

ARTICLES

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Domestic Violence and Health Care: Opening Pandora's Box – Challenges and Dilemmas

In this article we take a critical stance toward the rational progressive narrative surrounding the integration of domestic violence within health care. Whilst changes in recent UK policy and practice have resulted in several tangible benefits, it is argued that there may be hidden dilemmas and challenges. We suggest that the medical model of care and its discursive practices position women as individually accountable for domestic violence-related symptoms and injuries. This may not only be ineffective in terms of service provision but could also have the potential to reduce the political significance of domestic violence as an issue of concern for all women. Furthermore, it is argued that the use of specific metaphors enables practitioners to distance themselves from interactions that may prove to be less comfortable and provide less than certain outcomes. Our analysis explores the possibilities for change that might currently be available. This would appear to involve a consideration of alternative discourses and the reformulation of power relations and subject positions in health care.

Key Words: *discourse, domestic abuse, health care response, intimate partner violence, medical model, medicalization, relational change, subject positions*

INTRODUCTION

This critical analysis of policy and practice subscribes to a broadly postmodern perspective acknowledging the role of language in the construction of social and psychological life. Within this theoretical domain, language is in part constituted of a multiplicity of discourses, or 'sets of statements that construct objects and an array of subject positions' (Parker, 1994: 245). However, as Rose (1998) makes us aware, subjectification can never be a purely linguistic operation; there is no homogeneous domain of meaning and negotiation. Rather, meaning is located in

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particular sites and procedures where power is granted or limited, enabling ‘. . . some to judge and some to be judged, some to cure and some to be cured, some to speak truth and others to acknowledge its authority and embrace it, aspire to it, or submit to it’ (Rose, 1998: 175) Therefore, this ‘assemblage’ of ‘discursive practices’ is seen to facilitate, limit, enable and constrain what can be said, by whom, when and where.

Theorizing from this vantage point enables the acknowledgement of a ‘constitutive’ relationship between ‘power’ and ‘knowledge’. Power ensures the production and dominance of some knowledge(s), meanings, values and practices over others. Drawing upon the recent developments in the UK, we argue that the provision of services to those who experience domestic violence is a particular example of this constitutive relationship. Such relationships have relevance in terms of appreciating the way(s) in which women’s personhood is understood, defined and located within specific power hierarchies. Thus, the significance for feminists and psychologists looms large; ever changing dominant knowledges and their contested authority requires detailed and persistent attention. Indeed, the terms ‘domestic violence’ and ‘domestic abuse’ are both employed within this article in recognition of the power hierarchies and contested authority of such terms (see, for example, *British Medical Journal*, 2002, electronic responses to Ramsay et al., 2002). ‘Domestic violence’ is employed as it seems to convey the brutality, breadth and depth of the behaviours and actions which constitute the phenomenon. The term ‘domestic abuse’ denotes the inclusion of behaviours and actions that are less visible, but no less severe, being psychological and/or emotional in nature. We should say that the usage of these terms in no way indicates a notion of hierarchy in women’s diverse experiences.

In this article we discuss the recent departure, in the UK, from historically constructing domestic violence as an exclusively social care issue to its reconstruction as a social *and* health care issue. We make a case for recognizing that the response of policy makers, health care professionals, and those who experience domestic violence, to the ‘subject positions’ available within current discourses is fundamental to any appreciation of action. Therefore, subject positions available to both women accessing health care services and health professionals will be scrutinized, for as Shumway (1989) points out, although individual subjects may make themselves they must work with the materials their culture provides.

DOMESTIC VIOLENCE AND ITS DISCURSIVE REPOSITIONING

Relationships of power/knowledge are not static but are continually changing. Postmodern thinking is attractive in that it enables us to look creatively at power, selves and knowledge production and at how the power of language and representation operates (Hall, 1997; McRobbie, 1997). Asking questions about knowledge production necessitates consideration of how discourse operates, its history and effects and the connections between different discourses. However, when

exploring recent changes in the discursive positioning of domestic violence it seems appropriate to offer a situated account. Our account is founded upon a desire to offer context therefore we recognize, but make no realist claims for, the chronological sequencing of events and the linear, progressive narrative form that we posit. What we aim to project is the apparent transformation of domestic violence into an area of concern.

Since the women's liberation movement of the late 1960s and early 1970s first established the serious and widespread nature of domestic violence, the phenomena has been broadly represented as a predominantly 'social' issue. During the last 30 years research has focused predominantly on identifying prevalence and exploring and 'explaining' the causes of domestic violence. However, research, which has often been undertaken within a feminist political and ontological domain, has sought to establish and give 'voice' to the needs and experiences of women as they seek support and assistance (Roberts, 1981; Landenburger, 1989; Merrit-Grey and Wilest, 1995; Stark and Flitcraft, 1996; Hyden, 1999). Indeed, it has been said that crossing from the modern to the postmodern involves issues of voice where telling one's own story is 'reclaimed' (Frank, 1995).

A further substantial focus has been to study the responses of statutory agencies, such as the police, social services and housing (McWilliams and McKieron, 1993; Mullender, 1996). This research highlighted the diverse and wide-ranging needs of women experiencing domestic violence, making recommendations to improve access to, and the quality of, service provision. However, more recently attention has begun to focus on the lack of information about domestic violence within health care agencies and the identification of health as an area of concern. This shift in focus toward the inclusion of health and health care may have been provoked in part by international concern regarding the effects of domestic violence on women's health globally (United Nations, 1993a, 1993b; World Health Organization, 1997, 2001, 2002). This may be a rather 'strategic narrative' (Patterson, 2002), in that it implies calculated intentionality that is goal orientated; nevertheless there is evidence of a growing concern relating to domestic violence and its impact on health – both physical and psychological (see, for example, Richardson and Feder, 1996; Campbell, 2002). Yet Deetz (1992: 77) distinguishes between and privileges the 'power *in* knowledge rather than the power *of* knowledge'. Here, the way in which power is exercised and the development of knowledge is seen to have a close relationship. Therefore, it is accepted that while institutional practices are based on knowledge, they themselves hold the power to support knowledge production (Alvesson and Skoldberg, 2000). Therefore, exploring this in relation to domestic violence, any obvious strategic narrative is problematic in that it makes causal assumptions that may indeed be simplistic and partial.

However, it could be argued that this global interest and concern has served to impact upon and influence government policy and legislation in the UK. In 1995, legislation established multi-agency forums, consisting of local representatives from the police, criminal justice, housing, health and social care agencies, to

coordinate local strategies to combat domestic violence (Home Office, Welsh Office 1995). This was followed in 1999 by a review of domestic violence policy by the Women's Unit of the Cabinet Office, which resulted in the publication of *Living without Fear* (Home Office, Cabinet Office, 1999). This document presents specific objectives for addressing violence against women and locates domestic violence clearly within the Government's Crime Reduction Programme (CRP).

However, despite these government initiatives, early research with domestic violence forums found that representatives from health agencies were under-represented (Hague et al., 1996). It was not until 2000 that the Department of Health responded to the Government's call for front-line intervention from health professionals with the publication of two resources: *Domestic Violence: A Resource Manual for Health Care Professionals* and *Principles of Conduct for Health Professionals* (Department of Health, 2000a, 2000b). These documents aimed to integrate the fragmented and limited guidance provided by the various governing bodies of differing health professionals. The publication of these documents saw domestic violence, for the first time, represented as a health care issue as opposed to a predominantly social care issue.

Domestic violence cannot be addressed by the police and criminal justice system alone. The consequences for the well-being of those who experience domestic violence are of such magnitude as to constitute a major public health issue. (Department of Health, 2000a: 2)

Such documentation locates providing support for women experiencing domestic violence as occupying a 'pivotal role' for the National Health Service (NHS). The stated primary aim of this documentation is the provision of guidance that would aim to assist health professionals in their professional practice and thus daily interactions with those experiencing domestic violence. However, this recent change in the social construction of domestic violence appears to signify an apparent blurring of boundaries with the integration a complex 'social problem' into the obligations and responsibilities of health care providers and practitioners.

REPOSITIONING DOMESTIC VIOLENCE: BENEFICIAL IMPLICATIONS AND INHERENT DILEMMAS

While the repositioning of domestic violence is being presented within an obviously rational progressive framework, there are implications that may not be quite so obvious and thus may go unobserved. Therefore, we aim to somewhat challenge the authoritative progressive narrative associated with the repositioning of domestic violence. While acknowledging beneficial accompanying practices, we aim also to identify some of the less obvious inherent dilemmas that arise.

A notable beneficial outcome has been the allocation of funding for research into the causes, prevalence and strategies for reducing domestic violence, and

the development of services and training for health care professionals. This is illustrated by the already referred to inclusion of domestic violence and health-related research projects in the Government's CRP (Home Office, 1999) within its 'Reducing Violence against Women' initiative. This initiative aimed to seek out evidence of good practice in dealing with domestic violence, rape and sexual assault by known perpetrators. With a budget of £6.3 million, statutory and voluntary agencies and multi-agency partnerships have been able to bid for funds to develop and implement local strategies (see for example Tacket et al., 2003).

It is argued that a further benefit of the increased visibility of domestic abuse, and the acknowledgement of its associated impact on health, has been the necessity to devise appropriate policies and procedures (Williamson, 2000). Embedded within such policies and procedures is the development of programmes of 'routine enquiry' and/or 'screening'. These have aimed to establish the routine questioning of women about domestic violence within the taking of medical histories or within specific medical encounters, such as cervical screening appointments and pre and post-natal checks (; Department of Health, 2001; Tacket et al., 2003). However, despite these apparently progressive moves, dilemmas are evident. Not least amongst these is a concern over the lack of a consistent medical approach (Llewellyn et al., 1995; Warshaw, 1997) with the effect that the quality of response women receive varies greatly, dependent on their geographic location and the presence or absence of any local initiatives for responding. The outcome of such inconsistencies is seen to be that domestic violence related symptoms are often missed because health care professionals are uncomfortable operating in this domain (Denham, 1995; Hadley, 1992; Llewellyn et al., 1995). Bury (2001: 266) offers an account of why this might be the case:

The task of the doctor, increasingly in the 19th century and into the 20th, was to translate pieces of information into a definitive diagnosis that linked the disease to specific biological causes and outcomes, rather than to the patient's circumstances or lifestyle, let alone their beliefs or values.

However, discomfort in responding to domestic violence does not appear to be confined to any particular professional group (only doctors). Rather, research has indicated that some health practitioners in all professional groups remain reluctant to implement 'routine enquiry' for what they define as a social problem, despite evidence of the resultant health care implications (Kurtz, 1987; Abbott and Williamson, 1999). Thus, it might be argued that this results in 'diagnoses' that deny, dismiss and/or minimize the underlying contribution of domestic violence to women's ill health. Nevertheless, it is recognized that addressing the problem of consistency may lead to 'uniformity' and the potential for a failure to acknowledge the diversity of women and their unique health and social care needs. Routine procedures, consistency, and the related potential outcome of uniformity, may also have the effect of constructing a particular 'subject'; one who is open to interrogation, is passively consensual and, if identified as being

the 'victim' of domestic violence, is expected to acquiesce to medical procedures and practices. Therefore, consistency may result in serving to consolidate and conceal particular forms of authority (Butler, 1992). Yet a framework for consistency might serve to enhance the quality of the professional response women currently receive. This dilemma is not easily resolved; consistency may indeed be a double-edged sword that has the potential to both benefit and disadvantage women. Nevertheless, failing to initiate change because of a reluctance to integrate new policy initiatives into current practice would seem to be unacceptable.

Associated with concerns regarding uniformity is research undertaken within a declared feminist agenda that has highlighted potential problems associated with the 'medicalization' of hitherto social issues. In his writings Foucault (1979 [1975]: 26) refers to a 'network of relations' whereby power is exercised. Biomedicine has its own network of relations where dominant regimes of thought and practice operate. Technical expertise, specialized language, practical rationalities and the discourse of disease as individual pathology all create and make available different forms of accountability. Thus, it is argued the process of medicalizing social issues whilst disempowering in all patient and health service professional encounters (Gallagher and Ferrante, 1987), is particularly disadvantaging for women experiencing domestic violence (Reissman, 1983; Kurtz, 1987). Acknowledged is the danger that causes and interventions may become viewed from an 'individualistic' perspective with the concurrent social aspects becoming obscured, as indeed has been argued by Foley (1996) in relation to the medicalization of rape. Rose (1998: 105) refers to:

... individualizing humans through classifying them, calibrating their capacities and conducts, inscribing and recording their attributes and deficiencies, managing and utilizing their individuality and variability.

Thus, by taking an individualistic stance, the complex health and social factors involved are redefined becoming accountable in terms of the individual woman's attributes and her responsibility. Indeed, it has been argued that the social control of women is established and maintained through these processes of individualization and medicalization (Zola, 1972; Ehrenreich and English, 1979). Such processes have been linked to the misdiagnosis of women's symptoms and injuries (Herman, 1992; Gondolf, 1998) resulting in women being located within discourses which position them as the object of psychopathologization or ascribe to them quasi-psychiatric labels (Kurtz and Stark, 1988).

Such positioning suppresses alternative accounts that enable an acknowledgment and accommodation of the underlying and wider social circumstances that brought women into contact with health services. In her work with 'battered women', Hyden (1999) highlights the need to avoid attributing the social conditions under which women live, and the psychological process they undergo, with specific 'qualities' in the women themselves. An individualistic approach can effectively marginalize women (Reissman, 1983; Williamson, 2000) and simultaneously enable non-engagement with the wider social and political context that

perpetuates and supports the perpetration of domestic abuse. Of central importance is the possibility that consequentially this may lead to the de-politicization of domestic violence. Therefore, paradoxically the widening out of domestic violence to be inclusive of implications for health care could result in the dilution of domestic violence within political and policy agendas and its relegation to the margins. Hence, another dilemma becomes visible whereby the repositioning of domestic violence as a health care issue could have the effect of domestic violence being constructed as a problem merely for 'individual' women, rather than a globally shared social issue of concern (Williamson, 2000).

HEALTH PROFESSIONALS AND THE CONSTRUCTION OF DOMESTIC VIOLENCE AS A HEALTH CARE ISSUE

The development of an official and professional obligation for health professionals to intervene in what was previously constructed as a social care issue, and thus external to their interventions, surely presents certain challenges. This changing construction of domestic violence has resulted in a public, political and organizational reframing of roles and responsibilities. Only recently has research begun to document the implications for health care professionals when providing services for those experiencing domestic violence (BMA, 1998; Heath, 1998; Abbott and Williamson, 1999; Watts, 2000; Watts et al., 2002). Indeed, North American research has led the way in establishing the existence of domestic violence within the caseloads of health professionals; illuminating the implications of domestic violence on health *and* professional practice (Sugg and Innui, 1992; Stark and Flitcraft, 1996; Shornstein, 1997). However, this change in obligation needs to be viewed within the wider context of the extending role of primary health care to include health promotion and ill-health prevention. Reconstructing domestic violence as a health care issue squeezes it into a system already coping with a massive extension of its previous role and forces domestic violence to compete with other health and social issues for priority.

Research seeking to explore the effects of these changes has reported health professionals experiencing being 'saturated' by change, perceiving an increase in their workload, particularly in relation to routine enquiry or screening for domestic violence and documenting case histories (Watts, 2000; Ramsay et al., 2002). Indeed, in health care settings, where routine enquiry has been deemed a priority, the process of enquiring about and documenting domestic violence has apparently necessitated a re-negotiation of the traditional subject positions within the health care interaction. Here the traditional relational positions established between patient and practitioner have become disrupted, with women being characterized as '... the experts and the best judge of when to leave' (Abrar et al., 2000: 243). Consequently, health practitioners consistently report a level of vulnerability in that they feel as though they are being asked to respond to an issue for which they have not received adequate training (Davis, 1984; Sugg and

Innui, 1992; Frost, 1997). With such information, the reluctance of health professionals to engage with the underlying cause of women's ill health possibly becomes a more contextually located knowledge requiring further scrutiny

CREATING METAPHORICAL DISTANCE BY KEEPING THE LID ON 'PANDORA'S BOX'

As stated earlier our analysis is located within a perspective where language is not conceptualized as a passive tool employed by individuals to convey their inner 'thoughts' or 'truths' about a common external reality. Rather, language is a dynamic process through which the world and our understandings of it are constructed. The use of metaphor, as a means of discussing phenomenon and events in the social world, has been well documented (see Lakoff and Johnson, 1980; Davis, 1984), as Lakoff and Johnson (1980) suggest, the essence of metaphor is 'understanding one thing in terms of another' (p. 5). They argue that this allows us the power to define reality and can be employed to draw attention to unexpected aspects of social phenomenon. The metaphor of 'opening Pandora's box' has been identified as being commonly employed by health care practitioners to describe their experiences of providing services for women experiencing domestic violence (Sugg and Innui, 1992; Brown et al., 1993; McCauley et al., 1998). This is illustrated in the following quotation from a participant in a study of North American physicians' responses to domestic violence:

I think that some physicians, and I do the same thing, if you are very busy and have lots of patients waiting you just don't ask a question that you know is going to open a Pandora's box. Even if it crosses your mind, you don't ask. (Sugg and Innui, 1992: 358)

Therefore, even when domestic violence is accepted to be underlying the women's need to access health care services, there is a reluctance to open a Pandora's box. This metaphor arises from Greek mythology. Pandora was the first woman, created by Zeus (King of the Gods) to punish another god, Prometheus, for helping mortal men. Zeus reportedly endowed Pandora with a 'deceptive heart', a 'lying tongue' and a box that she was forbidden to open. Eventually, out of curiosity, Pandora opened the box releasing into the world all manner of evils, sorrows, plagues and misfortunes. However, the remains of the box held one consolation – *hope*. While recognizing the need to refute the negative and detrimental representation of women portrayed in this myth we concede that the generally understood interpretation of the use of the metaphor 'opening Pandora's box' is that even seemingly insignificant and well meant actions can unleash a flood of negative repercussions. Therefore, similarly Brown et al. in their study of health professionals' responses to domestic violence report the use of the metaphor 'opening a can of worms':

I find it very frustrating and intimidating to uncover this thing, and then just sit there and feel totally impotent about what to do. That is probably why I don't go digging for it, because what do I do with this can of worms. (1993: 188)

One function of metaphor is that it enables us to construct some elements of our experience in terms of something else that may be more generally understood, whilst also serving to obscure other aspects of our experience from view (Davis, 1994). This has significance in that it is proposed that by employing such metaphors to describe the reasons why they fail to intervene with women experiencing domestic violence, medical practitioners can draw attention to the negative aspects of intervening and distance themselves from the reality that their failure to intervene appropriately may perpetuate the women's situation.

THE MEDICAL MODEL OF CARE: PROTECTION, DIAGNOSIS AND 'NARRATIVE SURRENDER'

The distancing effect bestowed by metaphors such as 'opening Pandora's box' and 'opening a can of worms' seem to echo and be supported by discourses associated with the medical model of care (Warshaw, 1993). Harding (1986: 141) has argued that the medical model is based on a scientific, epistemological approach to understanding and dealing with problems. Within this mode of operating, problems are seen to arise from an individual 'disembodied' subject, soluble by rigorous searching for symptoms, which indicate a 'clear and certain truth', rather than an 'embodied' subject, influenced by social practices and interactions (Cromby and Standen, 1997). Drawing upon the biomedical discourse serves to 'medicalize' problems which enter the health care arena, reducing them to categories which can be diagnosed and successfully treated. (Warshaw, 1989).

Keller (1985) argues that such discursive practices play a distinct and important part in determining the thinking and behaviour of health professionals masking the 'protective motivation' which underlies the purported 'neutral' stance of western medicine. Indeed, Warshaw (1993) describes how problems shift from a social context which is inclusive of the woman's subjective experience, to a medical context which functions to distance and protect health professionals. Therefore, by remaining within the confines of the biomedical discourse of 'diagnosis' and 'cure', health professionals are protected from engaging in what might be termed, more 'messy' interventions, holding less certain outcomes. Furthermore, the medicalization of domestic violence is fraught with additional difficulties. In particular, this process relies on the homogeneity of experience and symptomatology, in order that a distinct diagnostic category can be established. This reductionist process runs the risk of attempting to fit the culturally diverse and unique experiences of women into a narrow diagnostic category, thus serving to ignore the specific difficulties women face. Further, inherent in the diagnosis of 'domestic violence' is a value judgement about the woman and her

lifestyle choices, with the effect that women's lives become pathologized (Warshaw, 1993). Hayne (2002) links diagnosis to 'naming' and then to 'name-calling':

In diagnosing a clinical judgement is brought to bear. Some classifiable symptomatology is given identity. . . . There seem to exist some common features between name-calling and diagnosis. Diagnosis like name-calling may only involve a single word. . . . Somehow that one word or that phrase . . . has such manifest power.' (pp.182-3)

There is no intention here to suggest that 'naming' of itself is an oppressive process. Rather, the point being made is that naming is one of the processes that constitute conventional forms of understanding and can have the potential to both acknowledge and deny the experiences of women living with domestic violence. Edwards and Ribbens (1998: 2) make this point, saying that '. . . routine public and disciplinary categories and procedures, insistently pull us towards conventional understandings that reshape, in particular, women's voice and experiences'. Thus, arguably, concurrent to this development of a diagnostic category for domestic violence is the development of discursive practices and subject positions consistent with the medical model. These discursive practices operate at the point of contact to determine the power relations between women and health professionals. Acknowledged is the complexity of such relations, in particular the operation of a hierarchy of power *between* women since many health professionals responding to women experiencing domestic violence will also be female. Beckwith (1999: 390) argues that this operation may be understood as 'a function of accessible discourses, plus opportunity and commitment to implementation'. Thus, the position of women with power over 'other' women is theorized as arising from both structural and hierarchical factors. In part the exercise of such power can be theorized as embedded within social structures and institutions characterized by patriarchy and gendered power relations, yet also arising from hierarchical structures of power and their concurrent dominant discourses. Fundamental, within this symbiotic relationship is the individual's power to embrace or resist dominant discourses and positioning(s) made available to them. Thus, exploring the exercise of women's power over women within the health care interaction may be understood to be related to the way in which female health professionals 'make' themselves and 'other women' within the structure of biomedical encounters (Shumway, 1989). Beckwith (1999) argues that women's failure to act in the 'interest' of other women is unsurprising, since they lack access to appropriate, alternative discourses and structural contexts from which to operate. Therefore, of concern is not merely the lack of resistance amongst female health professionals to disempowering dominant discourses, but the unveiling of structural and hierarchical factors which impede such action. A further facet within this complex picture is the likelihood that with one in four women experiencing domestic violence over their lifetime (British Crime Survey, 1998) many female health professionals may themselves be experiencing or

surviving domestic violence. The impact of such experience upon responding remains unresearched territory, perhaps in part because of the apparent 'invisibility' of domestic violence within the health professional population or perhaps because of the prevalence of myths which function to suggest that 'professional' women are unlikely to experience abuse (Bicehouse and Hawker, 1995).

The impact of the discursive practices of the medical model on the response health professionals afford, or indeed are able to afford, to women experiencing domestic violence has been the subject of considerable research in North America (Flitcraft et al., 1992; Warshaw, 1993, 1997; Brandt, 1997), having until recently received little attention in the UK. Warshaw (1993, 1997) has argued that the discourse of the medical model serves to reposition women from active 'agents' in their own lives to passive 'patients' who fit into prescriptive categories which homogenize their experience. This process of objectification or 'name-calling' involves the active reconstruction of information about domestic violence from the context in which it has meaning for the woman, into a context which is meaningful for medical practitioners. Frank (1995: 6) talks about medical care and its relational obligations as a form of 'narrative surrender' in that the 'ill person' is required to have their story told in medically determined ways. Thus, the process can perpetuate the woman's experience of domination. In a mirroring of the abusive relationship, once again a powerful 'other', this time the health professional invalidates, minimizes and/or ignores the woman's perceptions of her experience. She is expected to surrender herself, having her difficulties reconstructed to accommodate a discursive reality which enables health professionals to feel more comfortable and more in control. Cultural, racial, gender and class differences all serve to inflate this power differential perpetuating a cycle whereby women's needs and requirements are once again subordinated. (Muehlenhard and Kimes, 1999).

For Warshaw (1993), the situation is further exacerbated by the discourse employed within the medical record. This documentation is seen to separate the woman and her experience from the effects of the violence on her body. Thus, her narrative of the circumstances, which resulted in her injury or symptoms, becomes distanced from her and reduced to something that does not reflect her actual situated experience. This 'official story', presented in the medical record, again serves to invalidate the woman's personal experiences and silence her voice in favour of the 'expert' and the 'objective' observations made by the health professional. Further, constructing the injury or symptom as the object of importance serves to distance the reader of the medical record from the cause/perpetrator of the injury or symptom and the social circumstances under which it occurred. In her examination of the medical records of women experiencing domestic violence, Warshaw (1993) highlights how a diagnosis of 'atypical chest pain' obscured one woman's actual experience which, was 'pain secondary to her husband punching her in the chest or pain secondary to panic attacks that began after he threatened to kill her if she ever tried to leave' (p. 76). Moreover, Anspach (1987,1988) argues that the discourse of the medical model serves an

important function for health professionals in that it establishes and maintains a 'necessary' level of detachment from the patient which protects the health professional from becoming emotionally involved. Thus, by reducing the problem to a distinct diagnosis which can be controlled and manipulated, the health professional is able to take a seemingly practical course of action, rather than feel powerless and frustrated by an inability to change the actual cause of the problem – the woman's social situation. In reflecting upon these arguments, we recognize that this practice of responding might also be argued to occur in relation to other complex health and social care phenomenon, not only domestic violence. However, what we want to draw attention to here are the specific and seemingly detrimental effects such practices of responding would appear to have for women and for the health care interaction they share with health professionals.

EXPECTED COMPLIANCE AND EMPOWERMENT

Health professionals report frustration that women are often 'not compliant' in removing themselves from a situation that impacts so significantly on their health and well-being, repeatedly presenting with similar injuries and symptoms (Brown et al., 1993). This frustration and disappointment reflects a particular construction of not only domestic abuse but also the discourses of health care and the ethos of expected compliance that it exemplifies. Therefore, operating within the discursive practices of the medical model appears at odds with the kind of 'empowering' approach that research with survivors of domestic abuse has indicated is necessary. Ruddy and McDaniel (1995) have suggested that parallels exist for the health professional between domestic violence and chronic illness, in that part of their role in chronic illness is to empower the 'patient' to induce changes to their lifestyle or social situation in order to improve their health. However, in responding to domestic violence many health professionals report that for them the only successful intervention is for women to leave their abusive partners – reconciliation is viewed as non-compliance, as this quote from a physician in a study by Brown et al (1993) illustrates:

... you're always going to have the patients who go back. It's like anything that you deal with, there's tremendous level of non-compliance, and you can't understand why someone would ever go back into that relationship. But you also see a patient who's left an abusive situation and really grown in her self-confidence. She's made her way in life and developed a home where her children are secure. Every once in a while you see that and it makes it all worthwhile. (p. 188)

Since research has illustrated that many women remain unable or unwilling to leave their abusive partners (Ruddy and McDaniel, 1995; Itzin, 2000) this seemingly simple adjustment, in terms of employing a chronic illness type mode of responding to women experiencing domestic violence, becomes fraught with difficulty. Empowerment in this location seems to equate with an expectation that

women will follow a particular course of action in order to overcome their 'illness'. Yet research with survivors of abuse has indicated that the time women are most 'at risk' of serious injury or even death as a result of domestic violence, is when they have indicated an intention to leave (Jones, 1991; Radford, 1993; Lees, 2000). This situation appears to leave health professionals and women at a stand-off, with women unable to assist in the recovery process in the manner prescribed by the health professional (Williamson, 2000). Furthermore, research has demonstrated that this standoff can result in deterioration in the patient-practitioner relationship, which can ultimately end in victim blaming (Loske and Cahill, 1984; Easteal and Easteal, 1992)

As Landenburger (1989) highlights, abuse is a complex phenomenon that women rarely perceive in terms of such dichotomous options as 'stay' or 'leave'. Thus, it would seem that one of the fundamental challenges emerging from the inclusion of domestic violence within the health agenda is how to somehow move away from expected compliance. This move may create the space to engender the development of a jointly negotiated plan of action to which the woman could commit. The current dominant discourse, and the ensuing medical model of care, into which health professionals are educated and encouraged to practice seems unequal to the task. The ineffectiveness of this model in dealing with complex social problems that impact on health seems obvious – individualizing, categorizing and keeping women and their lives at a distance will not suffice.

MEETING THE CHALLENGE: DEVELOPING RELATIONAL CHANGE

This analysis would therefore seem to raise a number of issues in relation to responding to domestic violence which appear relevant to both the national and international health care community. Indeed, it would appear that if health care services are more effectively to fulfil their current obligations to women experiencing domestic violence, changes need to be made. These changes constitute a significant challenge to long-standing traditional health care practices that position the health professional as powerful 'expert'. The irony cannot be ignored here, in that research has highlighted the limited amount of input health professionals receive regarding domestic violence as part of their pre-registration (Warshaw, 1997) and post-registration training (Friend et al., 1998; Williamson, 2000). Indeed, research shows health professionals reporting a need for training to facilitate the necessary skills and awareness regarding effective identification and intervention (Brown et al., 1993; Sugg and Innui, 1992). Health professionals have further indicated that their lack of training and knowledge about the causes and effects of domestic violence can lead to feelings of inadequacy and frustration. Such consequential effects surely impact upon both health professionals and women at the point of contact, resulting in ambiguity about the most appropriate course of intervention (Dickinson and Tully, 1996).

Research with women who have experienced domestic violence has indicated

that the most helpful responses of health professionals arise from practices which are inconsistent with the medical model. One such practice is the adoption of a 'non-directive' manner (Sassetti, 1993). However, adopting such an approach necessitates a compromise for health professionals, since it requires a recognition that the seemingly most simple intervention, 'leaving now', is not an immediate possibility and may actually function to place the woman at greater risk (Jones, 1991; Radford, 1993; Wilson et al., 1993; Lees, 2000). Further, it involves adopting a commitment to work in partnership with the woman, within the boundaries of her situation. This requires the health professional to relinquish the power to issue 'directives'. Whilst functional for the health professional, often such directives make demands that the woman cannot accede to thus she is positioned as non-compliant (Sassetti, 1993).

The aim would be to assist health care professionals in developing alternative strategies that are located within different social constructions of women and their experiences. For example, representing women who experience domestic violence as 'victim' positions them as passive and weak, thereby dependent on others and lacking in control (Browne, 1991). Such a construction is consistent with the traditional subject positions and directive mode of responding evident within the medical model of care. Ignoring the woman's agency serves to invalidate her subjective experience and exclude her from an active role in any intervention. In contrast, the word 'survivor' implies that the woman has endured and possibly continues to endure against the odds (Profitt, 1996). The imagery here is one of strength, active coping and competence in making choices and seeking help. However, Dolan (1998) suggests moving beyond survivorhood to recognize that this is just one of many 'badges' that people wear. Here, the totality of the person is acknowledged while not losing sight of the 'accomplishments' of those who have endured traumatic life experiences. Such a construction is more likely to support an equitable medical encounter, assisting in positioning the woman as 'expert' regarding her own situation. Thus, the woman is able to 'accomplish' in collaboration with the health professional.

This relational change represents an inherent risk to 'comfortableness' for health care professionals (Warshaw, 1989) in that it would appear to reduce the level of control they are able to exert. Furthermore, the prospect of 'opening a Pandora's box' and thus engaging in a long-term intervention, where the possibility of further symptoms and injuries is likely before any potential resolution, involves the probable loss of protection from emotional involvement that the medical model and its discursive practices currently affords. Indeed, long-term interventions may necessitate liaison with external agencies, such as refuges, shelters and advocates whose models of responding and associated practices appear at odds with the medical discourse. Most fundamentally, change involves a renegotiation of the traditional subject positions within the health care interaction and the patient-practitioner relationship and a deconstruction of the power dynamics inherent within them. Thus, changing the practice of responding would appear to involve the development of alternative discourses which can accom-

modate both the needs of women and the needs of health professionals. Such alternatives would aim to privilege the woman's subjective experience and give consideration to her feelings, experience and perceptions of her situation. Obviously such change will require complex manoeuvrings that will inevitably reveal further challenges and dilemmas. Significant amongst these would appear the potential for, and realization of, change at a structural and hierarchical level within health services and within health professions. Indeed, Gillies (1999) and Willig (1999) when exploring women's health experiences argue that such changes are vital. They suggest that the lack of attending to these factors may result in blaming individual actors for the lack of effecting change. Such changes would appear pivotal in assisting health professionals to, metaphorically, open Pandora's box and thereby release the potential to stimulate 'hope' that at some point in the future woman may, with support, find a way to improve her situation and thus vicariously her health.

REFERENCES

- Abbott, P. and Williamson, E. (1999) 'Women, Health and Domestic Violence', *Journal of Gender Studies* 8(1): 33–102.
- Abrar, S., Lovenduski, J. and Margetts, H. (2000) 'Feminist Ideas and Domestic Violence Policy Change', *Political Studies* 48: .239–62.
- Alvesson, M. and Skoldberg, K. (2000) 'Reflexive Methodology: New Vistas for Qualitative Research', London. Sage.
- Anspach, R.R. (1987) 'Prognostic Conflict in Life-and-Death Decisions: The Organisation as an Ecology of Knowledge', *Journal of Health and Social Behaviour* 28: 215–31.
- Anspach, R.R. (1988) 'The Sociology of Medical Discourse: The Language of Case Presentation', *Journal of Health and Social Behaviour* 28: 215–31.
- Beckwith, J.B. (1999) 'Power Between Women', *Feminism and Psychology* 9(4): 389–97.
- Bicehouse, T. and Hawker, L. (1995) 'Domestic Violence: Myths and Safety Issues', *Journal of Holistic Nursing* 13(1): 83–92.
- BMA (1998) *Domestic Violence: A Health Care Issue?* London: BMA.
- Brandt, E.N. (1997) 'Curricular Principles for Health Professions Education about Family Violence', *Academic Medicine* 7(2): S51–8.
- British Crime Survey (1998) *The British Crime Survey: England and Wales*. London: Home Office Research, Development and Statistics Directorate.
- British Medical Journal* (2002) 'Should Health Care Professionals Screen Women for Domestic Violence?' *bmj.com* 2002, electronic responses, accessed 4 Dec 2002. Available: <http://www.bmj.com/cgi/eletters/325/7359/314>.
- Brown, J.B., Lent, B. and Sas, G. (1993) 'Identifying and Treating Wife Abuse', *Journal of Family Practice* 36: 185–91
- Browne, A. (1991) 'The Victim's Experience: Pathways to Disclosure', *Psychotherapy* 28: 150–6.
- Bury, M. (2001) 'Illness Narratives: Fact or Fiction?' *Sociology of Health and Illness* 23(3): 263–85.
- Butler, J. (1992) 'Contingent Foundations: Feminism and the Question of "Postmodern-

- ism", in J. Butler and J.W. Scott (eds) *Feminists Theorize the Political*, pp. 35–57. London: Routledge.
- Campbell, J.C. (2002) 'Health Consequences of Intimate Partner Violence', *The Lancet* 359, April: 1331–6.
- Cromby, J. and Standen, P. (1997) 'The Map is not the Territory: Discourse, Bodies, Selves', *Proceedings of the British Psychological Society* 5(1): 42.
- Davis, K. (1994) 'What is in a Voice? Methods and Metaphors', *Feminism and Psychology* 4(3): 353–61.
- Davis, L.V. (1984) 'Beliefs of Service Providers about Abused Women and Abusing Men', *Social Work* May–June: 243.
- Deetz, S. (1992) *Democracy in an Age of Corporate Colonization: Developments in Communication and the Politics of Everyday Life*, Albany, University of New York Press.
- Denham, S. (1995) 'Confronting the Monster of Family Violence', *Nursing Forum* 30(3): 12–19.
- Department of Health (2000a) *Domestic Violence: A Resource Manual for Health Care Professionals*. London: Department of Health Publications
- Department of Health (2000b) *Principles of Conduct for Health Professionals*. London: Department of Health Publications
- Department of Health (2001) *Why Mothers Die. 1997–1999. The 5th report of the Confidential Enquiry into Maternal Deaths*. London: RCOG Press.
- Dickinson, F. and Tulfy, L.M. (1996) 'The role of Public Health Nurses in Responding to Abused Women', *Public Health Nursing* 13(4): 2163–86.
- Dolan, Y. (1998) *Beyond Survival: Living Well is the Best Revenge*. London: Brief Therapy Press.
- Easteal, P.W. and Easteal, S. (1992) 'Attitudes and Practices of Doctors toward Spouse Assault Victims: An Australian Study'. *Violence and Victims* 7(3): 217–28.
- Edwards, R. and Ribbens, J. (1998) *Feminist Dilemmas in Qualitative Research*. London, Sage.
- Ehrenreich, B. and English, B. (1979) *For Her Own Good*. New York: Pantheon.
- Flitcraft, A., Hadley, S., Hendricks-Matthews, M.B., McLeer, S., Warshaw, C. (1992) *Diagnostic and Treatment Guidelines on Domestic Violence*. Chicago: American Medical Association.
- Foley, M. (1996) 'Who is in Control? Changing Responses to Women who have been Raped and Sexually Abused', in M. Hester, L. Kelly, and J. Radford. (eds) *Women, Violence and Male Power*, pp.166–75. Buckingham. Open University Press.
- Foucault, M. (1979[1975]) *Discipline and Punish: The Birth of the Prison*. New York, Random House.
- Frank, A. (1995) *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: University of Chicago Press.
- Friend, J., Mezey, G. and Bewley, S. (eds) (1998) *Violence Against Women*. London: Royal College of Obstetrics and Gynaecology.
- Frost, M. (1997) 'Health Visitors Perceptions of Domestic Violence', *Health Visitor* 70: 258–9.
- Gallagher, E.B. and Ferrante, J. (1987) 'Medicalisation and Social Justice', *Social Justice Research*: 1(3): 377–92.
- Gillies, V. (1999) 'An Analysis of the Discursive Positions of Women Smokers: Implications for Practical Interventions', in C. Willig (ed.) *Applied Discourse Analysis*:

- Social and Psychological Interventions*, pp.66–86. Buckingham: Open University Press.
- Gondolf, E.W. (1998) *Assessing women battering in mental health services*. London. Sage.
- Hadley, S.M. (1992) 'Working with Battered Women in the Emergency Department: A Model Program', *Journal of Emergency Nursing* 18(1): 18–23.
- Hague, G., Malos, E. and Dear, W. (1996) *Multi-Agency Work in Domestic Violence: A National Study of Interagency Initiatives*. Bristol: The Policy Press.
- Hall, S. (ed.) (1997) *Representation: Cultural Representation and Signifying Practices*. London. Sage.
- Harding, S. (1986) *The Science Question in Feminism*. Milton Keynes: Open University Press.
- Hayne, Y. (2002) 'Experiencing Diagnosis', in M. van Manen (ed.) *Writing in the Dark*, pp. 180–197. Ontario: Althouse Press.
- Heath, I. (1998) *Domestic Violence: The General Practitioners Role*. London: Royal College of General Practitioners.
- Herman, J.L. (1992) 'Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma', *Journal of Traumatic Stress* 5(3): 377–91.
- Home Office (1999) *The Crime Reduction Strategy*. London: Home Office.
- Home Office, Cabinet Office (1999) *Living Without Fear*. London: The Cabinet Office.
- Home Office, Welsh Office (1995) 'Inter Agency Co-ordination to Tackle Domestic Violence', inter-agency circular 17 August, Home Office, London.
- Hyden, M. (1999) 'The World of the Fearful: Battered Women's Narratives of Leaving Abusive Husbands'. *Feminism & Psychology* 9(4): 449–69.
- Itzin, C. (2000) 'Gendering Domestic Violence: The Influence of Feminism on Policy and Practice', in J. Hanmer and C. Itzin (eds) *Home Truths About Domestic Violence: Feminist Influences on Policy and Practice: A Reader*, pp. 365–81. London. Routledge.
- Jones, A. (1991) *Women Who Kill*. London: Gollancz.
- Keller, E.F. (1985) *Reflections on Gender and Science*. London: Yale University Press.
- Kurtz, D. (1987) 'Emergency Department Responses to Battered Women: Resistance to Medicalisation', *Social Problems* 34: 69–81.
- Kurtz, D. and Stark, E. (1988) 'Not so Benign Neglect: The Medical Response to Battering', in K. Yllo and M. Bograd (eds) *Feminist Perspectives on Wife Abuse*, pp. 249–66. London. Sage.
- Lakoff, G. and Johnson, M. (1980) *Metaphors We Live By*. London: University of Chicago Press.
- Landenburger, K. (1989) 'A Process of Entrapment in and Recovery from an Abusive Relationship', *Issues of Mental Health Nursing* 10: 209–27.
- Lees, S. (2000) 'Marital Rape and Marital Murder', in J. Hanmer and C. Itzin (eds) *Home Truths about Domestic Violence: Feminist Influences on Policy and Practice*, pp. 57–75. London. Routledge.
- Llewellyn, T. Roden, R and O'Neill, V. (1995) 'Support for Victims of Assaults and Domestic Violence: Are Accident and Emergency Departments Doing Enough?'. *Journal of Accident and Emergency Medicine* 12: 32–3.
- Loske, D.R. and Cahill, S.E. (1984) 'The Social Construction of Deviance: Experts on Battered Women', *Social Problems* 31: 296–310.
- McCauley, J., Yurk, R.A., Jenckes, M.W. and Ford, D.E. (1998) 'Inside "Pandora's Box": Abused Women's Experience with Clinicians and Health Services'. *Journal of General Internal Medicine* 8, 13 August: 549–55.

- McRobbie, A. (ed.) (1997) *Back to Reality? Social Experience and Cultural Studies*. Manchester: Manchester University Press.
- McWilliams, M and McKieron, J. (1993) *Bringing it Out into the Open: Domestic Violence in Northern Ireland*. Belfast: HMSO.
- Merritt-Gray, M. and Wuest, J. (1995) 'Counteracting Abuse and Breaking Free: The Process of Leaving Revealed through Women's Voices', *Health Care for Women International* 16: 399–412.
- Muehlenhard, C. and Kimes, L.A. (1999) 'The Social Construction of Violence: The Case of Sexual and Domestic Violence', *Personality and Social Psychology Review* 3(3): 234–45.
- Mullender, A. (1996) *Rethinking Domestic Violence: The Social Work and Probation Response*. London: Routledge.
- Parker, I (1994) 'Reflexive Research and the Grounding of Analysis: Social Psychology and the Psy-complex', *Journal of Community and Applied Social Psychology* 4: 239–52.
- Patterson, W. (ed.) (2002) *Strategic Narrative: New Perspectives on the Power of Personal and Cultural Stories*. Oxford: Lexington Books.
- Profitt, N. J. (1996) "'Battered Women" as "Victims" and "Survivors": Creating a Space for Resistance', *Canadian Social Work Review* 13: 23–38.
- Radford, L. (1993) 'Pleading for Time: Justice for Battered Women who Kill', in H. Birch (ed.) *Moving Targets*, pp. 189–217. London: Virago.
- Ramsey, J., Richardson, J., Carter, H., Davidson, L and Feder, G. (2002) 'Should Health Professionals Screen Women for Domestic Violence? Systematic Review' *British Medical Journal* 325: pp. 314.
- Richardson, J. and Feder, G (1996) 'Domestic Violence: A Hidden Problem for General Practice', *British Journal of General Practice* 46: 239 – 42.
- Riessman, C. (1983) 'Women and Medicalization: A New Perspective', *Social Policy* 14(1): 3–18.
- Roberts, H. (1981) 'Women and their Doctors', in H. Roberts (ed.) *Doing Feminist Research*, pp. 7–29. London. Routledge.
- Rose, N. (1998) *Inventing Our Selves. Psychology, Power and Personhood*. Cambridge: Cambridge University Press.
- Ruddy, N.B. and McDaniel, S.H. (1995) 'Domestic Violence in Primary Care: The Psychologist's Role', *Journal of Clinical Psychology in Medical Settings* 2(1): 49–69.
- Sassetti, M. (1993) 'Domestic Violence'. *Primary Care* 20: 289–305.
- Shornstein, S. (1997) *Domestic Violence and Health Care: What Every Professional Needs to Know*. London: Sage.
- Shumway, D.R. (1989) *Michel Foucault*. London: University Press of Virginia.
- Stark, E. and Flitcraft, A. (1996) 'Women and Children At Risk: A Feminist Perspective on Child Abuse'. *International Journal of Health Services* 18(1): 97–118.
- Sugg, N.K. and Innui, T. (1992) 'Primary Care Physicians' Responses to Domestic Violence: Opening Pandora's Box', *JAMA* 267: 3157–60.
- Taket, A.R., Beringer, A., Irvine, A. and Garfield, S. (2003) *Evaluation of the CRP Violence Against Women Initiative Health Projects: Final Report – Exploring the Health Service Contribution to Tackling Domestic Violence*. London. Home Office.
- United Nations (1993a) *Declaration on the Elimination of Violence against Women*. New York: Washington Free Press.
- United Nations (1993b) *Strategies for Confronting Domestic Violence: A Resource Manual*. New York: Washington Free Press

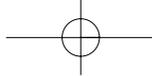
- Warshaw, C. (1989) 'Limitations of the Medical Model in the Care of Battered Women', *Gender and Society* 3(4): 506–17.
- Warshaw, C. (1993) 'Domestic Violence Challenges to Medical Practice', *Journal of Women's Health* 2(1): 73–80
- Warshaw, C. (1997) 'Intimate Partner Abuse: Developing a Framework for Change in Medical Education', *Academic Medicine* 72(1), January supplement: S26–37.
- Watts, S. (2000) *Evaluation of Health Service Interventions in Response to Domestic Violence Against Women in Camden and Islington. Report 1*. London: London Borough of Camden, accessed 4 March 2003. Available: <http://www.camden.gov.uk/camden/links/equalities/pdf/interimhealth.pdf>
- Watts, S., Watson, J., Sethi, D., Zwi, A., McCarth, C. (2002) *Evaluation of Health Service Interventions in Response to Domestic Violence Against Women in Camden and Islington. Report 2*. London: London Borough of Camden, , accessed 4 March 2003. Available: <http://www.camden.gov.uk/camden/links/equalities/pdf/health.pdf>.
- Williamson, E. (2000) *Domestic Violence and Health*. Bristol: Policy Press.
- Willig, C. (1999) 'Conclusion: Opportunities and Limitations of "Applied Discourse Analysis"', in C. Willig (ed.) *Applied Discourse Analysis: Social and Psychological Interventions*. Buckingham: Open University Press.
- Wilson, M., Daly, M. and Wright, C. (1993) 'Uxoricide in Canada: Demographic Risk and Patterns', *Violence and Victims*, 8(1): 3–60.
- World Health Organization (1997) *Violence against Women: a health priority issue* (FRH/WHO/97.8). Geneva: WHO.
- World Health Organization (2001) *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*. (WHO/FCH/GW/01.1). Geneva: WHO.
- World Health Organization (2002) *World Report on Violence and Health*. Geneva: WHO, accessed 28 February 2003. Available: http://www.who.int/violence_injury_prevention/
- Zola, I.K. (1972) 'Medicine as an Institution of Social Control', *Sociological Review* 20: 487–504.

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