Difficulty With Detecting:
Metanarratives and a Discourse Analysis of General Practitioners' Talk About Domestic Violence

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Abstract

This research project aims to report and analyse the texts of interviews with doctors as they talk about their experience of detecting domestic violence against women who are their patients. The doctors stories of their experiences are summarised and presented as a metanarrative to provide an understanding of their experiences. A discourse analysis of the transcribed interviews identifies and explores the linguistic resources available to doctors and used in common by them in constituting their experiences, themselves, and their women patients who are victimised by violent male partners. The effects and implications of these resources is discussed.

The doctors reported difficulty detecting and dealing with domestic violence as experienced by their women patients. Their accounts support existing research findings. Discourse analysis identifies a discourse of discovery and a discourse of confession realised in the doctors' talk about detection. In the doctors' talk about violence and women who are victimised by their male partners, a liberal humanist discourse, psychological discourses, and discourses of love and commitment were identified. The implications of these discourses used together in the context of medical practice are discussed. In co-articulation with medical discourse, these discourses realised by the doctors simultaneously perpetuate the difficulty detecting domestic violence, and make this difficulty comprehensible.

I want to thank the following people whose contribution enabled me to complete this thesis:

The ten doctors who were willing to participate in this research. They gave their time and shared their experiences with me out of concern for their women patients, and with the hope that through this kind of work (my thesis) the delivery of care to abused women may be increased and improved. They trusted me to treat their contributions with respect and sensitivity. Without them this thesis would not have been possible.

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Preface: Anna's story

For so long I had struggled to keep my secret. How could I tell anyone of my shame? Surely I must have done *something* to deserve the brutality. I couldn't go to our family GP again - I had done that the first time the violence occurred. The doctor was concerned only for my husband's state of health, and had given me much advice about supporting him through his 'problem'. Still now I had escaped with my children, and at last would find the help and support I so desperately needed...

Anxiously I scanned his face... I knew the words had tumbled over each other as my story poured out. Had he believed me? Had he understood? Had he really *heard* me? The pause stretched interminably.

"Well, yes, you have been having a bad time. Yes...I can see you're upset. I am sure we can help you - but I could only make it for ten days." He stretched out his hand, pulled the prescription pad toward him, and wrote a script for ten sleeping pills.

True, the doctor didn't know me for I had just arrived in a new town - visibly bruised, tearful, and accompanied by three shocked children. He avoided my eyes as he ushered us out of the surgery.

So began a second nightmare: the nightmare of struggling to regain a life of dignity in spite of the devastating aftermath of the incest perpetrated against two of my children, and the violence my children and I endured. In silence. Alone. Unheard.

CHAPTER ONE

Introduction

> We are supposed to be dispassionate, scholarly, to talk about really serious matters ... I am not opposed to any of this; all I want is to argue for the legitimacy of our own voices, of using the data of our experiences, of taking oppression seriously as we live it in our daily lives, and breaking through the stultifying, rigidifying forms of academic discourse to create new forms that can let us see, feel, and know in ways that more effectively capture and communicate our experience (Rockhill, 1987, p.16).

The realisation of the prevalence and impact of domestic violence is growing. Since the 1970's the problem of violence towards women within their intimate relationships has been of increasing research and political concern (Johnson, 1995; Whelehan, 1995). With a growing awareness of the problem there has also been a progressive realisation that since the relationships in which women are victimised may last years to decades, the attendant consequences will be severe and long term.

Alongside the criminal acts which constitute domestic violence, research and political concerns have increasingly focused on various health effects. The full health burden caused by domestic violence is slowly being recognised.

This study is motivated by my interest in contributing to research related to domestic violence within the field of women's health. As a researcher and service user it seems important to me to focus attention on health care delivery, rather than continuing the practice of researching women who have been victimised as if they were 'the problem'. While it remains important to identify health problems experienced by women, the problems they encounter when seeking health care also need to be addressed. Research has already identified problems in to women victimised by violent male partners; problems such as nondetection of victimisation, and the identification of symptoms of victimisation such as chronic pain, injuries, and substance abuse without attention to the cause of those symptoms - the victimisation (Browne, 1993; Randell, 1990; Stark & Flitcraft, 1991; Yam, 1995). Complicating these problems are attitudes of some medical health professionals and their assimilation of myths and stereotypes about women who have been victimised (Binney, 1981; Campbell, 1992; Stark, Flitcraft & Frazier, 1982), for example, that women 'ask for it', which positions women as deserving male partner violence against them (Yam, 1995). From these findings it would seem that although medical health professionals are in a particularly good position to render assistance, the relationship between them and their patients who are victimised by domestic violence

may be such that the experience of violence remains unspoken. These issues are explicated more fully in the following chapter.

Although health care delivery problems relevant to all medical health professionals - public health nurses, hospital doctors and nurses, emergency room staff, sexual health workers - general practitioners are prioritised in this study. General practitioners are likely to know women across time and the most likely type of medical health practitioner to regard the general health of their patients as the domain of their practice. They are also most likely to be able to detect subtle changes in their patients' general health, to attribute these changes to an effect of 'lifestyle' - exercise and diet and socioeconomic, psychological and emotional factors - and to prioritise detection of 'lifestyle' factors as part of their approach to, and treatment of, patients.

In the process of developing this study, I formulated a series of initial questions addressing the problems of health care delivery by general practitioners to women victimised by their male partners: Do doctors' understandings of violence towards women as psychological and sociological phenomena, constitute constraining 'factors' in the detection of current victimisation or histories of domestic violence? Do doctors make use of formal or informal protocols to identify the effects of violence? Do the doctors' positions of power, knowledge and authority also constitute constraining 'factors' in the detection of current victimisation or histories of domestic violence? How does gender, understood as an organising principle of psychological and sociological phenomena within our culture and society, function in the doctors' understandings of women's victimisation by their male partners? Has increased attention from the media, 'community', and government towards the problem of abuse of women by their male partners had any effect on the professional practice of general practitioners? Each of these questions is informed by the general question which is the focus of this study: How is it possible that abuse of women by their male partners so frequently remains undetected by general practitioners?

My interest in this question is derived from a variety of sources, and is informed by various theories. The following section introduces the personal and theoretical frameworks which structure and organise this project.

My Position And Approach

My interest lies where there are stark gender differences which cause women great harm. The area of men's violence to women is such a site.

The notion that gender differences have social effects which are harmful to women, as women, is a primary tenet of most forms of feminism. My experiences of feminisms and of men's violence to women, cannot be separated from my performance of this research. Some of these experiences provide a starting point for explaining my theoretical assumptions.

As a child and teenager I had access to many feminist writings, available due to my mother's interest in and commitment to feminism. I read the work of Germaine Greer, Shulamith Firestone, Phyllis Chesler, Betty Friedan, and the work of other feminist theorists. Such works had a huge impact on me, and influenced deeply how I interpreted information and my own lived experiences. By the time I was eighteen I had read and talked a lot about feminism. At university, academic study informed my feminism and allowed me to develop further my theoretical understandings. Thus, feminism gave me a way of making sense of the world, and it was from within a feminist framework and ideology that I approached the problem of men's violence to women.

I also bring my own experiences of relationships with men to this research, and one relationship in particular. My experience of this man was of psychological and emotional abuse. He attempted to estrange me from my friends and my mother. He was verbally abusive when he didn't get his own way, that is, when I didn't behave the way he wanted me to. He treated me like I was a recalcitrant child when I complained about his behaviour. He was manipulative, demanding, irrational and illogical, sexually coercive, and ultimately absolutely tiring. He consistently maintained that he was behaving rationally, that I was not being "sensible", and sometimes I thought that I must be the one with the problem. However, my feminism informed my response to him; it kept me aware and strong and out of the traps he was setting. When I was at the stage where I thought we could be friends still, I agreed to meet with him to talk things over. I became extremely anxious about the visit and remember getting quite frightened, thinking over and over again about the knives in the block on the kitchen bench. I kept wondering whether if he got really angry with me he'd stab me.

I knew him for only about five months, but we became close friends. He maintained that he wanted a relationship, and I consistently told him that I would never enter into one with him. It became progressively more difficult to maintain the friendship on the terms I wanted, which were to just be friends. As he became more insistent and sometimes verbally abusive I realised that I had to break off contact. What followed was two years of constant phone calls, being tracked when I moved house, letters, and being physically harassed on the street, at the university library, and in a public bar. I considered getting a restraining or non-molestation order from the police, but never did so as I did not want to

make the situation worse. I also worried that the police would not take me seriously. I found the whole experience deeply distressing. If I ever saw him anywhere my heart would race and I would feel fearful. I was afraid to answer the phone. I managed to find out how he got my address the first time I moved, and took steps to ensure he couldn't use the method (which was illegal) again when I moved on.

The stress I experienced was huge. I would never have considered for a moment taking the issue to my doctor as I didn't consider it a medical issue, and I would not have thought they would have been able to help me. From the information in the literature around the medical response to abuse of any kind, it is clear I was correct in this belief.

Through feminism I understand this experience as an experience of vulnerability to male violence that I share with other women. In my relationships with other women we have talked about various experiences of abuse, like mine, and different from mine. In relation to the women who I hope will benefit from research like this, I share concerns about safety (in all senses of the word) within relationships with men. I am aware of excluding experiences of women who are not in relationships with men through a focus on women's relationships with men. This risk is countered through my understanding of heterosexism as a dominant discourse of our culture and society (Rich, 1980). The safety issues involved in living in a world with men impact on women who are not heterosexual in identity or practice. Where the dominant discourse is heterosexist, heterosexism will be an issue for all women, as will safety in relation to men. Resisting heterosexism does not necessarily protect a woman against abuse from men. Thus, I notice the exclusion, and account for it in terms of gendered relations of power.

It is through feminism that I also understand that it is not possible to 'leave behind' my personal experiences when I engage in research. It is one of the tenets of feminist theory that academic research cannot be value-free and 'objective' (Harding, 1987; Reinharz, 1992). Rather than pretending to 'leave behind' personal experiences, I attempt to make them explicit, especially where I identify that they affect and inform my research practice. Personal experience may also become a site of analysis, of contradiction, of contention, of confusion, of change made explicit with this project. For me feminism is an important value system and theoretical context. To be reflexive about feminism requires that I am explicit about what feminism means to me and the feminist theories that I make use of. I practice reflexivity by being explicit about the values and assumptions I bring to my analysis, my writing about my experiences, and by locating them within specific theoretical contexts. There is no explicit reflexive 'voice' in the discourse analysis of the doctors' texts. But I chose the fragments of text to analyse, and the analysis is particular to me. Other readings are possible. My reading of the analysis as a whole and how I

make sense of it through the discussion of my findings, are all informed by my position which I have made explicit here. This is how I have used a reflexive approach in this thesis.

Feminism

To be grounded within feminism means that feminism is my mainstay, the focus and the formative aspect of my approach in its entirety. My feminism affects my interpretations, my approach to the research of others and to my own experience, my reading practices, my choice of method and methodology and therefore how I choose to write this thesis.

Feminism is not easily characterised by one theory or one approach (Whelehan, 1995), and diversity is common among individual feminists in terms of their own conceptualisations of feminism and how it informs their actions (Peplau & Conrad, 1989). One of the few things commonalities within feminism is agreement regarding the historical, cultural and social subordination of women. Theoretical debates abound regarding how to achieve optimum outcomes for women, what those outcomes might be, and the distribution and sites of theoretical emphasis and the implementation of practices addressing women's subordination (Whelehan, 1995).

Within this diversity and debate my starting point is that feminism is both a value system and a framework for conceptualising active interventions into socio-politics (Peplau & Conrad, 1989). The general principles of feminism are based upon the recognition of the oppression of women, and the historical exclusion of women from public life which entailed their relegation to the private sphere (Peplau & Conrad, 1989; Whelehan, 1995).

Exclusion of women in general has entailed excluding our experiences from academia, politics, work outside of the home. The use of the word 'man' as a generic term for 'human beings', 'humankind', or 'humanity', and within which women are supposedly subsumed, has functioned as a practice of exclusion complicit with practices of assuming that men's experiences are the 'norm' and women's differences from them are 'deviations' (Whelehan, 1995). For feminists, women's experiences are important and appropriate sites of academic inquiry (Peplau & Conrad, 1989). Not only does feminism value women's experiences, it politicises them (Whelehan, 1995). On these terms, taking up a feminist position entails deep questioning of every aspect of one's life; personal, social, political (Whelehan, 1995).

Feminist questioning of aspects of women's lives, and valuing of women's experiences, has led to a recognition of the diversity of truths and versions of realities which constitute women's experiences. This recognition produces deep "suspicion of the idea of one

reality and one truth" (Gavey, 1989, p.462). This questioning is extrapolated to include questioning the 'reality and truth' produced through the dominance of masculinist institutions which exclude or devalue women's experience.

From this position within feminism, like some other feminists, I have found poststructuralist theories of discourse, knowledge, power and subjectivity useful. Poststructuralist theories provide conceptual resources for questioning the singularity of traditional masculinist notions of reality and truth, the institutional practices which perpetuate the subordination of women, and the assumptions and 'common sense' notions of women's experience which correspond with those practices. Poststructuralist theories also provide useful analytics for theorising the effects of gendered practices on women's subjectivities through questioning both essentialist notions of gender and the idea that universalising women's subjectivities is possible (Bohan, 1997; Hekman, 1990).

Like feminist theories, poststructuralist theories are diverse. To be reflexive requires that I am explicit about what feminist poststructuralism means to me and the poststructuralist theories that I make use of.

I understand poststructuralism as arising from a crisis in epistemology which questions enlightenment principles of foundationalism and humanist conceptions of subjectivity as unified and rational (Hollway, 1989; Hekman, 1990). Poststructuralist theories focus attention on language and discourse, open up 'fixed terms' to plurality, attend to power and the politics of social relations, and theorise subjectivity in relation to discourse, plurality and power (Gavey, 1989; Hekman, 1990; Weedon, 1987).

Poststructuralist theories assert the power of language to "organise our thought and experience" (Lather, 1992, p.95). The term 'discourse' is used as a way of understanding language in use rather than language as an abstract system. The use of the term 'discourse' implies that meanings are not 'fixed' and are always socially and historically specific. Discourses provide different ways of making the world meaningful, and therefore competing discourses are implicated in political struggles and the organisation of social power relations (Weedon, 1987).

From this perspective, experiences become meaningful through discourses and do not have an 'essential' or 'inherent' meaning. Feminist attention to women's experience, and valuing of women's experience, is therefore understood as attention to the discourses through which women's experiences are made meaningful, and attention to the social,

historical and political contexts in which the meanings of women's experiences are systematically devalued.

The poststructuralist notion of 'discourse' also has implications for knowledge. Knowledge is no longer taken to be statements of fact or truth about reality. Rather, knowledge is the product of certain social processes such as research, commonsense, word of God, or logical argument, which legitimate discourse within a particular political and social contexts. From this perspective 'knowledge' is opened to questioning through attention to the discourses that are legitimated and the processes of their legitimation where there is political struggle over meaning. From a feminist perspective attention to discourse enables the disruption and disturbance of 'knowledge' produced in the absence of women's experiences and women's understandings of their experience by drawing attention to the social power relations involved in the legitimation of knowledge.

The notion of 'discourse' implies power relations. Discourses are implicated in political struggles, the organisation of social power relations, and the legitimation of knowledge. Discourse, knowledge and power are intimately interconnected (Foucault, 1972; 1980).

Discourses enable particular understandings, including our understandings of ourselves, our experiences, our relationship to the world and our places in it. The term 'subjectivity' is used within poststructuralist theories to designate a notion of 'personhood' in which an individual's sense of themselves is dependent on, caught up in and informed by discourse, power and knowledge (Weedon, 1987). This notion of subjectivity implies that the 'subject' is "subjected to the regime of meaning of a particular discourse and enabled to act accordingly" (Weedon, 1987, p.34). Subjectivity, then, is neither fixed nor unified, but a site of conflict and struggle over meaning. Where subjectivity is conceptualised through poststructuralist theory, the concept challenges psychology's traditional formulation of 'the individual' as a unified and rational subject, and allows the possibility of viewing the subject as changing with, and altered by, social, cultural and political change.

From this understanding of feminist poststructuralism I assume that women's experiences are produced through discursive practices which subordinate women to men, thereby producing very different and gender specific experiences. The formation of gendered subjectivity is a site of political struggle to the extent that our understandings of our minds and experiences of and in our bodies are sites of conflict and contest within social power relations of domination and subordination (Rockhill, 1987). Our practices of producing legitimate knowledge are also involved in the formation of our subjectivities. Challenging traditional practices of legitimating knowledges, such as

scientific methodology, is also a practice of political struggle with implications for subjectivity (Rockhill, 1987). Reflexive attention to my values and the theoretical frameworks through which I understand my values challenges the 'objectivity' of psychology's traditional scientific practices and the knowledge produced by those practices.

From feminist poststructuralism I have come to understand the problem of men's violence towards women through the notion of 'patriarchy'. Reflexivity also requires that I make this understanding explicit.

Patriarchy And The Link To Violence

> The disappearance of the family's traditional economic and social roles, the "decline of the patriarchy" as a specific familial form, contrasts markedly with the subjective and objective extension of male domination throughout every aspect of life in the U.S. We conclude by arguing that this seeming paradox is reconciled when we appreciate the extent to which the social services, broadly construed to include education, religion, and recreation as well as medicine, law, police, and welfare, function today as a reconstituted or extended patriarchy, defending the family form "by any means necessary," including violence, against both its internal contradictions and women's struggles (Stark, Flitcraft, & Frazier, 1982, p.180).

I regard writing my thesis as being engaged in a political activity, because I understand the position of women in society to be the result of what Kate Millet (1969) calls "power-structured relationships, arrangements whereby one group of persons is controlled by another" (p.23). Millet's early work resonates with my sense of how I understand 'patriarchy' to be this 'set of relationships', and the possibility of one 'group' controlling 'another' to be enabled by discourse, power and knowledge.

If I work from the assumption that we live in a patriarchy, various ways of theorising domestic violence become tenable and useful; this assumption provides a schematic for interpreting empirical research. Patriarchies operate to privilege men and subordinate women so that "patriarchy informs our perception of social reality by being entrenched in knowledge itself" (Whelehan, 1995, p.16).

Millett (1969) maintains that patriarchy is sustained by both ideological and structural factors. The ideological support stems from a system of socialisation that renders sex difference and differentiation 'natural' and 'commonsense'. Women are constituted as compliant, submissive and passive, placing them in an essentially subordinate position in society. Millett identifies the family, the class system and the economic and educational systems as the main structural bulwarks of patriarchy.

Regarding patriarchy, Millet (1969)writes:

> This system ... tends to be sturdier than any form of segregation, and more rigorous than class stratification, more uniform, certainly more enduring. However muted its present appearance may be, sexual domination obtains nevertheless as perhaps the most pervasive ideology of our culture and provides its most fundamental concept of power (p.25).

Patriarchy has been a central concern of feminism since the 1960s (Johnson, 1995). I believe that it should remain at the front of the agenda, because attending to patriarchy signals that it's effects continue to constitute women's experiences and subordination. Itzin (1992) asserts that women are oppressed on the basis of gender, in every society, and that men alone have power or access to it. Male power "is institutionalized so that men as a group have access to economic, social, sexual and political power and privilege that women do not have" (Itzin, 1992, p.57). Further, as a group, men are privileged in as much as they benefit economically, politically, socially and psychologically, from their position within unequal structures of social power (Itzin, 1992).

Patriarchy is hegemonic (Connell, 1987). As such it has the power to codify knowledge, and therefore social practices, forms of subjectivity, and power relations. Hegemony refers to an historically maintained dominance. Patriarchy remains hegemonic through the dominant discourses which structure power relations so that they are able to appear natural and normal, and which subvert, discredit, and silence competing or contradictory discourses. The most powerful discourses have firm institutional bases, in the law, medicine, social welfare, the family and work (Foucault, 1972). These claims resonate with the argument that although patriarchy may be no longer overt, the traces of patriarchal organisation have inscribed society such that the dominance of men over women has become the norm both personally and politically, individually and collectively (Whelehan, 1995). The problem of domestic violence against women has a long history even though its construction as a problem has not, and the concept of patriarchy offers a particularly useful and coherent framework for understanding the problem and related issues.

Johnson (1995) claims that patriarchy explains the historical neglect of domestic violence against women as a social concern. It was only in the 1970's that domestic violence was finally admitted onto the political agenda. This can be contexturalised by women's historical exclusion from politics, particularly through the marginalisation of 'domestic' issues (Whelehan, 1995).

Although the women's rights movement, particularly the 'second wave' of feminism, did bring about some change for women in many areas, women still suffer the adverse affects of patriarchy. This is unsurprising. As Whelehan (1995) points out, "formal

equality ... can prove chimerical when civic and political structures which permit such processes of equality already work in favour of the dominant group, and demonstrate that in fact the discourses of power assume relations of inequality at their very roots" (p.1).

The notion of patriarchy remains useful to feminism because it evokes women's systematic subordination at the level of discourse (Whelehan, 1995), enabling the 'recognition' of dominant discourses which continue to constitute 'unequal' power relations between women and men. The notion of patriarchy allows violence against women to be understood within the context of social power relations of domination and subordination.

Patriarchy and Domestic Violence

Theories of domestic violence, and evidence from empirical reports of the circumstances under which violence occurs and the motivations of violent men, may be organised into various 'models'. These explanatory models conceptualise domestic violence in terms of causality and risk factors. They include the interpersonal violence model, the family violence model, and the gender-politics model (Stark & Flitcraft, 1991). The gender-politics model most closely resembles an account which places violence within a socio-politic context of gender inequality and realises a social-systems discourse (O'Neill, 1998).

The gender-politics model invokes the concept of patriarchal rule and holds the most credibility, both as an analytic and from clinical evidence (Stark & Flitcraft, 1991) . Hamberger and Potente (1994) also found that this explanation of violence had the 'best fit' with empirical data. I understand these claims as legitimating social-systems discourse and 'knowledge' of violence against women as a socio-political effect of patriarchy through empirical research.

According to this model 'family' violence is a specific instance of practices of male control. These practices extend throughout intimate relationships between women and men, including dating, parenting, marriage and economic relationships. Violence becomes a practice chosen by some men when they feel that the extent of their control over personal or economic resources is compromised by women's actions or when they feel that women are inadequately fulfilling domestic duties (Stark & Flitcraft, 1991).

Empirical research has legitimated the gender-politics model of male perpetrated domestic violence, through 'data' which is understood as evidence of male domination and control over women, and men's assertion of the right to define gender roles, demand obedience, and specify expectations of female partners. Violence is the coercive means through

which men seek and often gain compliance. Many batterers exercise total control "over the material, sexual, and social lives of their victims" (Stark & Flitcraft, 1991, p.127). Further evidence supporting the gender-politics model is provided by the finding that women with higher levels of education or income than their partner are at greater risk of violence from their partner; men appear to find female status and/or independence threatening (Church, 1884; Stark & Flitcraft, 1991). They respond to the perception of threat through violence in an attempt to 'shift the balance' of power to themselves.

New Zealand research also provides evidence legitimating knowledge of the pattern of men's violent and abusive behaviour towards women:

> Most of the women in the sample described their husbands as selfish, demanding, abusive and violent. They described relationships in which they were forced to comply with their husband's demands, regardless of how unreasonable these might be. They described relationships in which a failure to comply invariably invited verbal abuse, physical assault, or both. They described relationships in which they ended up deprived of money, overworked, isolated, and frightened (Church, 1984, p.20).

Male chauvinism was described as a common characteristic of violent men (Church, 1984) and was displayed in several ways, specifically in the expectation that the woman will comply with and meet all her husbands demands. Demands were described in terms of the woman having to wait on her husband "hand and foot" (Church, 1984, p. 20), and having to 'comply' with her husbands sexual demands - most of the women in the sample had been raped by their husbands. Women were controlled in relation to: where they could go, who they could see, how they spent their time - whether they worked inside or outside of the home. Women were denied any right to the money they earned, and any say in how it was spent. They were controlled in terms of what they could say, and specifically described "not being allowed to disagree or to express any opinion" (Church, 1984, p.20) of their own. Some of the women were not allowed to leave the house, unless with their husband (Church, 1984). Violence was used to enforce the men's demands, most particularly regarding the division of labour and control over financial matters (Church, 1984).

This evidence from women's experience of men's violence is legitimated as knowledge about violence towards women through the use of empirical research understood through social-systems discourse. This process of legitimating women's experiences both values those experiences and works to 'include' women in formulating accounts of violence against them. It also legitimates understandings of violence against women as a product or effect of patriarchal power relations.

Patriarchy and Medicine

The notion of patriarchy also informs my understanding of practices which structure social services, including medicine. As institutionalised practices within the network of discourse, power, knowledge which perpetuates patriarchal social relations, medicine will necessarily display characteristics of patriarchal relationships. The control of medical practice is overwhelmingly in the hands of male doctors. The 'medical gaze' is structured through masculinist institutions of knowledge and governed by enlightenment principles. Relationships between doctors and patients are historically hierarchical. Despite the intentions of health provides, the process of "diagnosis, referral and treatment codetermines traditional sex and class hierarchies" (Stark, Flitcraft, & Frazier, 1982, p.179). In this context it would be unsurprising that the detection of violence against women is problematic.

From my position within feminist poststructuralism and my understanding of patriarchal social relations as constituted within networks of discourse, power and knowledges my interest in the detection of violence against women by general practitioners addresses the question of how detection is discursively maintained as problematic.

As a framework for addressing this question I review the literature which constitutes contemporary 'legitimated knowledge' of domestic violence, its health effects and the responses of medical services providers to the victimisation of women, in the following chapter.

CHAPTER TWO

A Review Of The Theoretical Literature

> Battered women pose enormous problems to medicine, not only because they are persistent and appear in such large numbers at the emergency service, but also because no apparent physiological event links one injury to another, or one presentation to the next. At first, their wounds are treated as legitimate medical problems. But as it becomes clear that neither the women, nor their injuries, on an aggregate, will respond to treatment, their problems are reaggregated as symptoms of particular social or psychopathologies, alcoholism or depression, for example. At this point the woman herself, rather than her assailant, appears as a legitimate object of medical control ... The "label" explains the failure of the medical paradigm and the continued suffering of the abused woman in a way that is intelligible, even acceptable, to the physician (Stark, Flitcraft, & Frazier, 1982, p.186).

This chapter summarises empirical literature on the issue of domestic violence so as to provide a background for this study within the context of literature legitimated as 'psychological knowledge'. The chapter covers theories and empirical findings on the characteristics of violence against women by their male partners, the prevalence and incidence of this type of violence, the economic and social costs of this violence, its health effects, and some of problems at the interface between women who are or have been victimised and medical health professionals.

Some Accounts Of Victimisation

Some accounts of violence from women who have been victimised by male partners precede the summary of literature. They provide a context for the 'knowledge' which follows, and may help contextualise the 'legitimate knowledge' with women's own accounts of their experiences.

> I have had glasses thrown at me. I have been kicked in the abdomen when I was visibly pregnant. I have been kicked off the bed and hit while lying on the floor - again, while I was pregnant. I have been whipped, kicked and thrown, picked up again and thrown down again. I have been punched and kicked in the head, chest, face, and abdomen more times than I can count (Dobash & Dobash, 1992, p.2).

> Punching, I had my nose broken, ribs broken, two black eyes - he dragged me out of bed by the hair and pulled me along the ground. He smashed the door of my parent's house down when I was there (Dobash & Dobash, 1992, p.3).

> I remember the tension of becoming aware that I had to notice what I was saying all the time, to make sure I didn't offend him. I had become afraid of him (Dobash & Dobash, 1992, p.3).

> I was always terrified (Dobash & Dobash, 1992, p.3)

> I realized I was under terrible strain the whole time ... I'd go into a blind panic about what side the spoon had to be on. It was that sort of detail everyday (Dobash & Dobash, 1992, p.4).

> And then he had his belt and I was whipped over the shoulders everywhere, on my face and everything. And this was to teach me not to argue with him (Dobash & Dobash, 1992, p.4).

> We were watching T.V. and talking companionably. I asked him to pass on a message to someone at work. He refused. Then he pounced on me and started strangling me, bashing my head against the sofa. Yelling, ranting and raving that he wasn't bloody well going to pass on my messages (Church, 1984, p.29).

> It was 1 am in the morning. He dragged me out of bed and demanded that I cook him a roast dinner. Half an hour later, when it wasn't ready, he started throwing the contents of the fridge around the kitchen. He hit me round the head with his fists so hard that my ears rang. He kicked me in the shins with his boots. I hit him back so he grabbed my hand and broke three fingers one by one. I rushed out of the house. He chased me to the car with an axe. I locked the car and got away in the car (Church, 1984, p.30).

> I just wanted him not to [] hit me [] not swear at me and call me names and that's (2) really all I wanted (Towsey, 1996, p.43).

> then he just picked me up off the ground (.) and then just threw me up against the (.) up against the wall and um (.) and then I woke up (1) it was like um mm (2) it was about 3 or 4 days later (.) I was in hospital yeah (.) and um apparently I was in the ICU for a couple of days too (Towsey, 1996, p.46)

> I was always nervous of (.) what I said or did in case I was going to you know get it in the neck (Towsey, 1996, p.77)

> I can remember driving driving home one night and (.) he was outside waiting for me and he dragged me out of the car and I didn't even know what I'd done wrong and ah (.) before I knew it he was doing it and into it with his steel capped boots (Towsey, 1996, p.49).

Defining Domestic Violence

Domestic violence is the term commonly used to define violence that occurs within the home. Violence is understood as aggressive physical and/or psychological acts, including intimidation and threat, generally perpretrated by a man against his female partner and usually only in the privacy of the home (Dwyer, Smokowski, Bricout, & Wodarski, 1995; Johnson, 1995).

Domestic violence is overwhelmingly gendered; men are consistently the perpetrators of the violence, and women their targets. In the United States male to female partner violence accounts for 85-95% percent of all reported domestic violence (Fischbach &

Herbert, 1997; Hamberger & Potente, 1994). Women are physically injured by abuse at least 13 to 20 times as often as men (Lamb, 1991; Stark & Flitcraft, 1991)

Some feminists have critiqued the use of the term 'domestic violence' as inadequate because of it's generality; it does specify gendered power relationships (Kelly, 1988). Although the word domestic is associated with the warmth of the family, I use it because it also means everyday, commonplace, and ordinary, and its use may draw attention to violence against women by male partners as the most prevalent, the most common and ordinary form of violence against women (Dwyer et al., 1995). I am aware of the problem of 'linguistic avoidance' which Lamb (1991) identifies as a form of writing which obscures the responsibility of men for their violence. Lamb commonly found these strategies used in journal articles about men who batter women, and I attempt to avoid these strategies in my writing. Therefore, I use the term domestic violence against women, or abuse of women by known men, or other strategies which make the structure of gendered relations and responsibilities for violence similarly explicit.

The literature has found that the relationship in which men are violent towards women is usually an intimate one: abusive men commonly systematically victimise only women to whom they are married or in a relatively long-term relationship (Bewley & Gibbs, 1991). However, these criteria do not cover all appropriate cases of violence against women by known men. Stark and Flitcraft (1991) found that divorced, seperated and single women were most likely to be the target of interpersonal male to female violence. While 'violence' in the most basic sense is the use of force to harm, injure or abuse others (Gilbert, 1996), Hegarty and Roberts (1998) assert that domestic violence is "best understood as a chronic syndrome characterised, not by episodes of violence, but by the emotional and psychological abuse used by men to control female partners" (p.53). Physically violent acts are only one part of a repertoire of acts of control. Abusive men typically deploy a range of control strategies (Cokkinides & Coker, 1998; Johnson, 1995) including sexual aggression, verbal abuse, and intimidation (Brown, 1993). Women's victimisation by their male partners takes place in a climate of male domination within which geographical and social isolation, economic control, and systematic attacks on the woman's sense of self worth are constant features (Stevens & Richards, 1997).

Because the victimisation of women is systematic it is not limited to discrete acts of physical violence. It is widely agreed that acts of physical violence within the context of 'domestic violence' increase in frequency and severity over time (Dwyer et al., 1995; Pahl, 1995). Although physical violence is more 'obvious' and physically injurious, many battered women report psychological violence as more deeply traumatic and damaging (Church, 1984; Smith & Gittelman, 1994; Towsey, 1996).

Any woman is vulnerable to victimisation by her partner, regardless of factors such as social class, economic status, education, occupation, ethnicity or race (Dwyer et al., 1995; Stark & Flitcraft, 1991). Further, despite theories to the contrary, personality characteristics of female victims are not a consistent predictor of abuse by a male partner (Campbell, Poland, Waller, & Ager, 1992). The diversity of women who have been victimised by male partners is so great that it makes any kind of 'psychological profile' of women victims meaningless (Stark, Flitcraft, & Frazier, 1982). Sterotypes of male perpetrators as belonging solely to the 'lower classes' are inaccurate; violent husbands in high or higher status occupations hit, injure, and rape their wives as frequently as men from lower socioeconomic groups (Church, 1984).

Some research does find social factors identified as correlates of abuse by a male of his female partner during pregnancy. In this research abused women were found to be poorer, more likely to belong to a minority group, less educated, had borne more children, more likely to be unmarried, and to be receiving social welfare benefits (Cokkinides & Coker, 1998). Some of these correlational factors may be understood as consequences of abuse, rather than antecedents or risk factors. The controlling behaviour of abusive men maximises a woman's dependence and lack of self-efficacy (Stevens & Richards, 1997) and often extends to preventing her from pursuing educational or career goals which relate to lack of education and poverty, determining the status of the relationship which may relate to de facto partnerships, and making decisions about the use of contraception and the frequency of sexual intercourse. Frequent pregnancy and many dependents keep a woman poor, often unable to study or work competitively, and vulnerable to manipulation and control related to her mothering.

Incidence And Prevalence

Statistics on incidence and prevalence are determined through surveys, police records, medical records, retrospective analysis of these records, psychological and nursing research, and the records of service providers.

Neither the incidence nor prevalence of family violence in New Zealand is known, although estimates are informed by a number of studies (Lapsley, 1993). An estimated prevalence rate for family violence commonly agreed by service providers in New Zealand is 14% or 1:7 (Snively, 1994). This equates to an estimated 481,989 people experiencing family violence either as victims or perpetrators per year (Snively, 1994). This estimate gives no indication of incidence, and it needs to be placed in the context of the long-term effects of violence and difficulties in measuring these effects.

Domestic violence is not uncommon. Taking account of a tendency for research to err on the side of caution in estimates of prevalence, violence against women by their male partners is a feature of a significant number of relationships (Campbell, Poland, et al., 1992; Cokkinedes & Coker, 1998). Although most statistics are based on American literature, there is little to suggest that New Zealand's rates of domestic violence against women are different. Australian statistics also suggest a similarity across Western/ised countries, and many other countries also, such as Africa and Asia (Fischbach & Herbert, 1997; Gilbert, 1996; Heise, Raikes, Watts & Zwi, 1994); domestic violence against women is a worldwide problem (Fischbach & Herbert, 1997). A United States national survey estimates 1.8 to 5 million women are the victims of physical assault by a male partner each year (Cokkinides & Coker, 1998). In South Africa, one out of every six adult women is assaulted regularly by her partner, and for the whole of Africa it is estimated that over 50% of all wives (not including de facto or other types of adult male-female partnerships) experience violence by their husband in some form during their marriage (Oloruntimehin, 1996).

Pregnancy can mark the onset of a male partner's physical violence, or an increase in the severity or frequency of assaults. Campbell, Poland, et al. (1992) found that 8.2% of their sample had experienced some form of physical violence during their pregnancy, and for 28.6% of women who had been physically battered by their partner this violence had increased since pregnancy. A study using a large representative sample (n = 6,718) found 10.9% of recently pregnant women reported having been physically hurt by their partner while pregnant (Cokkinides & Coker, 1998). Overall, clinical studies indicate that between 4% to 17% of all women are victimised by violent male partners while pregnant (Cokkinides & Coker, 1998).

Difficulty in determining exact prevalence rates is partly due to the definitions of violence used by researchers (Hegarty and Roberts, 1998), and under-reporting by victims (Browne, 1993; Fischbach & Herbert, 1997; Hegarty & Roberts, 1998). According to the findings of a United States National Crime Survey of domestic violence over a four year period, 48% of cases were not reported to the police (Dobash & Dobash, 1992). The consistently wide variation of estimates of domestic violence indicates that even if composite figures are generated, substantial underestimation of the extent and size of the problem is likely (Johnson, 1995).

Even when incidents of domestic violence against women are reported, either to police or to medical health professionals, they are frequently unrecorded, or are recorded in such a way that they cannot be specifically identified as domestic violence (Harris & Dewdney, 1994; Johnson, 1995).

Additional problems assessing prevalence rates are related to how information is elicited, when, and from what populations. Cokkinides and Coker (1998) specifically assert that women cannot safely report victimisation by a male partner if they are asked by mail or phone while they are living with the perpetrator. They also report that questioning women more than once made a significant difference to their data because women answered in the affirmative only after the question was repeated. In-person interviewing produces higher rates of disclosure (Cokkinides & Coker, 1998). Another problem is the possibility that women who do not see themselves as victimised do not report an incident that might be judged violent by others; people have dissimilar understandings of what constitutes violence and victimisation.

When I talked about my research to family, friends and aquaintances I was often met with responses like: "But women are violent too". Sometimes people told me anecdotes of relationships in which the female partner behaved violently towards her partner. I am concerned about this response as I believe that it diminishes the possibility of understanding the context of men's violence against women and I therefore do not wish to leave the issues raised by this response unaddressed. Hamberger and Potente (1994) argue that substantial research show that the rates 95% of battering is perpetrated by men against women in contrast to 5% perpetrated by women against men. Further, assualts by women tend to be substantially less physically injurious than assaults by men (Hamberger & Potente, 1994). These findings have been challenged by some empirical research, and the issue of the systematic gender imbalance in incidence rates remains contentious (Hamberger & Potente, 1994).

Hamberger and Potente (1994) reviewed two national surveys which indicate female-to-male violence occurs as frequently or slightly more frequently than male-to-female violence. Their commentary on these surveys, however, strongly suggests that these findings cannot be taken at face value as evidence that women are "just as" violent as men (Hamberger & Potente, 1994). They claim that violence perpetrated by women and men in relationships are essentially different and can only be regarded as equivalent if contextual information is removed from the measurement of incidence (Hamberger & Potente, 1994). Browne (1993) offers a critique of claims that incidence rates for women's and men's violence are equivalent in terms of the patterns of violence perpetration. Men are more frequently violent when the measurement of 'frequency' is based on a definition of violence which includes sexual aggression, forceable restraint, and threats as well as physical aggression causing harm. Men who assault are more likely to cause injury thanwomen who assault. Women are far more likely to be afraid or

intimidated by men's threats of physical harm than men by women's threats. Men are more likely than women to kill their partner.

The circumstances in which women behave violently and their motives for violence are also important. Women are typically violent in self-defence or retaliation. They will also use violence as a pre-emptive strategy of self-protection in response to indications from the man that violence or murder is imminent. Motivations for violence are different for men and women; women identified self-defense as their primary motivation for behaving violently, in contrast to men who were motived by the wish to control their partner and/or punish her. When couples were asked to detail the sequence of events regarding a violent incident, men were most likely to have been the first and last to use violence (Hamberger & Potente, 1994).

Hamberger and Potente (1994) concluded that domestically violent women are most appropriately regarded as battered women. As such, they have little control over the pattern of violence within which they are invovled, and which they did not introduce into the relationship. Further, violence becomes one of the few strategies left to them in any attempt to defend or assert themselves.

Health Effects Of Domestic Violence Against Women

The difficulties of quantitative research into domestic violence against women not only gives us an unclear understanding of its incidence and prevalence, it also suggests that the extent and significance of associated health costs, both social and economic, has been seriously underestimated (Fischbach & Herbert, 1997).

Domestic violence against women occurs so widely that the Surgeon General of the United States identified domestic violence as the primary public health risk to adult women (Dwyer et al., 1995). Research also reports that overall, battering is the most common cause of injury to women (Yam, 1995). This problem is not isolated to the United States. Hegarty and Roberts (1998) confirm that partner violence against women in Australia is a major health problem, in terms of both mortality and mobidity. It is becoming increasingly obvious that the relationship between the experience of violence and chronic health problems is a significant social health issue (Campbell, Harris & Lee, 1995). There is substantial evidence for much greater presentation with health problems and health care seeking in relation to both immediate and subsequent consequences of victimisation by women who are or have been abused than nonabused women (Campbell & Lewandowski, 1997).

As a medical issue, the conditions and status of women's health as a consequence of victimisation by male partners should be considered as *chronic*, rather than acute because of the repetitive, continuous, and multiple nature of abuse (Smith & Gittelman, 1994). Medical professionals should consider both physical and psychological effects of violence: physical abuse has psychological consquences and psychological abuse has physical consequences (Johnson, 1995).

Injury such as bruising, fractures, wounds and death are the most visible and obvious consequences of domestic violence. Men's violence causes physical injuries such as cuts, multiple bruising, internal injuries, scaring (Bewley & Gibbs, 1991), broken teeth and fractures, including fractures of the skull (Bewley & Gibbs, 1991; Cascardi, Langhinrichsen, & Vivian, 1992), and may cause permanent disfigurement (Bewley & Gibbs, 1991; Heise, Raikes, Watts & Zwi, 1994). The relationship between domestic violence and health is more complex and far-reaching than the immediate effects of physical injury. As research continues, the deep and abstruse connections between domestic violence against women and women's health problems emerges more fully (Fischbach & Herbert, 1997)

It is increasingly clear that the long term health effects of women's victimisation is complicated by the likelihood that incidents of male to female violence within a relationship are not isolated events. However, just one violent incident can lead to continuing health concerns such as joint damage, hearing impairment, visual impairment and neurological damage (Browne, 1993; Campbell, Harris, et al., 1995; Heise, et al., 1994). In such cases psychological abuse and intimidation are likely to also be present and have health consequences. Severity or frequency of assault does not determine the effect of violence on women and consequences such as fear and intimidation, and their physical effects may remain long after the actual incident (Fischbach & Herbert, 1997).

Research also indicates a link between domestic violence and delayed physical effects; the most obvious outcome of physical violence is pain. Women abused by their partners not only suffer the pain of immediate injuries but also experience *chronic* pain, that is, pain which is long-term and ongoing, (Campbell, Harris & Lee, 1995; Heise et al., 1994; Smith & Gittelman, 1994). Domestic violence contributes to the development of irritable bowel syndrome (Smith & Gittelman, 1994; Campbell, Harris, et al., 1995), arthritis (Heise et al., 1994; Campbell, Harris, et al., 1995), recurrent vaginal infections (Heise et al., 1994) and gynaecological disorders (Smith & Gittelman, 1994), and has been associated with unexplained vaginal bleeding (Campbell & Lewandowski, 1997). Heise et al. (1994) identified a history of abuse as the precursor particularly to hypertension and heart disease in women.

Injuries inflicted can cause permanent damage requiring long term medical care. Joint damage, partial or complete loss of sight or hearing, neurological damage (Browne, 1993; Campbell, Harris, et al., 1995), and physical disfigurement caused by men biting, burning, or stabbing their female partner are examples of such injuries (Heise et al., 1994).

Health effects of the violence inflicted upon women by their partners also include a variety somatic complaints (Yam, 1995) such as chronic headaches (Heise et al., 1994; Yam, 1995), chronic fatigue (Browne, 1993), abdominal pains and muscle aches (Heise et al., 1994) and sleep and eating disorders (Heise et al., 1994; Browne, 1993). The most frequently found correlates of battering identified in the literature are physical symptoms of stress or stress-related disorders, depression, and feelings of low self-esteem (Campbell, Poland, et al., 1992). Victimisation by male partners and depression are especially strongly linked (Campbell, Poland, Waller & Ager, 1992; Cascardi, Langhinrichsen & Vivian, 1992; Heise et al., 1994; Smith & Gittelman, 1994). Living with a violent partner is psychologically traumatic, causing anxiety and stress (Bewley and Gibbs, 1991; Campbell, Poland, et al., 1992; Smith & Gittelman, 1994).

It is not uncommon for women with abusive partners to be raped or otherwise sexually assaulted by them (Church, 1984; Heise et al., 1994; Seligson and Bernas, 1997). Women whose partners are abusive have a greatly increased risked of being infected by their partner with sexually transmitted diseases (STD's), including HIV, is greatly increased (Champion & Shain, 1998; Smith & Gittelman, 1994; Stevens & Richards, 1998). Stevens & Richards (1998) specifically identify the pattern of violence and domination used by a male partner as greatly limiting the woman's capacity to do anything to prevent him from infecting her with HIV. This is confirmed by Champion and Shain (1998) who found that previous or current victimisation in a sexually abusive relationship was a common history for 25% - 50% of women infected with STD's, including HIV.

Women whose partners are violent are especially vulnerable to attack when they are pregnant. In one study, the number of women battered during pregnancy was found to be as high as 20% (Taggart & Mattson, 1996). Further, it was found that victimised women delayed prenatal care because their partner was physically violent to them. Fear was often the factor determining delay, rather than the presence of obvious physical injury, although women in the study said that this too prevented them from seeking care (Taggart & Mattson, 1996).

Consequences of abuse specific to pregnancy are identified as miscarriage (Bewley & Gibbs, 1991; Helton, 1986; Smith & Gittelman, 1994), placental abruption, pre-term labour, stillbirth (Bewley and Gibbs, 1991), antepartum hemorrhage and fetal fractures (Browne, 1993). Assaults during pregnancy are often directed by the male partner to the woman's back or abdomen which can cause rupture of her uterus, liver or spleen (Browne, 1993). There is also a significant correlation with drug and alcohol use found among women battered by a partner during pregnancy (Campbell, Poland, et al., 1992). Delaying health care during pregnancy is a concern in itself; the realities of the violence women experience while pregnant exacerbate the health consequences of vulnerability to violence during pregnancy.

Alcohol and substance abuse was commonly found among women with violent partners (Campbell, Harris, et al., 1995; Yam; 1995; Campbell, Polland, et al., 1992; Helton, 1996; Smith & Gittelman, 1994). Evidence does not suggest alcohol and substance abuse prior to partner violence - conversely, they develop as a result (Heise, Raikes, Watts, and Zwi, 1994). Campbell, Polland, et al. (1992) state that depression, substance abuse, and anxiety are *consequences* of abuse, and should not be regarded as predictors of abuse. This finding is also supported by Fischbach and Herbert (1997) and by Stark, Flitcraft, and Frazier (1982): "there is no question from our findings that physical abuse is quickly followed by psychiatric disorders, self-abuse, and personal stress" (Stark, Flitcraft, and Frazier, p.184). The development of psychiatric disorders in women who are abused by their partner is significantly connected to an increased likelihood of suicide (Heise et al., 1994).

The risk of domestic violence against women resulting in death is substantial, either as a result of homicide (Campbell, Harris, et al., 1995; Gilbert, 1996; Yam, 1995), or suicide (Fischbach & Herbert, 1997; Heise et al., 1994; Smith & Gittelman, 1994). In the United States, a conservative estimate of the number of women beaten to death by their partner is one thousand annually (Yam, 1995).

In addition to the health problems associated with battering, Seligson and Bernas (1997) found that women who are victimised by their partner have reduced access to healthcare. This means that not only do abused women have much greater health care requirements than nonabused women, but that the provision of health care to them is crucial: victimisation compromises this provision.

The Cost Of Domestic Violence

Domestic violence against women results in significant levels of injury, death and ongoing social problems in New Zealand (Lapsley, 1993). Financially, the costs to

individuals and to the Government are high and in 1994 were estimated to be a minimum of $1.2 billion per year in New Zealand: the specific health care component of this was $140,721,000 (Snively, 1994). In societies where health care and services are readily available, a significant proportion of them is required by women with violent partners (Heise, Raikes, Watts, & Zwi, 1994). Delay of prenatal care, which is on average a significant 6.5 week delay, results in increased economic costs of care and the potential for complications (Taggart & Mattson, 1996). Thus, nondetection of domestic violence, the prevalence of domestic violence, and the health needs of women who experience domestic violence add up to enormous cost. It is difficult to assess the direct financial cost of the health care needed and under-reporting of domestic violence against women adds to this difficulty (Fischbach & Herbert, 1997).

In addition, economic costings are unable to estimate social and personal cost, which are of a qualitatively different kind. Women's labour and creativity, potential for self expression, and quality of life are disrupted and diminished by male partner violence (Gilbert, 1996).

Women's Help-Seeking Behaviours And Other Responses

There is a cultural stereotype that women who are victimised by their male partners are silent and do nothing about assaults against them. Some evidence does not support this. The frequency with which women physically retaliate to male violence, and rates at which women do report the abuse and violence that they experience belie steroetypes of women who are battered as helpless or masochistic (Stark, Flitcraft, & Frazier 1982). Whilst fear of the consequences of reporting is likely to be high, women are often active in seeking to escape the violence. As Dobash and Dobash (1992) point out, a nationwide United States survery found that 52% of women with violent partners did report the violent incidents to the police in the hope that reporting would prevent further violence. Women report injuries inflicted by a violent partner more promptly than they do injuries caused by auto accidents (Stark & Flitcraft, 1995).

It is, however, recognised that underreporting is an issue. There may be a variety of reasons for the decision not to report. These may include women's fear of reprisal or of being murdered by their abusive partner (Dobash & Dobash, 1992). Women who are victimised may also fear that some medical health professionals lack sympathy and the willingness to help them. This fear is not without foundation. Nurses and physicians accept as true some myths and stereotypes about women who are abused, including forms of 'victim-precipitation' (Campbell, 1992). The notion that some women are addicted to violence is identified as the idea most accepted by health-care professionals (Binney, 1981). There is no empirical support for this theory (Andrews & Brown,

1988). Within this context, it is unsurprising some women will simply not report or disclose (Bewley & Gibbs, 1991).

Women also provide accounts of receiving little or inadeuqate assistance when seeking help at emergency departments. Only 2-8% of women presenting at emergency departments with physical injury resulting from violence inflicted by their male partner were identified as abused on their medical records (Campbell, 1992). However, women victimised by male partners exhibit persistent help-seeking behaviour (Harris & Dewdney, 1994). Women's accounts of their experiences contradict theories of learned helplessness and increasing incapacitation. Harris and Dewdney (1994) report that the women they talked felt some sense of blame for their partner's violence when he first began abusing them, but as the abuse continued they ascribed more blame to their partners, and also came to view intervention services, including the criminal justice system, as failing to help them to stop or escape their partners violence. Research also reports that women make repeated and varied attempts to seek help (Harris and Dewdney, 1994).

Domestic Violence And Medical Health Professionals

The health service providers are likely to be among the few professionals who will have ongoing professional relationships with women throughout their lives (Heise et al., 1994; Pahl, 1995). As such, health professionals are in a unique position to recognise, diagnose and treat the effects of domestic violenceagainst women (Fischbach & Herbert, 1997). They are of particular importance considering that the isolation imposed on women by abusive male partners may estrange them from other support services which could render assistance (Stevens & Richards, 1998).

Although it is estimated that of all women patients who seek medical care from emergancy departments, between 22% and 35% are women who have been battered (Smith & Gittelman, 1994), all women who are abused by their partners will also have general medical issues, and will therefore seek nontrauma medical care at some point (Stark and Flitcraft, 1991). The health care system is often the first and most likely place for women who have been battered to seek help (Pahl, 1995; Smith & Gittelman, 1994). However, domestic violence histories go routinely undetected by medical health professionals (Campbell, Harris, et al., 1995; Harris & Dewdney, 1994; Yam, 1995). In addition, research reports that women rate health professionals as the least helpful service providers (Campbell, Harris, et al., 1995; Easteal & Easteal, 1992; Randell, 1990; Stark, Flitcraft, & Frazier, 1982). This is of concern because women who are abused are more likely to seek help from nonemergency primary care sites, such as general practioners, than emergency departments (Stark & Flitcraft, 1991).

The failure of health professionals to detect abuse means that the immediate health issues of the woman presenting are treated, but the cause of those health issues remain unaddressed (Kingston and Penhale, 1995; Yam, 1995). One reason for this may be that women are infrequently asked about abuse (Campbell, Harris, et al., 1995; Fischbach & Herbert, 1997). Cultural myths and stereotypes, such as the belief that women provoke men which results in violence, that 'fighting' is a normal part of an intimate relationship, that domestic violence against women is not a medical matter, and that women who are victimised by male partner violence cannot be helped, often deter practitioners from asking about abuse (Yam, 1995). Several sources suggest that women are reluctant to disclose or volunteer abuse histories due to shame and self-blame though they may be willing to disclose if asked (Bewley & Gibbs, 1991; Heise et al., 1994; Campbell & Lewandowski, 1997). Reluctance to disclose or volunteer information appears to indicate the need for greater awareness of abuse and the possibility of domestic violence histories on the part of health professionals, based on the consistent finding that most women who have been battered and sought treatment wish that someone had questioned them about abuse in a direct manner (Bewley & Gibbs, 1991; Campbell, Harris, et al., 1995; Fischbach & Herbert, 1997). One researcher suggests it is likely that the same attitudes which kept domestic violence a private matter inform the belief that the violence of men against their female partners is neither prevalent nor severe (Browne, 1993). These factors are used to account for the nondetection of abuse.

Medical Health Professionals Responses When Abuse Is Detected

Abused women do seek health care, especially when seriously injured, and regardless of their utilization of or reporting to other services such as the police (Stark, Flitcraft, & Frazier, 1982). However, medical response is less than satisfactory to the purpose of helping and treating women victimised by their male partners, whether this victimisation has been detected or disclosed, or not. Women consistently report that their disclosure of victimisation is not accepted by doctors (Stark, Flitcraft, & Frazier, 1982), medical health professionals do not implement protocols designed to assist abused women, they blame women for being victims, and they are unsympathetic to women's victimisation (Yam, 1995). Heise et al. (1994) point out that little training is given to medical professionals regarding the nature, incidence or sequelae of abuse.

In addition to being unsatisfactory, the medical response to women who are identified as having been abused by their partners is often inappropriate, if not damaging and destructive. Archival and observation research reports that women who are victimised by male partners are more likely than nonvictimised women to be referred to psychiatric services, institutionalised or denigrated by attendent service providers. They are also

more likely to be prescribed tranquillisers, antidepressants and pain medication (Stark & Flitcraft, 1991). It appears to be a mundane finding that health professionals respond to women who have been victimised by treating medical problems only, whilst the cause of these problems, the abuse, remains unaddressed or simply ignored (Randell, 1990; Yam, 1995). This means that the ongoing risk to the patient is never assessed (Browne, 1993). Moreover, mistreatment may occur when interventions related to secondary problems, such as substance abuse, exacerbate the women's vulnerability to victimisation (Stark & Flitcraft, 1991). Bewley and Gibbs (1991) found that there is often poor liason and communication between helping agencies so that even sympathetic responses to women victimised by their male partners may not result in adequate assistance being received.

As well as the dissatifaction women who have been victimised express at response to them of medical health professionals, doctors have expressed their discomfort regarding the problem of domestic violence and their professional response to it. In a review of empirical research on doctors' 'attitudes and responses' to domestic violence against women, Richardson and Feder (1996) identified doctors fears and worries regarding the detection of victimisation. Doctors had fears about the amount of time needed to deal with domestic violence, and that lack of time might prevent identification of the problem; fears that detecting domestic violence might 'open a Pandora's box' or lead to threats against the doctor by the perpetrator; close identifications with women from similar backgrounds to the doctor; worry about offending the woman or putting the doctor-patient relationships at risk; feeling powerless to 'fix' the problem and without control over the success of interventions; lacking medical training about domestic violence against women and also lacking knowledge about appropriate community services.

Researchers concerned with the medical health effects of women's victimisation by male partners make various calls for changes in the attitudes and protocols of medical health professionals, in their training and in their awareness of the prevelance and significance of women's victimisation. Research concerned with the care of abused women and the desire to better assist them was easily found, particularly in the Nursing and Midwifery literature. Campbell, Poland, et al. (1992) call for a greater degree of alertness, and the provision of extra nursing and follow-ups for women abused during pregnancy. Taggart and Mattson (1996) advocate greater awareness of the more subtle signs of abuse, namely psychosomatic compliants and other indicators of abuse such as explanations of injuries which are incongruous with them, missing appointments, and vigilant partner presence. Saunder, Hamberger, and Hovey (1993) caution physicians to be aware of domestic violence histories when treating divorced and unmarried women because of the long term health effects of abuse and the possibility of victimisation even after women

separate from violent partners. Stevens and Richards (1998) state that nurses are in a prime position to assist women through health care delivery, nursing's commitment to higher education and research, and their position in policy development.

Summary

This research indicates that the economic, social, personal, and health costs of the victimisation of women by their male partners is extremely high. Problems are multitudinous regarding the detection of and service provision to abused women. Research calls for changes to be made by medical health professionals in terms of what they should do to address these problems, yet there is little empirical research which addresses the problems some medical health professionals have regarding the issue of domestic violence against women.

This research project is therefore particularly concerned with the experiences of general practioners as primary nonemergency service providers for women who have been victimised by male partners. The following chapter addresses the specific research questions and methodology used in this study.

CHAPTER THREE

Method

In this chapter I seek to elucidate the poststructuralist theories that I engage with and from which I develop a methodology, that is, the specific way of doing the research of this project. Of particular importance are my understanding of Foucault's theory of discourse, power, knowledge, and subjectivity. I make use of Parker's (1990; 1992) criteria for doing a Foucauldian discourse analysis. I identify a particular problematic of discourse analysis, and explain how I address this through using narrative theory. How I collected the texts and how I proceeded with the analysis are also explained.

Epistemology concerns itself with theories of knowledge. Any research method and methodology has as its base a theory of knowledge, which will have implications for how the research proceeds, and what kind of 'knowledge' it can generate. All research methods entail certain theoretical assumptions (Potter, 1996).

The terms "method" and "methodology" are distinct, and are concerned with practice and theory, respectively. Research method refers to the technique used in order to gain information (Harding, 1987). Methodology refers to the theoretical base which informs the procedure of the research; it is concerned with the application of theoretical considerations within the research process (Harding, 1987; Tolich & Davidson, 1999).

The specific poststructuralist theories that I engage with to develop a methodology are Foucauldian theories of knowledge, power, discourse, and subjectivity. The methodology of discourse analysis is consistent with these theories. It is also a methodology which is acceptable to some forms/formulations of feminism (Gill, 1995; Gavey, 1989; Hollway, 1989), including mine. As a methodology, discourse analysis provides guidelines, rather than prescriptions for the conduct of research (Gill, 1996), so in this chapter I elaborate and explain how discourse analysis is used in this research. Discourse analysis also requires the analysis of text. The method used to access text here was interviews.

Foucault's theories and work based on his theories are presented below and contexturalised within his project of historicising subjectivity and the relevance of that project to psychology and to this project in particular. Foucault's project of historicising subjectivity attended to the processes through which people are made subjects (Rabinow, 1984), including subjects of psychology and subjects of medicine.

The terms of Foucault's theories most important to this project are discourse, knowledge, power and subjectivity. As Foucault theorises these terms, they can not be sensible if they are considered in isolation from each other. Although it is not possible to explain what is meant by them or their relationships to each other without 'separating' them, this separation should be taken as heuristic.

Discourse refers to a set of statements that are formed according to rules of admissibility within a discursive formation (Gutting, 1989). Foucault's historicisation of discourse is important to understandings discourse as social and cultural 'artefacts', not naturally occuring phenomena. As artefacts discourse are specific and bound, they are not static, and they may emerge at certain historical points, they may be discontinuous, intersecting, dominant, marginalised, overlapping; they alter, they 'fall into' disuse (Gutting, 1989). The historicisation of discourse also attends to the plurality of discourses and their potential for contradiction at specific historical points (Hollway, 1989).

Statements and the discourses which produce and are realised by them are taken by Foucault as objects of study in and of themselves (Gutting, 1989). Foucault's development of the idea of discursive formations and discourses arose from an attmept to understand the ways in which statements could be grammatically and sematically correct but still be inadmissible as an 'intelligible statement' within specific contexts. For example, within both medicine and psychology it would be inadmissible to state that 'a woman's violent partner was possessed by demons' even though that statment is both grammatically and semantically intelligible. The idea of 'discursive formations' is that they are the 'informal rules' to which discourses conform so that statements are admissible as intelligible (Morgan, 1998). Discursive formations govern groups of statements, however the notion of 'statement' is not a kind of 'linguistic unit' but is defined by function (Gutting, 1989). Discursive formations are constituted by discourses which refer to the same object, for example, the antomical body, or the subject, or the patient (Hekman, 1990; Hollway, 1989). Both form and function are important, but function is privileged over form because function refers to what is enabled. In the case of medical discourse Foucault refers to its function as enabling a 'medical gaze': a way of seeing the body which is neither neutral nor disinterested, but a product of a particular "mode of perception based on a complexly structured interpretative grid" (Gutting, 1989, p.136). Statements are admissible to medical discourse when they conform to the rules of formation of medical discourse and enable the medical gaze.

For Foucault (1980) discourses can never be isolated from power because they constitute the power of particular ways of constucting objects and subjects in the world. In as

much as these constructions are understood as 'knowledge' of objects and subjects, then discourse, power and knowledge operate together.

Knowledge refers to discources that have been legitimated as producing statements of truth which are culturally and socially specific. Legitimated discursive formations which are culturally accepted consitute what Foucault calls 'regimes of truth' (Foucault, 1972). Truth does not reside in the agreement between 'statements' and 'reality' but in practices of legitimation which are culturally and socially specific. Different cultures and societies have disparate legitimation practices. Where knowledge is legitimated, power is always implicated, and truth becomes a political issue (Hekman, 1990). The relationship between power and knowledge, and the political character of 'regimes of truth' has therefore been particularly useful to feminist theorists and researchers concerned with the politics of women's subordination, through theorising women's historical and cultural exclusion from the public sphere (Hekman, 1990).

Within the context of discourse and knowledge, power simultaneously enables and constrains. In this sense power refers to the positive construction of a particular object or subject, to the exclusion of other possible constructions. For Foucault objects and subjects do not have an 'essential character' intrinsic to them. Instead they are constituted as having certain characteristics through reticulated social power relations, 'regimes of truth' and discursive formations (Hekman, 1990).

The power of medical discourse, for example, enables the constitution of medical objects and subjects: the differentiation between objects through daily practices. These 'objects' of medicine are constituted through diagnosis, appear in descriptions of pathologies, and are "circumscribed by medical codes, practices, treatment, and care" (Foucault, 1972, p.33). Through such positive construction, medical discourse organises all the consequent social (hierarchical) relationships involved in medical practices, and enables institutional, treatment, and diagnostic practices, and ways of seeing bodies in the world. The more precise and more refined the construction of an object, or a subject, the more it becomes possible to document, measure, describe, characterise and calculate; the more legitimated discourse enables networks of control and discipline exercised on the objects and subjects they construct (Rabinow, 1984).

Since power operates through discourses which are specific historically and culturally, the political interests served by discourse can only be analysed where discourses are identified in operation, where they are realised in particular statements. It may not be always obvious what interests are served by the discourses realised in particular statements. For example, it may appear obvious at first that the interests served by

medical discourse are the interests of the 'patient' whose healing is the object of the discourse. However, regimes of truth may operate to mask the political interests served by discourses (Gergen, 1994; Weedon, 1987). It is necessary to idenify the function of statements within their field of operation to be able to specify the power interests served by those functions.

In part, discourses mask the power interests they serve through technologies which normalise the objects and subjects they construct within particular 'regimes of truth'. For example, both medical and psychological discourse include technologies which enable the identification of anomolies which other technologies can then be used to correct: to treat and normalise (Rabinow, 1984). These technologies appear to be neutral or impartial means of dealing with 'problems', but from a Foucauldian perspective they are the very techniques which enable 'phenomena' to be seen as 'problematic'. The appearance of 'impartiality' which accompanies the medical gaze, when doctors 'look' for the signs and symptoms of illness or disease, obscures the technologies and assumptions which enable the medical 'point of view' (Gutting, 1989).

The exercise of discursive power operates in and through modes of constituting and governing subjects (Weedon, 1987). In Foucauldian theory the term 'subject' refers to the construction of an individual through discourse by subjection to the discourse so that the individual is both governed by the discourse and also understand themselves to have an identity according to the discourse (Parker, 1989; Rabinow, 1984). Discourses enable 'positions' for subjects by speaking about individuals in particular ways. A subject position may be taken up by a speaker when they speak within a discourse. It may also be offered to another individual through the way in which they are spoken about. In this way subjects become "subjected to the power and regulation of the discourse" (Weedon, 1987, p. 119). Subject positions may be understood as enabling a particular way of conceiving oneself and others as well as specifying the rights, duties and obligations of such a person. The process of positioning is understood as a social process in which discursive power is excerised to enable social power relations among subjects. Just as discusive power is not necessarily obvious, discursive positioning is not necessarily intentional on the part of the speakers (Davies & Harré, 1990).

The interconnectedness of discourse, power, knowledge and subjectivity in Foucauldian theory provide the theoretical framework for this research project. The methodology which derives from this framework is a form of discourse analysis. There are numerous varieties of discourse analysis. The choice of a Foucauldian form is related to my assumption that the attention paid to social power relations and the historicisation of discourse and knowledge is appropriate to areas of concern for feminists and social

psychologists. Gergen (1973) argues convincingly that social psychological phenomena are historically and culturally bound (as are research practices and subject matter, and researchers themselves): "In essence, the study of social psychology is primarily an historical undertaking" (p.316). Forms of discourse analysis which historicise social phenomena are compatable with this version of social psychological inquiry.

Since discourses are multiple, discourse analysis attends to the competing and incompatible ways which discourse constitutes objects and subjects (Davies & Harré, 1990). Discourse analysis also attends to language within its social context and with regard to its function, especially how it enables subject positions (Gavey, 1989). Subject positions may be identified by attending to biographical aspects of speakers' statements which makes it possible to interpret how the speaker understands themselves and others about whom they speak (Davies & Harré, 1990).

Because discourse analysis is an interpretive activity and many interpretations are possible, any particular analysis will be guided by the orientation of the analyst. My reflexive commentary on my feminist orientation (see chapter one) identifies the analysis of this project as informed by feminist discourse.

A formal methodology of discourse analysis is untenable not only because discourse is historically and socially specific, but also because the interpretive orientations of analysts are various (Gill, 1995; Parker, 1992). For this reason each discursive analytic project needs to be developed in relation to the topic, its social context, and the orientation of the analyst (Parker, 1992). As a way of developing this project, I have made use Parker's (1992) criteria for identifying discourses.

Discourse analysis

Parker (1992) offers seven criteria and three auxilary criteria for the identification of discourses. In any research criteria there will be different emphases on these criteria, and they will combined in different ways. In this project Parker's criteria are employed to address the question of how domestic violence detection by general practioners is discursively maintained as problematic. The focus of this question attends to the construction of 'violence and abuse', 'abusive relationships', 'abused women' and 'abusive men', and 'detection' within the broad field of medical discourse, and seeks to elicudate the ways in which these constructions position women and constitute detection as problematic. Within the context of this focus, the criteria that discourses are realised in texts, that they are historically located, and that they support institutions and institutional practices, inform the method of the project: the collection of texts. The criteria that discourses are about objects and contain subjects, that they reproduce power

relations and have ideological effects, inform the interpretations of the texts. The criteria that discourses are coherent systems of meaning, refer to other discourses and reflect on their own way of speaking, inform the process of analysis.

Method: the collection of texts

Criteria one: A discourse is realised in, and inhabits, texts.

The working definition of a 'text' is anything which has "delimited tissues of meaning reproduced in any form that can be given an interpretive gloss" (Parker, 1992, p.6); a text is anything which needs to be interpreted in order to be understood. Texts draw on discourses for their construction. It is possible to analyse texts and identify the discourses that are realised or at work in the text (this means, what they are enabling and constraining, what function are they serving). This is the deconstructive aspect of discourse analysis. We read texts for detail and particulars, we are attentive to discourse as a concept and as a way in which certain meanings are delimited. Thus, we take texts apart, we deconstruct them, and through this identify the discourse realised in the text. It is in this sense that we do not read for gist (Gill, 1996).

The first step in discourse analysis is to "consider all tissues of meanings as texts and to specify which texts will be studied" (Parker, 1990, p.193). The texts I am analysing are the transcripts of my interviews with general practioners. These texts were chosen because general practioners are already positioned within medical discourse as legimate authorities on the medical gaze. When general practioners speak, as doctors, to address questions of the detection of domestic violence, they speak as experts within the institutions of medical practice. The decision to collect text from doctors was to enable analysing the discourse of experts.

Criteria seven: A discourse is historically located.

Discourses are located in time, in history, for the objects they refer to are objects constituted in the past by the discourse or related discourses. A discourse thus depends on past references to those objects - it is dependent on prior use. Indeed, every discourse has a history (of which some are longer than others), and this history can be traced - for example, the history of medical knowledge in Foucault's (1975) *Birth of the Clinic.* In any given historical period we can write, speak, or think about a given social object or practice only in certain specific ways. The ways in which doctors speak about the detection of domestic violence locates medical discourse within both the history of medicine and the history of talk about domestic violence. This historical location informs the decision to collect text from doctors so as to identify the particular problematics of the construction of domestic violence within medical discourse at this time.

Auxiliary criteria: Discourses support institutions and institutional practices

The institution and institutional practices which are the main concern of this project are those associated with medicine. The decision to focus on medicine, and especially its practice by general practioners, was made because women often seek the assitance of their general practioner as a first contact in dealing with the effects of violence, and because of an increasing awareness of the serious, long term health effects of violence. The discourses realised in the text produced by the doctors are understood here as authorised discourses of institutionalised medical practice; discourses authorised through the legitimacy of the doctors positions within that institution.

The institution of medicine is understood here through Foucault's (1975) historicising of the development of anatomical medicine and the increasing canonisation of medical knowledge. Foucault asserts that the antomical body is a text so that the body is subject to the terms of textuality; it is read and interpreted and these readings and interpretations are dependent on discourses. One example of the body as text is the reading of signs and symptoms of illness and disease.

> The sign announces: the prognostic sign, what will happen; the anamnestic sign, what has happened; the diagnostic sign, what is now taking place. . . . Through the invisible, the sign indicates that which is further away, below, later. It concerns the outcome, life and death, time, not that immobile truth, that given, hidden truth that the symptoms restore to their transparency as phenomena (Foucault, 1975, pp.90-91).

General practitioners have a particular relationship with the body as text, in as much as they have learnt to read the body through signs and symptoms. The framework for understanding given by medical teaching institutions to general practitioners teaches them how to see and interpret according to the construction of the anotomical body in medical discourse. That is, they are taught what to look for, what is 'information' and what is not, how to 'see' what they are looking for, and what it means when they see it. Medical discourse also gives them a vocabulary and a way to speak about what they see (Foucault, 1975). It provides them with a discourse supported by the institution. It is a discourse which carries the weight of the authority of the Clinic (in the sense of the institutional practices of anotomical medicine in all its forms) and therefore their status as emissaries of that institution. In summary, what they see, they see through the medical gaze and what they say, they say through medical discourse.

Medicine casts itself as scientific inquiry, aligning itself with the practices, assumptions, values, and authority of scientific inquiry. Nosology, the branch of medical science that deals with the systematic classification or investigation of diseases, was made possible through this alignment (Foucault, 1975). Historically the 'science' of medicine marks a

radical break with earlier medical practice. It is at the point of this radical break that Foucault identifies the 'birth' of anotomical medicine with the 'birth' of its' discursive formation.

This discursive formation legitimated a particular type of knowledge produced through empirical forms and empirical practices. There was a move from the lecture theatre to the ward as the site of training for doctors. At this point, the body in the hospital ward became the principal text of the ontology of the body. However, as Duncan (1997) points out, the anatomical body is not inherently natural: "What is read from the book is written into the book simultaneously" (Duncan, 1997, p.133). The body is inscribed by the techniques of medicine with 'anatomy', and it is this inscription which is read as anatomy.

As empirical inquiry, the medical gaze constructs empirical objects of study which enable 'objects' such as anotomical 'parts', diseases, abnormalities, systems of function, symptoms and so on, to be defined, classified, categorised, treated, disciplined and policed (Duncan, 1997). The 'objects' seen by the medical gaze are constructed through medical discourse and their 'truth' is guaranteed by medical and scientific practice. By this account, the objects seen by the medical gaze are no longer seen by "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, 1975, p.9).

In choosing to speak with doctors, and collect texts of doctors' talk, it is also clear that the medical discourse they speak is not simply a matter of their choice or intention. As Parker (1990) states: "once we start to describe what texts mean we are elaborating discourses that go beyond individual intentions" (p.193). Describing the meaning of the doctors' texts enables the identification of the discourses they use to constitute their 'medical gaze', but it does not tell us what they 'intended' to do by using these discourses. We can name these discourses as resources that make their way of speaking intelligible, and we can name these discourse as authorised by and supporting the institution of medicine, however we cannot assume that the doctors have self-conscious control over the functions of medical discourse.

In as much as the criteria that discourses are realised in texts, that they are historically located, and that they support institutions and institutional practices, inform the method of the project by providing guidelines for the collection of doctors interview texts, they also inform the understanding of those texts as 'expert' texts realising medical discourse and supporting institutions of medical practice.

Interpretations of the texts

Intepretations of the texts collected from doctors are guided by four of the criteria specified by Parker (1992): that discourses are about objects and contain subjects, that they reproduce power relations and have ideological effects.

Criteria two, part one: A discourse is about objects.

Parker (1992) suggests that a strong form of a discusive approach to the constitution of objects is that discourses enable objects to be spoken about and to 'appear' as if they were real. Discourses enable the construction of objects through providing the terms of understanding their characteristics. In talking about what the discourse refers to, we construct those points of reference as objects. Objects constructed within a text are thus brought into existence. According to the discursive specification of the characteristics of an object, whatever is seen to have those characteristics can then be said to be that object. The reference to something, through a process of reification, necessarily objectifies that something. An example relevant to this project is the objectification of violence through various discourses which in some cases construct violence as an act of physical agression, or otherwise an act of intentional harm, and elsewhere as a consquence of lack of control resulting in harm, or even an act of control. Parker (1990) argues that "language brings into being phenomena" and through "the reference to something, the simple use of a noun" an object is made visible and this makes it possible to see it and talk about it - it has been defined (p.196)

In interpreting the doctors' texts I focus on particular objects constructed (and subjects positioned) within the text; these are 'objects' given the status of 'real objects' by the general practitioners. These objects are visible to general practitioners within the field of my inquiry. The discourses which characterise the objects in particular ways are those available within the context of medical discourse. In interpreting the doctors texts I am concerned with how they talk about particular things, especially, 'violence and abuse', 'abusive relationships', 'abused women' and 'abusive men', and 'detection'.

Criteria two, part two: Analysis necessarily entails some degree of objectification.

In the practice of interpreting the doctors' texts as realising discourse, I am, in turn objectifying the discourses I identify in the doctors talk. In the process of 'looking for' and 'naming' discourse I remain aware of the necessity to use discourse to be able to 'see' and 'talk about' discourse. However, given this necessity I do not assume that the discourse characterised in my interpretations are 'real objects'. Discourse is assumed to be an heuristic device which enables looking at the ways the objects are constructed, and the functions these constructions serve (Parker, 1990).

Criteria three: A discourse contains subjects

In putting this criteria into practice as an intepretive guideline, it has been important to attend to the meaning of the word "contains". One meaning of "contain" is to *comprise* or *have in*. Others are: to *hold together, keep under control, restrain, restrict, confine*. I understanding the meanings of the sentence "a discourse contains subjects," as a play on all these possibilities. Discourses are 'made up of' subjects, or have subjects 'in them' to the extent that discourses have no status unless realised within a text interpretable by a subject. The connotations of boundedness and delimitation of other meanings of 'contained' are appropriate in as much as subjects are subjected to discourse and enabled and constrained by discourse in various ways, and in terms of the rights, duties and obligations that the discourse confers and entails.

Where a text is produced through a conversation, as in the structured conversation of an interview, the discourses used will position both speaker and addressee within a system of rights, duties and obligations (Parker, 1992; Davies & Harré, 1990). The relations between the speaker and the addressee are understood as relations between the text and interpretation. In the case of this research the interview process positions both the doctors texts and my interpretations within commonly understood discourses of research practice. The doctors' texts are produced through this discourse as positioning the speakers as expert participants, with the right to say how detection of violence is difficult in medical practice. My own position is produced through this discourse as enabling and delimiting the right to 'interpret' according to criteria for academic research. These subject positions, and the social process of their constitution are not the focus of this project.

In relation to the criterion that discourses contain subjects, the research focus here is concerned with interpreting the subject positions made available to women within the discourses used by the doctors to construct versions of violence and violent relationships. Specifically I am interested in the question of the rights, duties and obligations of women constituted as 'abused' or 'victimised' through medical discourse.

Medical discourse provides an example of the difference between rights to *speak* the discourse, and rights to *speak in* the discourse. Doctors are positioned as entitled to speak the discourse by virtue of their education and practice within the institution of medicine. Their women patients with whom this research is concerned, are entitled to speak in the discourse, but the status of their position, as patient, is very different from that of doctors. Medical discourse enables and constrains doctors and patients differently. The ways in which medical discourse is used to construct the objects related to detection of domestic violence will contain subject positions of patients that are

associated with the construction of violence. Where an object is constructed as a 'social object', such as the 'violent relationship', there is a close association between the object and subject positions.

In interpreting the doctors texts I am guided by the third criteria, that discourse contains subjects, in that I am seeking to identify the subject positions, rights, duties and obligations to which women patients are subjected in the doctors' constructions of violence, abuse and detection.

Auxiliary criteria: Discourses reproduce power relations and have ideological effects.
In as much as discourses support institutions and enable and constrain subject positions differently they produce and reproduce social power relations. In interpreting the doctors' texts this criterion has informed my interpretation of social power relations between doctors and patients as constituted through the institution of medicine and privileging the doctors' positions as 'experts'. The social power relations reproduced through positioning doctors and patients within medical discourse are heirarchical relations differentiated by rights to speak the discourse, and rights to speak in the discourse.

In as much as discourses construct objects and contain subjects they also have ideological effects. Parker (1990) relates the ideological effects of discourses to social power relations and the history of discourse to imply that ideologies, like institutions, are supported by discourses. For example, medical discourse may function ideologically when it practices medicating women in violent relationships to enable them to continuing living within a nuclear family.

In interpreting the doctors texts I am guided by these auxially criteria in as much as I understand the discourses realised in the texts to reproduce social power relations among doctors and patients, and attend to their ideological effects for women.

Process of Analysis

The remaining criteria, that discourses are coherent systems of meaning, refer to other discourses and reflect on their own way of speaking, inform the process of analysis.

Criteria four: A discourse is a coherent system of meanings
Language must make 'sense' in order to convey meaning - it must be intelligible and coherent. Intelligibility and coherence will be determined by the context, the speaker, the historical period, the culture, the society. Parker (1990) states that "when we look at discourses in their historical context, it becomes clear that they are quite coherent, and

that as they are elaborated they become more carefully systematized" (p.191). Discourse often employs 'metaphors', 'analogies' and 'images' which cohere and can be distilled into identifiable systems of meanings (Parker, 1990). It is this type of systematization that allows the formal codification of knowledge, for example, nosology.

Discourse analysis involves a search for these coherent systems of meanings, and focuses especially on what implications for action are involved. Of particular importance is the identification of who the discourse benefits and who it subordinates and the (discursive) means by which this is achieved. This informs my process of analysis in as much as I have read the doctors text specifically to code similiarities of metaphor, analogy and image which signal the realisation of a discourse.

Critera five: A discourse refers to other discourses

The coherence of discourse does not mitigate against the possibility of contradictions within the discourse in the constitution of objects and subjects. Where discourses are contradictory, it is possible that other discourses are at work in the texts and are making reference to each other (Parker, 1990). For example, where medical discourse constructs violence as a 'stressor of functional systems' and psychological discourse constructs violence as 'an inability to control anger', the two discourses working together may produce a contradiction in the 'character' of the problem to be addressed and its 'treatment': is it a problem of the victim's vulnerability to stress, to be treated through medication, or is it a problem of the perpetrator's emotional control, to be treated through anger management interventions?

In the process of analysis, I have attended to contradictions in the construction of objects so as to identify places where discourses refer to other discourses.

Criteria six: A discourse reflects on its own way of speaking

Discourses also include the possibility for their terms to be subject to comment on their usage (Parker, 1992). The possibility that a discourse reflects on its own way of speaking enables speakers to comment on their choice of terms, to hesitate over the choice of terms, or to equivocate about the meaning of terms. In the process of this analysis I have paid attention to places in the doctors' texts where they halt and falter in a sentence to explain, justify, amend, retract, supplement, qualify, and when they stumble or stutter over meanings, self-contradictions, inexplicabilities, and when they don't 'have the words' to say what they mean. These are read as places where medical discourse enables refection on its own way of speaking.

In this project each of Parker's (1990, 1992) criteria for the identification of discourses have been adapted to the context and historical location of the research question, the question of how domestic violence detection by general practioners is discursively maintained as problematic. Discourse analysis, however, also constrains what may be said in addressing this question. In the section below, I explicate my use of narrative analysis to supplement discourse analysis in this project.

Narrative Analysis

In the process of selecting text relevant to the process of my discourse analysis, I became aware of the omission of content which I thought was important to understanding the problems of detection from the doctors' points of view. I was particularly concerned that organising the texts according to the coherence of the discourse that they realised involved fragmenting the coherence achieved through the sequencing and ordering of the content of the texts. To address this omission I decided to present the content of the doctors' interviews as narratives. This required narrativising their accounts. Hence this section presents the theory of narrative appropriate to the context of the doctors interviews, the information contained within them, and redresses the omisson of narrative coherence in discourse analysis. The narrativised text - the doctor's stories - is the result of analysis only insofar as I edited and organised the text.

Mishler (1986) argues that narrative analysis provides a framework for interpreting the complexity of social relations which are meaningfully told through the sequencing of acts in narrative form. The usual practice of interpretation on the basis of 'fragments' taken from texts results in 'decontextualised' inference.

I was indeed troubled in the process of 'doing' my discourse analysis by, not decontextualisation per se - because discourse analysis is commited to attention to context - but by the inability of discourse analysis to contextualise content in relation to sequence and order. It is the imposing of sequence and order that constitute the meaning of a story, and while discourse analysis enables me to address a number of issues and questions the stories of the doctors enable me represent information from their point of view which is produced through the coherence of their narratives.

The concept behind narrative theory is that people 'naturally' story-tell, and that they construct and maintain their identity by way of the stories they tell about themselves and the events in their lives. Stories are a recital of events that have or are alleged to have happened; a series of events that are or might be narrated. In every narrative there is a certain connection of events, that is, a storyline. The storyline enables us to organise our concepts of ourselves as existing over time, our access to the events of our past through

our memories and the form through which we can speak of our past. Through narrating storylines we are able to include our understanding of past events and experiences (Freeman, 1993). Within these narratives we are able to construct our interpretations and our reasons for our acts in relation to events of our experience (Sarbin, 1986). Storylines organise events, linked thematically, into sequences which perform evaluative functions (Gergen & Gergen, 1986; Riessman, 1993). An analysis of these storylines provides an interpretation of how the storytellers evaluate themselves, the events in which they have been involved, and others who have been involved in those events. This 'evaluative' aspect of narrative analysis is omitted in discourse analysis.

The concept of narrative is appropriate in this project because the interview questions I asked took the form of requests for the doctors to tell me stories, and my interviewing technique (see participants/interviews section) allowed them to. The doctors did account for their past actions, individually, and each transcript offers an understanding of the doctors past in relation to the issue of domestic violence, it's bearing on their present experiences, and makes sense of their interest in the issue, their concern for solutions to problems of detection and their willingness to contribute to the research (Freeman, 1993). Storytelling so dominated the interviews that they also did not always answer my questions when the questions were not connected to a particular story they wanted to tell and subsequently did tell. They employed topic-centered narratives, which are characterised by the relating of past events that are linked thematically (Riessman, 1993). Thematic linking and the organisation of events into storylines enable narratives to be analysed to identify commonalities and to 'build up' an aggregate story which represents these commonalities. Reissman (1993) calls the result of this kind of narrative analysis 'metastories'.

Other important aspects of narratives are their constitutive and constructive powers. Reissman (1993) argues that research participants stories are not simple reflections or mirror images of a world outside the story. Rather they are"constructed, creatively authored, rhetorical, replete with assumptions, and interpretive" (Riessman, pp.4-5). Therefore, whether or not doctors told the "truth" is irrelevant. Their narratives are taken as *their* truth, in the sense that they are the ways in which the doctors understand their own experiences, themselves and others.

In analysing the doctors' texts, I attended to sequence both within and across stories (Riessman, 1993). I also attended to thematics. Through analysing sequence and thematics I was able to build up metastories around particular issues and events that the doctors commonly experienced.

As with everything else in this thesis, I bring my own interpretations to this work of analysis. Because narratives tell of the narrator's experience, and direct access to this experience is impossible for me as the researcher, my interpretation is inevitable; as always, neutrality and objectivity are impossible (Reissman, 1993). In this analysis, as in the discursive analysis, my attention has been drawn to the stories relating to my research question, and interpretable through my theoretical understandings. According to Reisman (1993) this interpretive 'involvement' is unavoidable because narratives constitute a sense-making activity.

Riessman (1993) asserts that preservation of the participant's narratives is important, although some omissions are inevitable because I am telling/constructing metastories. My analysis must collapse the transcript data into a form which allows the doctors stories to be told, and to be told commonly. As the person through which narrative content must pass and be in a sense transformed, my concern was to identify the similarities across the doctors' stories and draw them into an aggregate (Reissman, 1993). The process inevitably involved decision-making about what to include, what to exclude, and the anticipated response of the reader was always considered.

The doctors' stories are presented in the following chapter. Quotes from their transcripts accompany the narrative. By using the doctor's own quoted words in the retelling of the stories the reader is able to judge for her/himself the validity of the researcher's interpretative process: "interpretation involves an inescapably subjective dimension as well as a dimension of essential contestibility: strictly speaking, interpretations are neither true nor false, but better or worse, more or less valid" (Freeman, 1993, pp.5-6).

The procedure used for the collection of texts from general practitioners is detailed below.

Participant Recruitment

Criteria for participation and recruitment methods

The criterion for participation was that the participant be a general practitioner, currently practising or not.

Two methods were used to obtain participants for this study: letters and personal contacts. Letters were sent to general practitioners in the Manawatu region (Palmerston North, Foxton, Levin, Feilding, Otaki, and Bulls). The letter introduced myself and my status as a student (see Appendix A) and contained an information sheet regarding the research (see Appendix B), and a contact number if they wished to find out more about

the research and/or participate in it. Three general practitioners out of ninety responded to this mailing.

Due to the low response rate, twenty days after the first mailing I resent the original letters plus a note saying "Just in case you didn't receive this the first time". Five doctors responded to this mailing.

Two doctors were recruited through personal contacts.

The difficulty in finding participants may be attributed to several factors. Response rates to single unsolicited requests by mail are only around 20% (Bourque and Fielder, 1995). Also, people are less likely to volunteer to participate in studies they peceive to be on sensitive or threatening issues (Bradburn, 1983).

Another possible reason for the low response rate was the belief of some doctors that they do not see women patients who are the victims of domestic violence. Evidence for this was revealed by the responses of some doctors declining participation, and by some who were interviewed.

I received three telephone calls from receptionist/secretaries to decline the request to participate. One told me "We don't see that type of people here". Another told me that as the doctor she worked for was elderly he was not likely to see women experiencing domestic violence. I told both these callers that I understood and would still appreciate them passing my letter on to the doctor I had written to. I am unsure what level of 'gatekeeping' went on, or if anything would have been different if I had bypassed receptionists or secretaries by marking envelopes "Personal and Confidential".

Two doctors telephoned to decline, one of whom said he "didn't see that type of person" in his practice. I expressed the desire to interview him still, if he was willing; he was not.

Six doctors declined by letter. Two doctors refered to 'not seeing' domestic violence as their rationale for not wanting to participate, and their responses are as follows: "I hardly ever see any direct consequence of domestic violence probably only 1 in last 5 years"; "I haven't completed your research survey as I am a Specialist in Obstetrics and Gynaecology rather than a General Practitioner. I therefore have little personal involvement in cases of domestic violence and don't feel I would be able to contribute much to your study. I do wish you well with your ongoing research".

I received letters from two general practitioners after the second mailing, saying they were willing to be interviewed but had felt they would not have much to tell me. One stated that "I work part time, and have a large proportion of older patients in my practice, and therefore do not see many cases of domestic violence. I did not reply to your original letter, as I felt my contribution would probably not be very helpful to you." The other expressed similar feelings, saying that "I didn't think I could be of much use to you - only in a negative way as I seldom recognise this problem".

After assuring both that I was interested in any information they could give me, interview times were made and later took place.

The Participants

I did not request the ages of the doctors; none was under the age of 35. Eight of the general practitioners interviewed were men and two were women. General practitioners were not asked the length of time they had been in general practice. The years spent were presumed from graduation years, which were 1960, early 60's, 1966, 1969, 1970, 1970, 1975, 1975, 1983; one doctor was not asked directly, but from his age I would presume he graduated in the early eighties. Ethnicity of the ten general practitioners comprised nine Pakeha and one Sri Lankan. All were currently in general practice. All of the doctors were older than me, and spoke to me as a young, white, educated woman. As well as answering my questions, several talked to me about my research, and suggested other doctors I could interview. Their interest in the research positioned me as sharing concerns with them, as a student entitled to encouragement, and as an academic researcher who would eventually be able to tell them how other doctor's felt about the problems of detecting domestic violence.

Interviews

Interview Location

The general practitioners chose where they wanted to be interviewed. Eight were interviewed at their practices; two outside of hours, six during the working day. Two general practitioners were interviewed in their homes.

Interview Questions

As I entered into the interviews with a specific question I had an interest in, I had a list of questions to ask that I hoped would facilitate their talk about the issue. The interviews were conducted with the assumption that I knew nothing about doctors experiences of detecting domestic violence. Some questions were closed and others open-ended (see

Appendix C). They were composed so that general practitioners could also direct the interviews and to an extent talk about whatever came up for them during the interview, which many of them did.

As recommended by Tolich and Davidson (1999) I asked over-arching questions designed to encourage the participants to talk about the topic. This allowed me to be responsive to their answers and meant I didn't preclude ways of speaking or the development of issues of importance to the general practitioners. The questions were situated in the doctors experience (Tolich & Davidson, 1999) in that participants were particularly asked about their own personal experiences of encountering violence, how they felt about these experiences in particular, and violence in general. This approach therefore led to questions being asked that were not set out in the interview schedule.

Doctors were not asked if they had experience of domestic violence in terms of as perpetrators, or victims, at the present time or in childhood, or with close friends or family, or in any other similarly personal capacity.

Interview Process

My approach

I did not wish for the general practitioners to feel criticised or attacked and I was therefore careful in my wording of the introductory letters sent out, and my approach during interviewing. I cannot speak for the feelings of the doctors I interviewed or their experience of the interview process. I tried to be as sensitive as possible.

In addition, I decided to respond to interviewee's questions honestly and without evasion, therefore I answered questions from participants about what I was doing and why, within the interviews.

I was concerned that the interviewing process not be exploitative. My goal was that the experience of being interviewed would not be a negative one for participants and that, at best, it was an opportunity to talk to someone about their experiences of something which they may not ordinarily be able to do. In the course of the interviews I came to realise that many doctors feel powerless and concerned because of the 'limited' amount they can do. A common response to interview participation was the hope of doctors that by talking to me they could help women victimised by violent male partners, if in a roundabout way. They said they wanted to know how to help better, and wanting to know how to take positive action was a common theme, so if general practitioners believe that they were helping, I feel safe in thinking interviewer and interviewee both

came away with something of value. Although I was wanting information about general practitioners professional practice, I recognise that it is impossible to separate the professional and personal, and that general practitioners would also bring their personal concerns and experiences from beyond their professional experiences.

The interviews varied in length from 15 to 50 minutes. The shorter of the interviews was, in one case, because of limited time available. The other shorter interview was with a general practitioner who had never identified a woman patient victimised by her violent partner. All interviews were audiotaped with the consent of the participants. No participant requested that the audiotape be turned off during the interview; they were informed of their right to do this if they wished.

The interviews were semi-structured. All participants were asked the same questions; even so, each transcipt reads as substantially different from any other. This means that within the interview questions were asked in different orders, some questions were asked up to three times because the interviewee provided additional information each time I asked and some questions were not asked because the interviewee addressed the question spontaneously. I was asked questions by some general practitioners, mostly about my research, about why I had chosen the topic, what I would do with the research, and what I would do at the end of University study.

Because my aim in the interviews was to facilitate the doctors speech, I did not restrict their talk and they sometimes went off on 'tangents'. I took the stance that although the interviews were initiated by me, they were 'owned' by the interviewees, and therefore I regarded the content of each tape and transcript the property of the general practitioner from whom it had been produced. In practical terms this meant that each general practitioner was made aware that they could withdraw from the interview at any time and refuse me the right to use any of the information given.

All the participants were offered a copy of the transcript of their interview. Only two wanted a copy: they were posted their transcripts with a covering letter informing them of their right to change or delete any of the information within them if they so wished. One participant telephoned me with a request for some material to not be used, and to clarify some information given in the interview. I complied with these requests. Of the eight who did not want their transcript, several simply said "No, thanks", and some said they were so busy and received so much other reading material they would rather not receive a copy. Seven participants asked for a summary of results, and one asked to read the completed thesis. These requests will be met.

Transcription

Transcripts of the interviews included everything said by the participants and myself whilst the audiotape was recording. Sighing and laughter are also indicated where they occurred. I used transcription notation (Appendix D) that enabled pauses and their length, changes in volume, and stressing of particular words, to be indicated. The transcription method also indicates interruptions, 'talking over' (drowning out), and simultaneous speech. The notation used conveys as much meaning as is realistically possible and usefully important. Quotes from the general practitioners used within the main body of this thesis have included all transcription notation in the interests of retaining the meaning conveyed.

I transcribed the tapes of the interviews myself, and listened to each interview several times. This was invaluable to subsequent analysis as it brought me 'close' to the material. It is this 'closeness' that enabled me to be sensitive to areas of convergence and divergence across the interview material, and contradiction, consistency, and function in form and content, within each interview.

The interview with the Sri Lankan doctor has not been used in the analysis. This is due to the difficulty interpreting the tape because of the general practitioner's accent. Although in listening to the tape closely I could determine general meaning, I felt I could not transcribe with a sufficient degree of accuracy. Because of these concerns I chose not to include this interview for analysis.

Coding

I selected categories of objects which were relevant to the research question. The categories generated were 'violence and abuse in general', 'symptomology', 'disclosure and asking', 'constraints on asking', 'the abused woman', 'training', 'violence and abuse (specific acts)'. As a first step I selected any words, phrases, or references that related to the object. For the 'disclosure and asking' category, for example, I coded references to how and when doctors ask their women patients about victimisation, and occasions on which women spontaneously disclosed.

For each object I created a file. Close reading of these files allowed the recognition of repeated patterns and anomalies. This coding contained the beginnings of the data analysis. The discourse analysis involved the careful reading of the coded text with the aim of identifying the discursive patterns of meaning inhabiting and informing them. After disourses had been identified, material was reorganised so that the construction of objects by particular discourses could be read separately.

The stories the doctors told were analysed according to my goal of retaining their coherence and connectedness. Because the doctors accounts were presented as metastories I imposed structure while attempting to retain the flow of the structure doctors had told their stories in originally. This retained the sense they made of their experiences.

Ethical Considerations

This study meets the ethical requirements of the Massey University Human Ethics Committee.

All participants were informed verbally and in writing of their rights: to withdraw from the study at any time; to refuse to answer any question; to provide information on the understanding that it is completely confidential; and to have their anonymity preserved (see Appendices B and E). I have used single upper case letters that do not indicate participants names to mark each doctor's text. To preserve the anonymity of the woman who provided the preface I have not used her real name.

Participants were fully informed about the research process and their rights within it. Informed consent was gained from each general practitioner interviewed (see Appendix E).

In the following chapter the doctors' stories are presented. They tell of doctors' concerns, experiences, fears and worries regarding the detection of the victimisation of women patients. Two main stories are told. The first relates to the disclosure and detection of victimisation; the second, their feelings and responses regarding victimisation.

CHAPTER FOUR

The doctors' stories

This chapter presents two metastories of the doctors' experiences of the detection of women's victimisation by male partners, and the related issues that they identify.

Of the general practitioners I interviewed, all but one had experience of a female patient with a domestic violence history.

no one has ever brought up domestic violence with me
(Dr A, 26)

The general practitioners said that they are worried about failing to detect victimisation.

many cases of abuse we fail to pick that it occurred
(Dr B, 12)

looking backwards you wonder how many have been abused that you never know about
(Dr J, 13-14)

In part, this worry comes from believing that women often do not disclose a domestic violence history to their doctor.

I'm sure a lot just don't mention it to their doctor
(Dr R, 5-6)

they hide it
(Dr B, 14)

They are also concerned they have not been trained regarding domestic violence against women. They are not sure what to look for and don't know how to help - they talk about being trained at medical school in the 'dark ages.'

I was trained in the dark ages
(142, Dr G)

it's really sad that, ah, we didn't get much GP experience, and were thrown into the GP thing with no real professor of general practice
(Dr L, 166-167)

All nine general practitioners had not received training in the matter of domestic violence against women, including detection matters.

I can't recall being taught about domestic violence [inaudible] at medical school
(91-92, Dr C)

we were taught all the way through by hospital specialists and we were taught hospital medicine. I think we spent two weeks with a general practitioner in our sixth year
(Dr R, 53-55)

One doctor said that the reason for the low response rate to my request for participants may be due to this lack of training. Not being knowledgeable about the issue may be a source of embarrassment for doctors, and therefore felt by them to be weakness.

Yeah, I think, I suspect many doctors may not want to talk about it cause they may be embarrassed that they don't know much about it. ... You see it could be a weakness.

(Dr J, 441-444)

Regarding this matter, another doctor said that doctors may have not wanted to talk to me because domestic violence is not a comfortable thing for them to talk about. He also said that a doctor's personal life may mean they didn't want to discuss the issue with me, particularly if they have themselves been abused, or are abusive of their own wife/partner. He felt that it is important to deal with the effects of domestic violence, despite difficulties facing the issues, even when they are visually inescapable.

a lot of therapists are not comfortable with talking about things which they're not comfortable within their own being. ... So, you might have to begin to look at what goes on in doctor's lives. ... Have they been abused or are they abusing their own wives.

(Dr L, 238-243)

One doctor expressed the feeling that it is only possible for a general practitioner to never deal with victimisation by ignoring it.

if she didn't bring up that issue, it's not my department. ... Really and truly it is. But really and truly we have difficulties in our own beings, with confronting those issues. When we see it grossly visible - the fractured mandible, ... the bleeding scalp - "how did this happen?" " My husband beat me up."

(Dr L, 264-271)

The doctor who says he doesn't see it obviously doesn't look for it

(Dr J, 372)

The doctors tell two main stories. One story they tell is about how domestic violence histories come to be disclosed. The other is how they feel about and respond to the issue of women's victimisation.

Story one

Violence, detection, and disclosure

Doctors understand and account for violence in various ways. They become aware of, or find out about a domestic violence history in two ways: either through the detection of symptoms, or through disclosure.

Doctors recognise physical injuries resulting from physical violence and also include an understanding of verbal, psychological and emotional abuse as forms of violence.

Ah, (2) but, oh I guess just the indicators are as I said, um, that they're presenting with other things. ... Ah, so, (.) Especially if they don't have physical signs to show that they're being emotionally abused, or there's a lot of pushing or shoving or threats, those sorts of things.
(Dr C, 101-113)

I probably do see a lot more psychological violence
(Dr B, 92)

I've got a lot of women who I think are being mentally abused, verbally abused, but not physically abused
(Dr J, 115-116)

The denigration, criticism that occurs
(Dr N, 435)

I can think of several cases where there's never been any physical [inaudible] but it consists of insults and demeaning the person and so on
(Dr L, 143-144)

Some doctors talked about all forms of violence as related to the power and control of a violent man over his woman partner.

yeah well the word abuse has also shifted in it's meaning a wee bit, so that like power and control is now sometimes t-, t-, termed abuse
(Dr N, 257-258)

Some doctors said they thought that violence against women happened because of a problem in the relationship.

There's all sorts of things that are happening in this (.) relationship ... maybe there's something that happens between them that needs to be addressed
(Dr N, 548-555)

Doctors also said that society is more violent than it used to be, and that domestic violence has increased commensurate with this general rise. Due to the belief that violence is also more pervasive now, doctors feel that it is unsurprising, that violence will extend into the domestic sphere. They believe that there has been general societal breakdown; a certain laxness has lead to the violation of social rules.

Maybe because I'm getting older. I think society's in a big mess. ... Um, I think there was less bashing when I was a younger doctor, and I've been a doctor thirty years ... but society's freed up in what people think they can do and get away with. Um, I think there's more violence in general than there used to be.
(Dr G, 340-347)

So, violence is pervasive (2) and it's not only within the marriage thing, it's also within the total society. Naturally it will find itself into people's homes.
(Dr L, 330-332)

Some doctors felt that violence is taught, especially as a method of gaining short-term gratification.

I think a lot of people are brought up without love and they don't know how to relate to one another, so, they're taught that violence is one way of getting your way, and it does, it achieves the short-term goal, you know.
(Dr L, 324-327)

One doctor felt that the amount of violence in the media estranged people from understanding the reality of violence - that it is physically painful and injurious.

violence is a way of life um, you know, that um every morning if you watch TV three, or Sky four, or something you've got to get in behind the television set with a shovel and clean out all the bodies, you know, it's ah, um, I guess it's because people see so much artificial violence, they don't actually realise that a shot in the leg hurts, it hurts a lot. A dog bite hurts.
(Dr B, 294-299)

Doctors also feel that social pressure - that is, financial pressure and other stressors - are the cause of an increase in violence.

The relationship isn't happy, there's not enough money, the kids are whining.
(Dr G, 379-380)

I think the stresses and strains of, of, of life at the moment probably make, make abuse more common, cause I think that's when people fight more often
(Dr B, 237-239)

I think there's a lot of fiscal stress ... on society, and I think that when people are stressed they lash out
(Dr B, 279-281)

One doctor said that he had observed a decrease in domestic violence. He attributed this to a reduction in stressors, including employment and financial stress, and more positive community attitudes. He also said that policing had a positive effect, in terms of incarceration and law enforcement. The concept of zero tolerance was also making a difference to how people see domestic violence against women.

at the moment the town's pretty quiet, in terms of employment situation there's jobs, there's more positive attitudes, there's less drunkenness, a lot of the people who are perpetrators of crime and drunkenness are either in prison, or they've left town recently. All those, all those things have a bearing on the incidence of domestic violence. ... Um, so, so at the moment it's decreased (.) and there's more (.) more opportunity for men to seek ah, counselling now, too, than there was. ... So maybe men are seeking counselling sooner. I don't know. So. The Police are more involved which ah, guys are perhaps scared of now.

(Dr C, 158-168)

And I think there's a zero tolerance, there ah, I was reading the paper today, a guy, the ------ priest was actually, was talking about zero tolerance to domestic violence and he's trying to push that. And I think there's a lot of women say well, you know, I've got zero tolerance now

(Dr C, 150-153)

When doctors talk about detection they say that some patients will simply disclose. The doctors who practice in small towns know everyone, and find that disclosure is common. This may be due to the fact that it is less easy for their patients to hide abuse: Living in a small community enables the doctors to come to know their patients well. Knowing a patient well means that any change in them can be easily picked up, and the nature of the relationship allows the doctor to ask about their general family situation.

Usually the patients trust you, you shop with them, boundary issues are a major issue (indecipherable) and so therefore they usually tell you ... They walk in "he hit me" ... Simple, it's that sort of trust, it's that sort of rapport.

(Dr K, 36-41)

Probably is, 'cause I know them pretty well, I know them quite well and once you know a patient quite well when they come in with something a bit different you sort of (2) just ask the question "How are things going at home?"

(Dr C, 57-59)

Small town doctors become part of their community, and therefore know who is being abused and who is abusing. Because of this familiarity, women will assume the doctor knows the situation, and will just say what is happening for her. Doctors know their patients from contexts other than their professional relationship - as friends, members of the same committees, customers and so on.

Um (2) I, I guess ah, my patients round here I know I know who's being abused now and ah I know who the abusing partners are (laughs) ... A lot. And so (2) a lot of the women will come and they'll just tell me "He's knocked me around again"

(Dr C, 95-99)

These community links allow trust and rapport to develop more easily. Doctors live alongside families in this community sense, and may treat all members of a family, sometimes four generations at the same time. This implies that over time the doctor develops a comprehensive knowledge of a family and their domestic situation.

In rural practice you live with the community, you live with your families - you treat every single member of the family, you can treat four generations at the same time.

(Dr K, 32-34)

you can also do home visits, where you go out and see the family at home and watch the family function at home, or not function at home.

(Dr K, 71-72)

Patients of doctors in urban centres also may spontaneously disclose, without the doctor questioning or asking them. Women may arrive angry and with physical injuries. Sometimes they come for an assessment of their injuries because they aim to end the abuse by taking legal action.

(2) I don't normally need to question them about it because they tell me what's happened.

(Dr J, 63-64)

.... [they] arrive screaming, swearing, with black eyes, screaming, swearing about that prick, that bastard (laughs)

(Dr K, 230-231)

(4) Well, they'll either come in saying "I've had enough of this f-ing B", you know, get you to measure this, look at this - "I'm going to the cops"

(Dr G, 73-74)

Whether doctors are urban or rural, trust in the doctor allows the patient to disclose. Women seek medical attention for their injuries or for their management such as pain medication. They may also want to see their doctor just so they can tell them what has happened.

She came because she needed some, needed (.) something for the pain, yeah. ... But she came because she wanted to tell me.

(Dr G, 228-230)

It may take time for the doctor-patient relationship to build and develop, and only then women might refer back to previous injuries and disclose that the injury was actually the result of domestic violence.

I can think of a couple of middle-aged ladies in their fifties who've seen me on occasions, and one on one occasion had a large bruise on her upper arm, the other one had a bruise on her face ... and both of them, because I thought they looked strange, I commented lightly on them, gave me a reason such as they bumped into something, but at a later date when either they had more confidence in me or things were obviously wrong with their marriage they actually went back to this and said "Do you remember such and such" (3) "it wasn't really as I said".

(Dr R, 8-17)

Doctors are generally didn't talk about disclosure of psychological/emotional abuse, and tactics of control. However, they are aware of them, for example, partner presence at appointments, and threats.

there is <u>one</u> I have become more alert to and that is (4) the (2) the (.) presence of the partner at every interview ... I've had confirmation of that, um from the person [inaudible] and they came on their own finally and this is what emerged, which was that for them it was a control issue

(Dr N, 241-242/249-251)

they were out at the beach one day, one of the more isolated beaches and he said "I could kill and bury you here, and no one would even know you were here"

(Dr R, 114-116)

In response to being asked what makes them suspect abuse, doctors talked mainly about symptoms; that is, what they see.

Without disclosure, doctors read the body for signs. The doctors identified certain symptoms as indicators of abuse. They regard signs of physical trauma presented through the body of their patient as evidence of abuse. In these cases the doctors see abuse through an acute medical presentation of injuries such as bruising, fractures and wounds.

in the adult most of them are fairly obviously abused cause they are fairly well beaten up ... It's a fairly florid sort of acute medical presentation ... Most of the women come along with a black eye or a broken nose, or bruises on them and, and they're crying and they're upset and it's obviously a fairly acute thing.

(Dr J, 19-27)

women come in with, with signs of battery. ... Which are usually bruises

(Dr C, 17-19)

Well, obviously ... the bruising

(Dr G, 55-57)

Doctors realise that abuse resulting in injury is probably an extreme of violence that is perpetually present in the woman's life. They know the acute presentation may have been preceded by repeated presentation to them of minor injuries which they have not recognised as symptoms of domestic violence.

Ah, (2) yeah fractures and bruising are probably the tip of the iceberg, ah other, other sort of repeated seeking of help for other (.) minor injuries ... for minor illnesses

(Dr C, 48-51)

Doctors also suspect abuse when patients give them an account of an injury which is not consistent with that injury. This appears to be the only way they have been trained to see abuse - as a clinical phenomenon - and so they feel more confident in their diagnosis.

the story doesn't line up with how she got injured, with the things that you see

(Dr C, 40-41)

the main thing that we use clinically is an injury that isn't consistent with (.) the story

(Dr N, 112-113)

Doctors are sensitive to the demeanour and behaviour of their women patients and describe picking up their emotional state based on how they look. They then sometimes ask her about her life or general situation. By attending to these aspects of the woman's emotional presentation, the doctor may be able to let her know that it is safe for her to disclose if she wants to.

I guess yeah symptoms is when they're upset, eh, and when they're upset you pick that up

(Dr G, 57-58)

Usually, um, usually what I pick up on first of all is the fact that they look so awful and they look so miserable, and they look quite depressed and they're quite frightened and quite edgy, and that is what I focus on, and as part of focusing on that, I either ask them or they tell me that physically, sexually, if they've been abused at home.

(Dr K, 59-63)

Some doctors are likely to suspect abuse where women are from lower socio-economic groups, drink, smoke, are in relationships with gang members, or have many children.

there's a particular group of people that we suspect it in, that I suspect it in, ah, the lower social class, the, the, the, the drinking, smoking types, the ones with gang husbands, and the ones with lots of kids, um all those I think have got to be risk factors, you'd know better than I probably, but, um, but in my view they are

(Dr G, 14-18)

Indications of a partner's control over a woman suggested victimisation to doctors, as did a woman's reluctance to talk about her partner, or his presence at every appointment. Children's behaviour was also sometimes interpreted by doctors as an indicator of abuse.

you often get that feel for a person's relationship, I think. They can't make their own decisions, and they have to go check with their partner and all that stuff.

(Dr N, 261-262)

(6) Um, (3) I've got a lot of women who I think are being mentally abused, verbally abused, but not physically abused ... um, and that's something that you just get a gut feeling for they're frightened and they, they won't talk about their partner much, and, and, their children are perhaps showing abnormal behaviour patterns and things, but it's just a supposition.

(Dr J, 115-120)

When women present with depression, some doctors are not happy to simply provide medication. They are concerned to find out the cause of the depression. Sometimes they suspect victimisation, and sometimes they find out that victimisation is occurring. Doctors question in about the woman's situation general terms in an attempt to establish the cause of her depression.

Sometimes you don't see the abuse, sometimes you just see a depressed person, and um, we find out afterwards that there's an abuse there, yeah. [Because it's not just fractures, is it.] Definitely not.

(125-129, Dr L)

Certainly in every case of depression I'd ask what the situation's like at home

(34-35, Dr A)

When a patient is reluctant to have a cervical smear, doctors suspect abuse; either domestic violence, or other abuse such as childhood sexual abuse. One doctor stated that such patients may also find it physically difficult having the smear done, the cause of which doctors differentiate from medical conditions, such as vaginismus.

there's some questions with doing smears, if there has been something going on. ... there may have been some, um, sexual abuse at some stage which makes it difficult for a woman to ah, one, agree to have a smear, or to actually have one. ... Which may not just be vaginismus or one of the (.) medical conditions.

(Dr A, 13-20)

Doctors said that women in violent relationships often present to them with stress-related symptoms. Complaints of

Very often stress, stress symptoms occur, very obviously, ... And they very obviously not, and I guess headache, headache is a very common one, presentation of stress

(Dr B, 76-79)

headaches are a common indication to them the woman's life is stressful. Women may request specific medication, such as Valium, to help them cope with stress. Doctors feel it is important to determine exactly what the stressor is, and sometimes suspect domestic violence.

Um, or they may come in because they're just, ah, stressed out and they want me to give them some Valium or something.

(Dr G, 78-79)

Doctors are also concerned to search for causes of a woman's general deterioration and health problems, and questioned, aware of the possibility of victimisation.

Oh, I think to say "Look I recognise there's an obvious problem here," um "this may be reflecting on the reason why you're here today, and also oh, things that I've noticed, that I've noticed a deterioration in your function, I've noticed that you're anxious ... that you're (.) coming in and saying you can't sleep or you want some Valium or some of those sorts of things, why is all this?" You should be looking at the causes.

(Dr B, 174-180)

Doctors assume that it is both physically and psychologically damaging for women to be in a violent relationship. They are motivated to ask about abuse for several reasons. One of these is to get women outside help. They will refer women to the police and to counselling. They may also attempt to involve family members.

I refer people on, if they are prepared to, and that is often what a lot of GPs do for psychologists and, or psychotherapists, is to actually prepare the patient going to get the help

(Dr K, 139-141)

sometimes I'll refer them to counselling (6) but the cops first

(Dr G, 138)

I'd usually try and con-, you know (.) get the family involved, or get some other person to (3) link with ... get them to turn to someone else ... So that they can take them the next step.

(Dr N, 201-208)

Doctors hope that, through asking, they can offer and provide support to their women patients: support in terms of listening to her, telling her she deserves better and doesn't have to tolerate violence, and taking the position of a person in a caring profession who knows her situation and wishes to help her.

they need heaps of support, not just moral support but maybe [looking for] a safe house, or to um, (4) um, some encouragement just to formulate a plan

(Dr G, 126-128)

[support them] to shift them to the "I could maybe" ... "So therefore I'll get out"

(412-414, Dr N)

I try and point out to them that, that no one in this society has to live in fear of physical violence. And that nothing can be done about this until they do something about it.

(Dr B, 51-53)

I guess because I was concerned that something might be happening and they might feel they wanted to talk to me about it.

(72-73, Dr R)

they just need the acknowledgement by someone else that (.) that what they're going through is (.) is hurtful, and harming them. ... And ah, they, once, once they've acknowledge it, that in fact they're the victims, and ah, they shouldn't be going through that situation, that they can be directed to a helping agency

(Dr C, 75-80)

Knowing a woman's domestic violence history enables doctors to get to the core of her medical problems. Doctors can then treat her health conditions from a more informed position.

The main issue in asking about for it is that issues like that, like depression, like abuse are the most important single problem that you can have and that will prevent them from taking their blood pressure pills, and that will prevent them from sorting out their cholesterol, that will prevent them from caring for their children, that will prevent them from sorting out their kid's ear infections, so until you resolve those emotional issues before you start then you might as well go home.

(Dr K, 74-79)

Some doctors, who believe violence in a relationship to be a result of dysfunction of the interaction of partners, advocated marriage guidance, couples counselling, or anger management for the violent man. They feel, however, that it is not likely that the violent man will change. Leaving becomes the woman's only option for ending the abuse. Doctors see that, in addition to being beaten, psychologically abused, and treated in a degrading way, women in relationships with violent men are in life-threatening danger.

anger management courses for men are great. ... But you've got, the person's got to want to go

(Dr A, 222-225)

I've done a fair bit of anger management counselling over the years [inaudible] which I found quite good for those who were motivated to (.) change. ... But ah, those who didn't recognise that they had a problem, who thought the problem rested solely with the woman, (2) it didn't really help them

(Dr C, 179-183)

men ... can occasionally change but I don't think it's very often in my experience

(Dr J, 271-272)

if they batter once they'll batter again

(Dr G, 332-333)

it's a sort of demeaning of the woman

(Dr J, 146)

Doctors fear that women may be murdered by their partner. Therefore, part of trying to discuss her situation is to emphasise the danger she is in and how concerned they feel about her health and safety. Even though they recognise that leaving a violent partner is dangerous in itself, most doctors still regard leaving as the woman's best alternative.

I'm always worried that a lot of them are going to go back and get abused again and I point out to them (.) that there is a risk that they could be killed
(74-76, Dr J)

I just say that "Sooner or later the person will kill you"
(130, Dr B)

it's, it would be to say "look um, you know, the next step is more violent, you might in fact die, ... it is my job to protect you."
(120-123, Dr L)

Doctors therefore often tried to persuade women patients who were being victimised to leave their abuse partner

I was trying to persuade her right from the start whenever I could that she would be better off leaving
(138-139, Dr R)

Doctors said it was difficult to persuade women to leave. They talked about it in terms of working really hard to get her to do so, but ultimately having little control when she did not leave, or continued to return to the relationship.

And I remember halfway through this just prior to one Christmas I'd actually persuaded her. She was going to go up to Auckland to be with her relatives and plan to to not come back again. ... Um, and I was actually very cross, she actually saw one of my colleagues who said well was it a good idea maybe she'd be better to stick with him and give it another GO, and I was very cross about that (laughs).
(151-xxx, Dr R)

it was sort of prising her away from him and then she'd go back, prising her away and she'd go back
(135-137, Dr L)

The foremost concern for doctors when women present with injuries is to provide medical care, but as a diagnosis, doctors feel it is important to be clear about the cause of a woman's medical problems.

Um, they won't tell me often how often it's happened but obviously when they present with, with physical signs of damage, but I'm basically more concerned at the time to sort of sort out their medical problems
(Dr J, 66-68)

[I] Try to get them to deal with it, really. ... To, to at least, I mean what does one do in, in any situation in medicine, try to get someone to face, or what we see are the issues, say, well you can't go further on to deal with these until you, you accept the diagnosis.
(Dr B, 31-36)

The doctors say they are more able to provide women with ongoing support by building a trusting relationship and knowing a woman's abuse history. This allows them to check out the situation, and sustain the woman's awareness that she can talk to her doctor about it. Doctors recognise that it may take time for a woman to decide to leave, so their interactions are informed by taking a long-term view to their desired outcome stopping the abuse.

But, um, often it's a source of (.) you know, like (.) um, "What are you doing about this?" or "Where are you up to with this, with this issue?"
(Dr N, 170-171)

it just goes to the point of when, when's enough? For a lot of women
(Dr C, 136-137)

Doctors try to find ways of asking, or ways of relating to the woman, which they hope will facilitate disclosure. There are factors that make doctors feel safer asking a woman about abuse. If a patient has disclosed, doctors feel it is safe to ask her about the matter in subsequent appointments.
Doctors also find that rather than disclosing directly, patients will give clues that they are being victimised, which the doctors interpret as a signal that they would like to be asked and given the opportunity to disclose.

and often these things would, um, she would mention these things and towards the end I always used to ask her when she came in, anyway, how things were
(Dr R, 146-147)

And, very often they will give you clues as to what's going on, they'll, they'll say "We all have our ups and downs, don't we?"
(Dr B, 42-43)

they'll come in because they just don't know what to do and they want me to discover it so that we can talk it through and decide on a course of action.
(Dr G, 74-76)

When the doctors suspect abuse, but the patient has not disclosed, they use a number of methods to try to gain information. Doctors may directly question, ask what caused her injuries, or just bring up the fact she has them.

I have asked a few people if everything was all right at home.
(Dr A, 28)

if I'm at all suspicious I'll try and explore it.
(Dr N, 125)

Doctors will ask the woman about her state in general or about her home life if they are suspicious. They may also search for evidence of abuse so that they can then ask about it.

Ah, then you might say to the woman "How are you?" and then it all, then it all comes out why she actually came in.
(Dr C, 106-107)

I have asked a few people if everything was all right at home.
(Dr A, 28)

I would certainly bring up the fact that she's got injuries. And why is this occurring?
(Dr B, 39-40)

at the time I did say "I see you've bruised your arm"
(Dr R, 25)

Doctors use the presence of symptoms (or search for them if they have suspicions), which can then be asked about directly or indirectly. Symptoms are generally bruises. When women present their medical problem as something other than the injury that is visually obvious to the doctor, doctors simply side-step and ask about the injury. Doctors inquire about or comment on bruises, and may ask for an explanation for them. Suspicion leads to the search for evidence. Doctors feel able to use symptoms as a way 'in'; a way of initiating a conversation which they hoped would encourage the woman to disclose.

Well. I would look for some evidence and say "that's a funny looking bruise you've got there," yeah. ... "Can you tell me how it happened?" And when they say "the door slammed into my face" I'd say "I'm not sure: I find that hard to accept. Are you sure it wasn't something else?" or something like that.
(Dr G, 35-40)

Or they come in with some really obvious injury and say "I've hurt my hand," or some equally pathetic and really trivial, and I go "tell me about the face." ... And we're away
(Dr K, 44-48)

Doctors feel the need to approach their woman patient in a delicate and sensitive manner and they expressed their unwillingness to pursue the matter if the woman does not respond openly.

I can think of a couple of middle-aged ladies in their fifties who've seen me on occasions, and one on one occasion had a large bruise on her upper arm, the other one had a bruise on her face... and both of them, because I thought they looked strange, I commented lightly
(Dr R, 8-13)

I don't have a, I don't have a fixed um, way, of saying, you know, I might very delicately inquire about an injury
(Dr L, 95-96)

Therefore, doctors said that they will discontinue questioning if the woman denies she is being victimised, or gives other verbal indications that they do not wish to discuss the matter.

No, at the time I did say "I see you've bruised your arm" but no, I didn't make any comment like, you know "was it really accidental?" no, I didn't push it like that.

(Dr R, 25-27)

I would directly question, but I, I'm forced to back off when I'm, I'm when my, my question, you know if the answer's "No" then the answer's "No." ... I can't go any further than that

(Dr B, 157-160)

But, but occasionally it's a no go area and you know, like (2) "Don't want to know", or "I'm doing the best I can", you know what I mean?, or "Don't challenge me", sort of "Don't rock the boat." ... So you get the messages sometimes.

(Dr N, 164-168)

Doctors talked about noting abuse as a suspicion and not questioning due to the doctor-patient relationship being insufficiently developed, and not wishing to disrupt or damage the trust-building process. Not pushing the matter was also due to the doctors awareness of the reasons women may have for not disclosing. These reasons may be the realistic fear of retribution from their violent partner, especially if he has made threats to do so. Doctors also acknowledge that women may simply wish to keep the matter private.

Ah, and my way of handling that is to really just note it as a suspicion and wait and see, you can, you can ask them, but sometimes you can't ask them outright. ... You sort of have to wait for them to tell their story. ... Sometimes if you wait and if you give them enough time it'll come out, but I think it's a very threatening thing sometimes and if you put too much pressure on them you break that relationship which you don't want to break, you see. ... Mm. [So you feel you need to develop some kind of trust in the relationship <u>first</u>.] Yeah, if you, if you listen to them carefully and give them the support they'll tell you the story eventually ... Which is less threatening sometimes than trying to force it out of them ... cause you can do more harm than good.

(Dr J, 125-141)

Ah, it's purely up to them, if they, if they want to disclose, cause a lot of them being in a relationship where (.) ah, their partner will have told them "Don't disclose it or I'll do it again." Ah, I guess some would not disclose out of fear, some will not disclose out of a privacy of their own lives and relationship.

(Dr C, 28-31)

Doctors said that having the trust of their women patients can lead to spontaneous disclosure. They therefore feel that the ability to develop trusting doctor-patient relationships is an asset of general practice. Doctors feel more cautious with patients with whom they do not have such a trusting relationship and sometimes choose not to question them until the relationship has been developed.

Thus, asking is dependent on the kind of relationship the doctor has with the patient, with trust and knowing the patient over time cited as the factors upon which asking is contingent.

She came because she needed some, needed (.) something for the pain, yeah. ... But she came because she wanted to tell me.

(Dr G, 228-230)

[after denial in two separate cases that abuse was occuring] at a later date when either they had more confidence in me or things were obviously wrong with their marriage they actually went back to this and said "Do you remember such and such" (3) "it wasn't really as I said".

(Dr R, 8-17)

Well I guess the characteristic of the patient that makes it easier to ask is if you <u>know</u> them well.

(Dr B, 56-57)

if there's an ongoing, long-term, trusting relationship

(Dr L, 106)

Um, a previous relationship with her. ... It's much easier. ... Knowing her, or her knowing me. ... So the trust thing.

(Dr N, 375-380)

Oh, I, would-. No. I wouldn't come out and straight-forwardly ask. It depends how well I know the person. I think that's one of the good parts of general practice, it's relationship, building and built on, so there <u>are</u> some people I would just come out and say "tell me more" (indecipherable) and they tell me. ... Um, and um, (4) Yeah, because the relationship's already established, if it was someone I didn't know you'd be very careful.

(Dr G, 26-32)

Sometimes women bring their child for medical care and it becomes apparent to the doctor that the child does not have a medical problem. This makes the doctor suspect that the motivation for this presentation may be related to abuse issues; that the woman may be wanting to disclose, and not feel able to do so spontaneously.

Often they may bring their child in [inaudible] may bring the child in with something that's not really an illness. So you'll look at the child (2) for five or ten minutes, the child's fine (.) ... Ah, then you might say to the woman "How are you?" and then it all, then it all comes out why she actually came in. ... Ah, so, but that's a common presentation.

(Dr C, 102-109)

Doctors had several concerns regarding questioning patients or making comments. One concern was about offending the woman. This prevented doctors asking if the cause of an injury was partner violence. They did not want their enquiry to be perceived as an insult to the woman or her partner. Causing offence is undesirable in itself, but can also damage the doctor-patient relationship if it is young.

The doctors also worried about jeopardising the doctor/patient relationship by asking. They felt that asking may feel threatening to the woman and result in the woman withdrawing from them or becoming defensive. Because they don't want that to happen, they prefer to allow time to pass in order to develop the relationship to the extent that it becomes safe for them to ask and/or safe for the woman to disclose.

Doctors felt constrained from asking by pragmatic issues and their own fears.

Sometimes doctors did not ask about violence because they were frightened of harming the woman. One form of harm is the possible deleterious effects being asked can have on the woman: feeling threatened, breaking the relationship with a supportive person (the doctor), and interfering with the future

But a new patient who comes in with an injury, um (2) in a way I prefer not to ask because (2) suppose now her husband is innocent and I then, she'd say "Are you accusing my husband of doing me any harm?" You know. ... It may be perceived as an insult. And I have to be very careful not to (2) offend somebody.

(Dr L, 108-113)

Sometimes if you wait and if you give them enough time it'll come out, but I think it's a very threatening thing sometimes and if you put too much pressure on them you break that relationship which you don't want to break, you see.

(Dr J, 130-132)

Ah, and my way of handling that is to really just note it as a suspicion and wait and see, you can, you can ask them, but sometimes you can't ask them outright.

(Dr J, 125-126)

I, I, feel particularly women that age, if they don't want to tell you, (2) when they're ready they'll tell you and probably if you pushed harder if they weren't ready they'd just become defensive.

(Dr R, 77-79)

Yeah, if you, if you listen to them carefully and give them the support they'll tell you the story eventually. ... Which is less threatening sometimes than trying to force it out of them. ... 'Cause you can do more harm than good.

(Dr J, 136-141)

possibility of disclosure if the matter had been left alone.

so (.) you know, we (.) i-, it's a very difficult area for us to get into. It is also an area that may make the problem worse by people GPs getting into it ... when we have no counselling abilities
(Dr A, 110-113)

The other kind of harm doctors feel they can cause by asking is due to their lack of skills in dealing with disclosure, which they understand as counselling skills, and their lack of ability to provide appropriate continuing support as a result of disclosure.

Well, if you want (.) people murdered then [inaudible] people like us to stir up a can of worms then you get murders ... through the anger that is created. ... Because "Someone must have told." ... And there's, I mean, I don't want that, I don't want people to be hurt, sure ... I'm, we don't, them to be murdered either. ... [inaudible] a lot of domestic violence situations there's quite a high chance of that.
(Dr A, 161-173)

The doctors also said they fear that disclosure will place the woman in danger of retribution from her violent partner, and that she may even be murdered by them.

Doctors said that they felt that time pressure is a feature of the structure of general practice. They often simply do not have time to ask about violence issues. Instead they chose only to deal with what the woman offers as the reason for her appointment.

I think probably part of it too is the structure of general practice our fifteen minute appointments and we're often busy and running behind time and most of the time you tend perhaps not to delve as deeply as you should, from the time factor.
(Dr R, 38-41)

I first look upon it as a safety issue. ... For them and their children. ... And then once you've got that sorted out then you can have the luxury of looking at other things but in a ten minute consultation, you haven't got a hell of a lot of time so you basically look at their safety issue first.
(Dr J, 94-100)

Because, you know, when you've done a little bit of counselling it's certainly evident when we, got an hour to spend with people on other issues that all these things come up and you don't in a fifteen minute consultation.
(Dr A, 209-211)

The doctors also said that their awareness of time functions to prevent them from dealing with the problem, if it is disclosed, in an adequate way: this is because domestic violence against women is understood by doctors to be a multifaceted problem which requires the doctor to attend to all that it entails. Doctors therefore feared that domestic violence disclosure would be time-consuming.

you have to deal with it. I mean if you ask a question like that ... you've got to be prepared to spend another half hour and ... you know, very often I guess we don't ask the questions for that reason, but, um, no, you have to be prepared to follow it if you get an answer that indicates [inaudible] or say to the person that you offer them more time to come back and talk about it. Acknowledge that you've heard it, ... and that you can accept that this is happening, ... that they're not out of their mind, or that you don't believe them. Um, you give more time, say "Perhaps it's important for you to come back and talk about just that."

(Dr A, 54-68)

Doctors also feared opening a 'Pandora's box' if they identified abuse and disclosure occurred. They feel that dealing with disclosure involves a continuing and therefore time-consuming commitment from them to assist the woman with her situation. It seems as if they fear they'll get into it and not be able to get out. They also consider it to be almost a problem without a solution, or at least not a problem they can solve. So sometimes the doctors do not question or pursue disclosure.

Possibly some of the reasons we don't look for it (2) often enough is once you do find it, then you get into a dreadful tangle of trying to help and often there's no solution at the other end and then any of us who have done work for the police you have lots of cases where you're called, we do have a police surgeon here, but we get called if he's not available and three or four times over the last couple of years I would have been called upon to examine women who've complained to the police that they've been assaulted by their partner and I'll do an examination and send a report but it never seems to come to court - they presumably withdraw the charges.

(Dr R, 87-95)

you're stirring a can of worms with no supports for what happens, you know (2) because of the raw edges you've exposed

(Dr A, 117-118)

I know for myself (2) um, that definitely um, I would feel very hesitant to get into it, without support

(Dr A, 152-153)

Story two

Doctors feelings and responses

Doctors feelings and responses to victimisation are informed by a number of concerns, both personal and professional.

Doctors feel concerned and want to help. Doctors also feel powerless, and this can lead to a feeling of despair for them. They see the situation as one that cannot be fixed, or even approached in the same manner as a discrete medical problem. They also cannot use the same resources, namely their medical training, and doctors therefore feel that they do not have the necessary resources. This leaves them feeling inept and incompetent. The very believe the problem of domestic violence against women to be deeply complex, and an impossible problem for them to solve.

I'm trying to help as much as possible
(Dr G, 267)

you have this great feeling of <u>despair</u> I guess not only for the person but the fact that you can't really fix it. You see GPs like to fix things and when you <u>can't</u> fix things that's a bit depressing for <u>us</u> I think. ... And it's very frustrating, very frustrating too ... Cause it's a very hard thing to fix, isn't it. ... If you had a broken leg it would be easy, put it in plaster ... if you had a broken leg people could <u>see</u> your broken leg <u>too</u>, and they'd think "Oh, how bad," you can't fix domestic violence and you can't see it either ... it's a very difficult, I find it a very difficult condition.
(Dr J, 286-299)

I mean, there's <u>very</u> little, you, you end up feeling absolutely impotent as to what you can do to <u>help</u>. ... so (.) you know, we (.) i-, it's a very difficult area for us to get into.
(Dr A, 93-110)

[It is hard] to know quite how to deal with it, what to do for the best.
(Dr A, 212-215)

The doctors feel that even when they urge the woman to do things to help herself, she often does not. This ultimately leaves the doctors feeling that there is not much they can do, and they conclude that the woman must help herself as she is the only one who can.

And to (indecipherable) counselling, very seldom have I been able to make any dent. ... Even when I've appealed to the victim ... to seek legal redress, they often don't
(Dr L, 22-27)

I try and point out to them that, that <u>no</u> one in this society has to live in fear of physical violence. And that nothing can be done <u>about</u> this until they do something about it.
(Dr B, 51-53)

Related to the feelings of powerlessness is the doctor's experience of loss of control when attempts at intervention prove useless. The doctors find women in violent relationships extremely difficult to help. They attribute this to the woman's trouble accepting help, either because of her situation, or the possibility of gender issues - one doctor felt that being male may make it less easy for women to disclose to him. Difficulties were also encountered by doctors when they attempt to get women help from government agencies.

I mean, I can't tell them what to do, and often I suspect it doesn't matter what you tell them anyway, (2) and I'm, I'm always worried that a lot of them are going to go back and get abused again and I point out to them (.) that there is a risk that they could be killed

(Dr J, 73-76)

And ah, she had many incidents with really serious injuries and I was really quite concerned ... that the [injuring things] kept happening basically and police intervention and the guy (2) sort of (2) not, (.) didn't change and so she [left him].

(Dr N, 73-77)

And they are difficult people too, cause you can say "Now look, I'm worried about you and I'd like you to come back in the next week cause we've got so much to talk about," but you never see them sometimes, they are not very good at um (2) not very good at coming back and accepting help, whether they don't like men and I'm a male I, I don't know but they're hard people to try and help sometimes. ... Um (.) I think they find it hard to accept help from anyone, they are a rather special sort of difficult, not on purpose, just difficult people to help, I think

(Dr J, 305-312)

One doctor talked about frustration with welfare and justice systems, specifically Children, Young Persons and their Families Service and Family Court.

I sit there and I think about (3) I don't report to CYPS, if CYPS come to me it works brilliantly, (2) if you go to CYPS and get through their intake process, that's something I've never managed to wade through.

(Dr K, 178-180)

Doctors describe losing sympathy for the woman when they see her not changing herself or her life sufficiently to prevent her victimisation. Some doctors explain the woman's behaviour in terms of emotional dysfunction, and they speculate that the woman continually gets into a situation which she is familiar with, because she is familiar with it.

I think you'll find that health professionals, when you see a person coming back, having reinserted themselves into the same set of circumstances again and again and again, um, with different spouses, different de factos, um, that you tend to lose your, lose your sympathy, and realise that they are emotional victims of themselves and that, probably that they [inaudible] sort of person who abused or has a parent of (3) ...

(Dr B, 24-30)

This loss of sympathy is also experienced by doctors as frustration at what they see as the wilful continuation of the behaviour that keeps a woman in an abusive relationship. Doctors felt that this is because the woman denies to herself the reality of her situation. They speculate that the cause is an overpowering of the woman by her violent partner, which reduces her emotional strength and her ability to leave. They spoke of the possibility that the violent relationship is in a way co-dependent, which functions to keep the woman emotionally tied to her violent partner. The doctors said that their healthy and normal women patients would not tolerate any violence from their partner, and they contrast them to women who have been victimised, who do.

(8) Um, one of the most frustrating things I've found is the denial of the abused person (2) who (.) listens when you say "Look, this is a very potentially serious thing," um, (.) I've always found it very difficult to understand why a woman comes along and then three months later comes along again (2), it's something that obviously is a power thing and almost a co-dependency state sometimes but it never ceases to amaze me how they keep coming back (laughs) um, and I know in the Women's Refuge twenty-five percent come back to the refuge so I can't understand that, but I can, and it seems very odd. ... it makes me feel so sad for the lady, and you think, you know, now why does she do it? Now I think I know why she does it, 'cause she's so overpowered and so terrified that she does come back (.) um but you think, you almost feel like grabbing her and saying "Look, go away." ["What are you doing?"] Yeah, "What are you doing?" My, some of my healthy clients would say "Well if he even laid a finger on me, I'd plant him or I'd leave him," but these people get so overpowered by it, obviously they can't, they haven't got the strength to leave, now, I find that so frustrating, I'm sure everyone does, so it's the denial that's the hardest thing to understand.

(Dr J, 228-247)

Doctors had strong personal responses to abuse, and put them in terms of emotions. They experienced distress when treating a woman requiring care for the effects of a severe violent attack from her partner. Doctors speculated a connection between responses to abuse and previous experience of violence, especially personal experience.

Yeah - and it can, can be to a young um, GP I think a real, a severe abuse can be quite frightening, um and brings up your own, of course, issues, and how um, how you handle abuse yourself, or if you've ever been abused or whatever, but there's a lot of emotions involved

(Dr J, 183-186)

a person who can do it well is an exceptional person I think and they need to be pretty clever to cope with all those things at once, you know, you get all the emotional side and the, and the anguish and also um, be empathic and being able to sort of try and help them for their future, that's quite an exceptional person, I think.

(Dr J, 214-218)

I personally have never liked violence much and I think it's a matter of whether you are used to violence and if you handle it right.

(Dr J, 200-201)

Doctors said that they experience a great deal of worry about the consequences for a woman who remains in a relationship with her violent male partner, and for her children. This worry leads to frustration at the continuation of the problem and the lack of resolution.

Mm, so it is so frustrating ... and you worry about them you know, you think "Oh, God, what's going to happen to your kids and what's going to happen to you?"

(Dr J, 254-257)

Doctors talked about their personal involvement with some cases of continued violence against a woman patient. This personal involvement increased the impact of the patient's situation on the doctor.

I know that when, when I left South Africa, the couple concerned came to me and they gave me a gift, and they said "You know," um "You understand us." ... They actually went out of their way to do that ... Which I found really quite touching ... but it didn't help - "You were still beating her up regularly"!

(Dr L, 45-54)

Um, (2) and um, also I had a person (2) who was a patient that I knew very well who was in a violent relationship that kept, you know like (2) um (.) she had a terrible time ... (4) I can remember her pretty clearly, in fact it's probably the one that I remember most, um, so it's kind of really this thing that kept happening to her and it kept happening despite all of the intervention and a lot of support, it kept happening. Um, although eventually she did move out [inaudible, spoken very quietly and quickly], so that was another part of all that and, and then she, um, she had a dramatic death ... so, I, kind of feel like I'm linked to that story, really, it was a pretty amazing story.

(61-71, Dr N)

Doctors had fears about possible threats to them from the perpetrator of the violence. The doctors did not necessarily have to have come into contact with the perpetrator to experience this fear; the experiences of the abused woman was sufficient to instil it. Doctors had also been personally assaulted within their practices. Their fear of the threat to physical safety is therefore realistic and well-founded.

they're crying and upset and there's some big hairy monster in the background who's probably gonna knock your block off if you ever came within [inaudible] there's a threat to your own physical (.) safety sometimes

(Dr J, 188-190)[1]

I either ask them or they tell me that physically, sexually, if they've been abused at home. Occasionally you find out because you interview the partner, and he physically abuses you, which is always an exciting experience!! ... Whereupon you get to do those great expressions of "what is that like to live with?" while you are trying to get the ringing out of your ears and they are kind of shouting at you (laughs).

(Dr K, 62-68)[2]

Doctors had fears in terms of issues related to professional practice, one of which was the fear of harming or killing a patient due to lack of knowledge of specific physiological medical conditions. They stated that expectations of medical students are incredibly high, and the emphasis is on the possibility of a fatality if a doctor has insufficient medical knowledge.

[medical students] live in this very, very sort of boxed world, incredible expectations, if you don't know about these Japanese vascular diseases, one day you'll kill somebody, it will be your personal fault that that person dies a slow and agonising death because you failed, the public says you failed, if it is not a good outcome it is because the doctor failed.

(Dr K, 364-368)

Doctors feel that lack of knowledge and/or a patient's death will be perceived to be the doctor's personal fault and will result in public and professional condemnation.

it's just the fact that you are in this pressure cooker learning environment where if you don't know how to save the person's life with the heart problem, or the lung problem, or the whatever problem, you will be negligent, they will hang you. ... So you are so busy worrying about the concrete.

(Dr K, 371-375)

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[1] This doctor showed me that the chair provided to the patient was chained to the floor. He explained that a male patient had picked it up and tried to hit him in the head with it. It was not related to a domestic violence situation that he knew of.

[2] This doctor explained that he is assaulted by a patient at least once a year in the course of his practice.

Within this framework, doctors favour empirical and practical medical knowledge over learning about social problems with health consequences. They are also aware that they are not so likely to be professionally censured for inadequate treatment of health problems related to social issues.

And someone comes along and says "My husband hit me" and if it's not fractured (indecipherable), then what do I do? Robin Stent doesn't tend to strike people off because I mean if you get it wrong then they just hang you up for the bad outcome, no one gets hung for stuffing up emotional abuse.

(Dr K, 384-387)

Doctors are also wary of the possibility of being set up by a patient, and having to go through litigation. The feeling for doctors is that they appear caught between two sets of agents who have the power to damage them personally and professionally.

You have to actually be, ah, you know, how would, it, it, it's really quite a delicate issue. [So you feel that this delicacy is something that prevents doctors from approaching patients?] Yes. ... Especially in this litiginous age. ... You know? I mean look at what happened (indecipherable) I don't condone what I read about the goings on in Hawke's Bay, um (3) but (2) where it is possible that you could be set up by a woman who might see this as an opportunity to take you to the cleaners, and maybe, you know, so in the end you say well, well my notes look fine ah, you know, I've done everything according to the plan that says subjective, objective assessment plan, medical counsel can't (2) hammer me, I've done everything correct here, if she didn't bring up that issue, it's not my department.

(Dr L, 250-265)

Doctors feared the censure of the medical community for attempting to intervene on behalf of and help their female patients experiencing violence. They fear this censure would take the form of ostracism and unpleasant representations of them.

There are individuals who have a passion for it, and there are other professionals up in Palmerston North (.) most of us don't mention it. ... we are afraid of stereotyping (indecipherable) with impressions, being labelled, being rejected (2).

(Dr K, 247-251)

In this context of personal liability, doctors greatly fear making mistakes in the course of medical practice. Thus, they focus on making sure they have done everything formally required of them because they feel so afraid. They feel that public expectation of doctors is high. Doctors also feel continually alert to the surveillance of medical authorities, whilst also noticing that one group of doctors who should be dealt with by the authority are never formally disciplined and continue to practice - apparently with the support of the 'powers that be'. For most doctors, however, censure is severe, affecting the doctor professionally and personally, and therefore the possibility of it must be taken seriously. This concentration on following the rules, and the importance of doing so, deflects doctors away from pursuing abuse issues where they suspect a patient has them.

you do spend your life trying to cover your arse and making sure you've done everything right and it's been properly documented. ... So you spend most of your life being afraid you are um, you know, you get (sighs) I don't know how to describe it, almost like a victim of abuse of the medical system and the public expectation. ... And so you spend a lot of time being afraid, um ... So yeah, so there is one group who are incredibly arrogant, and incredibly hide-like-leather and don't give a damn about their patients, and so all sorts of awful things, often with really bad medicine and certainly atrocious psychological medicine, and the system seems to make sure that they practice, and practice forever, and the rest sit there largely with a great deal of fear because they re so afraid of being caught out by Robin Stent and the disability commissioners and um, discovering some retrospective piece of legislation from the health benefits [indecipherable] that they didn't know about and didn't discover until two months after they committed the offence. ... And they will be personally held liable for that.

(Dr K, 478-497)

And this is the only issue which is emphasised by the powers that be, and they hang it over your head continually, sort of Damocles, will you make it or will you kill your patient.

(Dr K, 377-379)

there's this tremendous protectionism but there's also tremendous fear, you've got to understand that a lot of doctors practice out of fear most of the time, they are afraid almost all of their practising time. [In case they screw up? Like you were saying before?] Partly because they screw up and partly because they, they're afraid, they're afraid of being harassed by patients. I mean I have been assaulted nearly every year I have been in practice, um (.) you get afraid of complaints by patients and of being found guilty, you know, you are guilty until proven innocent before the Medical Council.

(Dr K, 467-475)

Doctors also talked about the way their training only provides them with a particular point of view. Medical training is specialised so that doctors divide the body into parts, and each specialist area deals with a particular part.

A separate world, you are in that separate world, you are taught only by hospital doctors, about hospital medicine from hospital perspectives - nobody does integrative medicine, you know, it's all "the lung man will tell you about lung diseases" and then you finish the lung course and go on to the heart course, and then a skin course and then a kidney course and if you say "Is there a link between skin and kidney?", they decide which side of the white line you are on and if it's a skin question ask it and if it's a kidney question tell you to go and talk to the kidney man and that's how the specialist process works. If you go in with a cough - you'll be seen by the lung man who will tell you that it may be a (indecipherable) lung, if yes, he'll fix it, if no. ... Heart man says, yes, no, if no, he sends you to the tummy man, if no for the tummy you are out the door, because it is not lung, not heart, not tummy - but she's still got the cough. [Go home?] Well it's not go home, but it's just not my problem, it's my problem if it's a tummy problem, and it's not a tummy problem.

(Dr K, 346-362)

Most doctors were trained in hospitals and received little training in general practice.

'Cause we were taught nothing from the general practice slant and you had to go and find books yourself when you graduated

(Dr R, 67-68)

Health problems linked to social problems, such as victimisation and alcoholism, were specifically excluded as medical problems in these doctors' training. So the doctors feel that they lack a way of understanding health problems that arise from social problems.

It's a social problem, if her lungs were fine, her heart was fine, her kidneys were fine, it's not really our chair.

(Dr K, 393-394)

I remember seeing (2) alcoholic cases and, you know, told it was a social disease you know, we didn't have to get involved in it, and that meant I wouldn't see the patients

(Dr L, 176-178)

Doctors do perceive a change of awareness in the medical profession regarding the issue of domestic violence against women. They believe there is better awareness of its prevalence and perniciousness, in contrast to the past when little was published in medical literature on the issue and it was not talked about among doctors.

Like people were not aware of how prevalent it was and how serious it was and how dangerous it was, and and so on, you got me? And I think (.) over the years all of that has shifted. ... I think. Both in me, and doctors, and society, I think, basically. And sometimes with the public campaigns ... have helped, I think in that um, but, I don't know, it, it, subtle change occurs you know, like when you read articles about it in our journals, we discuss it at meetings and you know what I mean. I, it it's okay to talk about and so on, whereas before it was sort of like, oh yeah, you know? kind of thing. About twenty years ago.

(Dr N, 20-30)

The doctors talked about these changes being related to public campaigns, and changes in social attitudes, and personal change based on experience.

There's doctors that are fairly (2) unliberated and conservative in general, yeah I'm sure there are. ... Although I think that, I think that it's less and less acceptable ... um (6) yes it's interesting, I don't really know. Um (4) I mean it's kind of like a guess at their social attitudes, and um (2), I 'spose I'm [inaudible]. No, I think it's shifted, I don't think a doctor could defend this any more, (.) except in his own head or in his own family. ... But he couldn't, no one would buy it, in any discussion group he'd be jumped on by everyone else.

(Dr N, 335-343)

Oh, no. No, in my, I and remember, in my um, I can't remember whether it was paediatrics or what it was we were, [I was given] work with a social worker and um, that was my very first evidence of anything untoward happening in a family. Um, I was taken along to just a family who were harming their children, ... had, had had two deaths and um, then there was one child with lots of weird marks all over his body, they wouldn't come in for any treatment, the um, the department were concerned what was happening in the family ... and, um, it just blew me away, at that stage, I didn't believe that anyone - everybody wasn't a happy family, ... um, but no, and had I not been (.) allocate to that (.) um, social worker I guess I might have continued thinking that nothing ever happened to people.

(Dr A, 71-84)

One doctor feels that medicine as a profession still does not pay sufficient attention to issues with health effects which cannot be empirically tested or defined.

(Sighs) As a profession I think it does lip service to most issues it can't measure with a stethoscope.
(Dr K, 241-243)

Another doctor feels that an improvement in the ability of general practitioners to assist people in terms of psychological issues has risen commensurate with the rise in the quality of general practice in general.

Um, what I'm trying to say is that I think the quality of general practice in, in, has improved substantially and that I've, because, and because it's in ways that are easier to measure, I think it's probably fair to assume that we've improved in those which are more difficult to measure, like the psychological issues
(Dr G, 300-303)

Summary

Doctors expressed concern that they do not always detect victimisation, and had received no training regarding domestic violence or the detection of it during the course of their medical schooling. Doctors are aware however, of the forms violence can take, and that the effects of violence extend beyond physical injury. They expressed several views regarding the cause of violence, mainly accounting for it in terms of societal factors. Detection is a problem for doctors, as is asking patients about victimisation. Doctors feel that trust and knowing the patient reduces the difficulty of this situation. They are deeply concerned about the problem of victimisation, and try to support women to leave violent male partners. When women do not leave, doctors may experience worry, frustration, or a loss of sympathy. Doctors have fears of harming patients in the course of their professional practice. They state that social problems are often not regarded as part of their professional domain, and as such doctors may avoid dealing with them so as to not place themselves at risk professionally.

This chapter narrates what the doctors said. In the following two chapters, I use discourse analysis to identify the linguistic resources doctors' use to make sense of the problem of detection.

CHAPTER FIVE

Constituting detection

This chapter reports the analysis of discourses realised in the doctors' texts. The analysis focuses on the issue of detection as the problematic with which this thesis is concerned. It is organised around the objects constructed by the doctors to talk about the issue of detection, and the characteristics of doctor/patient relationships which are related to detection.

Clues And Symptoms

Clues

The doctors use constructions of 'clues' to talk about how they come to suspect that some women patients may be being victimised in their personal relationships. In one case the doctor's construction of 'clues' is explicit.

> And, very often they will give you clues as to what's going on, they'll, they'll say "We all have our ups and downs, don't we?"
>
> (Dr B, 42-43)

In this extract the doctor uses the term 'clues' to talk about general cases in which there is an indication of 'what's going on'. It is notable that acts of violence or the effects of violence are implied here. The example of a 'clue' given by women could be interpreted as an example of minimalising (Kelly, 1988) through constructing the violence as within a 'normal range' of 'ups and downs'. An effect of this construction is that the violence remains 'unspoken' (even in the doctor's talk) at least until it is discovered as outside the boundaries of 'the normal'.

Sometimes the doctors used implicit constructions of 'clues'.

> They'll usually tell, they'll usually look at me in a funny way and I know that there's a story, um, there's twenty-five reasons why they don't really want to tell me, and they usually do in the end.
>
> (Dr G, 46-48)

Here the doctor uses the notion of 'telling' to construct a version of a doctor/patient relationship within which women are reluctant to, but do eventually, disclose. The abused woman will 'usually tell' despite the fact that she 'doesn't really want to'. This reluctance is constituted as something overcome by the woman; disclosure takes place 'in the end' and in spite of all the ('twenty-five') 'reasons' that she 'doesn't really' want to. In this construction the doctors awareness that there is something to 'disclose' is

enabled through the clues given to the doctor - a 'funny look' - so that he 'knows there's a story'; and because stories must be told, women 'usually do'.

> Usually, um, usually what I pick up on first of all is the fact that they look so awful and they look so miserable, and they look quite depressed and they're quite frightened and quite edgy, and that is what I focus on, and as part of focusing on that, I either ask them or they tell me that physically, sexually, if they've been abused at home.
>
> (Dr K, 59-63)

Here the doctor talks about how a patient 'looks' in terms of demeanour. The visibility of how a patient 'looks' makes demeanour accessible; it is 'usually' what the doctor 'picks up on first'. Although 'misery' and 'depression' are internal phenomena, they are still constituted as accessible through 'looks', along with such things as the patient 'looking' 'awful', 'frightened', or 'edgy'. Adding to the constitution of their visibility is an 'amplification' of what is 'seen', indicated by the use of 'so' and 'quite'. The 'looks' of the patient are constituted as clues to the extent that they enable the doctor to suspect and then to focus attention on them. Subsequently, this focusing is constituted as having 'two parts': either asking or telling.

The explicit and implicit construction of 'clues' in relation to how the doctors come to suspect violence realise a discourse in which 'violence' becomes an 'object' to be discovered, something hidden, invisible, or inaccessible, and for which there are only the kind of indications that raise suspicion.

Symptoms

According to Foucault (1975), medical discourse constructs 'symptoms' as the form through which underlying disease or abnormality becomes 'visible' to the medical gaze. Through this construction disease or abnormality remain 'inaccessible' while the 'symptom' transcribes what is 'hidden' onto the body of the patient. The doctors made use of the construction of 'symptoms' in their talk about women patients whom they suspected had been victimised. In most cases, the doctors constructed 'symptoms' through physical injury.

> Well. I would look for some evidence and say "that's a funny looking bruise you've got there," yeah. ... "Can you tell me how it happened?" And when they say "the door slammed into my face" I'd say "I'm not sure: I find that hard to accept. Are you sure it wasn't something else?" or something like that.
>
> (Dr G, 35-40)

Here the doctor uses the notion of 'evidence' to construct a version of the doctor/patient relationship in which he attempts to facilitate 'disclosure'. 'Evidence' such as 'bruising' is visible through the body; enabling the doctor to 'look' for it. 'Evidence' is constituted as indicative of abuse and this enables the doctor's constitution of the verbal exchange as

an attempt to facilitate disclosure of this suspected abuse. Thus, when the woman gives a reason - 'the door slammed into my face' - which is not abuse related, the doctor's ability to 'see' the 'symptom' of violence enables the constitution of doubt: 'I'm not sure'. This doubt enables the possibility of another explanation - 'something else' - which, in turn, allows the doctor to invite disclosure at the woman's discretion.

> obviously when they present with, with physical signs of damage ... I'm basically more concerned at the time to sort of sort out their medical problems
> (Dr J, 63/66-68)

Here the doctor uses the notion of 'damage' to construct an account of medical response. 'Sorting out' the woman's 'medical problems' is constituted as the appropriate first level of response; 'basically'. The use of 'concern' functions to enable the doctor to preclude the possibility that this 'basic' response means a lack of care about the possibility of violence; hence he is 'more concerned' at the first stage - 'at that time' - with the delivery of medical care. He alludes to his knowledge of the possibility of violence through the 'obvious' indicator of 'physical signs of damage'.

According to Foucault (1975), the difference between signs and symptoms is such that the 'sign' says what the 'symptom' makes visible. In this case, 'signs' of physical damage say what 'symptoms' such as bruising, fractures or wounds are taken to be. Neither the 'sign' nor the 'symptom' make the underlying 'abnormality' directly accessible. Here, too, the construction of the sign is such that it is privileged as indicating the 'location' of a 'basic' medical response.

> I would certainly bring up the fact that she's got injuries. And why is this occurring?
> (Dr B, 39-40)

Here the doctor talks about 'injuries' as symptoms which lead the doctor to attempt to identify causes; 'why'. That she has the injuries is incontrovertible, it is 'fact'. This enables the doctor an 'empirical reality' to which he responds by 'bringing up' the 'fact' of her injuries.

> Or they come in with some really obvious injury
> (Dr K, 44)

Here the doctor talks about women presenting with visibly clear signs of abuse; 'really obvious injury'.

> Ah, or they come in and complain of injuries
> (Dr C, 21)

Here the doctor talks about women seeking medical attention for injury; they 'complain' of 'injuries'. In the context of medical discourse the term 'complaint' is usually used in

relation to symptoms which are not visible to the doctor, such as 'pain' or 'fatigue'. Even though, usually, injuries are visible to the medical gaze, in this case the injury is constituted as only available through the patient's 'complaint'.

> I can think of a couple of middle-aged ladies in their fifties who've seen me on occasions, and one on one occasion had a large bruise on her upper arm, the other one had a bruise on her face
>
> (Dr R, 8-11)

Here the doctor talks about two 'cases' as examples of having seen injuries, specifically bruising, as symptoms of victimisation.

> No, at the time I did say "I see you've bruised your arm" but no, I didn't make any comment like, you know "was it really accidental?" no, I didn't push it like that.
>
> (Dr R, 25-27)

Here the doctor talks about not 'pushing' in relation to questioning about injury and abuse. She 'did say' to the woman that she had noticed the injury, and this kind of comment is contrasted to a different kind of 'comment' which involves questioning of the cause, whether it was 'really accidental'. 'Pushing it' alludes to the use of force to achieve something. Questioning is constituted as 'pushing it' and enables the doctor to position herself as not forcing disclosure.

Depression was also constituted as a symptom of victimisation.

> Or, depression. Certainly in every case of depression I'd ask what the situation's like at home ... but on none of those occasions has anybody said to me "I am being physically abused, I am being beaten up"
>
> (Dr A, 34-38)

Here the doctor uses the notion of 'depression' as a possible symptom of victimisation. The presentation of 'depression' is constituted as the occasion on which the doctor asks about a patient's home life; 'what the situation's like' at home, as a matter of course; 'certainly in every case'. 'Asking' has never resulted in disclosure; on 'none' of those occasions of 'asking' has 'anybody' disclosed victimisation.

Summary

The doctors' constructions of clues and symptoms share the characteristics of manifestations of a problematic underlying condition which is invisible or inaccessible: they are the traces of that which is beyond the medical gaze. The 'underlying condition' remains to be discovered so that the problem can be resolved. So, both clues and symptoms realise a discourse of discovery in as much as they both position the doctor, like a detective or an archaeologist, as having the right to interpret traces of underlying

conditions so as to bring them to light. Through the discourse of discovery victimisation is constructed as an 'invisible reality' manifest in clues and symptoms.

Personal Injury - An unusual instance of discovery

In the following extract the doctor realises a discourse of discovery in recounting an unusual experience.

> Occasionally you find out because you interview the partner, and he physically abuses you, which is always an exciting experience!! ... Whereupon you get to do those great expressions of "what is that like to live with?" while you are trying to get the ringing out of your ears and they are kind of shouting at you (laughs)
>
> (Dr K, 63-68)

Here the doctor constructs an experience of being personally 'physically abused' by the violent 'male partner' of a woman patient to account for 'finding out' about victimisation. The experience is constituted as unusual through the use of 'occasionally'. The response to the violence is constituted as emotionally involving the doctor - it 'is always an exciting experience!!' and as an ironic response to the situation. The doctor is also physically involved; he subsequently has to try 'to get the ringing' out of his ears whilst still under attack - the man is 'kind of shouting' at him. This experience enables the doctor to claim an understanding of the woman's experience, because he has had it too, whilst acknowledging that he does not deal with it everyday, therefore he asks; 'what is that like to live with?'.

Disclosure And Asking

As well as constructing 'clues' and 'symptoms', the doctors also talked about the disclosure of victimisation, and situations in which they asked about victimisation. They distinguish between spontaneous disclosure and disclosure in response to 'asking'.

Spontaneous disclosure

> They walk in "he hit me"
>
> (Dr K, 39)

Here the doctor constructs the spontaneity with which violence can be disclosed. It is immediate 'they walk in', and specific 'he hit me'.

> (2) I don't normally need to question them about it because they tell me what's happened.
>
> (Dr J, 63-64)

In this extract the doctor's construction of disclosure distinguishes spontaneity from a response to 'asking'. Because 'disclosure' occurs without 'questioning them', asking the woman is not 'needed'.

> and so (2) a lot of the women will come and they'll just tell me "He's knocked me around again"
>
> (Dr C, 98-99)

Here the doctor constitutes spontaneous disclosure - 'they'll just tell me' - as common; 'a lot' of the women do so. The content of the disclosure is that their partner, 'he', has been violent to them; 'he's knocked me around'. 'Again' alludes to previous assaults and disclosure; the woman has told about prior assaults, and therefore the doctor knows. In this construction of disclosure there is an implication that the doctor's 'discovery' or 'knowledge' of the violence is not necessarily sufficient to even begin preventing reoccurrence.

> She actually, she, she was one who actually brought it up herself and said that life was very difficult for her.
>
> (Dr R, 133-134)

Through talking about a specific time when a woman disclosed without having been asked, she 'brought it up herself', this doctor also distinguishes between spontaneity and response to 'asking'. In this case, spontaneous disclosure is constituted as uncommon through emphasising the singularity of the case, 'she was one', and by twice using 'actually' to emphasise the unusualness of the situation.

> (4) Well, they'll either come in saying "I've had enough of this f-ing B", you know, get you to measure this, look at this - "I'm going to the cops,"
>
> (Dr G, 73-74)

Here the doctor talks about situations in which women will seek the doctors assistance, and hence disclosure occurs immediately; they will 'come in saying'. The results of assault are able to be seen, that is, 'measurable', and visible - 'look at this'. The doctor's ability to see is the reason given for the woman coming to her doctor - the doctor's ability to see enables him to deal with symptoms. Police intervention - 'I'm going to the cops' - is associated with the visibility of proof. The 'symptoms' substantiate the woman's claim, particularly where they conform to the legitimacy of a 'measured' injury. These actions taken by the woman are constituted as the result of deciding to leave her violent partner - 'I've had enough of this f-ing B'. In this construction of disclosure there is an implication that the doctor's 'discovery' or 'knowledge' of the violence will provide necessary 'evidence' to support the woman's actions in preventing reoccurrence.

> Ah, then you might say to the woman "How are you?" and then it all, then it all comes out why she actually came in.
>
> (Dr C, 106-107)

Here the doctor constitutes asking a woman about her general well being - 'how are you?' - as facilitating disclosure; 'it all comes out'. The use of 'then' establishes the connection between this form of asking and disclosure. That the woman wants to disclose is alluded to by the use of the term 'actually' - 'why she actually came in' - to qualify her 'reasons' for coming to the doctor. In this case, although disclosure is in response to a question, it is not a specific question about abuse. The doctors distinguish disclosure in response to specific questions regarding victimisation from 'responses' to other questions, and from spontaneous disclosure.

Responding to questions

Constructions of disclosure following questions which specifically involve victimisation are usually contextualised by accounts of women presenting with symptoms which enable the doctors' suspicion of abuse.

> Or they come in with some really obvious injury and say "I've hurt my hand," or some equally pathetic and really trivial, and I go "Tell me about the face." ... And we're away
>
> (Dr K, 44-48)

Here Dr K constructs an account of challenging the reason a woman gives for presenting. The disparity between the reason given for presenting and the obviousness of the injury allows the doctor to class the explanation as 'pathetic' and 'really trivial'. The wish to confess is alluded to in the contrast between the superficiality of the explanation and the injury which is 'really obvious'; this functions to enable the doctor to challenge the patient in a blunt manner: 'tell me about the face'. 'Disclosure' occurs quickly and straight forwardly - 'and we're away', and this functions to confirm the legitimacy of the doctor's approach.

> ...they are all totally different and then you say "what on earth is really going on?" ... they just spiel it all out
>
> (Dr K, 50-55)

Here the doctor constitutes all patients as 'totally different', so that 'finding out' occurs in more than one way. The doctor questions the patient where he suspects that something which is 'really going on' has not been disclosed. The use of the trope 'what on earth' emphasises the doctor's suspicion of any other reasons given for presenting. Questioning is constituted as facilitating immediate disclosure, without reservation; they 'just spiel it all out'.

> Ah, or they come in and complain of injuries and you finally find out why the injury occurred, who caused it, that type of thing. I ask, yeah, "How'd that happen?" [Right. And do, are women generally forthcoming?] Generally, yeah, probably.

(Dr C, 21-26)

In contrast to the ease with which disclosure after questioning is constructed in the previous extracts, here the doctor uses the term 'finally' to construct 'finding out' as a process which may take time, and is not necessarily easy; 'you finally find out'. Part of 'finding out' is achieved through asking for causes, but the doctor allows for the possibility that women will not always disclose after being asked; that they 'generally' do is amended to 'probably'.

> Yeah, I'd, I'd ask a few questions, ah (2) and often it will come out the, the woman might start crying ... or ah, and ah, or the story doesn't line up with how she got injured, with the things that you see ... So (.) they usually start crying.
> (Dr C, 40-46)

Here the doctor constructs questions as a response to accounts of injury which are not consistent, that is, do not 'line up' with the injury. It is the visibility of the woman's presentation that the doctor constitutes as important; 'the things that you see'. These 'things seen' are accorded more legitimacy than the woman's verbal account. Questions are constructed as following suspicion, and 'a few questions' will 'often' facilitate disclosure. Disclosure is constituted as a process through which 'it will come out', but this process, constituted through two reference to the woman 'crying', may be distressing. That the woman 'starts crying' is constituted as commonly accompanying asking and disclosure; 'they usually' do .

In one case the importance of disclosure, constructed as 'talking about' or 'naming' violence and abuse, is constituted explicitly as important to preventing violence.

> Um (2) maybe these things would be less prevalent if people would talk
> (Dr B, 153)

Here the doctor uses the notion of 'talking' to constitute the idea that 'talking' about abuse and violence - 'these things' - reduces their 'prevalence'. That it is 'people' rather than, specifically, victimised women who 'should' talk generalises the importance of talking beyond disclosure by victims. That 'people' don't 'talk' is implied in the use of the conditional 'if' they 'would'. The inverse of 'talking' is silence and this constitution implies that once silence is broken by 'talking' the problem of abuse and violence can then be dealt with.

The doctors also constitute 'silence', especially in accounts of non-detection.

> no one has ever brought up domestic violence with me.
> (Dr A, 26)

> Probably it hasn't been apparent, and I'm sure a lot just don't mention

it to their doctor.

(Dr R, 5-6)

Accounts of non-detection also include constructions of the 'invisibility' of victimisation, which may be construed as a form of 'silence' within medical discourse, because there are no 'signs' saying the symptoms.

they hide it

(Dr B, 14)

Sometimes you don't see the abuse, sometimes you just see a depressed person, and um, we find out afterwards that there's an abuse there

(Dr L, 125-126)

You always wonder of course, in general practice how many you don't see.

(Dr J, 34)

One doctor provided an account of 'silence' as non-disclosure through constructions of the behaviours of violent male partners, and the character of intimate relationships which result in victimisation being kept 'secret'.

Ah, it's purely up to them, if they, if they want to disclose, cause a lot of them being in a relationship where (.) ah, their partner will have told them "Don't disclose it or I'll do it again." Ah, I guess some would not disclose out of fear, some will not disclose out of a privacy of their own lives and relationship.

(Dr C, 27-31)

Here the doctor uses the notions of 'fear' and 'privacy' to account for situations in which the woman does not 'disclose'. 'Fear' is constituted a response of 'some' women to the threat of physical reprisal from their violent partner - 'I'll do it again' - and which is specific to 'disclosure' - 'don't disclose'. 'I'll do it again' lends support to the rationality of 'nondisclosure' as the violence has already been experienced by the woman. 'Privacy' is also constituted as an account of non-disclosure. Here the doctor draws on an implied 'common understanding' that personal 'lives' and intimate 'relationships' are not subject to moral requirements to disclose criminal behaviours. It is out of this constitution that the doctor takes the position of 'it's purely up to them' regarding disclosure; he recognises that he is not the one in the dangerous position nor does he have the right to 'hear' and 'see' what is not told or shown to him.

Summary

The doctors' constructions of spontaneous disclosure and disclosure in response to asking share an assumption that there is an untold underlying condition which has produced 'symptoms' or 'clues' which the doctor cannot interpret as victimisation without a confession of victimisation. The discourse of confession enables constructions

of 'disclosure', as well as constructions of 'silence' and 'secrets', which are the form and consequence of non-disclosure.

Foucault theorises confession as the revelation of an 'inner truth', a 'secret' that must be spoken to enable 'abnormalities' to be identified, especially abnormalities which are 'borne within' the individual (Morgan, 1999; Parker, 1989). Discourses of confession support institutional practices which 'locate' abnormality within individuals. In the context of the disclosure of victimisation, the 'individual woman' is constituted as the 'holder' and therefore the 'location of' the 'secret', while her 'intimate relationship' and 'victimisation' are constituted as 'abnormalities' to be identified. Thus, the doctor is only entitled to 'identify victimisation' where confession confirms the visible signs or symptoms which alone will only produce a suspicion.

> Ah, and my way of handling that is to really just note it as a suspicion and wait and see, you can, you can ask them, but sometimes you can't ask them outright. ... You sort of have to wait for them to tell their story.
>
> (Dr J, 125-128)

Here Dr J talks about 'waiting'. 'Waiting' is constructed as a result of an inability to 'ask outright', in some cases. 'Asking outright' is contrasted to 'asking' and alludes to a necessity to 'test the waters', 'go gently', 'tread carefully': outright asking might inhibit 'telling their story'. 'Waiting' is also constructed as a strategy for dealing with 'having the suspicion'. The 'suspicion' itself is constructed in contrast to the story telling. The implication is that without the woman 'telling', the doctor is constrained to 'suspicion' and to 'waiting'.

The Doctor / Patient Relationship

In the course of talking about disclosure and asking, the doctors also construct the characteristics of doctor/patient relationships which facilitate disclosure and enable 'asking'. In particular the doctors constitute the characteristics which enable the relationship to be 'safe' for disclosure of victimisation.

Knowing them, Trust, Confidence

One of the most frequently constructed characteristics of the doctor/patient relationship is the doctors' experience of 'knowing' the patient. In some cases the construction is explicit.

> [what] makes it easier to ask is if you know them well.
>
> (Dr B, 57)

Here the notion of 'knowing them' is used to account for situations in which it is 'easier' for the doctor to 'ask'.

> Probably is, cause I know them pretty well, I know them quite well and once you know a patient quite well when they come in with something a bit different you sort of (2) just ask the question "How are things going at home?"
> (Dr C, 57-59)

Here the doctor uses the notion of 'knowing the patient well' to construct a version of a relationship in which he would 'ask'. Knowing the patient well is stated three times, and the importance of the characteristic is constituted through enabling the doctor to gauge differences in the patient. Possibly these differences would not be obvious to a doctor who knew the patient less well - they are nonspecifically constructed as 'something'. This nonspecificity also operates within how the doctor questions 'the patients home situation' as a general rather than specific underlying condition. 'Knowing' also enables the doctor to ask easily, he 'just asks'.

> Oh, I, would, No. I wouldn't come out and straight-forwardly ask. It depends how well I know the person. I think that's one of the good parts of general practice, it's relationship, building and built on, so there <u>are</u> some people I would just come out and say "tell me more" (indecipherable) and they tell me.
> (Dr G, 26-29)

In this extract the doctor also uses the notion of 'knowing the person' to construct a version of a relationship in which he would 'ask'. As a 'good part' of general practice, the metaphor of 'building' implies that this relationship is incremental, takes time, is progressive in terms of strength, provides a 'foundation' and is evaluated positively. This relationship is contrasted to those in which the doctor would not 'straight-forwardly ask'. The use of the term 'straight forward' has similar implications to the use of 'outright' in the previous extract. In both cases the doctor's talk functions to explain a constraint on particular kinds of questions. Here this constraint is contrasted with the enabling effect of 'knowing the person'.

> Um (2) I, I guess ah, my patients round here I know I know who's being abused now and ah I know who the abusing partners are (laughs) ... A lot. And so (2) a lot of the women will come and they'll just tell me
> (Dr C, 95-99)

Here the doctor uses the notion of 'knowing' the patients in his practice and their partners; 'I know' is said three times and is specific about who is 'being abused', who is 'abusing', and when it is happening - 'who's being abused now'. This 'knowing' constructs a relationship within which women disclose. This disclosure is straight forward. The women 'will come' and they will 'just tell'.

Occasionally, constructions of 'knowing patients' are implied through accounts of experiences which enable the doctor to 'see' the woman's relationships.

> or you can also do home visits, where you go out and see the family at home and watch the family function at home, or not function at home
> (Dr K, 71-72)

Here the doctor uses the notion of 'functioning' to construct a version of family interaction. 'Functioning' and 'not functioning' is visible to the doctor, who can 'see' and can 'watch'. Location is important to the account; the doctor does 'home visits' to the family 'at home' (stated three times). The visibility of 'functioning' or 'not functioning' is contextualised as specific to the home, and is contrasted to the location of the practice; the doctor 'goes out' to the home. The contrast between 'functioning' and 'not functioning' implies that instances of victimisation are seen as 'dysfunctional' to the medical gaze.

For one doctor the characteristic of 'knowing the patient' is constituted through conflation with the characteristic of 'trust'.

> It's much easier ... Knowing her, or her knowing me. ... So the trust thing.
> (Dr N, 375-380)

Other doctors also constitute a 'safe' doctor/patient relationship through notions of 'trust'.

> if there's an ongoing, long-term, trusting relationship
> (Dr L, 106)

In this extract 'trust' is constituted as specific to the relationship, and developed and sustained over a period of time.

> Usually the patients trust you, you shop with them, boundary issues are a major issue (indecipherable) and so therefore they usually tell you ... Simple, it's that sort of trust, it's that sort of rapport, or conversely the daughter will arrive saying Dad hit Mum
> (Dr K, 36-37/41-42)

Here the doctor uses the notion of 'boundaries' to construct a version of a relationship in which there is closeness to patients outside of practice. It is because 'boundary issues' are a 'major issue', and are constructed as such, that they provide an account of the patients 'usually telling'. 'Boundary issues' speaks to the difficulty of maintaining boundaries when the doctor lives in the community for whom he provides medical care. Activity outside of practice takes the doctor into the community: 'you shop with them', and brings the doctor alongside his patients in their everyday lives: 'with them'. This disintegration of a clear cut boundary facilitates closeness which facilitates trust, and this

trust facilitates disclosure. It is 'usual' for the patients to trust, and therefore 'usual' for them to 'tell'. 'Usual' speaks to the ordinary, everyday nature of disclosure to the doctor. So, trust is constructed here as a special and specific 'sort of trust', characterised by 'rapport', which is 'simple' - straight forward, easy, and without complications.

'Closeness' encompasses knowledge of members of a family, so family members will disclose about other family members. This account of the 'simplicity' of this form of trust and rapport enables disclosure to be seen as immediate and without preamble: patients 'will arrive' disclosing.

Another doctor constituted 'confidence' as a characteristic similar in function to 'trust'.

> [after separately noticing bruises on two women] I commented lightly on them, gave me a reason such as they bumped into something, but at a later date when either they had more confidence in me or things were obviously wrong with their marriage they actually went back to this and said "Do you remember such and such" (3) "it wasn't really as I said".
>
> (Dr R, 13-17)

In this extract the notion of 'confidence' is used to construct a version of the doctor/patient relationship in which the patient is able to disclose some time after presenting with a symptom. The relationship is contrasted to one in which the patient would 'give a reason' which 'wasn't real'.

As the doctor constructs this account, the disclosing patient calls on the doctor's memory of a specific exchange so as to amend her previous account. The doctor constructs this 'amendment' within the context of the doctor/patient relationship as the patient's confidence in the doctor or a deterioration of the marriage relationship which becomes 'obvious' through disclosure.

In addition to characterising the doctor/patient relationship which facilitates disclosure, the doctors also construct the 'underlying condition' of victimisation in such a way that it is potentially damaging to their relationships with women patients and requires 'care'.

> Sometimes if you wait and if you give them enough time it'll come out, but I think it's a very threatening thing sometimes and if you put too much pressure on them you break that relationship which you don't want to break, you see. ... Mm. [So you feel you need to develop some kind of trust in the relationship first.] Yeah, if you, if you listen to them carefully and give them the support they'll tell you the story eventually
>
> (Dr J, 130-137)

Within the construction of the doctor/patient relationship as 'breakable', the notion of pressure is used to constitute questioning as threatening to the patient. This construction

functions to constrain the doctor in his behaviour towards her. 'Threat' and 'pressure' mean that the doctor must exercise caution; wait for trust to develop, and give support. Too much pressure/threat results in breaking the doctor/patient relationship 'which you don't want to break'. Listening and support are contrasted to pressure because they do not have the potential to 'break the relationship'. However, listening is still constituted as a sensitive practice - the doctor must 'listen carefully'. Disclosure is conditional - 'if you' - on the doctor's practices of care and these practices need to be maintained for the duration of the time it takes for the woman to disclose, which occurs 'eventually'.

In a number of accounts, doctors constructed practices of care which facilitate disclosure or enable asking.

> It may be perceived as an insult. And I have to be very careful not to (2) offend somebody ... It <u>is</u> a sensitive thing
>
> (Dr L, 112-115)

Here the doctor uses the notion of 'sensitivity' to construct a practice of 'care' not to 'offend'. Implicit in this construction is a notion of victimisation through which asking becomes a 'sensitive thing' - it <u>is</u>. This construction enables the doctor provide an account in which he is positioned as 'very careful' through acknowledging that asking may be 'perceived as an insult'. That his intent is not to 'insult' is suggested by the use of 'perceived'.

> You have to actually be, ah, you know, how would, it, it, it's really quite a delicate issue. Especially in this litiginous (sic) age.
>
> (Dr L, 250-256)

Here the doctor uses the notion of being in a 'litigious age' to construct a version of a doctor/patient relationship in which the doctor approaches the 'issue' of victimisation with 'delicacy'. The articulation of the difficulty of approaching patients about victimisation is also particularly hesitant (at least four 'hedges'). It is 'especially' the possibility of legal action against the doctor that enables the constitution of his approach as 'delicate'.

> I don't have a fixed um, way, of saying, you know, I might very delicately inquire about an injury
>
> (Dr L, 95-96)

Here the doctor uses the notion of 'delicacy' to construct an account of how he would 'inquire' about 'an injury'. The doctor states he does not 'have a fixed' way of asking; this suggests that asking is not straight forward, or done by rote, and is affirmed by the caution expressed by 'very delicately inquire'. Tentativeness is also alluded to when he states that he only 'might'.

Summary

These constructions of the doctor/patient relationship as characterised by 'knowing them', 'trust', and 'confidence' and requiring 'sensitivity' and 'care' may be interpreted as positioning the doctors as 'confessors' where medical discourse co-articulates with a discourse of confession. Confession characterises disclosure as the speaking of a 'truth' about an 'abnormality' so that in this case victimisation becomes an abnormality of an intimate relationship which is simultaneously constructed as 'private'. Through this construction secrecy is probable, and confession is problematic: therefore it requires practices of 'care' within a 'safe' relationship.

The following chapter explicates the discourses at work in constructing the 'woman' who is subject to both victimisation and confession.

CHAPTER SIX

Constituting 'the problem'

This chapter reports the analysis of discourses realised in the doctors' texts as they talk about the difficulties they experience in dealing with or helping to deal with violence against their women patients. The analysis focuses on how the discourses constitute women who have been victimised and their intimate relationships with men who abuse them.

Discovery and Confession

In their talk about the problems of detection, the doctors realised discourses of discovery and detection. These discourses are also realised in particular ways of constituting women who have been victimised.

> they'll come in because they just don't know <u>what</u> to do and they <u>want</u> me to discover it so that we can talk it through and decide on a course of action.
> (Dr G, 74-76)

Here the doctor uses the notion of the woman needing help. The woman needs help because she doesn't know how to prevent being victimised; the doctor constructs this aspect of needing help in terms of helplessness and inefficacy - 'they just don't know <u>what</u> to do'. This enables the doctor to talk about giving help - 'talk it through' and 'decide' what action should be taken - as a collaborative exercise; 'we can'. The woman's helplessness extends to being unable to disclose spontaneously, thus the doctor constructs the situation as one in which the woman 'wants' him to 'discover' 'it' (the abuse). It is only after 'discovery' that help can be given; discovery facilitates help - 'so that'.

The construction of the woman as 'wanting discovery' positions the woman, in relation to the doctor, similarly to some constructions within the 'confession' discourse.

> She <u>wanted</u> to come to me, but I wasn't on duty over that weekend ... and she, she told her mother the next day, Sunday ... Um but, she wanted to see me, so she came to see me today. ... She came because she needed some, needed (.) something for the pain, yeah. ... But she came because she wanted to tell me. ... Awful.
> (Dr G, 222-232)

Here the doctor talks about a particular woman 'wanting' certain things within the doctor/patient relationship. The specifications of what she 'wanted' progress through the account; she 'wanted to come to me' immediately after the incident, she 'wanted to see

me' so came when the doctor was back at work: although she needed pain medication, she ultimately came because she 'wanted to tell', as indicated by the subsequent use of 'but' to introduce that part of the account.

In some instances the woman is constituted not only as 'wanting' discovery or confession, but as in 'need'.

> Ah, often they don't necessarily need medical assistance. ... Ah, (.) they just need the acknowledgement by someone else that (.) that what they're going through is (.) is hurtful, and harming them. ... And ah, they, once, once they've acknowledged it, that in fact they're the victims, and ah, they shouldn't be going through that situation, that they can be directed to a helping agency, or (.).
>
> (Dr C, 73-80)

Here the doctor uses the notion of 'acknowledgement' to construct what the woman needs from 'someone else' and is able to receive through 'telling'. The recognition that the patient 'often doesn't necessarily' need medical attention enables the doctor to locate the woman's 'need' outside medical intervention. 'Acknowledgement' occurs both externally by 'someone else', and by the women themselves, and functions in three ways. Initially the woman 'just needs' someone else to acknowledge the nature of her experience, what she is 'going through': that it is 'hurtful' and 'harmful' to them. Recognition of the experience entails the woman realising her status as 'victim'; victims 'shouldn't' be in 'that situation'. It is only 'once' this type of 'acknowledgement' has taken place that it can function to facilitate movement towards resolution; referral to a 'helping agency'. Here the doctor constitutes victimisation as outside the sphere of the medical gaze, so that other agencies are needed to deal with the problem.

The doctors' texts also realise the discourses of confession and discovery in constructing the women as resistant to disclosure and resistant to recognising the 'reality' of their experiences.

> But, but occasionally it's a no go area and you know, like (2) "Don't want to know", or "I'm doing the best I can", you know what I mean?, or "Don't challenge me", sort of "Don't rock the boat." ... So you get the messages sometimes.
>
> (Dr N, 164-168)

Here the doctor's text realise the discourse of confession to construct a version of the doctor/patient relationship in which the woman resists the doctor's attempts to 'facilitate disclosure'. The woman's resistance is verbally established, as constituted by the doctor's account of what women have said to him. Thus, talking about the issue is constituted as a 'no go area' and, after the quotes, is described linguistically - the doctor receives the 'message'.

> Um, they won't tell me often how often it's happened
> (Dr J, 66)

Here the doctor talks about a particular form of resisting disclosure. Within this construction disclosure takes place, but a particular issue is not addressed; the woman 'won't' disclose the frequency of the abuse - 'it'-; 'they' won't say 'how often'. This form of resistance is constituted as common, that is, it happens 'often'.

> some will not disclose out of a privacy of their own lives and relationship.
> (Dr C, 30-31)

Here the doctor talks about resisting disclosure. 'Nondisclosure' is constructed as a consequence of wanting to keep certain things - 'own lives' and 'relationships' - private, and this desire is constituted as a choice - 'will not'. In contrast then, women necessarily relinquish this 'privacy' upon 'disclosure'.

The doctors' texts also realise discourses of discovery and confession in constituting strategies that the women use to rationalise or deny the victimisation they experience.

> And, very often they will give you clues as to what's going on, they'll, they'll say "We all have our ups and downs, don't we?" But, it's very easy to rationalise that, that's that the situation that you're in is is normal because it's much more comfortable to think of yourself as being normal, than being abnormal. ... Much more comfortable to say "Well, we all have our ups and downs" and ah "This happens" without having, wanting it pointed out to them that most ups and downs don't go as far as biffing someone.
> (Dr B, 42-49)

Here the doctor uses the notion of 'rationalisation'. 'Rationalisation' is constructed as the means by which women can construct themselves and their situation as 'normal' rather than 'abnormal'. So within this construction the text also constructs the woman and her relationship as 'abnormal'. 'Rationalisation' enables the doctor to state (twice) that it is 'much more comfortable' for the woman to justify 'ups and downs' as a normal experience - 'we all'. The validity of the 'rationalisation' is negated because the situation has been constituted as 'abnormal'. In contrast, 'normality' is constructed through negating that violence is a consequence of 'ups and downs' which mostly 'don't go as far as biffing someone'. 'As far as' constructs violence as an extreme behaviour - and part of the definition of an extreme is that it is not normal. Challenge to 'rationalisation' would function to disrupt the 'comfortableness' enabled by the strategy of rationalisation; hence the woman is constituted as resisting the doctor's attempts to 'point out' his version of 'normal'. Through this resistance she can retain her version of 'normality'.

> I find that so frustrating, I'm sure everyone does, so it's the denial that's the hardest thing to understand.
> (Dr J, 245-247)

Here the doctor talks about 'frustration'. 'Frustration' is constructed as the response to the 'denial' the woman uses as a strategy to resist discovery or confession. Frustration is amplified by 'so' and constituted as a common response; 'everyone does'. Part of the construction of 'frustration' is the inexplicability of the denial; it is the 'hardest thing to understand'. So, the woman is constituted as making use of an incomprehensible strategy.

> You still, you still find fifteen years later that, what the reasons really were for what things going wrong fifteen years ago in spite of all the denial, or straight out lies.
>
> (Dr B, 64-66)

Here the doctor talks about 'finding out'. 'Finding out' is constructed in relation to the truth of a situation. 'Finding out' the truth occurs after the elapse of time ('later'); 'what the reasons really were' is contrasted to the 'untruths' at the time 'fifteen years ago'. 'Finding out' enables the constitution of the reality as unchanging 'in spite of' the given account, and it is the 'denial', the 'straight out lies', which have changed.

Summary

Within the doctors' texts the discourses of discovery and confession constituted women who have been victimised by male partners as either wanting and needing to have the men's violence discovered, or to confess their own victimisation, or as resisting the discovery or confession of their victimisation.

Damage

In the course of accounting for problems of detection in general the doctors also provided accounts of the damage done to women through victimisation by their male partners. In these accounts the doctors' took up positions of expertise through medical discourse, and their experience as doctors, to constitute the characteristics of 'damage' and, by implication, the characteristics of 'health'.

> so they know, and kind of like, also it's kind of like trying to (.) help them (3) um, (2) to reinforce the (8) actually one of the things I say to them "You deserve better", cause often (.) they don't have that sense, it's a sense of (2) of, some worth, well that's one thing that happens ... But they don't feel that they deserve better and I think, I think that's important, to um, slip that in sometimes, cause it's often in that sort of um, lack of entitlement to a decent life sort of thing, I mean I've got to lift their self-esteem ... And I mean that, that's one of, one of the things that happens
>
> (Dr N, 138-147)

Here the doctor uses the notion of 'helping' to construct the woman as damaged in certain ways. Because of the violence of the man to the woman, she 'loses' feelings about her 'self', specifically feelings of 'worth' and 'self-esteem'; this loss is 'one of

the things that happens' to women in violent relationships. This construction of the damaged woman functions to enable the doctor to talk about what he does in terms of 'trying to help them', and is constituted in direct relation to what he sees as the damage. Thus he tries to 'reinforce' the message that they 'deserve better' because 'they don't feel that'. Constituting damage through a 'lack of entitlement to a decent life' enables the doctor to attempt to 'lift their self-esteem', and to construe this attempt in terms of necessity; he's 'got to', and it is 'important'. Through this construction, the damaged woman is constituted as 'lacking' a sense of 'entitlement' to a 'basic right': a 'decent life.' The use of the terms 'slip' and 'sometimes' indicate that doctor 'takes care', and implies that the damaged woman is also somewhat fragile.

> And I feel that anonymity is a (2) they feel embarrassed. ... Abused people feel embarrassed by it. Um, because they're made to feel unworthy.
> (Dr B, 108-111)

Here the doctor constructs abuse as enforcing 'feelings' of unworthiness - 'abused people' are 'made to' feel that way. The consequences of unworthiness are constituted as 'embarrassment' and 'anonymity'. The feeling of embarrassment - 'they feel', enables the doctor to surmise ('I feel') that 'abused people' would not want to disclose, they would rather stay 'anonymous'. 'Anonymity' within this context suggests feelings of 'shame' and the subsequent maintenance of 'silence'.

> I'm sure, um a lot of it's a sort of a demeaning of the woman as a person and she's useless and she's looked upon as a chattel, now that must be very demeaning, and they, apart from getting depressed, I think they get physically run down, and they, they're worthless, and they sort of end up that way. ... It's almost a sort of a - an inevitable thing. ... They, they lose their good health.
> (Dr J, 146-153)

Here the doctor uses the notion of 'demeaning' to constitute the consequences to the woman of victimisation. 'Demeaning' is constructed as a reducing the woman's status 'as a person'. She is 'looked upon' as 'useless', 'worthless', and as not even fully human - 'as a chattel', property or slave. This view of the woman enables the particular explanation of the consequences for the woman that the doctor offers. The emphasis of 'very demeaning' realises these consequences as unavoidable, it becomes 'inevitable'. They are constituted as psychological and physical; the woman 'gets' 'depressed' and 'gets' 'run down'. The loss of personhood is constituted as the fulfilment and embodiment of the 'demeaning' process - the woman 'ends up' 'worthless', and she 'loses' her 'good health'. The use of 'loss' supports the notion that the woman has had some 'thing' taken away from her.

> she often went back to the guy, trying to make it work again, and it didn't work. Until eventually you know, it was sort of prising her away from him and then she'd go back, prising her away and she'd go back and eventually she's

> recognised that she's got enough of her own intrinsic worth that she can stand on her own feet.
>
> (Dr L, 134-138)

Here the doctor talks about 'worth' in constituting the characteristic needed for the woman to leave the violent relationship. The metaphor of 'prising' is that it is difficult, resisted, that there is an 'adhesion' that must be dissolved. The 'adhesion' is constituted as 'trying to make it work'. It is dissolved through the woman 'recognising' her 'worth.' 'Recognising' 'worth' is thus constructed as an essential part of separation, and is constituted as occurring over time - 'eventually'. That the doctor uses the word 'own' - the woman has her 'own intrinsic worth' and can 'stand on her own feet' speaks to an essential realisation of an ability to be and function as 'separate' - which is what this is about - separation. She does not need her partner and therefore does not need to continue trying to make the relationship 'work'.

As well as constituting a sense of 'worth' that is damaged by victimisation, the doctors also constitute 'power' and 'strength' as damaged.

> We also do underestimate the fact that some of these people are certainly kept in a very um dep-, no ah, manipulated position of being very powerless. ... They're powerless economically, they're powerless emotionally, they're, they're um (.) they very much need the, the supportive part of the dominant relationship.
>
> (Dr B, 134-139)

Here the doctor uses the notion of 'powerlessness' to construct the 'position' of the abused woman. That the woman is 'very powerless' is constituted as a consequence of 'manipulation'. Further, this position is one in which the woman is 'kept'. The implications of the woman being 'manipulated' and 'kept' preclude freedom of choice, and enable the concomitant features of 'economic' and 'emotional' powerlessness. 'Powerless' people are also in 'need' of what they do not have, and get it elsewhere, specifically from the 'supportive part of the dominant' partner. The doctor expresses this firmly - they 'very much need' it. That the 'fact' of this 'position' is 'underestimated' strengthens the doctor's construction. In this construction the woman suffers a loss of power as a result of victimisation.

> My, some of my healthy clients would say "Well if he even laid a finger on me, I'd plant him or I'd leave him," but these people get so overpowered by it, obviously they can't, they haven't got the strength to leave
>
> (Dr J, 243-245)

Here the doctor uses the notion of 'strength' to constitute the abused woman as 'not healthy'. This construction is enabled through a comparison of 'these people' to the doctor's 'healthy clients' in terms of their response to partner violence. The healthy client would either 'leave' or physically retaliate - 'plant him'; furthermore, 'health' is

constituted as intolerant to the 'slightest' violence - 'if he even laid a finger'. This comparison functions to explain why the abused woman does not leave her violent partner, and it relies on the notion of 'strength'. The woman does not have the 'strength to leave' because she has been 'overpowered'; 'strength' and 'power' have suitably physical connotations. The connection is clear, it is 'obvious' they 'can't' leave.

> And part of it, she hoped that, you know, for the child's sake he would change, but I think part of it was she was powerless, really, because she had, her parents had died when she was young and I think she'd been brought up by relatives in Auckland, so even if she went off with the child she had no one to go to and they may have said "Why are you leaving your partner?"
>
> (Dr R, 121-125)

Here the doctor uses the notion of 'powerlessness' to constitute the abused woman's position as one in which she has no support. 'Support' is constituted in this particular case as familial; the woman does not have it - 'her parents had died' and 'she had no one to go to'. Because she did in actuality have people to go to ('they'), the construction of familial support is strengthened - the envisioned response 'they may have said' is unsupportive 'why are you leaving your partner?' This functions to bolster the positioning of 'powerlessness', and that she was 'really' powerless.

> But a lot of what happens is that the verbal abuse goes on 'til the woman is so insignificant in her own eyes she hasn't got the strength, her emotional strength is so sapped she cannot fight back. And that's emotional thing and you do see that. I can think of several cases where there's never been any physical (indecipherable) but it consists of insults and demeaning the person and so on.
>
> (Dr L, 140-144)

Here the doctor talks about 'insignificance' as a way the woman sees herself. 'Insignificance' is constructed as a result of 'verbal abuse' which is 'insulting' and 'demeaning' to the person. It is constituted as a kind of 'wearing down' - the verbal abuse 'and so on' 'goes on' until the woman's 'strength' is 'sapped' and she cannot 'fight back'. The notion of 'emotional effects' enables the result to be put in 'psychological' terms - she becomes insignificant 'in her own eyes', she perceives herself to be so.

The characteristics of power and strength which are damaged by victimisation are associated also with damaged autonomy.

> you often get that feel for a person's relationship, I think. They can't make their own decisions, and they have to go check with their partner and all that stuff. ... So, you know, and they're, they're kind of suppressed or depressed or (.)
>
> (Dr N, 261-264)

Here the doctor uses the notion of 'suppression' to construct a version of a particular relationship in which a woman has little autonomy in the sense of the ability to make and

act on her own decisions. This notion of 'suppression' is enabled by the constitution of the woman as not being 'allowed' to be autonomous. She 'can't make' her own decisions because she 'has to check' them with her partner. The difficulty of articulating this lack of freedom as 'suppression' is the stumbling of 'they're, they're', and the hesitancy of 'kind of'.

> Control, controlling relationship which is, which isn't very, in which the person hasn't a lot of autonomy.
>
> (Dr N, 272-273)

Here the doctor talks about 'autonomy' explicitly. A feature of a 'controlling relationship' is that it is one in which 'the person' lacks 'autonomy'.

> Um, (2) yeah and so (laughs) (2) yeah so that, that abuse which is psychologically attacking your autonomy, rather than just fighting, but ones where it's really criticism, and so forth, I think that would make it hard to leave.
>
> (Dr N, 440-442)

Here the doctor talks about 'psychological attack'. 'Psychological attack' is constituted as an assault on a person's 'autonomy'. The extreme is constituted as 'really criticism' and contrasted with physical assault - 'just fighting'; minimised by the use of 'just', and of 'fighting' which makes it sound like a relatively harmless 'scrap' between physical equals. It is this construction of psychological abuse which enables the constitution of the woman's decision and action to leave as 'hard'.

The notion of 'autonomy' in the sense of an ability to make and act on decisions is also implied in two extracts where doctors talk about the responsibility the woman who is victimised needs to take for herself.

> Um, but it's like a lot of things, they've got to really help themselves, you can only do so much for a person.
>
> (Dr J, 358-359)

Here the doctor uses the notion of 'help' in relation to abused women. It is because the help other people can give is limited - 'you can only do so much' - that the notion that the person has to 'help themselves' is enabled. 'Helping' themselves is constructed as the endpoint and the ultimate solution to the problem; 'they've got to really'. The implication of this construction is that the person must make their own decision and take their own action to restore their autonomy.

> I try and point out to them that, that no one in this society has to live in fear of physical violence. And that nothing can be done about this until they do something about it.
>
> (Dr B, 51-53)

In this extract the doctor constitutes the 'right' of all members of 'this society' to be free of fear of physical violence. This 'right' is an entitlement which some women may not be aware of - as implied by 'I try and point it out'. The condition that 'nothing can be done' without the person 'doing something about it' implies that if the entitlement is violated, it is the woman's responsibility to reinstate it herself.

Summary

As the doctors talk about the problems of detection, and constitute characteristics of 'damage' done by victimisation and, by implication, the characteristics of 'health,' their texts realise discourses which construct the 'damaged woman' as lacking or inadequate in a sense of worth, power, strength, and autonomy. Some doctors speak as if it is their duty to remind their women patients of basic 'moral rights': the right to a 'decent life', 'a life without fear of physical violence'. These characteristics, and the notion of 'rights', realise liberal humanist discourse in their construction of the individual woman.

Liberal humanist discourse constructs the individual as an agent who is an autonomous entity, the origin of their own intentions, empowered to exercise their will, capable of decision making and goal directed actions independent of others, responsible for themselves and entitled to basic moral rights (O'Neill, 199; Rose, 1990). The 'damage' constituted in the doctors' texts as damage to the woman who has been victimised is damage to the characteristics of the individual constructed in liberal humanist discourse. It is also the realisation of this discourse which delimits the doctors' responses as 'helping' or 'facilitating' the woman helping herself.

Love and Commitment

Accounts of the woman's emotions within the context of a violent relationship were also provided by the doctors.

> Um, I mean, it's really awful for these women because it's usually somebody they usually loved, or thought they loved, yeah. ... And they, they've opened themselves up to that person and got an earful, so, ... So, of course they're upset
> (Dr G, 62-67)

Here the doctor uses the notion of 'love' to construct the situation of the abused woman. The woman has made herself vulnerable to her partner 'opened themselves up' and been abused; 'got an earful'. That the woman's affections - the decision to 'open up' - were misplaced is indicated by the amendment of 'loved' to 'thought they loved'. The regard (esteem) given to the importance of 'love' is simultaneously indicated by and facilitates the constitution of the situation for 'these women' which is described as 'awful' and amplified by 'really'. This functions to enable the obviousness ('of course') of their

response - 'they're upset'. 'Usually' allows for the possibility that this isn't always the case.

> And part of it [not leaving], she hoped that, you know, for the child's sake he would change
>
> (Dr R, 121-122)

Here the doctor talks about 'hope'. 'Hope' functions as the reason why the woman stays with her violent partner. She 'hopes' that the man will 'change', that is, no longer be violent. This 'hope' is constituted as being for 'the child's sake' rather than her own.

> Um, now she know, most women know their options now. They know about Women's Refuges, they know about reporting things to Police, they know about safe houses, moving out of town, going to a (.). But they also know about the guy they love ah, who, who has been better in the past but is no good now and (.) they know about the promises he's made and the times he's [inaudible] you know going on the cycle of violence, how that how that works that that, that they've chosen the guy and often they feel if they've chosen the guy they've got to like it or lump it.
>
> (Dr C, 128-134)

Here the doctor uses the notion of 'knowing options' for leaving violent relationships in contrast to 'knowing' their violent partner. 'Knowing their partner' is constructed through 'love' and his 'deterioration' - 'better in the past', 'no good now'. Here the doctor also makes use of the notion of a 'cycle of violence' to constitute 'promises' to change the man has made. Through 'love' and the 'cycle of violence' the woman's choice to remain in the relationship, despite 'knowing her options', is constituted as an effect of having already 'chosen' to love 'the guy' and accepting the consequences of that choice - 'they've got to like it or lump it'.

In these extracts the doctors realise discourses of love and commitment, in intimate relationships or in the care of children to construct the woman as 'upset', 'hopeful', or 'accepting'.

Psychological and Emotional Abuse

In their accounts of the woman's emotions, the doctors also talk about psychological and emotional abuse.

> The odd, you know, um (.). I mean in a way to me that's [emotional abuse] harder to change than things which, where she's (2) is actually <u>physically</u> abused but she can <u>see</u> that it isn't on, you know what I mean? It's easier actually to say "I'm not going to be hit again." It's harder to say I think
>
> (Dr N, 444-448)

Here the doctor talks about 'psychological abuse'. 'Psychological abuse' is contrasted to 'physical abuse'. 'Physical abuse' is visible - it is constituted as occurring in physical reality; she is 'actually' physically abused. This enables the violence to be 'seen' and judged - 'it isn't on'. Constituted this way, it is 'easier' for the woman to respond to her physical reality on those terms - 'I'm not going to be hit again'. In contrast 'psychological abuse' is constituted as more difficult to deal with; 'harder to change' and 'harder to say'. To 'see' or 'speak' psychological abuse is problematic.

> Ah, so, (.) Especially if they don't have physical signs to show that they're being emotionally abused, or there's a lot of pushing or shoving or threats, those sorts of things.
>
> (Dr C, 111-113)

Here the doctor talks about 'signs' of victimisation. 'Signs' are constituted as physically inflicted and physically manifested. 'Emotional abuse' does not leave 'physical signs' which 'show' the abuse is occurring. Similar to 'emotional abuse' in their lack of physical indicators are 'pushing', 'shoving', and 'threats' - 'those sorts of things'.

> Oh yeah, and in fact, [emotional abuse is] much better, in inverted commas, because it doesn't leave any physical scars and she can't go and turn around and say "look what my husband's done to me, look at these bruises".
>
> (Dr L, 146-148)

Here the doctor talks about 'physical evidence'. The results of physical violence can be used as evidence by the abused woman to verify disclosure of victimisation. This is contrasted to emotional abuse, which does not leave 'physical scars'. She has no evidence of abuse and she therefore cannot complain of it as simply as with physical abuse; 'look at these bruises'. This is constituted as 'much better' for her violent partner; as she cannot 'go' to someone and tell with no visual evidence for them to 'see' through 'looking', so no blame can be placed after what her husband has 'done to her'. The doctor states that 'much better' is in 'inverted commas' which enables the articulation of the situation whilst asserting disapproval.

Summary

Emotional and psychological abuse are constituted as particularly problematic through the realisation of an empirical discourse constituting factuality as established through 'observation': through the visibility of evidence, signs or symptoms. Because these 'forms of abuse' do not leave visible traces they are more difficult to identify and to verify.

The Patient / Partner Relationship

As well as constituting the woman as 'damaged' through constructions of autonomous individuality, the doctors' text also constitute her in relation to her violent male partner.

> But she often went back to the guy, trying to make it work again, and it didn't work.
>
> (Dr L, 134-135)

Here the doctor uses the notion of 'going back' to construct a version of the woman's actions in which she continually returns to her violent partner: she goes 'back' 'often' and 'again'. The implied movement of 'back' is regressive in contrast to forward movement which is progressive. Therefore, going back precludes the possibility of ending the violence. The doctor constructs this 'repeated' action as failure. What she attempts is described in terms of failure - she keeps 'trying', as is the outcome: 'it didn't work'.

> it's extraordinarily rare that the relationship's going to survive, as they're gonna do anything they can to get out of it, basically. I mean, if they batter once they'll batter again (indecipherable). I think it's good to try and work through through that and (indecipherable) so obviously you don't want things to get as, as far as that.
>
> (Dr G, 331-334)

Here the doctor construct the inevitability of 'battering' to describe a version of the relationship between the woman patient and her violent partner. This inevitability is constructed in terms of the man's violence - once a man 'batters' he will do it 'again'. There is not much movement in the statement either regressive or progressive, that is, no possibility of any other alternative is given or suggested. The doctor's focus on prevention speaks to this immutability; it is 'obvious' that once the man has gotten 'as far as' battering there is no hope that he won't do it again. This enables the use of the concept of the inevitability of battering to construct the relationship in terms of 'survival', which is constituted as 'extraordinarily rare' because the woman will go to great lengths - 'do anything they can' - to leave, that is, 'get out of it'.

> Um, (2) and um, also I had a person (2) who was a patient that I knew very well who was in a violent relationship that kept, you know like (2) um (.) she had a terrible time (2) and I was quite um, (.) and that was all about the same time, I was quite um (4) I can remember her pretty clearly, in fact it's probably the one that I remember most, um, so it's kind of really this thing that kept happening to her and it kept happening despite all of the intervention and a lot of support, it kept happening.
>
> (Dr N, 61-66)

Here the doctor constructs an account of a particular woman patient's experience of violence. The doctor initially states clearly that his patient was in a violent relationship, but his subsequent reference to the violence becomes 'it's kind of really this thing'. The talk is heavily hedged and there are frequent pauses which suggest difficulty articulating the situation, the violence, and his response. The construction of the violence as 'this thing that kept happening to her', - 'kept happening' is repeated three times - implies

inevitability, repetition and inexorability. The construction positions the woman as entirely without responsibility for 'this thing' which 'happens' to her. The 'repetition' occurred 'despite' attempts to help, which are constructed as robust - 'all of the intervention' and 'a lot of support'.

> when you see a person coming back, having reinserted themselves into the same set of circumstances again and again and again, um, with different spouses, different de factos, um, that you tend to lose your, lose your sympathy
> (Dr B, 25-28)

Here the doctor uses the notion of 'coming back' to construct an account of the repeated presentations of women victimised by male partners. These repeated presentations are linked to 'the same set' which happen 'again and again and again.' Agency is attributed to the woman: she 'reinserts' herself into the 'same set of circumstances.' This 'set of circumstances' is a relationship with a violent male partner. The woman and the 'circumstances' of her victimisation are constant in this construction, as such she is the one attributed agency; she enters relationships with 'different spouses, different de factos'. As she is the one who keeps returning for help, 'coming back,' and her partner is 'different' each time, the implication is that she choosing her victimisation. This attribution of choice, and the 'repetitiveness' of her actions enables the doctor to state that he 'loses sympathy' for her. The use of the second person 'your' rather than the first person 'my' suggests that 'losing your sympathy' is a common and shared response.

> I've always found it very difficult to understand why a woman comes along and then three months later comes along again (2), it's something that obviously is a power thing and almost a co-dependency state sometimes but it never ceases to amaze me how they keep coming back (laughs) um, and I know in the Women's Refuge twenty-five percent come back to the refuge so I can't understand that, but I can, and it seems very odd.
> (Dr J, 228-235)

Here the doctor uses repetition over time - 'comes along', 'comes along again' - to construct the actions of a woman in a violent relationship who continually returns for help. Versions of returning are stated three times: 'comes along again,' 'coming back,' 'come back'. The doctor constructs this 'returning' as baffling; it 'never ceases to amaze' him, and he states twice that he can't 'understand' it. He amends this to 'but I can', utilising a psychological discourse to explain the phenomenon of returning; it is 'obviously' related to 'power' issues, and perhaps a 'co-dependency state', though only 'almost'. The repetitiveness of the pattern is constituted as 'frustrating' for the doctor.

> If they came along and said "Look, I really need some help, and I'll go, and I promise I'll never do it again," that's easier for us to handle, ... sometimes you know that's not going to happen.
> (Dr J, 249-252)

As above, the doctor contrasts what he would like to hear the woman say and then do - 'go for help' and 'never do it again' - with the actuality of her actions. This contrast is constructed as difficult for the doctor to handle: what he would like her to do is described as 'easier' for the doctor to handle. That the doctor says he 'knows that's not going to happen' functions to distinguish between his hope and his experience. By implication the woman's actions of returning to the relationship are constituted as the difficulty the doctor experiences.

> she lived with him for about eighteen months from the first time he assaulted her before I managed to persuade her to leave, she was always going to leave, and then decided to go back again.
>
> (Dr R, 116-119)

Here the doctor provides an account of attempting to 'persuade' a particular woman patient to leave her violent partner. The 'attempt' is constituted as having 'managed' the persuasion after some time, which implies some resistance. The decision to leave is constituted as possible future actions - 'going to', in contrast to the 'decision' to return. This construction of the process suggests that the woman repeatedly discussed the possibility of 'leaving' with her doctor. The notion of 'going back', after intending 'to leave' also enables the doctor to constitute the difficulty of the situation.

Summary

In these extracts constituting the woman's relationship with her violent male partner, the construction of 'repetition' in the incidence of violence - that 'it happens again and again' - and in the actions of the woman who 'returns again and again', and, more rarely, in the actions of the man - who 'batters again and again' - realise a discourse of recidivism. Recidivism may be understood not only as 'repetition' but as 'regressive' repetition, specifically the repetition of socially prohibited actions to the detriment of the social good. The most common realisation of a discourse of recidivism is in relation to the constitution of criminal behaviour.

Accounts of Violence

The doctors' texts also provide accounts of violence and of the silence which often accompanies women's victimisation.

> And um, um (3) for example (.) men are incredibly useless at expressing themselves with words, and I'm reasonably good at that and often that's part of (.) the kind of sequence that men report, which is that, um, (.) well no, they [they're] just unable to assert any of their desires or wishes with words, do you know what I mean? ... And they tend to resort to other controlling measures, you know. ... Like um, withdrawal and all that sort of stuff, so I mean, there's kind of dynamics in (.) which are related to (2) I think to (2) things that are quite common themes in relationships

(Dr N, 518-525/527)

Here the doctor uses the notion of 'inarticulateness' to construct a version of a violent relationship within which the man 'resorts' to 'other measures'. 'Inarticulateness' is constituted by constructing men as unable to use 'words'; this inability is presented in immutable terms - men are 'incredibly useless' and 'just unable' to achieve things 'with words'. They cannot 'express themselves' or their 'desires' or 'wishes'. That men 'resort' to other behaviours is constituted as a result of this inability; hence as part of a 'sequence' men 'tend' to do other things to 'assert' their desires and wishes. The use of 'men report' confers credibility upon this account. These other behaviours are constituted as 'withdrawal' and the less well defined 'all that sort of stuff' and are defined as 'controlling measures'. So the 'communication' of 'desires' and 'wishes' becomes about taking 'measures' to get them fulfilled. These 'measures' are alluded to as abusive, whereas communication generally is not. This account locates violence within the relationship, and particularly within the individual man: as an effect of his inability to 'use words', and his use of 'control measures'.

> in my earlier years I saw plenty of alchies ... the marriage was stressed because the husband was a boozer and his wife was a nagger and which came first who knows?
>
> (Dr G, 358-361)

Here the doctor uses the term 'plenty' to constitute a generic form of relationship in which the man is an alcoholic and the woman is a 'nagger'. This form of relationship is 'stressed'. The account of the 'stress' is constituted through the construction of an interaction between the partners in which it is impossible to determine - 'who knows?' - who is responsible for initiating the 'stressor' - 'which came first'. This construction functions to diffuse responsibility for individual actions and locates violence as a result of interpersonal interaction.

> I'm not wanting to get the men off the hook for their behaviour, no one is, ... but it's often as part of some interaction, you got me?
>
> (Dr N, 508-511)

In this extract the initial clause - 'I'm not wanting ... no one is' - functions as a disclaimer in relation to the later construction. The disclaimer uses the notion of getting men 'off the hook' to constitute attempts to diffuse or diminish men's responsibility for their violent acts against women, which is constructed as something 'no one' wants to do. The disclaimer relates to a construction of responsibility for violence as 'part of some interaction'. The use of 'it's often' constitutes this construction as frequent and implicates a common understanding of violence as a product of dysfunctional interpersonal interactions. 'You got me?' serves to invite understanding and agreement

from the interviewer and supports the need for the disclaimer through implying the possibility of misunderstanding.

> I suspect it in, ah, the lower social class, the, the, the, the drinking, smoking types, the ones with gang husbands, and the ones with lots of kids, um all those I think have got to be risk factors
>
> (Dr G, 15-17)

Here the doctor uses a notion of 'social class' and of 'types of people' to constitute the 'risk factors' which he asserts as the grounds - 'have got to be' - for his suspicions of violence. The 'types of people' are specified according to alcohol use and smoking, gang affiliation and number of children. The 'social class' is specified as 'lower'. This account locates violence as a 'risk' for individuals of particular 'types' within specified social 'locations.'

> I think the stresses and strains of, of, of life at the moment probably make, make abuse more common, cause I think that's when people fight more often
>
> (Dr B, 237-239)

Here the doctor uses a notion of 'stresses and strains' to construct 'life conditions' which facilitate violence - 'abuse' and 'fighting'. 'Stresses and strains' imply 'pressure' which may be 'released' through violence. The relationship is simply linear: as 'stresses and strains' increase, so does violence. This account locates violence as an effect of 'external pressure' - 'stresses and strains of life' - on individuals, and, by implication of the term 'make', beyond their volition.

> I can imagine if things go wrong in the town, there'll be more domestic violence. But at the moment the town's pretty quiet, in terms of employment situation there's jobs, there's more positive attitudes, there's less drunkenness, a lot of the people who are perpetrators of crime and drunkenness are either in prison, or they've left town recently. All those, all those things have a bearing on the incidence of domestic violence.
>
> (Dr C, 157-162)

In this extract, the doctor constructs 'less domestic violence' through specifying conditions which reduce the incidence of violence. These conditions are specified according to employment, attitudes, alcohol use, and criminal activity. This account locates violence within a specific social context: particularly the economic and social environment of the town.

> violence is pervasive (2) and it's not only within the marriage thing, it's also within the total society. Naturally it will find itself into people's homes.
>
> (Dr L, 330-332)

Here the doctor uses the term 'pervasive' to constitute violence as a social phenomenon which occurs in intimate relationships - 'the marriage thing' - and in general - 'the total

society'. That violence occurs in intimate relationships is constituted as a 'natural' effect of societal violence. This account locates violence within a general social context.

Summary

These accounts construct 'violence' through realising a discourse of expressive tension - an 'individual' account in which violence is an effect of a build up of 'pressure', a liberal humanist discourse - an 'individual' account in which violence is used as a strategy of control, an interactional account - in which violence is a result of interactions between individuals in relationships, and a social systemic discourse - a 'contextual' account in which violence is an effect of social conditions which determine individual behaviour. O'Neill (199) identifies these discourses as realised in psychological texts theorising violence and reporting the results of empirical studies.

Danger

The doctor's also provided accounts of the silence which often accompanies women's victimisation.

> Well, if you want (.) people murdered then [inaudible] people like us to stir up a can of worms then you get murders ... through the anger that is created. ... Because "Someone must have told." ... And there's, I mean, I don't want that, I don't want people to be hurt, sure ... I'm, we don't, them to be murdered either. ... [inaudible] a lot of domestic violence situations there's quite a high chance of that.
>
> (Dr A, 161-173)

Here the doctor talks about 'anger'. 'Anger' is constructed as something that is 'created' and 'caused'. It is the fear of this anger that is constructed as the reason for this doctor caution about asking; 'people like us stir up a can of worms'. If disclosure occurs, then 'anger' is 'created' 'because' someone 'must have told'. The rationality of this construction is supported by the amplification of the possibility of the risk entailed; it is common - 'a lot', and risky - 'there's quite a high chance'. The consequences are constituted at their extreme also; 'murder' is referred to three times, and as directly attributable to doctor interference through the use of 'I'. This construction justifies the doctor not asking; she does not 'want' (three times) the possible consequences of disclosure.

> With a stranger I would still go into this territory of, of, um (4) what would make it harder would be having her partner there (.) the abuser with her
>
> (Dr N, 384-385)

Here the doctor talks about 'territory'. 'Territory' is constituted as something you 'go into'; as a geographical metaphor it alludes to the idea of knowing some terrain better than others. Asking a 'stranger' about abuse is suggested as requiring caution through

this construction, even though the doctor 'would still' do so. Partner presence -the 'abuser' being 'with her' - would make it 'harder'; stepping into the 'territory' becomes more fraught.

> she's a woman of about thirty, and she's been beaten up (.) several times by the same guy (.) she's told him to leave and he's beaten up for that suggestion and ultimately he did leave.
>
> (Dr G, 212-214)

Here the doctor talks about repeated violence to construct a consequence of the woman taking action, that is telling 'him to leave'. 'She's been beaten up several times by the same guy' indicates the 'repeated violence'. The danger of telling the violent man to leave is constituted by 'he's beaten up for that suggestion.' However, the woman is constituted as finally successful in her actions - 'ultimately he did leave'.

> you just wonder how much of it you don't see 'cause they are too ashamed to come along or they're too frightened of their partner who'll make it worse if they do.
>
> (Dr J, 56-57)

Here the doctor talks about 'not seeing' abused women. 'Not seeing' is constituted as the result of women not 'coming along' to their doctor, and enables the doctor to state that he 'wonders' just 'how much' this is. 'Causes' of 'non presentation' are constituted as feelings of shame wherein the woman is 'too' ashamed to come, and as 'fear' of reprisal from their partner who will 'make it worse' in response. This construction implies that the woman's non presentation is rational: a woman in a bad situation would not do anything to make it worse.

> Um, yes, um, I think the first thing I refer people to if I can is the police, and because if they don't (.) because commonly they are very reluctant to proceed, and if they don't, they're going to get beaten up again.
>
> (Dr G, 117-119)

Here the doctor uses the notion of 'referral' to construct the violence as repetitive - 'they're going to get beaten up again'. Within this construction is the notion that it is 'common' for women to not want to deal with the issue through the police. This is constituted as difficult as indicated by the tenuousness of 'if I can' because they are 'very reluctant' to 'proceed', that is, take steps forward. The construction of consequences - 'if they don't' - take action 'they' are 'going to get beaten up again' enables the woman's reluctance to be constituted as a rational response to threat.

Summary

In these extracts a discourse of danger realises threats of reprisal or continuing violence as the rational 'reason' for women to remain silent and not seek help. It is also realised in the doctor's justifications of their reluctance to ask women patients about violence and

abuse. One effect of the realisation of the discourse of danger is to position the woman who has been victimised as rational in choosing silence.

The implications of the use of the discourses identified in this chapter to constitute the woman who has been victimised, her emotions, her relationship with her violent male partner, accounts of violence and of silence are discussed in the following chapter.

CHAPTER SEVEN

Discussion

This chapter discusses the implications of the analysis of discourses realised in the doctor's texts in relation to the problem of detection. These discourses are discussed in relation to the stories doctors tell of their experiences with women patients who have been victimised by violent male partners.

The previous chapter identified the liberal humanist discourse realised in the construction of women as 'damaged' by victimisation. Liberal humanist discourse constitutes the women as individuals and agents. Individuality assumes that personhood is bounded and separate from 'the social' (Hollway, 1989). Agency attributes to the individual the characteristics of conscious awareness of self, rationality, control over meaning, autonomy of action, intentionality, and entitlement to basic moral rights (O'Neill, 1998; Rose, 1990). Women constituted as 'damaged' by victimisation suffer a loss, lack or impairment of their ability to make decisions and take action, and to regard themselves as worthy and entitled to basic moral rights. The doctors' understanding of their own position in relation to the woman by constituting women through liberal humanist discourse is delimited so that they are constrained to 'help' or 'facilitate' her recovery from damage. The recovery is her responsibility, and it is up to her to take the first step of separating from the violent man.

Liberal humanist discourse also constitutes the women as subjects. As a subject, a woman is subjected to the practical consequences of what the discourse means (Weedon, 1987). Thus, through liberal humanist discourse, the women are seen as damaged, especially in relation to their autonomy, as in need of help, and as in need of the will and strength to act on their own behalf to restore their agency.

The use of liberal humanist discourse to construct women as agents also positions women within the discourse of recidivism. They are then seen to be choosing to return to an unsafe, damaging relationship, and therefore choosing to be damaged. Through this positioning it becomes possible for the doctors to condone or criticise the women's actions as choices. Thus, some of the doctors are able to account for their frustration, their lack of comprehension or sympathy, and their powerlessness to 'help', because they understand the woman as the one who has to choose to make changes. One doctor provides an account of how much 'easier' it would be for the doctor if the woman made and kept a promise not to choose to return to the relationship: if she would only decide to

act and consistently enact that decision. This account is enabled by the co-articulation of liberal humanist and recidivist discourse. When the woman is constituted as resisting or refusing to make a choice for, and to act for her own benefit by 'going back' to the place where she is damaged, then the damage becomes her responsibility, not her partner's.

A woman's choice to return to or remain in a violent relationship is made comprehensible or even rational through the co-articulation of liberal humanist discourse with discourses of love and commitment and a discourse of danger. Love and commitment are understood as imposing constraints on the woman's freedom to choose to leave. Danger is also constraining, even to the point where choosing to stay so as to avoid 'more damage,' becomes a rational choice, that is, the choice of a rational, unified subject.

Liberal humanist discourse is the dominant discourse constituting the meaning of subjectivity within Western societies (Weedon, 1987). The discourse constitutes women victimised by male partners paradoxically as lacking or impaired in some of the characteristics of a liberal humanist subject, and also as using those characteristics to decide and act. The dominance of the discourse means that any resolution of this paradox needs to preserve the agency of the woman so that her social status, as a subject, is not systematically undermined, while the effects of victimisation are taken into account.

As liberal humanist discourse constructs the woman who has been victimised, it also positions the doctor through a co-articulation with medical discourse. According to Foucault (1975; Gutting, 1989), modern medical discourse constructs the doctor as working for positive goals: not just the curing of illness or disease, but also the restoration of normality, and the organisation of help to achieve normality. The doctor is an 'expert' in judging the standards of an ideal, 'normal', physical state. In co-articulation with liberal humanist discourse the doctor is positioned as an arbiter of these standards of normality. These standards are met by the exercise of will, rationality, and choice to act to fulfil the ideal of the unified rational subject. From this position the doctor is able to 'judge' the decisions and actions of the woman as 'normal' or 'abnormal' and also judge and organise the help which will be provided for the woman in the work of restoring her to normality.

Medical discourse also co-articulates with psychological discourses realised in the doctors accounts of violence. These accounts variously 'locate' violence as a problem of the individual man, who is unable to control his emotions or exercises control over others; of the relationship, in which both parties contribute to creating dysfunction; or of the social system, which produces 'stresses and strains' which enable violence or

'normalise' violence. Psychological discourse and medical discourse are also co-articulated in the doctors' accounts of emotional and psychological abuse. Here an empirical discourse constructs a particular problem for doctors identifying victimisation where it leaves no traces observable to the medical gaze. The 'fact' of emotional or psychological abuse is difficult to establish without visible traces. An empirical discourse realises medical knowledge as progressive through the commitment to observation, objective in as much as it seeks the 'nature of the object' revealed through systematically observable data, and atheoretical in approaching the 'object' so as to enable the object to reveal itself (Foucault, 1983). Where empirical discourse appears at a site of co-articulation of psychological and medical discourse the problem of the 'invisibility' of emotions or 'psychological states' becomes a problem of the limits of the medical gaze.

The limits of the medical gaze are also problematic at the site where the detection of women's victimisation by male partners is constituted through the co-articulation of a discourse of discovery and a discourse of confession. Discovery discourse is realised in the doctors' talk about detection as a problem of identifying victimisation through 'clues' or 'signs and symptoms' which suggest an invisible underlying condition. Discovery discourse constitutes women who have been victimised as 'needing', 'wanting', or 'resisting' discovery of her victimisation. Confession discourse is realised in talk about disclosure of victimisation.

Discourse of discovery co-articulates with medical discourse at the site where the medical gaze enables clues, signs and symptoms to be 'read' in order to discover underlying conditions. Medical training teaches doctors how to 'look', and how to 'see' and 'read' the body (Duncan, 1997). The structure and specificity of the medical gaze exclude the possibility that it can be neutral or disinterested, and as agents of the gaze doctors are subject to medical discourse. Thus, as medical discourse is realised in the doctors' texts, the body is the object of the medical gaze. Visible signs of injury or symptoms of victimisation such as bruising, fractures and wounds may enable the doctor to suspect an 'underlying condition', however, where the 'underlying condition' cannot be located within the body - as with victimisation - it cannot be seen with the medical gaze; it is invisible. Medical discourse does not speak directly of violence as an underlying medical condition, so psychological discourses are realised in the doctors' constructions of violence as the 'condition' underlying signs and symptoms of victimisation. And since the medical gaze cannot 'see' this underlying condition, the confirmation of its 'discovery' depends on the confession of the victim. Where the signs and symptoms of the body do not 'speak' to the doctor, it is necessary for the woman to speak. Where the woman does not speak she becomes a particular kind of problem, for the clues and signs

and symptoms cannot confirm the underlying condition of victimisation. The inability of the medical gaze to 'see' the underlying condition, disturbs the process of judgement and organisation of assistance the doctor requires in order to restore 'normality.'

> And they are difficult people too, cause you can say "Now look, I'm worried about you and I'd like you to come back in the next week cause we've got so much to talk about," but you never see them sometimes, they are not very good at um (2) not very good at coming back and accepting help, whether they don't like men and I'm a male I, I don't know but they're hard people to try and help sometimes. ... Um (.) I think they find it hard to accept help from anyone, they are a rather special sort of difficult, not on purpose, just difficult people to help, I think
>
> (305-312, Dr J)

This section of text exemplifies a struggle for the doctor. The doctor is positioned as the one who has the rights, duties and obligations of care, but who is also constrained by the medical gaze to rely on the woman speaking so that care in the form of assistance can be rendered. If she chooses not to speak, which she is entitled to do according to her constitution as a liberal humanist subject, then she creates a problem for the doctor and therefore becomes 'difficult'.

Confession discourse enables the 'disclosure' of victimisation to be constituted as confirming suspicions or diagnosis of victimisation as the invisible underlying condition, and restores the doctor's ability to judge normality and organise assistance for recovery. At the same time as the woman discloses and authenticates the doctors' diagnosis she admits and confesses to victimisation: she takes up the position of victim. Confession requires the 'hidden' to be 'revealed' or a 'secret' to be told. Confession is the antithesis of silence.

In co-articulation with medical discourse confession discourse positions the woman in the place of the 'object' of the medical gaze. Foucault (1983) theorises the relationship between the 'knowing subject' and the 'known object' in medical discourse as a reciprocal positioning determined by the 'arrangement' of knowledge. This 'arrangement' is not a matter of progress made through empirical investigation, but of an epistemic assumption of the 'factuality' of observations made by the medical gaze: the 'known object' gives up its secrets to the knowing subject (Foucault, 1983). The medical gaze does not simply 'read' or 'interpret' 'reality' through visible signs. It is also a process of 'discovering the secrets of reality' through a particular form of training, a way of seeing that confers the status of 'knower' and holder of 'expert knowledge' on the medical practitioner. The reciprocal positions of 'knowing subject' and 'known object' in medical discourse merge with the reciprocal positions enabled through confession discourse at the site of their co-articulation. At the same time that medical

discourse positions the woman as object of the medical gaze, confession discourse positions her as the 'subject' of the statements she makes about herself and her victimisation. And as medical discourse positions the doctor as 'knowing subject,' and expert of the medical gaze, confession discourse simultaneously produces this 'subject' as an 'authority figure' who facilitates and judges the woman's confession. As the doctors' knowledge is authenticated by the woman's confession, so the woman's position as the subject of her confession is "guaranteed by the 'expert' enquiring voice" (Weedon, 1987, p.120). Confession discourse constitutes the relationship between doctor and woman patient as requiring 'trust', and 'confidence': the doctor, as confessor, needs to be sensitive and caring in relation to the woman so as to provide a nonthreatening environment in which the confession of an 'abnormality' can take place safely. Confession discourse also constitutes women who have been victimised as 'needing', 'wanting', or 'resisting' confession of their victimisation. The assumption of confession discourse is that the 'underlying condition,' or 'abnormality' is known to the woman who has been victimised as an 'abnormality' or a 'condition' needing to be confessed or discovered. This assumption is misplaced in those instances where women do not recognise their experience as victimisation, as feminist researchers have found in interviewing women about victimisation (Gavey, 1989; Kelly, 1988).

Confession has been identified as one of the technologies of discursive power constituting a form of 'individuality' which is self-policing (Barkty, 1990; Parker, 1989; Rose, 1990). The realisation of confession discourse within the doctors' talk about disclosure risks constituting women who have been victimised as failing to adequately 'police' their subjectivity where they do not recognise, and admit to, victimisation. Simultaneously, women whose talk of their experience is constituted as confession, realise victimisation as constitutive of their subjectivity - victimisation is not a matter of what happens to them but becomes some part of who they are, and more especially, 'a part' they are required to police. Thus the doctors' texts constitute women who have been victimised as 'in denial' or 'rationalising' where they do not confess to what the doctor suspects.

Each of the discourses realised in the doctors' texts entail subject positions to which the doctor is subjected. Liberal humanist discourse entails a position in which the doctor is 'another subject' whose rights, duties and obligations include the recognition and respect of others' rights. From this position the doctor is enabled to 'view' a woman victimised by her male partner as an agent, with rights to choose and the ability to act. The doctor is also able to respect the woman's 'privacy', and able to understand their own position as 'helping'. The doctor is constrained to attribute responsibility for victimisation, especially in the case of repeated incidents, to an agent where an agent is understood to

be an individual acting on the basis of rational choice. Thus, doctors understand repeated victimisation as either the woman irrationally choosing to be victimised, or as a rational choice based on love and commitment, or fear. They realise psychological discourses in providing accounts of the woman's 'irrational' choices. The doctors' fears of the possibility of threats or retaliation from their women patients violent partners may be understood through liberal humanist discourse as the effect of the ability to see themselves as 'another subject' whose rights are also able to be violated.

Medical discourse entails a position in which doctors are experts of the medical gaze. From this position the doctor is enabled to 'see' the woman's body as a site of signs and symptoms of abnormal or dysfunctional 'underlying conditions'. The doctor is also constrained to prioritise the treatment of medical conditions, to distinguish between medical and social 'underlying conditions', and to experience difficulties with 'detection' where the 'underlying conditions' remain invisible to the medical gaze. Thus, doctors understand a woman's victimisation by her male partner as a social problem for which she needs help. However, the doctor feels inadequate to give this assistance - even when victimisation is 'seen' for what it is - because they feel a lack of training and lack of knowledge about social problems. Doctors fears of the 'dreadful tangle' or 'can of worms' as effects of their involvement - either by asking inappropriately, or trying to help - may be understood through contradictions between the construction of domestic violence against women as a 'social' problem and their position as 'experts' with the skill and knowledge to 'fix' medical problems. Doctors realise discourses of discovery and a discourse of empiricism when they account for their experience of detection and their difficulties 'seeing' victimisation through the medical gaze.

Confession discourse entails a position in which doctors are authorities and judges charged with the right, duty and obligation to facilitate, hear and judge women's confessions of victimisation by their male partners. From this position the doctor is able to establish a caring and trusting relationship with the woman and make judgements about her experience. But the doctor's actions are also constrained by confession: the confessor hears, judges and absolves but does not act otherwise of their own volition. Thus doctors understand themselves as having 'difficulty helping', 'loss of sympathy for' and 'frustration with' women whose 'policing' of their victimisation is judged ineffective. They realise medical and psychological discourses by judging the woman's medical conditions and health, psychological well-being, choices and decisions as either normal or abnormal, functional or dysfunctional, rational or irrational.

The co-articulation of liberal humanist, medical and confession discourses position the doctors and constitute the 'problem' of detecting women's victimisation by male partners

in contradictory ways. Liberal humanist discourse constitutes the problem as a violation of the woman's rights, and positions the doctor as 'another subject' who should be supportive in the restoration of the woman's rights. Medical discourse constitutes the problem as a 'social problem' which is outside the view of the medical gaze, and positions the doctor as active in restoring health and repairing damage caused by the victimisation. Confession discourse constitutes the problem as a problem of the woman's subjectivity: a vulnerability to, or a responsibility for, victimisation. The position of the doctor is one in which appropriate action is judgement and absolution.

The contradictions of construction and positioning among these discourses are realised in the metanarratives which tell of the doctors' concerns regarding the problem of detection. These narratives tell of fears and worries, feelings of inadequacy and powerlessness, and lack of knowledge and training. They account for all but two of the empirically defined 'attitudes and responses' of doctors to domestic violence against women identified by Richardson and Feder (1996).[1] In these stories doctors constitute themselves through the discourses the stories realise. Their fears that dealing with domestic violence against women is time consuming, and their worry that detection is made more difficult by the lack of time available to them may be understood through contradictions between liberal humanist and medical discourse. Doctors are aware of the need for long term support as part of the responsibility of supporting someone whose rights have been violated. They are also aware that the structure of general practice is such that doctors cannot spend very long with each patient. In addition, they are required to give as immediate and rapidly effective care as possible.

Contradictions between medical discourse and liberal humanist discourse, and between medical discourse and confession discourse may be used to understand the doctors fears of offending the woman, and of threatening the doctor/patient relationship by asking about victimisation. Through medical discourse, doctors are entitled to ask questions to determine diagnoses and treatment. Through liberal humanist discourse subjects are entitled to 'privacy' and 'nondisclosure', and so are entitled not to be asked. The possibility of 'offence' is a result of the possibility that asking about victimisation may offer an inappropriate subject position to the woman - the position of 'victim', and of 'in a relationship with a victimiser' - a position which entails the violation of rights. Through confession discourse, the confessor has no right to ask questions, while medical discourse not only entitles but also requires the doctor to ask. 'Asking' to prompt disclosure, which is understood as confession, may then be understood by the doctor as a threat to the trust and confidence of a patient in a doctor.

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[1] The two exceptions are: close identifications with women victimised by their male partners, and lacking knowledge of appropriate community services.

The doctors' feelings of powerlessness to 'fix' the problem, and lack of control over the success of interventions may be understood through contradictions among all three discourses. Through medical discourse, doctors *qua* doctors, should have the power to 'fix' problems, and should be in control of treatment outcomes. Through liberal humanist discourse the problem of domestic violence against women is a problem of the violation of someone's rights; this is not a problem which medical discourse is equipped to 'fix.' Moreover, the woman's right to choose to return to or remain in the relationship is a fundamental right, so the doctor cannot intervene without her permission, and also cannot control intervention outcomes. Confession discourse also constrains the doctor's control of 'outcomes': a confessor may pass judgement but the rights, duties and obligations of a confessor do not include any acts other than pardoning and acceptance.

Medical discourse is dominant throughout the doctors' talk. The doctors' accounts of the reason for their discomforting fears, worries and concerns are constituted through medical discourse as a lack of knowledge. Through medical discourse a doctor who is afraid, worried or concerned is most likely to lack appropriate knowledge which would 'see', 'treat' or 'solve' the problem. According to this discourse, the 'problem of detection' would most likely be solved by extending the medical gaze to include examinations of social relationships or interventions into women's subjectivity. This extension or reformulation of the medical gaze would result in the further objectification of women.

As a result of this discourse analysis it seems unlikely that there is any 'knowledge', particularly any 'knowledge' of an 'object' which could be brought into the medical gaze, which would dispel the doctors discomforts, make detection 'easier,' or provide them with more control over 'outcomes'. This is because the discourses that are used to realise the problem of women's victimisation by male partners and the difficulty of detection by health professionals create contradictions which 'more knowledge' of the 'problem' will not resolve.

Nor is a resolution of the 'difficulty of detection' merely a matter of altering how doctors talk about the problem of women's victimisation by male partners. Altering talk does not change social power relations which are institutionally based and institutionalised (Weedon, 1987). Medical discourse includes various technologies and practices which support doctors' discursive positions. Liberal humanism includes ideological practices and the governance of social relations in education, work, medicine, law and other disciplinary institutions which also support doctors' discursive positions. Confession discourse is a technology of constituting subjectivity as subject to the judgement and

authority of an 'expert voice'. The institutions, technologies and histories which support the doctors positions as they speak of the problem of detecting women's victimisation by male partners also must also be challenged and changed if the 'problem' is to be addressed.

As a result of my analysis I have been thinking about what I would like to say to the doctors who participated. I feel I understand some of the difficulties of their positions better than I did when I began. Their concern and care for their women patients touched me. Simultaneously feeling really disturbed and sometimes angry at some of the things that the doctors said, especially about their women patients, I now have more of a understanding of the ambivalence that I felt. The analysis has helped me understand this ambivalence by giving me an account of the constraints of the discursive practices that doctors realise *as doctors*. I can now see how doctors can be both concerned and also say things that are hard to hear as a woman who might have been one of their patients.

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APPENDIX A

Letter sent to general practitioners

Massey University
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School of Psychology
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5673

Amy Aldridge BA(Soc Sci & Hum)
286 Tremaine Ave
Palmerston North
Telephone: 353 6826

Dear

I am a student at Massey University doing a thesis towards gaining the qualification of Master of Arts in Health Psychology. I am interested in the increase in profile of domestic violence, and how doctors are dealing with this issue in their general practice. Please find enclosed an information sheet with further details about this study.

I will be conducting interviews with doctors in the Palmerston North area. If you would be willing to contribute your time - about 20-40 minutes - I would be happy to hear from you.

I can be contacted at the home address or phone number above. Please feel free to contact me with any questions you may have, whether you decide to be interviewed or not.

Yours faithfully

Amy Aldridge

APPENDIX B

Information Sheet

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Psychology
Private Bag 11 222,
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New Zealand
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Health Professionals Dealing With Domestic Violence Study

Information Sheet

What is this study about?
In the last decade there has been a lot more public attention and debate regarding domestic violence. As part of a larger project I am interested in how professionals on the front line are dealing with this increase in attention. I would like to talk to you about how you have dealt with this issue and how things may have changed for you in your practice. This research project is being carried out by Amy Aldridge, a student doing a Masters degree in Health Psychology through Massey University.

What would you have to do?
You are invited to participate in this study, and if you decide to do so, you would take part in an interview with the researcher that would take around 20-40 minutes of your time. The time and place of the interview would be at your discretion. In the interview I would like to ask you some questions about your experience of identifying and treating patients who have been victims of abuse. I would also like to cover issues such as the increase in attention to domestic violence, whether you received any specific training in how to deal with domestic violence with respect to your patients, what you look for when you suspect abuse. The interview would be tape recorded, and transcribed.

What can you expect from the researcher?
If you take part in the study, you have the right to:

-decline to answer any particular question, and to withdraw from the study at any particular time.
-request that the tape recorder recording your interview be switched off at any time.
-ask any questions about the study that occur to you before or during your participation.
-provide information and ideas on the understanding that the utmost will be done to maintain confidentiality. All records are identified only be codenames. It will not be possible to identify you from any reports that are prepared from this study. Where interviews are transcribed by someone other than the researcher, the transcriber will sign a confidentiality agreement.
-be given a summary of the findings from the study when it is concluded.
-respond to the findings orally or in writing and have your responses taken into account.

You are welcome to contact me with any further enquiries you might have. I can be reached by telephone on 353 6826. My supervisor is Dr Mandy Morgan, and she can be contacted on 350 5799, extension 2063.

Amy Aldridge

APPENDIX C

Schedule of questions

When did you graduate from medical school?

Did you receive any training there regarding domestic violence against women?

Have you ever detected domestic violence as an issue for a patient?
What do you do if you detect?

Have you ever suspected domestic violence was an issue for a patient?
What do you do if you suspect?

What indicates to you that domestic violence is or may be an issue for a patient?

Has a patient ever disclosed that domestic violence was an issue for them?

Have you ever asked a patient about domestic violence?

Are there any characteristics of the patient which make it easier or more difficult to ask?

What prompts you to ask a patient about domestic violence?

What is your purpose in asking a patient about domestic violence?
Medical reasons
Legal/criminal reasons
Referral reasons
Other reasons

Do you refer patients?
Who to?
Refuge
Police
Rape Crisis
Counselling

Is there anything I have not asked you about that you would like to discuss?

APPENDIX E

Consent Form
Health Professionals Dealing With Domestic Violence Study

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I can request that the tape recorder recording my interview be turned off at any point during the interview. I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions. I agree to participate in this interview on the understanding that it is completely confidential.

I wish to participate in this study under the conditions set out on the information sheet.

Signed: .....

Name: .....

Date: .....

Researcher: .....

APPENDIX D

Transcription notation

(indecipherable)	indicates this speech was indecipherable
(inaudible)	indicates this speech was inaudible
(laughs)	indicates speaker laughs
(sighs)	indicates speaker sighs
(.)	indicates a pause of less than one second
(3)	indicates a pause in speech, and the length of pause, in this case a pause of three seconds
I was <u>cross</u>	underlined words indicate speech was emphasised
I was CROSS	words in capitals indicate they were spoken louder than the surrounding speech
=	used at the end of an utterance indicates one speaker was interuppted by another and points at which both speakers were talking
...	indicates that material has been omitted from the transcript
[text]	indicates that this is not the participant's speech. Text within these brackets are either the interviewer's speech or an explanatory note
(23-78)	numbers within a bracket indicate the lines excerts from doctors' transcripts come from