such shortcomings, these estimates do indicate substantial differences between health visitors. As this reflects the knowledge base which informs their practices, a closer examination of these differences is important to the overall analysis. This is partly achieved by contrasting the

qualitative data from the interviews with these health visitors who gave very different estimates regarding the levels of domestic violence.

Melissa was aware of only 1 or 2 incidents of domestic violence on her caseload of over 250 families. An estimate informed by feminist understandings, which has pointed towards the prevalence of domestic violence to be at least 10 per cent (McGibbon et al 1989; Stanko et al 1998), would indicate that a minimum of 25 mothers with children on Melissa's caseload could be experiencing domestic violence. This illustrates that Melissa is clearly under-estimating the levels of domestic violence amongst women with whom she has professional contact. In contrast, Vicky thought that at least 25 per cent of the mothers on her current caseload were experiencing domestic violence, a figure which compares to feminist work (McGibbon et al 1989). These differences between the understandings of Melissa and Vicky are further illustrated in the following data extracts.

> *.... it is not something that I encounter. You know, it is not part of my everyday sort of caseload. .... there is not a number of women who I am concerned about or whatever. I mean, it really is isolated. .... It has not really been a big issue for me (Melissa).*

> *....there are a lot of issues of domestic violence in this area we work in, which fit into these definitions, that I am aware of, and also stuff through other people. You know third hand stuff, which means that I know it is going on but people aren't being overt in telling me. And also I think there is even more around that we don't have any kind of handle on at all. And sometimes some of the clients where I feel things are OK, and then surprised when something comes up, and there are issues around domestic violence. And I think it is so (.) common ....(Vicky).*

In comparing these data extracts there are marked differences between their expectations regarding domestic violence. Melissa indicated that she thought domestic violence occured rarely and thus did not really expect to encounter women experiencing this problem in her everyday work. In contrast, Vicky considered it to be a frequent issue in women's lives, and one that was likely to be experienced by women she had health

visiting contact with. These differences reflect the extent to which feminist understandings about domestic violence underpin the work of these health visitors.

This is further illustrated by examining their understandings of the nature of domestic violence. For example, even though Vicky gave a high estimate, she was aware of the complexities of quantifying the issue in this way. In particular, she was "open to the possibility" of domestic violence, considering it to be an issue in women's lives rather than a rare occurrence. Vicky was also more aware of the range of abusive situations experienced by women, and did not just focus upon incidents of physical violence.

This reflects a key issue in feminist work which has challenged understandings that domestic violence only involves physical violence (Kelly 1988a; Mooney 1993). This work has focused upon the diversity of women's experiences of abuse and violence from men, making visible a range of physical, emotional, and sexual violence and abuse, as well as other types of abusive behaviours such as intimidation and economic abuse. Kelly (1988a) developed the notion of a continuum of sexual violence to include the diversity and range of women's experiences. Throughout this study there were differences between the health visitors in their awareness of the complexities of women's experiences of domestic violence. Pamela, for example, described her work with a woman who had experienced a wide range of abusive behaviour, referring to the strategies used by men to inflict injuries which were not easily seen by the outside world.

> *.... he made her a prisoner in her own home, and dictated everything she did, and he hit her around the head with a pressure cooker. But he hit her around the head on the back, so nobody could see the bruises (Pamela).*

Mental cruelty and emotional abuse were also recalled by a number of health visitors, usually those with a higher awareness of domestic violence. A word which was used often in this context was "undermining". Many of the descriptions suggested that because this was usually less overt than physical violence, health visitors themselves became involved in naming situations as domestic violence. The following data extracts illustrate the range of situations which were described.

.... And it is somebody who is at home all the time, and feels very trapped, and isn't allowed to go out to work, or get a job at all. And only has a certain amount of money to spend each week. .... And I feel that situation will get worse as well. And this woman has previously left a very good job, had very high self esteem, and it is just being slowly being eroded (Natasha).

.... (he) is.... consistently negative towards her, and won't support her in what she does. He is very sexist.... (Joe).

.... he puts her down all the time. .... And I had a long session with her about low self esteem and confidence. And it is her partner. And I am sure he just think it as a joke, he doesn't obviously see how badly effected she is by it. .... openly tell her that she is thick. .... And I think that there is a lot of that, undermining, that goes on all the time (Michelle).

A few of the health visitors also understood that domestic violence involved situations where men inflicted their power over women in ways which deliberately led to their discomfort and humiliation. Both Grace and Sanji described similar incidents in which women had been forced by their male partners outside their homes during the winter often when they were unsuitably dressed or naked. Only a few health visitors reported that they were aware of women's experiences of sexual abuse.

The interview data presented here suggests that health visitors have a range of understandings regarding the extent and nature of domestic violence. A few were aware that domestic violence occurred frequently in women's lives, and consisted of a range of abusive and violent behaviours. This reflects feminist understandings about domestic violence (Kelly 1988a; McGibbon et al 1989; Mooney 1993) suggesting that these had, at least to some extent, begun to influence professional health visiting discourses. However, the majority of health visitors continued to work with understandings that domestic violence was a rare event, characterised by physical rather than other types of violence and abuse. This represents a point of difference between health visitors, as those who considered that only a few women were experiencing domestic violence often

concentrated upon physical abuse. The image of the "battered woman" permeated their descriptions, which often involved situations which were easily defined and named and probably also reasonably easy to recall. Often such incidents were recounted in detail, sometimes as "atrocity stories" (Dingwall 1977b). Even when health visitors were aware of the range of women's experiences of domestic violence, it was physical violence which dominated all their descriptions. This is illustrated in the following data extracts.

> *She lost all her teeth recently, he punched her in the face because of his drinking (Grace).*
>
> *And I remember over about nine months she had had about two or three black eyes at one time or another, and other bruises (Poppy).*
>
> *....he used to beat her black and blue, and in the street and everything (Theresa).*

This emphasis upon physical violence is confirmed by quantitative analysis of the interview data. This involved identifying "cases", defined as segments of interview data which refer to both domestic violence and health visiting work. These took the form of narratives of varying length and complexity. A total of 60 cases were identified throughout the health visitors interview data. Each "case" was analysed in order to identify the types of abuse involved. The results of this exercise are displayed in Figure 5.2. A total of 75 types of abuse are documented, because in several cases more than one type of abuse was involved. No details about the types of abuse were given for 5 cases, because it referred to women who had escaped domestic violence.

Figure 5.2: Types of Abuse in Identified Cases.

Types of Abuse.	Number of Cases.	Comments.
Physical Violence.	44	
Mental Cruelty.	24	
Sexual Abuse.	2 (+1 suspected).	Sexual abuse suspected in one case.
Other.	4	3 examples of financial abuse. 1 reference to housework abuse.
	74 (+1 suspected).	

Despite a range of abusive behaviours being described by the health visitors, physical violence is mentioned considerably more often than other types of abuse. This may be because of the visibility associated with physical violence, such that when marks or injuries are left on a woman's body the issue is more easily recognised, named and recalled. It may also be related to the horror of such abuse, for these incidents were often reported as part of a harrowing and detailed narrative. Certainly the visibility of physical abuse made it more likely that health visitors would both recognise domestic violence, and ask women about its occurrence. As Isobel said,

> *.... I suppose if it is very overt, like a woman has got a black eye, then you ask, I suppose. It will trigger it off (Isobel).*

This emphasis upon physical violence permeated throughout all the health visitors descriptions of their work. However, despite the privileging of physical violence, there were differences between health visitors concerning their overall awareness of the extent and nature of domestic violence. These differences can be illustrated by examining health visitors' practices of recognising and naming situations as abusive. The processes by which women name their experiences of male violence have been discussed by Kelly and Radford, J. (1991). However, the interview data suggests that workers are also reluctant to name situations as domestic violence. This was the case for Isobel, who initially said she had never come across any women experiencing domestic violence, but later in the interview she (re)-named a situation as domestic violence.

> *.... It is not what I would first think of as domestic violence, but it is, when I am looking back now it is emotional, you know. .... she does feel, yes, mental torture (Isobel).*

Isobel had been providing quite detailed support work with this particular woman, recognising her experience as problematic; however, she had not previously considered it to be abusive. The processes of reflecting upon her work in the context of an interview concerned with domestic violence led her to recognise and name this woman's experiences of emotional abuse.

The practices involved in "naming" domestic violence are also reflected in Tina's account of her record keeping practices in relation to domestic violence. Here she refers to her reluctance to record, and thus "name" a woman's experience of sexual violence.

> *I feel more comfortable about putting that down, if there is an actual sort of injury that I can see. Or obviously if a woman had to go to casualty or something like that. I feel comfortable to put that down. .... But then it is things like, sort of rape, this is more difficult. And I don't know whether people want that stuff writing down in the health visitor records. Whereas if they are going around with a black eye, well you can't hide that can you? (Tina).*

The reluctance expressed by Tina to record a woman's experience of sexual abuse reflects her personal and professional understandings about responding to this issue; this is compared to her responses to physical violence. It suggests that because domestic violence is more commonly encountered in terms of physical rather than sexual violence, there is a familiarity with this issue. Indeed, the issue of visibility of physical injuries may itself be the trigger making her aware of domestic violence. Thus, Tina may simply be accounting for the ways in which she feels more comfortable naming, and thus recording, a woman's experiences of physical violence. However, her comments suggest an uncertainty about the issue of responding to sexual violence, which is particularly marked in the context of record keeping. This may reflect a prevailing discourse which simultaneously minimises a woman's experience of rape, while engaging in naming other situations which are primarily related to physical violence. It also suggests that the reluctance of women themselves to name and disclose their experiences of rape may be magnified where this involves inscriptions in a public record, such as those held by health visitors. This reflects one of the many complexities apparent between mothers and health visitors concerning their knowledge's and practices of domestic violence. A similar situation is described by Mary, who, in the following data extract, expresses her reluctance to record, and thus name, mental cruelty.

.... I would find that one particularly difficult to detect. .... I think sometimes you think it may be there, or you sometimes wonder quite what is going on. You know, when you get the vibes, or women saying certain things. But, I don't think I could ever say, heart on hand, that I (.) would ever write it in someone's notes, do you know what I mean. I would find that, quite, well very difficult (Mary).

This reluctance to name certain situations is suggestive of the practices of minimisation (Kelly and Radford, J. 1991). It appears that dominant discourses which limit understandings of domestic violence as being physical, visible and a rare event have informed the knowledge base of many health visitors. This is translated into practice in ways which make health visitors reluctant to recognise or name other situations, particularly emotional or sexual abuse, as constituting domestic violence. However, in the context of health visiting work this may represent a partial analysis. In particular, the practices of record keeping reflect wider professional discourses, but also point to some of the complexities inherent in the relationships between mothers and health visitors, especially in the context of domestic violence.

Feminist work has made visible the experience of domestic violence across the social divisions of class, race, and age, challenging assumptions that it is only a problem for particular women (Hanmer and Saunders 1983; Mama 1989a; Mooney 1993; Cosgrove and McLeod 1995; Rai and Thiara 1997). Despite this feminist work, the dominant discourse suggests that domestic violence is more likely to be an issue for certain groups of women, such as working class women. Thus many of the health visitors who participated in the study, failed to recognise when domestic violence occurred to middle class women. This is illustrated by Mary, who worked in a predominantly middle class area, and did not expect domestic violence to be happening in middle class homes.

.... this is a professional area. Nearly all my clientele tend to be professional people, both male and female. And, they nearly all work. So in this particular caseload I haven't come across domestic violence very much (Mary).

The failure of health visitors to recognise the experiences of domestic violence amongst middle class women is also illustrated in the following data extracts.

> *I have worked in lots of different areas. But it has obviously come to light more, and I think again for lots of different reasons, in more deprived areas. But I have worked in quite middle class areas and there have certainly been relationship problems there, but they take longer, if ever, to come to the surface (Michelle).*

> *.... I was working in [local suburb], which is a very nice area. Yes, I am sure that domestic violence happens everywhere, but it doesn't seem so obvious in nicer areas (Chris).*

> *.... it is not obvious at all. And I mean, we get marital break up, but. And when I go and visit families around here, it seems that everything is very nice, on the surface, yes. I mean, it is all lace curtains and it is what is behind it, isn't it? ..... I should think if there is any child abuse or sexual abuse around here, it is just so well hidden. We don't pick it up, we don't pick it up unless it is so obvious (Beverley).*

The greater visibility of domestic violence amongst working class and poorer women may reflect the increased surveillance of these communities by agencies such as health visiting (Abbott and Sapsford 1990; Symonds 1991). It may also reflect the greater access to resources enjoyed by middle class women which means they are more able to conceal their experiences of domestic violence. Despite an awareness that domestic violence occurred across the boundaries of race and ethnicity, many health visitors expressed a reluctance to intervene, particularly in relation to Asian women.

> *.... you don't know about domestic violence until it is brought to you. Health visitors don't actually pick up on domestic violence. And the families I used to work with in [inner city area], they are mainly Asian families, and they don't talk about it do they? (Isobel).*

.... it does exist within the Asian population which I find a whole lot more difficult to deal with. ..... that is my area of work now, I have got a small percent on my caseload that are non-English speaking women (Tina).

.... being forced to have sex without consent. .... I sometimes wonder in the Asian households, whether that goes on. I have got a lady who has just had her sixth child. Before, she wanted to be sterilised, but her husband wouldn't let her. .... I think in that household, I think she is forced to, I am not saying she is, I am not sure she is forced to have sex, but to have children. She wants to get sterilised (Beverley).

The cultural assumptions underpinning these statements, together with a lack of practical resources such as interpreting services, reflects previous work which has drawn attention to the extra difficulties facing Black women experiencing domestic violence (Guru 1986; Mama 1989a; Southall Black Sisters 1993; Bhatti-Sinclair 1994; Bowstead et al 1995; Rai and Thiara 1997).

An analysis of the health visitors interview data suggests little attention is paid within their professional discourses concerning the issue of diversity. In particular, the health visitors appeared to have little awareness of the extra difficulties facing particular groups of women, such as disabled or lesbian women, who may be experiencing domestic violence (Kelly 1991; 1996; Lie and Gentlewarrier 1991; Burstow 1992; Cosgrove and McLeod 1995; McCarthy 1996; Hendey and Pascall 1998). Despite including a specific question addressing diversity, there were no references in the data pointing to health visitors awareness of disability issues in the context of domestic violence. Only one health visitor (Marian) raised the issue of sexuality, referring to her practice experience of providing health visiting services to a lesbian couple with a new baby. Even though she suspected a degree of abuse and violence within this relationship, she felt ill equiped to incorporate this issue into her work with these women.

Emerging discourses about the interconnectedness between child abuse and domestic violence has suggested there is considerable overlap (Bowker et al 1988; Stark and

Flitcraft 1988; O'Hara 1994; Farmer and Owen 1995). However, there is a growing body of evidence suggesting that even when child abuse is known about, the issue of domestic violence often remains unidentified or marginalised (O'Hara 1994; Farmer and Owen 1995; Humphreys 1997). All the health visitors who participated in this study were asked to think about their child protection work as an avenue to identify situations where there was domestic violence. It is significant that only a few health visitors were able to conceptualise these links. This was the case for Chris, who made the following comments.

> *.... There is only one family that I am visiting every week because of child protection issues, and it wouldn't surprise me if there were issues going on of domestic violence there. But I am not aware of any. They haven't told me, there haven't been any signs that I feel that I could ask any questions about. But if the social worker rang me tomorrow to say that this was happening, I would probably say yes, yes, I am not surprised (Chris).*

Other health visitors found it more difficult to understand any links between their known child protection cases and possible domestic violence. This is illustrated in the following data extracts from Emma and Kay.

> *I can't off the top of my head think of an example actually. It is difficult to think. There hasn't been actually, no, no. Not that I can recall at the moment, no..... No, no. There hasn't been one (Emma).*

> *Nothing springs to mind. ..... It is not something that I have thought about, if I think about it. Unless it is. If it is there it has been covert. Nothing there what has been open, you know, where in the case conference they say, this woman experiences violence (Kay).*

What is notable is the failure to systematically check situations where there are known child protection concerns to ensure that women are not being abused.

An important aspect of feminist work has been concerned with challenging the notion that domestic violence is a private concern, pointing to its' public and criminal nature (Radford, J. 1987; Radford, J. and Stanko 1996). There was very little consideration within the health visitors' discourse regarding the criminal nature of domestic violence. A few health visitors were aware that women experiencing domestic violence often required access to legal services, but their discussions remained focused upon individual solutions, and did not engage with discourses about crime. There was also little overt consideration of the public or private nature of domestic violence. However, in tracing their discourses about domestic violence, the hidden and private nature of domestic violence within health visiting work was apparent. Thus, health visitors participating in the research pointed to the lack of knowledge and discussion about domestic violence within the professional arena. This was contrasted to their everyday practice where even though domestic violence was an issue in their work, it was not one they were used to talking about, either in the context of research interviews or through formal or informal professional support. The theoretical perspectives underpinning this work suggest that such "private" notions of domestic violence within health visiting discourses can be considered as "subjugated knowledges" (Foucault 1980b, p. 81-82; Cain 1993). This can be compared to accounts of feminist research practices which have made visible private aspects of women's lives (Oakley 1976; Ribbens and Edwards, R. 1998). This occured in this research project, where the processes of undertaking the field work itself served to "break the silence" about domestic violence, uncovering issues within professional practice which had previously been hidden or not spoken about.

Summary.

A number of key themes arising from feminist discourses about domestic violence have been used as conceptual and analytical tools in order to present and discuss the health visitors interview data about their awareness of domestic violence. These have focused upon the extent and nature of domestic violence, addressing issues of diversity, and the

strategies through which women, and workers, fail to name and recognise situations as domestic violence. Analysis of these themes enables an understanding of the differences amongst health visitors, and reflects the extent to which professional practice is informed by both non-feminist and feminist discourses about domestic violence. The preceding analysis has suggested that, at least to some extent, feminist discourses have informed health visiting practices. However, the continued dominance of a non-feminist discourse is noted. The analysis continues by using feminist notions of "silence" as an analytical tool to further examine health visiting practices.

THE SILENCE.

The notion of "breaking the silence" has been an important aspect of feminist activity regarding domestic violence, describing a set of practices which are concerned to ensure that male violence is exposed and challenged. There are many examples which illustrate this, including work which has established the extent and nature of domestic violence (Dobash and Dobash 1979; Hanmer and Maynard 1987; Kelly 1988a; Mama 1989a; McGibbon et al 1989; Mooney 1993; Fawcett et al 1996; Hester et al 1996; Stanko et al 1998) and its impact upon child welfare (Mullender and Morley 1994; Hester and Radford, L. 1996). All these attempts to "break the silence" need to be understood in the context of prevailing patriarchal discourses about domestic violence, which have ensured that women's experiences of male violence are unamed and remain hidden (Kelly and Radford, J. 1991).

A review of the professional literature indicates there is a silence within the knowledge base of health visitors concerning domestic violence. A few references were located (Orr 1986; Chalmers 1992; McClelland 1995; Frost 1997), but taken together they suggest that domestic violence has not received a great deal of professional attention. It is in this context, therefore, that the notion of "silence" is used as an analytical tool to further examine health visiting practices regarding domestic violence. This was identified by a number of health visitors.

....The very silence is almost as if it doesn't exist, and if you do come across it then just work it out yourself (Kay).

I suppose it was because you have had no training as a health visitor about domestic violence, you don't know about domestic violence until it is brought to you (Isobel).

The omission of training about domestic violence emerged as a key theme. Only 4 (16.7 per cent) health visitors who participated had attended any domestic violence awareness training. There were 5 (21 per cent) health visitors who were able to recall the topic of domestic violence being included in their health visitor course, but they all thought it had been inadequately addressed. This is illustrated by the comments of Beverley in the following data extract.

.... Perhaps our training needs to be looked at in more depth, to be more relevant. I just don't think we pick it up, because I don't think we ask the right sort of questions, and I don't think we pick up the signs for it. I mean, unless you see something that is quite obvious, then we don't ask, do we. Then when it does occur, what do we do? (Beverley).

This omission of domestic violence from health visiting training programmes has an important impact upon practice. This can be further illustrated by the narrative of Tina. During the course of the interview, Tina acknowledged that domestic violence was a real issue occurring in women's lives, and one which occasionally had implications for her health visiting work. When discussing her training experiences, however, Tina suggested that her work was undertaken in a discursive space where the issue of domestic violence had not been on the professional agenda.

.... it had never really struck me until you said about training, that I hadn't had anything since I trained. Not anything specifically about domestic violence. It gets mentioned as a sideline, it gets mentioned in child protection. But I have never had a study day just on domestic violence. And I don't think I have even seen

anything advertised. .... I mean every so often they send stuff out saying what requests have you got for training, but I never thought to put domestic violence. Yet it is something that I don't know that much about (Tina).

The notion of discourse is central to Foucault's ideas about power/knowledge, and about disciplinary power (Foucault 1979; 1984; 1988; 1990). Discourses are a set of knowledges and practices which have powerful effects upon those involved. This type of analysis can be applied to the situation described by Tina. Her work had been informed by a set of discourses about health visiting work and women's lives which had not included understandings about domestic violence. This had such powerful effects that it inhibited her from a realisation that she was herself located within a silent discursive space. The notion of "silence" has been a corner-stone of feminist work; it also resonates with the ideas of Foucault regarding discourse and power. While Foucault pointed to the powerful effects of discourse in constituting power/knowledge, he also acknowledged that this could be productive of silence.

> "Silence .... is less the absolute limit of discourse, the other side from which it is separated by a strict boundary, than an element that functions alongside things said, with them and in relation to them within overall strategies" (Foucault 1984, p.27, quoted in Bell 1993, p. 79).

There were many examples in the interview data of health visitors describing how their knowledge base, which was silent about domestic violence, ensured that they also remained silent about this issue.

> *.... I go out and do lots of visits, and truthfully it doesn't even cross my mind to think about it. And I just don't know why it doesn't. Unless it is so obvious that it hits me in the face, I never ever think about it, truthfully (Beverley).*

> *I would have to be very comfortable with the relationship I had with the woman before I would think of bringing the issue up. I have done it once or twice, but it does take a lot of courage. I find it a difficult issue to broach. I think on the*

occasions I have raised it, I have been right, and it is (.), and it has been OK. But, if I was wrong. I keep thinking, if I was wrong, and something else is happening, and I am bringing up this subject, they would wonder what on earth is going on in my head to make me think about it (Irene).

An alternative perspective was offered by Maeve who described how she had broken the silence in her own practice regarding the issue of domestic violence. This led her to a greater consideration of domestic violence in her work with women.

.... I am different now, but I know I, you know, before I was involved, before I had had exposure, I was much. I didn't confront people about bruising, about things that I suspected really. .... And I do that much more now, because I think it gives women permission then, and I think it gives them an opportunity. And you might be wrong. But if you are wrong they will say, "oh no, you know". But if you are right it gives them an opportunity. Or they might not even tell you the first time, they might say, "oh no, you are wrong". But at least some of them might have some indication that, you know, we are willing to hear it, if they want to say it (Maeve).

The differing perspectives about recognising and addressing the issue of domestic violence within health visiting work reflect the ways in which these practices are underpinned by a particular knowledge base. As the earlier quotes suggested, a knowledge base which is largely silent about the issue of domestic violence, produces "silent" health visitors; this in turn impacts upon women, who themselves remain silent.

This analysis has drawn upon the ideas of Foucault (1979; 1984; 1990) who points to the ways that subjectivities are discursively produced. In the context of the current study, an analysis which takes account of the subjectivities of mothers in relation to prevailing discourses about male violence and motherhood, offers a partial explanation for the continued silence between mothers and health visitors regarding domestic violence.

For many of those participating in this study, their health visiting practice was informed by the dominant non-feminist discourse about male violence, which is marked by silence and minimisation. Moreover, as understandings about domestic violence are not part of the normalised discourses of motherhood which informs health visiting work (Stark and Flitcraft 1988; Abbott and Sapsford 1990; Smart 1996), this ensures that health visitors do not recognise or speak about domestic violence as part of their routine contact with mothers. This non-recognition and silence contributes further to the prevailing discourses about domestic violence, ensuring that mothers maintain their silence (Kelly and Radford, J. 1991).

Summary.

The notion of "silence" has provided an analytical tool to examine the practices through which health visitors recognise women's experiences of domestic violence. This has drawn attention to the knowledge base underpinning practice, which has largely excluded domestic violence. This silence is reflected in the health visitors descriptions of their work, which is marked by a lack of training and awareness about domestic violence. This not only impacts upon health visiting work, it also discursively produces silent mothers, thus perpetuating prevailing non-feminist discourses which have ensured that women's experiences of male violence are minimised and silenced (Kelly and Radford, J. 1991). Using "silence" as an analytical tool enables further consideration of the extent to which feminist discourses have influenced professional practices. The notion of "silence" also highlights some of the broader omissions within the health visiting discourse. In particular the lack of understanding and acknowledgement of the issue of difference, arising from race, class, (dis)-ability, sexuality and age was particularly marked.

"GETTING TO KNOW": THE MICRO-PRACTICES OF HEALTH VISITING.

The extent to which health visiting work is informed by feminist discourses about domestic violence, is inter-linked with the considerable differences in their overall practices. This is demonstrated in the preceding analysis which has illustrated some of the differences between health visitors concerning their awareness of the nature and extent of domestic violence. The discussion now turns to examine the micro-practices through which health visitors "get to know" (May 1992a; 1992b) about domestic violence. Foucault's notions of pastoral power and the clinical gaze (Foucault 1976; 1979; 1984; 1988; 1990) are used as analytical tools for examining these micro-practices, in order to illustrate the exercise of disciplinary power between mothers and health visitors.

This analysis which understands health visiting in terms of the social regulation of mothers draws attention to the practices through which the relationship between professional and client is developed and maintained. This is an important aspect of their work (Chalmers 1991; De La Cuesta 1994). However, the notion of "health visitor as mother's friend" (Davies 1988) hallmarks a particular gendered form of regulation, representative of "tutelage" (Donzelot 1979; Dingwall and Eekalaar 1988; Dingwall and Robinson, K. 1993). Developing relationships with mothers enables health visitors to monitor, on behalf of the liberal state, the welfare of children in families. The gendered and normalised nature of these practices, which focuses upon mothers as the mediators for young children, has been extensively critiqued (Orr 1986; Mayall and Foster 1989; Abbott and Sapsford 1990; Mayall 1993; Edwards, J. 1998).

All the health visitors who participated in this study had contact with women because they were mothers of young children. Despite differences between health visitors regarding the extent to which they engaged in either child-centred or woman-centred practice, it was the presence of young children which underpinned the health visitor-mother relationship. In order to monitor the welfare of children, health visitors need to establish some knowledge and understanding about the families they are visiting; such surveillance is achieved through their contact with mothers (Bloor and McIntosh 1990).

In their search for information, a number of techniques are used. These include asking questions, engaging in directive conversation, talking and listening. These activities are all part of the exercise of disciplinary power with which "psy" professions engage (Rose 1985; Bloor and McIntosh 1990; May 1992a; 1992b; Porter 1996a). This increasing interest and engagement with the personal spaces of client's lives has been described by Silverman (1987) as representing a "discourse of the social" (Silverman 1987, p. 191). His work has focused upon these practices in the context of encounters between doctors and their patients (Silverman 1987), but the idea has been applied to other sociological analyses of health care practice (Fisher 1991). This engagement with the "discourse of the social" is reflected in the practices of the health visitors who participated in this study. There are a number of examples in the interview data whereby health visitors describe using these techniques in order to find out information about the social circumstances, relationships and welfare of their clients. This is illustrated, for example, in the following data extract in which Sanji explains how she would try to find out about the nature of adult relationships in the family.

> *It obviously depended on how well I knew the family, and how confident they felt in talking to me about their relationships. But, it always, sort of, is on the agenda with health visiting. You know, when you do a new birth visit you ask about the other members of the household. And as your relationship develops with the client you would ask whether the partner helps her at times, or if there is the possibility of her having time out, away from the baby, so she has some time to look after her own feelings. .... trying to ascertain whether there is any significant support there, or not. And if there wasn't the support, then trying to find out whether, you know, as well as the lack of support, was their pressure from the partner. That is how I would work it really (Sanji).*

This extract demonstrates the extent to which health visitors engage in a "discourse of the social" (Silverman 1987, p. 191), often penetrating into the private spaces of women's lives. This is a key practice in relation to regulation. Understanding health visiting in these terms sheds light upon how they are able to find out about domestic violence. The

techniques used are non-coercive, relying upon the establishment of social relationships with mothers, and the practices of "talking and listening" (Donzelot 1979; Davies 1988; Dingwall and Eekalaar 1988; Dingwall and Robinson, K. 1993). This is further illustrated in the following data extract from the interview with Grace.

> *.... they think we are .... there just to hear and listen and be talked to, which is fine..... And often it is not to ask for any help or advice, it is purely just to talk to. But in doing so they will touch on subjects, about, you know the absolute sort of, the abuse that goes on, and it can be terrible, the sexual abuse, the psychological abuse, and they feel able to talk about it. .... And you realise that they have just (.) talked to you like you are in a confessional box or something. And (.) I think, well I don't know, but yes given the opportunity of anybody else, they may have talked to them. So you are not special, you are just (.) somebody they have got access to, to talk to (Grace).*

In his later work Foucault suggested that one of the disciplinary techniques in modern societies associated with the "psy" professions was that of pastoral power (Foucault 1984; 1988). This refers to the ways in which the professions have deployed the human sciences in order to interpret and regulate the population; this is undertaken more by means of a "confession" than through overt discipline. This notion of pastoral power appears to apply to the above data extract, in which Grace described the processes through which women "become known" to her. The concept of pastoral power has been used by May (1992a; 1992b) for understanding the processes by which clinical nurses "get to know" their patients.

> "Pastoral power, then, finds its expression in a therapeutic gaze directed at the production of truth about the subject. Through being "known" and through "talking and listening", the patient is encouraged to give voice to her private and authentic concerns - and so to produce and expose her own truth" (May 1992b, p. 597).

The notion of pastoral power enables an understanding of the practices involved in "getting to know". This is much more than simply finding out, for in describing pastoral

power, Foucault refers to discourses and the production of subjectivities. It is a process that involves "knowing and becoming known", such as mothers become the subject and object of the health visiting gaze. The following extracts from interviews with Jenny and Rebecca illustrate how health visitors "get to know" about domestic violence. Using the notion of pastoral power as an analytical tool, the regulatory role of health visiting work is revealed.

> *.... very often we are the only sort of person going into a house outside the family. And also therefore you see what happens, and over a period of time, the person who is receiving the violence will, hopefully, gain confidence in you, to be able to talk about it. .... But on occasions where I have suspected it really, I have just kept going back until something became visible, or there is an appropriate comment that you can bring something up (Jenny).*

> *When you are working with a family you don't go and sit down and they say "Oh my husband is beating me". You know you have to work in very subtle ways, and often for a very long time. I think the model of working has got to be one of actually getting to know the families very well, because nobody is going to tell anybody, or very rarely, on the first occasion (Rebecca).*

Pastoral power is a useful analytical tool for understanding the micro-practices through which health visitors "get to know" about domestic violence. However, the notion of "power/knowledge" (Foucault 1979; 1980a; 1980b; 1984) demonstrates that power is necessarily intertwined with knowledge, drawing attention to the notion of a "clinical gaze" (Foucault 1976). This is, as Nettleton (1992) has explained ".... an effect of what is knowable rather than an effect of a seeing subject" (Nettleton 1992, p. 109-110). Analysis of health visitors' descriptions of their work illustrates how "what is knowable" informs and constitutes the gaze; this enables health visitors to became aware of women's experiences of male violence. In the following data extract, Marian recalls her contact with a woman she had been concerned for.

..... she seemed quite, you know, over anxious really .... She didn't appear to have much support. She did seem very anxious. She did seem quite fearful of talking about her partner in conversation. It was just. There was something about her whole demeanour really, that suggested, perhaps not violence, but certainly an emotional kind of abuse, you know. There was something quite cowered about it. And she wasn't, I mean she had very poor self esteem, which isn't that unusual. But, you know, there was just something about that whole combination. And she, when I asked her if she ever went out, what kind of social things she did, it was obvious that he didn't allow her to do this, that, and the other. It was that kind of conversation, you know "he won't let me, or, he wouldn't like it, he is very possessive". .... So yes, it was a combination. She never had any obvious injury. .... And neither did the children (Marian).

Even though Marian had been open to the possibility that this woman was experiencing domestic violence, she recalled that the woman herself did not tell her for quite a while. There are a number of examples in the data that, not only describe feeling that "something is wrong" in women's lives, but which are informed by a knowledge base which allows the possibility of domestic violence to become known to the health visitor. In such situations, it is the health visiting gaze that produces the awareness that these problems could be due to domestic violence. For example, in the following data extract Vicky describes her lack of surprise about what she was being told.

... I sit there and she slowly brought it out, and I think it is early days yet for doing anything else about it. It's me just sitting there on the settee, listening to what she wants to do. .... And from the beginning, I thought this is really frightening. So I wasn't surprised, I knew what she was going to say (Vicky).

The gaze is an effect of the discourse because "what is knowable", both inform and constitute the gaze. While for Vicky the issue of domestic violence was "knowable", this was not the case for some other health visitors. For example, Joe explained that the

knowledge base which underpinned his health visiting work did not incorporate understandings of domestic violence. This meant that he missed situations.

> *.... I tend to be very open, if I see something I will try to address it. I think one problem for me is that I don't always see what I should be seeing. Or somebody says something, and I don't always realise. .... With particular regard to domestic violence, I think I have probably seen it but I have not recognised it until it has hit me in the face. .... I have not been particularly aware or conscious of violence between adults in the family (Joe).*

The issue of domestic violence was not part of the knowledge base underpinning Joe's work. As it was not "knowable", it was not produced by the health visiting gaze. Thus, while it is likely that in his everyday work Joe had contact with women experiencing domestic violence, his lack of knowledge about this issue was associated with a failure to recognise these situations. A similar lack of recognition is also reflected in Beverley's description of her work with a woman who had been experiencing escalating violence and abuse from her male partner. Even though she had realised that "something was wrong", Beverley remained unaware of the domestic violence situation for quite a while, despite some fairly intensive visiting on her part.

> *I knew from the very beginning there were problems when they had this baby. .... there did seem to be these underlying, sort of, marital problems. And she was post-nataly depressed. .... there were a lot of underlying issues, and financial things as well. And I was doing quite a lot of visiting just supporting her, and helping her..... I knew that she wasn't terribly happy with him. .... It never occurred to me at the time that there was marital violence, and perhaps I didn't pick up on the signs. I mean, she was never seen with any bruises, ... after the baby was born I thought it was just post-natal depression..... I thought that was the reason. It never occurred to me at that time that there was any violence there (Beverley).*

In explaining how she had initially missed domestic violence, Beverley reveals how her work was constituted by the dominant discourses of motherhood and of health visiting.

Her gaze had led her to inaccurate conclusions about the woman's situation. This example illustrates how the issue of postnatal depression, and not domestic violence, is part of the health visiting discourse about motherhood (Nicolson 1990; Ussher 1991; Busfield 1996) This again demonstrates how health visiting work is constituted upon a set of practices concerned with the social regulation of mothers (Abbott and Sapsford 1990; Smart 1992).

The above analysis has focused upon the techniques used by health visitors in their surveillance and monitoring of families. Using the notions of pastoral power and the health visiting "gaze" as analytical tools, it has examined the micro-practices through which health visitors "get to know" about domestic violence. However, health visiting is part of a wider net of social regulation of mothers, which involves other "psy" professions as well as the techniques of self-discipline (Foucault 1988). The contribution of other agencies and members of the community towards the social regulation of mothers has been described by Bloor and McIntosh (1990) as surveillance by proxy. In the current study, health visitors described a number of situations in which they become aware that women were experiencing domestic violence as a result of surveillance by proxy. This usually involved being given information by representatives of another agency, or by members of the woman's family or community. This is illustrated in the following data extracts.

> *.... An anonymous phone call from a relative of the woman who has been experiencing violence..... This particular person is a relative. .... It was just like, you know, ringing up, and you must never say that anybody has rang and I just want you to keep an eye out, or pop in.... (Melissa).*

> *.... I have other women tell me, of women in the community that experience it, when women don't necessarily tell me themselves (Daisy)*

Health visitors were also informed that mothers were experiencing domestic violence through a number of other avenues. These included statutory agencies such as the child's nursery, practice nurses, the police, and social services. These examples support the

concept of surveillance by proxy (Bloor and McIntosh 1990), as well as further reinforcing the argument that health visiting is concerned with the social regulation of mothers.

Bloor and McIntosh (1990) used the term surveillance by self report, to describe the techniques whereby mothers are invited to furnish health visitors with the necessary information to enable them to carry out their monitoring of children in families. In the current study, the health visitors described very few situations where women directly approached them for help about domestic violence. This probably reflects the numerous difficulties faced by women experiencing domestic violence (Dobash and Dobash 1979; Hanmer and Maynard 1987; Kelly 1988a; Hester et al 1996), and these understandings made visible by feminists are important to the overall analysis developed here.

Summary.

This section has examined the micro-practices through which health visitors "get to know" about domestic violence, using the notions of "pastoral power" and the "gaze" as analytical tools. These ideas have been developed within the overall analytical framework which understands health visiting as the social regulation of mothers. This focuses attention upon the exercise of disciplinary power between mothers and health visitors (Foucault 1979; Bloor and McIntosh 1990). The practices of "getting to know" about domestic violence are intertwined with the discourses which inform the professional knowledge base of practitioners.

The analysis has demonstrated that health visitors "get to know" about domestic violence because their work is constituted upon a set of practices concerned with the surveillance and monitoring of children in families. However, paradoxically this also constrains the ability of health visitors to find out about domestic violence. This is because the exercise of power between mothers and health visitors enables concealment, whilst an inadequate knowledge base about male violence is associated with health visitors failure to recognise domestic violence.

CONCLUSION.

Health visiting practices are shaped by a number of competing discourses. This may include feminist discourses about motherhood and male violence, but these compete with malestream understandings which marginalise women's experiences of domestic violence. While these competing discourses about domestic violence, and motherhood, impact upon the individual practice of health visitors, they also impact upon women, reinforcing their silence. This examination of health visitors understandings and awareness of the domestic violence experienced by mothers with whom they have professional contact, has traced the extent to which their work is informed by feminist discourses. This provides a framework for understanding the differences between health visitors. In particular, using a number of conceptual themes from feminist work as analytical tools has provided a means for examining the extent to which feminist discourses about domestic violence have leaked into the professional knowledge base of health visiting.

Feminist understandings about domestic violence provide a framework for examining health visiting practices regarding "getting to know" about domestic violence. However, viewing these practices through the lens of regulation enables further analysis. This focuses attention upon the exercise of power relations between mothers and health visitors, illustrating how these operate in everyday practice. In particular it argues that it is the nature of health visiting work, concerned with the social regulation of mothers, which frames the extent of their overall awareness of domestic violence. This occurs because of the techniques involved in surveillance and regulation (Donzelot 1979; Bloor and McIntosh 1990) which enable women's experiences of domestic violence to either become known or remain concealed to health visitors. By focusing upon power and discourse, feminist poststructuralism (Foucault 1979; Weedon 1997) has provided an analytical framework for examining the practices through which health visitors "get to know" about domestic violence. This analysis has focused upon commonality and diversity within these practices, opening up further insights concerning these practices of "getting to know" about domestic violence.

CHAPTER 6.

HELP SEEKING IN THE CONTEXT OF SOCIAL REGULATION.

INTRODUCTION.

Women who are experiencing domestic violence face a number of difficulties seeking help. Whilst this may include a reluctance to name their situations as abusive (Kelly and Radford, J. 1991), they also face practical concerns such as fears for their own safety and lack of knowledge regarding sources of support and protection (Binney et al 1981; Dobash et al 1985; Pahl 1985). In addition, mothers are fearful that reporting their own experiences of male violence to statutory agencies may lead to loss of custody of their children (Stark and Flitcraft 1988; Abrahams 1994; Kelly 1994). Even though some women seeking help may obtain appropriate protection and support, many others receive negative or inappropriate responses (Dobash et al 1985).

All the mothers who participated in this study had faced difficulties in seeking help about domestic violence. These included a reluctance to talk about their situation until they were experiencing escalating abuse and violence, and a difficulty in accessing appropriate support and protection. These themes, which reflect the findings of previous studies (Binney et al 1981; Dobash et al 1985; Pahl 1985; McWilliams and McKiernan 1993), are intertwined throughout the women's accounts, and form the structure of this chapter which concentrates upon their help-seeking. Understanding that health visiting work is concerned with the social regulation of mothers enables the resultant analysis to reflect the complexity of these relationships, and to demonstrate the ways in which this impacts upon women's practices of help seeking.

The chapter commences by examining the extent to which women either disclose or conceal their experiences of domestic violence; this is followed by an examination of the

support or protection women received from health visitors, once they became aware that they were experiencing domestic violence.

DISCLOSURE OR CONCEALMENT?

Women experiencing domestic violence face a number of difficulties when seeking help. These include making decisions about where to seek help, and whom they should talk to about their situation. Previous research has found that only a minority of women approach health visitors for help. For example, only 29 per cent of the 42 women interviewed by Pahl (1982; 1985) had talked to their health visitor about their husbands violent behaviour. This can be contrasted to 23 per cent (out of 636) of the women surveyed by Binney et al (1981), and 45 per cent of the 56 women interviewed by McWilliams and McKiernan (1993) who reported they had contacted a health visitor about domestic violence. These figures suggest that women experience some constraint about approaching health visitors for help about domestic violence.

Reluctance to talk to health visitors about domestic violence emerged as a key theme in this study. This was the case for all the mothers who participated, regardless of whether they had actually made a disclosure, or remained silent about their experiences. For the six women who eventually disclosed their experiences of domestic violence to a health visitor, their reluctance to take this step meant that they delayed seeking help until their situation became extremely serious. This was the case for both Moira and Ruth who had experienced domestic violence for many years, but had kept this from their health visitors. As the following data extracts illustrate, both these women let their health visitors know about their situations because they were experiencing escalating violence and abuse. Indeed, Moira's disclosure was associated with a growing sense of desperation.

> *.... But I finally confessed. I saw her one day coming in, and I just thought "sod it, I will tell her". So I just told her. And she appeared shocked, she had had <u>no</u> idea....*

I don't know what made me do it. I had just had enough. I was getting scared, and I just opened up to her, and told her (Moira).

It wasn't until things started getting really bad that I suppose I opened up to her. There is a few times, with the domestic violence that I got hurt quite badly. And that is when I started talking to her... I actually called her up, and I was in tears, threatening suicide and all this sort of stuff (Ruth).

The situations described by Moira and Ruth were very different. However, both women reported having a good relationship with their health visitors; they were mothers of young children, and had each seen the same health visitor for a number of years. This reluctance to approach statutory agencies such as health visitors reflects the findings of previous studies which suggest that women may delay seeking help from these sources until other avenues of support have been tried, or until they are experiencing escalating and severe violence (Dobash et al 1985).

In contrast to Moira and Ruth who eventually sought help from their health visitors, six women remained silent about their situation. There were a number of different reasons for doing this. For example, Aimee did not tell anyone about her experiences of abuse and violence from her husband, because she was worried about the consequences for her own safety if he had discovered anyone else knew about the situation. Aimee had two small children, and at the time had regular contact with her health visitor and other members of the primary health care team. However, despite this regular contact, ongoing concerns about her own safety ensured she remained silent. Looking back on her situation, Aimee regrets not being able to seek support before she escaped from her husband.

Meera also described how she had remained silent about the abuse and violence she was experiencing. At the time she had a young baby and was having regular contact with her health visitor. However, as an Asian woman with a limited understanding of spoken English, Meera faced an extra difficulty regarding seeking help. In particular her lack of access to interpreting services, reflects some of the difficulties facing Black and Asian

women regarding access to appropriate services (Mama 1989a; Bhatti-Sinclair 1994; Bowstead et al 1995; Ria and Thiara 1997). In contrast, Zoe explained that she concealed her experiences of domestic violence from her health visitor because of the prevailing discourse about male violence ensured that women's experiences were minimised and silenced (Kelly and Radford, J. 1991). As she said,

> *.... when my children were babies, that was when the domestic violence was taking place. That was several years ago now, and at the time domestic violence was kept more behind closed doors, it was not spoken about (Zoe).*

Zoe has now escaped domestic violence and is bringing up her two sons who are now aged 11 years and 8 years old as a lone parent. In the past, she has experienced two extremely violent relationships, and apart from one instance when she was seen by a health visitor with a visible injury, she remained silent about her situation. In describing her practices of concealment, Zoe is acknowledging the impact of the prevailing silences about domestic violence. This suggests that because domestic violence is not openly on the health visiting agenda, it is difficult for women to begin talking about it. In effect, a silent discourse produces silent mothers. This silence is further illustrated by the absence of information leaflets and posters about domestic violence. When these are not displayed in health centres and GP surgeries, this sends out to women a very clear message that domestic violence is not on of the health visiting agenda. This point was raised by Moira who observed the lack of information about domestic violence.

> *.... there were things up in the surgery. And there might have been in clinic one or two things, but I can't remember seeing anything about violence. Everything else bar violence. .... I mean, maybe they should carry leaflets in their bags or something. They don't, you only see medical things, and everything for <u>your child</u>. I have yet to see a health visitor, you know, say look here is a leaflet (Moira).*

Similarly, Aimee observed the absence of information or leaflets about domestic violence during her contact with health visitors and other primary health care workers. This is important because, even though Aimee chose to remain silent and conceal her

experiences of domestic violence from her health visitor, this choice was undertaken in a context where the issue continued to be shrouded in silence.

The experiences of Maggie were very mixed, and reflect some of the processes whereby domestic violence led to her changing circumstances. Maggie first experienced domestic violence around the time of the birth of her son. At that time she had regular contact with a health visitor because of post-natal depression, and recalled that she found it relatively easy to talk to her about the domestic violence she was experiencing. When Maggie moved away from her violent partner, she continued to experience violence and harassment from him during child contact. At this point, Maggie was experiencing mental health problems and despite having contact with a health visitor, she did not tell her about the domestic violence. When Maggie transferred to a different General Practitioner, however, this was associated with a change of health visitor. Maggie has found this health visitor approachable and has confided in her about the domestic violence and abuse she has experienced. This demonstrates that, because women's experiences and circumstances of domestic violence are different and changing, their experiences of help-seeking from health visitors is also not fixed.

The fear of losing children acts as an important constraint upon women's practices of help-seeking (Stark and Flitcraft 1988; Abrahams 1994; Kelly 1994). This was identified as a concern by 74 per cent (out of 58 responses) of the mothers who participated in the study reported by Abrahams (1994). Pointing to the difficulties facing mothers experiencing domestic violence, Kelly (1994) made the following observation.

> "Ideologies of motherhood, women's awareness of potential punitive responses if they tell about violence, and their own ambivalence, trap women in a vicious Catch 22. Their dilemma is that they cannot protect their children unless they are themselves protected; but if they speak about the violence, they fear that their child/ren may be removed. This fear is the single most cited reason for women not contacting certain organisations (other than the police) about domestic violence, or for not telling workers about its occurrence if they are in contact already" (Kelly 1994, p. 53).

For all the women in this study, prevailing discourses about "good enough mothering" had permeated their expectations about statutory agencies, such that nearly all the mothers interviewed had been anxious about help-seeking, fearing this might be translated into a child welfare concern. This was the case for Anita who, although she had eventually spoken to her health visitor about her experiences, her initial reluctance arose from fear of losing custody of her children.

> *.... I didn't say anything in the beginning, because I thought they would get the social services involved and I would lose the kids. .... I thought my kids might have to be taken into care ....my kids were safe with me, it was just that I was so down and it was hard for me to look after them. .... I wanted help, but I didn't want help. I was frightened about what might happen, if I got help. .... I was worried that social services would get involved and take the kids from me (Anita).*

This fear of losing custody of children was echoed by Claire.

> *.... It really scares you. You have the fear of the perpetrator, and then on top of that you have the fear of statutory agencies getting involved (Claire).*

During her interview, Claire reflected upon a period of about 18 months, following the birth of her second child, when she had fairly regular contact with her health visitor. Her account describes the powerful effects of the discourse of motherhood, suggesting that the practice of concealing domestic violence from her health visitor also involved the discursive production of herself as a good mother.

> *I used to kid the health visitor. Whenever she came, the house was always spotless. I always had a stew cooking, so the house was filled with cooking smells, even if I had to get it sorted out at nine o clock in the morning. .... I always looked well, put make up on and everything. I was never, ever down in front of the health visitor. I used to always put on a good face (Claire).*

Claire also actively avoided the health visitor, because she was concerned about the implications for the custody of her children if a worker from a statutory agency such as health visiting knew about the domestic violence.

> *Sometimes, if I was really down, I would hide when she came, pretend that I wasn't in. .... I'd never let her see me with a black eye or anything like that. .... I used to hide and just not answer the door if the health visitor called. It was just too much authority. I felt very threatened about her authority, especially around children (Claire).*

Claire described a set of practices which involved concealing her experiences of domestic violence from her health visitor. These reflect the themes identified in previous work which has pointed to the dilemmas faced by mothers in their contact with child care agencies (Stark and Flitcraft 1988; Abrahams 1994; Kelly 1994). As Stark and Flitcraft (1988) have pointed out.

> "Battered women cannot fully protect their children from the assailant. To protect themselves from child services, however, they pretend they can" (Stark and Flitcraft 1988, p. 110).

Understanding health visiting in terms of social regulation enables the development of further insights about the complexity of women's practices of help-seeking. In the following data extract Paula is describing her concerns about talking to health visitors about the domestic violence she was experiencing. Paula had recently had her first baby, and probably was experiencing regulation as a mother for the first time.

> *.... Though they are calling on you, and I think they are, I know they are there to help. But they are like an authority figure really. It is hard when you are talking to a health visitor to know what is confidential. You know, like what you say. There might be repercussions about what you say later. .... when I first spoke to [name of health visitor], and I told her everything about what had happened. It wasn't until I sat down and thought about what I had said. And then I thought. [Name of*

son] had only just been born then, and he had never been touched by him. But you hear so many stories of children, and social workers. And I thought, well it is not just me and [name of male partner] now. I am dealing with health visitors. And it is just. And I didn't really know what to think. I mean you want to be open, and get help. But sometimes you don't want to get help, because you don't know what is going to happen (Paula).

These practices of disclosure or concealment, while reflecting the findings of previous studies, also represent the exercise of women's own agency regarding help-seeking. There were some examples in the data, however, which demonstrated that health visitors "got to know" about domestic violence through processes which do not involve women directly exercising their agency. This issue has not been identified in previous studies.

One of the ways in which health visitors have contact with mothers is through home visiting, which as Dingwall and Robinson, K. (1993) have pointed out is a key site for undertaking the practices of social regulation. It is also a key site for health visitors "getting to know" about domestic violence. This was the case for both Moira and Ruth who chose to disclose about their experiences during a home visit. Home visiting also provided the site at which health visitors found out about Anita's and Madina's experiences of domestic violence. As the following data extracts illustrate, both Anita and Madina were visited at home by their health visitors at a time when they were clearly distressed, or physically harmed as a result of the violence.

I was right down and everything. I was crying all the time. I was having continued harassment from him, and I was really scared. .... Looking back, I was very low, I felt suicidal (Anita).

.... I opened the door, and had on a night shirt. I was unable to move my arms, because of heavy bruising. And the health visitor asked me what had happened and how I had got these bruises (Madina).

Both Anita and Madina suggested that it was the nature of their contact with health visitors, occurring in the private spaces of their homes, which led them to disclose about their experiences of domestic violence. Anita had regular contact with her health visitor prior to and following the death of a young baby. This monitoring and support had continued when she had another child, who was fifteen months old at the time of our interview. Despite such regular contact, Anita had concealed her experiences of abuse which had been ongoing for several years from her health visitor. This was challenged through having contact with a health visitor at a time when she was visibly distressed. Despite these circumstances, Anita remained reluctant to talk about her situation, and recalled that it took her some time before she felt confident enough to take this step. Similarly, Madina had previously concealed her experiences of domestic violence from her health visitor. This was despite having a good relationship with her, and frequent contact through her three young children. However, it was because her health visitor saw her injuries and asked about how they had been caused that provided the cue for Madina to disclose her experiences.

After initially concealing their situations, both Anita and Madina eventually talked to their health visitor about the domestic violence they were experiencing. It is significant that for both women this occurred at a time when they were experiencing escalating violence and abuse which was difficult for them to conceal. These practices of concealment and then later disclosure, can be partially understood as responses to the social regulation role of health visitors.

Other women considered that health visitors got to know they were experiencing domestic violence as a direct result of their practices of social regulation. This was the case for Paula, who had experienced abuse during her pregnancy. At one point she went to a women's refuge, and after she had returned home to her violent partner, her sister rang her health visitor to tell her about the violence. As a result, Paula was visited by this health visitor on a number of occasions, both before and after her baby was born. This is an example of surveillance by proxy (Bloor and McIntosh 1990), arising directly from a concern with the welfare of children in families. This also describes the experiences of

Valerie and Angela., as both these women reported their health visitors had "got to know" about the domestic violence through social services involvement. Angela found it difficult to distinguish between the health visiting and social work input, suggesting that she felt unsupported by both agencies due to their involvement in statutory child protection work. In contrast, Valerie who had four young children reported that despite feeling comfortable discussing domestic violence with her health visitor, she did not offer her any practical support.

This analysis of the experiences of Paula, Angela and Valerie provides further evidence to support the assertion of Bloor and McIntosh (1990) that health visiting work incorporates surveillance by proxy. In these situations it involves health visitors getting to know about domestic violence as a result of receiving information from relatives or other statutory agencies. However, understanding health visiting as the social regulation of mothers, involves acknowledging the "double-edged sword" such regulation represents (Foucault 1979; Nettleton 1992). Thus, the surveillance by proxy experienced by Paula, Angela and Valerie, may also represent situations in which health visitors provide care and support.

Analysing the practices of help seeking of these women suggests that health visitors often got to know about domestic violence because their work is constituted in terms of social regulation. This occurred in different circumstances, from the opportunistic contact offered by home visiting, to a formalised role in inter-agency child protection work. However, all these situations represent an aspect of regulation. This has not been identified in previous research about women's help-seeking (Binney et al 1981; Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993). Three of the women who remained silent about domestic violence reported that they thought that their health visitor knew "something was wrong"; this finding has also not been identified in previous research. Barbara, Alex and Yasmin each described a range of signs and symptoms suggestive of abuse or violence, such as physical injuries, depression, lack of confidence, and frequently leaving the marital home. In all these situations the health visitor failed to pick up on these clues, suggesting that domestic violence was not part of the professional discourse informing their practice.

.... yes, I think they knew about the situation..... I think because I had left the house on a few occasions. I went to my mothers house, and they came to visit me there as well. There were a few different ones. I don't think any of them ever talked to me about it. But they just knew about the situation. .... they knew that something was wrong. I was never asked about it, although I am sure they knew. (Barbara).

I think the health visitors knew something "wasn't right", that "something funny is going off". But they never indicated that they thought this may be anything to do with domestic violence. .... They kept talking about postnatal depression. .... I was never asked by the health visitors about domestic violence, or even anything about the relationship. I think if they had brought it into the conversation, even once, I would have told them about the domestic violence. I remember waiting to be asked, thinking please ask me. .... I was crying out for help. But they never asked, ... and I never told them (Alex).

.... The health visitor used to come home for the children, she used to weigh the children and ask me questions about how I am doing. I didn't tell her about the problems I had. You know sometimes they are very private things. .... But I am just thinking they could have asked, you know about the bruises I had, the state of me. .... one thing I am clear about is that they knew that something was wrong, they knew that something was wrong. It was so clear if you see something .... the bruises, or how I was treated. You know if you are frightened .... I would never feel confident.... And I am thinking, you know health visitors should pick that up, you know how a woman looks, how the child looks (Yasmin).

The failure of health visitors to recognise, or ignore, these women's experiences of domestic violence, suggests that even though their work is mediated through mothers, it remains primarily concerned with children and child care. It also reflects the prevailing professional discourses. While these exclude feminist understandings about domestic violence, they do include particular constructions of motherhood, which, as Abbott and

Sapsford (1990) have suggested constitute a eurocentric, normalised and middle class view. This is illustrated by the experiences of Alex, who suggested that her health visitor had reframed her situation to one of postnatal depression, thus reflecting a normalised view of motherhood (Nicolson 1990; Ussher 1991; Busfield 1996). Alex acknowledged she had been feeling depressed following the birth of her baby, but considered that her main problem was the continued abuse she had experienced.

Yasmin also felt that her health visitor should have picked up on the signs indicating domestic violence. However, at the time Yasmin had been living in this country for only a few years, and was unable to speak or understand English. This meant that she required, but did not receive, interpreting support to help her communicate with health care workers. This reflects previous work which has pointed to the additional difficulties faced by Black women in accessing help about domestic violence (Guru 1986; Mama 1989a; Bhattti-Sinclair 1994; Imam 1994; Bowstead et al 1995; Ria and Thiara 1997).

The silent discourse about domestic violence produces silence in both mothers and health visitors. This is illustrated by Alex, who suggests that because the issue of domestic violence was not part of the health visiting agenda, it was difficult for her to raise the issue first. The analysis focused upon the discourse of domestic violence, and of motherhood, arguing that, even though health visitors were in contact with women experiencing domestic violence, they were often unable to recognise this. Here, the notion of a clinical gaze is useful (Foucault 1976; Bloor and McIntosh 1990; May 1992a; Nettleton 1992).

As already described, many of the women who participated in this study had concealed their experiences or been reluctant to talk to a health visitor about them. In contrast, Janet suggested that she would have disclosed to a health visitor but had faced a number of difficulties in accessing this service. At the time Janet had two pre-school age children, and had tried very hard to make contact with health visitors, but, because of staff shortages, she had received very little health visiting contact. When her children were young she was experiencing escalating violence and abuse from her husband for a number of years. Her account reflects some of the issues in women's help-seeking

behaviour (Dobash et al 1985). In the following data extracts, Janet refers to the difficulties she faced in raising the issue of domestic violence.

> *And I did ring up to say, "can somebody call out", and she said, "well she has left and there is only me" and you know "is it urgent?" And I said "well oh no don't bother then". You just want them to say what is wrong, you don't want to say it. You just shut up and put the phone down. So I didn't actually say to them, look my husband is beating me up. Or he is abusing me now, and he is making me live like this and everything (Janet).*

> *.... I mean they should just come around to make sure things are going all right anyway, because nine times out of ten people <u>don't</u> go round shouting about that someone has hit them, do they? (Janet).*

In describing a service which for her was largely absent, Janet's narrative suggested that she understood health visiting to represent a form of surveillance. However, she anticipated that this would be cognisant of the welfare of herself, as well as that of her children. This is indicated in the above extract, but this theme is more clearly expressed in the following narrative. Here she comments upon the failure of the health visitor to follow up about her welfare, after she had told her that she was feeling low after the birth of her youngest daughter.

> *.... And she said, "well all right, we will have to keep an eye on that". She never even came back to me. I thought I could have plummeted into depression, and she never came back. [.]. I told her that, and she didn't come back. ..... And then just a few months after that, things had really gone down hill in the relationship and like you know, she should have been checking me still about depression. And she wasn't even calling around about depression, to even see what was happening to me and that. Because indoors and that, like when the sun tans fade and everything, you could really see the bruises and everything. And I thought, well she didn't even come round to check (Janet).*

In acknowledging that health visiting is concerned with the surveillance and regulation of mothers, Janet also implies that this involves issues of welfare and care, suggesting that such surveillance of mothers would recognise and take seriously her experiences of violence from a known man.

Summary.

The mothers who participated in this study all faced difficulties in talking to health visitors about the domestic violence they were experiencing. A few women decided to disclose their experiences, but this occurred at a time when the violence was escalating in severity or frequency and they were becoming desperate for help. A few mothers eventually told their health visitors because they had contact with them at times of distress, making it more difficult to continue to conceal their experiences. Others chose to remain silent, either because they feared for their own safety, they were unsure about broaching the issue with outsiders, and they feared about the custody of their children if they reported domestic violence to a worker from a statutory agency such as health visiting.

The overall pattern of help seeking from health visitors reflects the findings of previous work which have highlighted the continued problems women face in relation to accessing help (Binney et al 1981; Dobash et al 1985; Pahl 1985; McWilliams and McKiernan 1993). In particular, the additional difficulties in accessing services for Black and Asian women (Mama 1989a; Bhatti-Sinclair 1994; Imam 1994; Ria and Thiara 1997) is reflected in the experiences of Yasmin and Meera who were unable to break their silence about their experiences of violence and abuse because no attempt was made to provide them with safe and private interpreting services. Kelly (1994) has pointed to the "catch 22" facing mothers regarding their choices about telling child care workers about domestic violence. This was clearly a paramount concern of many of those who participated in this study, a finding which has also been discussed by Stark and Flitcraft (1988) and Abrahams (1994).

Understanding that the contact and relationship between mothers and health visitors is constituted upon the double bind of welfare and surveillance, provides an analytical tool for examining both how health visitors "get to know" about domestic violence. It also sheds light upon the reasons why mothers conceal their experiences. This analysis of the practices of concealment illustrates the exercise of power relations between mothers and health visitors. Using Foucault's notion of disciplinary power (Foucault 1979; 1984), it builds upon previous studies which have examined the power relations between clients and health care workers (Bloor and McIntosh 1990; May 1992a; 1992b). Viewing these practices through a feminist poststructuralist lens also enables analysis of the discourses which inform health visiting practice. These include normalised views about motherhood and non-feminist discourses about domestic violence, both of which operate to create an overall silence about women's experiences of male violence and abuse. However, it is important to set this theoretical analysis within the overall context of the difficulties women face in relation to domestic violence. Such difficulties are enormous, and include fears for their own safety, and fears about losing their children, as well as the constraints faced by women in accessing support and protection within patriarchal society.

SUPPORT OR PROTECTION?

For many women, the difficulties they faced in seeking help, continued even after they had talked to health visitors about domestic violence. This was because health visitors did not offer them either adequate support or protection; findings which have been highlighted in a number of previous studies (Binney et al 1981; Borkowski et al 1983; Dobash et al 1985; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996).

This was the case for Moira, Anita, Madina and Paula; for these women disclosing about their experiences of domestic violence had not led to the provision of adequate support or protection. It is probably significant that even though I interviewed all these mothers while they were staying at a women's refuge, none of them had been given information about this service from their health visitors. This suggests a serious failure of health visitors

regarding the support or protection they offer to women experiencing domestic violence. Moira, Anita, Madina and Paula had all experienced escalating and severe abuse, and at the time they were having contact with health visitors were becoming increasingly concerned about their own safety and required information about protection, as well as support. For example, Moira appreciated the opportunity to talk about her situation, but regretted the absence of any practical help.

> *... you know I cried, I cried my eyes out. Which made me feel better at the time, but then the problem would still be there. You know, she has gone away, I am not going to see her for a while..... And like they try and build you up, but, at the end of the day, you have still got left with the problem of your husband hitting you (Moira).*

> *.... You know I wasn't pointed towards any group, or anything. .... I didn't know places like this existed, or else I would still be at home. .... She said, "be careful", and "why don't you leave". But that was it basically (Moira).*

This lack of support and protection was echoed by Anita who found that disclosing to her health visitor about domestic violence did not improve her situation. In particular she observed that even though her health visitor knew about the domestic violence, she had no more visits than usual.

> *.... they just left me there. .... they said to ring if I needed anything (but) .... they were really hard to get hold of anyway, she was never in (Anita).*

In contrast, Madina was able to describe an increase in visits once her health visitor was aware of her situation. But despite of this increased contact, Madina did not feel that she received adequate support or protection. As she pointed out.

> *....she would sit down and listen to me talk, and maybe stay for an hour or so. .... But I knew it was only a slot, because you could feel the clock going round, and that she would have to go to the next visit. .... And then she would leave me, and I*

was crying a lot. .... And she would pat me on the arm, and say I'm sure you will be OK (Madina).

Similarly Paula also pointed to an increase in contact with her health visitor who was aware of her situation, but observed that she was not offered any practical support or information about protection.

.... she came to talk to me, but she didn't really, I don't think she knew what to do. I mean, she just came and talked to me, and to see if I was OK. .... I mean she did know what was going on. I mean last time I saw [name of health visitor], I was actually in tears when she left, because I was desperate, I just needed somebody to say that it was going to be OK. .... she didn't really seem to be able to tell me about what to do, you know where to go, and who to ask for help (Paula).

Feminist work has made visible the difficulties facing women living with, and leaving violent relationships (Dobash and Dobash 1979; Hanmer and Maynard 1987; Kelly 1988a; Kirkwood 1993; Hester et al. 1996), recognising the need to provide support and protection. As the responses these women received from their health visitors all suggested a failure to offer adequate support or protection, this suggests their knowledge base was not informed by such feminist discourses.

As already mentioned, Janet had faced a number of difficulties in accessing health visiting services. A part of her overall help seeking involved contacting the GP.

I wanted someone to come in and rescue me. I wanted someone to come in and say this will happen, and this will happen. And when I went to the doctors, I thought, he will tell me what to do, he will sort it out, and there will be health visitors coming in and everything. And I thought that all this was going to happen, and nothing happened. And I came away, you know, completely deflated. And I think that gave me a knock back, for about six months (Janet).

His failure to offer her any support when she went to see him following a violent physical assault from her husband indicates the importance of ensuring that requests for help are

met with adequate responses that enable women to access support and protection, rather than receiving negative responses (Dobash et al 1985).

Ruth was the only woman to recall a positive response from her health visitor once she had talked to her about the domestic violence she was experiencing. Ruth had the same health visitor for all her children and was grateful for the support she had received.

> *She has been there for me all the time. .... she kept in good contact with me, making sure that I was OK and everything. And, she pulled me through, basically. .... But we struck up a very good friendship, I think. She was always there for me, you know, always there for me. I can't say enough about her really. She was just a great help to me when I needed her (Ruth).*

As well as being understanding and supportive, Ruth also valued the practical help she had received from her health visitor. This had included being given information about relevant women's organisations, particularly Women's Aid.

> *..... Although she didn't advise me to leave .... she just said, "I will put you in touch with Woman's Aid, I think you should have a word with them, and, you know, choose your options from there, really". ... I wouldn't be here if it wasn't for her. Because I would have just stuck it out, again, and not bothered to have made the move.....I mean I would never have known. I wouldn't have known who to go to, who to talk to whatever (Ruth).*

In contrast, Maggie's changing circumstances was associated with a mixed experience of health visiting support. She recalled that her first health visitor gave her ongoing emotional support, as well as information about appropriate voluntary agencies able to provide support and protection concerning domestic violence. Even though Maggie has escaped from her violent husband, he continues to abuse and harass her. She has now received support from her current health visitor who has put her in contact with a local domestic violence project.

I mean, she has said that there is not a lot that they can do. But she has actually done quite a lot. As I said, she has got me in touch with this domestic violence unit. The doctors actually, are more sympathetic. Well, they are not sympathetic, but they can see the whole picture now. So that helps a lot (Maggie).

All the mothers had received health visiting services in relation to their young children, and they all considered it to be focused upon the welfare of the child. As Alex pointed out.

.... they are there to protect children. I think that women see health visitors as not here to help me, here for the kids. I think that, and I think that around here, that it is a common view (Alex).

Previous feminist work has highlighted the tendency for workers in statutory agencies to reframe domestic violence as a child protection concern, often preventing women from achieving appropriate support (Kelly 1994; Mullender 1996). Studies have also suggested that health visitors are more concerned with the welfare of children, than with the mothers own safety and welfare (Borkowski et al 1983; Pahl 1985). As Pahl (1982) has observed.

"Some health visitors seemed to behave as though the wife had no claim to be helped in her own right, as though her welfare was subsumed under the heading of the welfare of the family or of the children" (Pahl 1982, p. 529).

A focus on the welfare of children was a recurring theme recalled by the mothers who participated in this study. This is illustrated in the following data extracts from the interviews with Moira and Claire.

So really, [name of health visitor], when it came to my children, her primary concern was them, she said, "are they in any danger?". And I assured her that they never had been, and never were. What they were <u>seeing</u> wasn't very nice, I appreciate, but he never ever physically abused them. .... But really nobody gives you any pointers about what to do, you know, it is just "are the kids all right?". .... I think their primary concern is your children. I mean, they do come to see how <u>you</u>

are, but at the end of the day they still leave you, you know. As long as your kids are all right .... (Moira).

....She asked me if the kids were at risk. .... They were never in any danger, he wouldn't have harmed them at all. The violence was just directed at me. .... You still feel they are doubting you. It is like, well why are you still there? (Claire).

Once again this reflects the incongruence within health visiting discourses regarding the issue of male violence. This involves a concern with child welfare and child protection, which often operates alongside a marginalisation or exclusion of the domestic violence experienced by women (Farmer and Owen 1995; Humphreys 1997). The data suggests that despite regular and sustained contact, health visiting work is focused upon the welfare of children and often ignores the health and welfare needs of women themselves (Hennessy 1986; Abbott and Sapsford 1990).

The focus upon children was a recurring theme throughout the data. However, despite this expressed concern, many mothers commented upon the lack of practical help they received. This was the case for Barbara, who discussed at length the impact of domestic violence upon her two sons, describing the difficulties she had in managing his behaviour and mood swings.

.... I could have just done with a little bit more help. .... I thought at that time with my kids, it would have been good to have had somebody to talk to, to have got a bit more help. .... he started being really aggressive and nasty. I could have done with just a little bit more help. He seemed frightened of everything, cartoons, any kind of violence (Barbara).

Alex was concerned about the continuing welfare of her son. She and her children have now escaped from domestic violence, but her son, who is now aged 6 has been quite emotionally damaged by his experiences and is currently receiving support from a child psychologist. Looking back on the situation, Alex thought that if her health visitor had talked through the situation with her, some early damage may have been avoided. This

was echoed by Janet, who regrets the absence of any preventive work with her children. As she pointed out.

> *.... if a health visitor had come forward, perhaps like she might have been able to have delved into that side, and she might not have been so emotionally affected now. .... they could tell you like, she is going like this because of this. You know. And they might have been able to get you out that couple of years earlier than what you did (Janet).*

Health visiting work continues to be focused upon child welfare. However, in the context of domestic violence responses to children, and their mothers, appear to do little to support or protect them. This theme recurred throughout the women's interviews, suggesting the urgent need for professional responses to children living with domestic violence to be improved (Mullender and Morley 1994; Mullender 1996; Hester et al 1998).

Summary.

Feminist work has made visible the difficulties women face when living with, or leaving violent men (Dobash and Dobash 1979; Hanmer and Maynard 1987; Kelly 1988a; Kirkwood 1993; Hester et al 1996) as well as the need to provide appropriate support and protection to women and their children (Dobash and Dobash 1992; Debbonnaire 1994; Kelly 1994; Hague et al 1996b; Mullender 1996; Hester et al 1998). In this study, the difficulties women faced in seeking help continued after they had talked to health visitors about domestic violence. These included a failure to access adequate support or protection for women, or their children, and a continued focus upon child welfare, reflecting the findings of previous studies (Binney et al 1981; Borkowski et al 1983; Dobash et al 1985; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996). This absence of support or protection to mothers and their children raises concern about current health and welfare practices.

CONCLUSION.

The difficulties women face in seeking help about domestic violence are considerable. These include practical concerns such as fears for their own safety, lack of knowledge regarding appropriate sources of support and protection, and concerns about losing custody of their children. Despite these difficulties, some women do approach statutory agencies such as health visitors, disclosing their experiences and seeking support and protection. Even though many women wish to remain silent about their situation, they are not always able to achieve this, largely because of the nature of health visiting work which is concerned with the regulation of private conduct (Dingwall and Eekelaar 1988).

The experiences of the women who participated in this study reflect the findings of previous studies which have pointed to the difficulties women face regarding help-seeking from health visitors (Binney et al 1981; Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993). Although suggesting that many women do not approach health visitors for help, these studies have been unable to provide a detailed analysis of women's practices of disclosure or concealment. This study has viewed health visiting work as social regulation, and this has provided the framework to examine women's practices of help-seeking.

This study has also examined health visitors' responses once they were aware that women were experiencing domestic violence. Although previous work has suggested a mixed practice (Binney et al 1981; Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993), the data reported here point to a number of practices through which health visitors fail to offer women, or their children, appropriate support or protection. This suggests that feminist understandings about the difficulties women face when living with, or leaving violent men (Dobash and Dobash 1979; Hanmer and Maynard 1987; Kelly 1988a; Kirkwood 1993; Hester et al 1996) do not inform health visiting work.

CHAPTER 7.

DIVERTING THE GAZE.

INTRODUCTION.

This chapter focuses upon health visiting responses to women experiencing domestic violence, building upon the previous analysis (chapters 5 and 6) which pointed to the complexities regarding their practice of "getting to know". Analysing these responses necessarily concentrates attention upon the work of those health visitors who described both recognising, and responding, to domestic violence. These health visiting responses are diverse, and the examination is subdivided into three sections. These are all concerned with the practices through which health visitors are involved in the social regulation of mothers, but each section focuses in turn upon different aspects. It begins by exploring health visiting work which aims to support and protect women experiencing domestic violence. These practices illustrate the extent to which health visiting work has been informed by feminist discourses, opening to scrutiny those aspects of professional practice which are constituted upon non-feminist discourses. This is followed by an examination of those practices whereby health visiting concern turns towards the welfare of children, arguing that this serves to reinforce the scrutiny of mothers and mothering. The final section examines the gendered nature of their work, focusing upon health visiting practices in relation to men. The analytical framework for this examination understands health visiting as the social regulation of mothers. This makes visible the processes through which silences about male violence towards women and children and the invisibility of men, co-exist alongside the increasing regulation of mothers.

PROTECTING OR SUPPORTING WOMEN?

This analysis of health visitors responses to women experiencing domestic violence suggests a mixed practice; this mirrors the findings of previous studies (Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996). These make visible the difficulties women face in living with, and leaving, violent men (Dobash and Dobash 1979; Hanmer and Maynard 1987; Kelly 1988a; Kirkwood 1993; Hester et al 1996), and underpin work designed to support and protect women facing these situations (Dobash and Dobash 1992; Mullender 1996). These feminist discourses are used as a framework to understand the differences between health visitors in relation to their responses to women experiencing domestic violence. The practices of those health visitors who described providing such support or protection to women experiencing domestic violence are represented as resistance, in order to reflect the titular themes of this thesis.

The notion of "support" was a recurring theme running throughout the health visitors interview data. This often involved emotional support, and the practices of "talking and listening" (May 1992a; 1992b). For example, Irene described her work "supporting" a woman who she knew was experiencing domestic violence.

> *.... I usually spend, when the women tell me about it, I usually spend quite a while on that visit just talking to them, and trying to find out when and how it began, and if there are any trigger factors. And then I would go on to (.) really continue visiting the woman, and supporting her, and really exploring her own feelings about it, and the amount of damage it has already done to her, both physically and emotionally, and to see if she has been to the GP on any occasions, or had to be hospitalised because of it (Irene).*

However, there were different dimensions to the type of "support" described by the health visitors. The following data extract from the interview with Theresa points to the importance of providing woman-centred suport, and adopting a stance which avoids blaming the woman herself for the violence she is facing.

.... you would get women saying things like "you know I wind him up, I wind him up until he hits me." And you say, "well what do you mean, you wind him up. Because should he hit you?, even if you are being so called irritating, or whatever". But they seemed to almost feel that (.) they participated. They would actually say to you "well it is my fault, because I know he is going to hit me, but I wind him up, and I just go on and on". I found that really strange and used to try and talk around that with them, about, you know, "Are you doing it deliberately really, or is it just your justification of what he is doing?". It was very difficult to get around that one. .... You know if you weren't careful, they would convince you that it was their fault. .... They had got trapped in this syndrome of almost blaming themselves (Theresa).

Examining the extent to which feminist discourses have influenced this knowledge base enables the differences between health visiting practices of support to be understood. For example, understanding that it often takes several years for a woman to leave a violent relationship enables feminists to ensure they adopt a long term view when supporting women. They also recognise that male power over women often leads them to blame themselves for their own situations. These feminist understandings were reflected in some of the health visitors descriptions of their responses. Natasha, for example, recognised the importance of providing continued support, and not expecting women to make instant changes to their situations.

I also think it depends very much on what your priorities are as a health visitor as well, as to how much work you tend to put into it, how much you feel you have to support women. .... I think I am very feminist in the way that I approach my work, which is probably why I am very interested in it, and I stick in there when things are going very slowly, and I try not to be disheartened by it (Natasha).

The importance of providing long term woman-centred support was recognised by Grace who described her response to a woman who was experiencing severe and escalating domestic violence.

But she tells me, she sort of, it is like she looks after me and tells me not to worry and that she is planning to move out. And that means that she doesn't have to talk anymore about it until next time. So I try not to be too heavy with her, and if she chooses to stop talking about it and start talking about weaning or something, then that is what we have to do (Grace).

In the above data extract, Grace acknowledges the importance of providing long term support and recognises that women face a number of difficulties leaving violent men. However, the above data extract also illustrates this woman's practices of resistance (Bloor and McIntosh 1990). In contrast, other health visitors had different perspectives regarding the need to provide long term support. This is illustrated in the following data extract in which Tina describes her work with a woman who made several attempts to leave a violent man.

.... What I used to find was, we would get it all organised and she would go, and she would stay for a couple of months and then she would move back. And everything would be OK for a while, and then he would start abusing her again. It has got implications when you have done that four of five times. You know her situation is awful, but just the sheer practical effort of trying to get that off the ground is really hard work, to know that in a few months you are, you know, probably going to be repeating it (Tina).

In the above data extract Tina points to the difficulties she has experienced in providing long term support to a woman attempting to leave a violent relationship. Even though Tina describes providing some practical support to this woman, her narrative suggests that her ability to provide ongoing support was constrained. This may reflect the context of her everyday working practices as a health visitor, where the issue of domestic violence is marginal. This would suggest that even in situations where health visitors are able to acknowledge the needs of women experiencing domestic violence, the organisational constraints upon their time serve to limit the extent to which they are able to provide appropriate long term support. This is in contrast to work informed by feminist discourses,

such as the work of Woman's Aid groups and refuges, which is constituted upon woman-centred practices.

In her study exploring women's perspectives, Pahl (1985) identified some of the ways in which health visitors responded inappropriately to domestic violence. These included implying that the violence was the fault of the woman, or by working for a reconciliation when the wife was asking for support in challenging the violence. Such inappropriate responses may reflect the knowledge base underpinning health visiting practice. In order to respond appropriately to women in situations of domestic violence, it is important for health visitors to understand the difficulties faced by women living with, and leaving, violent men. This is illustrated in the following data extract in which Theresa refers to some tensions in her own practice regarding supporting women around the issue of domestic violence.

> *.... it was easy to go in, sit down, listen to it all, and then you come out and you know that they were in exactly the same position that they were when you went in really, they are still going to get hit. (.). And, I used to feel that you let them know where they could go, what they could do etcetera, etcetera. And I was always torn between, "if I do that often enough they might go", and "am I going in there, making them feel even guiltier about staying, but achieving nothing?" So I used to sort of oscillate. Some weeks I would feel really good because I had gone in and told them about where they could go, and I had given them all the right numbers. And then another time I would see a lady and I would think, "I am just pressurising her, I am just really making her feel even worse about the fact that she can't leave" (Theresa).*

This example illustrates the importance of responding in ways which are underpinned by understandings of the issues faced by women experiencing domestic violence. An awareness of the difficulties women face in living with, and leaving, violent men, is really important for workers if they are going to be able to provide appropriate support or protection to women. Even though such difficulties are heard clearly within feminist

discourses, these have not always informed the knowledge base which informs professional practice. As Pahl (1995) observed.

> "When (health services) professionals fail to help abused women the explanation often lies in their attitudes to women, to marriage and to family life. These attitudes include assuming that women could leave if they wanted to, while taking for granted male domination within the home, male control of finances, and women's responsibility for any marital problems. The effect is to lay the blame for the violence on the woman and to ignore the perpetrator of the violence and the context in which the violence took place" (Pahl 1995, p. 148).

This lack of understanding is associated with the provision of inadequate responses to women. However, it also impacts upon workers themselves, often leaving them with a sense of helplessness when faced with women in situations of domestic violence. This is illustrated in the following data extract from the interview with Kay. She is describing her feeling regarding her work with two separate Asian women who had approached her for help about the domestic violence they were experiencing.

> *.... I found that I couldn't. They didn't want to take it any. They wanted help, but in a secret way. .... I didn't think, without confronting the issue, I didn't know how I could help. Because what would happen if they talked, and then go back into the same situation (Kay).*

Despite her feelings of helplessness, Kay had been able to offer these women some practical help. This included enabling them to access appropriate legal advice, and supporting a housing application. However, her uncertainty about responding to women experiencing domestic violence reflects, to some extent, the knowledge base underpinning her practice.

Understanding the difficulties faced by women living with violent men is central to feminist work which recognises the importance of providing long term support and protection. In examining the extent to which health visitors were concerned about the protection of women, a number of issues were identified which reflect the findings of previous research

into agency responses (Dobash and Dobash 1979; Dobash et al 1985; Pahl 1985; Mama 1989a; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996). These include the tendency for some health visitors to make inappropriate referrals. This needs to be understood in relation to the local context for this research. In the city where these health visitors worked, a range of agencies provide support, advice and protection to women experiencing domestic violence. This included Women's Aid groups, refuge provision, and a number of community based domestic violence projects. Moreover, the multi-agency domestic violence forum had produced practice guidelines, although at the time of the fieldwork these has not impacted upon the individual practices of the health visitors.

Despite such service provision, health visitors often made inappropriate referrals. This reflected a lack of knowledge of the contributions of other services, particularly voluntary sector provision, as well as a failure to understand the needs and difficulties of women in violent relationships. As Dobash and Dobash (1979) have observed, because it often takes women a number of attempts to seek help from different agencies before they actually receive an appropriate response, this has a negative impact upon women who fail to acquire help from agencies when it is requested.

In her study which focused upon women's experiences of help-seeking, Pahl (1985) identified the important role health visitors could play in providing practical help to women about domestic violence. This included giving relevant and accurate advice and information on specific issues, such as benefits, housing, legal advice and refuges. In this study, the term "protection" was rarely used by the health visitors, either to describe their activities, or in relation to the needs of women. However, it is an important concept which underpins feminist activity around the issue of domestic violence. Throughout the data, there were many examples of health visitors responding in ways which were designed to assist in the protection and safety of women. These included enabling women to access refuge services, legal and other advice, provided by a range of voluntary and statutory organisations. The following data extracts illustrate range of such responses, represented as resistance to dominant malestream and professional understandings about male violence.

.... I came across a woman, not so long ago. And the health visitor had actually gone to the telephone box to pick her up, drive her around in her car, and then she dropped her off at the hostel. And then subsequently the health visitor herself had been verbally abused by this man's family. And you know, she protected that woman. And that woman was very, very happy with what she found. And that health visitor had supported her, for about two years I think, and she had been telling her that she had been beaten and abused (Maeve).

..... we can just give them the information, really, and let them make up their own minds .... and be there for them. .... I have given lots of leaflets out to women, and weeks and weeks later they will say we rang [project worker], she helped us do this, she put us in touch with the refuge, we have been to housing, we have done this (Pamela).

.... She came to the baby clinic on this one occasion and just said that she needed to leave her husband, she needed to go. And could I get some help for her, so that she could go back and pick the children up from the house. This was a very, very depressed lady who had been through a horrendous time. So I made lots of phone calls, and eventually we managed to get a police escort to go into the house to get her things and get the children, to get her daughter, she had only got the one child. She got her daughter, and she went off to the refuge (Sanji).

In the wider context of agency responses to domestic violence, Dobash et al (1985) have suggested these can be categorised as "supportive" or "challenging" responses. The latter includes giving advice about leaving the violent relationship, confronting the man, referring to other agencies, and assisting the woman to escape. There were many examples of health visitors describing challenging responses regarding the support they offered to women experiencing domestic violence. This usually did not involve directly confronting the violent man. However, concern about their own safety was a recurring theme throughout the health visitors interviews when they described their work directed at supporting or enabling women to access protection about domestic violence. This fear

was usually associated with the aftermath of supporting women to escape from violent partners. This is illustrated in the following data extracts.

> *So she got off to the refuge. And I sort of reeled back from it all, thinking he is going to come looking for me because he will wonder whether I put her on to this, you know (Sanji)*

> *.... then he started ringing clinic. .... he was threatening to run me down, and all sorts of things. And it was really quite frightening really (Pamela).*

As these extracts suggest, health visitors often feel very vulnerable, particularly as their work makes them visible and identifiable, and they continue working in the same community after women have left violent relationships. These concerns about personal safety reflect the nature of health visiting work.

Summary.

The responses of health visitors to women experiencing domestic violence were marked by diversity. A few health visitors were aware of the difficulties facing women living with or leaving violent relationships, but many health visitors failed to understand the key issues. This lack of understanding was associated with a failure to offer women appropriate or adequate support. In particular few workers were fully aware of the need to provide long term support to women, and to ensure that women avoided taking responsibility for male violence. Even though some health visitors were able to provide long term support, and enable women to access appropriate sources of protection, there was little consideration of the difficulties facing women in deciding to leave violent men. Despite these shortcomings, however, many health visitors described undertaking work which challenged male violence, offering women both support and protection. These practices have been represented as resistance to the dominant professional discourses about male violence.

"But Are The Kids All Right?"

When health visitors knew that a woman was experiencing domestic violence, they invariably expressed concern about the safety and welfare of her children. Understanding health visiting as the social regulation of mothers provides the conceptual and theoretical framework for analysing such concern. This demonstrates that the practices through which health visitors prioritise children's welfare, and make mothers responsible for protecting their children from male violence, are aspects of regulation.

Health visiting work is concerned with the monitoring and surveillance of children in families (Donzelot 1979; Dingwall and Eekelaar 1988), focusing their attention upon the welfare of children. In the context of domestic violence, however, it is interesting to note the extent to which they privileged this concern for children over that of the welfare and safety of women. This is a common thread running throughout the data, and one which reflects the findings of previous studies where the responses of health and welfare professionals have been marked by a concern for children (Borkowski et al 1983; Maynard 1985; Pahl 1985; McWilliams and McKiernan 1993). The notion that children are a priority permeated all aspects of the health visitors discourse about their practices around domestic violence. This is illustrated in the following data extracts from the interviews with Melissa and Beverley.

> *.... I think a mother is experiencing domestic violence then I would, you know, I would prioritise the children in that family, that is a family that I would try and work with. I would try and see more of the children, not in a monitoring way, but it is something that I would be aware of (Melissa).*

> *.... it is really the children that you have to be concerned about..... See as a health visitor, I always feel that my priorities are with the children. That they are growing up to be safe, and well, and happy. And that is where I put my energies (Beverley).*

The privileging of child welfare is also apparent in Sanji's description of how she responded when a woman told her about an incident of male violence.

> *.... he had dragged her by the hair and threw her out of this friends flat. With the children watching. And she told me about this incident, and I sort of highlighted to her the effect on the children of watching something like that would be very significant (Sanji).*

This privileging of child welfare concerns was also mirrored in their discussion of record keeping practices. In the following data extract Mary is referring to a situation where she had ongoing involvement with a woman who was experiencing domestic violence, and had escaped on at least one occasion to a woman's refuge.

> *The only thing that is in those records is the fact that she went to a refuge, (.) due to violence. And a note that the partner is now back in the household. .... I would be more inclined to put, you know, whether the children were OK, and how they were faring. And, you know, providing she is all right, then no mention of it (Mary).*

In this example, Mary is not only privileging her concern about the welfare of children, but is minimising the domestic violence experienced by this woman. In this way, the practices of record keeping both constitute and reinforce the silences around domestic violence. The priority given to child welfare is similarly reflected by Vicky. In the following data extract she is describing her work with a woman who, when she had initially disclosed her experiences, had asked for this not to be included in the health visitor's records.

> *.... That particular time when she asked me, I didn't feel there was time <u>there</u> to talk about whether I would or wouldn't. .... But I hadn't write anything down until .... I had spoken to her again. And then it would be around issues of, it is not just saying about their domestic violence. I am talking about real issues, the implications that she must be aware of the child etcetera (Vicky).*

In discussing her record keeping practices, Vicky suggests that the "real" focus of her work is concerned with child welfare. This serves to minimise the welfare and safety of

women, in contrast to that of children which she is clearly privileging. These practices illustrate the child focused nature of health visiting work, and support the overall argument relating to the social regulation of mothers. They also illustrate how male violence is simultaneously ignored and addressed within health visiting discourses, depending upon whether it is focused upon women or children. This highlights a paradox whereby violence or abuse directed towards women is silenced and minimised, while any threat directed towards children is prioritised. These conflicting discourses about child abuse and woman abuse both underpin and contribute to workers feelings of dismay and helplessness when faced with male violence directed against women.

The privileging of concern for the welfare of children is further illustrated by examining health visiting discourses regarding the impact of domestic violence upon children, and its inter-connectedness with child protection. There were a number of examples in the data which suggested that some health visitors had developed an experiential understanding about the impact of domestic violence upon children. This is illustrated in the following data extracts which refer to children witnessing domestic violence.

> *.... And my concerns were, the effects it was having on this child, seeing continuous violence. And, to the point where the child started displaying, not real violence but. She was quite a loving child, but started hitting, and talking about it. And, I don't know, and I have not really read anything around it. But what are, and what real effects is that going to have long term..... it is what emotional effects it is having on the child (Jenny).*

> *.... it doesn't take much, to start picking up the vibes, watching the relationship between their parents. And they respond with perhaps more attention seeking type behaviour, and they just don't feel quite as secure as they should, and their behaviour reflects that. .... it is a very negative, damaging environment for children (Marian).*

Despite a number of difficulties in understanding the complexity of the connections between children and domestic violence (Kelly 1994), there is adequate evidence to

suggest there is a cause for concern (Jaffe et al 1990; Abrahams 1994; Mullender and Morley 1994; Saunders 1995). In particular, the research reported by Abrahams (1994) suggested that children develop a range of emotional and behavioural responses to witnessing domestic violence. These included being frightened, "clingy", quiet or withdrawn, to being angry and aggressive, and developing bed wetting problems. Even though these emerging discourses have pointed towards the adverse impact of domestic violence upon children (Jaffe et al 1990; Abrahams 1994; Mullender and Morley 1994; Saunders 1995), at the time of the fieldwork for this study it was not being heard at the level of practice. Thus, when health visitors talked about their concern for the welfare of children in the context of domestic violence, the absence of an established professional discourse about this meant that they were often guessing at the implications of this, both for children as well as for their own professional practice. As Mullender and Morley (1994) have observed,

> "Any professional working with children may observe the results of living with domestic violence but will typically be equipped with little idea of how to respond" (Mullender and Morley 1994, p. 2).

The existing knowledge base highlighting the impact of domestic violence upon children (Jaffe et al 1990; Abrahams 1994; Mullender and Morley 1994; Saunders 1995) suggests that health visiting concern for child welfare is appropriate. However, what is at issue here is the ways it is translated into practice. In this study, many health visitors were guessing at the impact of domestic violence upon children, but they were unable to underpin their concerns with practical strategies to support children in such situations. There were a few examples of work which aimed to support children, for example, negotiating extra resources such as an early nursery place. However, there was a mismatch between the concern for child welfare and the available practical support. In the following statement, Mullender (1996) is referring to social work practice, although her point could be equally applied to health visiting.

> "There is a paradox in the fact that social workers in Britain, intervening in situations where women are being abused, appear often to be motivated chiefly by the presence of children - and yet social work as a profession has not systematically recognised the issue of children living with domestic violence as a matter of concern in its own right. In situations where this is recognised, there tends to be a rather unsophisticated and sometimes punitive child protection response as opposed to constructive work with the non-abusing parent -the mother- to help and her children be safe" (Mullender 1996, p. 138).

Domestic violence has recently emerged as a child protection concern (Bowker et al 1988; Stark and Flitcraft 1988; Abrahams 1994; Farmer and Owen 1995). This impacts upon the practices of health visitors, forcing them to consider and address male violence in the context of their professional concern about children. This is illustrated in the following data extract from the interview with Grace.

> *.... In our job as you know, we have tried to be there for the woman particularly, and the family. But predominantly, it always ends up being concerned about the child protection issues, no matter how hard you try to steer yourself away from that. That is what tends to get us more involved if you like. And start asking questions in a way that tries to find out about what it is like for the woman involved, but really implications it has for the child, child protection issues (Grace).*

The prevailing discourses about child protection shaped and informed Grace's practices. While this ensured that domestic violence was reframed as a child welfare concern, it also reinforced the prevailing silence and minimisation of women's experiences of male violence and abuse (Kelly and Radford, J. 1991). To some extent this mirrors the situation faced by mothers regarding their practices of help seeking about domestic violence; their need for support and protection is balanced by their fears that disclosing about their experiences of male violence may lead to removal of their children (Stark and Flitcraft 1988; Kelly 1994).

Even when health visitors expressed their concerns for children within the prevailing discourse of child protection, their practices can only be understood in the context of wider service provision. A key theme running throughout the data pointed to the failure of other agencies, particularly social services, to address children's experiences of domestic violence.

> *... We want to support the woman, but at the same time we have got to make sure the children are safe. .... So that may involve social services, which is another nightmare (.) trying to get the social services support. Unless there is an actual injury, it is really really difficult at the moment, they are just so pushed up there. .... So I mean they will see people on a duty basis, but it is really hard to get any ongoing support (Tina).*

> *.... unless there is something definite that we want them to investigate, that they can actually say, "yes that is a case, I will send two workers out". We don't really let them know, because they have just not been able to respond. And so obviously domestic violence would be something we would be highlighting for them, and hoping that they would be, in normal circumstances, be able to intervene, and support, and try and prevent anything else happening. But like lots of other issues, we haven't been shouting about it, because we know they haven't been able to respond (Michelle).*

The failure of social services to provide support or protection to children living in families where there is domestic violence impacted upon the practices of health visitors. Even though their overall work can be understood in terms of the surveillance and monitoring of children in families, in the context of domestic violence this was translated into an increased regulation of mothers. In particular, in the absence of any other means of protection or support for children, health visitors placed this responsibility for protecting children upon the mothers themselves. This increased scrutiny of mothers was usually associated with no further resources to ensure she was herself protected from the violence and abuse she was experiencing. This is illustrated in the following data extracts.

..... we have a clear role to protect the children, and to ensure that the mother knows that she has a responsibility to protect her own children from the violent partner (Marian).

And also talk to the women about their need to protect the children, and that they have got a duty to think of the child's safety (Emma).

.... And I try and be quite open about it, the concerns that I have about children. .... And you are also judging how well a woman can protect the children, which is always quite difficult isn't it. You want to support them, but at the same time you need to protect the child sufficiently, you need to ensure their safety (Natasha).

Thus a set of practices which acknowledged the safety and welfare of children in the context of domestic violence placed responsibility upon their mothers for their protection. As well as constituting the increased regulation of mothers, such practices are problematic because they do not ensure the safety and welfare of women or children. This can only be achieved by ensuring the safety and protection of the mother and working with her to address the protection of her children (Kelly 1994; Debonnaire 1994).

The interplay between seeking help and protection for themselves and their children, while also and at the same time, acting to protect themselves and their children from unwanted interventions from statutory agencies, serves to ensure that women may both speak and remain silent about their experiences of domestic violence (Stark and Flitcraft 1988; Kelly 1994). This is illustrated in the following extracts where, in commenting upon their practices of turning their gaze towards children, it becomes apparent that women continue to minimise or deny the extent to which they are experiencing domestic violence and abuse in order to protect their children from this health visiting gaze.

And I always ask when they disclose, and there has been a disclosure, "Are the children being hit at the same time?". And to date nobody has said yes (Emma).

..... Once the girls have confided in me that the partner is violent, as a health visitor you would ask them when this happens, so, do they make sure that the

children aren't around. The majority of them say the kids are in bed, they don't hear it and that. I find that quite unbelievable really (Pamela).

.... A lot of situations .... the women said, you know, the children weren't there when the violence went on. I certainly didn't always believe that, but I felt it quite important that they didn't bring up their children witnessing this. And to some extent I believed that there probably were a lot of things which went on when the children were in bed, but .... (Theresa).

These extracts suggest that even in those situations when women are able to discuss their experiences of domestic violence with health visitors, they continue to be constrained by, and thus resist, the regulation and control exercised by statutory child-care agencies.

Summary.

Health visiting work is constituted in terms of the social regulation of mothers. This provides the framework for the analysis which makes visible the practices by which health visitors, through knowing about domestic violence, increase their scrutiny of mothers. As the health visiting gaze turns away from women towards the welfare of children, it simultaneously becomes more focused upon "mothering". This leads to the increased scrutiny of mothers. To use the imagery offered by Foucault (1979), such practices take place within the spaces of a Panoptican whose architectural design has become more imposing.

THE PROBLEM WITH MEN.

The focus of health visiting work upon mothers represents a specifically gendered form of social regulation (Graham 1979; Mayall 1990; Edwards, J. 1998). This is particularly apparent in the current context which is focusing upon domestic violence. In these situations it is children and women, rather than men, who are the subject of their attention. Turning our gaze towards health visiting work in relation to men, therefore, enables analysis of a recurring theme within contemporary welfare. As Edwards (1998) has pointed out, the attitudes of health and welfare workers concerned with children and families portray an ".... ambivalence about the role of men in the home: trouble if they're there and trouble if they're not" (Edwards, J. 1998, p. 260).

This analysis of the practices through which men are included or excluded from health visiting work, suggests that this ambivalence towards fathers is contravened in situations where men are known to be violent. In such situations, even though men continue to be excluded from health visiting work, they exert a constraint upon practitioners. This is largely because workers fear for their own safety. However, by presenting themselves as "plausible", men may further undermine health visitors' already limited understandings about domestic violence. Such undermining challenges and circumvents women's practices of help-seeking, and further contributes to the prevailing discourses which silence and minimise male violence (Kelly and Radford, J. 1991).

The gendered nature of health visiting work permeated throughout the data. In describing their practices, health visitors focused their attentions upon women as mothers, having relatively little direct contact with men. This is illustrated in the following data extracts.

> *.... it is still mainly with women, yes mainly women. There is a particular group of Asian families where the men speak for the women, during the conversation. It could hardly be described as meaningful communication really. It is just that they tell us what they want us to hear. So it is not working on health issues with them (Marian).*

It is mainly women, definitely women. There is maybe a handful of men who actually come and bring their children to clinic. And in the home, I tend to find ... they may be there, just hovering at the beginning, of a consultation. But they are not so bad, they tend to go (Kay).

Health visitors rarely had direct contact with men, but their work was often constrained by their presence or absence. These were common themes arising from the data, and reflects previous work (Edwards, J. 1998; Williams 1998).

The tensions inherent in health visiting work with men is particularly visible in the context of this research focused upon domestic violence. As the following narrative from Natasha demonstrates, her work involves the active inclusion and exclusion of men depending upon her knowledge of their practices of violence and abuse. Thus the dominant discourse about fathers rights and parenthood serves to construct how men are viewed. However, this is disrupted by her knowledge of male violence which problematizes men and shapes her practices in relation to them.

.... If the men are around I really do make a point of trying to get a feeling of what they are like, whether they are bonding with the child, and how they are feeling, what their relationship is like, how they are coping. Just what sort of person they are really. So I don't avoid them, I do really try to include them in things. And I always make it clear that they can attend well baby clinic, and anything else really. And that they can access me. [.].

S.P.: Have you had any contact with the men in those situations where there is domestic violence?

Only brief. No, not really. I probably go out of the way not to have any contact with them (Natasha).

In describing her practices, Natasha is making visible a tension within health visiting work regarding men. This promotes work which is focused upon the presence of "normal fathers", while at the same time discouraging and avoiding contact with "violent men". The

paradox inherent in these constructions of working with men, incorporates and questions the shifting boundaries of men and masculinities.

As the focus of this research was on practice issues arising from domestic violence, it may not be surprising that knowledge of male violence transformed the way that men were experienced. This was particularly noticeable in relation to their descriptions of working in the private spaces of the home, where a physical and often spatial awareness of men became a key dimension. The presence of men, often lurking in the background, upstairs, or in the kitchen, is illustrated in the following data extracts.

> *.... he was an aggressive man, you could feel it when you went into the house, it was quite intimidating. ..... But often he was there, I would see him standing in the corner (Chris).*

> *.... I was going into homes and people were telling me about it. .... I have never experienced it like that, going into a home whispering downstairs while the man was upstairs, ... (Grace).*

> *And I think they are always on tenterhooks because either he is in bed, and as soon as he hears another voice he will be down, which has happened there (Michelle).*

In contrast, the data lacked any descriptions about the physical or spatial dimensions of health visiting work with women.

There were many examples throughout the data where it was clear that knowing about domestic violence meant that health visitors could no longer afford to ignore the presence or absence of men. Instead, it draws attention towards men, not as a focus of work, but as a potential threat, provoking anxiety about their own safety. This emerged as a key theme, regardless of whether men were physically present or absent during health visiting contact.

.... it is not very pleasant is it going into a house where there is this man and you are frightened of yourself. You know I have been in houses where I am scared to death of the chap. .... there was one, well it was a horrendous situation. And I used to think, oh please don't let him be there (Rebecca).

I have had feelings of feeling anxious about being, thinking I want to get out, you know. .... It has often been, that I have been talking to the woman, and he has been around in the house, but not coming in, you know, that sort of thing (Melissa).

.... if I go in and the male partner is there, particularly if I wasn't expecting him to be there, I try and make sure I have got an escape route. Why I should think that, because he attacks his partner, he should attack me as well, I don't know. But it is a concern to me (Irene).

.... I mean these violent men who I have found, they are actually quite violent to me as well sometimes. I don't mean they physically assault me, obviously I don't. But they are verbally violent, I have had many who are verbally violent (Rebecca).

Health visitors relationships with men were also underpinned by the gendered power relations in which their work was located. In describing such contact, both Grace and Jenny allude to the ways in which men seek to extend their power over them as women.

.... he is frightening for me. He treats me with better respect because he knows I belong to an agency, but the more I visit the more familiar he becomes with me and the more he tries to exert his kind of authority on me. So I am trying to not visit when he is there, trying to avoid him (Grace).

.... I felt really uncomfortable. And his view he expressed of women, to me, was quite low..... I was quite worried about him. .... I don't know what he would have done but he was a man, he was a man that just made me feel uneasy. .... I think it was just his view of women generally (Jenny).

This analysis which has examined health visiting work through the lens of social regulation has illustrated the gendered nature of this work. It has shed light upon some of the tensions and paradoxes inherent in health visiting work in relation to men. Focusing upon the problematics posed by known violent men, which include fears for their own safety and intimidation, also sheds light on these gendered practices. However, in the context of domestic violence, there is a further paradox regarding the gendered nature of this work. This involves the practices through which men presented themselves as plausible to health visitors. There were many instances in the data in which known violent men were passive in the presence of health visitors.

> *.... Sometimes when I go, the thoughts of going back in again are quite frightening. I mean, even though I meet [man], he is very pleasant to me, he is very, not submissive but you know, he is sort of, he is like a pussy cat, do you know what I mean (Beverley).*

> *.... it did seem to be purely her that he hit out, had a go at, every now and again. I mean if you met him you would think he was the most, sort of, mild gentle giant out. And when he was all right he was fine. Which I suppose explains why she kept going back (Tina).*

> *.... we do see a lot of the men. And some of these who .... are violent towards their partners. They are there when we visit. And they are usually as nice as pie. But some you feel are, from the histories that you get from social workers and things, they are actually quite dangerous and unsavoury characters. But they are quite sort of chatty and very plausible .... they just go through the motions of being pleasant and polite (Michelle).*

> *.... he did all the talking. He came across as being extremely caring about the child, cradling the child. He was a very big man, with really big hands with this tiny baby in, very gentle. And that was the immediate impression I made. And the impression I made of her was somebody who was nervous, on the edge, and was probably going to have perhaps postnatal depression. .... on every occasion he*

has been totally reasonable and presentable, and if you had to guess you would think that she was the one who was kind of strange and mentally ill and he was a reasonable person who you would want to talk to (Grace).

The practices by which men present themselves to workers as reasonable and caring challenges their understandings of domestic violence. This serves to place some doubt in health visitors minds about women's experience of domestic violence, which is reinforced by the prevailing discourses through which this is already minimised and silenced (Kelly and Radford, J. 1991).

Summary.

It is acknowledged that the effects of researching male violence might shine a strong light upon the problematics surrounding men and masculinities. However, the data suggests that the gendered power relations existing between men and health visitors reinforces these tensions. In this study, men pose a number of problems for health visitors. These are apparent in relation to the gendered nature of health visiting work which focuses largely upon mothers; this both reinforces and reflects the absence of men (Milner 1993; Edwards, J. 1998; Williams 1998). However, knowledge that men are violent forces health visitors to reconceptualise the location of men within their work. Thus, even though men may continue to be excluded, or avoided, health visitors are constrained in their work by knowledge of this male power and control over women. Unsurprisingly this is translated into practice as a concern for their own physical safety.

There study also highlighted a paradox regarding the constraints men were able to exert over health visitors. This relates to the ability of known violent men to present themselves to workers such as health visitors as "plausible" or "credible" characters. For those health visitors who had a limited understanding of domestic violence, this (re)-presentation served to cast doubt upon women's accounts of their experiences, a position which was

supported by the prevailing patriarchal discourses which serve to minimise and silence women's experiences of male violence (Kelly and Radford, J. 1991).

CONCLUSION.

The absence of a gendered analysis about male violence, not only serves to make men invisible, but actually makes women responsible for their children's welfare and accountable to investigating agencies for fulfilling roles of "good enough mothering". Thus diverting the gaze towards children, focusing upon their welfare and safety and acknowledging potential child protection concerns, ensured that health visiting practice became more tightly enmeshed in the regulation of mothers. This often occurred alongside an absence of a gendered analysis of male violence, and a lack of support or protective services for women and children experiencing domestic violence.

In understanding the health visitors responses to domestic violence, there were a number of instances where it was apparent that they resisted the dominant discourses about motherhood, male violence and professional practice. Even though there were many examples of woman centred practices, these were often marked by complexity and contradiction. While not intending to minimise the strategies of resistance employed by some of the health visitors, these were undertaken from within the Panoptican of professional practices surrounding motherhood and male violence, which served to ensure that even for those health visitors who engaged in woman-centred work, this was always underpinned by concerns about child welfare and child protection. As Kelly (1994) has pointed out, for mothers experiencing domestic violence there is a "Catch 22" in relation to their contact with welfare workers such as health visitors. Thus health visiting responses to domestic violence were often constrained, both by the practices of men, and by the knowledge base which underpinned professional practice. This appeared to privilege child welfare alongside a minimisation of male violence against women. This ensured that very few health visitors were able to provide effective suport, or protection, to women and their children, experiencing domestic violence.

SECTION D: DRAWING CONCLUSIONS.

The notions of "regulation" and "resistance" threaded throughout this thesis have provided the conceptual, theoretical and methodological framework for this analysis of health visiting work with women experiencing domestic violence. These titular themes have arisen from feminist post-structuralism which underpins this research, focusing attention upon the issues of power, discourse and subjectivity. This has enabled the practices between health visitors and women experiencing domestic violence to be examined, leading to an original analysis. Thus, there are a number of conclusions to be drawn from this research, relating to both the theoretical issues, as well as the policy and practice implications. These are addressed in the final chapter of this thesis, which reviews both the process and content of the research. The discussion focuses in turn upon the theoretical perspectives which inform this research, before turning towards the policy and practice issues arising from this study.

CHAPTER 8.

BEYOND THE PANOPTICAN?

INTRODUCTION.

This study of the practices between health visitors and mothers experiencing domestic violence represents an original contribution to the existing knowledge base. This is apparent both in terms of the study's contribution to the area of policy and practice, and to scholarship informed by feminist post-structuralism (Foucault 1979; 1984; 1988; McNay 1992; Weedon 1997). The conclusions to be drawn from this research include, for example, the development of new insights about the relationships between mothers and health visitors, and the limited ways that domestic violence has been understood within professional practice. These conclusions are discussed in this chapter, which is sub-divided into two inter-related sections focusing upon theory and practice.

The first section discusses the theoretical perspectives that underpin this work, reviewing how feminist post-structuralism underpins the analytical, conceptual and methodological processes of the research. This is followed by a discussion of the policy and practice issues that arise from this study of health visiting work in the context of domestic violence. Both sections consider the extent that this research has contributed to existing knowledge. This separation of the issues of theory, from policy and practice, is largely a heuristic device. However, doing this does provide a useful framework for drawing the conclusions arising from this research. It also illuminates the ways in which the theory and practices inter-connect with each other, thus enhancing the overall coherence of the thesis.

THE THEORETICAL PERSPECTIVE.

This examination of the practices of health visitors and mothers experiencing domestic violence has drawn upon feminist post-structuralism (Foucault 1979; 1984; 1988; McNay 1992; Weedon 1997). This underpins the titular theme of "regulation" and "resistance" that permeates throughout the thesis, and provides the theoretical, conceptual and methodological framework for the overall research. Feminist post-structuralism has provided the theoretical tools enabling a set of issues, that are puzzling, to be examined and analysed. This is achieved in ways that are theoretically coherent, but which acknowledge the inherent complexity, diversity and contradictions. Using feminist poststructuralist ideas in this way, represents an original application of a set of intertwined ideas to a practice issue that has previously been under-theorised.

The application of feminist poststructuralist ideas was introduced in the opening chapters that reviewed previous research and established the context for understanding health visiting work in relation to mothers experiencing domestic violence. This established a discursive perspective regarding domestic violence, as well as arguing that health visiting is constituted upon a set of practices concerned with the social regulation of mothers. The methodological implications of feminist poststructuralism were also examined. These perspectives, which drew attention towards both discourse and power, provided the framework for the analysis of the interview data and presentation of the results. The following discussion reviews the issues arising from the application of this theoretical perspective, and assesses the theoretical contribution.

The Exercise of Power.

The theoretical perspective of feminist post-structuralism has drawn attention towards the issue of power; this has emerged as a key analytical theme throughout this thesis, heralded by the titular themes of "regulation" and "resistance". Power is the site of

analysis for the practices between mothers and health visitors, which, in the context of domestic violence, are further constituted by discourses.

The work of Foucault (1979; 1984) enables an understanding that the relationships between mothers and health visitors represent a form of disciplinary power. This builds upon previous sociological analyses of health care practice (Bloor and McIntosh 1990; May 1992a; 1992b; Nettleton 1992), and provides an analytical tool for examining these micro-practices. The analysis remained cognisant of the productive effects of the exercise of power, pointing to the ways in which it produced subjectivities, and provoked resistances. This has significantly extended the understandings of health visiting work with mothers, providing new theoretical insights. Indeed, this study represents the first application of feminist post-structuralist ideas to the practices of health visitors and mothers.

The theme of regulation threaded throughout this analysis provides an analytical framework for contextualising previous work. It provides a coherent means to analyse the historical and contemporary narratives of health visitors work with mothers. In particular, it shows how the enduring concept of health visitor as "mothers' friend" (Davies 1988; Machen 1996) is itself an aspect of regulation. This has been variously described as "tutelage" (Donzelot 1979; Dingwall and Eekelaar 1988), policing (Abbott and Sapsford 1990; Dingwall and Robinson, K. 1993), or surveillance (Bloor and McIntosh 1990). The notion of regulation opens the spaces to allow the contradictory understandings between lay and professional perspectives to be acknowledged and understood (Graham 1979; Mayall and Foster 1989; Abbott and Sapsford 1990; Symonds 1993; Cowley 1995b). This suggests that these arise, not simply because of different perceptions, but because of the "double-edged" sword of welfare and surveillance (Nettleton 1992, p. 149) which defines the practices of health visitors with mothers. It also problematizes the assumptions underpinning some of the multi-agency studies examining responses to domestic violence which have implied a straightforward relationship between women seeking help, and helping agencies. Thus the notion of regulation is a recurring theme throughout this thesis.

The notions of the "the gaze" and "pastoral power" are used as analytical tools for examining the micro-practices involved in the exercise of power between mothers and health visitors (Foucault 1976; 1979; 1984; 1988). This enabled, for example, the health visiting practices of "listening and talking" to be analysed and discussed. It also pointed to the differences between health visitors, demonstrating the ways in which contrary understandings of domestic violence shaped health visitors' abilities to recognise and respond to women's experience. As the recognition of domestic violence, designated as "getting to know", emerged as a complex and puzzling feature of health visitors' accounts of their practice, these analytical tools were particularly valuable.

The focus upon the exercise of power relations draws attention to the issue of resistance. This has been a central theme in feminist theory and practice, which has consistently and effectively challenged and resisted male violence (Stanko 1985; Hanmer and Maynard 1987; Kelly 1988a; Mama 1989a; Dobash and Dobash 1992; Hester et al. 1996). Resistance was identified within the study in terms of the practices of the women, and some of the health visitors who participated.

The women who experienced domestic violence are represented as "survivors" (Hoff 1990; Kirkwood 1993). This terminology draws upon feminist attempts to resist the language of victimhood, instead pointing to the practices through which women in situations of domestic violence challenge, resist and survive these experiences. All of the women who participated in this study have named their experiences and taken steps to reclaim their lives from the violence and abuse they have experienced from male partners. This resistance was inherent throughout their accounts, defining their individual and collective subjectivities. Moreover, the benefit of theoretical hindsight has also enabled me to identify the practices of resistance amongst women who did not wish to participate in this study; this issue is discussed in relation to methodology.

A key theme arising from the accounts of the women who did participate concerned their practices of resistance to health visiting work. The degree to which women talked openly about their practices of concealment, avoidance and resistance was surprising. This was particularly so, given my identity, and probably represents a degree of under-estimation

(Bloor and McIntosh 1990). Nevertheless, these findings indicate considerable activity amongst mothers designed to resist the regulatory role of health visiting.

The findings also point towards resistance in the practices of health visitors, and this provided a conceptual tool for analysing the differences amongst health visitors. This is particularly salient for those health visitors who resisted dominant discourses about motherhood, and male violence, and undertook practices concerned to ensure women were supported and protected. The extent to which they engaged in these practices of support or protection reflects the knowledge-base that underpins their work. This in itself represents engagement with a resistant discourse, as illustrated by the ways in which different understandings of the difficulties facing women living with, and leaving, situations of domestic violence impacted upon practice.

Furthermore, even though the theme of gendered regulation is supported by historical and contemporary analysis, professional discourses focusing upon "health" and non-judgmental relationships (Council for Education and Training of Health Visitors 1977; Chalmers 1991; Twinn 1991; De La Cuesta 1994; Cowley 1995a) has been represented as resistance to this narrative of gendered regulation (Graham 1979; Davies 1988; Dingwall and Eekelaar 1988; Abbott and Sapsford 1990; Edwards, J. 1998). Contrasting them in this way may mask some underlying differences between the nature of professional and sociological discourses. Nevertheless, constructing these professional discourses as resistance continues the titular themes of the thesis, and points towards the practices through which the subjectivities of practitioners are constructed and (re)-constructed.

The theoretical concerns about resistance threaded throughout this study have provided detailed examples of the resistances of both women and health visitors. It has also pointed to the ways in which discourses are themselves resistant to dominant malestream understandings of male violence (Stanko 1985; Hanmer and Maynard 1987; Kelly 1988a; Dobash and Dobash 1992; Hester et al. 1996). The notion of resistance, however, represents a key site in the struggle between feminist advocates and opponents to post-structuralist theories of power (Harstock 1990; McNay 1992; Ramazanoglu 1993; Weedon

1997). These struggles have focused upon the issue of women's agency, which has been problematised by many feminists concerned particularly with the impact of Foucault's work (Ramazanoglu 1993). However, Weedon (1997) has argued that post-structuralist theories of power allow women's resistance to be recognised and theorised (Weedon 1997, p. 125).

This engagement with post-structuralist theories of power (Foucault 1979; 1984; 1988; McNay 1992; Weedon 1997) has also enabled the development of analytical insights regarding the practices of the research. This problematised some feminist arguments regarding power in social research (Oakley 1981; Edwards, R. 1990); these are built upon modernist notions of power as a commodity, usually held by the researcher. Post-structuralism focused attention upon the exercise of power and knowledge, in the context of both interviewing and interpretation. Despite the research being informed by feminist methodological debates regarding reflexivity (Harding 1987; Stanley and Wise 1993), the adoption of a poststructuralist framework drew attention towards the issue of subjectivity (Henriques et al. 1984; Weedon 1997). This enabled me to understand and analyse my own "fractured subjectivities", as they shape and are shaped by the practices of the research.

Thus the issue of power is a key analytical theme for understanding the practices between mothers and health visitors. This research has engaged with feminist post-structuralist theories of power in a number of ways, represented by the related themes of "regulation" and "resistance" that are threaded throughout the thesis. However, this primary concern with the exercise of power is inter-related to other key analytical themes arising from feminist post-structuralism, particularly the concepts of knowledge and discourse. The following discussion focus upon the ways that the theoretical perspective of feminist post-structuralism drew attention towards the issue of discourse.

A Discursive Perspective.

The feminist poststructuralist theories of power are underpinned by understandings that this is closely inter-linked to knowledge. Indeed, Foucault (1979; 1984) refers to these two separate but interconnected concepts as power/knowledge. However, in the dense writing associated with post-structuralism it is sometimes difficult to understand the ways in which these concepts of power/knowledge are necessarily inter-linked. This is not the case in the current study. The focus upon domestic violence brings into the picture an issue which, although a long-standing feminist concern (Stanko 1985; Hanmer and Maynard 1987; Kelly 1988a; Mama 1989a; Dobash and Dobash 1992; Fawcett et al 1996; Hester et al 1996), is not part of the professional discourses of health visiting (Pahl 1982; Orr 1986; Frost 1997). Thus this examination of an aspect of health visiting work that has been marked by "silence" utilised the concepts of discourse and power/knowledge (Foucault 1979; 1984; 1988) in order to develop a theoretically informed understanding. This drew attention towards the knowledge-base that informs practice.

The research is underpinned by feminist understandings of domestic violence (Hanmer and Maynard 1987; Kelly 1988a; Fawcett et al. 1996; Hester et al. 1996). These acknowledge the commonalities and differences amongst women, paying particular attention to the social divisions of race, class, age, (dis)-ability, and sexuality, and how this impacts upon women experiencing, and surviving, domestic violence (Guru 1986; Kelly 1988a; Mama 1989a; McGibbon et al 1989; Bhatti-Sinclair 1994; Bowstead et al 1995; Cosgrove and McLeod 1995; McCarthy 1996; Whittaker 1996; Rai and Thiara 1997). This set of knowledge's was presented as discursive, and was contrasted with the professional discourses of health visiting (Council for Education and Training of Health Visitors 1977; Twinn 1991; Twinn and Cowley 1992) where domestic violence is not addressed (Pahl 1982; Orr 1986; Frost 1997). The theoretical perspectives drew attention to the emerging discourses regarding domestic violence. These included particularly the impact of domestic violence upon children, and upon health, suggesting that these would ensure that domestic violence became an issue of concern for health visiting practice. This provides a theoretically coherent means for beginning to explore the knowledge-base of

practitioners. It also has policy and practice implications regarding future changes in the professional discourses of health visitors, suggesting the need for a number of training and education initiatives about domestic violence.

An important practice issue arising from the research concerned the extent of health visitors' overall awareness of women's experiences of domestic violence. This illustrates how the adoption of a discursive perspective contributed to the emergent analysis. This centred around an interest in demonstrating the extent to which feminist discourses concerning domestic violence (Hanmer and Maynard 1987; Kelly 1988a; Fawcett et al. 1996; Hester et al. 1996) had informed professional practice. For example, feminist challenges to malestream understandings of domestic violence have made visible the extent and nature of women's experiences of domestic violence. These themes provided analytical tools for examining the health visiting discourse; in particular, the extent to which health visitors shared feminist understandings regarding the extent and nature of domestic violence. This enabled the differences between practitioners regarding their overall awareness to be more closely examined. A recurring theme within this research, and previous work (Borkowski et al. 1983; Dominy and Radford, L. 1996) suggests that health visitors under-estimate the extent of domestic violence. The analysis developed here, using themes from feminist discourses about domestic violence, has enabled further understandings about how and why this occurred.

The notion of "silence" has been an important theme in feminist work. It was used in this study as an analytical tool for examining the health visitors interview data to establish their awareness and understandings about domestic violence. This illustrated that for many health visitors, their practice is informed by a knowledge base that was largely silent about domestic violence. This is evidenced, for example, by the lack of attention paid to this issue within their professional education and training. Another related and important analytical theme that arises from feminist discourses concerns the issue of "naming" (Kelly and Radford, J. 1991). This was used as an analytical tool in order to illustrate some of the constraints upon health visitors abilities to recognise women's experiences of domestic violence. The emergent analysis indicated that workers themselves may be

reluctant to name situations as domestic violence. This issue has not been identified in previous research.

The theoretical insights of feminist poststructuralism enabled further analysis of the notion of "silence". This suggested that the silences about domestic violence within the health visiting knowledge-base impacted upon their practices, and in turn reinforced the silences between them and the mothers with whom they had contact. Thus, the silences surrounding the issue of domestic violence continued. This analysis draws upon post-structuralist theories of power, discourse and subjectivity; this illustrates the ways in which subjectivities are discursively produced, in this case producing "silent health visitors" and (re)-producing "silent mothers" (Henriques et al 1984; Hollway 1989; Nettleton 1991).

This engagement with feminist poststructuralist ideas reinforces the need to consider subjectivity, alongside discourse and power, throughout this study. This is particularly important in understanding the knowledge-base that informs health visiting work. As health visitors are predominantly women, and often mothers, their practices are shaped and informed by a number of discourses; these may be professional or personal. Thus, it may be that their practice knowledge about domestic violence is informed by feminist perspectives; however, this may have arisen because of particular personal interest or circumstances. This research did not explicitly focus upon this issue, although in some instances, health visitors did disclose or refer to their own personal experiences of male violence.

Most importantly, it is likely that some health visitors knowledge's about domestic violence may be informed by personal experiences of violent relationships. This is indicated by feminist research which suggests that domestic violence occurs in at least one in ten relationships, and occurs across the social divisions of age, race and class (Mama 1989a; McGibbon et al. 1989; Mooney 1993; Stanko et al. 1998). Thus it follows that many of the health visitors who participated in this study may have experienced, or be currently experiencing, domestic violence. It is important to be aware that these health visitors will bring these personal experiences to their work practices. Thus health visitors have "fractured subjectivities", subject and object of diverse and complex regimes of

knowledge. However, even though their personal knowledge's may shape their professional practice, these cannot themselves be considered to constitute professional discourses.

In his extensive writings concerning the issue of discourses and power/knowledge, Foucault (1979; 1980a; 1980b; 1984; 1988) refers to the existence of "reverse discourse" and "subjugated knowledge's" (Foucault 1980b; Cain 1993). These ideas provide useful pointers for understanding the status of discourses that exist in juxtaposition to the prevailing dominant discourses. In the context of understandings about domestic violence, the concept of "reverse discourse" has not been utilised, overtaken instead by the adoption of a position that has represented feminist work as "resistance". This is not to deny the possibilities of "reverse discourse". Rather, it chooses to celebrate the challenges to dominant malestream understandings concerning domestic violence represented in feminist work. This celebration occurs alongside an acknowledgement of the strength and momentum of these feminist discourses. However, this continues to be represented as "resistance", contrary to arguments that suggest radical feminism has itself become the dominant discourse (Featherstone and Trinder 1997).

In contrast, the concept of "subjugated knowledge's" (Foucault 1980b; Cain 1993) has provided a useful means for further developing this analysis, particularly in relation to a paradox within the health visitors' accounts of their practice. This pertains to the differences between individual accounts of work with women experiencing domestic violence; often these indicated that health visitors had considerable practice experience of domestic violence, featuring regularly in their everyday work. This is in sharp contrast to the analysis of professional discourses that continue to be marked by silence (Pahl 1982; Orr 1986; Kingston et al. 1995; Frost 1997). Moreover, these silences were experienced even by those health visitors who described regularly working with women in situations of domestic violence.

This is an interesting paradox, and one that has not previously been identified. However, adopting a feminist poststructuralist perspective enabled these differences between private work and public agendas to be identified, and provided the theoretical tools to

develop the analysis. It is in this context that the concept of "subjugated knowledge's" (Foucault 1980b; Cain 1993) has been utilised; it provides a means of understanding this "private" aspect of health visiting work. As already mentioned, a recurring feature of my fieldwork contact with the health visitors revolved around their developing awareness of domestic violence within their work. Comments such as "nobody has ever asked me about this before" arose frequently. This draws parallels with some feminist work that drew attention towards aspects of women's lives that had previously been invisible (Oakley 1976), and suggests that for some health visitors, knowledge of women's experiences of domestic violence is a "subjugated knowledge" (Foucault 1980b; Cain 1993).

Weaknesses of the Theoretical Position.

The feminist poststructuralist perspectives regarding power (Foucault 1979; 1984; 1988; Weedon 1997) which underpin this research provide a useful means for understanding health visiting work with mothers experiencing domestic violence. However, there are some issues associated with its application where care needs to be taken.

The analysis focuses upon the practices of "concealment", "avoidance" and "resistance". This further develops the work of Bloor and McIntosh (1990), providing new insights about disciplinary power. However, there are limitations to the extent of this type of analysis in the context of understanding the practices of mothers experiencing domestic violence. This revolves around the ways in which power is understood, reflecting debates about feminist appropriations of Foucault's ideas (Hartsock 1990; Soper 1993). For women experiencing domestic violence, their resistance to disciplinary power is aggravated by wider structural constraints impacting upon their lives; this includes their experiences of poverty, racism and other types of social exclusion, in addition to their experiences of male violence and abuse. Thus, in developing this analysis, it is vital not to forget or ignore the constant fear and constraint commonly experienced by women. Thus concealing their experiences from a health visitor does not just represent the exercise of disciplinary

power. It may also reflect fears about their own safety, or losing their children. It may also represent an inability to seek help, arising from their experiences of male abuse which are associated with a restriction on their own agency (Binney et al 1981; Pahl 1985; Kelly 1988a; Stark and Flitcraft 1988; Kelly 1994).

These considerations do not weaken the overall theoretical argument. However, they do reinforce the care which needs to be taken in feminist appropriations of Foucault's work. It also points to the need to develop specific analyses and understandings of power, differentiating between "power over" which is marked by force, violence and domination, and the exercise of power which exists within disciplinary relationships. This distinction has been made by Smart (1988) in the context of child custody, although others have failed to distinguish between different types of power (Porter 1996a; White, S. 1997). In the current context, therefore, it is important to differentiate between the type of power which is represented by male violence and abuse, and the disciplinary power which is exercised between mothers and health visitors. In this study, feminist poststructuralism is not challenging radical feminist work on domestic violence (Kelly 1988a; Hester et al 1996), by proposing new and different analyses about power. Rather, these perspectives are used to provide a framework for understanding the additional problems mothers face in relation to their contact with state agencies such as health visiting, drawing upon analyses of disciplinary power.

The feminist post-structuralist framework which underpins this research has largely drawn upon the ideas of Foucault regarding power and discourse (Foucault 1979; 1984; 1988); this has excluded other poststructuralist perspectives. This reflects the arguments underpinning Weedon's (1997) promotion of these ideas to feminist projects, suggesting they represent a set of theoretical tools to be used as appropriate. In the current context, concerned with knowledge and power, it was the ideas of Foucault which were more appropriate, compared to those of other poststructuralist writers, such as Irigiray, Cixous and Lacan. However, it is acknowledged that some other poststructuralist perspectives may have enhanced my overall argument. For example, Fox (1997; 1998) has favoured the writings of Derrida concerned with "frames" and "differance" (Derrida 1978). His

application of the notion of "frames" (Fox 1997; 1998) may have offered further theoretical credence to my overall argument which was concerned with silence surrounding the issue of domestic violence within the professional health visiting knowledge base. This recognition of the potential value of other post-structuralist perspectives may have arisen with the benefit of theoretical hindsight. However, it may also reflect the issues raised in the writing and textual reproduction of poststructuralist research (Fox 1995; Rhedding-Jones 1997).

Assessing the Theoretical Contribution.

This examination has viewed the practices of health visitors and mothers experiencing domestic violence through the lens of feminist post-structuralism (Foucault 1979; 1984; 1988; McNay 1992; Weedon 1997). This has provided a theoretical, conceptual, and methodological framework for the research, enabling the practice issues to be examined and analysed. The research has made a significant and original theoretical contribution, and this is discussed in the following section.

There is a growing body of work that has applied the ideas of Foucault concerning the exercise of power to sociological analyses of health care practices (Daly 1989; Bloor and McIntosh 1990; May 1992a; 1992b; Nettleton 1992; McKie 1995). This study contributes to this growing body of work, representing the first complete empirical work to use such an approach in the context of analysing health visiting. This claim acknowledges the paper by Bloor and McIntosh (1990) which has advocated such an approach. However, even though Bloor and McIntosh (1990) wrote about surveillance and resistance in the context of health visiting practice, their work represented a retrospective data analysis of a study concerned with consumer satisfaction (McIntosh 1987).

Given the possibilities, and indeed gaps opened up by previous sociological work (Bloor and McIntosh 1990; May 1992a; 1992b; Nettleton 1992; McKie 1995; Daly 1989), it seems a little surprising that the work of Foucault has not been more widely applied to the study

and analysis of health visiting. My professional knowledge of health visiting suggests that it would be appropriate. For example, the concept of surveillance has direct parallels with one of the four conceptual principles underpinning practice; this advocates "the search for health needs" (Council for Education and Training of Health Visitors 1977; Twinn and Cowley 1992), undertaken at both the individual and community level. Thus health visiting activity combines both the surveillance of individual bodies with the surveillance of populations, mirroring Foucault's conceptualisation of bio-power (Foucault 1979).

The approach, which has viewed the research practices through the lens of feminist poststructuralism, has led to new methodological insights. In particular, the application of poststructuralist theories of power serves to problematise some previous feminist arguments concerning power relations within social research (Oakley 1981; Edwards, R. 1990). Even though feminist methodological debates concerning reflexivity provide useful insights concerning the role of researchers within social research (Harding 1987; Stanley and Wise 1993), theorising this in terms of subjectivity has enabled the development of new understandings. Together, the poststructuralist ideas regarding power, knowledge and subjectivity enable the development of new perspectives about data analysis, interpretation, and writing.

Moreover, this study has promoted feminist post-structuralism as a means to develop analyses about applied problems. This follows the approach recommended by Weedon (1997), who suggests that feminist post-structuralism offers practical tools which are able to make a valuable contribution to the overall feminist emancipatory project. This is in sharp contrast to previous theoretical and epistemological preoccupations with the challenges and opportunities offered by feminist post-structuralism, which have problematised its approach and application.

In this context, viewing the practices of agencies through the lens of feminist poststructuralism provides a means to analyse the issues of power and knowledge. This can be contrasted to previous empirical work which has consisted of primarily sociological analyses (Bartky 1988; Bordo 1988). It is more difficult to locate applied applications of feminist post-structuralism. This is embraced, however, in the study by White, S. (1996)

which examined how mothers experiencing post natal depression were regulated, rather than supported, through the conflicting work of child care and mental health agencies.

Summary.

Health visiting work with mothers is bounded by regimes of knowledge and the exercise of power; it is complex, diverse, and puzzling, and making sense of it is a challenging enterprise. In the context of domestic violence this is further complicated, and issues both within, and beyond, the professional knowledge base and set of practices must be considered.

The theoretical perspectives that underpin this research arise from feminist post-structuralist theories (Foucault 1979; 1984; Weedon 1997; McNay 1994). These draw attention towards the exercise of power, discourse, subjectivity and social practices. Together these provide a framework for beginning to understand the complexity and diversity of the practices between health visitors and mothers experiencing domestic violence. By illustrating the complexity of health visiting, a feminist poststructuralist analysis has demonstrated that it is not just enough to add in domestic violence. Regulation, implied by the double bind of welfare and surveillance, suggests that the relationship between mothers and health visitors is complex. Understanding the regulatory role of health visiting, alongside their welfare and caring role, draws attention to the exercise of power, and the discourses that produce health visitors and mothers. This has implications for developing policy and practice.

POLICY AND PRACTICE IMPLICATIONS.

My interest in researching the work of health visitors in relation to domestic violence arose from my personal experiences of professional practice. This was underpinned by understandings that practice could be further developed and improved in order to provide a more appropriate and sensitive service to women and their children experiencing domestic violence. Alongside these expectations lay an awareness of the policy developments which were occurring at the time the research was taking place. These included the focus upon inter-agency work (Home Office 1995; Hague et al 1996a), the interest in the impact of domestic violence upon children (Abrahams 1994; Mullender and Morley 1994), and its' construction as a health care issue (Bewley et al 1997; Scottish Needs Assessment Programme 1997; British Medical Association 1998). This provided the contextual framework for the study, and pointed towards a number of potential policy and practice issues to be addressed.

This examination of health visiting practice concerning domestic violence has built upon the findings of previous work, developing new insights into this issue. Unlike previous studies that have considered health visiting alongside the work of other agencies (Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996), this research has adopted a single agency focus, but has incorporated both lay and professional perspectives. This has provided the overall framework to develop a detailed analysis about health visiting policy and practice regarding domestic violence. Some of the findings reported here have reflected or confirmed those of previous studies (Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996). However, one of the strengths of this study lies in the detailed presentation of the findings, underpinned by a firm theoretical framework. The policy and practice implications of this research are considered in this section.

Health Visitors' Awareness of the Extent of Domestic Violence.

The issue of health visitors' awareness and recognition of domestic violence emerged as an important theme. This was highlighted in both the health visitors' and women's interview data, discussed in chapters 5 and 6. These findings built upon previous work that has suggested health visitors under-estimate the extent of domestic violence amongst women on their caseloads (Borkowski et al 1983; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996). The detailed analysis developed in this study focused upon a micro-level analysis of health visitors practices of "getting to know", enabling the differences, as well as the similarities, between practitioners to be addressed.

Health visitors under-estimation of the levels of domestic violence amongst women they know has been an enduring theme in previous work, but one which has been subjected to little detailed analysis. This is often due to the multi-agency nature of these studies which have focused predominantly upon other agencies considered to have a more substantive role, such as the police or housing departments. There has also been a failure to distinguish between agencies within the health sector, often conflating the varied practices of a range of workers, such that the contribution of health visiting is lost within this broader context (Dominy and Radford, L. 1996). In addition to this lack of focus, previous studies asking health visitors to estimate the extent of domestic violence have often relied on survey methods (Borkowski et al 1983; Dominy and Radford, L. 1996). This method has provided an overview, but lacked little detail concerning health visitors awareness of domestic violence. It has also failed to address some of the complexities involved, such as defining, naming, and minimising women's experiences of male violence (Kelly and Radford, J. 1991). These, however, have been observed by Humphreys (1998) in a study of social work practice.

The findings of this study indicate there is an overall lack of awareness amongst health visitors concerning the extent of domestic violence, although there are considerable differences between practitioners. The majority of health visitors under-estimated the

extent of domestic violence; however, a few reported levels more congruent with the results suggested by feminist work (McGibbon et al 1989; Mooney 1993; Stanko et al 1998). The detail within this study, including the use of pseudonyms to ascribe a research identity upon the participants, enables the relationship between such estimates and descriptions of individual practice to be related.

Analysis of these individual descriptions of practice reinforced these quantitative estimates; this was undertaken using a number of analytical themes arising from feminist work concerning domestic violence. For instance, that domestic violence is a common event in women's lives; that it involves a range of experiences of abuse and violence; that it is experienced across the social divisions of race, class, age, and (dis)-ability (Guru 1986; Kelly 1988a; Mama 1989a; McGibbon et al 1989; Mooney 1993; Bhatti-Sinclair 1994; Bowstead et al 1995; Cosgrove and McLeod 1995; McCarthy 1996; Whittaker 1996; Rai and Thiara 1997). Feminists have also recognised the difficulties women face in naming their experiences (Kelly and Radford, J. 1991). These themes were used as analytical tools, together with the notion of "silence", in order to examine health visitors understandings of domestic violence. It demonstrated, for instance, how prevailing malestream understandings of domestic violence constrained health visitors' abilities to recognise particular situations. This provided the context for understanding the differences between practitioners concerning their awareness of domestic violence. It also provided a framework for analysing the extent to which feminist discourses about domestic violence had been absorbed by the health visiting knowledge-base.

There was also a marked contrast in the estimates given by the health visitors regarding the extent of domestic violence amongst women with young children on their caseloads, compared to their accounts of everyday practice. These estimates of reported levels of domestic violence were often incongruent with health visitor's practice experience, where domestic violence was an everyday event, often representing the backdrop and substance to women's lives. However, in their everyday work, the issue of domestic violence was not always named, and certainly not always addressed. The feminist analytical framework explained how this could be understood as reflecting, and reinforcing the prevailing

silences about male violence and abuse (Kelly and Radford, J. 1991). It was also used in order to examine the professional discourses which underpin practice; these reveal, in particular, that domestic violence is largely excluded from the official knowledge base. This professional silence was evidenced from a review of the literature, and the lack of attention to domestic violence which permeated throughout all the health visitors descriptions of their practice preparation. This enables the somewhat paradoxical findings to be understood; that even though domestic violence is an everyday part of health visiting work, it continues to be excluded from the professional "public" agenda of health visiting.

This focus upon these analytical themes arising from feminist discourses pointed towards the conceptual and methodological difficulties in establishing overall awareness of domestic violence, and explained some of the difficulties encountered in this exercise. However, the adoption of these themes also enabled a more textured analysis to emerge, acknowledging the complexities of examining an aspect of health visiting work which has previously been marked by silence.

Frustrated Help-Seeking.

A considerable body of feminist work has pointed towards the difficulties women face in seeking support and protection concerning domestic violence (Dobash and Dobash 1979; Binney et al 1981; Dobash et al 1985; Pahl 1985; McWilliams and McKiernan 1993) difficulties that are particularly acute in the context of help-seeking from statutory agencies. Indeed, recognition that women often face what has been referred to as "frustrated help-seeking" (Dobash and Dobash 1979) underpins some of the recent developments promoting inter-agency work (Home Office 1995; Hague et al 1996a). The findings of this study confirm that women experiencing domestic violence face many difficulties in seeking support and protection from health visitors. This was reflected in the accounts given by both the women and the health visitors who participated in this study.

A number of recurring themes concerning women's experiences of help seeking emerged throughout this study. These include, for example, the valuing of support, particularly long term enduring support, the need for protection, and information about accessing sources of protection. The prevailing professional "silence" about domestic violence was reflected in the lack of information available to women, and the difficulties both women and practitioners felt in talking about this issue. Moreover, the additional problems faced by Black and Asian women in seeking help reflected those reported in previous work (Mama 1989a; 1989b; Mooney 1993; Bhatti-Sinclair 1994; Bowstead et al 1995; Rai and Thiara 1997). These suggest that health visitors' practices are informed by a lack of awareness of issues regarding diversity, making it difficult for Black and Asian women to access their services.

These findings mirror previous studies that have pointed towards the difficulties women face in seeking support concerning domestic violence (Dobash and Dobash 1979; Binney et al 1981; Dobash et al 1985; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996). In particular, it reinforces feminist understandings that statutory agencies such as health visitors urgently need to improve their responses to women seeking support and protection. Of particular concern in this study was the high numbers of women who, although they had broken their silences about domestic violence and talked to health visitors openly about their situations, reported that this often failed to lead to any practical support or protection. As already mentioned in chapter 6, despite meeting with a number of women who were currently, or who had previously, lived in women's refuges in order to escape their situations, they had not received information concerning these services from health visitors. This omission represents a serious lack of duty of care to women, and children, and points towards the need for an urgent response in order to improve health visitors' abilities to ensure that women receive appropriate information about accessing support and protection.

Domestic Violence and Children: The Health Visitors' Response.

The recent interest in the impact of domestic violence upon children, and its interconnectedness with child abuse (Stark and Flitcraft 1988; Jaffe et al 1990; Abrahams 1994; Mullender and Morley 1994; Saunders et al 1995) reflects a long-standing feminist concern (Debonnaire 1994; Hague et al 1996b; Women's Aid Federation of England 1996b; Mullender et al 1998). It also represents the site at which the issue of domestic violence is most likely to become established upon the policy and practice agenda of health visiting. However, at the time the fieldwork was carried out, this emerging discourse about children and domestic violence was not being heard at the level of practice. Nevertheless, there are a number of policy and practice implications related to this issue.

The findings of this research suggests that health visitors continue to work with a set of complex and contradictory ideas regarding children and domestic violence. The analysis has focused upon how health visitors, concerned about children but unsure about the appropriate responses because of a silence about children and domestic violence in their professional discourses, actually increase their scrutiny of mothers. As Stark and Flitcraft (1988) and Kelly (1994) have observed, mothers experiencing domestic violence face a "catch twenty two" in their dealings with workers from child care agencies, such as health visitors. This was echoed by many of the mothers who participated in this study; even though they were concerned about the impact of domestic violence upon their children, they expressed reluctance to tell about their situation because they feared for the custody of their children. Many women recognised their own and their children's needs regarding support, but too often this was not available (Abrahams 1994). Moreover, mothers fears that health visitors would reframe domestic violence as a child care issue were often realised. When this happened, however, it often failed to lead anywhere and was not translated into the provision of support or protection to children or women. It was very often, nothing more than a "diverted gaze", from mother to child and back again.

Thus, the study identified a paradox concerning health visitors work with children. Their interest in the welfare of children emerged as an important conceptual theme in both the

mothers and health visitors interview data. However, the apparent coherence of such a theme masks a set of complex and contradictory practices and understandings. The theoretical perspective enables these to be articulated in terms of the practices of regulation and resistance, focusing upon the exercise of power and the knowledge base underpinning professional practices.

The Health Visiting Knowledge-Base.

The theoretical perspectives underpinning this study have drawn attention to the discourses which inform the practices of health visitors; this clearly has a number of policy and practice implications regarding future training and education. Health visiting work is shaped by a number of competing discourses. Even though this may include feminist discourses about both motherhood and male violence, these are often excluded or in competition with malestream and conservative understandings about women and health (Graham 1979; Mayall and Foster 1989; Abbott and Sapsford 1990). In particular, there exists a professional health visiting discourse which has constructed a normalised, middle class and eurocentric view of motherhood (Abbott and Sapsford 1990) which, as Stark and Flitcraft (1988) have pointed out, excludes understandings that "good" mothers have relationships with violent and abusive men.

Moreover, despite the emergence of domestic violence as a health care issue (Bewley et al 1997; Scottish Needs Assessment Programme 1997; British Medical Association 1998) there is little evidence that domestic violence is part of the public health discourse within health visiting. So for example, in their search for health needs (Council for Education and Training of Health Visitors 1977), health visitors may not consider that women could be experiencing domestic violence. Thus in practice, health visitors fail to recognise women's experiences of male violence and abuse, perpetuating the prevailing discourses which ensure that domestic violence remains hidden and is not spoken about. Similarly, at the time the fieldwork was taking place, the discourses regarding the impact of domestic violence upon children and the inter-connections with child abuse (Stark and Flitcraft

1988; Jaffe et al 1990; Abrahams 1994; Mullender and Morley 1994; Saunders 1995; Hague et al 1996b) had not yet impacted upon the health visiting policy and practice agenda.

This lack of knowledge regarding domestic violence indicates the need for a number of policy and practice improvements concerning future training and education programmes for health visitors and other nurses. In particular, the study has demonstrated that feminist discourses about domestic violence are not part of the professional health visiting knowledge base. This was evidenced by discussion of continuing myths and stereotypes regarding domestic violence; for instance, that it is a rare event, or one that is marked by physical violence.

The absence of feminist perspectives in health visiting (Orr 1986; Abbott and Sapsford 1990; Rolls 1992), may account for the prevailing silences about male violence and abuse. This is suggested, for instance, in the research undertaken by Appleton (1994b; 1996) which has focused upon the ability of health visitors to detect vulnerability in the context of child protection. Even though she acknowledges the ambiguity inherent in the term "vulnerability", her work displays a gender blindness; thus, she focuses upon "families", rather than considering abusing and non-abusing gendered parents. In the current study health visitors were able to detect that "something was wrong", but they were often unaware that it might be domestic violence. This may reflect similar perspectives about "vulnerable families" (Appleton 1994b; 1996) and a lack of gendered awareness about male violence and abuse.

A number of specific areas of policy and practice emerged from this research as topics which suggested the need for future development work. These included the issues of safety, record keeping, supervision, and confidentiality. These are generic issues across health visiting work, which need to be addressed at an organisational and professional level (Butterworth 1992; United Kingdom Central Council 1993). However, the findings of this study indicate the extra considerations which domestic violence places upon practitioners work loads. This has pointed towards the need to address the issues of safety, record keeping, supervision, and confidentiality in the context of domestic violence.

In the case of record-keeping, for instance, this may indicate a response at the professional or policy level, while the issues of supervision and safety need to be considered and addressed at the local organisational level.

This study has also highlighted the absence of protocols, policies and guidelines concerning domestic violence, as well as identifying the need for a training or awareness raising programme for health visitors. In this context, it is important to highlight a positive outcome of this research. My preliminary results suggested a training need regarding domestic violence, which was recognised and responded to by the nurse manager concerned. This led to the establishment of a training programme for health visitors employed by the Trust, organised in conjunction with the local Domestic Violence Forum. This has opened the way for continuing dialogue and further training and development work.

The prevailing professional "silence" in health visiting work about domestic violence is complex, aggravated by broader discursive strategies which serve to minimise and hide women's experiences of domestic violence (Kelly and Radford, J. 1991). This points towards the importance of ensuring that domestic violence secures a place upon the health visiting agenda. Otherwise, health visitors, in their "search for health needs" will continue to miss domestic violence. Moreover, the findings identified the somewhat paradoxical position which suggested that even though domestic violence is an everyday part of health visiting work, there is a silence about this reflected in the professional "public" agenda of health visiting.

Developing Health Visiting Work.

This study has been undertaken at a time when health visiting is facing further developments arising from the emerging public health discourses (Department of Health 1998). However, the findings suggest that the bulk of practice continues to be spent with mothers of young children. Many of the women who participated in this study reported

uncertainty about the health visiting role, mirroring the findings of previous studies (McIntosh 1987; Mayall and Foster 1989). However, such uncertainty may be experienced more profoundly in situations of domestic violence where women faced a number of difficulties. In particular, there was evidence that they experienced the notion of "health visitor as mothers friend" (Davies 1988) as ambiguous and contradictory. Similarly, amongst the health visitors there was a lack of awareness about the regulatory or policing nature of their role, and particularly the gendered nature of this. As Abbott and Sapsford (1990) have observed,

> "In their mode of intervention they can be seen as targeting the mother, working with definitions of "good" and "bad" mothering, and attempting to shape mothers in particular directions" (Abbott and Sapsford 1990, p. 120).

This suggests the need for professional debate to make visible and examine this issue of gendered regulation, in order to change existing patterns of submerging this collective, professional subjectivity.

The gendered nature of health visiting, highlighted in previous work (Graham 1979; Mayall 1990; Edwards, J. 1998) was made particularly visible in this study, which focused upon mothers and male violence. In particular it demonstrated the ways in which men were problematic to health visiting work, using notions of absence and presence to illustrate these complexities. The analysis suggested continued tensions regarding health visiting work with parents, which despite a rhetoric of inclusion for fathers, remains gendered, and renders men invisible. However, the focus upon male violence illuminated further the problem of men, demonstrating again how men were able to constrain and obstruct health visiting work (Pahl 1985).

Addressing Diversity.

This research has demonstrated very clearly how professional discourses have failed to acknowledge social divisions. This is particularly marked in relation to the gendered nature of health visiting work; the professional discourses remain largely silent about the issue of gender (Orr 1986; Rolls 1992). Even though materialist perspectives are becoming more visible (Blackburn 1996), there remains little consideration of other social divisions such as race, age, sexuality and dis-ability, which are often constructed as "other". This has previously been raised by Marshall (1992) who pointed towards the lack of incorporation of gender, class and race, within health visitors accounts of their work (Marshall 1992, p. 222). This can be contrasted to social work discourses where social divisions perspectives which underpin anti-discriminatory practices can be more easily traced (Ahmed et al 1986; Dominelli and McLeod 1989; Ahmad 1990; Wise 1990; Langan and Day 1992; Ahmed 1994; White, V. 1995; Cavanagh and Cree 1996; Mullender 1996). This issue has received little previous attention within the nursing and wider professional literature, with the exception of work by Gerrish et al (1996) who have pointed towards the lack of training and education regarding diversity within nursing professional education agendas. Given the commonality and diversity of women and children's experiences and lives, this suggests an urgent need for health visiting knowledge and practices to address issues of race, class, sexuality, (dis)-ability and age in order to provide a more sensitive and appropriate service to clients.

Contribution of Policy and Practice Related Findings.

This study has focused upon health visiting work in the context of domestic violence. The findings reflect those of previous multi-agency studies in which health visiting has been considered (Borkowski et al 1983; Pahl 1985; McWilliams and McKiernan 1993; Dominy and Radford, L. 1996). However, this research makes an original contribution due to the specific and detailed focus upon health visiting. In particular, it points towards the

contradictions within health visiting regarding domestic violence. These arise because it is an issue which is almost an everyday part of practice, but which paradoxically has not been part of the professional knowledge base. These contradictions permeate throughout the study, but are particularly visible in relation to health visitors work with children. These contradictions also underpin the policy and practice implications of this study. For recognising and taking seriously women's experiences of domestic violence necessitates an overhaul of a number of policy and practice issues. These include examining the knowledge base underpinning practice, as well as establishing specific procedures and policies which will enable practitioners to contribute effectively to the support and protection of women, and their children, experiencing domestic violence.

There have been a number of studies focusing upon health visiting work which have been undertaken by researchers who have previously worked as practitioners (Pearson 1991; Appleton 1994b; 1996; Cowley 1995a; 1995b; Machen 1996). My experience as a practitioner contributed greatly to the planning and undertaking of this research. However, unlike these previous studies, this is the first study to have developed an analysis of health visiting work informed by feminist perspectives.

Summary.

There are a number of policy and practice implications arising from this study of health visiting work in the context of domestic violence. These build upon the findings of previous work, suggesting that a number of measures need to be taken in order to improve health visitors' recognition and responses to women, and their children, experiencing domestic violence. In particular, Pahl (1985) previously identified three themes arising from health visiting work. These included a primary concern with the welfare of children, a lack of detailed knowledge regarding appropriate support and protection, and the difficulties in their work arising from their encounters with men. All these themes have arisen in both the health visitors and mothers interview data, confirming them as key policy and practice issues to be addressed. These measures need to be underpinned by developing the

professional knowledge-base of health visitors, ensuring that domestic violence is included in future training and education programmes.

The current professional "silence" in health visiting work about domestic violence is complex, aggravated by broader discursive strategies which serve to minimise and hide women's experiences of domestic violence (Kelly and Radford, J. 1991). However, it remains important to ensure that domestic violence secures a place upon the health visiting agenda otherwise, in their "search for health needs" (Council for Education and Training of Health Visitors 1977) health visitors will continue to miss domestic violence.

CONCLUSION.

This examination of the practices of health visitors with mothers experiencing domestic violence has contributed to existing scholarship. This has been achieved throughout the research which has intertwined the theoretical perspectives of feminist poststructuralism (Foucault 1979; 1980a; 1980b; 1984; 1988; McNay 1992; Weedon 1997) with a practice issue. Together this combination has enabled the development of new insights regarding both theory and practice, representing an original contribution to the existing knowledge base.

The theoretical perspectives derived from feminist post-structuralism underpins the analytical, conceptual and methodological processes of the research. This has provided a theoretically coherent means to develop the analysis, which has drawn attention towards the issues of power and knowledge. This has enabled the relationships between mothers and health visitors to be problematised; it has also illustrated the additional tensions which arise when these practices are examined in the context of domestic violence. The research has offered more than a purely sociological analysis, however, as it addresses a number of policy and practice issues. These have drawn attention towards the knowledge-base which underpins practice, as well as highlighting areas for future development. These policy and practice implications have been enhanced by the detailed findings of the

study, which have arisen due to the single agency focus which was adopted. This separation of the issues of theory, from policy and practice has provided a useful framework for drawing the conclusions arising from this research. However, it has been acknowledged that in numerous ways the theory and practices inter-connect with each other. It is this dynamic that underpins and enhances the overall coherence of this thesis.

Undertaking this study has provided an opportunity to focus upon an issue arising from my personal experiences of health visiting work; in particular, my concerns about the silences within the professional practice and knowledge base about male violence and abuse against women. The research has both problematised and celebrated aspects of health visiting work with women. In particular, it has pointed towards an urgent need to improve future policy and practice in order to ensure that women, and their children, are able to resist and survive male violence and abuse. However, the gendered nature of health visiting work also provides opportunities for redefining the professional discourses about male violence, and motherhood, thus enabling health visitors to provide positive support to women's practices of resistance. The walls of the Panoptican could be adjusted, thus (re)-creating the structures of power and knowledge which shape the practices of "regulation" and "resistance" between women and health visitors.

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APPENDIX A: CONSENT FORM USED WITH HEALTH VISITORS.

"Health Visiting and Domestic Violence" Research Project.

Consent For Interview.

I agree to be interviewed by Sue Peckover as part of the "Health Visiting and Domestic Violence" research project.

I understand that my conversation will be confidential and my name or any identifying characteristics will not be used in any discussion or report unless I request otherwise. I understand that I can stop the interview or refuse to answer a question whenever I wish.

Signature: .....

Date:.....

Consent For Tape-Recording.

I agree for a tape-recorder to be used during the interview.

I understand that I am free to stop the tape-recorder at any time during the interview if I wish.

Signature: .....

Date:.....

APPENDIX B: TRANSCRIPTION NOTATION.

Adapted from Appendix of Potter and Wetherell (1987).

Underlining indicates that words are added emphasis; words in capitals are uttered louder than the surrounding talk, e.g.:

It's not <u>right</u>, not right AT ALL

Round brackets indicates that material in the brackets is either inaudible or there is doubt about its accuracy, e.g.:

I (couldn't tell you) that.

Four dots .... indicate that some transcript has been deliberately omitted.

Material in square brackets is clarificatory information, e.g.

Brian [the speaker's brother] said .... it's okay.

A full stop in brackets indicates a pause, e.g.:

I went a lot further (.) than I intended.

No attempt has been made to measure length of pauses, overlap between utterances, extended vowel sounds or audible intakes of breath.

APPENDIX C: DEMOGRAPHIC DETAILS OF HEALTH VISITORS.

"Health Visiting and Domestic Violence" Research Project.

In order to complete this interview, I would be grateful if you could answer the following questions. Thank You Very Much.

1): How long have you been working in your current job?

	Please tick. ✓
Less than 12 months.	
1-3 years.	
3-5 years.	
5-10 years.	
More than 10 years.	

2): How long have you been working as a health visitor overall?

	Please tick. ✓
Less than 12 months.	
1-3 years.	
3-5 years.	
5-10 years.	
More than 10 years.	

3): In your current post, are you a full-time, part-time, or bank health visitor?

	Please tick. ✓
Full-time.	
Part-time.	
Bank.	

4): How many hours do you work each work? Please specify.

.....

5): Are you a Community Practice Teacher?

	Please tick. ✓
Yes	
No	

6): Which category best describes your age group?

	Please tick. ✓
Under 30 years.	
31-40 years.	
41-50 years.	
51-60 years.	
Over 60 years	

7): Are you a parent yourself?

	Please tick. ✓
Yes	
No	

Thank you very much for completing this sheet.

Please return to:

Sue Peckover,

Research Student,

Department of Appled Social Studies,

University of Warwick,

Coventry CV4 7AL

APPENDIX D: THE INTERVIEW GUIDE USED WITH HEALTH VISITORS.

- *To thank health visitors for their participation in the research. Introduce the scope and purposes of the research project, and my role.*

- *Acknowledge that they may find some of the issues difficult to talk about. Are free to not answer any questions, or to stop interview at any time.*

- *Consent form to be explained and signed.*

- *Introduce my definition of domestic violence, and invite comments.*

PRACTICE ISSUES: AWARENESS AND RESPONSES.

- Can you tell me about your practice experience of domestic violence?

- For example can you tell me about the times you have come into contact with women experiencing violence. Can you give me some examples of families you have been involved with where you are aware women were experiencing domestic violence?

- Thinking about your current caseload, can you give me some idea about how many women you are aware of experiencing domestic violence? Numbers known and/or numbers suspected. How do you know/suspect? Do you ask women about domestic violence?

- Can you tell me about how you have responded to women when you have known they have been experiencing domestic violence? How have you responded when you have suspected women were experiencing domestic violence?

- Does the issue of domestic violence pose any tensions or dilemmas in relation to work? For example, in terms of the focus of work with women or children?

- Do you have any concerns about the impact of domestic violence upon children?

- Do you have any experience or comments about the overlap between domestic violence and child protection?

- Are you are aware of any local policies or procedures about domestic violence?

- Are you are aware of any services or agencies providing support or protection to women experiencing domestic violence?

- Do you know how to contact these agencies? Have you used any of these services?

- Are you aware of any particular issues which might arise for Black and/or Asian women, or women with disabilities etc. Do you have any practice experience of working with Black and/or Asian women?

PROFESSIONAL ISSUES.

- Have you ever attended any training about domestic violence? Was the issue of domestic violence discussed during your health visitor training course?
- What about child protection training? Is domestic violence discussed at all?
- Can you tell me about how you would write your records in cases of domestic violence?
- Can you tell me about any provision of support for yourself as a worker?
- Are there any issues about your own safety?
- Do you have any contact with men? Have you ever been asked by women to challenge men, or to talk to men about relationship, or domestic violence issues?
- Do you think there is a role for health visitors in supporting women who are in violent relationships, and in relation to domestic violence issues more generally? What about the wider level role of health visiting in the community, in relation to domestic violence issues?
- Do you think there is a silence in health visiting about domestic violence?

APPENDIX E: CONSENT FORM USED WITH WOMEN.

"Health Visiting and Domestic Violence" Research Project.

Consent For Interview.

I agree to be interviewed by Sue Peckover as part of the "Health Visiting and Domestic Violence" research project.

I understand that my conversation will be confidential and my name or any identifying characteristics will not be used in any discussion or report unless I request otherwise. I understand that I can stop the interview or refuse to answer a question whenever I wish.

This confidentiality applies throughout my interview with Sue Peckover. The only exception to this would be in the unlikely event that I inform her that a child is currently at serious risk of being abused, in which case I understand she is legally bound to take further action.

Signature: .....

Date:.....

Consent For Tape-Recording.

I agree for a tape-recorder to be used during the interview.

I understand that I am free to stop the tape-recorder at any time during the interview if I wish.

Signature: .....

Date:.....

APPENDIX F: INTERVIEW GUIDE USED WITH WOMEN.

- *To thank women for their participation in the research. Introduce the scope and purposes of the research project, and my role.*

- *Acknowledge that women may find some of the issues difficult to talk about. Are free to not answer any questions, or to stop interview at any time.*

- *Consent form to be explained and signed.*

Current and Past Contact with Health Visitors.

Can you start of by telling me about the contact you have had with health visitors, both currently and in the past.

- Do you have a health visitor now? Have you had a health visitor in the past?

- How often do/did you see a health visitor? Can you tell me how this is arranged? e.g. at home, clinic, elsewhere. How is this contact initiated? e.g. by yourself, health visitor, other.

- How long have you known your health visitor? Did you know your health visitor well? Have there been any changes in health visitors?

- Is your health visitor female (or male)?

- How many children do you have? What are their ages?

Awareness of Domestic Violence.

Thinking now about your overall contact with health visitors, were you ever able to talk to them about your own situation as a woman in a violent relationship?

- Do you think your health visitor was aware that you were experiencing violence? Do you think she knew? Do you think she suspected? Did your health visitor ever ask you directly if you were experiencing domestic violence? Would you have liked your health visitor to have asked you about this?

- Did you consider discussing your situation with your health visitor? Would you have liked to? Do you think this would have been appropriate?

- Were there any issues arising from your situation which affected your health, which you would have liked to have discussed with/got help about from your health visitor? e.g. injuries, depression, pregnancy/contraception/abortion etc.

- Were there any issues arising from the impact of the domestic violence on your child/ren which you would have liked to have discussed with/got help from your health visitor?

The Provision of Support.

- Thinking now about your overall contact with health visitors, did you ever get any help or support from them regarding your own situation as a woman in a violent relationship?

- Can you tell me about this help or support? What type of help, e.g. more frequent contact, advice (legal, benefits, woman's aid etc.), referral (to whom/where), etc.? Was it appropriate? Would you have liked more help from your health visitor? What would you have liked?

- In your opinion, can you think of ways in which your health visitor was not helpful to you? (e.g.. either by providing a service/advice/whatever which you did not find helpful, or by failing to provide something you may have found helpful).

- Did you receive any help which arose indirectly from contact with your health visitor? e.g. leaflets or posters displayed at the baby clinic, talking to other women at baby clinic/women's group, referral to other service (statutory or voluntary, specify).

- Were any agencies helpful to you in seeking support relating to domestic violence? Who was the most helpful? How did you hear about (name of agency)?

Focus upon Men.

- Did you ever discuss with your health visitor any other issues concerning your relationship with your male partner? e.g. money, child care issues, arguments,

- Did your health visitor ever undertake any work or interventions with your partner/husband/boyfriend? Was this ever in relation to the violence you were experiencing? Do you think that would have been helpful?

Overall Health Visiting Role regarding Domestic Violence?

- Do you think health visitors have a role in supporting women who are experiencing domestic violence? What do you think health visitors could do to support women who are experiencing domestic violence?

- Do you think health visitors in their everyday work with women with young children should routinely ask about domestic violence?

Any Other Comments.

- Do you have any other general or specific comments about how health visitors could provide help to women experiencing domestic violence?