

**Conspicuous invisibility: A grounded
theory approach to exploring the discovery
and disclosure of violence against women
attending general practice**

A thesis presented to for the award of PhD

Dublin City University

Rita Lawlor

January 2014

Title page

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discovery and disclosure of violence against women attending general
practice**

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A thesis presented for the award of PhD

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Submitted: January 2014

Volumes submitted: 1

Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of PhD is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Date: 22nd January 2014

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No research about people is possible without willing participants. I am indebted to the 30 participants who took part in this study. Sincere thanks to them for giving up their time, for being supportive of the research and sharing their experiences. A special thank you to the women who shared their stories so openly. Without their input, this study would not have been possible.

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List of Abbreviations

BCS = British Crime Survey

CHAT = Case-finding and Help Assessment Tool

CTS = Conflict Tactic Scale

DCU = Dublin City University

DOHC = Department of Health and Children

EIGE =European Institute for Gender Equality

EU = European Union

GP = General Practitioner

GPs = General Practitioners

HARK scale = Humiliation, Afraid, Rape, Kick

HITS scale = Hurt, Insult, Threaten, Scream

ICGP = Irish College of General Practitioners

PN = practice nurse

PNs = practice nurses

SAVI = Sexual Abuse and Violence in Ireland

WAVE = Women Against Violence in Europe

WEAVE = Women's Evaluation of Abuse and Violence Care

WHO = World Health Organization

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Appendix Two = HITS Screening Tool

Appendix Three = HARK Screening Tool

Appendix Four = CHAT - Case-finding and Help Assessment Tool

Appendix Five = Recruitment letter for health professionals

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ABSTRACT

Conspicuous invisibility: A grounded theory approach to exploring the discovery and disclosure of violence against women attending general practice

Rita Lawlor

Background: Violence against women is recognised as a common problem worldwide. In Ireland, 1:5 women experience emotional, sexual, physical, or financial violence from an intimate partner (Kelleher and O Connor 1995). However, little was known of how health professionals identify the issues, or how women make known their circumstances of domestic violence during general practice consultations.

Aim: The aim of the study was twofold: a) to determine how the general practice team (GPT), discovered women who experience domestic violence from an intimate partner and, b) to determine how women were enabled (or not) to disclose their experiences of domestic violence when attending the clinical consultation.

Participants and setting: Participants of the GPT included general practitioners, practice nurses and administrative staff working in urban general practices in the Republic of Ireland. All of the women participants had experienced intimate partner violence and had disclosed their experiences to others, but not always to the general practice team.

Methodology: Using a grounded theory approach, 30 in-depth interviews were conducted with the GPT and women. Data were analysed in accordance with grounded theory methodology. Health professionals' clinical experiences of discovering (or not) violence against women and women's experiences of living in abusive relationships informed the data.

Findings: The dynamics of general practice consultations were influenced by organisational factors and factors concerning the person: Firstly, *choreographing the consultation* in which the performance of engagement was explored through the iterative process of a choreography. Secondly, *spiralling silences* gave voice to the process of engagement (or not) with the issue of violence against women during clinical consultations. Thirdly, *compartmentalising* identified organisational factors in general practice that hindered, or enhanced, the discovery and disclosure of violence against women.

Conclusion: This study advances a theory of conspicuous invisibility, which illuminates our understanding of women's circumstances of disclosure and health professionals' process of discovery of domestic violence. Underpinning the theory is a process of engagement, conceptualised as *lifting the stones and seeing the slugs beneath*. The model of engagement identified in this research illustrates three levels: level one, non-engagement; level two, first impression engagement or 'on the face of it' engagement; and level three, purposeful engagement.

Chapter One: An overview of the thesis

1.0 Introduction

This chapter is set out in three sections. The first section sets the scene for the study with an excerpt from a modern day novel about a woman experiencing domestic violence. In the excerpt from *The Woman Who Walked into Doors* (Doyle 1996) Paula Spencer, the main character is attending a doctor for treatment following a physical beating from her husband. These passages from the novel are chosen for three reasons. Firstly, it depicts an instance of domestic violence between intimate partners; secondly, the woman involved is attending a medical clinic for assistance where there is an opportunity for the doctor to discover the violence Paula is experiencing; and thirdly, Paula is waiting to disclose the recent abusive experience if the doctor makes enquiries. In the second section, I give an overview of my experience as a nurse, my professional journey that led me to the research subject of violence against women and a background to the study. This overview is followed by a summary of general practice as an organisation, which contextualises the study. The aim of the study is outlined and the roles of the participants are identified. The third section gives an overview of each chapter of the thesis.

1.1 Setting the scene

Paula Spencer is engaged in a conversation with herself:

The doctor never looked at me. He studied parts of me but he never looked at my eyes. He never looked at me when he spoke. He never saw me. Drink, he said to himself. I could see his nose twitching, taking in the smell, deciding. None of the doctors looked at me

Ask me. In the hospital.

Please, ask me.

In the clinic.

In the church.

Ask me, ask me, ask me. Broken nose, loose teeth, cracked ribs. Ask me.

(Doyle 1996)

The above excerpts from Roddy Doyle's Irish novel entitled *The Woman Who Walked into Doors* are used to set the scene for the current study which aims to explore the social process, or the course of action, of the disclosure and discovery of violence against women, particularly within a general practice setting. The excerpts demonstrate two silent narratives that Paula Spencer (the main character in the novel) is having with herself while being examined by the doctor following another domestic beating from her husband. In the first passage the doctor is examining Paula but does not discover, during the consultation, that there is a history of domestic violence which is masked by the presenting symptom of alcohol. The second conversation shows Paula still talking to herself, while internally pleading with the doctor (in the clinic) and silently begging with anyone who will listen (for example, in the church) to be asked about the abuse that she is experiencing. If she is asked about how she sustained her physical injuries, of which there are many, she is ready to disclose her abusive encounters. However, she is not asked. Again she takes her secret home with her and continues her life of silence.

1.2 Background to the study

When working in a general practice setting¹ relationships are built up with families and communities over a long period of time which differs from other health care settings where

¹ In Ireland, the general practice setting is the context where GPs and practice nurses deliver care for families and individuals of all ages. This clinical environment is situated within the community. In the USA, health professionals known as family physicians and office nurses provide a similar service.

patients attend a specific department for a short period until their specialist needs are resolved, for example, a diabetic or gynaecology clinic, or accident and emergency department. During the years I worked as a practice nurse I developed a special rapport with the patients and families that I cared for, especially those I saw regularly. I was the first practice nurse to be employed in both the surgery and the locality, so there was a period of adjustment for the patients, the medical and the administrative staff. All were unsure about the role of the practice nurse. The title 'practice nurse' is also misleading. Some patients initially thought I was just 'practising' and were reluctant, or fearful, to attend a nurse whom they thought was "just learning". Up to that point, they attended the general practitioners for all their health needs and did not understand that a nurse could also provide competent care within a general practice setting. It takes time to build up trust and affinity in such a healthcare setting, where people return regularly to the same health professional over a long period of time. Very quickly, I built up my own caseload and saw patients every 10 minutes just like the general practitioners². One day 'out of the blue' a woman who attended me every fortnight for repeat nursing procedures³ disclosed to me the details of her daily life of abuse. Her exterior confidence bore no hallmark to the inner sadness she carried⁴. As a health professional, I had no idea of her history of domestic violence and would not have discovered her situation without her voluntary disclosure. This was the first time she disclosed her

² The average duration of a non-emergency consultation for both general practitioners and practice nurses in general practice is 10 minutes long (see also Mc Kie, Fennell and Mildrof 2002).

³ Repeated nursing procedures in this instance refer to repeat blood pressure monitoring, injections, venepuncture (blood tests), or wound management. For nurses it means recognising the importance of nursing work, knowing that nurses can and do act on clinical knowledge and exercise their clinical judgment (Buresh and Gordon 2000).

⁴ Goffman (1959) described how individuals present a "front" of themselves in the everyday world in order to show a particular side of the self. The "front" or "wearing a mask", which the performer presents to the audience, is also suitable for other different routines such as accentuating certain facts or concealing others and exerting sufficient self-control (Goffman 1959). It is important to acknowledge that from a patient's perspective, health professionals are viewed as the performers and may be putting on a front also.

situation to anyone. She was not seeking help nor did she want her circumstances recorded, which Barry et al. (2000) describes as patient's unvoiced agendas⁵ within the general practice consultation. What she stated were the facts of her life, her normality. I wondered how many other people I saw, while failing to discover the signs, the nuances, or the clues they may have given within the 10 minute window of a clinical consultation. The situation of this woman had a profound impact on me as a nurse who was attempting to provide holistic⁶ healthcare. However, I realised, then, that the provision of holistic care needs to take cognizance of the circumstance of the patient as well as the desire of the health professional. In other words, the care provided by health professionals is often determined by the facts presented by the patient, regardless of how long the patient may be attending the service, or how well the health professional may think he/she knows the patient.

Later, in my career as a practice nurse, I was invited to join a steering committee by the Irish College of General Practitioners to represent practice nursing in the development of a domestic violence guideline for general practitioners and practice nurses (Kenny and Riain 2008). Apart from the incident outlined above, I never knowingly encountered anyone in general practice that had experienced domestic violence, nor did I ever see it recorded in medical records, or discuss the topic with the general practitioners of the surgery. The subject of domestic violence did not form part of the nursing clinical consultation.

⁵ The most common unvoiced agendas in general practice consultations relate to issues regarding information of a social context (Barry et al. 2000). This will be explored further in the section on disclosure and the notion of the invisibility of domestic violence.

⁶ The notion of a holistic view of health includes different dimensions of health, including, physical, mental, emotional, social, spiritual and societal health, and all of which are interrelated and interdependent (Ewles and Simnett 2003).

At a policy level the Department of Health and Children advocates for measures to support victims of domestic violence. However, twelve years from the publication of the *Quality and Fairness Health Strategy* (Department of Health and Children 2001a) there is still a dearth of research concerning the phenomena within general practice. There are no studies that simultaneously explore the experience of the general practice team⁷, as service providers, and women who encounter intimate partner violence, and their experience of attending general practice, within an Irish context. One Irish study, Bradley et al. (2002) interviewed female patients and general practitioners only. Likewise, a study by Paul, Smith and Long (2006) focused on both male and female patients and one discipline of health professionals, general practitioners. The absence of engagement with other members of the general practice team – practice nurses and practice administrators – is a limitation of both of these studies. Both studies are further critiqued in the literature review.

In summary, my clinical experience, my knowledge of the general practice system, and the absence of research evidence in relation to the discovery and disclosure of domestic violence within the general practice consultation stimulated my interest in this study. I believed there was a need to explore theoretically, from both the health professionals' and woman's perspective, how the process of violence against women is discovered by health professionals and how disclosure is enabled.

1.3 Aim of the study

The aim of this study was to gain a deep understanding of the discovery and disclosure of domestic violence within a general practice setting, regardless of the format of violence (physical, psychological, sexual, financial and emotional) experienced. Specifically, the

⁷ For the purpose of this study, the general practice team is defined as general practitioners, practice nurses and general practice administrators.

research explored women's experience of disclosing (or not) domestic violence within general practice; it also explored the social process of discovering domestic violence by the general practice team. For the purpose of this study, the definition of the disclosure and discovery of domestic violence by Liebschutz et al. (2008) is outlined. When the topic of domestic violence is voluntarily spoken about, or conversation is initiated by the participants [women], it is termed 'disclosed' (Ibid). Domestic violence is labelled as 'discovered' when, in the course of a clinical consultation, it becomes apparent that violence exists, and when the patient has not made an explicit disclosure of an abusive relationship (Ibid). While the literature acknowledges that abuse is not a single gender issue (Paul, Smith and Long 2006), this study was concerned with violence against women and the discovery and the disclosure of their experiences within general practice, for two reasons. Firstly, in Ireland, more women than men attend⁸ general practice (Thomas and Layte 2009) and secondly, statistically greater numbers of women experience abuse from intimate partners (Watson and Parsons 2005). The study also explored how general practice administrative staff, when conducting their administrative role, discovered (or not) women who experienced domestic violence.

1.4 Overview of General Practice

The area where the research was conducted is general practice. General practice is a multidisciplinary specialty of community health within primary care⁹, where general

⁸ During the period 1995-2001 the average number of GP visits was higher for women than men between the ages of 16 and 80 years (Thomas and Layte 2009).

⁹ Primary Care is an approach to health care where first-level contact services are provided, that are fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being. *Primary Care – a New Direction* (Department of Health and Children 2001).

practitioners¹⁰ and practice nurses¹¹ provide for the physical, mental and social healthcare needs for all ages of the population. According to the *Primary Care Strategy*, DOHC, (2001), primary care is defined as the first point of contact for health interventions. General practitioners (GPs) and practice nurses (PNs) are key providers of community health within the general practice setting. Both disciplines care for the same cohort of patients and frequently look after the needs of entire families. In Ireland, the majority of non-urgent health interventions and decisions commence in general practice. Screening for disease, to assess, diagnose, treat and rehabilitate, are commonplace in general practice settings (Department of Health and Children 2001; 2001a). Currently, screening for domestic violence does not form part of the routine general practice consultation. Hence, it may be difficult for patients to broach the subject or for health professionals to enquire if domestic violence is an issue. The principal actors of the organisation of general practice are medical, nursing and administrative staff and patients. The following sections provide an outline of each of the principal actors of the study, within the context of general practice, and their relevance to the research.

1.4.1 General practitioners

Within a given surgery there may be several general practitioners practising and managing their consultations. Each consultation is allocated a time frame of 10 minutes. There is usually one principal GP and an assistant, or assistants. The views of general practitioners are relevant to the study as they are usually familiar with most of the patients and families who

¹⁰ General practitioners are self-employed family physicians. Depending on the number of state funded public general medical services (GMS) patients they have, they may receive a subsidy towards the recruitment of a practice nurse from the Health Service Executive

¹¹ Practice nurses are privately employed by general practitioners to provide a nursing service to the patient population of an individual surgery.

attend the practice. They make clinical decisions based on physical examination, history taking and observation which can illuminate how the discovery and disclosure of domestic violence within general practice occurs.

1.4.2 Practice nurses

Like general practitioners, practice nurses manage a patient caseload and see patients on average every 10 minutes. Practice nurses can inform the study about nurses' experiences of the social process of the discovery and the disclosure of domestic violence within general practice, through a nursing gaze. Their input is relevant as they are viewed as part of the multi-disciplinary team caring for the same cohort of patients. However, nurses may not have the same autonomy to make clinical decisions as general practitioners. Nonetheless, they build relationships with patients and families, and provide care for all populations. Currently, there is a dearth of literature which includes both practice nurses and general practitioners in the same studies on violence against women.

1.4.3 Administrative staff

When patients require a consultation with a general practitioner or a practice nurse, they usually telephone the practice beforehand, or they will call to the surgery to arrange the visit for an agreed time. This process is generally managed by the administrative staff in the practice who are an integral part of the general practice team. Although administrative staff do not have clinical responsibility, they are frequently the first person that the patient meets or speaks to over the phone when communicating with the practice. They also have a role in prioritising the appointment system for the clinical staff in the surgery and may delegate patients to specific health professionals. This may occur if one clinician's consulting time is fully booked or there is a request by the patient to be seen by a specific male/female general

practitioner or practice nurse. Furthermore, administrative staff keep records of those who attend the practice on a frequent, regular or seldom basis. Evidence from the literature indicated that those who experience domestic violence attend general practice on several occasions before the issue is discussed (Landenburger 1989). The World Health Organization recognised that health administrators may be able to give visibility to domestic violence by gathering data and fostering inter-agency contacts to develop a range of responses to the needs of abused women (World Health Organisation. 1997). Thus, because of their role and function within general practice it was deemed appropriate to include administrative staff as participants in this study.

1.4.4 Women participants

No health service functions without service users, namely patients. The voices of women must be heard in order to illuminate our understanding of the social process of their experience of disclosing (or not) domestic violence within general practice. Evidence from the literature suggests that incidents of domestic violence are generally not a once off event but occur repeatedly (Watson and Parsons 2005; Kelleher and O Connor 1995). However, despite women being the most frequent users of general practice services, little is known of the experience of those in abusive intimate relationships accessing the health service that is described in the *Primary Care Strategy* as the “first point of contact” (Department of Health and Children 2001:15).

1.5 Chapter outline and structure of the thesis

Chapter 2 explores the definitions and terms, used in the literature, relating to violence against women. The prevalence of domestic violence and a review of empirical national and international literature on issues are provided. The literature concerning the discovery and

disclosure of violence against women is discussed, with reference to screening and case finding. A brief overview of the literature on patriarchy is included.

Chapter 3 gives an overview of the methodological issues. A grounded theory research methodology was used in this study. Several versions of grounded theory are discussed, including the variations between each, before making a case for the chosen version employed in this study. The key characteristics of grounded theory methodology are outlined including coding, constant comparative analysis and memoing.

Chapter 4 records the practical issues of conducting research including, gaining access to the research site, details of data collection, fieldwork and the analysis procedure. In addition, I provide an overview of my personal experience of doing grounded theory as a researcher. Chapter 5 presents a prologue to the findings chapter. This chapter introduces a recurring theme of *lifting the stones and seeing the slugs beneath* which weaves throughout the study. It sets the scene for the findings chapters by describing participants process of engaging with the discovery and disclosure of violence against women.

Chapters 6, 7 and 8 present the findings of the study. Each chapter is grounded in the voice of the participants to illuminate particular patterns that emerged in the data. In each chapter diagrammatic representations of the core categories and sub-categories are provided. Chapter 6 discusses how participants perform within a clinical consultation using the analogy of a choreograph. Chapter 7 discusses participants' concerns of speaking about the issue of violence against women through the core category spiralling silences. Chapter 8 focuses on the structure of general practice and how it influences the discovery and disclosure (or not) of violence against women.

Chapter 9 has two main functions. Firstly, it distils the research findings and presents a middle range theory of conspicuous invisibility Secondly, a model of the levels of

engagement, relevant to the findings of this study and which underpins the theory, is presented. This chapter critically engages with the literature relevant to the current findings.

Chapter 10 presents an evaluation of the research, the implications for practice, the limitations of the study and recommendations for future research. This chapter concludes the study.

Chapter Two: Literature review

2.0 Introduction

The literature review¹² informs the present study by outlining and defining violence against women and identifying gaps that are present in the national and international literature on the topic. Various terminologies for violence against women are discussed in order to provide an understanding of the phenomenon. The literature on gender and patriarchy is reviewed as an underpinning theoretical framework to inform this study. Studies that are specific to the general practice setting, and explore women's experience of domestic violence, are discussed to provide context for this research.

2.1 The literature review in grounded theory studies

Literature searches are seen as open-ended iterative processes, where the research question of interest is honed, over time, as the nature of the evidence becomes more apparent (Finfgeld-Connett and Johnson 2013). For those employing grounded theory methodologies, the decision with regards when to engage with existing literature is often problematic (Dunne 2010). According to Cutcliffe (2000), by avoiding a literature review at the beginning of the study, it is more likely that the emergent theory will be grounded in the data. Nonetheless, a number of studies were reviewed prior to undertaking this study. The literature was reviewed pre-, intra and post-entry to the field (McCreddie et al. 2010). The rationale was twofold.

¹² Several electronic databases including the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Pub Med and the Cochrane Library were searched using keywords such as violence, domestic violence, intimate partner violence, abuse, marital abuse, spousal abuse or disharmony, battering and sexual abuse. Other sources included textbooks, national and international government publications, published and unpublished theses. The reference lists of journal articles were examined for relevant articles and preference was given to those related to general practice, community, family physician, office nurse or primary care setting. Personal communication with researchers in the area of violence against women also took place.

Firstly, it was to inform the researcher on the justification for the study and secondly; a literature review was a necessary element of the application for ethical approval.

2.2 Defining violence

Defining and conceptualising violence is often contested in debates within power, the state, culture and symbols (Walby 2013:96). Alternatively, violence has been analysed as a distinctive phenomenon, as a non-reducible form of power, a form of practice, a set of social institutions, and with its own rhythm, dynamics and practices (Ibid). The complexity of communicating and defining violence is influenced by the interpretation of the issue (y Garcia et al. 2012). The literature acknowledges a distinction between those experiencing severe abuse (a pattern of behaviour that has significant impact) and those experiencing minor incidents that have little impact (Watson and Parsons 2005). Severe domestic abuse is defined as:

A pattern of physical, emotional or sexual behaviour between partners in an intimate relationship that causes, or risks causing, significant negative consequences for the person affected (Watson and Parson 2005:23).

The World Health Organization (WHO) broadened the definition of violence to include that which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation (Dahlberg and Krug 2002). In the case of domestic violence specifically, articulating a definition is complex as there is no clear, universally agreed term to summarise the notion of violence. The term violence conjures up images of physical abuse as outlined in the literature, for example women battering (Naumann et al. 1999), or battering syndrome (McCauley et al. 1995) describes when abuse occurs repeatedly in the same relationship (Heise and Garcia-Moreno 2002). Richardson et al. (2002) suggested that some investigators focus on physical violence alone, whereas others (Al-Busaidi 2010; Thistlethwaite 2009) included a broader range of abusive behaviours, such as emotional and

non-physical abuse. Given that domestic violence is described as a vague term (Corbally 2001), women experiencing violence in intimate relationships often recognise violence by the array of behaviours involved, for example economical, threatening and verbal abuse (Hearn 2013). Defining domestic violence depends upon the notion of harm experienced by the violated person(s) (Hearn 2013). However, Hearn (2013) argued that the possible paradox of violence and intimacy in the *phenomenon* [original italics] creates a tension in defining domestic violence. A review of the literature indicated that the term domestic abuse is used to describe physical, sexual, verbal or emotional abuse of a person with whom there is a close or intimate adult relationship (Health Service Executive 2010; Women's Health Council 2007; Watson and Parsons 2005; McGee et al. 2002; Oifig an Tánaiste 1997), or dating abuse (Rodríguez-Franco et al. 2012; Kimberg 2001) to address teen or violence affecting young persons. Watson and Parson's (2005) preference for using the broader term domestic abuse, because it is less associated with physical violence only, emphasises that domestic violence may be too narrow a term to use to capture the nuances of abuse. In addition, various types of abuse, generally, co-exist in the same relationship (Heise and Garcia-Moreno 2002; Corbally 2001). Family violence is also used to describe the recurrent theme or cycle of violence within families, between partners and with children (Lutenbacher, Cohen and Conner 2004).

A guideline for general practitioners and practice nurses developed by the Irish College of General Practitioners (ICGP) entitled '*Domestic Violence – A guide for general practice*' uses the term domestic violence throughout the document (Kenny and Riain 2008). This is in keeping with the language that is familiar in Ireland, and is used by health professionals and patients to describe the phenomenon, where the phrase 'domestic violence' is used as a generic term to encompass all forms of abuse. Throughout this study the terms domestic

violence, domestic abuse, intimate partner¹³ violence, gender based violence, or emotional abuse are used interchangeably, reflecting their varied use in the literature.

2.3 The prevalence of violence against women

The WHO acknowledges that various factors influence the prevalence of violence against women, including the definition of violence and abuse, variations in sources of data, methodological variations and willingness of respondents to speak about their experiences of violence (Krug et al. 2002). Violence against women is recognised as a worldwide phenomenon. Evidence from a multi-country study (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania) found that between 15% and 71% of women, aged 15-49 years, who had an intimate partner, reported physical or sexual violence, or both, at some point in their lives (Garcia-Moreno et al. 2006). The wide variability of the levels of violence was explained by the cultural differences in what are “acceptable means for husbands to control or chastise their wives” (Garcia-Moreno et al. 2006). In the United Kingdom, the British Crime Survey (BCS) provided a detailed assessment of intimate partner violence (male and female) through a large national victimisation survey in England and Wales (Khalifeh et al. 2013). In 2010/2011, the BCS self-completion survey identified that 7% (1.2 million) women experienced domestic abuse, which included emotional, financial, sexual or physical abuse. Non-physical (such as emotional and financial) abuse was the most common form (57%) experiences by women. The report stated that 28% of victims received medical attention. The majority (82%) of those who did so, obtained care from a GP or at a surgery (Smith and Britain 2012). Furthermore, and which has relevance to this study, it did not indicate how many respondents disclosed abuse to the GPs, or how they sustained their injuries.

¹³ Intimate partners include husbands and wives, cohabittees and boyfriend/girlfriend (Watson and Parsons 2005).

In 1995, Ireland signed the Beijing Declaration Platform for Action which *inter alia* highlights violence against women as a key concern of its work on gender and equality. Obtaining data on the international prevalence of violence against women is complex, especially when there is no agreed method for gathering data on the phenomenon. Nevertheless, in 2012, the European Institute for Gender Equality (EIGE) compiled a study conducted by WAVE (Women Against Violence in Europe). It presented an overview of the prevalence of violence against women following the implementation of the Declaration of the Beijing Platform for the 27 European Union (EU) member states and Croatia. However, compiling comparable data across the EU, for example, is problematic, due to methodological limitations and differences in styles of questioning. Furthermore, in the WAVE study, not all countries conducted prevalence surveys on violence against women between 2000 – 2011. Based on the information that is available, across the 27 EU members and Croatia, the findings for lifetime experiences indicated that the percentage of women who experienced physical violence from their partner ranged from 4% (Estonia) to 37% (Greece). Most studies presented rates of physical intimate partner violence between 12% and 35% (European Institute for Gender Equality, 2012).

2.3.1 The prevalence of violence against women – an overview of the Irish and international literature

Within an Irish context, the research document *Making the links* (Kelleher and O Connor 1995), written for Women's Aid¹⁴ provided the first systematic data on violence against women in the Republic of Ireland. It reported a national survey which was conducted in conjunction with the Economic and Social Research Institute (ESRI). A random sample of 1483 women was selected. A total of 679 (46%) questionnaires were returned. Of the 679

¹⁴ Women's Aid is a national organisation that is working to stop domestic violence against women and children since 1974.

women surveyed, 575 (85%) (p 11) had been in an intimate relationship and 101(18%) had been subjected to some form of violence (p15). The findings illustrated that 1:5 women had been abused by a current or former partner. Where women reported domestic violence, 29% reported to the GP, 37% to relatives and 50% to friends (Ibid). There was no mention of reporting to nurses, although practice nursing was in its infancy at the time.

In 2002, the Sexual Abuse and Violence Ireland (SAVI) report was published (McGee et al. 2002). Over 3000 men and women were interviewed as part of a national survey to estimate the prevalence of various form of sexual violence in Ireland. Participants were randomly selected from the general population. More than 40% of women reported some form of sexual abuse or assault that occurred in their lifetime. Almost one quarter (23.6%) of the perpetrators of sexual violence were intimate partners or ex-partners. Patterns of disclosure included interaction with professionals, for example, Gardai, counsellors and therapists. Most respondents (85%) felt that they would only disclose to a doctor if they deemed it to be medically necessary, or if the doctor asked them about sexual violence.

A more recent national survey, *Domestic Abuse of Women and Men in Ireland*, by Watson and Parsons (2005), in conjunction with the Economic and Social Research Institute (ESRI), found that 15 % of women (about one in seven) and 6% of men (one in 16) have experienced severe abusive behaviour of a physical, sexual or emotional nature from a partner. Using a telephone survey methodology, the results showed that in the region of 213,000 women and 88,000 men in Ireland have experienced severe abuse by a partner at some stage in their lives. Domestic violence was a more prevalent experience for women and the injuries sustained by women, in comparison with men, were generally more physical in nature. According to Women's Aid female homicide media watch, 191 women have been murdered since 1996 in the Republic of Ireland; 117 (61%) of the women were murdered in their own home (Women's Aid 2013). Approximately, one woman a month is murdered in Ireland (Ibid),

which correlates with New Zealand figures where 12 women a year are murdered by an intimate partner (Clark 2003) which has a similar population size to Ireland. On average, an intimate partner will assault a woman or ex-partner 35 times before help from the police in addressing the violence is sought (Paul, Smith and Long 2006; Yearnshire 1997).

Research studies, specific to general practice, identified the number of women attending the service that have experienced abuse. Findings from an Irish study conducted by Bradley et al. (2002) found that 39% of women attending general practice had experienced domestic violence from an intimate partner. The study does not indicate if the women had disclosed their experiences of domestic violence to general practice health professionals prior to participating in the study. Using a cross sectional survey Bradley et al. (2002) interviewed 1871 women attending 22 urban and rural general practices with a total of 49 participating GPs. A number of the participating surgeries had practice nurses employed but they were not included in the study, despite caring for the same cohort of patients as general practitioners. The results correlate with other international studies that focus on women and domestic violence. For example, a questionnaire administered to 1207 consecutive female patients in 13 general practices in London reported 41% of women had experienced physical abuse (Richardson et al. 2002). Likewise, findings from a study conducted in South Carolina, sample size (n=657), reported that 37% of the women attendees, who had a current intimate partner, encountered domestic violence (Coker et al. 2002). None of the above studies indicated if domestic violence was discovered by the general practice or if the female participants had disclosed their experiences of abuse prior to taking part in the studies¹⁵. Each of the studies mentioned from a national and international perspective identified that over one third of women attending general practice for health care have experienced domestic violence (Coker et al. 2007; Bradley et al. 2002; Richardson et al. 2002). Given the complexities of

¹⁵ The issue of discovery is explored in Section 2.5.

discovering and disclosing domestic violence, it cannot be assumed that domestic violence was not an issue for all the remaining two thirds of women. Coker et al. (2007) and Richardson et al. (2002) argued that clinicians often do not identify women experiencing domestic violence, and the success of general practitioners discovering cases of domestic violence has not been investigated.

Despite domestic violence being accepted as a widespread problem, evidence within the literature indicated that details of the presentation of the phenomenon within the area of general practice, is under researched (Hegarty et al.2010; Richardson et al. 2002; Richardson and Feder 1996). In a Swiss general practice study Morier-Genoud et al. (2006) identified that out of a total of 366 patients interviewed, 36 (9.8%) experienced domestic violence. However, the physicians only discovered four patients as encountering violence and cited their own lack of awareness and understanding that their patients were exposed to violence as the main reason for the low suspicion and detection rate. Using a cross sectional survey, Rodriguez et al. (1999) found that primary care physicians¹⁶ in the USA (n=582), failed to note the presenting symptoms of domestic violence. Findings from their study indicated a lack of training (39%), lack of time (37%), lack of resources and referrals (30%) and a sense of inefficacy (18%) as common barriers to the discovery (or identification) of women patients who were experiencing domestic violence (Ibid).

Other evidence indicated that primary care physicians under estimate the prevalence of domestic violence and community violence (Hegarty et al. 2012; Morier-Genoud et al. 2006), or do not consider intimate partner violence when assessing lifestyle issues (Hegarty et al. 2012). Furthermore, primary care physicians fail to document or under record the number of incidents and narratives of domestic violence in medical records (Coker et al. 2007;

¹⁶ The primary care physicians were practicing in family medicine, general medicine and obstetrics/gynaecology (Rodriguez 1999).

Hathaway, Willis & Zimmer 2002; Richardson et al. 2002). Because of poor documentation and under recording of incidences of domestic violence the figures that exist for violence against women are not reliable. The next section discusses gender issues to provide a theoretical lens from which to view domestic violence.

2.4 Living in a gendered world

Freedom of thought, speech, movement and working are now considered natural by the majority of women (Zwiech 2009). It is over 30 years since the feminist movement placed violence against women on the agenda. Since the grassroots feminist campaigns of the 1970s and 1980s, awareness has steadily grown about domestic violence (Westmarland, Hester and Reid 2004). Up until that time the notion of speaking openly about matters, which were considered private family affairs, did not occur. Domestic violence was still awaiting discovery as the women's movement of the 1960s and 1970s began (Ashcraft 2000). According to Mc Phail et al. (2007), the first and second wave of the feminist movement addressed violence against women, as a public policy problem, by demanding legal reform and cultural change. Prior to this, an earlier period of feminism (Wolfgang 1966:1) developed a theory of the "subculture of violence." This theory argued that an overt and often illicit expression of violence is part of a sub-cultural normative system (Ibid). In other words, violence and aggression is accepted as a normal value system in some cultures or strata of society. Examples include: organised crime, war, the carrying of knives or weapons for protection and juvenile gangs (Ibid:2). However, Brownmiller (1975) suggested that those in charge (the dominant culture) can operate within the law of civility and have little need to resort to violence to get what they want. It is worth noting that women who were silenced by the 'dominant culture' and patriarchal forces were the first to assist in breaking the silence of domestic violence as a valid issue which required addressing in the public domain (Hague

and Wilson 2000). According to Lundgren (1998:170) *normalisation* [original italics] is a process by which violence is seen, justified, and experienced as normal and / or acceptable behaviour between men and women. Furthermore, *naming or defining* [original italics] violence (Lombard 2013:14) appears to commence in childhood or teenage years, and young people learn to accept this behaviour as part of their normalised gender order, which contributes to the invisibility of violence (Lombard 2013). In other words, the toleration, acceptance and normalisation of violence contribute to permitted patterns of gendered behaviour that originates at a young age.

Evidence from the literature suggests that, historically, it was the feminist movement that responded to issues of violence against women, by bringing a voice and language to bear on the topic, which, in turn, allowed the conversation to be brought into the public domain, thus giving the issue of violence legitimacy. According to Mc Phail et al. (2007), the feminist model gives strength, resilience and agency to women towards naming domestic violence. This reality notwithstanding, it should be noted that in today's society females can be perpetrators of violence, albeit to a lesser extent than men. While this study acknowledges that violence against men exists, women's experiences of domestic violence are the focus of this research and, in particular, how the social process of discovery and disclosure occurs, specifically in a general practice setting.

In giving domestic violence a voice, the Women's Health Council (2007) highlighted the need to understand violence in the context of women's and girls' subordinate status in society, and, in so doing, they referred to gender discrimination as gender based violence. The notion of subordination suggests that the issues underpinning domestic violence relate to power, control and gender inequality. These concepts are useful explanations to explore the issues of violence and to enable the subject to be named or spoken about by those who experience abuse. Subordination is a complex phenomenon; it suggests a hierarchy of gender

roles. According to Anderson (2009:1448), gender involves rituals that position men as dominant and women as subservient, and this facilitates men's ability to control women.

The concept of patriarchy is according to Walby (1989), an essential tool in the analysis of gender relations; thus, in this context patriarchy is explained. Systems of male domination and female subordination are core concepts of patriarchy, which continue to appear in the literature in disguised language (Hunnicut 2009; Smith 1987). Patriarchy is a system of social structures and practices, in which men dominate, oppress and exploit women (Hunnicut 2009; Walby 1989; Smith 1987). Crenshaw (1996) contended that patriarchal arguments are those which justify values, attitude, beliefs and policies that subordinate women to men. More recently, earlier critiques and uses of the term patriarchy have been imported into terms such as *male-dominated society*, *sexual inequality* and *feminist perspectives* [original italics] (Hunnicut 2009). Furthermore, there have been suggestions that of all the concepts generated by feminist theorists, patriarchy is probably the most overused and under theorised (Kandiyoti 1998). Nevertheless, despite the apparent lack of theoretical debate concerning patriarchy, patriarchy is an appropriate theoretical lens to contextualise the issues relating to the discovery and disclosure of violence against women, particularly where patriarchy is described as a private and public occurrence (Walby 1989).

2.4.1 Public and private patriarchy

According to Walby (1989), two forms of patriarchy, namely a public and private patriarchy, exist. Private patriarchy is based on the exclusion of women from arenas of social life, apart from the household, with a private patriarch appropriating women's services individually and directly in the apparently private sphere of the home. In such circumstances, women are viewed as the homemaker and do not work outside the home. Women living in violent relationships are also restricted in the way that they take part in family life and in the

participation that they make to society (Baird and Salmon 2006) which, in turn, contributes to women's invisibility both in and outside the home. Indeed, it is argued that the lack of visibility for women who are experiencing violence makes the disclosure for women and the discovery by health professionals a more invisible agenda; hence the need for this study.

While a public patriarchal system does not exclude women from certain work sites *per se*, oppression and exclusion occurs collectively, for example, in the circulation of pornographic images and in circumstances of inequality in the labour market (Walby 1989). Two systems of patriarchy – micro and macro – were identified by Hunnicutt (2009): those at a micro-level existing within families and as patterned behaviour between intimates. Hunnicutt's (2009) notion of micro patriarchy is similar to Walby's (1989) private patriarchy. Likewise, understandings of patriarchal systems at a macro-level (Hunnicutt 2009) parallel Walby's (1989) notion of public patriarchy; they include bureaucracies, government, law, market, and religion. According to Hunnicutt (2009), it is necessary to understand patriarchy holistically, in terms of the interlocking structures of domination and the victimisation of women. She pointed out that patriarchy means social arrangements where men dominate women. The disparity of power relations between men and women appears to be more visible where patriarchal attitudes within the labour market contribute to the notion of male domination within the workforce (Ibid). The patriarchal attitude includes the exclusion of women from paid work, or the segregation of women within the workforce which, in turn, devalues women not only in the domestic sphere but also in other aspects of gender relations (Hapke 2013; Walby 1989).

An understanding of the nuances of gender relations is critical to this study, since women, living in an environment where male patriarchal domination exists, may find the discourse of domestic violence challenging when attempting to disclose their experiences to general practitioners who work in a public (organisational) patriarchal system. This may be due to the

inequalities in the power relationship described above by Hunnicutt (2009) as the interlocking victimisation and domination of women. According to Lavis et al. (2005) the exercise of gendered power relations can be theorised as embedded within social structures and institutions characterised by patriarchal domination. In this macro environment, although women are not necessarily excluded from the public sphere of employment, they are segregated and subordinated with the structures of paid employment (Hapke 2013). While Walby (1989) acknowledged patriarchal exclusion within the workplace, evidence from the literature suggested that patriarchal exclusion can commence at home (Zwiech 2009; Smith 1987). Furthermore, where systems of micro and macro patriarchy exist women do not have access to the public (working) sphere, their role is reduced to housework and they are denied the possibility of taking power, which makes them subordinate to men (Zwiech 2009).

The belief that men should maintain women is a remnant from the times when a woman was her husband's property (Zwiech 2009) and women were not seen as independent and self sufficient, but rather as an appendage to a male provider. Crenshaw (1996) analysed how, and why, a patriarchal line of argument privileging the male norm is produced. She looked at both legal opinion and the print media in adopting a foetal protection policy barring all women capable of bearing children from jobs involving lead exposure in the battery division of Globe Union Corporation. Even though the courts argued that women were either different from men, or the same as men, in every decision, the role of women in the workplace was always evaluated in relation to men. Findings from Crenshaw's (1996) study illustrated one significant line of patriarchal argument that appears in legal precedent, the assumption that men's experiences should be the measure of human experience - that men are normal and women are abnormal in comparison. The legal opinion, outlined by Crenshaw (1996), suggested that a patriarchal supremacy exists which is the norm to which women in the workforce must aspire; anything less is abnormal. Furthermore, Tichy, Becker and Sisco

(2009) argued that a woman's worth is often measured by her relationships and her ability to serve her male counterparts such as her husband, father or guardian, while Walby (1989) noted how women's work, in both the home and society, becomes invisible and devalued in the shadow of male dominated influences.

Both Bettman (2009) and Lavis et al. (2005) recognised patriarchal discourse as the foundation of domestic violence. Bettman (2009) reported that violence at home is passively condoned and not given too much public consideration, citing as an example, if a man tells someone that he has hit his wife, while the other would be horrified, they would not call the police or do anything else about the incident. When violence against women is hidden or not talked about, it is dismissed as a rare occurrence and not viewed as a serious problem (Lombard 2013). By domino effect where violence is not challenged in society, the non-discovery or non-disclosure continues in silence. Thus, for women who live in a gendered world and encounter patriarchal domination, the discovery and disclosure of domestic violence may go undetected for many years. Notwithstanding Bettman's (2009) contention, Lavis et al. (2005) argued that from a woman's perspective, policy makers and health professionals do have the power to increase the visibility of domestic violence through repositioning it as a health care issue.

2.4.2 Summary

An understanding of domestic violence as a gendered issue provides a suitable lens to explore and illuminate how women's circumstances of intimate partner abuse are discovered and disclosed in general practice consultations. Living in a gendered world suggests that, for some women, the value of the female role in the home and in society is measured by a woman's ability to serve male peers, or to function within the patriarchy. Systems of patriarchy are described as private or micro (within the home), and public or macro

(organisational and institutional). Within a gendered world, human experience and women's contribution to society is viewed against a norm of male privilege. In other words, male standards are the yardstick by which women are both dominated and measured. Within a patriarchal world, the occurrence of domestic violence can be either condoned, or not taken seriously enough to warrant reporting. In reaction to the patriarchal attitudes toward women, the feminist movement was the first to publicly name domestic violence, and to give it a voice and language so that the issues might be discussed in the public domain. The next section discusses violence against women as a health issue.

2.5 Discovering domestic violence

The issue of violence *per se* is not new. Violence in war torn countries and violence demonstrated through fictional literature, on the internet or in drama, are common public displays of aggression that present the phenomenon in a socially acceptable and legitimate manner. However, the cultural-social acceptance and tolerance of abuse, and its normalisation which creates a general acceptance of violence within society (McWilliams 1997) are the most significant barriers inhibiting the discovery of the phenomenon by health professionals and preventing women from disclosing domestic violence (Lombard 2013; Yount et al. 2013; Iglesias Padrón 2004; Lundgren 1998). Within the domestic sphere, women in abusive relationships experience violence as a private matter, within families and within societies and view it as an issue that is not for public discussion (Tichy, Becker and Sisco 2009; Hinderliter et al. 2003). According to Troy (2007) and Abbott (1999), general practitioners and practice nurses are ideally placed to assess if patients are experiencing domestic violence as services are readily accessible and there is no particular stigma attached to visiting a surgery. Primarily there are two ways for health professionals to discover violence against women in the course of a general practice consultation: firstly, through

routine screening (universal) by asking all women in a specific cohort the same set of questions; secondly, through case finding (selective) where a health professional responds to suspicious or prompted case histories, indicative of domestic violence, but without any evidence of presenting symptoms.

In Ireland, access to many primary care professionals is available on a same day service *Primary Care Strategy* (Department of Health and Children 2001). However, as in other countries such as Australia and the United Kingdom, the clinical practice of assessing or routinely enquiring about domestic violence, within general practice, is by and large not standard procedure (Hegarty et al. 2013b; Spangaro, Zwi and Poulos 2009; Taket et al. 2003; Ramsay et al. 2002). As a result, discovery is unsystematic and identifying women that experience domestic violence can be difficult. Further exploration of both types of enquiry – screening and case finding – toward discovery are presented in the next two sections.

2.5.1 Screening as a process of discovery

Differentiations between case finding and screening are not clearly defined in Irish government policies; on searching the literature there are times where the terms are used interchangeably. When one is looking to discover or identify health/illness phenomena in individuals or populations who do not display symptoms, the literature describes this activity as screening for the purpose of disease prevention and management (Health Service Executive 2010; Department of Health and Children 2008; Department of Health and Children 2001; 2001a). Screening programmes in the Irish healthcare system, for example, Breast Check and Cervical Check, are structured programmes of care for the prevention, screening, detection and management of cancer for an identified cohort of patients (National Cancer Screening Service 2010). While the Breast Check programme is provided at a dedicated centre, GPs and practice nurses, provide the Cervical Check programme within

general practice. Currently, however, screening for domestic violence does not form part of the routine general practice consultation in Ireland.

Screening, in the case of violence against women, aims to identify those who have experienced, or are experiencing, intimate partner violence from a partner or ex-partner, in order to offer interventions leading to beneficial outcomes (Taft et al. 2013). It is important to acknowledge the difference between the 'discovery of' and the 'screening for' a phenomenon toward identifying its existence. Within the context of general practice, discovering violence against women may occur in two ways: firstly, when there are no overt symptoms, a group of patients, for example, ante natal women, may be screened for domestic violence; secondly, through appropriate history taking and analysis, health professionals may 'link the story' (Mildorf 2002) and may discover a case (in this study, violence against women) without the patient actually mentioning abuse (Lazenbatt, Taylor and Cree 2009; Mildorf 2006). Case finding is discussed in more detail later in this chapter.

There are a combination of mixed attitudes (Bonds et al. 2006) and reluctance (Jaffee et al. 2005; Richardson et al. 2002; Gerbert et al. 1999) by health professionals toward the use of screening as a method of identifying women who are experiencing abuse. Findings from a Canadian study conducted by (Beynon et al. 2012), with a sample size of 931 respondents, reported that doctors (n = 238) and nurses (n = 527), working in family practice, emergency medicine, public health, obstetrics, gynaecology and newborn care, did not adequately question women in intimate relationships towards enabling the discovery of abusive situations. The key barriers identified by participants for failing to discover incidents of domestic violence related to lack time, insufficient training and behaviours attributed to women living with abuse. Women's behaviour included staying in the abusive relationship, resulted in a sense of frustration by some health professionals where women had disclosed their situation, then returned to their abusive partner. Barriers identified by Beynon et al.

(2012) concur with others, and it was noted that many of the barriers to abuse were similar to those identified in the previous 15 years. Reasons cited in earlier studies include a lack of time, training and education (Taft et al. 2013; Hegarty and Bush 2007; Ramsay et al. 2002; Hegarty and Taft 2001; Sugg and Inui 1992) insufficient evidence that screening for domestic violence is beneficial (Hegarty et al. 2013b; Taft et al. 2013; Jewkes 2013; Moracco and Cole 2009; Ramsay et al. 2002; Richardson et al. 2002) fear of offending or putting the woman's life in danger (Gutmanis et al. 2007; Haggblom and Moller 2006; Schoening et al. 2004; Ramsay et al. 2002), a lack of confidence about the subject (Lazenbatt, Taylor and Cree 2009) and a belief that the issue is not relevant to general practice, or that physicians have nothing to offer women in abusive relationships (Morier-Genoud et al. 2006).

The Irish Department of Health and Children made recommendations for the management of domestic violence. The health document *Quality and Fairness* (Department of Health and Children 2001a:73) proposed that “measures to prevent domestic violence and support victims of domestic violence will continue” through the promotion of health, education and early intervention programmes in schools. Almost a decade later, the *National Strategy on Domestic, Sexual and Gender Based Violence 2010 – 2014* recommended implementing a range of measures such as routine enquiry programmes by GPs, to enable the detection of domestic violence and/or sexual violence at an earlier stage as well as those that are presenting with long term consequences (Cosc 2010)¹⁷. Despite the recommendations from the Department of Health and Children, and more recently Cosc, no national, standardised approach to routinely enquire about violence against women exists in general practice consultations. Hence, in the absence of clear guidelines for practice, or a national standardised approach to care for women who experience abuse, the implementation of

¹⁷ Cosc is the National Office for the Prevention of Domestic, Sexual and Gender-based Violence in Ireland.

procedures toward the discovery of women attending general practice who are experiencing intimate partner abuse remains problematic and requires understanding and illumination.

During the past 40 years, several screening tools used in the identification of domestic violence are described within the literature. The Conflict Tactic Scale (CTS)¹⁸ was developed in 1973 and was further modified in 1996; it measures psychological aggression, physical assault, sexual coercion, injury and negotiation (Relva, Fernandes and Costa 2013). The CTS (2) is a 78 item self reporting measurement tool and takes 10-15 minutes to complete. Critics of the scale argue that it focuses on physical violence alone and is too time consuming for general practice (Hegarty, Hindmarsh and Gilles 2000). Other scales, for example, the HITS scale¹⁹ is a four question instrument for use in general practice. The acronym HITS derives from the focus of the instrument - if a partner hits, insults, threatens, or screams (Sherin et al. 1998). The HARK²⁰ scale is another instrument for use in general practice. The acronym HARK denotes four questions used to identify if a woman has been humiliated, afraid, raped or kicked by a partner within the past year (Sohal, Eldridge and Feder 2007). Findings from a survey of 232 women, with a response rate of 54%, showed that if a clinician asks these four questions they can quickly identify a high proportion of women experiencing intimate partner violence (IPV) (Ibid). The clinical utility of the four item screening tools found favour in discovering IPV where women were attending antenatal, mental health and substance abuse services in Australia (Iverson et al. 2013; Spangaro, Poulos and Zwi 2011) and with female veteran patients (n=369) with a response rate of 63.5%, in New England (Iverson et al. 2013). Using screening tools to discover women in abusive relationships has the advantage of standardising practice. Nonetheless, evidence suggests that health professionals are reluctant

¹⁸ Appendix One = an example of the CTS screening tool used to identify intimate partner violence.

¹⁹ Appendix Two = the questions of the HITS screening tool for use in general practice.

²⁰ Appendix Three = the questions of the HARK scale for use in general practice .

to screen women about domestic violence, due to insufficient evidence of the benefits (Taft et al. 2013; Moracco and Cole 2009; Taket, Wathen and MacMillan 2004), and lack of time, confidence and comfort when engaging with the issue (Gutmanis et al. 2007; Miller and Jaye 2007).

In Australia, a study known as the WEAVE trial (Women's Evaluation of Abuse and Violence Care) used a cluster randomised control trial with family doctors (n=52) and women (n=272), who identified as being fearful of their partner in the previous 12 months, to assess whether brief counselling²¹ from GPs, as a response to women who experienced violence, identified through screening, increased their quality of life, safety planning and mental health (Hegarty et al. 2013a). Findings indicated that where family doctors are trained to respond to IPV, counselling can reduce depressive symptoms for women who disclose abuse, but not necessarily improve the quality of life for women in abusive relationships (Ibid). In addition, the study recommended that family doctors should be trained to ask about the safety of women and children in abusive relationships. In Australia, Taft et al. (2013) compared the data of 11 trials used for universal screening of IPV or target (selective) screening of at risk groups, such as pregnant women attending antenatal clinics in hospital and community settings. While screening increased the identification rates it did not reduce the level of violence or improve women's health or well-being 3-18 months following screening. Findings by Taft et al. (2013) concur with those of Hegarty et al. (2013) who noted that evidence of the benefit of interventions to help women who screen positive for intimate partner violence, in primary care settings, is limited. Moreover, Roush (2012) argued that screening alone is not adequate, no more that colonoscopies reduce the rate of colon cancer. Screening women as a process of discovering abusive relationships is limiting in the

²¹ Women participants in the WEAVE study were offered the option of brief counselling sessions from trained family doctors to discuss their safety, the safety of children and any depressive symptoms they experienced.

absence of training, education and adequate support services. Augustyn and Groves (2005) argued that inadequate training of health professionals is a barrier to screening women for IPV. They debated the need to recognise the sense of powerlessness felt by physicians when it comes to discovering violence against women, and argued that where success depends on efficiently diagnosing and treating problems, domestic violence may represent a failure, or a frustration, that leaves health professionals feeling powerless and unsuccessful (Ibid). In addition, Taket, Wathen and MacMillan (2004) reported how health professionals were hesitant around their perceptions about which women were being abused, and which were not, and fear of them often getting it wrong.

Despite evidence that questions the value of screening for domestic violence from health professionals perspective, research evidence relating to women who are screened suggests some benefits. Belknap and Sayeed (2003) explored Mexican American women's (n=7) thoughts and feelings of being asked questions about domestic violence by a nurse or health care provider. The women had self-identified as being in an abusive relationship. Findings from this qualitative study indicated that none of the women had experienced being asked about their abusive relationship by health professionals. The study did not illustrate how the participants self-disclosed; however, they all women welcomed the opportunity to discuss the issues with a doctor or nurse, as part of a screening process, citing improved communication with health professionals as a benefit. Other studies (Bostock, Plumpton and Pratt 2009; Howard 2008) also found that relationship building, raising awareness, empathy and a shared understanding between women and health professionals emerged as a consequence of screening for violence against women. Furthermore, women found it helpful when health professionals reassured them that they had met others who had experienced abuse (Bostock, Plumpton and Pratt 2009).

Some evidence suggests that screening interventions succeed in primary care, if they are customised to fit clinical need (Bonds et al. 2006), and if they are supported by policies and guidelines (Clark 2001). Additionally, asking everyone the same questions does not isolate or indicate a bias toward women; instead, everyone is treated the same and, as Nelson, Bougatsos and Blazina (2012) ascertained screening instruments or tools helps to accurately identify women experiencing IPV. Noteworthy, Taket, Wathen and MacMillan (2004) argued the case for screening by suggesting that screening contributes to changing social attitudes to domestic abuse and is less likely to make women experiencing abuse feel stigmatised.

In summary, a growing body of literature exists on the experience by health professionals and their use of screening as an approach to identifying violence against women. There is less evidence within the literature of the effects of, and attitudes to, screening from women's perspective. Overall, evidence from the literature indicated reluctance by health professionals to engage in screening or routine enquiry as a process of discovering violence against women, specifically in general practice consultations. Insufficient education, time and support services were cited as factors that impede their engagement with this form of identification. In this regard, the non-discovery of violence against women concerns not only insufficient training, but unease about the health professional's image of the self and fear of failure, in terms of patient expectations and the management of the issue, once disclosed or discussed. A second method of discovering domestic violence within a general practice setting is case finding; this is explored in the next section.

2.5.2 Case finding as a process of discovery

Case finding is a system of initiatives that are recommended to identify people that are at high risk (Laffoy et al. 2008). For example, opportunistically identifying at risk individuals of

domestic violence may include women where there is a known history of family violence. Case finding may identify a case of domestic violence before there are any presenting symptoms, and the early detection or discovery may lead to an early disclosure. It is argued that case finding is more conducive in situations where health professionals know patients well enough (such as general practice) to identify those that may be at risk, thus, pre-empting an issue before the situation arises. As an early intervention, to overcome the barriers to the disclosure and the enquiry of domestic violence within general practice, Hegarty and Taft (2001) identified case finding in high-risk female populations (e.g. pregnant, young, recently separated or divorced women and those presenting with psychological symptoms) as desirable practice. Several studies identified pregnancy as a trigger for domestic violence for some women (Lazenbatt, Taylor and Cree 2009; Watson and Parsons 2005; Bacchus, Mezey and Bewley 2003). The case finding approach requires that GPs and practice nurses have an awareness of the factors associated with abuse, physical injuries, fear, depression and lifestyle issues - drugs and alcohol (Hegarty et al. 2012; Goodyear-Smith et al. 2008; Hegarty and Taft 2001). According to Goodyear-Smith et al.(2008), GPs and nurses are ideally placed for case finding of patients with lifestyle risk factors. Case finding can begin in the waiting room of the surgery, with the self-administered Case-finding and Help Assessment Tool²² (CHAT). The CHAT tool identifies tobacco use, alcohol and other drug misuse, and problems including abuse and violence (Goodyear-Smith et al. 2008). A study involving 1,000 patients who completed the CHAT tool in primary care practices in Auckland, New Zealand provided response rates for each item range from 79.6 % (negative for anger questions) to 99.8% (positive for nicotine dependency) (Ibid). Despite incorporating questions of violence amongst the list for self-selection, the response was poor, which suggests that the discovery

²² Appendix Four = an example of the self-administered case finding and help assessment tool. Domestic violence is two of the 18 questions.

of domestic violence is at the discretion of the patient. A more direct approach to case finding involves health professionals asking only patients that they believe may be victims of intimate partner violence about abuse, or those who they deem to be at high risk (Taket, Wathen and MacMillan 2004). This style of case finding focuses on the need for a more in-depth assessment, where there is an index of suspicion or evidence of “red flags²³” (Burman et al. 2002). However, a limitation of case finding is that it may miss opportunities to discover those in abusive relationships, as the accuracy of discovery depends on how health professionals interpret the context of clinical consultation (Taket, Wathen and MacMillan 2004).

According to Stark (2004), the numbers of people who suffer the casualties of abuse and present to primary care settings are actually higher than the numbers discovered in the accident and emergency department. He contended that if health professionals “wait for physical injury to walk in the door” of general practice, the emergency room or obstetrical setting, they will “miss 99% of all physical abuse” in the practice (p16). Rather, Stark (2004) argued that health professionals need to understand the regime of terror, associated with domestic violence, including that which is created by constant physical intimidation, even if there are no broken bones. In other words, the symptoms of domestic violence are most likely to be invisible.²⁴ While the discovery of domestic violence within the general practice setting is problematic, in settings such as the emergency department, or in-patient hospital care, the opportunity for discovering violence against women may be greater (Liebschutz et al. 2008; Jaffee et al. 2005). Reasons cited include women’s presentation with acute injuries that require immediate attention (Liebschutz et al. 2008). However, the most challenging

²³ The term “red flags” is a metaphor that is used to describe warning signs indicating that further investigation of the patients history or symptoms are required.

²⁴ The notion of invisibility as a theoretical lens to illuminate this study is discussed later.

elements of discovering domestic violence within a general practice setting requires an ability to look beyond physical consequences toward an awareness of the non-physical forms. A study in South Carolina by Coker et al. (2000) of the psychological impact of abusive relationships indicated that of 1152 women surveyed, 13.6% experienced psychological IPV without physical IPV. Psychological IPV presented with a number of adverse health outcomes including, arthritis, migraine, stomach ulcers, indigestion, and bowel problems. A study by Beaulaurier, Seff and Newman (2008) of women (n=135) aged 45 to 85 years, found that although women frequently do not explicitly articulate vulnerabilities, women who remain in abusive relationships find ways of accommodating and surviving abuse, at least physically, which, in turn, makes the visibility of violence against women problematic.

Many instances of domestic violence are not associated with physical abuse alone, and GPs and practice nurses need to be cognisant of the non-physical forms of intimidation if they are to discover women who are experiencing abuse. According to Nortvedt (2003), an engaged narrative between nursing and medicine for the sake of restoring patients' subjectivity, when it is immersed in suffering and vulnerabilities, is required. The questioning of at risk, or what health professionals perceive as vulnerable groups, such as ante-natal women, may exclude a large cohort of invisible women who experience abusive relationships. Similarly, the dynamic of the health professional-patient relationship within a general practice setting is linked to greater familiarity with patients, and it can be conducive to case finding at risk groups for domestic violence. According to Jabaaij et al. (2008), personal continuity or familiarity between a patient and a GP is associated with favourable patient outcomes. Furthermore, general practitioners, practice nurses and administrators build relationships with extended families within community settings; they get to know their patients. However, Liaschenko (1997) posits that access to knowing the patient is limited as the relationship between the person and the nurse focuses on the functioning and monitoring of physical and

psychological processes (p25). Thus, knowing the patient and knowing the person are different (Ibid). In other words, elements of the process of general practice are conducive to case finding; however, it does require interaction within the clinical consultation to accommodate a flexible response to the needs and expectations of different individuals (Thistlethwaite 2009).

In conclusion, the literature highlights several common themes that address the barriers to health professionals engaging in case finding towards the discovery of women who experience domestic violence. While the general practice setting, which is conducive to getting to know the patient, is viewed as a fitting environment to engage in case finding, the corollary is a fear of getting it wrong, when it comes to asking women about possible circumstances of domestic violence.

2.5.3 Summary

Two approaches underpinning the process of discovery of women experiencing domestic violence – screening and case finding – were explored in this section. Screening involves the discovery or identification of health and illness phenomena in individuals or populations who do not display symptoms, for the purpose of disease prevention and management. Case finding, on the other hand, involves a system of initiatives toward identifying people who are considered to be at high risk of domestic violence, or where there are suspicions on the part of the health professional that domestic violence is an issue. Concerns as to the value of screening, along and with the time needed to do it, were identified. While general practice was viewed as an ideal setting for case finding, fears about misreading circumstances of domestic violence were articulated. A key element of the challenges associated with discovering violence against women is its invisibility.

The next section presents evidence from the literature on how women disclose their experience of domestic violence within a general practice setting.

2.6 Disclosing domestic violence

Disclosing domestic violence can be very difficult for many women (as identified in this study) as it involves not only decisions about whom to disclose, but also considerations around when, where and how to disclose. Factors around disclosure and the sharing of personal information include: the dynamics of the therapeutic relationship between individuals and health professionals, the structure of the organisation, and being given the opportunity to disclose (Chaudoir and Fisher 2010). In addition, women's "readiness to discuss" (Taylor et al. 2013) influences their course of action. According to Dienemann, Glass and Hyman (2005) a woman's decision to disclose IPV (or not), to a nurse or physician, depends on the contextual factors of the environment, the woman's characteristics, her past experiences and her expectations of the consultation. Women often attend general practice for their own health needs and the needs of their children; however, disclosure of domestic violence does not necessarily occur during these consultations (Hegarty and Taft 2001). The intersection between health professionals' beliefs and abused women's views about disclosure remains under investigated (Prosman et al. 2013; Taylor et al. 2013). In particular, little is known of how GPs perceive the process of disclosure and how they might initiate (or avoid) discussing domestic abuse with patients (McKie, Fennell and Mildorf 2002).

2.6.1 Time factors

Time for disclosure refers to the number of times women who experience domestic violence attend general practice and the length of the clinical consultation. According to Thomas and

Layte (2009), more women than men attend general practice consultations and they attend more frequently.²⁵ A study by Morris et al. (2012) in England engaged a mixed method approach – examination of records and qualitative interviews, to study the clinical characteristics and patterns of health care use by regular attenders to general practice. Face-to-face attendance with the GP on 30 or more occasions in two years, excluding routine health monitoring²⁶, was determined as regular attendance, with normal attendance being 6 to 22 visits over two years (Ibid). In the report of their findings, Morris et al. (2012) were also critical of the use of the term frequent attenders, a term often used in the literature (Smits et al. 2013; Wiklund-Gustin 2011; Peters et al. 2009), which Morris et al. (2012) suggested is an offensive term as it implied a criticism of the patient for attending general practice too often. Specifically, in relation to women in abusive relationships, Hegarty et al. (2013a) noted that they consulted general practice more frequently than those who did not experience abuse, though the exact number of consultations was not stated. In Scotland, research on service provision to women experiencing domestic violence, noted by MacNeil et al. (2004, referring to Henderson 1997) found that some patients returned to surgeries between 30 and 40 times before they managed to disclose that they were victims of domestic violence. According to McKie, Fennell and Mildorf (2002), in no other part of the general practice communication literature related to similarly sensitive matters (e.g. HIV²⁷, STDs²⁸) is there any suggestion of such extreme experiences of repeat visits. The level of repeat attendance needs to be viewed within the context of the circumstance of abuse, where women endure an abusive relationship

²⁵ The average number of GP visits among women is higher than among men in each age group, a pattern which has been repeatedly observed across a number of countries and contexts (Thomas and Layte 2009).

²⁶ Routine health monitoring referred to patients who required regular blood monitoring if taking the drug Warfarin, or had a serious physical illness such as cancer, or serious mental health problems such as schizophrenia (Morris et al. 2012).

²⁷ HIV = human immunodeficiency virus.

²⁸ STDs = sexually transmitted diseases.

for some time before disclosure occurs, and it may never be disclosed. On average, an intimate partner will assault a woman or ex-partner 35 times before help from the police in addressing the violence is sought (Paul, Smith and Long 2006; Yearnshire 1997). However, the study did not indicate the number of years women were in abusive relationships prior to seeking help.

As well as exploring the literature relating to the number of visits a woman experiencing domestic violence is likely to make to a surgery, evidence on the duration of visits and the time allocated to consultations within general practice is discussed. Principally within the therapeutic relationship²⁹, there are the intertwined notions of communication, care and time (Chan, Jones and Wong 2013). Time, within the context of a therapeutic relationship, is not a fixed or linear measure but something that needs to be considered as flexible, used efficiently or inefficiently, and conserved or expended (Armstrong 2002). However, 21 years ago an ethnographic study by Sugg and Inui (1992:3159) found that the majority of primary care physicians (71%) described “the tyranny of the time schedule” as the time constraints of a busy surgery, one of the major deterrents for enquiring about violence; fearing that it will consume more of their scarce time. The duration of the consultation identified in Sugg and Inui’s (1992) study was between 20 – 30 minutes. More recent evidence also highlights the problem of time as a resource within general practice, with evidence to indicate that the average consultation length is nine to ten minutes long (Ogden et al. 2004; Mc Kie, Fennell and Mildorf 2002), a circumstance which makes the context for engagement in general practice consultations problematic. Thus, it is argued that restricted consultation times in general practice militate against the discovery and disclosure of domestic violence. The

²⁹ A therapeutic relationship is one that develops over time, with understanding and skill (Shattell, Starr and Thomas 2007). Bearing witness or engaging is according to Naef (2006) another way of developing the nurse-patient relationship.

notion of ‘clock time’ operated within the context of primary care was described by McKie, Fennell and Mildorf (2002: 330):

The performance of a consultation in primary care does move through specific space and time patterns: for example, from arrival at the health centre, reporting to the receptionist³⁰ for a pre-determined appointment time, the acceptance that a wait may follow and agreement that there will be a specified time allocation which can only be extended if the symptoms are considered serious enough by the GP.

Noteworthy within this description of time is the location of the agency of time within the context of general practice. Beyond arranging for a suitable time and turning up at the allocated time, decisions about the length of time a consultation requires is not the prerogative of the patient. A qualitative study by McKie, Fennell and Mildorf (2002), where six GPs were interviewed about their experience of the discourse on disclosing domestic abuse in primary care, found doctors used the “myth of time” (p332) in deciding when to give a woman an opportunity to further disclose or explore issues. GPs mythologised time by asserting they did not have enough time to discuss domestic violence; yet, they revealed themselves as being powerful enough and had control to overcome time constraints by extending consultation time if it was considered necessary to do so, if symptoms were serious enough or if children were involved (Ibid). While McKie, Fennell and Mildorf (2002) described the notion of the myth of time as a powerful tool, Geneau et al. (2008) argued that using time differently – adding five minutes to the length of a consultation – is enough to modify a GP's approach and attitude.

³⁰ Although the administrators do not provide a clinical role in general practice, their input into the performance of the consultation is an essential component to the social process within the surgery (and to this study). The administrator within a general practice setting has an important role in communication, liaison and in setting the dynamics of the practice at the point of entry. They frequently manage the time keeping and appointments system for the clinicians of the practice, for example, where consultations are booked in advance, by the administrator, health professionals' time is accounted for prior to the commencement of the consultation.

Lack of available time within clinical consultation is acknowledged extensively in the literature as one of the barriers to women disclosing abuse (Taylor et al. 2013; Rose et al. 2011; Liebschutz et al. 2008; McKie, Fennell and Mildorf 2002; Sugg and Inui 1992).

Time, in and of itself, reflects more than the presence or absence of minutes; it suggests an “asymmetry of the GP consultation” (Ariss 2009:916) between the service provider (GP) and service user (woman). While, ultimately, time management is a flexible instrument that can be manipulated, Buetow (2004) suggested that general practices principally manage time in ways that first and foremost meet their own work needs. Evidence suggests it is the time of the medical profession that carries weight and is worthy of recording the limitations of ‘clock time’ (Buetow 2004; McKie, Fennell and Mildorf 2002). However, there is a paucity of literature that refers to the value or importance of the other key players’ time, implying that the time of the practice nurses and administrators, and chiefly the women who attend the practice is of lesser significance than that of general practitioners.

2.6.2 Enabling disclosure of violence against women

There is a dearth of literature that explores how women are enabled to disclose their experiences of domestic violence in general practice consultations within an Irish context. Exploration of the international literature indicates that many women choose never to disclose their experiences of domestic violence and decide, instead, to keep their abusive encounters private. The non-disclosure of domestic violence, which contributes to the veil of invisibility, is attributed to stigma, shame, fear of repercussions (Naved and Persson 2010), threats of losing children (Rhodes et al. 2010), loyalty to partners (Nair and Osman 2012; Barnish 2004), potential loss of family dignity (Nair and Osman 2012; Vandello et al. 2009) and secret keeping (Nair and Osman 2012). Some women used their religious faith to present a façade to conceal their experience of domestic violence from their community

(Knickmeyer, Levitt and Horne 2010).³¹ Kandiyoti (1998) noted how women used patriarchal bargaining as a strategy to avoid their disclosure of abuse. She coined the term patriarchal bargaining to describe powerful influences on the shaping of women's gendered subjectivity and to determine the nature of gender ideology in different contexts. Patriarchal bargaining influences both the potential for, and specific forms of women's active or passive resistance in the face of their oppression. Women may reach a point of acceptance and endurance of male domination through learning to bargain or negotiate within such a relationship, which, in turn, can lead to a point of toleration (Ibid). While the women in the above studies (Naved and Persson 2010; Rhodes et al. 2010; Barnish 2004) chose to engage in strategies of concealment with regard to their experience of domestic violence, their motives were determined by self-preservation, feelings of helplessness and a desire to protect their children. Goffman's (1959) work, *The Presentation of Self in Everyday Life*, (1959) illuminates our understanding of the concept of self-preservation. He uses the analogy of individuals wearing masks in a performance to describe people putting on a front in order to present a side of themselves they want others to see.

A performer tends to conceal or underplay those activities, facts and motives which are incompatible with an idealized version of himself and his products. In addition, a performer often engenders in his audience the belief that he is related *to them* [original italics] in a more ideal way than is always the case...Individuals often foster the impression that the routine they are presently performing is their only routine or at least their most essential one. As previously suggested, the audience, in their turn often assume that the character projected before them is all there is to the individual who acts out the projection for them. (Goffman 1959:56-57).

³¹ The 10 participants in this qualitative study were Christian women who experienced domestic violence (Memphis, USA). The findings explained how patriarchal domination, conformity to their religious faith and their effort to maintain face impeded the women's help seeking and obscured the reality of domestic violence. The consequences of the pressure to maintain a façade influenced participants' silence (Knickmeyer, Levitt and Horne 2010).

A consequence of using strategies of concealment is the invisibility³² of circumstances of domestic violence. However, a paradox of concealment is women's wish to be enabled to disclose their experience of domestic violence as reported from a Scottish study by Taylor et al. (2013). Using a critical incident technique, to explore the process of convergence and divergence toward enabling disclosure of domestic violence between health professionals (midwives, health visitors and general practitioners) (n= 29), and women (n=14), the research found that women wanted to be asked about abuse, and to be enabled to disclose their experience; yet, health professionals were uncomfortable asking about the issues (Ibid). Similar findings emerged from a phenomenological study in North East USA, which focused on women's (n=17) experience of disclosure (Kelly 2006). Despite their anxieties and fears about disclosure, women wanted health professionals to ask them about their relationship:

They harboured a wish that someone, such as their health-care provider, would ask them about abuse or, better yet, figure it out for themselves. However, they would not disclose the abuse unless asked. A code of silence prevailed, maintained by both the woman and her health-care provider, with many of the women left with a continuing sense of isolation and resignation (Kelly 2006:87).

Further evidence from the literature reported that patients seldom verbalise their emotions directly and spontaneously, tending, instead, to offer clues, but if invited to elaborate, they were prompted to express emotional concerns (Suchman et al. 1997), and to talk about domestic violence once health professionals took the initiative and opened the discussion (Beynon et al. 2012; Women's Health Council 2007). According to Liebschutz et al. (2008), direct communication, where clinicians use verbal and non-verbal cues to convey concern, while not forcing the participants to take action (to disclose), is beneficial. In other words,

³² A study by Mildorf (2004) which analysed general practitioners' (n=20) narratives about their experiences of discovering patients who were in circumstances of domestic violence found that doctors only remembered patients with dramatic stories of abuse, were not sensitive to more hidden signs of abuse and hence, may have missed cases of domestic violence. Mildorf's findings illuminate the complexity of patterns of concealment and invisibility.

where health professionals take the initiative by engaging with women on domestic violence issues, the onus for disclosing, breaching loyalty and breaking the silence is removed from women. Thus, it is argued that such an approach can validate women's circumstances but without expecting them to take the first step. When a woman in an abusive relationship seeks help, the attitude of the health professional is critical. Evidence suggests that a woman's experience of disclosure is determined by her relationship with the health professionals she meets (Liebshutz et al. 2008; Battaglia, Finley and Liebschutz 2003). Fostering a therapeutic relationship in times of distress not only influences the discovery, it can enable the disclosure of domestic violence and a process of mutual engagement, which Natan & Rais (2010:116) described as "heightened awareness".

2.6.3 The dynamics of the therapeutic relationship in general practice

One of the key tenets of the clinical consultation in the discovery or disclosure of violence against women is the dynamics between women (as in this study) and health professionals in general practice. Knowledge of the patient and a sense of a shared history are valued aspects of the doctor-patient relationship (Ridd et al. 2009). However, symptoms are powerful drivers of healthcare utilisation (Elliott, McAteer and Hannaford 2011) and as a result the doctor-patient relationship is largely based on clinical assessment, founded on the signs and symptoms that women present within the consultation.

Bacchus, Mezey and Bewley's (2003) study of 16 post-partum (14 months) women who experienced domestic violence revealed a lack of awareness of the issues by health professionals (GPs and accident & emergency staff) as a contributing factor regarding women's experience of disclosure. The participants scored highly for post-traumatic stress disorder, suicidal thoughts and attempted suicide and depression. However, very few women in the study voluntarily disclosed their experiences of domestic violence to a health

professional and even fewer were asked directly about the issue (Ibid). According to Elkins (2009) the use of the medical model to treat psychological problems, as if they were physical illnesses that require healing is both limiting and inadequate. Instead, what is required of general practice is a more flexible engagement in emotional problems in routine consultations and the provision of quiet spaces for talking therapies (Davidsen and Reventlow 2010).

An understanding of the dominant focus, the treatment of physical conditions, within the medical model, is offered by Foucault's (2003) concept of the medical gaze. According to Foucault (2003) physicians are caught up in an endless reciprocity that focuses on visible disease, even if the patient hides the visible element of disease. In other words, physicians must reach the truth of disease through their knowledge and recognition of the signs, even where a woman presents her story in a covert manner, physicians should have the knowledge to discover women's (as in this study) narratives through the medical gaze. A consequence of the medical gaze is that patients are regularly viewed as 'the eye, the jaw, the spleen or the liver' which is typical of the medical language that makes domestic violence invisible to the eyes of health staff (Romito 2008). Davenport (2000:311) argued that the notion of seeing a "case" or "condition", rather than a human being, is a dominant paradigm in critiques of modern medicine. This is not surprising given that the medical gaze has long been privileged over the voice of the patient as the source of medical knowledge (Malterud, Candib and Code 2004).

Nursing philosopher, Gadow (2000) proposed that many women experience their body through a social narrative of vulnerability, and a scientific narrative of mechanism:

The body is a machine without ambiguity: unequivocal, unequivocal, reducible to components, every part accessible, parts interchangeable, tended by experts who are adjunct parts, themselves interchangeable (Gadow 2000:90).

A consequence of this social narrative is that women are acknowledged by the body part requiring attention. Essentially a mechanistic view of the body occurs, resulting in the body being likened to a 'machine' and (physical) bodily functions perceived to be separate from the workings of the mind (sensory experiences) (Hyde, Lohan and McDonnell 2004). In other words, when a woman experiencing domestic violence is viewed within a medical gaze, the diagnosis becomes the focus of attention, rather than her experience. In effect, with the focus on the diagnosis or the body part and the legitimisation of illness (Abbott and Williamson 1999) women become invisible in the consultation, which in turn impacts on their capacity to disclose their experiences of abuse (Liebschutz et al. 2008; Mullender and Hague 2005).

While the notion of the medical gaze is problematic in terms of its limitations of engagement, and the narrowness of its scope in terms of non-physical illnesses, acceptance of the medicalisation of everyday life has a degree of legitimacy and is defined as a social contract (Abbott and Williamson 1999; Parsons 1991) between diseased people and the medical profession, where the medical profession is given social power to control access to the sick role (Morrall 2009). The sick role is a modernist narrative of social control (Frank 1995). An analysis of the sick role suggests a business arrangement between a service user and a service provider where one has the power or licence to control what the other needs. Within such an arrangement, the medical profession have the power to medicalise a problem or label an individual with a diagnosis, for example diabetes. Viewed within the sick role, as a narrative of social control (Frank 1995), the presentation of self by the woman (Bacchus, Mezey and Bewley 2003) enables the physician to medicalise or label the situation as a diagnosis. According to Illich (1995), the process of medicalisation leads people to see themselves as two legged bundles of diagnoses, while Warshaw (1993) argued of the dangers with medicalising social problems. For example, the risk of legitimising domestic violence as a condition to diagnose and treat, creates a new diagnostic category that has the potential to

merge women into a generic battered woman and fails to recognise the individual difficulties women face (Ibid:75). Again the work of Goffman (1959) illuminates this discussion of the therapeutic relationship. Goffman argued that individuals perform differently in different settings; and many crucial facts lie beyond the time and place of an interaction, or lie concealed within it. In other words, the true or real attitudes, beliefs, and emotions of an individual can be established indirectly, by subconscious behaviour. For example, where women have experienced domestic violence there are a range of factors that contribute to the absence of the presentation of the real self during a medical consultation: from the woman's perspective, stigma, shame, fear of repercussions (Naved and Persson 2010), threats of losing children (Rhodes et al. 2010), loyalty to partners (Nair and Osman 2012; Barnish), potential loss of family dignity (Nair and Osman 2012; Vandello et al. 2009) and secret keeping (Nair and Osman 2012), and from a general practice perspective, insufficient time (Hathaway, Willis and Zimmer 2002) and health professionals need for education and training on the subject (Bacchus, Mezey and Bewley 2003).

2.6.4 Summary

To conclude, the literature acknowledges several reasons that inhibit a woman in an abusive relationship seeking help and which impede her disclosure of domestic violence within general practice consultations. Reasons for non-disclosure relate to both the woman and her presentation of the self against a fear of disclosure, and to general practice and the dominance of the medical model and the medical gaze, including also, time restrictions and an absence of education and training in how to handle domestic violence as a health issue. While there is evidence that proposes that general practice is the an appropriate environment to afford women the opportunity to disclose their experience of domestic violence, there are few research studies in an Irish setting that analyses how both medical and nursing health

professionals, working in general practice settings, discover or enable the disclosure of domestic violence.

2.7 Chapter summary of literature review

This chapter reviewed the range of terms used to describe the phenomena of intimate partner violence against women before exploring a broad literature review on the subject of domestic violence and domestic abuse. As violence is described primarily as physical in presentation, the term domestic abuse acknowledges a wide range of behaviours and illuminates an understanding of women's circumstances of living in a relationship that encompasses more than physical abuse alone. The language used to define violence against women is critical as it influences understanding of the notion of prevalence factors (Krug et al. 2000); that is, of interpreting whether a relationship may be determined as abusive or not. Indeed, research suggests that use of terminology influences patterns of disclosure by women.

The literature review highlighted the occurrence of violence against women from a national and international perspective. Studies, albeit mainly quantitative in design, demonstrated that women's circumstances of domestic violence are worldwide. However, due to poor documentation, under reporting and low detection rates, prevalence figures are not a reliable indicator. This is partially due to a lack of awareness by health professionals that domestic violence may be a possibility, in circumstances of women seeking health care and by inadequate education and training. Most studies were conducted from health professionals' or from women's perspectives, with a focus on two single cohorts rather than the integrative perspective of service provider and service user.

Engagement with the literature on gender inequalities and patriarchal domination provided a critical framework toward understanding the issue of violence against women. The notion of

public patriarchy illuminated my understanding of circumstances of domination of women within the workforce and in public spheres; while private patriarchy illuminated circumstances of domination within the home. The long term affects of patriarchal domination are documented by attitudes of normalisation and an acceptance of domestic violence behaviours. These patterns meant that women's circumstances of domestic violence in the home remained largely invisible, and furthermore challenged their ability to disclose issues to a public organisation (such as general practice).

Finally, I critiqued the literature on universal screening (asking everyone) and selective case finding (asking women within a specific cohort) as a process for discovering and enabling disclosure of violence against women. The literature acknowledges that the use of these programmes is problematic. Despite the availability of screening tools to identify the presence of violence against women for use in general practice, there is reluctance by health professionals to use them, citing lack of time and uncertainty of the their benefits as reasons for avoidance. The role of case finding is more favourable in services such as midwifery, but not in general practice. The literature acknowledges that the duration of the consultation influenced what was discovered in the clinical consultation. Evidence suggested that disclosure and discovery are complex processes underpinned by social, personal and structural factors, including *inter alia*, stigma, fear, loyalty (woman), knowledge and skills (health care professionals), time and the dominance of the medical model (structural factors). The next chapter addresses the methodology used in the study.

Chapter Three: Research Methodology

3.0 Introduction

This chapter gives an overview of the philosophical underpinnings of the methodological approach – grounded theory – used for the study. I make the case for grounded theory as a suitable qualitative strategy of enquiry and appropriate system of analysis for this study, as determined by the research question. According to Holloway and Biley (2011) qualitative researchers do not only write a story, they are also story analysts. There is a balance, therefore in qualitative research between art and science (Corbin and Strauss 2008) where the science is expressed from “grounding” concepts in data (Ibid:48). A brief description of the aim of the study is given to situate it within the context of the methodology followed by the rationale for using grounded theory. The origins of grounded theory, its characteristics and the notion of symbolic interactionism are discussed.

3.1 Aim of the research

The aim of this study was to develop an in-depth understanding of how the general practice team (GPT), namely, GPs, practice nurses and general practice administrators, discover issues of violence against women attending urban general practice services in the Republic of Ireland. The factors that facilitate or impede GPs and practice nurses enquiring about and discovering (or not) violence against women were explored. The research also explored how women disclose (or not disclose) domestic violence to the general practice team.

3.2 Rationale for the methodology

Defined broadly, qualitative and quantitative research paradigms originate from different sets of assumptions about the nature of knowledge, the nature of reality and the aims to achieve

different goals (Jeon 2004). This study did not fit into a positivistic paradigm, which tests cause and effect as in quantitative research. Rather it required a qualitative approach, and specifically a grounded theory approach. According to Bailey, White and Pain (1999), grounded theory is a robust and systematic method of designing, conducting, analysing and evaluating research, which at the same time facilitates and integrates the scientific and creative aspects of research. Kearney (2001:271) remarked that grounded theory studies can portray “the range of influences on human action, and the process of change in response to context, a goal well suited to understanding women’s varied and changing responses to domestic violence.” Creswell (2007) suggested that grounded theory is a good design to use when there is no theory available to explain a process. Like many forms of qualitative research, grounded theory makes its greatest contributions in areas where little research has been done (Mc Cann and Clark 2003b; Morse 2001; Chenitz and Swanson 1986).

One of the major strengths of grounded theory is that it provides tools for analysing processes, and these tools hold much potential for studying social justice issues (Charmaz 2005). A grounded theory approach allows the researcher to remain close to their area of study and to “develop an integrated set of theoretical concepts” (Charmaz 2005:508). Grounded theory is an emergent design and, as a research method, is beneficial in discovering the structural processes which explain behaviours when exploring the interaction between subjective experiences and social structures (Wuest 2000). Grounded theorists develop an understanding of research participants’ actions and meanings between human agency and social structure that pose theoretical and practical concerns in social justice studies (Charmaz 2005). The philosophical underpinning of grounded theory is symbolic interactionism³³ which focuses on “the dynamic relationship between meanings and action” (Charmaz 2006).

³³ Symbolic interactionism is discussed in section 3.6 of this chapter. It is a theoretical perspective that informs how meanings arise out of actions, and in turn influence these interactions (Charmaz 2006:189).

An overview of the historical perspectives of grounded theory, including the various schools of thought on the methodology is presented first, followed by a discussion on theory development, including symbolic interactionism.

3.3 Versions of Grounded Theory

Grounded theory is a qualitative and quantitative design developed by Barney Glaser and Anselm Strauss, two sociologists, who, in 1967, believed that the theories used in research were often inappropriate and ill-suited for the participants under study (Creswell 2007). Under the legacy of multiple mentors (Covan 2007) several versions of grounded theory exist, with a set of common characteristics pertaining to each method. Depending on the researcher's ontological and epistemological beliefs, there are several points of departure along a spiral of methodological development (Mills, Bonner and Francis 2008). Constructivist grounded theory is positioned at the latter end of this methodological spiral, actively repositioning the researcher as the author of a reconstruction of experience and meaning (Ibid). Charmaz's (2006, 2005) constructivist view of grounded theory takes a reflexive stance of locating the researcher in modes of knowing and understanding the research field.³⁴

3.3.1 Glaser and Strauss

It is over 40 years since Glaser and Strauss first published *The Discovery of Grounded Theory*. Glaser trained in quantitative sociological backgrounds (Glaser and Strauss 1967) while Strauss trained in symbolic interactionism. They presented their methodology of grounded theory research based on their study on *Awareness of Dying* (Glaser and Strauss

³⁴ In undertaking this study, which explores a social process of enquiry, I position myself as a woman, as a nurse and as a researcher in order to illuminate my ontological and epistemological beliefs of the discovery and disclosure of violence against women within the general practice setting.

1965). The key concepts outlined by the authors then were that grounded theory is the discovery of theory from data which is systematically obtained from social research (Glaser and Strauss 1967). When undertaking a grounded theory study it is important for the researcher to be honest about the data (Glaser 1998), or run the risk of misrepresenting what is grounded. Grounded theory is NOT [original emphasis] invented but is the discovery of constant comparison and a verification of data which must ‘fit’ (applicable to the study); it is not data which is forced (Glaser 1998). In other words, the categories and themes emerge naturally through the data which, in turn, generate theories. Researchers must allow themes to flow without forcing the data. The result is that all data are conceptualised into categories and integrated by detailed grounding over a period of time (Glaser 1978). Through their work, Glaser and Strauss aimed to provide a clear basis for systematic qualitative research, although Glaser has always argued that grounded theory applies equally to quantitative inquiry (Bryant and Charmaz 2007). Furthermore, they offer a grounded theory methodology with a solid core of data analysis and theory construction (Ibid). According to Bryant and Charmaz (2007), Glaser’s achievement is a redirection of positivist-oriented concern among qualitative researchers seeking reliability and validity in response to criticisms from quantitative methodologists. Qualitative research of the 1960s was viewed as ‘impressionistic, anecdotal, unsystematic and biased’ while ignoring human problems that did not fit positivistic research designs (Charmaz 2006:5), at a time when quantitative research was viewed as the gold standard³⁵ for researchers to aspire to. Glaser and Strauss (1998) were keen to demonstrate that their method was *inductive*, [original italics] as opposed to the conventional *deductive*, [original italics] approaches they were challenging. They stressed the importance of

³⁵ Evidence based practice advocates for the quantification of clinical decision making, and considers the results of double-blind randomized clinical trials to be the “gold standard” of research designs (Gilgun 2006). However, Morse (2006:416) argued that although qualitative researchers adhere to rigorous techniques and strategies, qualitative research “remains on the fringe of science” because qualitative researchers have failed to *sell* [original italics] qualitative inquiry to the public.

developing or generating novel theories as opposed to verification of existing ones, and urged social researches to go into the field to gather data without a ready prepared theoretical framework (Ibid). In other words, they advocated for researchers to be tolerant of what they found in the field and not to be influenced by external sources, for example the literature, which, they suggested, could influence or ‘contaminate’ the development of a substantive theory. However, the notion of remaining totally neutral is problematic. For example, in my own case, I have worked in the general practice setting (discussed earlier), and the participants in this study are general practitioners, practice nurses and administrators. I have also encountered a woman who voluntarily disclosed her experience of domestic violence to me. Thus, as a former practice nurse it could be argued that I am ‘contaminated’ by my insider knowledge of the field. However, rather than eschewing the notion of exposure to external influences, constructivist grounded theorists take a reflexive stance on knowing and advocate for the locating of the researcher within the study (Charmaz 2006). The notion of reflexivity will be referred to in this chapter and discussed further in Chapter Four.

Glaser and Strauss urge novice grounded theorists to develop fresh theories and to delay the literature review to avoid seeing the world through the lens of extant ideas (Charmaz 2006). Although novice researchers may wish to embrace Glaser and Strauss classical approach to grounded theory, Dunne (2010) suggested, in terms of the argument that engaging with literature may contaminate the research by imposing assumptions and preconceptions, that the idea that any researcher undertakes a study without some level of prior knowledge or ideas is simply unrealistic. Furthermore, Cutcliffe (2000) contended that no potential researcher is an empty vessel, a person with no history or background. Thus, prior to undertaking any research, it is important to identify what is known or has previously been researched about the subject; and when submitting a research proposal to a governing body, or seeking ethical approval to embark on research, knowledge of the relevant literature is

required. Despite Glaser's (2002) contention that prior knowledge of the literature can lead to bias and can be a hindrance to remaining open-minded he states:

If the researcher is exerting bias, then this is a part of the research, in which bias is a vital variable to weave into the constant comparative analysis. It happens easily in "hot" or "passionate position" issue oriented research, such as political, feminism, or abuse type research (Glaser 2002:3).

An analysis of the meaning expressed in this quote suggests an acknowledgment by Glaser of the role of the researcher as part of the research process, which, in essence, is contradictory of his earlier notion that 'contamination' by the literature is to be avoided. Writing about issues and tensions in qualitative research Olesen (2005:250) referring to what Schepher-Hughes (1992) called "the cultural self", described the self in research "not as a troublesome element to be eradicated or controlled but as a set of resources." Olesen (2005) argued that the researcher goes beyond the reflection on the conduct of the research, but assesses their interpersonal dynamics of producing qualitative research (Ibid: 251). In the words of Charmaz (2005) grounded theory does not occur in a vacuum, but depends on *how* [original italics] we conduct the research process; "we bring past interactions and current interests into our research" (Ibid:510). The present study is "abuse type research," and the location of the researcher as a health professional is woven within the study to inform both the reader and the participants.

In summary, discovery is the core concept of the grounded theory methodology developed by Glaser and Strauss (1967), where the aim is to generate novel theories grounded in the data. Glaser (1998; 1978; 2002) advocated that researchers should not be influenced by external sources, such as the literature, prior to undertaking a grounded theory study due to the risk of developing researcher bias. However, the notion that researchers can neutralise themselves is also problematic (Olesen 2005), as is the idea of undertaking a research study without some engagement with the literature (Dunne 2010). Due to the purist stance of the Glaser and

Strauss classical approach to grounded theory I have not opted for this approach to grounded theory. Rather, I deemed Charmaz's constructivist approach to grounded theory as more appropriate to my study. Before exploring the work of Charmaz I move historically towards it, by first describing the work of Strauss and Corbin.

3.3.2 Strauss and Corbin

In the 1990s a split in the partnership between Glaser and Strauss led to Strauss and Corbin writing and publishing their version of grounded theory methodology, namely an interpretative method. The interpretative method is deductive with concepts linking statements where the analysis is constructed from the data (Corbin and Strauss 2008). The main difference between the two versions³⁶ (Glaser & Strauss and Strauss & Corbin) lies in the processes which reflect different methodological assumptions (Walker and Myrick 2006). Strauss and Corbin take a more liberated approach than Glaser to the notion of being contaminated by the literature, or other external influences, when undertaking grounded theory research. They contended that choosing a research problem, through the professional or personal experience route, was not necessarily as hazardous as the literature route (Corbin and Strauss 2008). Furthermore, Kirby (2007) argued that, what he termed the experiential alertness of the researcher within grounded theory, deepens the understanding of the phenomenon being researched rather than risking researcher contamination as described by Glaser (1967). The movement from the purism of Glaser to the inclusion of the experiential alertness described by Kirby (2007) acknowledges the self, or the reflexive position of the researcher, within the study (Corbin and Strauss 2008; Charmaz 2006). Kirby (2007:54) stated: "with experiential alertness we are celebrating the abilities experience allows us in

³⁶ Both Glaser's and Strauss and Corbin's versions of grounded theory adhere to the same basic research process: gather data, code, compare, categorise, theoretically sample, develop a core category and generate a theory. While very similar, the differences arise in how these processes are conducted (Walker 2006).

relation to the phenomenon.” In other words, Kirby (2007) articulated the importance of the role of the researcher within a study and the acquired prior expertise and knowledge that researchers bring to a study and to the field. Specifically, the reflexive researcher brings experience into the study (Corbin and Strauss 2008; Kirby 2007; Charmaz 2006). Charmaz (2006) also discussed how researchers locate and position themselves within their studies, through the constructivist version of grounded theory.

In summary, Strauss and Corbin take a more liberal approach to grounded theory, acknowledging the role of the literature but without the risk of researcher contamination prior to embarking on a study. Being aware of the field and being experientially alert is viewed as advantageous rather than as a problem for the researcher. Prior experience and the researcher’s familiarity with an organisation is viewed as a contribution toward a deeper understanding of the phenomena under review, rather than being viewed as a contamination risk to the development of substantive theory. A core component of this more liberal view of grounded theory, expressed by Strauss and Corbin is the requirement that researchers take a reflexive stand and are aware of their position within the research. The next section discusses the work of Charmaz and her constructivist approach to grounded theory.

3.3.3 Charmaz

Charmaz, a former pupil of Glaser and Strauss, acknowledged the evolving nature of grounded theory since the originators developed the classical approach in 1967 (Charmaz 2006). As a consequence of building on the heritage of grounded theory, she developed a methodology to serve inquiry in the area of social justice (Charmaz 2005). She articulated an interest in social justice as democratic processes and “thinking about being human, creating good societies and a better world” (Charmaz 2005:510). She stated that her view of grounded theory is through a methodological lens of the present century (Charmaz 2006) which

includes a set of flexible guidelines to enable researchers to build middle-range theories through successive levels of data analysis and conceptual development, based on strong empirical foundations, in order to achieve credibility (Charmaz 2005). Charmaz approaches grounded theory from a constructivist perspective, which places priority on the phenomena of study, how both data and analysis are created, from the shared experiences of participants, and how meanings and actions are attached to specific situations (Charmaz 2006).³⁷ Within these shared experiences, a theoretical perspective, derived from pragmatism, assumes that people construct themselves, society, and reality through symbolic interactionism³⁸ (Ibid).

Consistent with symbolic interactionism, the researcher must be able to actively interact with the persons being researched and see things from their point of view, and in their natural context (Jeon 2004). In other words, the research study starts with the experiences or area of inquiry and asks how the members of the study (in the case of this study members included GPs, practice nurses, administrators and women) construct or locate themselves within the phenomena (in the case of this study the discovery and disclosure of domestic violence). Multiple views are obtained, thus, acknowledging that interpreting the studied phenomena is itself a construction and grounded theorists develop a theory based on the data generated from participants telling their stories (Charmaz 2006). However, in an earlier paper, Glaser critiqued Charmaz's constructivist approach to grounded theory as being "a misnomer" (Glaser 2002:1). He argued that Charmaz remodeled grounded theory to a descriptive, qualitative data analysis method from its original conceptual core. He further challenged Charmaz by refuting her notion of 'story telling' arguing that grounded theory is not descriptive but that the theory is emergent from the careful tedium of the constant

³⁷ Charmaz (2006:7) critiqued Glaser's approach by arguing his method "imbued grounded theory with dispassionate empiricism, rigorous codified methods, an emphasis on emergent discoveries and the use of somewhat ambiguous specialised language that echoes quantitative methods."

³⁸ A brief overview of symbolic interactionism is presented later in this chapter (see Section 3.6).

comparative method and theoretical sampling, fundamental in grounded theory procedures (Ibid). According to Glaser (2002), Charmaz uses constructivism as justification, in reverse, for engaging in recidivism which he claimed makes the researcher's interactive impact on the data more important than the participants. For example, Charmaz (2005:514) argued that her study of chronic illness and suffering illuminates social justice concerns by un-tapping "the potential for innovative studies". Using a grounded theory methodology the study explored the experience of two women living with chronic illnesses. Charmaz (2006; 2005) described both women as telling their stories, prior to her description of the process of analysis, and how the stories of the participants became the data for analysis. According to Creswell (2007), Charmaz's variant of grounded theory is a social constructivist perspective that includes an emphasis on diverse local worlds, multiple realities and the complexities of particular worlds, views and actions.

Charmaz emphasised the flexible nature of grounded theory to study empirical events and experiences, and how it allows grounded theorists to pursue their hunches and potential analytical ideas about them, but cautioned that confirming ideas and checking hunches does not equal verification³⁹ (Charmaz 2006). She argued that the objective of developing a theory is to seek *explanation* and *prediction* [original italics], and grounded theory provides the tools for this action (Charmaz 2006; 2005). Explanation and prediction is a logical process that begins with initial coding where the researcher compares data with data, learns what research participants view as problematic and treats it analytically. Continual memo writing keeps researchers involved in the analysis while increasing the level of their concepts (Denzin 2010; Jones 2009; Charmaz 2006; McCann and Clark 2003b). The researcher continually engages with the data, is informed by the data and is directed by the data. The

³⁹ The goal of grounded theory methodology according to Bryant and Charmaz (2007:19) is to aim for *theorizing* [original italics] rather than verification because of data gathering, constant comparative analysis and conceptual development of the method.

process is described as a cyclical one where, researchers, not participants, are obliged to be reflexive about what they bring to a study, what they see, and how they see it (Charmaz 2006). Reflexivity is thus an essential part of the research process and a means of communicating the self to the reader (Heath 2006).

Charmaz's constructivist approach to grounded theory was deemed the most suitable version for this study as it places emphasis on the views, values, beliefs, feelings, assumptions and ideologies of individuals as they underpin the methods of research. In tandem, she also described the practices of gathering rich data, coding the data, memoing and using theoretical sampling (Charmaz 2006). Since the experience of participants and their ontological assumptions are paramount to the development of understanding, a grounded theory methodology was used to explain *how* [original italics] actors in an applied field – general practice – seek information or actually practice: in other words, this study developed what Jones (2009:30) referred to as “a *theory* [original italics] of how this is done in actual practice” - how women's circumstances of domestic violence are discovered and how disclosure is enabled within a general practice setting.

Corbin agreed with the constructivist viewpoint and its principal tenets: that concepts and theories are *constructed* [original italics] by researchers, out of stories constructed by research participants who are trying to explain and make sense of their experiences and lives, both to the researcher and themselves (Corbin and Strauss 2008). The phenomenon under scrutiny in this study – the discovery and disclosure of violence against women – represents an issue of social justice inquiry. According to Charmaz (2006), interest in social justice inquiry is demonstrated in the researcher's attentiveness to ideas and actions concerning fairness, equality, status and hierarchy of both individuals and collective rights, including taking a critical stance towards actions and social institutions. Furthermore, social justice researchers also consider what “ought” and “should” be done (Charmaz 2006:510). In other

words, social justice inquiry illuminates our understanding of what works and does not work within organisations, society and for individuals. Having considered each version of grounded theory from the key contributors, I decided on Charmaz's approach as the most appropriate to develop a theory on the discovery and disclosure of violence against women, specific to the general practice setting. This constructivist approach to grounded theory acknowledges that people construct realities in which they participate and it foregrounds the reflexive stance of the researcher within the research.

3.3.4 Summary

This section provided an overview of grounded theory and the key differences between the variations in this methodology. While there are similarities between the approaches, the differences lie in how the methodologies are conducted. Glaser (1998) advocated that researchers should avoid contact with external sources which may contaminate research; however, Corbin and Strauss (2008) took a more liberal approach and acknowledged the need to be experientially alert within the research process. Charmaz (2006) advocated a constructivist approach, including: using the literature to set the scene for the study, researcher attentiveness and participants' stories as data. Her constructivist approach to grounded theory offers a systematic method to social justice inquiry. Thus, my decision to use a constructivist grounded theory approach for this study was informed by its relevance to studying an issue of social justice; the discovery and disclosure of domestic violence within the general practice setting; the use of participants, women, general practice health professionals and administrators; stories as data; and the complementarity of my biography as a researcher with experience and understanding of the social, organisational, work and political environment of the organisation of general practice which, in turn, allowed me to

develop a level of experiential alertness and awareness toward the research site, general practice.

3.4 Grounded theory and theory development

Two types of theory can be developed using grounded theory: formal or substantive theory (Corbin and Strauss 2008; McCann and Clark 2003b). Corbin and Strauss (2008:264) described the stage of theory development as “the point of final integration” where the main categories or themes move into a unified theoretical explanation. In grounded theory, an inductive model of theory development exists, where the process is one of generating or discovering a theory grounded in views from participants in the field (Creswell 2007). According to Charmaz (2006:8), the “logic of grounded theory can reach across substantive areas and into the realm of formal theory, which means generating abstract concepts and specifying relationships between them to understand problems in multiple substantive areas.”

While theory contributes to research by allowing researchers to stand back and view phenomena critically (Kelly 2010), the process of formal theory development is one which transcends across several substantive areas of study which are abstract. The process of formal theory development involves negotiating a conceptual area of enquiry where the formal theory specifies the links between the concepts (Corbin and Strauss 2008). An example of formal theory, derived from a grounded theory study is “enduring love” (Kearney 2001:270). Kearney analysed 13 qualitative research reports from nursing, sociology, criminology and educational backgrounds to synthesise a middle range theory of women’s responses (n=232) to violent relationships. Enduring love explains women’s experience in violent relationships, including moving through various stages of romantic commitment. The theory draws from a variety of contexts and integrates psychological, socio-cultural and practical considerations.

Many grounded theories are substantive theories because they focus on specific areas of study. In this study, the substantive area is violence against women.

The basic steps of constructing substantive and formal theory in a grounded theory research are the same (Kearney 1998); they include theoretical sampling, constant comparative analysis and theory development. As such, the theoretical philosophy underpinning grounded theory is rooted in the tradition of symbolic interactionism which speculates on social roles as they relate to human behaviour (Speziale and Carpenter 2007; Chenitz and Swanson 1986). Symbolic interactionism is discussed in the next section.

3.5 Symbolic interactionism

The foundations of symbolic interactionism were laid in the 1960s, by George Herbert Mead from the University of Chicago (Jeon 2004). However, it was Blumer (1969), a sociologist from the University of Chicago, who coined the phrase ‘symbolic interactionism’. He stated that the “fundamental premise of symbolic interactionism as an approach to research is that human beings move towards things based on the meaning they have for them” (Blumer 1969:2). According to Jeon (2004), symbolic interactionism is one of the interpretive perspectives in research. Symbolic interactionism holds that people are in a continual process of interpretation and definition as they move from one situation to another situation (Eaves 2001). Symbolic interactionism is based on three principles:

1. What individuals encounter in daily life - The meaning of such things is derived from or arises out of the social interaction one has with others.
2. Meanings are handled in, and modified through, an interpretive process used by the person dealing with the things she/he encounters.

3. Human beings act towards things on the basis of the meanings that things have for them. Things include: physical objects; other people - friends or enemies; institutions e.g. schools, organizations; value systems – honesty or independence. Blumer (1969:2)

Within symbolic interactionism the notion of meaning is one of the major elements in understanding human behaviour, interactions and social pressures (Jeon 2004). Meaning in this context is not static, as individuals' behaviour can change, or be influenced by intrinsic or extrinsic factors that are relevant to them at that time. According to Charmaz (2006:189), the theoretical perspective of symbolic interactionism assumes that interaction is inherently dynamic and interpretative; and symbolic interactionism addresses how people create, enact and change meanings and actions which, in turn, rely on language and communication. Symbolic interactionism explains social phenomena from the perspective of the participants (Barry and Yuill 2002). Consequently, symbolic interactionism was considered as an appropriate theoretical framework to explain the social phenomena of violence against women. Since meanings arise out of actions, and, in turn, influence actions (Charmaz 2006), this study addressed how women, who were experiencing domestic violence, disclosed their experience, and how health professionals discovered, in the course of a clinical consultation within a general practice setting, that domestic violence was an issue for a woman. In this way, this study addressed how health professionals, and women who experienced domestic violence, gave meaning to the discovery and disclosure of domestic within a general practice setting⁴⁰.

⁴⁰ As stated earlier, for the purpose of this study, the term disclosure is used when a woman voluntarily speaks about domestic violence during a clinical consultation; the term discovery is used when it becomes apparent in the course of a clinical consultation with the general practice team that violence exists, and when the patient has not made an explicit disclosure of an abusive relationship.

3.6 Grounded theory research: a methodological approach

As argued previously, a major strength of grounded theory methods is that they provide tools for analysing processes which hold much potential for social justice issues (Charmaz 2005). An essential task of the grounded theorist is to identify the often un-articulated basic social problem shared by participants (Bruce et al. 2011). The objective of using a grounded theory methodology for this study, which is a social justice inquiry, was to develop a theory to illuminate our understanding of the process of the discovery by health professionals, and the disclosure by women, of domestic violence within a general practice setting. To date, no Irish study has been conducted in a general practice setting which explores the experiences of general practitioners, practice nurses, general practice administrators and women regarding the discovery and disclosure of violence against women. As grounded theory has the potential for engaging in untapped social issues and innovative studies (Charmaz 2006), it was deemed an appropriate method for this study.

The research design for grounded theory is described as an emergent design – a design that develops during the course of the data collection (Polit and Beck 2001) - where emerging grounded theories are shaped by the researcher's constructions of concepts and processes (Charmaz 2006). The ability to modify the design, as it progresses, allows for greater flexibility as the study develops and themes emerge. The flexibility afforded by grounded theory was critical to this study, where the initial design of this study was to explore how health professionals in general practice discover women's circumstances of domestic violence; however, as themes began to emerge, it became apparent that the study needed to include women's own experiences of the social process of their disclosure (or attempts to disclose) domestic violence when attending general practice consultations. Thus, both women's experiences and those of the general practice team were the stories and subsequent

data of this grounded theory study. Adding the voice of women to the study, illuminated the emerging understanding of the phenomena of the disclosure of domestic violence and how, or if, health professionals discovered or enabled disclosure within a general practice setting. The emergent need to add the experiences of women will be further discussed in the section 3.6.2 on theoretical sampling.

The key characteristics of grounded theory which were employed in this study are discussed in the next sections. They include:

- theoretical sensitivity
- theoretical sampling
- constant comparative analysis
- coding and categorising the data
- theoretical memos

(Charmaz 2006; McCann and Clark 2003b).

3.6.1 Theoretical Sensitivity

My original question in this research was around gaining an understanding of how general practitioners, practice nurses and general practice administrators recognise and respond to issues of domestic violence within a general practice setting. However, following my early experiences of gathering data in the field I quickly realised that using the term recognise in the research question prompted a response on the physical aspects of abuse only despite the intended focus of this study – all aspects of domestic violence. Thus, I allowed “theories [to] flash illuminating insights and make sense of murky musings and knotty problems” (Charmaz 2006:128). I took cognisance of the notion that the construction of theory necessitates that an idea be explored fully and considered from many different angles or perspectives (Corbin and

Strauss 2008). Furthermore, in my ongoing engagement with the literature, I was directed toward other theoretical concepts that needed to be examined in order to inform the substantive theory; these included *inter alia*: invisibility and the notion of privacy and secrecy for women who remain silent, and theories of gender and patriarchy (see Chapter Two section 2.4). Consequent to this, and in accordance with the emergent design of grounded theory, I changed the language of the research question to more accurately reflect the social process of the study, namely the discovery and disclosure of domestic violence. In other words, I did what Corbin and Strauss (2008:56) advised: “a researcher has to make choices and should choose the approach to, and aims for, research that are most suitable to the problem of study.” In essence, through my engagement in the process of theoretical sensitivity I enhanced my awareness of the nuances of the emerging data. The next section discusses theoretical sampling where the researcher seeks relevant data sources and participant stories to inform the study.

3.6.2 Theoretical Sampling

Theoretical sampling is based on the premise that data collection and analysis go hand in hand (Corbin and Strauss 2008). Charmaz (2006) argued that sometimes qualitative researchers claim to use theoretical sampling but do not follow the logic of grounded theory. She outlined a clear distinction between initial sampling (sampling criteria before you enter the field) and theoretical sampling: “initial sampling in grounded theory is where you start whereas theoretical sampling directs you where to go” (Charmaz 2006:100). Theoretical sampling differs from other non-probability sampling strategies commonly used in qualitative research, such as purposive and selective sampling (Creswell 2007; Jeon 2004). When embarking on a study the research question determines the sample population or research participants most suitable to provide the appropriate data. In the words of Corbin and Strauss

(2008:146) “a researcher using theoretical sampling never knows what twists and turns the research will take – the researcher follows the analytical trail.” The first stage of the sampling process may be purposeful sampling, which is then “superseded by theoretical sampling” when the emerging data and theory development direct the second stage of sampling and what to pursue (Cutcliffe 2000). A researcher using a grounded theory methodology must be open minded to the emerging data and must theoretically sample any new data in order to illuminate the study. In this way, a researcher may have a broad idea of the participants prior to commencing a study, but this may change along the way due to the development of theoretical categories. The current study commenced with members of the general practice team. However, as they spoke about women and their perception of women’s experiences of disclosing domestic violence, it was necessary to include the voice of women in the study to inform the emerging categories. In this way, Corbin and Strauss (2008:144) states that the researcher is like a detective. Hence, following the principles of theoretical sampling, women who experienced abusive relationships were included as participants in this study. Their experience of attending general practice was explored to discover how they were enabled to disclose (or not) domestic violence during the clinical consultation. Theoretical sampling is especially important when studying new or uncharted areas because it allows for discovery (Corbin and Strauss 2008). The next section discusses the process of constant comparative analysis.

3.6.3 Constant comparative analysis

The process of data analysis in grounded theory methodology is defined as constant comparative analysis as the collection of data and the analysis procedures are interwoven and run simultaneously. The researcher begins with open coding, in order to code the data for its major categories of information (Creswell 2007). Initially, during the open coding phase the

researcher will go through the data line by line, often labelling the information into multiple categories. Open coding requires “a brainstorming approach to analysis because, in the beginning, analysts want to open up the data to all potentials and possibilities contained within them” (Corbin and Strauss 2008:160). Many codes are generated at this stage of the process. According to Kearney (1998:181), who used fashion and clothing terminology to define grounded theory “*coding* [original italics] of data in constant comparative analysis begins at a descriptive level in which all aspects of a phenomenon as seen by the participants are labelled and categorised exhaustively.” While the researcher continues to collect data, the coding continues in tandem. Creswell (2007:64) described this as a “zigzag” process: going out to the field to gather information, analysing the data, back into the field to gather more information and so the cycle continues until saturation is reached. This process occurs until no new data emerge relevant to particular categories and subcategories, when categories have conceptual density, and all variations in categories can be explained (McCann and Clark 2003b). Categories are ‘saturated’ when gathering fresh data neither sparks new theoretical insights, nor reveals new properties of core theoretical categories (Charmaz 2006; Chenitz and Swanson 1986). Charmaz (2006) criticised researchers for foreclosing possibilities for innovation without having first fully explored their data. When engaging a constant comparative analysis it is necessary to cross check emerging concepts against participants’ meanings (Cooney 2011). This process of constant comparative analysis within the grounded theory methodology is one of constantly comparing new data with existing data, data with categories and categories with categories. The back and forth (zigzag) process continues until no new categories emerge or the data is described as being saturated. A key element in the process of comparative analysis is the coding and categorisation of data.

3.6.4 The coding process

The purpose of coding is to conceptualise the data by analysing it and identifying patterns or events in the data (McCann and Clark 2003b). Data in grounded theory studies may include interviews, field notes and observational notes. Glaser's mantra has always been: all is data (Glaser 2001; 1978; 1967). Some are critical of this all inclusive notion of data suggesting that Glaser's stance implies that the researcher does not need to be concerned with quality of the data, range of data, amount of data, or accuracy of data (Bryant and Charmaz 2007). However, quality data are essential to ensure a quality study. According to Charmaz (2005:511) by "gathering rich empirical materials" and by "recording these data systematically," analysis can be increased. Analysing data by the grounded theory method is an intricate process of reducing raw data into concepts, where categories are developed and integrated into a theory (Chenitz and Swanson 1986). The ultimate use of categories is in the development of a taxonomy, in which the researcher identifies relationships between categories and smaller units, or subcategories (Morse 2008). An example of a breakdown and coding of data was outlined in Lichtenstein's (2006) grounded theory study of how domestic violence diminishes HIV positive women's ability to access health care from a public health clinic in Alabama. The results were illustrated in 4 case studies (3 focus groups and 50 in-depth interviews of women were conducted in the full study). The results, described as four clusters in the study: sexual slavery and confinement; surveillance and stalking; depressed helplessness; fearful nondisclosure, offered an initial framework for understanding why domestic violence was a barrier to regular HIV care for so many women (p130). Other recurring themes from the data related to feelings of shame, fear and stigma (Lichtenstein 2006). Lichtenstein's study illustrated how common themes emerged through an iterative process of coding data to inform the complexities of domestic violence behaviours. Likewise, this study used a similar process of coding data to identify common themes in the data that

illuminated an understanding of women's process of disclosure in general practice consultations.

Glaser (2002a) advocated looking for patterns and similarities in the data. He describes the process of grounded theory as “the generation of emergent conceptualizations into integrated patterns, which are denoted by categories and their properties (Glaser 2002a). Charmaz (2006) suggested that careful word-by-word, line-by-line, incident-by-incident coding moves the study toward fulfilling two criteria for completing a grounded theory analysis, fit and relevance, and recommended dividing coding into three types: *in vivo* codes, focused codes and theoretical coding, all of which are discussed in the next section. For completion, a discussion on axial coding which is also a version of grounded theory (Corbin and Strauss 2008) is presented.

3.6.5 In Vivo codes

In vivo codes help researchers to preserve participants' meanings of their views and actions in the coding itself (Charmaz 2006). They are particular markers of participants' speech and meanings: whether or not they provide useful codes in the later more integrated analysis depends on how one treats them analytically (Ibid). In vivo codes can be defined as the common language used by participants – the everyday language that has meaning for the participants.

3.6.6 Focused coding

Focused coding involves a more analytical level in the coding process. Focused coding requires decisions about which initial codes make the most analytic sense to categorise the data incisively and completely (Charmaz 2006). Coding does not occur in a linear fashion but is cyclical with the researcher constantly reading and re-reading the data; through a process of

comparing data with data, a focused code is developed (Ibid).

3.6.7 Axial coding

Axial coding is a process of crosscutting or relating concepts to each other (Corbin and Strauss 2008). Axial coding relates categories to subcategories, specifies the properties and dimensions of a category, and reassembles the fractured data during initial coding to give coherence to the emerging analysis (Charmaz 2006). Essentially, both open coding and axial coding go hand-in-hand, with the distinction between the two being considered artificial and for explanatory purposes only (Corbin and Strauss 2008). In other words, the process is an indication to readers that though data are separated apart, concepts are identified to stand for the data and data have to be put back together again by relating concepts to each other. Charmaz, however, does not support Corbin and Strauss's (2008) formal procedures of axial coding; she developed subcategories of a category and demonstrated the links between them in her studies on suffering with a chronic illness (Charmaz 2006). She argued that at best axial coding may help to clarify emerging ideas but at worst it may "cast a technological overlay on the data" (Charmaz 2006:63). In other words, the constructivist approach to grounded theory ascertains that subcategories can be developed without engaging in axial coding. According to Charmaz (2006:61) "those who prefer simple, flexible guidelines and can tolerate ambiguity do not need to do axial coding."

3.6.8 Theoretical codes

Theoretical codes are used to combine substantive codes to form a theoretical model about the domain under scrutiny (Kelle 2005). These codes help the researcher to tell an analytic story that has coherence, as they not only conceptualise how the substantive codes are related, but also move the analytic story in a theoretical direction (Charmaz 2006). Theoretical codes

do not suddenly emerge; they evolve out of a constant revisiting of the data analysis in order to ensure that they have “earned their way into the theory” (Glaser 1998:164). Theoretical coding facilitates the researcher in asking the questions: 'What is happening here?' and 'How do the substantive codes relate to each other as hypotheses?' (Cutcliffe 2000:1482). At this stage of the analysis the researcher asks questions of the data, to see where gaps lie and to see a theoretical picture form (or the emergence of a theoretical picture). Theoretical codes add “precision and clarity as long as they fit the data and substantive analysis” (Charmaz 2006:63). The importance of precision and clarity is to demonstrate the trustworthiness or “accuracy” of the study which Creswell (2007:207) calls, “validation strategies.” Finally, theoretical codes tell the story of how the categories relate to each other conceptually (Hunter et al. 2011).

3.6.9 Memoing

For researchers, memo writing is the cornerstone of the analytical process. Memos are an opportunity for the researcher to reflect on the data, to write freely about what is happening in the research and to analyse the direction of the study. Writing successive memos throughout the research process keeps the researcher involved in the analysis while increasing the level of abstraction of ideas (Charmaz 2006). Chenitz and Swanson (1986) described the purpose of memo writing as a way for the analyst to keep an account of the developing theory and to compare and verify the findings as the study proceeds. According to Charmaz (2006:72), “through conversing with yourself while memo-writing, new ideas and insights arise during the act of writing.” The first purpose of memo writing is discovery and theory development, not application (Lempert 2007). Continuous memo writing, re-reading and re-writing, leads to progressively more abstract levels of theorizing (Ibid). In other words, memo writing allows the researcher to remain intimately involved with the data at a conceptual and

analytical level, to record the personal journey and to engage in further deeper exploration of the data in order to illuminate the study.

3.7 Challenges to using grounded theory

The first challenge in using grounded theory is the question of how or when to engage with the literature. While Glaser (1998) cautioned against being contaminated by the literature, others, (Dunne 2010; Corbin and Strauss 2008; Charmaz 2006; Morse 2001) argued for the use judicious use of the literature, as a preparatory process. Morse (2001:9) critiqued Glaser by stating that “such a naïve perspective as working without consulting the literature may be possible for a senior investigator with a vast knowledge of social science theory. Literature should not be ignored but bracketed and used for comparison with emerging categories.” Critically, the researcher needs to set aside theoretical ideas or notions so that the analysis will emerge (Creswell 2007). Another challenge for researchers is the use of grounded theory language or jargon which may be confusing, or lead to uncertainty for those new to the methodology (McCann and Clark 2003a). Reaching theoretical saturation of the data and knowing when to stop (Holton 2010; Creswell 2007) can be difficult to determine. One strategy to move toward saturation, suggested by Creswell (2007:68), is to use “*discriminant sampling* [original italics] by gathering data from individuals similar to those people initially interviewed to see if the theory holds true for the additional participants.” The researcher who wants boundaries and the reassurances of working with set structures (McCallin 2003) may find the process of developing “theoretical insights and abstract conceptual ideas” (Holton 2010:23) a further challenge. Given the complexity of these challenges, McCallin (2003) suggested skills to enhance the positive experience of conducting grounded theory: thinking skills and an ability to deal with complexity and ambiguity; communication skills as an effective interviewer; organisational skills and the ability to work independently; creative

ability and an ability to live with confusion and trust emergence.

3.8 Evaluating grounded theory

There is no overall system for evaluating grounded theory. Part of the difficulty in evaluating and critiquing grounded theory research is due to the nature of the methodology itself (Chenitz and Swanson 1986). Nonetheless, attention to the analytical process, how conclusions are drawn, and the extent that they are grounded in the data is critical (Cooney (2011). Since Charmaz’s (2006) approach to grounded theory was employed for this study, her criteria for evaluating grounded theory studies and the questions they prompt are outlined in Table 3.1:

Table 3.1 Criteria for Grounded Theory Studies (Charmaz 2006:182-183)

Credibility	<p>Has your research achieved intimate familiarity with the setting?</p> <p>Are the data sufficient to merit your claims?</p> <p>Are there strong logical links between the data, argument and analysis?</p> <p>Is there enough evidence for the reader to form an independent assessment?</p>
Originality	<p>Are the categories fresh? Do they offer new insights?</p> <p>What is the social and theoretical significance of the work?</p> <p>How does the study challenge, now, or current ideas or concepts?</p> <p>Does the analysis provide new conceptual data?</p>
Resonance	<p>Do the categories portray the fullness of the studied experience?</p> <p>Does the study make sense to the participants who share the experience?</p> <p>Do the findings identify taken for granted meanings?</p>
Usefulness	<p>Is the study applicable so that people can use it in everyday life?</p> <p>Do the analytic categories suggest generic processes?</p> <p>Can the analysis spark further research in other areas?</p> <p>How does the study contribute to knowledge?</p>

These criteria are considered again in Chapter Ten.

3.9 Chapter Summary

This chapter provided an overview of grounded theory, grounded theory approaches and the methodological variations between them. The constructivist approach to grounded theory (Charmaz 2006) was deemed the most suitable methodology for this study as it holds much potential for social justice issues. An overview of the key characteristics of grounded theory was outlined, namely: theory development, theoretical sensitivity, theoretical sampling, constant comparative analysis, coding and categorisation of data, and theoretical memos. Symbolic interactionism as an interpretative perspective of research, where meanings arise out of actions and social interactions was discussed. The challenges of the methodology and the criteria for evaluation were explored. The next chapter explores my experience of conducting the research.

Chapter Four: Undertaking Grounded Theory

4.0 Introduction

This chapter describes my process and methods in undertaking this grounded theory study. The research procedure including negotiating entry to the research site, the process of participant recruitment, collecting data, interviewing participants, ethical considerations and the analysis of data are presented. Putting grounded theory into practice requires performing research, or what Pergert (2009:1) describes as “learning-by-doing”, a process that requires much learning and much reflection. Although the steps to the research procedure are presented in a linear fashion, many overlapped through the iterative nature of conducting grounded theory. The personal reflections documented in this chapter are an account of my experience of doing grounded theory.

4.1 Accessing the site

My experience of working in general practice provided me with an understanding of the dynamics of the clinical environment and the organisational structure of the clinical setting. The dual nature of the nurse researcher role, and the idea that nurse researchers bring to the field nursing-specific knowledge, skills and attributes, can have methodological, practical and ethical implications (Borbasi, Jackson and Wilkes 2005), which supports Kirby’s (2007) notion of the researcher being experiential alert and having insider knowledge. For the purpose of this study individual general practice surgeries were selected. There was no central point of contact to access the research sites; gaining access to each site had to be negotiated on an individual basis. All of the sites were group practices with at least one practice nurse and more than two GPs, and I met participants in a variety of places both inside and outside the practice setting. Although I am comfortable in a clinical setting,

accessing health professionals in a clinical site created a consultation type scenario. In other words, I had to make an appointment through the administrator, I was given a time slot and, and, as I waited for the interview, I was surrounded by clinical paraphernalia (Manderson, Bennett and Andajani-Sutjahjo 2006). It is important to note that I met women in several locations ranging from their office, hotels or their homes, depending on their circumstances and their choice of location. According to Manderson, Bennett and Andajani-Sutjahjo (2006), research interactions are shaped by the social context of the interview; they described the impact of environment:

The coffee shop or park provide a relatively anonymous space, less formal but still public, influencing confidentiality, informing perceptions of what may or may not be discussed, and potentially inhibiting the introduction of private and potentially emotive topics. The choice of the interviewee's home, conversely, invites the interviewer into his or her private life, shifting the balance of power. It also provides context, the interviewer is witness to the class and social status of the interviewee through the location and kind of housing and its contents, and to clues to identity and history through personal artefacts (such as photographs), which, in turn, are open to comment. Invitations into the private domain also obviate certain descriptions and validate accounts.

(Manderson, Bennett and Andajani-Sutjahjo 2006:1318).

One woman and one practice nurse arranged to meet me in their homes. Using such an informal site was of benefit as it resulted in the creation of a social occasion and a less formal meeting, where in the words of Corbin and Morse (2003:338) there was strong suggestion of "the very essence of trust and conversational intimacy." Unlike the clinical setting, conducting interviews in the privacy of the home was "a quiet location free from distractions" (Creswell 2007:133). Sitting in the waiting room of surgeries was an opportunity to reflect on the health information material on view and how a woman in an abusive relationship may be enabled or not to disclose her circumstances of abuse (this is further explored in section 4.4.1 of this chapter).

4.2 Recruitment and sampling

I used the Irish Medical Directory to obtain the contact details for GPs and practice nurses to commence the process of recruiting participants for the study. Initially I sent out 12 letters to general practitioners (6 male and 6 female) and 10 letters to practice nurses⁴¹ (all female) inviting them to participate in the research (see Appendix Five). I included a stamped addressed envelope with each letter for responding to the invitation and requested a return date of two weeks for replies. No GP responded and two practice nurses agreed to participate. After three weeks I phoned six surgeries, randomly selected from the original list of 12. Two surgeries were engaged when I rang and I successfully spoke with four general practitioners (all in different surgeries). All four agreed to be interviewed. Only one GP remembered receiving the letter, while the others did not recall “ever seeing” the letter. Recruiting participants can be problematic especially when there are several cohorts to recruit. Furthermore, the complexity of contacting multiple sites, with different working hours and working systems, slowed up the process considerably. According to Reeves (2010), gatekeepers may help or hinder access to the research sites, depending on their personal thoughts or values. In this research, all messages were filtered through the general practice administrator and I, as a researcher, had no way of knowing if my call was passed on to a general practitioner or practice nurse. Following a slow start, I contacted participants in person via telephone and outlined the details of the study. In some cases, I emailed the details of the research following a request to participate in the study. The remaining five GPs and six practice nurses, which I contacted in person, were very positive about the study and agreed immediately to take part. The majority of interviews with health professionals occurred during lunchtime or at the end of the evening surgery.

⁴¹ All practice nurse participants were female as there were insufficient number of male practice nurses at the time of the study. There were five male and four female GPs interviewed for the study.

Following my interviews with GPs, I discussed the feasibility of recruiting administrators to my study. My request was well received; however, on one occasion, on my behalf, one GP asked the administrators in the practice if they were interested in participating in the study, but they declined. On reflection, this may not have been the best idea as I do not know how the GP explained my study to the potential participants. Thereafter, and once I had the agreement of the GP, I contacted the administrative staff myself directly, by telephone. Rather than go through a third party, it was important that I explained the study myself to potential participants and used the opportunity to answer any impending queries. According to Ward and Mc Murray (2011) receptionists are the administrative gatekeepers to GPs. However, GPs and the staff of the surgery have a “contractual relationship” (McEvoy 2000:244) of employment, therefore, it was necessary to communicate with the GPs prior to recruiting administrative staff. This was particularly important for the administrators as they are less familiar with engaging with research than health professionals. Communicating with the GP in this way allowed me to ‘pave the way’ for my research with participants.

4.3 Developing a theoretical sample

The initial participants in the study were health professionals (GPs, practice nurses and general practice administrators). However, the interview questions related to how women are enabled to disclose domestic violence. Quickly, I realised that data arising from such a focus, that is without the women’s perspective, ran the risk of “the meaning of the tale [becoming] invisible, incomplete, or even incomprehensible” (Charmaz 1999: 375). As noted previously, theoretical sampling involves starting with data, constructing tentative ideas about the data, and then examining the idea through further empirical inquiry (Charmaz 2006). Critically, researchers must decide when to shift from selective to theoretical sampling (Draucker et al. 2007). Initial findings from this study suggested that the inclusion of women’s perspectives

was necessary in order to illuminate my understanding of what goes on during a process of discovery/disclosure of domestic violence specifically within a general practice setting. When a grounded theorist commences a study, the first stage of the sampling process may be purposeful sampling, which is then “superseded by theoretical sampling” as the data/theory directs the second stage of sampling to pursue (Cutcliffe 2000:1477). Furthermore, in Ireland there is a dearth of research that reflects the experience of discovering violence against women within the clinical consultation by primary care health professionals, which also includes the voice of women’s experiences of disclosing violent encounters. According to Mullender and Hague (2005) and Hathaway, Willis and Zimmer (2002) most abused women who do participate in research feel their views have been overlooked to a considerable extent by service providers or policy makers and health professionals. Thus, the rationale for including women in this study is well supported by the principles of theoretical sampling, and principles of social justice which are a key element of constructivist grounded theory.

A number of different strategies were used to recruit women participants. They included contacting domestic violence support agencies, snowballing and following up on media leads. Initially, women participants were sourced from an organisation that offers a support service to women who experience, or have experienced, domestic violence. In order to interview women who had experienced intimate partner violence, I met with a senior social worker responsible for the service and discussed my study with him. I furnished the organisation with a recruitment letter (see Appendix Six) outlining the details of the study. The case workers in the support organisation informed women about the study. Three women contacted me. Two women agreed to be interviewed in person and one woman was interviewed by phone. However, no subsequent communication from the organisation was received. Shortly afterwards, I heard a woman interviewed on the radio about her experience of living in an abusive relationship. I contacted the radio show outlining the details of my

study and asked if they would forward my contact details to the participants on the show (see Appendix Seven). However, this did not yield any results. Consequently, I made contact with one of the women who participated in the radio show, via the support group she mentioned during her interview. We arranged to meet prior to one of the organisation's support meetings. Following the meeting with the first participant, a further three women agreed to with meet me on the same day. The women were found through an existing social network and through the use of snowballing techniques (Davies and Dodd 2002). A process of snowballing recruited the remaining three women participants. The use of snowball sampling is a widely employed method in qualitative research on hard-to-reach populations (Heckathorn 2011). According to Lee (1993), snowball sampling has an advantage in cases where those being studied are members of a vulnerable or stigmatised group. He argued that security features are built into the method because the intermediaries, who form the links of the referral chain, are known to potential respondents and trusted by them. Therefore, convening a population sample of women for this study was enabled by a mutual mediator, an approach especially suitable when exploring sensitive issues such as violence against women.

4.3.1 Sampling criteria

Participants for a qualitative study are not selected because they fulfil the representative requirements of statistical inference but, rather, because they can provide substantial contributions to filling out the structure and character of the experience under investigation (Polkinghorne 2005). Therefore, when seeking to hear the stories of participants in relation to phenomena of research interest, in the case of this study, the discovery and disclosure of domestic violence within the general practice setting, it was important to recruit participants who had a story to tell. Accordingly, selection criteria for health professionals included:

health professional participants with a minimum of three years' experience working in general practice where the study took place. Information regarding GPs years of graduation are identified in the Irish Medical Directory, which also indicates how long they are working in general practice. I required GP participants with three years' minimum experience in order to ensure familiarity with the clinical setting and to allow staff to have developed a rapport between them and the practice population. When contacting practice nurses and administrators I asked them how long they were working in the particular surgery. Participants' years of experience working in general practice ranged from 5-35 years (GPs), 3-16 (practice nurses) and 7-15 (administrators). The criteria for the selection of women participants were as follows: women who have already disclosed their experience of an abusive intimate partner relationship. Disclosure to a general practice health professional was not deemed necessary; however, due to the sensitivity of the subject, it was essential that the occasion of the research interview was not their first experience of disclosure.

4.4 Data Collection Methods

This section outlines data collection methods used and the issues associated with the process. One-to-one interviews were the main method of data collection. However, other methods, such as observation and domestic violence training workshops, were also used to inform my understanding of the study. These opportunities helped me to understand the clinical interactions within consultations, to observe general practice from a patient's perspective and to make sense of the data.

4.4.1 Observation

I visited nine surgeries to conduct interviews where, as part of the process of gathering data, I used the opportunity to put myself in 'patient mode', to observe what health information

displayed in the surgeries would enable a woman to get any help without asking for the service. None of the nine practices displayed information on domestic violence. There was no indication in the surgeries that violence against women was an issue that may be discussed with the general practice team. Waiting, in this way, also illuminated my understanding of time and its management in general practice from two perspectives. I was able to observe patients who were waiting to be seen by a health professional and health professionals whose time schedules were running late and who were then expected to meet a researcher. These periods were an opportunity for me to reflect and observe as a former clinician and now a researcher. Glaser (1998) suggested that in grounded theory there is no such thing as observation without interviews to give them meaning: they go hand-in-hand. Periods of observation, as I waited to do my interviews, were an opportunity to build the context, to see the communication dynamics between the staff of the practice and the patients, including the provision of health information leaflets. According to Mulhall (2003), observation is valuable because it is made up of people's behaviour and informs the researcher about the influence of the physical environment, though data about the physical environment are seldom collected. In practical term, observation by grounded theory researchers allows for the sharing of some of the experiences of participants, but not necessarily all view points with those being studied (Charmaz 2006:26). My engagement in observation illuminated my understanding of the emerging findings.

4.4.2 Training workshops

Other opportunities for data collection occurred during the facilitation of training workshops on violence against women. Since this study commenced I have conducted several training programmes and given lectures and seminars to various groups of health professional, including those attending the Women's Health Summer School (Irish College of General

Practitioners (ICGP)), Diploma in Women's Health Programme (ICGP), Practice Nurse Educational Workshops and BSc Nursing Programmes, Dublin City University (DCU). In total, there were over 100 attendees between all programmes. Through the recording of memos I was able to use each of these opportunities to inform my study. Prior to each training session I informed the attendees that I was undertaking research in the area of violence against women and I asked them if they had met a woman who was experiencing domestic violence within their clinical consultations. In addition, I asked how they may (or may not) have discovered the phenomenon. The process of enabling disclosure was also discussed prior to the main training session. These pre-training enquires were conducted in small groups and had the benefit of being a relevant 'ice breaker' prior to the main presentation. All training sessions were recorded in my memos and field notes. Invitations to present at various training workshops were received after I commenced my studies and therefore were not an anticipated source of data collection prior to undertaking my studies. Nevertheless, these opportunities illuminated my understanding of the data and informed what Charmaz (2002:307) described as "the gap between expectations and experiences."

4.4.3 The interview process

The principal source of data collection was one-to-one semi-structured interviews. In total, 9 GPs, 8 practice nurses, 3 administrators and 10 women participated in interviews. According to Charmaz (2006:25), the "nature of an interview facilitates the eliciting of each participant's interpretation of his or her experience." Interviews enable re-entry into the field at different intervals to develop existing categories and identify concepts (Dearnley 2005). Hence, they are suitable for qualitative research where the iterative process of collection and re-entering the field is in line with grounded theory methodology. The purpose of an interview is to satisfy the needs of the researcher. In this study I needed to hear stories of experience, thus,

my interviews with the participants were conversations with a purpose (Kvale 2006; Kvale 1996), rather than an *interview dialogue* [original italics] which, according to (Kvale 2006) is a misnomer. Hence, the progression of interviewing participants commenced with the “pre-interview” or “tentative phase” (Corbin and Morse 2003:341) in order to build rapport.

4.4.4 Pre interview

Prior to commencing the formal interview I spent some time engaging in general conversation with participants. This included thanking participants for agreeing to participate in the research, discussing the current happenings of general practice, giving an outline of the study and answering any questions about the study. This enabled a rapport to develop between the researcher and participants and involved establishing trust and respect for them and for the information that they were sharing (DiCicco-Bloom and Crabtree 2006). Building rapport, prior to an interview, requires researchers, who are essentially “outsiders” to a community, to address the psychosocial distance between themselves and the participants in order to gain valuable insights into their everyday lives (Sixsmith, Boneham and Goldring 2003). I usually brought refreshments, as the interviews were conducted over lunchtime, or got them at the site (e.g. hotel) where the interview occurred. Such activities of reciprocity have been viewed as trying to benefit from an exchange, by repaying in kind (Ben-Ari and Enosh 2013). In reality, it was a way of acknowledging and appreciating the efforts by participants to contribute to the study. I was very conscious that in some cases (general practice settings), I had a very short window of time before an afternoon surgery commenced and I wished to avoid the risk that participants involvement in research in the primary care setting would become just another item on a “to do” list, and hence be rushed. Hence, building rapport with practice staff was critical to maximise the occasion of the interview (Gaglio, Nelson and King 2006). Where the interviews were conducted in participants

homes, the 'pre interview' included being introduced to family pets, viewing family photos and, in one instance, being shown the garden. These opportunities were invitations into the worlds of the participants and implied the "very essence of trust and conversational intimacy" and a welcome for the "interviewer as a friend" (Corbin and Morse 2003:338). Time spent in building rapport was a chance for participants to get to know me in an informal way and to set the tone for the interview prior to exchanging information. Finally, prior to commencing each interview, the plain language statement and the issue of consent were discussed (see also Section 4.6.2 of this chapter).

4.4.5 Developing an interview guide

According to Charmaz (2006) a grounded theory study calls for the creation of open-ended, non-judgmental questions in order for unanticipated statements and stories to emerge. In this study, semi-structured interviews were used; these allowed me to ask participants the same questions within a flexible framework (Dearnley 2005). As part of the application for ethical approval for this research I developed an interview guide with a list of possible questions for discussion during interviews (see Appendix Eight). However, due to the progressive nature of the interviews, the structure of the questions changed between participants; hence, the process of my research interviews were characterised by a methodological awareness of the questions needed to focus on the dynamics of the interactions between myself and interviewee and to pay critical attention to what was being said (Kvale 1996). In the first two interviews I asked about the recognition of domestic violence; however, I realised this question was limiting as attention appeared to address physical violence only. Subsequent interviews encompassed questions on all forms of abuse, including less obvious signs, in order to illuminate an understanding of the visible and invisible signs of violence against women.

4.4.6 Fieldnotes and audio recording interviews

Much debate has arisen over the virtues of recording interviews in grounded theory research. Glaser (1998:109) suggested that “taping just collects words, not observations.” Charmaz (2006), on the other hand, contended that using tape recorders enables the researcher to see when your questions do not work. Prior to commencing my data collection, I conducted a pilot interview with a practice nurse; this was to rehearse my interview skills and to practice using the digital recorder. On this occasion the recording failed and I had to repeat the interview. It was a useful personal lesson for the need to do early checks to establish that the technology is working and not to become too dependent on it for recording interviews. In the research itself, all interviews were audio recorded except one GP interview and one telephone interview with a woman were recorded using field notes. I was concerned about my ability to multi-function – to listen, record, interview and document field notes simultaneously. After a few interviews my notes became single words which were used as prompts, with lines or diagrams to the next question or cue. In essence, the documentary evidence of the interviews looked like mind maps supported by the recordings. However; one woman asked for the recorder to be turned off during the interview which allowed her to speak more freely. On other occasions, conversations continued beyond the recordings where greater ease in articulating in-depth ideas about sensitive issues emerged when interviews were off the record. Having conducted qualitative interviews in this research I find myself agreeing with Glaser’s (1998:111) belief that “the richness of grounded theory comes from off-the-record data.”

According to Nunkoosing (2005), the popularity of the interview should not mean that we take the interview for granted. Interviewing require skill, expertise and inward inspection. When listening back on early interviews, or reading my fieldnotes, I realised I had missed

opportunities for more in-depth questioning or further probing, and that I had missed signals. On other occasions, when conducting interviews during a participants lunchtime, I hastened replies due to my perception of the time limitations. Awareness of these occurrences early in the data gathering process helped to inform future interviews (McIlfatrick, Sullivan and McKenna 2006) and assisted me in recognising the need to go at the participants' pace and not mine. By the same token, it was necessary to be aware of myself, and my role as a researcher in order to develop interview awareness, to work toward being "the skilled, embodied interviewer" using my personhood to communicate with people in the creation of stories (Nunkoosing 2005:698). Finally, my overall experience taught me that successful interviewing is more than asking questions; it requires active listening and astute observation of verbal and non-verbal cues.

4.4.7 Interviews as a process for raising awareness

During the course of data collection, some participants acknowledged how the experience of the interview raised their awareness about the issues of violence against women. Comments included:

I enjoyed that, you [researcher] got me thinking about things that I hadn't thought about in a very long time (Dr Oak).

But it's good to think about it [violence against women] and it will be more at the forefront of my mind (Dr Elm).

I personally have never thought about it [violence against women] until you [researcher] spoke about it (Nurse Rose).

Participating in the interview dialogue was an opportunity to raise awareness about the substantive issue. It was also a chance for health professional participants to personally consider their current practice and evaluate their behaviour. Thus, the interview facilitated a process of personal reflection for some participants. Women's experience of participating in

the interviews enabled them to have their stories heard. One woman, Crystal, came back for a second interview, pleased that someone was interested in hearing about her experiences; her personal narrative. Recounting her experiences enabled her to engage in a process of personal reflection also. According to Maiter et al. (2013) the ability to reflect on ourselves, on each other, and construct meanings that validate our shared experiences requires a critical self awareness. Through the process of conducting the interviews both the interviewer and interviewee developed a deeper understanding of the substantive issue of violence against women and the process of discovery and disclosure.

4.5 Data analysis

This section outlines the process of coding the data, memoing and the use of software to facilitate data analysis.

4.5.1 Open coding

When using a grounded theory approach, the coding process of the interviews commences in tandem with the continuous collection of data (see Chapter Three section 3.5.3). Initial or open coding is the first stage of the coding process; often it is described as fracturing or decontextualising the data. According to Holton (2010:24), “line by line coding forces the researcher to verify and saturate categories, minimises the risk of missing an important category and ensures relevance by generating codes with emergent fit to the area under study.” In my initial coding, and in keeping with Charmaz’s (2006) recommendations⁴², I use

⁴² As part of my research process I attended a grounded theory workshop in Trinity College run by Kathy Charmaz, where there was an opportunity to ‘practice’ open coding.

gerunds⁴³ or action words (where possible) to reflect the interpretation of the text. In so doing, I was mindful of the questions: ‘What is happening in the data?’(Glaser 1998) and ‘From whose point of view?’ (Charmaz 2006)

The breaking of the data into manageable codes enabled me to establish meanings from the data (see Appendix Nine)⁴⁴ and to engage intimately with the emerging patterns (see Table 4.1). Following the transcription and coding of my first three interviews, I had generated 65 codes and several memos.

Charmaz (2006:48) recommended working quickly during the initial coding process, which did. However, the challenge was to avoid labelling data and, rather to concentrate on coding and comparing incidents, while asking the above two questions, I found myself duplicating codes in an effort not to neglect anything in the process, for example, setting for disclosing and explaining the setting.

Text from Interviews	Initial code
We are poor at thinking about it and picking it up or asking about it, or discretely asking about it. Or being alerted to it.	Not recognising domestic violence
I mean there is an awful lot of stuff to get through.	Feeling over burdened
But there is not a whole lot more you can do	Feeling helpless
Different symptoms- chest, backache, earache, stomach ache	Looking at medical symptoms

Table 4.1 Example of open coding process

⁴³ Examples of a gerunds include, ‘missing the plot’ and ‘explaining it away.’

⁴⁴ Appendix Nine = an example of open coding from N Vivo, there are two pages to this appendix.

4.5.2 Selective coding

Coding, like constant comparative analysis, is a cyclical process; it occurs at several levels at once (McCann and Clark 2003b). The second stage of the coding process involved a process of selective or focused coding where codes were scrutinised for similarities, combined and collapsed further into categories (see Appendix Ten)⁴⁵. Despite condensing the open codes considerably, I still had a lot of selective codes that I found difficult to collapse into categories⁴⁶. Throughout the coding, several categories were merged and renamed and the process was both time consuming and challenging. However, it did ensure that “only relevant aspects of the phenomena under scrutiny are [were] recognised” (Kelle 2005:10). In time, and through a process of delimiting and theoretical sampling, my analysis became more focused. At this point in the research I started memo writing in earnest which assisted with the simultaneous process of collecting data and data analysis.

4.5.3 Theoretical coding

My engagement in theoretical coding involved a move toward higher levels of conceptual abstraction, core emergence and theoretical emergence (Holton 2010). At this stage my aim was to create emerging theoretical links between categories, and to hone my work with a sharp analytic edge (Charmaz 2006). This process involved a constant revisiting of the data to ensure that my emerging theoretical codes earned their way into the theory (Glaser 1998). In this research, three core categories emerged from the data, which forms the structure of the findings’ chapters that follow. They are: choreographing the consultation; spiralling silences and compartmentalising. The theme *lifting the stones and seeing the slugs beneath* (an in-

⁴⁵ Appendix Ten = is an example of selective coding from women’s interviews using a word document. There are over 2 pages to this appendix.

⁴⁶ For example: giving time; owing time; needing time; structuring time; eventually, all these were collapsed into the category time.

vivo code, meaning it emerged from a term used by one the participants) interweaves the three core-categories. These three core-categories underpin the theory of ‘conspicuous invisibility’ which emerged from this study to illuminate understanding of the process of discovery and disclosure of violence against women, specifically in general practice consultations. The theory is used to explicate how the issue of violence against women, is often conspicuous (known in a public or generic sense), but invisible (the signs and evidence of circumstances of domestic violence are frequently hidden or invisible in the context of a clinical consultation) (see Chapters 5-8). The term conspicuous invisibility has been used descriptively in a variety of ways: by Stevenson (2003) to describe cultural competence between Black people and researchers in school-based mental health services in the USA, as a shadowing strategy to negotiate distance between researcher and participants (Quinlan 2008); and to describe the presentation of wealth in everyday life in Vietnam (Harms 2013). Previous authors’ use of the term conspicuous invisibility, to describe a situation or a set or circumstances, differs from the generation of a theory, as in this study. Specifically, in this study the theory of conspicuous invisibility is developed through a sequence of systematic steps that are grounded in the data and illuminated through an understanding of the experiences of the participants toward the discovery and disclosure of violence against women. Moreover, by doing grounded theory (Glaser 1998) the use of theoretical coding and data analysis clarified the context and specific conditions under which the phenomenon was evident (Charmaz 2006:63), as is the case in this study. Therefore, through the process of coding, and constant comparative analysis, an explanation for what was happening in the data occurred. This informed the development of the theory of conspicuous invisibility which generated a theoretical understanding about the discovery and the disclosure of women’s circumstances of domestic violence, during general practice consultations. The inductive method of theory building, documented by the process outlined in this chapter, illuminates

how the theory of conspicuous invisibility emerged. Other examples of the development of grounded theory include “enduring love” (Kearney 2001), (see section 3.4) and Charmaz (1999:362) theory of “suffering” to illuminate an understanding of the relationship between those experiencing a chronic illness and the self. Thus the use of common terms – Kearney (2001), Charmaz (1999) and this study – to explain complex situations that are grounded in the voice of participants is not unusual. Indeed the meaning of such terms is illuminated further through understanding that emerges from a developing theory. The theory of conspicuous invisibility is discussed further in Chapter Nine, section 9.2. The next four chapters are an analysis of the findings of the study.

4.5.4 Theoretical saturation

Theoretical coding concludes with theoretical saturation. Categories are saturated when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties or core theoretical categories (Charmaz 2006:113). Reaching theoretical saturation is not about knowing everything there is to know about an issue; rather, saturation of data is described as the ‘best’ that is achieved at a particular time (Coyne and Cowley 2006). Recognising saturation can be difficult and one of the concerns is knowing when to stop collecting data (Holton 2010). I completed 30 interviews in total in this research study, realisation that I had reached saturation of the data occurred around the time of my 25th and 26th interview. Interviews conducted thereafter confirmed this realisation. I had collected and analysed an extensive amount of data and I had arrived at a point where no new information emerged.

4.5.5 Memoing

Memo writing is the foundation of the analytical process. Memo writing does not happen in isolation but operates in tandem with the process of constant comparative analysis and data

collection. I used memoing to bank my emerging ideas for use at the time of recording interviews, or at a later date when analysing them. Initially, my memos were short paragraphs that extended to abstract levels of thought. At the start, the process of recording memos was unstructured, almost like a diary; it was a safe place where I could process thoughts, ask questions and write to myself about what was occurring in the data (see Appendix Eleven). As I became more practiced in memoing, my process changed. Memoing provided an ongoing dialogue between the data and me, which helped to clarify what was happening in the field (Ghezeljeh and Emami 2009). My memos “serve[d as] analytic purposes” for my personal use (Charmaz 2006:80); they informed the process of my conceptual analysis.

4.5.6 Sorting memos and mind maps

The process of sorting memos was a manual task of moving emerging concepts around, asking questions of the data, merging, re-naming and sorting. It involved “pulling the pieces together” (Charmaz 2006:155). I managed this process with two rolls of wallpaper and several highlighter pens. Kneeling on the floor, I drew diagrams and mind maps between piles of memos, exhausting the possibilities of the major categories. In this manner, I “grappled with the material” (Ibid:157). Although challenging at times, due to the volume of memos, nevertheless the process was invaluable as it enabled me to view “significant events” (Ibid:115) with greater clarity and to move the process of conceptual analysis and theory development forward.

4.5.7 Use of computer technology

From the outset I used NVivo 8 for the management of data. One of the key advantages of NVivo 8 is that it provides a single location for the storage of data. In addition it provides easy access to material and has the ability to handle large amounts of data with consistent

coding schemes (Bergin 2011). The disadvantages include the time and effort to become proficient in the programme (Ibid). I attended two training courses in order to learn how to use the software. However, I also invested a considerable amount of personal time self-learning how to navigate the system so that I could store and retrieve data. Despite this, I found that the visual process of making connections between concepts was easier with highlighter pens and paper. In the course of doing this study, two further updates of the package NVivo 9 and 10 came out. Each system brought changes that required new learning. Personally, the benefit of the system was the ability to archive and retrieve data, but due to the amount of time required to become familiar with the system, I found the use of technology somewhat limiting.

4.6 Ethical considerations

The ethical considerations for conducting qualitative research include informed consent, maintaining confidentiality and anonymity, and risk management strategies. The value of the research depends as much on its ethical veracity as on the novelty of its discoveries (Walliman 2006). Veracity is the commitment of a professional to be open and honest with a participant, despite the discomfort that might occur (Kress et al. 2013). In seeking ethical approval, it was necessary to apply to the University's research ethics committee. The role of the ethics committee is to act as a gatekeeper and advocate for participants and others who take part in research (Parahoo 2006).

4.6.1 Ethical approval to conduct the study

Approval for the study was obtained from Dublin City University (DCU) research ethics committee. Initially approval was obtained from the DCU to interview health professionals (see Appendix Twelve). However, as a consequence of theoretical sampling and the decision

to interview women participants, I made a second application to the research ethics committee to amend the original study. This application was approved (see Appendix Thirteen).

4.6.2 Informed consent

Written details of the study outlined in the plain language statement accompanied all invitations to participate in the research (see Appendix Fourteen). Following the initial contact by phone to health professionals, I emailed those who agreed to participate the invitation and the plain language statement prior to the interview. Women who contacted me to participate in the study (by snowballing) received the written details of the study on the day of the interview. Details of the study were also given to the support organisations whom I contacted to recruit participants. Where potential interviewees made contact with me via the organisations, they received the initial details of the study from the support organisation and further details by telephone from me, prior to participating in the interview. Posting invitations to women was not an option due to the sensitivity of the subject. When I met each participant, I allowed sufficient time to discuss the study and to answer any questions that emerged. On meeting each participant the consent form was discussed and any concerns around it addressed. Participants signed the form indicating their willingness to participate in the study. Through the process of seeking informed consent I facilitated the performance of my professional tasks (both as a nurse and as a researcher) in a morally defensible way by bringing the participants' informed preferences into the my research plans (Dhai and Payne-James 2013). Once the consent form was signed, each participant was provided with a copy, a second copy was kept by me (see Appendix Fifteen, health professionals and Appendix Sixteen, women participants). It was explained to the participants that they had the right to withdraw from the study at any stage; no one did.

4.6.3 Confidentiality and anonymity

Respecting the confidentiality and anonymity of all participants and locations was paramount when conducting qualitative research. As Houghton et al. (2010:20) observes, “it is essential to employ robust methods in order to ensure confidentiality.” Thus, in this research, all participants have been allocated pseudonyms – the GPs (trees); practice nurses (flowers); administrators (herbs); and women (gem stones) - and every effort has been made not to identify persons in the reporting of the study. In addition, all identifying details were removed from transcripts. All transcripts were stored securely by me during the process of the study; these will continue to be stored until two years after the completion of this study, when they will be personally shredded by me. In circumstances where a participant chose to disclose their involvement in the study to another individual, it was their decision, and beyond the control of the researcher.

4.6.4 Risk management strategies

Qualitative research demands subtle, sustained and humanistic consideration of ethical issues (Iphofen 2011). During the research I was cognisant that disclosing personal narratives may be a sensitive experience for some women. Likewise, I was also aware that the research topic could be an emotive area for health professionals. As previously discussed (see Section 4.2), participants were recruited from various sources and all women participants had a choice whether to bring a case worker,⁴⁷ relative or friend to the interview as a support, should the need arise. At the beginning of each interview I stated that the participant’s welfare was paramount and if necessary or desired by the participant the interview would be discontinued.

⁴⁷ A case worker acts as an advocate on behalf of clients. One woman came to the interview venue with her case worker. The case worker did not attend the interview but remained a distance away in case the woman got upset. The situation did not arise. Having a familiar person present for the woman was also a support for me as I engaged in gathering data that had the potential to be emotive.

Another risk management strategy I had available was to give the details of support organizations such as Women's Aid, in circumstances where I deemed it appropriate and necessary. Neither of these two strategies had to be implemented.

4.7 Reflexivity in grounded theory research

Reflexivity is defined as conscious self-awareness (Finlay 2002) in the analysis of qualitative research, where the researcher pays particular attention to the values, biases and experiences he/she brings to a research study (Creswell 2007). While Glaser (2002:5) disputed the notion of reflexivity in research and argued that "personal input by a researcher soon drops out as eccentric and the data becomes objectivist not constructionist," others (McCabe and Holmes 2009; Mruck and Mey 2007) argued for reflexivity as a chance for researchers to reflect, justify their decisions and to communicate the process of theory development to research participants. Hence, this section discusses reflexivity in grounded theory research and how I, as the researcher, engaged with it as a process during this research study.

Because researchers have a broad array of experiences which they bring to a study, grounded theory explicitly recognises this, and as such reflection upon the role of the researcher in the research process and the outcomes of reflexivity are presented within the documentation of the inquiry (Bailey, White and Pain 1999). According to Charmaz (2005:509) "the constructivist grounded theorist take a reflexive stance on modes of knowing and representing studied life." During the course of this study, I was conscious of my position within the research and throughout this research report I have acknowledged my role as "being part of, rather than separate from, the data" (Cutcliffe 2000:1478). In addition, during interviews with health professionals I consciously considered the image I projected. For example, in the course of interviewing one practice nurse, she stated: "well you know how it is Rita; you have been a practice nurse..." This statement suggested a few things to me:

firstly, that I may have been seen as having all the answers before I had even commenced the interview; secondly, perhaps the participant was questioning the necessity of the study; and thirdly, that I was viewed as an insider. Reflecting on this I considered that there are times when participants might not see value or relevance in research, believing perhaps, that the knowledge is already out there. In addition, I reflected on how participants might see research as an intrusion into their already busy schedule, or, in accepting the researcher as an insider, assume that what was about to be said was already understood. In order to ensure clarity around roles and the purpose of the research, the role of the nurse researcher needed to be explained, and understood by participants (Houghton et al. 2010). Thus, I was aware that it was necessary to make the distinction between being a nurse and a nurse as a researcher, if required, at the beginning of each interview.

The need to locate “my self” in the research process is further emphasised in the written nature of this study. I took cognisance of Foucault’s critique of the “apparatus of writing” (p202) and, in so doing, avoided describing, analysing and documenting individuals as objects with specific features and, measured phenomena (Foucault and Rabinow 1984); rather I sought to hear and bring forward their stories as data (Charmaz 2006), while all the time including my own previous and evolving role(s) in this process. This style of declaration is part of how grounded theorists acknowledge the interplay between the researcher’s prior knowledge, values and beliefs and the flow of data (Cutcliffe 2000). Specifically, the outcome of my reflexivity and its presentation within this study alerts the reader to this research process and how knowledge was produced (Bailey, White and Pain 1999).

4.8 Chapter summary

This chapter provided an overview of how I employed a grounded theory approach to this study. Issues concerning access to the research sites, participant recruitment, collection and analysis of data and ethical matters were discussed. I illustrated the practicalities of my own personal experience of the methodology and my reflexive endeavours. Although the experiences of my research study are presented in a linear fashion, several stages ran concurrently as I worked to allow the emergence of a theory – conspicuous invisibility. These stages included: theoretical sampling, constant comparative analysis, coding, memoing and sorting. The next four chapters discuss the key findings that emerged from the study and presents the theory of conspicuous invisibility.

Chapter Five: Prologue to the findings chapters

5.0 Introduction

The aim of this study was twofold. Firstly, to illuminate understanding of how the general practice team discover, during the interaction of the clinical consultation, women who are in domestically violent relationships with intimate partners, and secondly, to explore how women are enabled to disclose their experiences of violent relationships, during the clinical consultation. There were two groups of participants in this study: the first group were health professionals, general practitioners (GPs), practice nurses and general practice administrators⁴⁸; the second group were women who had experienced domestic violence. The general practitioners (GPs), practice nurses and administrators are collectively referred to as health professionals, the general practice team or, where appropriate, their individual disciplines. Findings are derived from analyses of the interview data from health professionals working in the general practice setting and from women who have encountered domestic violence. Data were gathered from 30 semi-structured interviews: general practitioners (GPs) (n=9), practice nurses (n=8), administrators (n=3) and women (n= 10) between 2010/2012. All participants were given pseudonyms to maintain their anonymity.

This chapter is a prologue⁴⁹ to the findings chapters. The prologue is defined by the Oxford dictionary (Sykes 1982) as a “preliminary discourse” and is presented prior to the key findings of the research. The purpose is to set the scene for the findings of the study by

⁴⁸ Although practice administrators do not have a clinical role, they are generally the first person a woman meets when contacting the surgery, either by phone or in person. Therefore, they interact with women on a personal level; hence, their inclusion in the study.

⁴⁹ Following discussion with my supervisor (Dr Clarke) and having given it due consideration, it was decided to include a prologue to the findings chapter in order to address the complexities of the theme lifting the stones and seeing the slugs beneath, which is common to all the findings chapters.

foregrounding the main theme of ‘*lifting the stones and seeing the slugs beneath.*’ The theme lifting the stones and seeing the slugs beneath weaves throughout the study, as a common thread that links the findings together in order to illuminate a process of engagement.

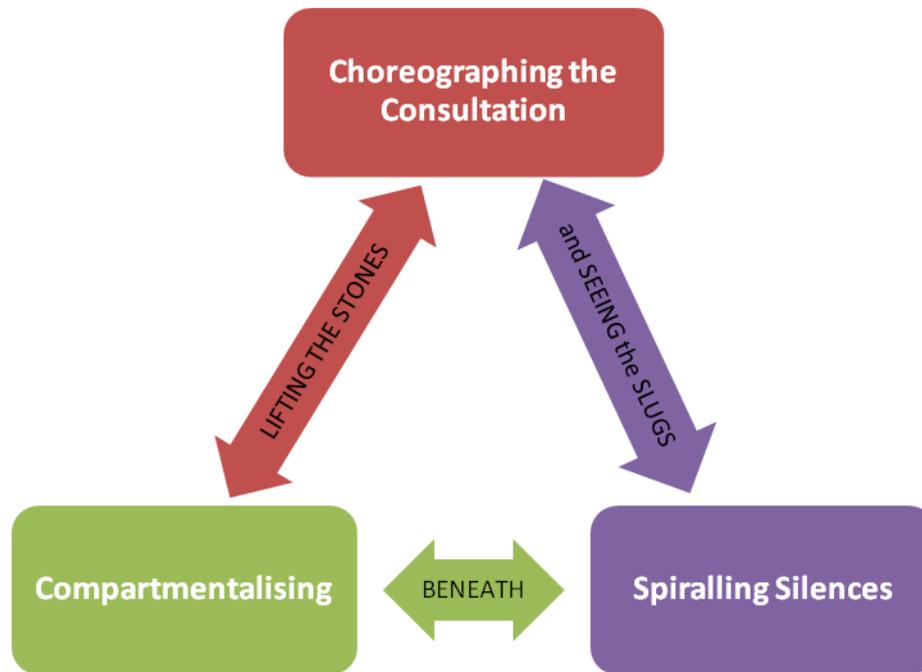


Figure 5.1: The theme of lifting the stones and seeing the slugs beneath weaves between the three core categories of the findings of the study

Presenting the chapter in this way is not to imply that it is of lesser importance than the remaining three findings chapters. Instead, the significance of the theme⁵⁰ lifting the stones and seeing the slugs beneath paves the way for the theory of conspicuous invisibility which emerged from this study. Foregrounding the theme provides a lens to view the process of engagement which underpins the core categories of the findings chapters: choreographing the consultation, spiralling silences and compartmentalising.

⁵⁰ A theme is a meaningful “essence” that runs through the data; it is sometimes in the foreground, sometimes in the background; but it is recurring and is the basic topic that the narrative is about (Morse 2008:727).

5.1 The theme of lifting the stones and seeing the slugs beneath

The theme lifting the stones and seeing the slugs beneath is an in-vivo code meaning that it emerged from a term, or language, used by one of the participants. In this study, it was a term used by one of the women (Opal) inviting GPs to acknowledge the presence of violence against women by engaging with the issues in the course of clinical consultations.

I think [if] they [GP's] just lift up the stones to see the slugs beneath them and the slugs are there for a very good reason. (Opal)

The action of lifting the stones is a metaphor⁵¹ to illustrate the beginning of a process of engagement in clinical consultations toward the discovery or disclosure of violence against women. Seeing the slugs beneath illuminates a process of exploring beneath the surface and not accepting what is presented at face value.

Lifting the stones, in this context, implies the beginning of an emancipatory action⁵² where discovery or disclosure is happening. Lifting the stones, means removing the obstacles in order to see what lies beneath; it is a process that describes participants' responses to the action of the discovery and disclosure of domestic violence. Symbolically, by lifting the stones, the slugs – i.e. the medical and social issues that lie beneath – are revealed. The slugs symbolise the underlying symptoms, the hidden thoughts or experiences that women have

⁵¹ The theme that weaves throughout the findings is explained using a metaphor. A metaphor, in this context, is part of a 'native speaker's ability to grasp meaning in a text' (Ryan and Bernard 2003:92). Through metaphor people can relate to objects and symbols that have meaning for them in accordance with the principles of symbolic interactionism (Blumer 1986). According to Blumer (1986:41), getting close to the social world is not a matter of approaching a given area and looking at it; instead, it requires rigorous "exploration" and "inspection", a process that is initially broad but, as the inquiry proceeds, becomes sharper and more focused. Hence, objects like stones and slugs have meaning when explored in a conceptual sense, relevant to the topic of the study. They are not taken at face value but are analysed for meaning relevant to the interaction that occurs in clinical consultations.

⁵² The notion of lifting stones may suggest other connotations, for example, where Sharia law is practiced. It must be acknowledged that in the Middle East, where Sharia Islamic law is legal practice, the custom of stoning women who have broken the law is a regular occurrence. Lifting the stones, in this instance, is not an emancipating action but one that publicly demonstrates a violent act against women.

endured. Like the experience of domestic violence, which can remain unseen and undisclosed slugs lie dormant until they are discovered or disturbed. A natural function of stones is to reduce erosion and to protect that which lies underneath. Stones are visible and conspicuous objects; they may be weighty, not easily carried and, in some instances, are not easily moved. Frequently, stones themselves may go unnoticed as they blend into the surrounding terrain. Like the pattern of domestic violence, it may take time and awareness before stones become visible. While health professionals knew about the existence of domestic violence in society in general, they stated that they 'did not see it' (see Chapter Six) within their own clinical practice. Where one is unaware of the stones and they remain fixed, then that which lies beneath them also remains hidden, undiscovered and undisclosed. Stones can be kept in place also by women who attempt to keep hidden, from everyone, their experiences of domestic violence. Hence, the stones can become obstacles to disclosure and discovery; they can lie undisturbed, ignored or unseen. However, to address the issue of domestic violence it is necessary for general practice health professionals, in the first instance, to see and to recognise the presence of stones (obstacles). While stones can be lifted and the slugs beneath seen, the process is complex and challenging, as is evidenced by the findings of this study.

In summary, lifting the stones and seeing the slugs beneath is a theme that is conceptualised to metaphorically illustrate the discovery and disclosure of domestic violence. Where the existence of stones is acknowledged, and where they are lifted and what lies below them is examined, or explored, a process of engagement begins. Engagement involves a process of choreographing the consultation (Chapter Six), spiralling silences (Chapter Seven) and compartmentalising (Chapter Eight).

Chapter Six Choreographing the consultation

6.0 Introduction

This chapter describes the core category of *choreographing the consultation* which is part of a process of engagement toward the discovery, by health professionals, and disclosure, by women, during the interaction of the clinical consultation of circumstances of domestic violence. The context of the interaction, which is the clinical consultation takes place in a general practice setting is not only person specific but is also influenced by the environment of general practice.

6.1 An overview of the core category of choreographing the consultation

Choreographing the clinical consultation is one of the core categories that illuminates our understanding of the performance that occurs between women and the general practice team in discovering and disclosing women's circumstances of domestic violence. The notion of a performance is used to describe the interaction that occurs in the general practice consultation. In the case of women who experience domestic violence, the pattern of the consultation is not a linear process, but rather is described as a series of back and forward steps, where health professionals and women attempt to synchronise moves, almost like a dance. While one partner is generally managing the tempo or rhythm of the consultation, the other is engaged in the dynamics of the interaction, following (or not) in tandem with the flow of the movement. Either the health professional or the woman may be leading the choreography of the consultation and once this occurs a relationship, or a process of engagement within the consultation, commences. Each of the sub-core categories, *seeing and*

not seeing and *reading the person* (see Figure 6.1) and the properties of the category are explicated to illuminate how the performance of general practice consultations are played out.

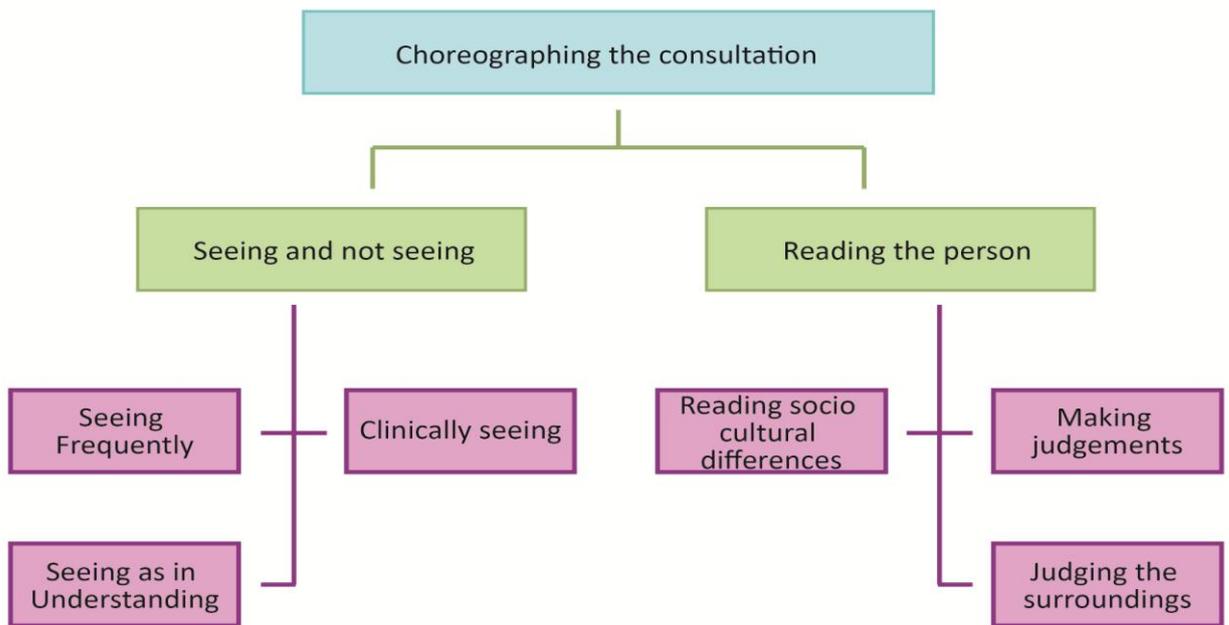


Figure 6.1: The core category of choreographing the consultation with the sub-core categories and the properties.

6.2 Seeing and not seeing

This section focuses on data of seeing and not seeing, a process that occurred when women who experienced domestic violence and general practice health professionals interacted within a clinical consultation. ‘Seeing’ as a process of engagement emerged throughout the data. ‘Seeing’ is open to several interpretations; seeing as visually perceiving a situation and also engaging, meeting or knowing an individual. Seeing may also be used to imply the present tense – the way things are at the moment, in the here and now. Health professionals

spoke of seeing women as patients with clinical conditions who attended the practice to be 'seen' for a consultation.

Some health professional participants spoke of seeing or not seeing women who experienced domestic violence from a visual perspective alone. Being open to seeing the presence of domestic violence issues influenced how health professionals interpreted, or viewed, the extended picture of the woman's presentation in the clinical consultation. In other words, where a GP or practice nurse noticed the presence of the stones and, through the process of engagement lifted the stones, the slugs were revealed. Examples of stones in this case were physical injuries and evidence of abuse, which in turn prompted further 'seeing' of the situation. However, in the absence of physical injuries, or evidence of abuse, the discovery of violence against women was problematic.

Some women participants, who experienced abusive relationships, also spoke of seeing GPs and practice nurses in the surgery. Seeing, in this context, referred to attending or visiting the general practice setting, including interacting in the choreography of the clinical consultation with the associated expectation that the GP, or practice nurse, would address or see to their needs. However, some women spoke of not seeing their GP, or practice nurse. The not seeing, in this instance, referred to not visiting, or not seeking, medical attention from a general practice health professional regarding domestic violence.

In summary, the sub category of seeing and not seeing, in the context of choreographing the consultation is complex. It illuminates the findings in a number of ways – visual observation, cognitive understanding and interpretation of the role of general practice in the management of domestic violence issues. Seeing and not seeing is explored in the following sections; seeing frequently, clinical seeing and seeing as in understanding.

6.2.1 Seeing frequently

Some women frequently attended and saw health professionals in the local general practice. Seeing was the lens used by health professionals to visualise or optically choreograph the consultation and was influenced by the number of visits by some patients to the practice. Due to the frequency of attendance a level of familiarity between women and health professionals developed that resulted in superficial or repetitive communication. Several health professionals spoke of seeing patients returning regularly to the surgery, the majority of who were women:

You see them [patients⁵³] weekly; you know them inside out and back to front; you practically know what they are having for breakfast. (Dr Willow)

There are the regulars⁵⁴ to the surgery... [they attend] weekly or fortnightly... you hear it all the time, so and so is here again. (Nurse Violet)

I was in there [general practice] once a week or every other week, no kidding I was in there constantly, over 3-4 years. ...[Although] I am a huge fan of my doctor because he never said, 'oh my God what are you doing back here again?'... I wasn't getting necessarily what I needed. (Pearl)

Maybe you were hoping someone had noticed something...I think I probably felt invisible, because when you are a victim of domestic violence you felt invisible because nobody sees what is happening to you. (Ruby)

I was going to my doctor for 20 years and domestic violence was never detected. (Crystal)

Here seeing appears to have been conducted on a shallow level, with the health professionals developing a sense of “practically” getting to know patients, but in a matter-of-fact way. Women, on the other hand, wanted not just to be seen, but to be observed; they wanted health professionals to look and to recognise their situation, to see beneath the surface and to acknowledge and address violence against women. However, this rarely occurred and seeing by the health professionals was limited; engagement occurred as a routine form of

⁵³ At times the word patient is used, depending on the word or phrase that is used by the participant.

⁵⁴ Regulars is a term used to describe those that attend the surgery on a regular basis.

communication. Recurring patterns of seeing led to not seeing. Dr Willow explained: “if you totally deal with what someone comes in with you could miss the plot completely.” The property of seeing frequently within this context implied that health professionals set eyes upon the women in the consultation, yet wittingly or unwittingly did not appreciate, or recognise the fundamental reason for the consultation.

Identifying the reasons for women’s frequent attendances to the surgery were “difficult to pinpoint” (Nurse Violet) and did not necessarily prompt understanding for discovering issues of domestic violence:

I could see her [woman] 20 times a year but I never actually say, ‘how are you?’ Really. (Dr Willow)

Doctors don’t recognise it [domestic violence] whether you frequently or infrequently attend them. It didn’t seem to matter, because the awareness [by GPs] is not there. (Garnet)

Being acquainted, as in a health professional-patient relationship does not always imply the visual observation associated with knowledge and understanding of the real reason for the consultation. Rather, an attitude of customary or habitual communication can develop due to the blunt acceptance of seeing the same woman regularly attend general practice, where the visual perspective of seeing dominates. Seeing a woman “weekly” or as “regulars” becomes a habit of accepting the presence of the woman in the consultation but not seeing below the surface, or truly acknowledging her attendance. A dance of evasion appears to occur, where the social interaction in choreographing the consultation is one of superficial observation, rather than one of engagement, or seeing beneath the surface.

6.2.2 Clinical seeing

Overall, when speaking of the interaction with women who attended the surgery, most health professionals spoke of such visits in terms of general medical consultations. Many believed

that women who are, or have been, in abusive relationship “are not seen” by the general practice team. Not seeing in this context suggests abused women chose not to attend general practice for medical attention:

I don't see a lot of domestics, maybe once every 6 months or so. They are definitely not coming in every day of the week... they go to A & E departments... I think a lot of them [women in abusive relationships] don't come to doctors. Full stop!
(Dr Ash)

I wouldn't see them [women who experience domestic violence] because most of the patients are generally booked in advance.⁵⁵ (Nurse Cherry)

As an admin role in a GP setting I have come across a lot of different circumstances, [but] specifically domestic violence, I haven't seen much of it at all. (Sage, Administrator)

Health professionals spoke of not seeing women who experienced domestic violence, meaning that they did not witness the phenomena in a clinical setting. By not seeing they illustrated a pattern of not looking, being aware or recognising the presence of possible indicators:

I wouldn't have seen it [domestic violence] if it was in front of me. (Dr Willow)

I am sure that there has been people in here with me...who are sufferers of domestic violence but I've never noticed it...or they didn't give me any triggers, any clues or anything like that. (Nurse Heather)

Comments by Nurse Heather suggest the onus to disclose the presence of domestic violence issues was firmly located with the woman, rather than a responsibility to discover, or to see abuse resting with the health professional. However, comments by the women suggest that they were attempting to disclose the reality of their circumstances:

I was attending my GP for 10 years before I left [my relationship]...slipping her bits of things [information]. (Sapphire)

⁵⁵ Suggesting that the nurse-patient encounter is always planned and the process of the consultation follows the planned schedule of the encounter and is not concerned with opportunistic case finding.

I don't think you have to look too far to make a connection between what is happening with your mental health and what is happening with your body. So I didn't spell it out for him [GP] but he didn't connect it either. (Pearl)

Although some women were not prepared, or not able, to disclose everything about their experience of domestic violence, for a number of women, the action of offering a cue or signal to indicate their experiences, illustrated how they wanted health professionals to see and understand the broader aspects of their situation⁵⁶. On the one hand, an expectation by health professionals that women present as “sufferers” (Nurse Heather) of domestic violence implies seeing women in a predetermined manner, where a woman appears as helpless prey. Women, on the other hand, did not want to be seen as “victims” but “kept a persona going” (Ruby) and wanted to be seen as a “thrivers”⁵⁷ (Opal). Furthermore, findings suggest that although health professionals sometimes suspected domestic violence issues, there were times when the unseen was not explored or unravelled. As Dr Palm explained, “you suspect there is lots [of domestic violence issues] you don't see.”

Where there was an index of suspicion by health professionals that domestic violence exists, the data suggest there was not an automatic practice of greater enquiry. Further comments from health professionals illustrate why domestic violence was not always seen within the general practice setting:

Domestic violence is not high on the checklist to consider. There are many silent cases where women never talk to health professionals. We [GPs] miss it a lot, especially sexual and psychological violence. (Dr Cedar)

From the point of view of the health professionals spotting it [domestic violence], [it is important] to give the patient an opportunity to disclose. (Nurse Rose)

I mean there is an awful lot of stuff to get through. I mean I have about five or six people positive for diabetes... and they have to be dealt with obviously. (Dr Palm)

⁵⁶ Seeing with understanding will be further explored in the next section.

⁵⁷ “Thrivers” is used to describe a person that is flourishing, has prospects or is making progress (Sykes 1982).

Several GPs and practice nurses discussed how domestic violence “was not on their radar” meaning that they did not see or consider the phenomena when clinically assessing women during the choreography of the consultation: where they did not expect to see domestic violence they did not look for it. Health professionals considered the clinical issues of consultations of greater priority. For example, Nurse Heather defined the role of a GP: “[to] examine, then they [GP] decide what’s up with you.” In other words, seeing was based on viewing with a medical lens⁵⁸, through diagnosing signs and symptoms of illness, or being the “fixer” (Dr Birch, Dr Oak, Ruby, Pearl & Garnet) by providing treatment:

You are just seen as the illness to disclose, anything further than that illness, it’s like - what’s the problem today - earache - how long have you got it, take this - you’ll be better. (Ruby)

I was there all the time. I would go for different things. Sometimes I would get chest pains. I got panic attacks. I got chest infections. I just didn’t feel good. (Pearl)

Engaging with women from a clinical perspective alone suggests not witnessing underlying issues that contribute to the reality of their situation. Women wanted the GP to acknowledge what was happening to them by identifying their circumstances of domestic violence, through a process of engaging with more than the presenting symptoms of the consultation. However, by accepting symptoms at face value health professionals did not run the risk for them of “delving too far” (Dr Ash) or “prying”⁵⁹ (Dr Willow).

The practice of health professionals not seeing the presence of violence against women occurred for several reasons: firstly, by not looking for the issue; secondly, health professionals believed there was an onus on women to give an indication that domestic violence was present; thirdly, by missing the cues and fourthly, by only focusing on clinical reasons presented or obvious within the consultation.

⁵⁸ Data that is viewed with a medical or clinical lens is discussed in the findings chapter on compartmentalising.

⁵⁹ Health professional’s process of enquiring about domestic violence is discussed in the next chapter.

In summary, the steps between the dance partners (women and health professionals) were not always in time. The visual perspective of seeing and not seeing identifies how a technique of habitual communication, through recurrent attendance to general practice, influenced how the consultation is choreographed (or not) toward lifting the stones and seeing the slugs beneath. The next section further develops the sub-category of seeing and not seeing by explicating the properties of seeing as in understanding.

6.2.3 Seeing as in understanding

Some women described how their experience of seeing general practice health professionals appeared to influence the level of engagement between them, their GPs and/or practice nurses. Apart from attending the surgery, women's expectation of seeing a health professional was to have their situation understood. Seeing from the women's perspective involved moving beyond a visual interpretation alone to include also verbal and non-verbal communication, and cognitive engagement:

When I went to see him [doctor] he was leaning over his desk writing in the notes. He didn't look up, didn't see me sitting in the chair, he just recorded the fact I was there. He didn't have the time to look up and see me. (Ruby)

Ruby outlined a sense of being invisible as a person, where the body language portrayed by the physician implied a sense of his not seeing, not respecting and/or not understanding the reason for her presence in the consultation. In attending for a medical check up, her expectation of the notion "to see him" (Ruby) was to be observed and have her reason for attending understood. Ruby's experience of engagement in the consultation suggests an asymmetry in the communication process, where she wanted to be seen and understood, while the doctor was more concerned with writing the notes. Ruby's experienced herself as a 'fact to be recorded' in notes rather than as a woman who was seen and understood. For other

women too, the choreographing of the consultation involved a negative encounter with clinicians:

Looking back he [GP] didn't understand [about domestic violence]...I didn't go back to him. I didn't do anything about domestic violence for years. (Quartz)

She [GP] just didn't totally get the whole thing. (Sapphire)

Data suggest that failure to choreograph a consultation of affirmation and understanding did, for some women, lead to an interruption or postponement of disclosure. For example, Ruby's experience of her GP not "hav[ing] the time to look up and see me" meant a 10 year delay in her disclosing her experiences of domestic violence. The decision by some women in similar situations to steer clear of general practice consultations explains, somewhat, health professionals' view of domestic violence as "silent⁶⁰ cases" (Dr Cedar) or "suspected [but] not seen" (Dr Palm). An observation by Nurse Rose's that women needed "an opportunity to disclose" implied some tentative appreciation of seeing towards a choreography of understanding.

Woman too showed some insight into why domestic violence issues might not be seen and understood within the general practice consultation:

I didn't feel bad about him [GP] because he didn't know what to do either. He [GP] brushed it in and brushed it out [my experiences of domestic violence]. (Quartz)

I don't think he knew what to do with the information. I may have been the first person to disclose to him what had happened. I hope he was a lot better the next time, a nice fella [GP], but completely clueless, totally clueless and in need of some help himself. And it never went any further. He never referred to it again. (Opal)

If you go into a surgery and the doctor has his head down and is not looking [at you], you are not inclined to confide [in him]. (Garnet)

⁶⁰ The category of spiralling silences is discussed in more detail in the next chapter.

While the notion of seeing appeared to be a critical process of the clinical consultation for both women and health professionals, data suggest that seeing but not grasping an understanding of the full picture can result in non-engagement:

I was just thinking as you were going along, the more you think about it the more you realise, yes but it is still nothing close to the one in five⁶¹, partners or former partners, or the ones that are physically abused and things like that. (Dr Palm)

I don't know whether it's burn out, but I think as health professionals there is a huge lack of paying attention [to patients' needs]. (Nurse Violet)

If a health professional relays a sense of not paying attention to a woman during the consultation emerging issues in the consultation, can be lost.

For women participants being seen was more than a visual process; they expected engagement, understanding and an appreciation of their situation:

If he [GP] can see something, that is the thing. It's not in his training because he is trained for the body, bones and all that, but if he sat there and said, "wait a minute I see something, [I] see the change". (Pearl)

Women perceived that GPs' education focused on "fixing" physical health alone (Ruby, Garnet, & Pearl). Having physical symptoms appeared to ease women's entrée into a consultation that would somehow recognise their experience of domestic violence, without the onus being on them to disclose:

I was hit on [the] head, [there were] no cuts, I didn't seek medical attention; I had nothing to show... [Another time] I went to [see my] GP with bruises and it was great to have something to show, because they were hidden up to that. (Sapphire)

It's easier for a woman to disclose herself if her face is black and blue. (Crystal)

People present with the physical [signs]. (Garnet)

The presence of physical signs or injuries allowed for the conspicuous visibility of domestic violence and for the woman's experience to be seen and understood. The presence of injuries

⁶¹ One in five relates to the 1: 5 Irish women have experienced domestic violence from a current or former intimate partner in their lifetime (Kelleher and O Connor 1995).

permitted a choreography that allowed for the symbolic lifting of the stones and the seeing of the slugs. In essence, the presence of injuries legitimised the existence of domestic violence and authorised both its disclosure and its discovery. In reality, seeing with understanding only occurred following the visual perspective, in the presence of (and a willingness to show) physical signs and symptoms of domestic violence. Being seen with physical injuries during the clinical consultation meant some degree of public validation for what the women were experiencing:

When I did disclose, I got the support I needed because I looked for it. (Crystal)

I felt great [when I disclosed] because I wanted [the GP] to know that there were a lot of women like me. (Sapphire)

I would certainly know some patients who were beaten up by their partners. Unless you [the patient] have broken your arm or whatever [you may not see the patient] .
(Dr Palm)

However, in circumstances where physical injuries or signs indicating abuse were absent, women continued to desire an opportunity within the consultation to disclose their experience of domestic violence, though there was some ambivalence as to whether such an occasion would enable disclosure:

Maybe, if you were sat down and were asked a couple of questions? Perhaps there is something you might disclose, I don't know. (Ruby)

When I look back I think of all the times I attended the surgery; I must have been looking for something. (Ruby)

The notion of “looking for something” implies a dual meaning. Firstly, it suggests the action of searching or gazing for the signs or prevalence of a phenomenon, for example in this study, health professionals’ ability to look for, to delve and to discover the signs of violence against women. (This will be explored further in the section 6.3 reading the person).

Secondly, looking for something suggests women being enabled to articulate what is contributing to their underlying reason for the consultation. The women wanted health

professionals to discover domestic violence issues or enable them to disclose their experiences of violence. In particular, women wanted to be understood and not observed:

Understanding it [domestic violence] takes time and then they [health professionals] have to work through that. If the GP is non-judgemental, [is] understanding and tell[s] her [woman] she is safe and be (sic) generic by saying “nobody deserves this,” not, “you [woman that is disclosing domestic violence] don’t deserve this.” (Sapphire)

Women viewed a demonstration of empathy by health professionals as an indication of their understanding the situation, which, in turn, prompted them to disclose:

She [GP] is well meaning and did help me tremendously and she did probe and did realise there was a problem, I am very grateful to her for those things. (Sapphire)

I told the woman doctor after I got help from Women’s Aid⁶² and she is very kind. She asks me how I am now. I told her because I was on the verge of a nervous breakdown and I needed help. (Quartz)

Acts of understanding of a woman’s situation allowed general practice health professionals to establish a “therapeutic relationship” (Nurse Ivy), which brought them into harmony with the woman’s rhythm of the dance. Seeing as in understanding was not a one off occurrence, but allowed for continuous engagement with a woman’s well-being. The dynamics of this type of health professional-patient relationship was one of knowing how to support the woman following her disclosure of domestic violence. However, data suggest that some women did not succeed in having their experience of domestic violence understood by general practice health professionals, which meant non-disclosure and culminated in a culture of spiralling silences.⁶³

To summarise, the findings illustrate how women in violent relationships attended general practice regularly, and for many years, expecting to be more than just observed in the consultation; they wanted to have their experiences of domestic violence understood. Where

⁶² Women’s Aid is a voluntary organisation, which helps women and children who are suffering physical, mental, emotional and/or sexual abuse in their homes.

⁶³ Some women stated that their family or friends did not know about their life of domestic violence, so they lived a life consistent with a spiral of silence (see Chapter Seven).

physical injuries were present health professionals more promptly witnessed the conspicuous visibility of domestic violence. In the absence of visible injuries, women did not always disclose their abusive experiences, nor were they discovered. However, women wanted general practice health professionals not only to see, but also to acknowledge the cues and signals given by them and to recognise the consequences of ailments that are sustained by abuse. Such seeing, as in understanding, influenced the level of engagement between health professionals and women in abusive relationships. Findings suggest that seeing as in understanding allows for synchronised choreography within a consultation, a choreography of steps that enables the lifting of the stones, and seeing the slugs beneath. The next section discusses participants' choreography of the consultation based on the sub-category reading the person in general practice.

6.3 Reading the person

One of the initial observations of choreographing the consultation between general practice health professionals and women involved reading the person. The technique is both a visual and intuitive activity, which includes reading the person's physical appearance, attitude, eye contact and psychological mood. Unlike the sub-core category of seeing and not seeing, reading the person is influenced by impressions generated in the consultation; personal preconceptions and opinions. Data suggest at the time of the clinical consultation not all emotions or physical medical problems were verbalised by women who experienced domestic violence.

Health professionals' reading extended beyond visual observation alone through to "building relationships" and "get[ting] to know the patient" (Nurse Ivy) and, by using intuitive knowledge, to reading women who "appeared depressed" (Dr Willow, Dr Birch, Dr Elm, &

Nurse Ivy), identifying if “somebody is down” (Nurse Daisy) or “get[ting] vibes from people” (Nurse Rose). Reading the person includes findings regarding clinical observation, the physical appearance of how women were dressed and their demeanour. The properties of making judgements and judging the surroundings, which illuminate the sub-category of reading the person, are discussed in this section.

Some practice nurses commenced reading the person by engaging in small “chit chat” (Nurse Daisy) with patients. For example, such opening questions as “How is the baby?” and “How many children have you?” (Nurse Lily) laid the foundation toward reading the person and building rapport between the general practice team and women. While administrators do not have a clinical role, data suggest that some women experienced them as an appreciative presence, at the point of entry to the general practice service. Quartz explained how the administrator read the anxiety she felt prior to attending the general practitioner:

She [administrator] is real friendly; she comes out with a magazine. She has a personality behind her. (Quartz)

Creating a tone of comfort and reassurance for women prior to, or post the clinical consultation, through listening and being available to women, suggests an appropriate context to read the person:

The girl [administrator] in my surgery knows more about me than the doctor. (Quartz)

The use of clinical experience, based on identifying “warning signs” (Nurse Heather), contributed to the health professionals’ method of reading women beyond what was presented at “face value” (Nurse Lily), thus enabling women to disclose issues such as domestic violence. Reading the person is synonymous with the analytical reasoning of reading between the lines when drawing conclusions about the circumstances presented:

I would say a lot of the time people will come into the doctors with something else and it is usually the doctor reading between the lines will tease out the real reason

why they are there. (Hazel, Administrator)

In the back of your mind you need to have that little bit of a tick box in your head, is somebody abusing this lady? (Dr Willow)

I think you may not be a good listener but you might be good at reading signals, reading what hasn't been said from a GP point of view. (Nurse Rose)

Health professionals require sufficient knowledge to identify what can be implied but not verbally stated. Openness to discovering domestic violence exists where health professionals demonstrate knowledge, experience and an ability to intuitively read women. Paying attention to cues or signals suggests how reading between the lines and “having your antennae raised” (Nurse Heather, Nurse Ivy & Dr Willow) can alter the context of the consultation and increase the awareness of discovering violence against women.

In addition, data suggest that prior to choreographing the consultation health professionals drew conclusions based on the demeanor and external appearances of the woman's style:

The first thing I noticed was that she was very guarded and that her mood was very low...I noticed that she was lonely as well even though she appeared to have everything materially. But there seemed to be a type of vacant look about her as well, sad, a sadness about her, I just felt that I was able to read those things about her. (Nurse Violet)

There is one hurdle, if the patient is coming in with something else, well dressed and with a husband – you [GP] have a biased opinion. Whereas, if she is down trodden, you have a stereotypical image of someone in an abusive relationship. (Dr Cedar)

You have other people beautifully put together and you think they don't have any worries, but they could be. God knows what is going on. We are totally, completely fooled into thinking; if you have a good front you're fine. (Dr Willow)

Goffman (1959) described the importance of creating a positive first impression as “impression management”⁶⁴. Health professionals “suspected” (Dr Palm) that a woman who appeared “downtrodden” (Dr Cedar & Dr Willow) with the weight of oppression or “having a sadness about her” (Nurse Violet) was more likely to be in an abusive relationship. However, an outward appearance of security and contentment did not lead health professionals to

⁶⁴ Goffman's theory of saving face and impression management will be debated in the discussion chapter.

suspect the presence of domestic violence as readily. At the same time, they realised these attitudes were based on optics and general assumptions.

Women were also conscious of how they presented themselves and how health professionals read them. Image and the presentation of self were important for women. Pearl's acting suggested her need to present a positive self-image: "I can act, I am good." She commented further that she wished the GP to read the indicators, read through her joviality and be able interpret her situation:

Somebody coming in a little too happy all the time, this is not normal. [The GP should] know there is something going on – I know they [women] are sick and they are in here still smiling and joking, I believe that could be a symptom [of domestic violence]. (Pearl)

Health professionals spoke of having their "antennae raised" in the consultation, suggesting the presence of issues such as domestic violence, while at the same time being aware of the risk of generalising situations:

[The presentation of a woman with] a steady income, holding down a job, which around here is a big thing. You know, well dressed; you can be very fooled into thinking there are certain groups that [do, or do not, experience domestic violence]. (Dr Willow)

I think the area I am working in at the moment XXX area. I feel that people have learned to carry huge burdens on their back. I don't say that they cope with them but they carry them. (Nurse Violet)

When there is an expectation that a pattern of behaviour exists, with specific cohorts of individuals, reading the person can be problematic. Health professionals explained how they read women based on their own beliefs, rather than the evidence of discovering violence against women:

I've never had a young girl come in and say that she has been physically abused. Young girls, they'll walk [away from a violent relationship] really you know, if it's in a relationship. But... it tends to be the older age group I think.... Getting in to married [women] is difficult...it's difficult to walk [away from a violent relationship] when you are married [and]in the 30s [or] 40s rather than [being in your] the 20s. (Dr Ash)

It's just stereotypical...I have the vision of married women, unfortunately...they can't...they feel that they can't get out of this relationship, when you think of it as teenagers you think ...yeah they're not married to them [men], may not get married to them, they could walk away, it's easier to walk away... It's just a vision I have. (Nurse Heather)

Grouping women together based on their age, marital or family status, or community suggests health professionals applied generalisations when reading specific cohorts of women (whether they experienced domestic violence, or not). Furthermore, the visibility of domestic violence was dependent on how the health professional not only read the person, but perceived her choices (of being single or married) and having an ability to enable herself in the given situation. For example, women who appeared as “being submissive” (Dr Birch) were read as more “vulnerable” (Dr Willow, Dr Oak, Dr Cedar, Nurse Heather & Nurse Rose), while single and married women were seen to have different options.

Data suggest that generalisations and pre-conceived ideas blurred the uniqueness of the individual and militated against reading the person as one with distinctive characteristics. Instead, women were read as a collective group. The presentation of the self and the reading of such appearances influenced the ability, or otherwise, of health professionals to discover violence against women who attended general practice.

However, where reading involved tuning in to the subtle nuances of the person, their non-verbal clues, and seeing beyond their visual presentation the choreography of the consultation was more informed:

I would like to think that since the two discoveries [of women in abusive relationships] I made, I am sensitive enough to think about it. It is almost like looking for an aura that people have. (Nurse Violet)

GPs might get an inkling ...there could be the slightest faltering, the cast down of an eye, the turn of the head. She is there with a pretense maybe, one of the children has a cold, something - and not to treat the woman who comes for help as the patient, because she may not be the real patient but may be the result of the real patient. (Opal)

Health professional's ability to demonstrate insight within a consultation, as suggested by Opal, implies a capacity to see the individual beyond what is presented.

Health professionals also read women "in the context of the community and how you [GP] view[ed] people" (Dr Willow). Thus the boundary of the clinical consultation extended beyond the physical environment of the surgery and into the community when the GP did house calls⁶⁵:

The doctor often does house calls and he knows the families, relations, brothers, sisters, aunts and whatever the hell it is and I only know one or two people, the tip of the iceberg. (Nurse Cherry)

Nurse Cherry's metaphor of "the tip of the iceberg" suggests that it is only possible for health professionals to familiarise themselves with a small portion of a patient's life or needs. Much remains under the surface or exists outside of the general practice consultation:

I have been out to a lot of their [patients'] homes at this stage over the years. Invariably they all need at least one house call at some stage and you get a good sense of what is going on. (Dr Willow)

Reading the person in the environment of their home suggests developing a knowing beyond the presentation of the self in the practice and an opportunity to see what might be the submerged components of a patient's characteristics and reality. Conducting clinical consultations in a patient's home allowed health professionals to challenge any preconceived expectations:

I have a family that I look after and I was at their house today. They are filthy and smelly and whatever, but you know, they are the happiest family you could meet but you think they should have all kinds of problems, and you are nearly saying "are you not sad?" You go in the morning and they are full; they are chatting; they are as happy as Larry. (Dr Willow)

In summary, discovering violence against women, based on reading the person and where women make efforts in the presentation of the self, is problematic. Reliance on visual

⁶⁵ Practice nurses do not do house calls.

presentations in the case of domestic violence is too simplistic, particularly where preconceived clinical and social impressions are interwoven with health professionals' interpretation of reading the person. Furthermore, engagement toward lifting the stones and seeing the slugs beneath can be distorted when specific groups of women, rather than individual women, are compartmentalised as potential persons likely to experience abuse based on their outward appearances, financial or marital status. Where women were read on the basis of socio-cultural difference this too influenced the choreography of the consultation.

6.3.1 Reading socio cultural differences

GPs and practice nurses discussed how they engaged in a choreography with non-Irish women during the consultation⁶⁶. References were made to differences in “rapport” (Nurse Daisy, Nurse Rose, Dr Elm, & Dr Willow), “communication” (Nurse Daisy & Dr Oak) and “culture” (Nurse Heather, Nurse Lily, Nurse Ivy, Nurse Rose, Dr Elm, Dr Ash and Dr Birch).

They [non-Irish women] will always be on time for their vaccinations; they will come in for their smears; they'll come in for ...But they don't tend to... they will say to you, I have a discharge or I have this or whatever, but they don't tend to really verbalise anything non-clinical, even though you would try, like I would try and chat and try and help but they tend to be [private].... They don't seem to have that rapport with you, you are the nurse, or you are the doctor. (Nurse Daisy)

Being aware of the socio-cultural differences of women attending the practice influenced how health professionals read the person. The practice nurse suggested that engaging with women

⁶⁶The issue of cultural differences was raised during my interviews with health professionals; comments by health professionals, specifically relating to non-Irish women, suggest the existence of greater challenges with that group when attempting to choreograph a consultation that might explore issues of domestic violence. However, in my endeavours to meet women who experienced abusive relationships, I did not meet any non-Irish women. Thus, I acknowledge that findings in relation to cultural differences and the choreography of the consultation are somewhat limited. Full illumination of the process of discovery and disclosure of domestic violence in circumstances of cultural differences requires further study, with a focus on the experiences of non-Irish women living in Ireland.

beyond the clinical reason for the consultation did not occur. Furthermore, GPs and practice nurses hypothesised about what occurred for women from other cultures regarding their experience of domestic violence:

Yes she had a notion that this is my life, this is what I have accepted by coming over here with my [husband]... and this [domestic violence] is what is acceptable in my country. So therefore it should be acceptable here. Because he, along with all his compatriots from XXX, they all accept that this is part of it. So all the family support unit, which is not a family here, is his family, his friends and she is isolated in that way as well. She doesn't have friends that will support her and she has a whole culture against her here in this country which is a XXX culture of acceptance, she says. (Nurse Ivy)

We had a Muslim [patient]. Some of the men who don't actually allow the women to talk and take over everything and the women can't talk and I would feel that the women are being suppressed. (Dr Birch)

Reading the person was based on the GPs' and practice nurses' perceived cultural norm, rather than having an understanding of the cultural differences of the woman. For example, in an attempt to read the person, Nurse Lily questioned herself, as well as her cultural knowledge:

It is hard to assess [non-Irish women and their culture] because you don't know: why is that man sitting there? Is it a cultural thing? Is it because his culture dictates that he must be there at all times or whether it is that he doesn't want his wife talking to you? That is hard to assess really. All I was really saying is that quite often in other cultures the husband will always come in with the wife, no matter what it is for, for an ECG⁶⁷, for bloods, with the babies. And you don't know why. Sometimes you would get a feeling; it is hard to tell though because it is in a different language. You know when people have a good relationship ... You know, if they come in and there is a good banter between them, well then [the partner's presence], it is a cultural thing, or maybe she wanted him in here [in the clinic]. But sometimes it would be hard to assess.

As well as reading the woman during the consultation, health professionals were engaged in a double choreography of assessing the dynamics between the woman and her partner. On the one hand, health professionals were reading the situation from the woman's perspective while, on the other hand, they were reflecting on their own discomfort with a male presence

⁶⁷ ECG = Electro cardio graph, is a test that is conducted to measure the electrical activity of the heart.

and an inability to engage with the woman one-to-one. Furthermore, where language and communication difficulties existed, it was acknowledged that the discovery of violence against women could “go under the radar” (Nurse Rose & Dr Ash). Some GPs questioned their level of care due to the complexities of reading women from socio-cultural diverse groups:

Maybe they [non-Irish women] are happy [with a dominant male partner]. You have always got to stand back and say that is the way it is.... It is a problem..., [Am I] over reading something. But it is very difficult because every time you ask a question, sometimes you think they [women] can understand and I don't know what it is like for them. (Dr Birch)

We've had a lot of non-nationals for years and years and [we are] getting to know more over the years, but I could see how there would be some slipping the net there. They are a very sort of stoic people; ...I think again, that their pride wouldn't let them disclose. (Dr Elm)

Health professionals found it difficult to read women from other cultures due to their difficulties in understanding and interpreting socio-cultural differences. They were reluctant to address domestic violence issues with non-Irish women due to a sense of being unfamiliar with the individual's society; perceived complexities of a cultural choreography and difficulty in reading migrant women as “they are very defensive” (Dr Elm). However, data suggest that health professionals misread Irish women also, suggesting difficulties with, or without, a familiarity and understanding of the cultural backgrounds of women. In circumstances of cultural differences there appeared to be a cultural choreography of engagement that foregrounded a shrouded silence. Part of that silence was attributed to the behaviour of the women, which was seen to be culturally situated, an absence of knowing the person or understanding their way of life and a lack of professional education and training. In the absence of cultural understanding, some preconceived ideas were articulated:

No, again I think it is probably a cultural thing as well and certainly whatever about we are not trained to deal with the Irish domestic violence, I think certainly not... I think the way they [non-Irish women] tend to be not as expressive anyway about feelings; they don't tend to [discuss non-clinical issues]. (Nurse Daisy)

They [non-Irish women] seem to accept it [domestic violence] in their own way and I think a man...in their [culture]...he probably has a right to chastise his woman.
(Dr Ash)

Although this study is about exploring the interaction that occurs within a clinical consultation between women, regardless of their ethnicity, comments by health professionals specifically relating to non-Irish women suggest the existence of greater challenges with that group when attempting to choreograph a consultation that might explore issues of domestic violence. Issues such as the presence or absence of emotion, and how the latter might mask a potential circumstance of domestic violence, were considered. The presence or absence of the woman's partner, the notion that domestic violence might be an acceptable norm⁶⁸ (for some), and cultural differences, whether in behaviour (women) or knowledge and understanding (health professionals), were also mentioned as reasons for "not going there" and for cases of domestic violence going under the radar.

While cultural differences were cited in relation to choreographing the consultation with non-Irish women, issues relating to rapport, communication, and fear of misreading a situation were also present when health professionals referred to Irish women. Indeed a belief that women (who may or may not have experienced abuse) from some cultures employ a "stoic" (Dr Elm) public image of themselves is not necessarily different to the pattern of women (who experienced domestic violence) maintaining or saving face⁶⁹ Cultural norms seemed to exist for Irish women (interviewed in the study) too, in that, they wanted to fit in, to engage in self-preservation and to maintain dignity:

You don't want to be that image [of an abused woman] in your community and so you keep the persona going - hence the mask. (Ruby)

⁶⁸ The category of acceptance is discussed in the Chapter Seven.

⁶⁹ The meaning of Goffman's (1959) theory of saving face is discussed in Chapter Nine.

In a similar way, health professionals were also concerned about maintaining face. They combined reading the person with internalising their own concerns of being “judged” (Nurse Heather) incorrectly as a clinician. Participants process of making judgements are discussed in section 6.3.2.

To conclude, findings indicate health professionals are reluctant to engage with the topic of domestic violence with non-Irish women. Reasons cited include an inability to read the person, to engage with the topic and apprehension around understanding the cultures of non-Irish women. Gendered differences also emerged where health professionals believed the presence of a male partner may suggest patriarchal dominance. Overall, health professionals’ unfamiliarity with and absence of knowledge of different cultural norms inhibited their attempt to discover violence against non-Irish women. Data suggest the dynamics of the consultation are choreographed, frequently subconsciously under the guise of maintaining face. The next section discusses how judgements occur in clinical encounters.

6.3.2 Making Judgements

Within the clinical consultation both health professionals and women engaged in a cognitive process toward reaching a decision, or drawing a conclusion, by making judgements about situations or individuals:

I have to have enough information to make a judgment but not be too pushy ... because it is not my position ultimately to be making a judgment call. ... I do find it very hard to do because of course a lot of the time people [who are] phoning or making contact with the doctor are in some sort of stressed situation, whether it is a physical stress, whatever it is, it feels the most important thing in their lives at that precise moment. (Sage, Administrator)

Decisions were made by the administrator based on the woman’s story, while also determining, without appearing inquisitive, the important issues prompting the consultation. Finding a balance between probing for details, and at the same time feeling a need not to be

intrusive prompted some reflection on how consultations were choreographed. For example, Sage, an administrator, spoke of how she “wrestle[d] with myself sometimes.” GPs and practice nurses also judged their level of engagement and self-evaluated their management of the consultation:

When you do [make a decision] its very satisfying no matter what it is, whether it be a situation like that [domestic violence] or making a quick diagnosis, “I’m glad I didn’t miss that one” or whatever, I mean you miss them too [women in abusive relationships]. (Dr Oak)

General practice health professionals experienced internal conflict between their duty of care to women, versus a perceived threat to their professional relationship as they engaged in judgement and decision making, toward discovering a circumstance of domestic violence. Health professionals did not want to bring their own professional reputation into disrepute by “getting it wrong” (Nurse Rose); neither did they want to neglect patients situations, to “miss them” (Dr Oak). They were also concerned about their professional competencies to manage or choreograph a disclosure of violence against women and their lack of clarity around how they believed a woman might feel at a time of discovery or disclosure:

I think the thing is that before somebody even puts a hand on them [women] they have put in [up with] the psychological [abuse], like you need to be made feel worthless first and if you are made feel worthless then whatever anyone does to you, you feel like you deserve it or it is your fault or whatever... . If somebody just walked up to you the first time you met them and hit you, you wouldn't take it. But by the time the actual violence starts you often find that a lot more has gone before. (Dr Maple)

I think they [women] feel embarrassed and they kind of look at me [practice nurse] [as if they are saying]: ‘why am I putting up with this?’ and ‘I shouldn’t put up with this.’ And ‘[are you] look[ing] at me as if I am some scum, that I am with somebody who bashes me?’...I think it takes an awful lot of guts for somebody to do it [disclose]. (Nurse Daisy)

Although this practice nurse did not recall a circumstance of a woman disclosing domestic violence, she hypothesised how a patient may interpret being read by a nurse. In an attempt to understand the experiences of abused women attending general practice, GPs and practice

nurses created fictional cases, or put themselves ‘in their shoes’ and in so doing, implied how making judgements would be part of the choreography of the consultation:

I think if I were to ask that [about domestic violence], they [women] would kind of take a step back as if I was accusing their husband of something ... I know that if I was giving a past history and somebody asked me ...I...I would be taken aback by it.
(Nurse Heather)

Nurse Heather foregrounded herself and how she might feel being asked about domestic violence and, in so doing, illustrated how health professionals’ values and beliefs and a need to protect the self can influence clinical reasoning and the process of engagement toward the discovery of violence against women.

In a similar way, Dr Ash judged the risk of jeopardising the relationship between the health professional and the patient and how it could reflect on him as a clinician:

Well you go to the doctor and he starts asking you ... ‘are you involved in an abusive relationship at home’? ...well [a feared response might be] ‘what’s he about’? You know!

Data suggest that apprehension of being negatively evaluated, by women, influenced health professionals’ management of the consultation. Concerns about causing offence to women through a “fear of getting it wrong” (Dr Willow & Dr Elm) or “jumping to the wrong conclusions” (Nurse Daisy) inhibited health professionals in how they addressed (or not) a suspicion of violence against women. Factors such as clinical expertise, discomfort, knowledge and understanding of domestic violence, and the perceived consequences of women’s disclosure were also considered as health professionals attempted to (or hypothesised how they might) choreograph engagement toward the discovery of women who experienced domestic violence:

I would say a GP trainee, or a junior doctor, or a doctor who is busy will fob it off [the disclosure of domestic violence]. I think [ignoring] it would be very destructive [to women]. (Dr Willow)

It’s a discomfort about confrontation... a don’t go there [attitude]. (Dr Pine)

Being ill equipped to manage disclosure, by women, posed a challenge to both GPs and practice nurses. Health professionals spoke of “[not] hav[ing] the knowledge to take that [domestic violence issues] on board; I wouldn’t go there” (Nurse Daisy). Other reasons for not “go[ing] there” included fear of finding oneself potentially in a legal quagmire. For example, Nurse Daisy judged discussing domestic violence issues as “a very dodgy area... [where] you can open a minefield and not be able to cope with it.” However, data suggest that rather than fear the legal⁷⁰ ramifications of discovering violence against women, health professionals were in a position, when required, to support women with documentation for legal reports:

She was a huge help when I went to court. She wrote a letter saying how violent it was and saying how myself and[my] son’s health and wellbeing was in jeopardy. It was a very, very strong letter and that letter was the basis of me getting my barring order and my safety order. It was really powerful, so much so that I didn’t have to go on the stand because he [husband] agreed to things because she was a well recognised doctor in the local area and the judge had huge respect for her. (Sapphire)

Three or four [women] would have been sent up [to the surgery] by probably solicitors or policemen just for a report; you know when you have bruising over the rib cage, or whatever. You know. (Dr Ash)

Some would just tell me so that I can make a note in the chart if something happens. Again, that at least, they have gone to the doctor and if they want to get a barring order or a protection order that at least they will have it recorded that this has happened before. (Dr Maple)

Where women had already disclosed domestic violence, in some cases not necessarily to the general practitioner, the opinion and support of the clinician was sometimes sought from other agencies. In such circumstances, rather than being fearful of “getting it wrong,” (Dr

⁷⁰ This study is not about women’s negotiation of the legal system. However, it is necessary to acknowledge how a woman’s narratives alone are not considered adequate to give strength to her story within the legal system. The judicial system seeks testimony from the woman’s GP, testimony that is generally framed within a medical model of care. Stories do not stand alone; testimony from the GP bears witness to the woman’s narratives. The high esteem GPs are held in – valued and authoritative – allows for what Goffman (1959) describes as “impression management,” in other words, advocating for the authenticity of the woman’s story.

Elm, Dr Willow, Nurse Rose) the health professionals were able to advocate on behalf of women in abusive relationships, at least within the legal system.

The process of judgement and decision making described by health professionals, including fear of wrongly adjudicating a circumstance of domestic violence and potentially embarrassing the woman, was not always echoed by women when they described their experiences of the clinical consultation. Women did not verbalise the low self-esteem that GPs and practice nurses expected (“made worthless” Dr Maple or “look at me as if I am some sort of scum” Nurse Daisy when they hypothetically placed themselves in the role of a woman attending the practice), nor did they adjudicate the consultation based on the clinical expertise of the health professional. Noticeably, women foregrounded the empathetic qualities of good listening, non-judgemental engagement and acceptance:

[It helps] If the GP is non-judgemental, understanding and tell[s] her [woman] she is safe and be generic by saying “nobody deserves this”... [and] “you don’t deserve this” [to be abused]. (Sapphire)

The key thing is [for health professionals] not to get frustrated with her [when a woman does not disclose or leave the relationship] because there are so many factors to consider, the home, the children, standard of living, the farm, all sorts of complications and men will lose their children. (Amber)

While judgement, in terms of wrongly suspecting domestic violence, was a concern for health professionals, so too was their concern that women might adjudicate them to be less than understanding of their circumstance of domestic violence, or, might feel reproached for having disclosed their experience:

The one thing that would inhibit me [discussing domestic violence] is the fear that they [women] would think I am judging them, that they would assume that they have been a victim of it, that people feel that they themselves are at fault if they have been abused or if they are vulnerable... But even still, I feel they always feel it is and that I would be judging them or thinking less of them. (Dr Willow)

I will put them through to the doctor because I'd rather play it on the safe side. I think if there are any particular instances, emotional situations when they come into us. (Sage, Administrator)

I don't want them to think I am accusing their husbands of something.
(Nurse Heather)

I felt she [GP] is judging me now because I haven't left [the relationship]. She knows what's going on and I haven't left, do you know that kind of a thing. But, I mean, she was my GP for 10 years before I left [my husband]. (Sapphire)

Further illumination of the vulnerability associated with a fear of being judged was articulated by Sapphire:

I would have to have a very good relationship with a practice nurse before I would tell her. I was constantly worried, after telling the GP, that she was judging me. I told the GP that my husband said that she [GP] was talking about me in the village. The GP said, "but I am not taking any notes, the discussion stays in the room". I needed to hear that. Feeling secure about confidentiality would facilitate women to disclose. I know about the Hippocratic Oath. But when you are in an abusive relationship everything is turned upside down, so you do need to hear that, to know you are not being judged, to know you are being listened too, to know you are being understood.

In summary, the property making judgements focuses on image and, in particular, the need to maintain a positive image. The findings indicate that in consultations with emotive content (in the case of this study domestic violence) health professionals grappled with the complexities of judgment and decision making as they sought to avoid misjudging women who may, or may not, have been experiencing domestic violence. For women, their need to find a non-judgmental environment was their focus when engaging in the choreography of the consultation. Making judgements is about an avoidance of humiliation and the choreographing of a consultation that moves beyond pre-conceived ideas, and fear, toward empathetic engagement and a sense of knowing between women and health professionals. It is about seeing the stones and deciding to lift them to explore what lies beneath. The next section discusses how women judged the surroundings and physical environment of general practice as a location to disclose domestic violence.

6.3.3 Judging the surroundings

Adjudication of the suitability, or otherwise, of the general practice setting for the disclosure of the experience of domestic violence began when women spent time in the waiting area of the surgery. From the point of entry, women read the landscape of the surgery surroundings. Women perceived the presence, or absence, of information posters on domestic violence as an indication (or not) of general practice health professionals' awareness of domestic violence issues:

[Domestic violence] is ignored. I didn't notice any leaflets in my GPs practice about domestic violence. (Garnet)

I think if the GPs never went there [but made an attempt to discover circumstances of domestic violence], if they offered the services or a number [support services to women] rather than avoid it all together. I think there is an avoidance [of domestic violence issues]. I never saw information on domestic violence in the practice, no posters, nothing to indicate that they know about domestic violence. I felt it wasn't on their radar. A phone number in the waiting room would mean they were aware of the services... [I could have been enabled to disclose] by seeing a number say "ring such and such." (Ruby)

However, for Coral the presence of an information poster about violence against women initiated her disclosure, a journey that began which she described as an emotional "outburst" in the surgery waiting room and later, followed up by a phone call from the practice nurse:

I remember the day: it was three weeks before I gave birth to my son. The waiting room was full, I just burst into tears and I was brought in next, so that's when I disclosed fully the pressure I had been under...I felt comfortable speaking to her [GP]. When it got so overwhelming I just talked, it was the nurse and the GP, I was just distraught. It just got so overwhelming I couldn't hold back any more, I was self-harming myself... it was a way of venting off any anger I had towards my husband and the situation that he had us in. So when I disclosed that [domestic violence] they got me on to counselling straight away. There was a poster in the surgery and the [practice] nurse even rang me back within a few hours with the number of XXX [local support service] and instructed me what to do.

While posters were described as "useful" (Dr Elm) as a reference point for health professionals to enable women to disclose domestic violence, women judged an absence of posters as a sign of disinterest and a lack of knowledge and understanding on the part of

health professionals. There was a level of ambivalence towards the use of health promotion information in the surroundings of the waiting room, and, in some circumstances, a reliance on an external company to manage and decide the content of the health information.

We used to have so many posters for different stuff... we have some leaflets, we have a leaflet board down below with a variety of stuff, no we don't have it up ...if you are experiencing blah, blah, blah, no. (Nurse Daisy)

There is a lady that comes in and does all that so half the time I don't know what is there but I don't think there is anything... there are leaflets, I have seen one or two leaflets but there is no big poster. (Nurse Heather)

I couldn't tell you what is on the walls; I just walk through the waiting room to my room to see the patients. (GP at a meeting)

Reasons for the indifferent attitude to the availability of written health information on domestic violence were identified. Some GPs believed that information on clinical issues such as smoking, diet and alcohol intake had a greater impact on clinical health than domestic violence, confirming statements that the issue of domestic violence was “not on the radar” (Dr Ash, Nurse Rose & Ruby). Furthermore, delegation of the management of health information literature to a third party suggests an absence of clinical responsibility for the health messages displayed. However, one GP engaged in a process of conjecture as to possible consequences to women of displaying advice on domestic violence support services:

Obviously, there is a risk in sometimes highlighting it [by displaying posters] or bringing it up with people, that if it becomes apparent to the person who is being violent that it is being discussed or that; it can increase violence in the home, can't it? (Dr Elm)

However, a comment by Quartz was unambiguous as to the usefulness of information:

Women want support [from health professionals] ... and to be pointed in the right direction. Having the information [about services, rights and entitlements] is only the start of their journey.

Apprehension that the display of support material could draw attention to the content of clinical consultations, as well as jeopardise health professionals' relationships with family members and women in abusive relationships, mirrors, somewhat, health professionals'

apprehension about making things worse for women and increasing their vulnerability (see section 6.3.2 making judgements). However, Dr Elm's question "can't it?" suggests a lack of knowledge and understanding of the complexity of the circumstance of domestic violence and how information may or may not help women or make them more vulnerable.

Apart from reading the visual display of material, while waiting to attend the clinician, women engaged in judging the dynamics of the waiting room before meeting the GP or practice nurse. For example in relation to waiting time⁷¹, women either read it as an indication of how available the GP might be to them – a longer waiting time indicating interest – or how much time they might take up – taking too much time with the GP and increasing the waiting time for the other patients:

You hear people in the waiting room getting pissed off about that [waiting], but you know that when you get into that room he [GP] is with you 110% (Pearl)

You were reassuring and apologising to them [other patients] and promising that you weren't going to delay him [GP] and not take longer than you need. (Ruby)

Prior to engaging in the clinical choreograph, women found themselves engaging in a social choreograph with other patients also attending the practice, by reassuring them and by negotiating and apologising for any delay which they perceived might occur. In essence, women judged the "chaos" (Quartz) in an already overcrowded surgery and, in some instances, minimised their need for time toward accommodating the needs of other patients to be seen without too much delay.

Women found themselves silently bargaining with themselves, with the system of general practice and with those competing to have their needs met by the general practice team. Judging the surroundings, allowed women to contemplate the physical and social context of the general practice setting and how disclosure friendly they perceived it to be. Furthermore,

⁷¹ Time is discussed in Chapter Eight.

prior to negotiating access to the GP or practice nurse, or entrée into “that room”, some women engaged in a social choreograph with other patients. Their reading of the waiting room dynamics enabled (or not) their performance in the clinical dance. While women’s comments about the waiting area spoke of the importance of that context to the clinical consultation, the ambivalence of health professionals about health information provided in the waiting area suggests an absence of understanding of the extended context of the clinical consultation and its potential for influencing the choreography of the consultation.

6.4 Chapter summary of choreographing the consultation

This chapter has focused on choreographing the consultation and the interaction between general practice health professionals and women who experienced domestic violence. Lifting the stones and seeing the slugs beneath is a theme that provides a meaningful essence to underpin the process of negotiating the choreography of a consultation and health professionals’ ability to discover violence against women while also enabling women to disclose their experiences of abuse. Like the undisturbed slugs, the absence of physical symptoms allowed, at times, domestic violence to go undetected by clinicians. Similarly, where women were not enabled to disclose domestic violence, they themselves did not lift the stones to show the slugs beneath. In some instances, they remained in place, undisturbed for many years. The iterative pattern of the general practice consultations did not always allow for the principal issues of concern to emerge. Rules of engagement existed. These rules were often unstated but were embedded in a dance of seeing and not seeing; reading the person; and reading socio-cultural differences. Repeat visits by women to the clinic were mostly accepted without a deeper reading or seeing as to the circumstances of such visits.

The discursive rhythm of the choreography of the consultation altered, depending on who took the leading steps. If women disclosed their situation of being in an abusive relationship, general practice health professionals integrated the subject of domestic violence into the consultation. Then, seeing became one of a shared knowing. However, in the absence of physical evidence, GPs and practice nurses did not commence the clinical choreograph of discovering the prevalence of violence against women. Although health professionals in general practice engaged with women on a daily basis, engagement with the substantive issue of domestic violence, as a possible differential diagnosis, was not common. Through a process of internalised beliefs (often misbeliefs) about domestic violence, some health professionals believed it was “not on my radar”, or they decided not to “go there”, or they engaged in a process of “fobbing off”, the consequence of which were a dance of evasion with domestic violence issues. Where there was an absence of physical symptoms, or where women did not voluntarily disclose circumstances of domestic violence, discovery by health professionals was problematic. The core category of choreographing the consultation begins a complex process of engagement toward our knowledge and understanding of the discovery and disclosure of violence against women. The next chapter discusses the core category of spiralling silences.

Chapter Seven: Spiralling silences

7.0 Introduction

The previous chapter focused on the process of negotiating the choreography of the consultation between health professionals and women who experienced domestic violence. This chapter is concerned with verbal and non-verbal communication and the disclosure of violence against women. The core-category *spiralling silences* describes processes of engagement where issues that are difficult to verbalise are avoided in conversation during the clinical consultation. Being silent reflects what is unsaid; if something is unspoken, it is unheard. Findings from this study indicated that silence frequently inhibited the disclosure of issues that individuals wanted or felt a need to keep private. Silence allowed issues to be concealed, while finding one's (or having a) voice and speaking about a matter, allowed women to say what was happening to them. In other words, silence is concealing and talking is revealing, and remaining silent about an issue, such as domestic violence, avoids exposure. Listening to silences in consultations, through intuitively reading the person, (see Chapter Six section 6.3) can also be a process of hearing messages (or not). Silence is a powerful tool that can be used by choice, can be enforced by another, or can be a learned behaviour. Silence is about not speaking at a given moment in time; it does not imply not wanting the opportunity to speak about issues of concern. If an opportunity to speak, is not being given (either wittingly or unwittingly), being silent means withholding the need to articulate and address an issue within the clinical consultation.

7.1 An overview of the core category

Spiralling silences is a core category that includes the sub-core categories of *cultivating silence*, *strategic silencing* and *breaking the silence*. The core-category spiralling silences illuminates the process of finding and giving voice, through conversation, toward the discovery and disclosure of domestic violence issues in a general practice consultation. There is no linear transition between silence and voice. Like a spiral that does not have a clearly defined beginning or end, silence can be ongoing. Each sub-category has its own properties; these emerged through a process of constant comparative analysis. Although each sub-category is discussed separately, a certain amount of crossover exists, indicating the ongoing process of spiralling. Each of the sub-categories have interlocking cogs that spiral in a continuous loop and, at times, overlap (see Figure 7.1). The arrows represent how the spiral motion of silence circumnavigates each sub-category, thus illustrating the interconnection between the sub-categories.



Figure 7.1: Diagram of spiralling silences

7.2 Cultivating Silence

Central to the core category of spiralling silences is the sub core category of cultivating silence, which suggests an action that grows over a period of time, takes hold and develops roots. With nurturing, the silence continues to a point where issues become invisible and are overlooked. Silence, as in not giving voice to the issues of domestic violence, is a pattern of behaviour that occurs due to a perceived normality or acceptance of the issue in everyday life. Hence, health professionals miss domestic violence issues in the clinical consultation, due to non-discovery and an absence of disclosure by women. Cultivating silences is underpinned by three properties: accepting and normalising; naming the situation; and realisation awakening. Each of these properties is discussed in detail.

7.2.1 Accepting and normalising

Accepting and normalising illuminates an understanding of the social acceptance of the presence of violence and contributes to the sub-category of cultivating silences. Several factors influence the toleration of violence in society including how the media portray it; learned behaviour from childhood; and substance abuse by patients or partners. Remaining silent about violence, or being dismissive of it, suggests it is a customary part of everyday life and does not require special discussion and attention. When health professionals recalled patients' narratives, their account of their engagement appeared to indicate, either an emphasis on remaining neutral or a questioning of the accuracy of the account. Nurse Daisy recounted a comment by a woman who had attended the practice and said, "I was walking along and they [Gardai] jumped me you know." Then commented:

"We get a lot of that [laugh] and they could have [acknowledging their might be truth in what the patient said]. "God knows what happened, the guards: I'm not saying, you just have to say, ok! Well! You know!"

This account by Nurse Daisy suggests that at times patients' experiences of violence were viewed, somewhat, as a normal pattern of everyday life and that violence begets violence. Dr Birch used an example of the acceptance of violence by the media to illustrate how similar behaviour infiltrates into the home and can be accepted as normal:

If you watch *Eastenders*⁷² [you can see] all the aggression and the rows and the people storming out. So it [domestic violence] could be constant rows at home. It could be that sort of stress, rather than just physical violence [and] emotional. You [GP] get immune to it a little bit, or think it is acceptable.

Within a clinical discourse the term immunity is generally used to refer to the prevention of disease, or illness. However, the use of the term in this instance implied developing an acceptance of, or an indifference to and resilience towards issues of domestic violence. While health professionals acknowledged that violence in society is a regular occurrence, sometimes portrayed through the media as entertainment, or experienced at a state and community level, their comments suggested a belief that violence was not necessarily a health issue. Furthermore, a comment by Dr Oak's that, "we all have verbal rows, verbal violence occurs between all families" implied a degree of ambivalence toward the issue of domestic violence, particularly circumstances of verbal abuse.

The notion of acceptance and normalising emerged as a significant property of the experience of cultivating silence. Women spoke of accepting their circumstance of living in an abusive relationship. Quartz spoke of how she, "put up and shut up," while Sapphire "learned to live with it." There was also a belief by health professionals that women accepted "their lot" (Nurse Ivy). Women's silence appeared to grow from their acceptance of their situation at that time, and this along with a perceived toleration of their circumstances mitigated the likelihood of disclosure or discovery of their experiences of domestic violence. Dr Ash explained, in a matter-of-fact way, how some women accepted their abusive relationship and

⁷² Eastenders is a television dramatisation set in the East end of London.

spoke of his experience of them attending the general practice looking for analgesics (painkillers) following “a beating”:

I would say, “Are you going to stay with him?” And they’d say, “No, no I’m going to stay with him.” They are quite blasé about it ...Yeah like your mother smacks you with a wooden spoon, you know, you forget about it the next day. (Dr Ash)

Society’s method of normalising violent or abusive acts with a sense of ease, commenced with violence as a way of chastising children.⁷³ Being groomed to accept violence from parent to child illustrates how acceptance is learned and is nurtured over a lifetime. A pattern of accepting, normalising and cultivating silence commences early in development. The idea of not discussing it, of forgetting about it, suggests that once the violent act is over, the conspicuous behaviour of smacking is deleted from memory and rapidly rendered invisible. Reference by the GP to the practice of disciplining children, through physical force with a wooden spoon, and his reference to the transience of such violence implied some degree of indifference about domestic violence as an issue.

Conditioning and an acceptance of their situation meant that some women remained silent for a long time about their abusive relationship. Their acceptance of their circumstances was by way of endurance, not by way of tolerance:

You are conditioned and groomed to accept that violence. If all that psycho stuff didn’t go on you wouldn’t let someone hit you but because you think you deserve it. You believe you provoked him. You believe that it was your fault and you wouldn’t believe that unless that psychological stuff went on. That’s my opinion. (Sapphire)

You can normalise the behaviour to some degree, I know I wasn’t happy or 100% safe with him but I learned to live with it. I had become accustomed to it. (Amber)

It becomes normal, part of life. What is normal to a woman who is not being abused? Abuse to another woman is [normal]. So they just cope on a daily basis and that becomes who they are. It’s like as if you don’t know any different. (Quartz)

Some women’s acceptance of domestic violence suggested that it was not a subject for public

⁷³ Fergus, H. 2007. *Listening to children: Children's stories of domestic violence*. Office for the Minister of Children, Department of Health and Children.

or for clinical deliberation. Being reluctant to openly talk about issues, which are generally shrouded in silence, is a way of illustrating how silences are cultivated and grown over time. Silence occurs in a spiralling, continuous loop: it becomes a way of life. Silence towards acceptance was experienced by Sapphire as a process of being “groomed to accept.” She spoke metaphorically:

Put a frog into boiling water, he will jump off. Put a frog into cold water and heat it up, he will stay in it and will slowly die. (Sapphire)

Women experienced being conditioned into remaining silent about their abusive relationship, a situation that resulted in their experiences of domestic violence remaining invisible and undisclosed⁷⁴.

However, acceptance did not mean being content. Women whose “self-esteem is in tatters” (Garnet) were aware that building the confidence to disclose was challenging. In essence, women’s acceptance was illusory. For them, the notion of acceptance was a public appearance of endured silence about something they found difficult to discuss, or felt they could not talk about. Endurance and silence were on a continuum for women where disclosure was either not enabled or not an option. Non-disclosure was more indicative of an inability to communicate with the issue rather than a resistance to disclose:

Unless you live in a person’s shoes you don’t know [what it’s like]... that’s why I don’t say anything. People would rather run a woman down... [even] other women can be the cause of the silence. (Quartz)

It had become a normal pattern of behaviour chipping away at my confidence. (Crystal)

Some health professionals believed women’s high threshold for abuse was due to learned behaviour, where acceptance of abuse in relationships developed over time and between generations and families:

⁷⁴ Some of the women interviewed never disclosed their experience of domestic violence to GPs or practice nurses. However, they did disclose to support services such as Women’s Aid.

A lot of them actually may have grown up in a home where there is violence and then they meet someone and it goes on and goes on and is a vicious cycle. (Dr Maple)

Women will tolerate a lot – influenced by their own upbringing, their acceptable norm - before they will disclose an abusive relationship. (Dr Cedar)

The first reason [I don't hear about domestic violence] is that it is just so acceptable...I think in some places it is accepted and it comes down then through families where it would have been accepted, maybe violence towards the mother and she would have seen a lot of it at home maybe. There is that and then they see it all around them in other households and probably think it is bound to happen. Probably not so much the physical violence, but the psychological abuse, you know, that it is almost accepted...experience, maybe the experience of their friends. (Nurse Lily)

An implied acceptance of the presence of violence against women is problematic. It suggests some level of acceptance on the part of the health professionals also and, perhaps an absence of the need to address issues of domestic violence within the clinical consultation. Findings suggest part of the reason for health professionals not discovering violence against women is due to the perception that some women tolerate and accept their abusive relationships. In other words, if women appeared to accept “their lot” (Nurse Ivy), and did not disclose their experiences of domestic violence, a culture of silence developed. Both health professionals and women were party to this culture of silence:

They don't tell us [about domestic violence]. (Dr Birch)

[Some women are] submissive. (Nurse Lily, Dr Birch)

There was nothing he [GP] could have done with the information [being told about the abusive relationship]. (Ruby)

Data suggest that due to an acceptance and normalisation of domestic violence, opportunities to discover the issue by lifting the stones and seeing the slugs beneath are missed. In other words, when women appear to accept their circumstances of living in violent relationships, health professionals accept their situation, also as their norm.

The notion of acceptance of one's circumstances of domestic violence is complex. For example, acceptance as in a realisation of being in a violent relationship was for one woman a consequence of being “helped” to disclose. Crystal explained how she had stayed with her

husband and had accepted living in an abusive relationship for many years. However, through being “enabled [by a support group] to talk and open up I was in a better position and able to stand up to my husband” (Crystal). Accepting her situation was for Crystal both an acknowledgement of her circumstance and an opportunity for self-development. She learned to speak up for herself, and in so doing to resist her husband’s controlling behaviour. Data suggest that for some women acceptance and the dynamic of disclosure (to the general practice team and/or to others) was one of conspicuous empowerment, of standing up for the self. However, for other women acceptance was a way of life, a life they choose to keep invisible from others.

Findings suggest that the normalisation and masking of domestic violence is, in part, a consequence of specific lifestyle behaviours and how they are tolerated. For some, their abusive relationships were underpinned by the use of alcohol and drugs, though this is not to suggest that substance misuse is the cause of domestic violence.

A lot of doctors must know [about domestic violence] because in my experience there is a lot of alcohol and drugs involved and that’s when the real abuse takes place. If you look at that as being an acceptable part of our society, it’s very complex. (Garnet)

The presence of substance misuse was used to explain violent behaviours, possible contexts for an acceptance of such behaviours, and a reason for doubting the existence of circumstance of domestic violence:

So as people say, 'if he is taking alcohol he is a different person, when he is not drinking he is lovely.' So you know it [alcohol] is the relaxant, it is the drug that will relax somebody and when you are either coming off that drug or coming into the DTs [delirium tremens], the anger can start. (Nurse Ivy)

A lot of them [women] come in with smacks ok, and it mightn’t even be a long term [relationship], it could be just a fella they met that night or whatever. ... You know, it’d be very...it’s kind of different, the drug scene and substance [abuse] is a different kind of scene. ... They tend to flit between partners. I mean, regularly. (Dr Ash)

There is a lot [of domestic violence] when it is drug and alcohol dependent and you hear a lot of stuff and you don’t know whether its life or their kind of lifestyle and

sometimes they might say there is a partner but you wouldn't know whether there was or there wasn't you know. (Nurse Daisy)

They [partners] have a few drinks and they get the bad temper and they [women] kind of say, "oh God I hate Saturdays and Sundays because at home they are shouting and ranting" or whatever, that sort of thing and the kids are there. And then the whole week is wonderful. (Dr Maple)

The existence of substance abuse militated against the potential for either discovering or disclosing women's circumstances of abuse. In essence, it helped to mask the issue and contributed to the silence and invisibility that surrounds domestic violence. Where substance use was accepted as a regular pattern of behaviour, domestic violence in such circumstances was tolerated too.

In summary, this section has explored the properties of accepting and normalising domestic violence issues. Overall there was an acceptance by both women and health professionals that domestic violence existed "out there" (Dr Ash, Dr Willow, Dr Birch, Nurse Rose, Garnet & Sapphire) and associated with that acceptance was some degree of normalisation, particularly in circumstances of verbal abuse and alcohol and substance abuse. Domestic violence was also normalised within a general acceptance of violence within society. Patterns of acceptance and normalisation help to cultivate a silence where violence against women issues are not addressed and contributed to the ongoing spiral of silence within general practice consultations. The next section explores the various terminologies and names used for domestic violence and how these influence the process of cultivating silence.

7.2.2 Naming the situation

Due to differences in perception, some health professionals and women indicated how putting the title of domestic violence, or naming a situation as abusive was, at times, difficult. Health professionals were loath to diagnose or label a relationship as domestically violent that could be mis-interpreted as their own opinion when describing the issue. The sub-category

naming, illuminates the complexities of the language used and the process used by health professionals and women to name a relationship as abusive (or not). The challenge in differentiating between various forms of abuse and the behaviours of individuals suggests that achieving clarity about the term domestic violence is complex:

There's other types of bullying, sort of stuff that happens domestically...you know, but you're dealing with domestic violence, rather than abuse. There is definitely abuse where the man hasn't hit the woman but they are bullying them and they are controlling their money and all sorts of stuff and young women where men are quite jealous of them going out, we've had plenty of that. You're going into relationship difficulties at that stage. (Dr Ash)

I find the older generation are probably more controlled by men in so far as like, "my husband will come in and pay the bill" or whatever, meaning that the man is in control of the finances...controlling the purse strings. But I mean that isn't domestic violence I suppose, it is just a different generation. (Hazel, Administrator)

Some aspects of abuse are more readily recognised than others, and rather than name a relationship as domestically violent, health professionals focused on the consequences of abuse. Therefore, during the consultation, the results of abuse appeared to take precedence over addressing women's experience of being in a persistently abusive relationship. Attempts toward understanding the linguistic complexities suggest that health professionals were sensitive to avoid inappropriately labeling a woman as being in a violent relationship. One way they did this was through using tentative language:

I get around the language depending on who the person is. (Nurse Ivy)

You can say it in a roundabout way without saying domestic violence.
(Nurse Heather)

Health professionals' style of meandering through the terminology of violence against women suggests discomfort when articulating some language. The use of non-specific language suggested a verbal strategy employed for ease of communication when health professionals were unsure how to name the circumstances in the clinical consultation and were unaware of the woman's feelings on the issues.

Although health professionals discuss sensitive issues⁷⁵ in clinical consultations, in this instance, circumnavigating the vocabulary was more than about the avoidance of certain words. It was about avoiding the topic of domestic violence, so as not to “open a minefield” (Nurse Daisy) or a “nest of worms” (Dr Pine). On the one hand, naming the issues indicated awareness, openness and understanding of a need to discuss the women’s circumstances of domestic violence. On the other hand, their engagement in a non-directive way, by not naming the substantive issue of domestic violence, suggested health professionals were concerned about misinterpreting women and being misinterpreted themselves. Hence, during the clinical consultation, health professionals did not always acknowledge the possibility of the presence of violence against women.

The process of applying terminology to their situation was a complex process for women. Once disclosure occurred, women experienced different responses both to the naming of the events and to the naming of their experiences. Firstly, the realisation, by some women, that the terminology of domestic violence was applicable to their situation was a revelation (this issue is discussed in section 7.2.3 realisation awakening). Secondly, some women reflected on their situation, and expressed annoyance and anger at health professionals and other agencies (such as family, law enforcement, health services) for not naming the phenomena with a decisive level of affirmation:

Domestic violence is a beautiful word - domesticity, so when you bring it back to [the] doctors again - it's a domestic. Domestic violence is not the right term. If somebody assaults somebody they should be charged. People present with the physical. Domestic softens it. The terminology and the issue, it's a lot more than having a domestic. It has to be seen as a crime, it should be called assault. Women don't get depressed for nothing. Domestic is not a good term because it doesn't allow for any charges to be brought. (Garnet)

⁷⁵ Sensitive issues describes the management of particularly delicate clinical consultations, for example, sexual health conditions or child abuse issues.

Describing the word domestic violence as beautiful suggests anger, frustration and disdain. Prefacing the act of violence with the word domestic appears to alleviate the seriousness of violence against women. Therefore, the term domestic (meaning family, security, home and privacy) suggests there is a boundary implying containment, where disclosure is not necessary. Furthermore, when the language used to describe violence against women softens the reality and seriousness of that experience and the complexity of the issue (for example, as a crime) it means that it may not be treated with the same degree of seriousness of response that it warrants. This, in turn, can contribute to the culture of silence that exists around domestic violence. Furthermore, use of the term domestic violence⁷⁶, to soften a harsh reality, may in fact disable disclosure by women and so contribute to a sense of their acceptance of their circumstances. In addition, data suggest when the term, minor “family row” (Dr Oak & Dr Birch) is considered as “having a domestic” (Garnet), the experience is minimised. Hence, the discovery of domestic violence is more complex if the terminology used is trivialised, or the matter is not addressed with a level of importance.

When women reached a stage where they began to face the realities of their circumstance of domestic violence, they struggled to name it. Like the health professionals, they used understated or diluted language to disclose their circumstances within the clinical consultation. For example, some women described their experiences of abuse as “only physical”, or “only psychological”, (see section 7.2.3 realisation awakening).

Some women found it difficult to communicate and apply the terminology of abusive relationships to their personal situation. The following comments illustrated women’s experiences of circumnavigating the linguistic complexities of domestic violence:

⁷⁶ Only one woman in this study referred to the term domestic prefacing the word violence as an inappropriate term. Several women discussed the type of abusive relationship as physical, psychological and emotional.

I found it hard to say the word violent or accept that my husband was abusive. Instead, I used to tell the doctor that my husband was difficult. (Topaz)

I am not sure if I would have used that term abuse, but I knew I had to leave. I knew he had abused me when he had kicked me the entire length of the kitchen. (Amber)

Women minimised the experience of domestic violence by contemplating the language they applied to their situation. These strategies were cultivated over time. Women's ability to find the language to express abusive situations was made more difficult by stress, their low self-esteem, difficulties in speaking about sensitive matters, the prevailing web of silence about the issue and health professionals' inability to read their situation. The use of obtuse language, during the clinical consultation, lead to a circuitous and convoluted route of disclosure, which, for some women, delayed the eventual disclosure and discovery of their experiences of domestic violence.

In summary, there is no clear terminology for violence against women. Use of various names were used by health professionals, which were, in turn, open to interpretation and could influence engagement with the issue in clinical consultations. Some women minimised their experiences of abuse when disclosing domestic violence, by minimising the terminology to define their situation. In other words, not naming the stones as stones meant that the slugs remained hidden and contributed to the invisibility of violence against women. The next section discusses the property of realisation awakening, which relates to women's awareness that their intimate relationship was abusive

7.2.3 Realisation awakening

The concept of realisation awakening further builds on our understanding of the sub-category cultivating silences. Realisation awakening is about understanding, and awakening women's understanding regarding the issues of domestic violence. Some women were not aware of living in an abusive relationship and the realisation was their awakening:

I had no idea. It had been building up into full blown domestic violence. (Opal)

I didn't recognise it [domestic violence] that is the other thing...I could tell you something was wrong. (Pearl)

I didn't recognise what I had gone through from [19xx] to [20xx] as depression but I look back on it now and I was severely depressed [as a result of emotional abuse]. (Amber)

Realisation awakening links with the category of 'seeing' (see Chapter Six); it describes the process of women moving beyond seeing their situation, toward naming their circumstances, and in some cases to taking action to change their situation of domestic violence. The process of realisation began with the verbalisation of their own thoughts on their situation. For several women, this process commenced beyond the surgery, in women's support groups (Crystal, Garnet & Sapphire) or counselling services (Pearl). Although disclosure was not automatic, the process of realisation enabled women to develop an awareness, to acknowledge their circumstances and to realise that disclosure was empowering:

The lid is off the horrible secret... that does something for ye, or once another person knows, [it's] like a problem shared. (Quartz)

Because once you say it out loud it helps you to process it and accept it, yet you are terrified because you have to do something. (Sapphire)

It is probably there, you can't quantify it as such. It does take people a long time for themselves to admit or to realise [their relationship is abusive]. (Dr Maple)

While verbalising the circumstances of domestic violence was a form of awakening from the long period of silence experienced by women, it also placed before them a challenge to act. The consequences of realisation awakening, where women disclosed their experiences of domestic violence, were described as "terr[ifying]" (Sapphire), "liberating" (Amber) and an opportunity for women not to be seen as "a victim, not a survivor, but [as] a thriver" (Opal). These pivotal moments prompted some women to activate change, by initiating their process in seeking help. Once women were aware of their situation and developed the confidence to express themselves, disclosure became a "weight lifted off my shoulders" (Quartz). The consequence of realisation awakening involved a dismantling of the spiralling of silence.

Realisation permitted an awareness of their circumstances which allowed some women to acknowledge the underlying issues, gain understanding, take ownership, share insight, become empowered and enable disclosure.

However, a realisation awareness was also a reason for some women not to acknowledge their situation, but rather to minimise, or mask over, their attempts (or opportunities) to disclose. Awakening was accepted with trepidation. One of the central concerns for some women was the use, by others, of a label to describe their relationship. For example, Opal was concerned about being defined or “classified” with a mental health problem by health professionals regarding the psychological abuse she experienced. While some women had accepted their circumstances, Pearl explained her difficulties when she heard about the reality of her circumstances from a therapist, rather than coming to the realisation herself:

If you had asked me, I would have said something is wrong but I couldn't tell you what it is. I am not oblivious to what domestic violence is - or the different ways. I know about mental abuse, I know what it is - and it's hard to hear. It wasn't until I went into therapy after we separated that I was told what it was.

The gradual process of realising and grasping the actuality of their circumstances enabled some women to move away from invisibility toward one of awareness. However, some women did not feel ready, or prepared, for this awakening:

It was really hard to accept. It was hard to justify things, really, really hard. I had to see things in black and white. I just didn't know it was me. (Pearl)

The violence grows and grows, you are tested where your boundaries are, and if your boundaries are flexible they will be pushed from here to Mushroomore⁷⁷, and young women ought to be taught where their boundaries are or eventually you will end up being clattered. (Opal)

While the “uprising problem” [of living in a continuously abusive relationship] (Opal) awakened a need for change in some women, for others, a way of reconciling their circumstances was they “learned to live with it” (Amber). Recognition of domestic violence

⁷⁷ Infinity.

was less distressing for women who came to a self-realisation of their circumstances than for those who heard it from others:

Then it dawned on me [that] all my health problems were connected [to the violence].
(Crystal)

This [awareness] just doesn't happen from the last night I was there [in the relationship] because this had grown from some tiny germ of a matter to an oak tree until it fell on me [indicating a realisation of psychological abuse over a long period].
(Opal)

Awareness is important as it has implications for women's ability to disclose their circumstances of domestic violence. Findings suggest that the process of realisation awakening was hard for women, as they grappled with the reality of domestic violence while, at the same time, recognising "it was me" (Pearl). It was a time when the process of spiralling silences was challenged and the pattern of acceptance, toleration and being silent was becoming unstable. While realisation was growing, it did not automatically imply acceptance and a willingness to disclose.

Overall, data suggest that realisation awakening is part of a gradual process of seeing and acknowledging the circumstances of domestic violence. Women's realisation enabled their own awakening and awakening enabled their own visibility. However, along with their struggle with recognising their experiences as domestic violence women grappled with the reality of hearing the terminology (see section 7.2.2 naming the situation) of violence applied to their situation

In summary, three properties build the sub-category of cultivating silence: accepting and normalising; naming the situation and realisation awakening. Where society has a tolerance of violence, due to the various classifications and the many perceptions of domestic violence, there can be indifference to its seriousness and an ambiguity as to what it entails. Commonly, general practice health professionals believed the consequences of domestic violence to be

primarily physical in nature; thus, other forms of violence were essentially invisible to them. Both women and health professionals acknowledged a process of acceptance and normalisation around the experiences of domestic violence, which for women meant living with it, and for health professionals a sense of reduced responsibility for its discovery. Finding the right language to name the situation of domestic violence was difficult for all participants in this study, either because of fear and discomfort of being misinterpreted (health professionals) or a fear of having to face the reality of their situation (women). Finally, the process of realisation awakening began a journey beyond acceptance, as in a tolerance of the circumstances of domestic violence, toward one of recognition, of seeing oneself in a violent relationship (women) and hearing the language of abuse to describe that situation. The next section discusses the data on strategic silencing.

7.3 Strategic silencing

All participants employed various strategies toward understanding the engagement (or not) of how domestic violence issues were negotiated, or choreographed in the general practice consultation, including taking a stance of avoidance where issues were not acknowledged, including “not going there.” A strategy related to tactics was used by participants that were preconceived, planned, deliberate, and calculated to achieve a specific result. Suppression of engagement with the subject of domestic violence by women and / or health professionals resulted in a strategic silence. Three properties illuminate the sub-category strategic silencing, and the core category of spiralling silences: avoiding; weighing things up and protecting (see Figure 7.2). Each property is discussed in detail in this chapter. Although there are times when activities between each property appear to overlap, there are distinct differences between the properties, each giving an in-depth understanding of the category strategic silencing. Due to the pre-contemplation involved in strategic silencing, this sub-category

differs from the sub-category of cultivating silences, where the former enables the development of plans or tactics for the non-disclosure of the issues.

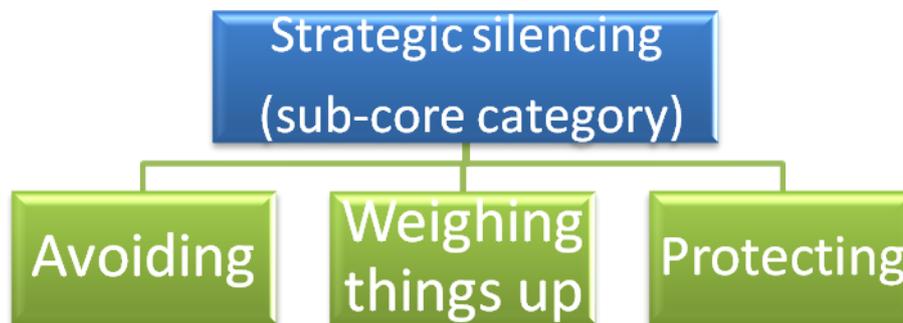


Figure 7.2 Sub-core category and properties of strategic silencing

7.3.1 Avoiding

Avoidance emerged as a significant category in the data. Both health professionals and women spoke of how they avoid engaging in a process of discovery and disclosure of violence against women. In some cases the circumstances of domestic violence remained firmly under the stones. Data suggest that, at times, there was a conscious effort by both women and health professionals not to lift the stones, or to see, or to explore the slugs beneath:

I was hiding it [domestic violence] from family and friends; I hid it from everybody. I was pretending that everything was ok. I did that all the time like I could get an award. (Pearl)

I am not sure I would have disclosed to him [GP]. I would have lied. I wanted attention in a different way. I was acting outdoors. (Ruby)

There isn't a written process and it [domestic violence] is never discussed, no, any practice that I have ever worked in it wouldn't be on their radar. (Nurse Violet)

No I don't have a policy for the want of a better word of routinely asking everybody, [I'm] probably afraid that I would get a raspberry [be reprimanded] back at me. (Dr Oak)

Data suggest that women became experts at avoiding disclosure. The notion of silence does not exist alone. Where disclosing domestic violence was not an option, women developed

strategies that contribute to a spiral of silence by putting on a front to save face and create an impression that all was well. Women did not want to receive attention as “victims” (Ruby & Garnet). Therefore, adopting a strategy of not speaking out suggests that women did not want “to go there”, but neither did health professionals:

Because if you open up that can of worms, where are you at? (Dr Maple)

I wouldn't go there, I think that is why we have psychologists and counsellors and that. You know...it's not fair to go there. (Nurse Daisy)

Health professionals mirrored women's pattern of behaviour by avoiding discussing the topic of domestic violence during the clinical consultation. According to Nurse Daisy, “people don't really want to go there,” implying that it is women's decision to avoid the subject. Health professionals' decision not to go there was more than a strategy of avoidance: it was a strategy of not wanting to know, not wanting to engage with the issue of domestic violence and in some instances, not knowing what to do with the information:

Is it that they [health professionals] don't know what to do with [the information] or how to react? (Nurse Violet)

It's a big bit of information to take back from somebody. (Dr Willow)

Avoidance of the topic was related to the health professionals' personal discomfort with the subject and reluctance to invest the time in the consultation (see Chapter Eight section 8.4).

Adopting a strategy of avoidance suggests taking a tactical stance of evasion – remaining silent on the matter - to evade addressing the issue of domestic violence. Some GPs explained how they were “bad at dealing with emotional issues” (Dr Cedar, Dr Birch, & Dr Ash). Moreover, emotional issues were seen as the responsibility of other professionals, such as counsellors. A belief that domestic violence is an emotional issue meant an avoidance of the issue, a “missed opportunity” (Dr Birch & Dr Willow) for engaging with the issue in the consultation. As such, the stones were avoided, hence the slugs beneath were not explored.

Health professionals cited several reasons for avoiding discussion on the subject of domestic violence during the choreography of the consultation. These included: “insufficient knowledge” (Nurse Daisy); “little training” (Dr Elm); “[domestic violence is an issue] outside of my scope of practice⁷⁸” (Nurse Cherry); “[I] prefer the doctors to manage it” (Nurse Heather); “[it is not] on my radar” (Nurse Rose); and “time is an issue” (Dr Cedar, Dr Birch, Dr Ash & Nurse Violet). The difficulties experienced in addressing the issue of domestic violence contributed to its invisibility. In other words, avoidance grew from a pattern of strategic silences, a consequence of which was failure, or delay, in both discovery and enabling disclosure of domestic violence.

Avoidance of domestic violence issues not only involved a reluctance to verbally engage, but was also illustrated in poor record keeping. The documentation of a diagnosis or differential diagnosis of domestic violence was also problematic:

I think a lot of stuff isn't put into the chart. (Nurse Rose)

We should really code it, if we had a diagnosis. It would be easier to put up [on the computer system]. (Dr Palm)

When health professionals read presenting signs as vague, or inconclusive, they experienced uncertainty and the process of recording the issues became problematic, especially when documentation was saved electronically. Where there was “an index of suspicion”⁷⁹ (Dr Elm & Dr Palm) that domestic violence existed, evidence suggests there was a void in documenting that suspicion, unless health records were tailored to specifically record that information “by the use of a tick box”⁸⁰ (Dr Elm). Also, some health professionals

⁷⁸ The term Scope of Practice refers to the range of roles, functions, responsibilities and activities, which a registered nurse, or registered midwife is educated, competent, and has the authority to perform (An Bord Altranais 2000).

⁷⁹ In cases where the patient's behaviour, symptoms or injury patterns give rise to suspicions but she does not discuss domestic violence, the GP or practice nurse may need to ask the question (Kenny and Riain 2008).

⁸⁰ Tick box refers to a system of recording data on computers by drop down menu boxes where yes/no answers are ‘ticked’. Similar questions include questions about smoking or alcohol intake.

"deliberately omit information" from clinical notes, on the premise that "we wouldn't like it getting out" (comment from GP on training workshop). If evidence is not documented, opportunities for discovery in future consultations may be missed. Furthermore, while the use of tick boxes may be an efficient method for health professionals to record facts, documenting women's experiences by "tick box" can be counterproductive, particularly when women feel objectified:

You are only a number, no matter who you tell. You could go to the guards and you are a number on a case file. (Quartz)

Written documentation of discovered or disclosed evidence of violence against women was also problematic. Nurse Rose spoke of how such evidence was recorded in the medical records with phrases such as "long discussion." The use of obscure language in the documentation of domestic violence issues was seen as a way of protecting patient confidentiality. It also contributed to the invisibility of the issue:

[GPs are] just protecting the patient... [so] that staff within the surgery won't find out and stuff, or won't pass on information that shouldn't be passed on. (Nurse Rose)

A desire to protect women was also offered as a reason for avoiding documentary evidence of disclosure by women of their circumstances of domestic violence:

I don't have to write it down if you feel that you are in fear for yourself physically or any other way and I always make the comment that I don't have to record it but feel free to tell me in any way if you are compromised. (Dr Willow)

You know that [details of any patients in abusive relationships] is all kept very, you know [pointing to her head], by the doctor ...in his oul' head and it wouldn't be known by the rest of the team. He might say something alright if I was dealing with a patient. (Nurse Cherry)

The use of poor documentation (and in some circumstances, no documentation) appears to mirror the hidden nature of the phenomenon of domestic violence. Avoiding documentation is essentially a pattern of strategic silencing. In other words, the issues are discussed but there is no documented evidence of discovery, or disclosure, of domestic violence. The

choreography is tentative; there is uncertainty around the lifting of the stones and an apprehension about the slugs that lie beneath.

Overall, data indicate that both verbal and documentary avoidance of circumstances of domestic violence are elements of a pattern of strategic silencing within general practice. While women have control over what and how much they disclose, health professionals can determine what and how much they document. Avoidance strategies are influenced by discomfort, the need to save face, a belief that it is an emotional issue better managed by other professionals, a wish to protect the self and/or the other, the type of clinical documentation available, time management issues, insufficient knowledge, and resistance to engage. The next section focuses on the property of “weighing things up” and how a consideration of the outcome of making a decision influences the process of strategic silencing, within the choreography of a consultation.

7.3.2 Weighing things up

Weighing things up describes a process of calculating the outcome before making a decision. For women, weighing things up was akin to balancing and, at times, prioritising situations. Other actions included rationalising their circumstances, or cognitive bargaining with the self. Some women in abusive relationships used the notion of weighing things up as a survival strategy. It allowed them to consider the consequences of disclosing, or remaining silent to consider was disclosure worth the effort. Health professionals also bargained internally when considering enquiring about violence against women issues during the clinical consultation, for example, in circumstances where they feared being judged negatively, or possible repercussions from the extended family. Weighing things up commenced from the first point of contact with the surgery; it involved a process of surmising, of taking an “if what then, perspective?” This strategy enabled or inhibited engagement in the consultation. Women

developed a pattern of learning to weigh up the pros and cons of their situation and how much of themselves they were prepared to expose. Sapphire commented: “disclosing is a gradual process.” In other words, before women lifted the stones to show the slugs beneath, they engaged in a process of calculating the situation by contemplating possible outcomes. Quartz explained how, from the moment of her entrée into the surgery, she gauged her willingness to engage:

If there is a very young person on the reception and it's not their fault but if they are half listening to you as you give your name and address, well... [you are not going to disclose anything to them].

Communication at this point was used as an indicator or a barometer to guesstimate the tone of the service and the potential for disclosure. Inattentiveness and perceived disinterest were identified as reasons for non-engagement by women. Several administrators and health professionals explained the mode of entrée in their respective surgeries. Patients⁸¹ attending practice nurses were generally “booked in advance” (Nurse Cherry & Nurse Heather), and some GP services provided “walk in clinics⁸²” (Nurse Heather & Nurse Ivy). Having a planned schedule provided an opportunity to prepare for the patient’s arrival. In non-planned visits, decision making and the process of weighing things up occurred during the choreography of the consultation.

In some surgeries, women were asked, by the administrative staff what was the nature of their visit:

If they [patients] don't initially tell me I don't push to find out what the situation is but it does help us in the running of the practice if we have a vague idea if it is going to be a short or a long appointment. So I might ask if it is something they want to tell me about and then maybe they will at that point tell me what the appointment is about. The other 50% of the time they will say, no. (Sage, Administrator)

⁸¹ The term patient is used this instance to reflect the language of the participants, and to illustrate that both men and women are asked about the nature of their visits.

⁸² Walk in clinic is a service where no prior appointment is necessary. A first come, first served policy applies.

The only enquiry we would make now for an appointment is [to ask], is it just a regular consultation. In other words is it something gynae⁸³ maybe or minor.[procedure]. so you would have to give them an extra long slot [length of time]. But no we wouldn't ask them the nature [of their visit]... A few times people have said "I need to make a long appointment because I have something to discuss." We have had that a few times. But generally it is something to do with their medical history or whatever, it wouldn't necessarily be anything to do with domestic violence. (Hazel, Administrator)

Yes, we ask patients as to the nature of the visit, for the running of the practice. The amount of patients that object is minimal; we have a bit of rapport with them. (Mace, Administrator)

Although the findings illustrate that women do not disclose domestic violence experiences to general practice administrators *per se*, exercising discretion in allocating appointments indicated how weighing things up at the point of entry was a forerunner to the choreography of the consultation. However, the strategy of expecting patients to disclose the nature of their visit to the general practice administrator had a dual function. Firstly, it prepared health professionals for topics that might arise in the consultation. Secondly, it allowed participants to weigh up carefully the risk of engaging in the discovery or disclosure of domestic violence issues. Moreover, weighing things up could be problematic:

If you go looking for it you might get swamped [with discovering domestic violence] ... so you stick to what's easy. (Dr Pine)

Not everybody is going to pick up on that [domestic violence in the consultation], not all the health professionals are going to pick up on it because there are too many other factors involved, the time, the finances, a waiting room full of patients. (Nurse Rose)

You kind of groan internally when they say things aren't going well at home. [I think], Oh God...what's she going to tell me now? (Dr Ash)

It's hard enough to get the medical help you need and then to bring in a social problem on top of things. (Garnet)

Fear of the anticipated interaction in the consultation suggests that clinicians did not wish "to go there" but also did not want to know about a woman's situation. Engaging in their own internal conversation enabled health professionals to employ strategies of silence, particularly

⁸³ Gynae=an abbreviated term for gynaecological issues.

if the volume of work in the surgery needed to take precedence over an individual woman and her desire to disclose.

Weighing things up involves a continuous process of taking context and consequences into consideration. It is more than health professionals and women reading the person; it includes assessing the dynamics of the consultation and evaluating the potential outcome:

And then if you did come across it [violence against women] you would very quickly get the sense of whether they wanted to talk about it or not. Like here some people are very private, whether it is denial or they just want to sweep it under the carpet or what, I feel some people just don't want to talk about it. (Nurse Lily)

If you suspect [domestic violence] yes you can say it to somebody, but you know quite often somebody is just going to deny it or else they are going to come in and show you what has happened, one or the other in my experience. (Nurse Daisy)

In essence, weighing things up is about stage managing the consultation where health professionals have the authority to enable disclosure or to strategically use their position to control what can, or cannot be said within a consultation, thus avoiding engagement and strategising a silence.

In a similar way, women in abusive relationships also weighed up what to disclose, based on their perception of the pressure of the GPs' workload. Topaz explained how she never felt enabled to disclose to the GP, as the surgery was always "full of screaming kids" and he [GP] didn't show any interest in what my problems were." Women also engaged in weighing up the possible outcomes should they disclose. Some had minimal expectations of the general practice team, believing there was little point⁸⁴ in disclosing abuse:

I don't think there is anything he can do because there is no pill for that [domestic violence]. What should a GP do? He is no more equipped other than he is in the health care [business]. (Pearl)

What can the doctor do? (Crystal)

⁸⁴ Underpinning the sub-category of weighing things up was a level of acceptance by some women of their situation. The futility of disclosing to GPs was supported by women's belief that GPs focus on medical issues alone. This is discussed further in Chapter Eight, section 8.8, working the medical model.

What could the GP do for me? I didn't have bruises or bumps. (Amber)

Likewise, a comment by Dr Cedar "wonder[ed] if the general practitioner is the right person for women to disclose to at all," suggesting that women's ambivalence about the wisdom, or otherwise, of attending their GP with issues of domestic violence were well founded. By not disclosing, women developed a strategy, either by choice or circumstance, to contain their "secret" (Quartz) as a form of self-protection (see section 7.3.3 protecting).

In summary, weighing things up has a bearing on decision making and potential outcomes, for women and health professionals. Issues considered when weighing things up include: health professional's workload, potential consequences for disclosing and women's engagement with staff from the moment of contact with the surgery. When, because of weighing things up, discovery or disclosure is not achieved, through non-engagement with the issues of domestic violence, the dance became a calculated choreography.

7.3.3 Protecting

The property of protecting emerged in the data, albeit to a lesser extent than the previous properties discussed. Nonetheless, participants' methods of protecting themselves, protecting family and protecting health professionals illuminate women's decisions about self-disclosure (or not) of domestic violence in the general practice setting. For some women in the study, their need, as mothers to protect their children was an important factor when contemplating disclosure:

I went looking for help for my son... but women who are in abusive relationships from my experience, from the ones I've meet are all very kind, caring women, who are concerned about other people. (Sapphire)

Well if their kids were starving and they needed nappies or baby food [they] would be out the door if they disclosed. And if I am around conversations like that I don't say anything, 'cos I would only go on a rant 'cos I don't want anyone to know me business. (Quartz)

Women who were in abusive relationships were not only aware of their own feelings regarding disclosure, but considered the effects of disclosing their abusive relationship on others. Data suggest that protecting in this instance, is distinct from the previous two constituents of strategic silencing. The findings indicate that women were anxious about receiving a negative reaction from health professionals if they disclosed their situation. Avoiding humiliation and the risk of upsetting the other partners engaged in the choreography of the consultation were also factors which informed patterns of protecting. Participants spoke of loyalty towards their family and health professionals, which inhibited their disclosure:

I was very protective of him [husband]. After all, he is the father of the children. (Pearl)

I think probably loyalty [to their partner] comes in there too. (Dr Oak)

Women also considered protecting themselves regarding disclosure:

You are too fragile to admit the extent of the abuse and admit that you have stayed that length of time ... I stayed in [the relationship] too long, as a form of self-protection. (Sapphire)

So it's almost like you are letting yourself down. You are not thinking about protecting him [husband] but you are thinking about protecting yourself and I think it is how in your mind somebody sees you, or the community sees somebody, as a victim of domestic violence. (Ruby)

In addition, women considered protecting the feelings of the health professional by not burdening them with the details of their violent relationships. Furthermore, despite the absence of lifting the stones or seeing the slugs beneath during the consultations, women showed empathy towards the GP:

I can't blame him [GP], I didn't know myself [it was domestic violence]. (Pearl)

I never blamed my doctor; I know it wasn't his fault. (Quartz)

Crystal explains that she did not want to disclose her abusive relationship to the general practitioner:

I was afraid of disclosing to the GP. I was considering his reaction with this outpouring of grief.

Hesitancy and women's perception of undervaluing their presence in the consultation inhibited the disclosure of domestic violence. Instead, not disclosing was a way of avoiding a double humiliation during the consultation. Firstly, "if they [women] feel it is a safe place to disclose, they will" (Nurse Ivy). However, data suggest contemplating the coping skills of the GP increased women's anxiety. Concern for the self and for others influenced women's ability to disclose. Secondly, women's sense of burdening health professionals, and almost apologising for sharing their narratives of suffering, suggests they were concerned with how they were viewed following disclosure and the effect their story had on others.

I didn't need to go to the GP. I wasn't going to disclose to anyone. I had made a decision not to tell anyone. I was quite ashamed of my role in it. (Amber)

Unless a person wants to acknowledge domestic violence, there is nothing can be done about it. (Garnet)

On the one hand, believing domestic violence to be a private matter challenged women's attitude to disclosing; and on the other, protecting the self and others due to feelings of humiliation disabled disclosure. Conversely, for some women, taking a stance of strategic silencing was their way of self-protection.

Some participants spoke about the doctor-patient relationship and the meaning of that relationship:

As I say there are women in here who would have grown up with me, I would have vaccinated them and now I am vaccinating their children...Yes we would almost be friends come to think of it. (Dr Oak).

I have known him [GP] for a long time. I have known him since I was a kid; I just figure he would be sad if he knew that it [my marriage] didn't work out very well. I do think you fool them [GPs]; you fool a lot of people, the biggest one is yourself. (Pearl)

Data suggest that emotional bonding, saving face through avoiding self-humiliation, and the longevity of the doctor- patient relationship illustrate the strategies used by women for protecting themselves against disclosing domestic violence to general practice health professionals. Knowing health professionals for a long time and valuing that relationship was, for some, a disabling factor in disclosing circumstances of domestic violence. For others, the longevity of the clinical relationship was also problematic, but not for reasons of protection or value, but due to family connections:

[He was] my husband's doctor since childhood, the doctor was fond of him. (Quartz)

I married into the family and he [GP] had known the family for generations. (Garnet)

Women avoid disclosing, for me it would have been easier to disclose to a stranger because he was the family's GP. (Ruby)

The duration of the relationship between women and health professional did not influence their ability to disclose their experiences of domestic violence. The women in the study ranged from meeting their GP only once to attending the same GP for over 20 years. Some of the women had never disclosed their experiences of the abusive relationship to the general practice team. Data suggest that non-disclosure was a form of self-protection, which contributed to their strategy of silencing. Opal's comments provided a good example of women's method of protecting the self when choreographing the consultation:

Like don't open any magic boxes that are closed in my head because I am preserving myself on a subliminal level. I have closed certain boxes in my head in order to survive; I have locked them and put the key somewhere safe. The chances are I will never find it. I do not require anybody to come along and open those boxes and to see what is in them and to clear my background persona of any nasties that are in it. Those memories are in boxes for a very good reason. I think I am having to protect myself from facing those things and if that is my way of getting around it by not dealing with it I have managed so far, I am X (years of age) and I may never need to open those boxes.

7.3.4 Summary of strategic silencing

To summarise, analysis of the data suggest that all participants engaged in internal conversations, and sometimes internal turmoil, when using strategies of avoidance and weighing situations up in clinical consultations. Frequently, both women and health professionals mirrored each other in the process of strategic silencing. Therefore, as has been shown, the complexities of strategic silencing are linked to spiralling silences, which inhibit the discovery and the disclosure of women who are in domestically violent relationships and are attending general practice. The next section discusses the data on breaking the silence.

7.4 Breaking the silence

Central to the core category of spiralling silences is the sub-core category of breaking the silence. Properties of this category are broaching the subject and building opportunities to ask. Some health professionals found it difficult to ask women, in the course of the clinical consultation, if they were encountering domestic violence in intimate relationships, while others asked more readily. Likewise, some women found broaching the subject of domestic violence difficult during a clinical consultation. Breaking the silence describes the process of women's discourse and health professionals' enquiry of domestic violence issues during the clinical consultation. Once the silence is broken, the stones are lifted and the slugs beneath are seen and a process of engagement has commenced. The property, 'building opportunities to ask' presents participants' attitude to developing a structured system of enquiring about violence against women within general practice. However, the silence may never be broken, but may continue unwittingly to spiral. In some instances, the point of disclosure occurred spontaneously when circumstances reached a level where women could cope no longer:

I burst into tears one day in the waiting room. I was overwhelmed and totally distraught. I was brought in to see the doctor straight away...I told her everything. (Coral)

Rather than choosing a specific health professional with whom to share their narrative, breaking the silence occurred regardless of who was present in the surgery. Women's need was to have their voice heard. For others, disclosing was more considered:

I must have been in a bad way to go and tell him [GP]. It wouldn't have been the first time abuse happened but it was the first time I told him. I just wanted somebody to know at that stage. (Quartz)

Some women prepared themselves for the occasion when they disclosed their experience of domestic violence to health professionals. Prior to taking the floor, they contemplated the steps of the choreography before engaging in the consultation. Health professionals also considered "pick[ing] their moment" (Nurse Daisy) when seeking details of woman's circumstances. Strategising in this way suggests that breaking the silence is a pattern of engagement that is linked with reading the person and making judgements. Thus, the decision to "tell" or break the silence was, for some women, a premeditated deed.

Data suggest that the longevity of the doctor-patient relationship did not promote ease of communication or speed up the process of breaking the silence concerning violence against women. Several women explained how they would have welcomed the opportunity to break the silence:

Yes [I wanted to be asked]. It might have been helpful if he had noticed and said, "look Pearl you are in here a lot"...I don't know if I would have said it [disclosed abusive relationship]. (Pearl)

I attended the GP for 16 years, including maternity care and he never knew - he still doesn't know about the domestic violence...I was never asked, nor I never disclosed. (Ruby)

I was going to my doctor for 20 years and domestic violence was never detected. Only when I admitted it, and he [GP] allowed the tears to flow...The GP was very good and understanding... three of my family were attending the psychiatric services. I had been receiving treatment [for depression] myself for many years. (Crystal)

Women were looking for engagement by health professionals. Engagement in this instance was not only to have their experiences of abuse identified, but also to have the opportunity to have their voice heard. Although health professionals acknowledged “missed opportunities” (Dr Willow & Dr Birch) to hear women’s stories, ample opportunities existed for health professionals to enable women to disclose. However, while women are a conspicuous presence in consultations, the issues of domestic violence remain not only invisible but silent. The silence continues because of the complexity of understanding (or not) of domestic violence as an issue within general practice and how it might be dealt with, and women’s fear, reluctance and inability to disclose the issue. The next section discusses participants’ processes toward taking steps to broach the subject of domestic violence, specifically in general practice consultations.

7.4.1 Broaching the subject

Broaching the subject illuminates participants’ approach to discussing the issues of violence against women, irrespective of whether there was an index of suspicion⁸⁵ (or not) that a woman might be in a violent relationship. Health professionals reflected on how they initiated enquiring from women about domestic violence issues. Generic forms of greetings such as “How are you?” “How are things?” “How is it going?” were used to establish rapport, identify mood and wellbeing from all patients, not only those in abusive relationships. Where a suspicion existed, that a woman might be experiencing relationship difficulties, health professionals used what they perceived as specific questions to elicit the dynamics of the relationship. For example: “How are things at home?” (Nurse Daisy, Dr Maple, Dr Birch, Dr Willow & Dr Ash) “How is everything?” (Dr Willow). “How is the relationship?” (Nurse

⁸⁵ In cases where the patient’s behaviour, symptoms or injury patterns give rise to suspicions but she does not discuss domestic violence, the GP or practice nurse may need to ask the question (Kenny and Riain 2008).

Daisy). Seeking disclosure by asking women about their general wellbeing or their relationship did not always ensure that disclosure occurred:

It's up to them [women] to tell me after that [asking how are things?]. (Dr Ash)

I suppose you ask are there any problems at home. But then they mightn't tell you.
(Dr Birch)

The onus on women to disclose their situation rather than health professionals to discover their circumstances posed a challenge in breaking the silence on domestic violence issues. In other words, health professionals asked generic or broad questions but expected specific answers; whereas, women wanted specific questions in order to articulate specific answers. The interaction in the consultation is closely linked with the categories of seeing and not seeing (see Chapter Six section 6.2).

The findings indicate several approaches by women and health professionals were used toward broaching the subject of domestic violence during the clinical consultation. Differences from “ask directly” (Dr Pine), or more indirect approaches to “wiggle it in some way” (Dr Oak), being “tricky”⁸⁶ (Pearl) to health professionals being “uncomfortable” (Nurse Lily, Nurse Cherry & Dr Ash) in asking demonstrates that broaching the subject is dependent on a participant's willingness or ease to engage with the issues and consultation style:

Most of the times you hear about domestic violence is to ask directly and if you don't ask you don't necessarily receive the information. You rarely receive the information without asking. (Dr Pine)

You must have your antennae out and you must be listening and asking the right questions, because if you are not then I think we are a failure. And I think we are letting people down. (Nurse Violet)

In my experience GPs and practice nurses need to be able to ask the right questions, for example, “are you able to get out?” Women may feel trapped if they don't drive. (Crystal)

⁸⁶ Being “tricky” means enquiring about domestic violence issues in a non-direct manner. See Pearl's explanation for her use of the term “He [GP] would have to have been tricky, like, “would you do that [marriage]again”?”

Unless asked, they [women] are not going to tell you [health professional].
(Pearl)

Participants' techniques of asking about domestic violence were "not just the simple words" but were a "method of communication" (Dr Pine), which suggests a process of knowing and observing women beyond the reason for the consultation. Asking about issues of violence against women requires health professionals to widen their clinical gaze⁸⁷ to observe the unseen, in order to assist with the unspoken. Through observing, listening and waiting for the right moment, health professionals can demonstrate a level of clinical expertise and intuitive practice by "delv[ing] deeper" (Dr Ash, Dr Birch and Nurse Ivy) with questioning. In addition, women require assistance to disclose, initially by being asked about their experiences of abusive relationships. Where the subject of violence against women is broached, data suggest, the choreography of the consultation is not taken at face value alone. However, directly asking about domestic violence issues was problematic for some participants:

I like a direct approach in a lot of things but if we are going to ask doctors to be proactive and they say, "is your relationship violent?" I would have stated "no." You are not going to say "yes", otherwise why would you be hiding it. (Pearl)

If you push it too hard [with asking about domestic violence issues] too soon you can scare somebody off and they might never come back to you again. But without sort of saying, being too blunt and direct about it, if you are dealing with someone who is fragile. (Dr Maple)

[I wouldn't] ask a bold question like that [enquire about domestic violence]. It is not that I wouldn't do it; it would be a bit uncomfortable I suppose. (Nurse Lily)

There is only so much digging I think a nurse can do. You can only enquire as to, is somebody ok or is there anything they want to talk about? I don't think I have ever asked somebody [about domestic violence]...and then it is up to them whether they trust you enough [to disclose]. (Nurse Rose)

I'll chat away and go oh, how are things, blah, blah, blah, but I don't think it is my role to really probe, probe, probe. (Nurse Daisy)

⁸⁷ The clinical gaze allows health professionals to observe, monitor and survey what we see in clinical consultations (Foucault 2003). Nurses describe the clinical gaze as *looking at* [original italics] patients and when they do it is with embedded knowledge, skills and attitudes (Dunlap 2013). This is explored further in the discussion chapter.

Several practice nurses did not see broaching the subject of violence against women as their responsibility⁸⁸, but considered it the role of the GP (Nurse Heather, Nurse Lily, Nurse Cherry). In addition, asking women about domestic violence was interpreted as being unnecessarily intrusive. For some health professionals, having a sense of helplessness and “not knowing what to do with the information” (Dr Willow) meant the issue was avoided altogether. Hence, choosing not to broach the subject was a covert strategy used by some health professionals who perceived they did not have the courage to enquire. Health professionals’ awareness of the sensitivity of the subject mirrored women’s anxieties about being asked in a direct manner. Direct and probing questions were viewed as too confrontational for some participants. Instead, effortless communication was described where violence against women was discovered and disclosed “just in conversation” (Nurse Daisy) in clinical consultations:

The stories just come out, they just naturally come out because you are talking about a [intimate] relationship and they come up quite naturally...If you don't have to ask questions it means you don't see it as your role. And I believe it is my role, other people may not, and it is totally dependent on... how you have your consultation. (Nurse Ivy)

Sometimes it just comes up, it is easy if it just comes up in a consultation where it's very appropriate to ask, whereas if you bring it in when it's something completely different it's a bit of a funny thing to ask. So it depends. (Dr Willow)

Broaching the subject of domestic violence was very much taken in “the context” (Dr Willow) of the consultation through seeing and reading the person. Data suggest where health professionals demonstrated an ease of communication toward the subject of violence against women, the process of engagement was spontaneous between participants. Hence, the discovery of domestic violence was enabled through the confidence of the clinician to enquire about the issues and by hearing women’s narratives. However, disclosure is also about the woman’s readiness to disclose:

⁸⁸ Reasons cited include scope of practice, lack of training and discomfort with the issue.

I could be in there all day [surgery] and if I am not going tell I am not going to tell. (Pearl).

Despite women's difficulty in discussing their experiences of abusive relationships with health professionals, they did want to be asked about domestic violence issues by health professionals as they "have a duty of care" (Pearl). Being enabled to disclose, was "like a problem shared" (Quartz).

I personally would have had no problem discussing it with my GP had it occurred to me. I was never given an opener to discuss it [the violent relationship]. I was never asked if there was stress. (Amber)

Maybe if he [GP] had asked directly you would have said - but if you are never asked then you're not going to have the opportunity to answer. You are looking for that open door but it was never there. (Ruby)

If it became a normal part of the [consultation], if the doctor twigged anything and if they just asked the question then I think it would be easy for women to ...say yeah, it is happening, if it was more out there in the surgery. (Quartz)

While not all the women in the study disclosed their circumstances to health professionals, being asked gave them a choice whether to engage with the topic of domestic violence or not when attending general practice. Furthermore, being asked also meant that "an index of suspicion" (Dr Elm) was identified. Therefore, extending the opportunity to disclose what is often unspoken takes the onus from women to take the initiative in breaking the silence. Where health professionals ask about violence against women, they demonstrate the potential to discover "silent cases" (Dr Cedar).

Much of the concerns regarding broaching the subject of violence against women in general practice related to the most appropriate method of enquiring and disclosing:

If he [GP] would have asked it in a tricky way, like "what do you think of marriage"? He would have to have been tricky, like, "would you do that [marriage] again"? It could open the door to a little bit of probing if that was his inkling. (Pearl)

Depending on how well I know the patient and depending on how vulnerable they are, so sometimes I am very comfortable and sometimes I really feel it's very hard to ask,

so you know case by case, it does vary but a lot of the time - I feel if I am comfortable and have time. (Dr Willow)

Tentatively enquiring, or breaking the silence of violence against women in a covert manner, suggests participants perceive a circuitous route as less confrontational than directly asking about abuse. Pearl wanted to be asked about the wellbeing of her relationship rather than living in an abusive relationship. Underpinning the notion of tentative enquiry is a desire to be covert, to be less than upfront about it, which in essence mirrors the covert nature of domestic violence itself. However, it is also about a desire to be sensitive toward women in abusive relationships and women appreciated that:

I remember going in [to the surgery] one day saying, “I keep making mistakes, I keep making mistakes, I can’t get anything right” and that was very good because she [GP] said “everybody makes mistakes”, she stayed generic. (Sapphire)

In summary, the findings illustrate that the choreography of breaking the silence involves direct, indirect and evasive rhythms. While opportunities to enquire, explore and discuss the issues exist within the clinical interaction they are not always recognised. Broaching the subject is about the relative ease and skill of the health professional to ask the appropriate questions and the willingness of the woman to respond. It is a choreography of two partners. The next property describes building opportunities to ask.

7.4.2 Building opportunities to ask

Building opportunities to ask relates to the development of purposeful openings in general practice consultations to enquire about circumstances of violence against women. Rather than an unplanned system of enquiry, building opportunities to ask, or intentionally asking women about domestic violence contributes to breaking the silence. Knowing that violence against women may be a possibility is informed by health professionals awareness of the substantive issue.

Health professionals were asked if, during the course of the clinical consultation, they had a system of routinely enquiring⁸⁹ or screening⁹⁰ for issues of violence against women. Opportunities were identified, such as new patients joining the surgery, women's health clinics or ante-natal clinics. However, none of the GPs or practice nurses enquired about violence against women as part of taking a clinical history from new or repeat patients to the practice. No systems of screening or routine enquiry were employed in any practice:

Well not really [I don't have a routine of asking about domestic violence]. Not really, no...I think it's... one it's so rare you know then... well the perception is with us is that it is rare that we don't see it too often...eh.. I think you are delving a bit too much then. I think it's up to them to tell you really. (Dr Ash)

Oh well I feel it [routine enquiry] would have to be very carefully done. If somebody is new to the practice or joining...it's [pause], you would have to be very careful, you can't just ask someone on a questionnaire that they are filling in reception for new information, do you ask them when you first meet them and then all the details, possibly but it's something that is going to take people back. I'd say they would be surprised that you would be asking that at a first meeting. (Dr Elm)

Unless it was part of if we were doing a specific survey or something like that, who experienced domestic violence. But as part of a new patient registration I wouldn't think it would be appropriate. (Nurse Lily)

The notion of incorporating the issues of violence against women as a routine enquiry was met with some resistance. Generally, there was a reluctance to engage with routine enquiry, due to the risk of "opening a minefield" (Nurse Daisy), a "can of worms" (Dr Willow), or a "nest of worms" (Dr Pine), particularly where there was an expectation that there may be a situation created which could not be contained or could get out of control. However, several health professionals were aware that they "should be asking more" frequently (Dr Birch, Dr

⁸⁹ Routine enquiry is a system of asking all women attending the practice if they experience domestic violence (Taket 2004).

⁹⁰ Screening is a term used to identify specific populations of individuals who are at a health risk, usually for the prevention of disease (see Chapter Two Section 2.5.1).

Elm, Dr Willow & Dr Palm). Nonetheless, asking about domestic violence issues on a regular basis appeared problematic:

You should be asking more ...but I don't. (Dr Elm)

I think we should be asking [about] it more but whether we should be asking it in every single consultation – no, because our patients certainly frequent a lot and Jesus they would start giving out to us [laugh]. They would say that you really think I am, so I think you need to be careful. Maybe we should have a box on the chart, separate to just tick, like in a computer system. It is very easy to tick a box that you should ask once a year for instance, that you just tick it, that you have touched base again but at every single consultation, I think you would annoy them at the level that we see our patients here. There's quite a high return rate, they would start getting paranoid. (Dr Willow)

It would be one of the boxes to tick... it would probably be a structured thing if you were to bring it up and ask if you were to, rather than to wait for it to apparently come out of the blue. (Dr Elm).

Data suggest that the practice of health professionals not routinely asking about the issue of domestic violence and their fear of doing so contributed to their sense of ambivalence towards it. Rather than jeopardise the doctor-patient relationship, the routine enquiry of domestic violence was avoided. The use of tick boxes is problematic (discussed earlier in this chapter), not only are they reductionist but they do not provide occasions of understanding and empathy, which women valued in their efforts to disclose circumstances of domestic violence. Recognition that there existed scope for regularly asking women about domestic violence was compared to asking people if they take drugs, daunting but possible:

The one thing that would inhibit me is the fear that they would think I am judging them, that they would assume that they have been victims of it, that people feel that they themselves are at fault if they have been abused or if they are vulnerable or that, you know, it's a weakness within themselves. But I would usually preface it by saying this is a question I ask lots of people so just let me know but it is not specific to you, but even still I feel they always feel it is and that I would be judging them or thinking less of them. So, that is the one thing but it is silly because I know they don't mind if I preface it properly, they absolutely don't mind being asked. Because another question I would routinely ask here, sometimes again when I remember to ask it is, "do you use drugs of any kind" and again you have to preface it with "I ask everybody this, so please don't take it personally" because again they take terrible insult but yet you have a sense they could be using X, Y or Z you know based on behaviours' and such

and again it is a similar type of question and if you preface it properly they don't take offence and even yourself when you are asking for a reason you do feel a bit like you are prying or whatever. (Dr Willow)

Women recognised that health professionals regularly investigate lifestyle issues⁹¹ that require asking patients intimate and questions that may be perceived as intrusive and wondered at their reluctance to ask about domestic violence.

They ask about everything, like have your bowels moved today - why not ask if you are safe at home. I wouldn't have a problem if they asked everybody. You would answer the exact same way as have you moved your bowels today. (Ruby)

If they [GPs] ask everybody on a regular basis, is there anything going on at home, if you ever need to talk to anybody, then it's not a shame any more, it's not a secret. It's out there. There might be some women that would say "God no" and give out about the doctor for that but at least he is asking. It's like asking, "are you smoking a lot, is there violence going on in your home?" why should that be [different]... you know what I mean, for women who are not putting up with it, I mean, they would probably be disgusted if they were asked but that is just they're blessed. (Quartz)

In summary, health professionals recognised the potential of the clinical consultation for building opportunities to ask about the issue of violence. Opinions differed on whether this should be an oblique reference to the issue, an impersonal one in the form of asking the woman to tick a box, or a direct questioning of the woman. A recognition of the opportunities to ask were considered alongside a fear of compromising the doctor-patient relationship, in circumstances where there was no issue of domestic violence, or concern about the capacity and ability to respond if circumstances were disclosed. Women, on the other hand, welcomed and were open to being asked; suggesting that as a routine question it should be no different to being asked about other health matters, and, most critically, it would de-stigmatise the issue and break the silence.

⁹¹ Screening for lifestyle issues (e.g. smoking, alcohol, diet and exercise) are common in general practice (Hegarty et al. 2012).

7.5 Chapter summary of spiralling silences

This chapter presented a core category spiralling silences, which is essentially a choreography of two, often dancing similar styles of steps. Many of the concerns of both women and health professionals explored in this chapter actually mirror each other. Health professionals do not want to ask about domestic violence; not all women want to tell; health professionals do not know how to ask; women do not know how to tell; health professionals do not realise domestic violence is present; some women did not realise their relationship was abusive . Unless there is a conscious effort to communicate with the issues, a process of silencing occurs in a continuous spiral.

The findings indicate that addressing the three principle themes that emerged from the data: cultivating silences; strategic silences; and breaking the silence, can contribute to deconstructing the spiral of silence. The category of cultivating silences illustrates how the concept of silence commences in childhood and is nurtured through adulthood; violence that is accepted in the wider community infiltrates into the home and over time the silence grows and can become an accepted way of life. Language and women's difficulty in applying specific terminology to their situation enabled the silence to continue. The second category of strategic silences discussed the complexities of avoidance by both women and health professionals. The complexities of weighing things up and protecting illustrate how decision-making is not a linear process. Breaking the silence is a complex procedure of considering the appropriate way to ask about domestic violence while at the same time maintaining the doctor-patient relationship and dealing with a fear of not getting it right (health professionals) or not being in a space to tell (women). While broaching the subject was viewed as being problematic it was also seen as familiar, whether in terms of similar experiences of asking people about other complex issues such as drug misuse (health professionals), or being asked

about more routine issues like one's bowels (women). Finally, evidence suggest that despite GPs' concerns, women do not object to being asked about domestic violence issues. The multifaceted nature of violence against women and how the skills and understanding about the issue within general practice indicates how silences spiral over long periods and can continue for many years without the issues being discovered or disclosed.

The next chapter discusses the structure of general practice and how it contributes to health professionals' discovery and women's disclosure of domestic violence.

Chapter Eight: Compartmentalising

8.0 Introduction

This chapter discusses a core category, *compartmentalising* which explains health professionals work practices, the organisation of care and how general practice facilitates (or not) the discovery or disclosure of violence against women. An explanation of the role boundaries within general practice describes how the organisational structures are compartmentalised, while the action of compartmentalising, informs who takes responsibility for specific areas of clinical practice. These influence women's approach to choreographing the consultation when seeking assistance or contemplating disclosure of abusive relationships.

8.1 An overview of the core category

Compartmentalising influences how work practices impact on the organisation of care in general practice consultations. Patterns of compartmentalisation do not apply to organisations alone; they exist also in day-to-day life, where individuals (in the case of this study, women who experience domestic violence) separate the public and private self, engage distinct resources to survive, and decide what aspect of themselves to exhibit within clinical consultations. Compartmentalising involves patterns of engagement that are distinctive, selective, partitioned or sectioned off. In this chapter the category is presented as follows: firstly, health professionals' process of compartmentalising in the clinical setting; secondly, women's experiences of compartmentalising and; the remainder of the chapter discusses the overlapping themes from both groups.

8.2 Compartmentalising by health professionals - an overview

Overall, the division of care into mainly medicine and nursing roles and compartments set clinical roles apart, where independent working and the management of a caseload and each consultation, as a separate entity, was the norm. Nevertheless, there were occasions when consultations were collaboratively managed; this was usually prompted by the practice nurse, when there was concern about a patient's condition, though regular and ongoing communication between health professionals within general practice was not standard. The division of care into mainly medicine and nursing roles also reflected the hierarchical structures within general practice. The emphasis by physicians was on diagnosis and treatment of clinical issues, while practice nurses provided skills based services to patients by conducting procedures and implementing tasks, generally delegated by the doctor. Role and role performance within these segregated and hierarchical functions involved varying priorities of engagement, by general practitioners and practice nurses, when executing the choreography of the consultation.

Compartmentalising, as in separating, allowed health professionals to develop knowledge in clinical areas of interest and to isolate ways of practising by focusing on specific areas of clinical expertise. However, the risk of compartmentalising is that it narrows the clinical lens of the health professional, and issues beyond the clinician's focus can be missed within the consultation. Compartmentalising enabled health professionals to practice within a comfort zone, but without challenging their clinical gaze. They saw what was clinically presented as the reason for the consultation; for example, a person needing a blood pressure check or cervical smear; or they saw what interested them: for example, cardiac disease. One of the difficulties of the practice of compartmentalisation was that it foregrounded issues taken at face value. In other words, what was overtly presented by the patient, such as a symptom of

depression was accepted but without an exploration of the underpinning factors that may, or may not, have contributed to the cause of the presenting symptom.

Although general practice is a generalist strand of health care, there are times when the expertise of specialists is required, which involves referring patients to agencies external to the surgery. Communicating with other services, for example, counselling services was a way of extending beyond the organisation. Evidence in this research exists where GPs moved beyond the compartmentalised structures of the practice, by referring women to external services, which enabled women to disclose domestic violence (discussed later in this chapter).

8.3 Compartmentalising by women - an overview

Women's pattern of compartmentalising was demonstrated by placing a demarcation line between their time in the abusive relationship (private life) and their process of help seeking (going public). For some women, it meant before seeking help and after seeking help. Separating their life in this way was a method of compartmentalising their circumstances into easily defined partitions. Compartmentalisation describes a process where women simultaneously partition many factors of their lives: for example, family life; living in (or departing from) an abusive relationship; new beginning; remaining silent; or disclosing. Choreographing their contact with health professionals (or not) and support services for domestic violence was influenced by their ability to negotiate the structures of general practice: for example, the appointment system. Women compartmentalised what they considered disclosing to a doctor or a practice nurse, based on their interpretation of the roles and function of clinicians. They separated their experiences of domestic violence and the reason to attend a doctor for the management of illness as a way of hiding the experience of domestic violence, remaining private and not letting it seep into the public persona.

8.3.1 Sub- core categories of the core category

Compartmentalising as a core category is further divided into two sub- core categories: *time and working the medical model*. This is further fractured into the properties of paying for time, rationing time and investing time. Working the medical model is illuminated within the property of medicalising. Each sub-category and their properties are discussed in detail. Although they appear as squares, independent of each other, they are inter-related and do overlap at times, though there is no particular hierarchy or sequence between them (see figure 8.1). Each of the sub-categories supports the core category of compartmentalising.

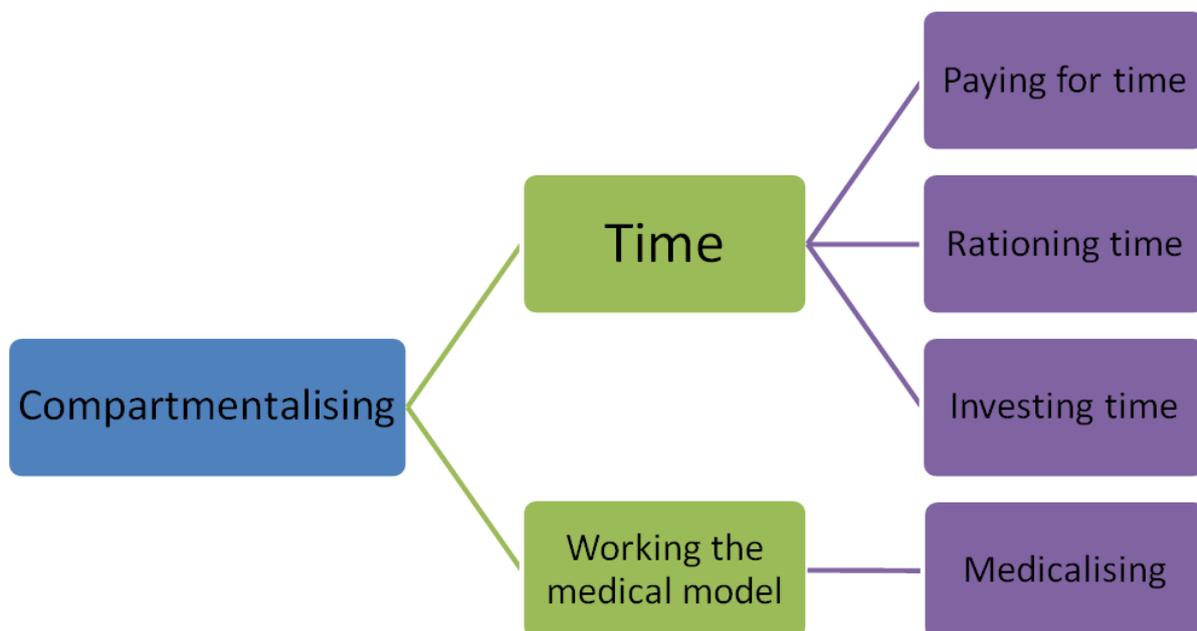


Figure 8.1 Model of compartmentalising and the sub-core categories and properties

8.4 Time

Central to the core category of compartmentalising in general practice is the sub-category of time. The findings indicate that time for health professionals centred on the length of the consultation, the number of patients seen per session⁹² and the number of hours worked by

⁹² Session = a period of consulting time per clinician, usually a morning or afternoon.

the clinicians. General practice consultations are usually ten minutes long (see section 8.4.2 rationing time).

Time as a continuum is constantly moving; broadly it ranges from the past, to the present. In this study, when time was referred to by the participants it did not include future time. Time and the passing of time had different meanings for participants. Women contextualised time by remembering the past or speaking of their present situation. Health professionals considered time gone by as history, and the present time as dealing with the here and now, or current issues of concern in the organisation.

For some women, looking back was reflective, a recognition of the passing of time.

This huge chunk of your life [the years in an abusive relationship] nobody can see ... I went to a local [clergyman] after about 26 years [and] spoke to him about it. But again I had to go [leave the relationship]. (Ruby)

The passage of time allowed some women to distance themselves from their experience of domestic violence and enabled them to discuss their abusive relationship. Women evaluated time by the duration of their violent relationship. The category of time is linked also with the property of accepting and normalising (see Chapter Seven section 7.2.1).

I was in the relationship 19 years. (Sapphire)

It [domestic violence] was a way of life 20 years ago...Hopefully, I think things have changed. (Quartz)

Quartz comment “a way of life” identifies with an attitude consistent with traditional socialisation of older women.⁹³ Professionals were also influenced by the attitude of the time:

[The] GP and his reaction [was advised to stay with husband] isn't any different from any other person in [an] authority figure [and their] reaction at the time, for example,

⁹³Beaulaurier, R.L., Seff, L.R. and Newman, F.L. 2008. Barriers to help-seeking for older women who experience intimate partner violence: A descriptive model. *Journal of Women & Aging*, 20(3-4), pp.231-248.

the Department of Social Welfare, they never leave you alone [received correspondence from the Department of Social Welfare for years after leaving the relationship]. (Opal)

The process of reflection, or looking back, enabled women to consider where their situation intertwined with the attitude of society of the time. When looking back, women realised how the attitude of the services involved influenced their ability to disclose domestic violence or not:

The GP was hand fisted (awkward) in a whole row of people, I mean not in the slightest way able to deal with the situation in front of him. He couldn't understand why I wouldn't go back [to my husband], pleaded with me to go back, so they were all awkward, ill equipped, personally and professionally awkward and in every way making you feel worse. (Opal)

Women's experiences of abuse and the culture of patriarchal dominance made the issue of domestic violence invisible. Findings of this study illustrate that choreographing clinical consultations toward making visible the issue of domestic violence is still difficult for some women in abusive relationships. The passage of time in terms of enlightened health professionals has not always achieved the understanding required to interact with domestic violence issues during general practice consultations:

Well the perception with us is that it [domestic violence] is rare, we don't see it too often. (Dr Ash)

I have never noticed it [domestic violence] or they [women] didn't give me any triggers. (Nurse Heather)

For some women, the decision to seek help was acknowledged as a key timeline in their lives, not just in relation to the time they spent in the abusive relationship but also the time it took to decide to leave:

So, for 7 years I was depressed, and in the sixth year it took me the bones of six to seven months to leave [the abusive relationship]. (Amber)

Time allowed women to compartmentalise their life into before and after disclosing their situation to another, or leaving the relationship. Reflecting on memories was a form of acknowledging the meaning and significance of timelines. Their ability to stand back and

consider where they were then, within the relationship, and where they were at the time of the interview situated their concept of time and its meaning in terms of life experiences and life changes. A key process associated with historical time was, for some, their engagement with a support group and the opportunity it offered for self-reflection and developing a sense of empowerment, based on evaluating their actions over time:

I learnt a lot when I got involved with a [support] group about how women were perceived. That began my education and, as a result of my own domestic violence, I didn't go downhill, I went up hill. (Garnet)

Despite their experiences of being in an abusive relationship, the passage of time associated with their moving out of the violent circumstances was, for some women, associated with a renewed sense of self. Rather than mourning for lost years, some women considered leaving as time for a new beginning, developing a new identity, building self esteem and moving on. It was their way of lifting the stones, seeing the slugs beneath and implementing changes. Compartmentalisation clearly defined timelines of a period before and after the change, the self before and the self after the change and the sense of achievement obtained. In circumstances where women did not leave their relationship, women considered time frames when they declared their relationship as abusive: “[I] firstly admitting to myself I was in an abusive relationship” (Crystal). Shifting their compartmentalised structure from being in denial and remaining private about domestic violence toward acknowledging the reality of their situation enabled some women to disclose. However, their disclosure was not necessarily to health professionals:

My family know there was something wrong...[but] I wasn't telling my GP. (Pearl)

The notion of time was necessary to assist women to “process” (Amber) their situation prior to engaging (or not) with health professionals and consider disclosing (or not) domestic violence. Time and women's method of ‘seeing’ their circumstances are linked with their

realisation awakening (see Chapter Seven section 7.2.3). Women's ability to draw conclusions about their situation occurred with the initial step of realising their circumstances, which in some instances took a long time.

Even where women had left their relationship, the stress of their experiences continued to the present day. For example, Pearl spoke of "constantly worrying," while Amber spoke of how her experience of domestic violence "still gets to me." They were acknowledging how their experiences of abuse that occurred in the past, continued to affect them over a period of time; as if the abusive relationship was ongoing. Thus, for women disclosure was not a once off experience where the events became history; instead, they needed time within the clinical choreograph to share their narratives toward enabling them to disclose their experiences⁹⁴. An understanding of the process of disclosure as a continuum, over time, for women is critical compartmentalising life into before (leaving the relationship) and afterwards was not always clear cut.

Health professionals interest in patients past, was related to their tendency towards a particular disease or clinical event. They spoke about "family history" (Dr Elm, Dr Birch & Dr Oak) or "medical history" (Nurse Cherry). This context did not include an overview of the history of attendance to the practice, where the number of visits by women, in and of itself, was considered as part of the medical history. Lifting the stones to see the slugs beneath did not always occur when events were viewed as being "done and dusted" (Nurse Heather) at the time of the consultation.

In summary, the different meanings attached to times past, and how they were viewed by participants in this study, illuminates why the discovery of violence against women is

⁹⁴ This issue is further discussed in Chapter Seven– Spiralling Silences.

problematic within the general practice consultation. Another element of time that challenged the discovery of violence against women related to paying for professional time.

8.4.1 Paying for time

Time in general practice is a resource with two elements – clinical expertise and financial. Firstly, there is a clinical requirement to see patients who attend the surgery for medical consultations. Secondly, the income of the surgery is based on the size of the patient list and whether patients pay privately for the services of the GP or practice nurse, or are in receipt of free general medical services⁹⁵. In other words, time and the clinical expertise of health professionals are a resource with economic implications in general practice consultations. Thus, clinicians' time generates an income for the business of general practice:

The whole idea of the moment is to get the money in [in a private practice]; it is a priority in our surgery at the moment...the main thing [is to] get as many people in [for consultations]. (Nurse Rose)

I know that in an ideal situation everybody should have free healthcare. (Dr Birch)

Whereas you feel guilty calling a private patient [back] even though you may not always charge them, but then you are an eejit [fool] if you never charge them. (Dr Willow)

Competing demands to provide care, and a desire, or need, to generate income for the practice was problematic; it led to the quick processing of greater numbers of patients through the system:

The computer as well I think could be a deterrent [for engaging with domestic violence issues]... [knowing] who the next patients are, you can see the queue behind [from the computer], whereas before you didn't see that. (Dr Birch)

I suppose in the private environment, the emphasis was that people were not to be kept waiting. (Nurse Violet)

⁹⁵ Where patients have a general medical service (GMS) card, the GP is paid an annual capitation fee from the Health Service Executive (HSE) for each eligible person. The patient receives free GP and practice nurse care. Eligibility for the GMS card is means tested, based on income, dependents, property, savings and investments.

The GP always seemed to be busy, under pressure and seemed unapproachable.
(Ruby)

In addition to short time slots, work schedules influenced the work practices of the health professionals, particularly in general practice with a large number of part time staff. Specifically, several clinicians could see the one patient in the course of the patient's contact with the practice, since shorter working hours and working part time were seen to minimise the opportunity to meet women experiencing domestic violence:

I am only here three mornings a week - so that would cut down on it [seeing domestic violence] for a start. (Nurse Lily)

You often have patients that attend me once and another GP the next time, you know, within our group of three or four GPs. So the danger there I suppose is that I see somebody with a black eye and then somebody else sees them with something else...I only work three days a week. (Dr Elm)

In addition, being aware of the need to fast track patients through the system, impacted on time management structures, and being cognisant of the business acumen of general practice restricted the prospect for lifting the stones and seeing the slugs beneath. Compartmentalising of the appointment system was a pressure in itself to limiting the scope of discovering and disclosing domestic violence. Managing time was based on the role of the clinicians and a method of further compartmentalisation:

GPs like to pass [work]... taking diabetes for an example...[GPs] are happier when they have a nurse that they can pass the diabetic patients over to from the point of view of... more time can be given by the nurse than the GP. And the GP is losing money from seeing another patient if they are educating [patients]. (Nurse Rose)

The GP was there to fix things or to send you off to the next stage in your treatment whereas the nurse was not the fixer but had a specific task to do and I wouldn't think of telling her about domestic violence. (Ruby)

If we had a special clinic, like a women's health clinic [in collaboration] with the practice nurse [we could explore issues like violence against women]. (Dr Elm)

Data suggest the emphasis in consultations focused on the disease medical model of task and cure (see section 8.8) and where consultations required more than a medical model of care they were delegated to practice nurses. Delegation to practice nurses was viewed as a cost

effective management of the GP's time. Furthermore, comments by Nurse Rose suggest that she too viewed her role within the practice, at least in part, as a cog in the wheel of managing scarce medical resources, rather than one that viewed time as necessary to respond to the complex needs of patients beyond cure and repair. Indeed, Ruby's comment about the nurse's engagement in tasks and her decision not 'to tell... about domestic violence' suggests a cycle of non-engagement around complex health issues that do not fit neatly into a medical model of cure and repair. The management of time was a more complex factor when it came to treating patients who were fee paying, as opposed to those who were treated under the GMS system. For example; those who held a GMS card were more advantaged than those who did not have a card:

I could pick you off at random several GMS patients [who disclosed domestic violence]. In fact I know very few private patients who disclosed domestic [violence]... in fact I don't think I know any who have disclosed domestic violence. (Nurse Ivy)

In other things, not just this,[domestic violence] in other facets of medicine, as soon as someone gets the medical card you say "oh great, it's real easy to treat you now, I [with emphasis] can keep calling you back for regular treatment, do this, do that." (Dr Willow)

Money is an issue, but you have to pay for his [GP's] time. I couldn't justify talking about domestic violence and not have messages [groceries] for the week. It's sad that everything boils down to money but that's what it is like for a lot of women. Even if I wanted to go back a month later and tell the doctor, I haven't got it [the money]. (Quartz)

Repeat visits to general practice were considered less burdensome where patients had a medical card; where women had to pay to attend the doctor, repeat visits were not feasible. Data support the existence of an interdependence between time and resources, both on the part of the woman and the general practice:

The cost of attending general practice is an inhibiting factor to disclosure [of domestic violence],especially for women who may have mental health issues and require regular repeat visits. This puts attendance at GPs prohibitive. (Dr Cedar)

I had no money [for the GP]. There were no shelters in XX. There was nowhere to go. (Opal)

I couldn't afford his fee to attend him [GP] regularly. I just felt I wouldn't waste me money going to the doctor again, paying to be ignored. (Quartz)

In summary, time issues in general practice are complex. They include, an emphasis on personal timelines, managing organisational time, and the business acumen of general practice. A key consideration of the complexity of time is the associated cost of professional time, both in terms of using professional time to discover issues of domestic violence (health professionals), or affording professional time to disclose circumstances of domestic violence (women). The sub-core category time is further developed within the property of rationing time, which follows.

8.4.2 Rationing time

Rationing time categorises how time for general practice consultations⁹⁶ were allotted. As previously mentioned, in this study, the majority of clinical consultations were allotted a ten-minute timeframe. Compartmentalising involved measuring the length of the consultation against the stated or assumed reason for the patient's attendance at the surgery, which, in turn, influenced health professionals' ability to lift the stones and see the slugs beneath, to discover, or enable disclosure of circumstances of domestic violence against women.

Noteworthy within the data were evidence to suggest that the time frame of ten minute consultations was flexible, at least for practice nurses, and albeit for conditions that fitted within a medical model or disease model of health care:

I would have double slots for certain things, first vaccine and MMR⁹⁷, diabetic visit, so the receptionists know that I will need double slots [to educate patients], 20 minutes for those. Doctors will generally get ten minutes slots. (Nurse Rose)

⁹⁶ General practice appointment systems are usually separated into those that are pre-booked, with an appointment time allocated in advance, or else there are "walk in" clinics. Emergency cases are seen as they arise. The timeframes usually have one or a combination of the above appointment systems in order to facilitate dealing with patients' presenting signs and symptoms. Within the same organisation, different appointment systems may apply for different clinical staff. For example, GP visits may be walk-in and the practice nurse consultations may be booked or vice versa.

⁹⁷ MMR = Measles, mumps and rubella are childhood vaccinations.

Compartmentalised consultations based on a medical model of health care or a clinical procedure are problematic, as they do not allow for an individualised choreography responsive to unexpected elements (either evident or suspected) within any given consultation, such as a woman's experience of domestic violence. In addition, the rationing of time for a consultation suggests the existence of a hierarchical model of professional assumptions, as to why a patient is attending for the consultation, which in turn mitigates the potential for disclosure of circumstances of domestic violence. In other words, there is little room or time for accommodating the unexpected.

Rationing time was a challenge for both health professionals and patients:

There was always a big queue to see your doctor, a pressure to get the patients through. You were in and out as quickly as possible and all the patients were doing exactly what you were doing - waiting to get in. (Ruby)

Busy surgeries ... [means] cutting corners. (Dr Birch)

Comments by Ruby and Dr Birch, suggest the rushed tempo of the choreography of a consultation began even before the patient met with the doctor. Workload volume set the pace, and both health professionals and women appeared to mirror similar patterns of the need to get things done quickly. The practice of time rationing suggests an assembly-line⁹⁸ model of operation, with an expectation that the steps of the choreography of any consultation will follow in sequence with a precision of efficiency, when, in reality, such rationing of time puts pressure on all participants:

He [GP] is with you; he is listening to you; he is rushed. I can see it in his face. But, at the same time, every time I went in I felt he was giving me his time, I had it. (Pearl)

Referring them on usually takes months and the moment [for disclosing] has passed, the best time is now [in the consultation], if you can get the time. (Dr Oak)

⁹⁸ Assembly-line theory is discussed in Chapter Nine.

Data suggest that rationing time can inhibit health professionals from discovering and in some cases, disable women's disclosure of domestic violence. Nonetheless, efforts of empathetic engagement were recognised by health professionals and women in a system that was overburdened and time poor. Women also experienced pressure, resulting in feelings of hopelessness regarding having their needs met:

He [GP] would rush you in and out. You were lucky if you got five minutes there. (Quartz)

The context of a clinical interaction where the consultation is rushed and there is pressure on clinician's time is a barrier to engagement with any issue (not only domestic violence). For women in abusive relationships, a sense of being despatched through the system was not conducive to disclosure, being hurried, compromised the woman's sense of control in the clinical interaction. However, despite the limited time, there was a sense of gratitude, by some, to receive the five minutes.

GPs in particular, placed a lot of significance on time, thinking about it and complaining about not having enough of it. They complained about having insufficient time to manage their volume of work and the impossibility of trying to do so:

[Sigh]... well one, [thing], time is a big issue you know. (Dr Ash)

Time is the key determinant of everything in general practice. (Dr Pine)

To do all that [fully assess patients] in 10 minutes [is limiting]. (Dr Birch)

Time, and a perception that time was limited, influenced both the medical regime of the clinic and the choreography of the consultation. Just how successfully time was managed within the surgery was questioned:

My personal opinion about time is that with doctors it is bad management, because if you are going to allot everybody ten minutes in a morning, and you're in surgery we'll say nine till eleven. How many people is that you are seeing? How many people can you say that you are truly listening to and we are supposed to be listening, and supposed to be helping them? (Nurse Violet)

There is always a fear the if you pick up a cue like that [domestic violence] you will end up spending ages on the consultation and that things will build up. (Dr Pine)

While adhering to a tight consultation schedule was seen as a way of processing a large throughput of patients through the system, the experience of the participants suggests that such a tight schedule for consultations was not conducive to either discovery of, or disclosure by women experiencing domestic violence. Furthermore, when extended consultations were seen as necessary or desirable challenges of moving outside the ten-minute timeframe existed:

Well, it's [domestic violence] obviously not something that you want to start talking about, if you have an extra person⁹⁹ after a long surgery. (Dr Elm)

And I think maybe if she [GP] had come across somebody with domestic violence she would actually have said, "And one person who needed more time than I could give her," or something like that. (Nurse Rose)

A ten-minute slot is a difficult time because if somebody comes in and says they are depressed... your heart sinks and you are saying [to yourself], "I can't deal with this in ten-minutes." (Dr Birch)

Time is used as an excuse [to not go there]. (Dr Cedar)

I think time can be used as an excuse [for not dealing with issues] because both of those ladies that divulged [domestic violence] to me [did so] in a ten minute slot. Now if I took an extra five minutes, well I wouldn't watch the clock anyhow, I just apologised to people [in the waiting room] if I delayed them. (Nurse Violet)

In circumstances of rationing time, the findings indicate that some clinicians shaped the agenda of the clinical interaction to suit their timeframe. Feelings of hopelessness and discouragement emerged where health professionals struggled with balancing a scarcity of time and their "mad busy" (Nurse Daisy) workload. However, rationing time is more than just balancing "slots" alone as mentioned by Dr Birch, Nurse Rose and Nurse Violet. It impinges in the overall process of communication between health professionals and women (in this study). While it is possible to discover violence against women within the ten minute time frame as explained by Nurse Violet, rationing time is just one factor that contributes to

⁹⁹ The term extra person refers to a patient attending the clinic who is not booked in advance. In other words, seeing a patient for an unexpected consultation.

barriers for discovery and disclosure, (others include, not seeing, silencing, reading the person and insufficient training as previously discussed).

Where extended time in the consultation was required, some health professionals “groan[ed] internally” (Dr Ash) as time rationing made it difficult to engage with more complex symptoms, toward a discovery of the underpinning issues. Consequently, complex issues were generally avoided:

The most they [women] get with me is 10 – 15 minutes to spill out their heart, so it’s time. ...whereas they need a few sessions of pouring out their heart to people, that’s where counselling is really needed. (Dr Ash)

Implied within this comment is a suggestion that general practice consultations are designed to manage non-emotional issues within a 10-15 minute time frame. Furthermore, in order to fit within this regime, women who wished to disclose domestic violence would need to articulate their situation in a fluent and efficient manner:

If you [patient] are ringing for an appointment for the nurse and you get asked, “what is it for?” by a receptionist, you are not going to want to tell a receptionist, “no I just want to chat with her,” The receptionist will say, “well she is too busy just for a chat.” (Nurse Heather)

Women struggled to find the words to articulate their situation and especially when they heard the language of domestic violence applied to their own circumstances (see Chapter Seven section 7.2.2 naming the situation). Being expected to “spill out their heart” (Dr Ash) or being denied the opportunity to “have a chat” (Nurse Heather) in a system that is time strapped suggests that the current management of general practice consultations, where rationing time takes precedence, is not conducive to women disclosing circumstances of domestic violence.

I just felt so confused and found it very hard to explain what was happening (Coral)

I don’t believe women are enabled to disclose because it would be one more thing for the doctor to deal with. (Garnet)

The notion of sitting or talking with patients, was perceived by some clinicians as an inappropriate use of their time. Dr Ash commented: “we don’t have the time to sit there for an hour [and talk]” Women who needed to talk were referred to counselling services as they had “time to talk” (Dr Ash). Reference to time, its availability and how it is used in this context suggests a compartmentalised structure of general practice organised to accommodate a medical model of conducting procedures and completing tasks.¹⁰⁰

Where domestic violence issues arose in consultations, insufficient time was not the only difficulty experienced within the process of engagement between women and health professionals. Some GPs spoke of “[not being] good at emotional issues” (Dr Cedar, Dr Ash and Dr Birch), suggesting the absence of skills and knowledge to engage in sensitive issues, within a consultation:

Well...[sigh] you see, we wouldn’t [discuss domestic violence]...once they start going into that [disclosing domestic violence], we say...well to be honest I start to say, “you need counselling.” And [they need to see] people who have more time to spend with them, who are probably better trained than me to let them talk out their issues. I’d point them in that direction. (Dr Ash)

While choreographing a consultation toward addressing a woman’s circumstance of domestic violence was viewed as time-consuming, it was also about the level of proficiency and knowledge of the health professional to deal with the issue. Both women and health professionals questioned the suitability of general practice as the best place for the discovery and disclosure of violence against women:

I am not sure if general practice is the best place to see women who are experiencing violence. (Dr Cedar)

I believe a GP is no better trained than [at] recognising [domestic violence] and not trained [for anything] other than fixing [physical health]. It [domestic violence] is a mental health issue. It is about getting someone safe [and] gathering the pieces up. The GP can’t do that. It’s like asking the GP to build your house; it’s not [in] their scope. Are we asking too much of GPs because we put so much importance on GPs,

¹⁰⁰ Despite a belief that time management did not allow time for talking with patients, Thielke, Thompson and Stuart (2011) noted that “talk therapy”, or giving people the opportunity to explore what is going on for them and how it makes them feel, is the most effective ways of applying psychological principles in primary care.

like priests in this country? They can't be the be all and end all. There are other people, other supports out there and we should be calling on them. (Pearl)

The discovery and disclosure of domestic violence needs time, someone to talk to and someone who has the skills to listen to sensitive issues in an appropriate environment.

In summary, rationing time, a factor within compartmentalising, is critical to understanding the process of discovery (or not) and disclosure (or not) of violence against women within clinical consultations. Rationing time leaves little or no opportunity to deal with sensitive issues such as domestic violence. Time rationing is not conducive to hearing and listening to the narratives of women who are in abusive relationships. Managing time rationing is burdensome for health professionals and a disincentive to women to tell their story. Further analysis of the category of compartmentalising is provided in the next section where the property investing time is discussed.

8.4.3 Investing time

Investing time involves health professionals ignoring their own workload and investing time toward prioritising the need to listen and talk to women who are in violent relationships. In such circumstances women are more likely to disclose their experiences of domestic violence:

If somebody mentions it [domestic violence] you can't just leave it high and dry and say, "come back" because you owe it to them [women]. If you ask, you must be able to give them time to speak about it, because this could be the first time [for disclosure]. They may never mention it again. It's a big bit of information to take back from somebody, and I think you have to be able to sit back no matter how busy you are outside [in the waiting room] and say, "Would you like to talk about it? Is it worrying you?" Now it could be appropriate to say, "Let's come back to that another day," but you would have to give them the chance to, what's the word, debrief, or express, or to offload it, if it is boiling up inside so there is an element of that. (Dr Willow)

You make time, like if somebody came in to me [for a blood test], it's like everything, like if somebody came into me today and then something else happens [such as the patient getting upset] you make the time. (Nurse Daisy)

The doctor is quite good with time. Initially it was in and out; but eventually, when I did disclose, she did give me the time that I needed. (Sapphire)

Enabling women to disclose domestic violence is more than giving them time alone. It includes listening to women's narratives, reading the person and putting aside organisational issues that occur in the practice, that is foregrounding the woman's agenda, not that of the health professionals. Giving time to women creates an atmosphere that enables disclosure, enhances the process of engagement and changes the choreography to one of a partnership.

Data suggest that once women made the move toward disclosure, and where health professionals recognised that move, and were prepared to give time, followed by the next step which is listening, then collaborative empathetic engagement began. However, health professionals did not always take the first step in the choreography of discovering domestic violence as experienced by Sapphire. Instead, over a period of time, some women initiated the moves of disclosure; they took the lead in lifting the stones and showing the slugs beneath. Once awareness of a woman's abusive relationship was established and the GP invested time in the consultation, a rhythm of understanding occurred allowing the health professional and the woman to interact in tandem:

She was understanding and encouraging and gave me advice. I trusted her and felt comfortable. (Coral)

I think it's just that you need to build that rapport up with somebody. (Nurse Daisy)

It is down to developing a therapeutic [relationship]... whether somebody comes in and just wants a service from you or somebody who actually wants a relationship with you. (Nurse Ivy)

I have a strong relationship with the women who attend the practice and I know the patients well. The relationship is cultivated over time. (Dr Cedar)

Investing time in consultations is linked with the sub-core category of reading the person (see Chapter Six section 6.3). Viewed together, reading the person and investing time illuminate the complexity of the process of enabling disclosure and discovery, within the clinical

consultation, for women who experience intimate partner abuse. Investing time allowed consultations to move beyond the compartmentalised framework of the medical model of care alone, toward a realisation of the health needs of women who were in violent relationships:

Suddenly you can sort out all the frequent attending they have been doing, or their anxieties, or their physical illness can all be explained away. I think once you have that kind of relationship with someone where you have that kind of information and they know you know it, you are much more intimate with them in a much more holistic health professional way. (Dr Willow)

The process of realising the full extent of women's needs, or what Ruby described as "putting the bits and pieces of your life together" allowed for the development of a "therapeutic relationship" (Nurse Ivy) between health professionals and women. Realisation in this context was not just about an 'ah-ha' moment vis-à-vis the circumstances of the woman but a moment of reflection also, on how time can be best used within general practice, and how it cannot be viewed independently of the skills and knowledge of the health professionals and the safety of the patient. Dr Pine commented:

I don't think it takes that much more time actually, you see I think that is the mistake they [health professionals] are making. It depends how skilled you feel in it [assessing domestic violence issues]. So for example, maybe I am investing too little time, so maybe I will explain what I do just to clarify to me if someone comes in with domestic violence I still manage it quite quickly. Because there is a time pressure and I feel if you don't manage it quickly then you will not go there. So when I say manage it quickly, obviously you will be sympathetic and say obviously this is huge. I think you need to be sympathetic but when you are being sympathetic you would need to get them to someone who has got the time because we don't have time. One is we don't have time and I think the things we need to do in the meantime when we get them to someone is to firstly get them to recognise that domestic violence is serious and can cause death. And secondly to tell them there are things you can do to... sometimes if I think someone is in immediate danger I go straight into those things immediately. And then, listen you need to talk to someone. And arrange for them to go to people who work with domestic violence...I suppose what I am saying is it does take extra time but it is not a huge amount of time. Because I think people's fears will be [the consultation will take] 25 minutes, half an hour and then you have a crowd of people in your waiting room baying at your door.

In circumstances where workload was seen to militate against an immediate investment in time health professionals spoke of asking women to return at a later date, though that too was problematic as women often did not return:

What we used to do was bring them [patients] back maybe. Then you try and get as much [information]... sometimes if they are ready to talk about something...[I would say] “come back tomorrow, I can't talk to you today, [I'm] too busy”...Bringing people back, maybe they don't come back. (Dr Birch)

I would bring them [patients] back on a Wednesday very often, sit here like this [side by side, in an open relaxed fashion with time to speak and with the computer off] and we would talk about it because I can sit here and relax and they can relax. Sometimes when you prepare them they don't turn up for the appointment. (Dr Oak)

The waiting room can be full and you feel like telling a woman to come back on another day. But that isn't fair to her, because she may never come back. (Dr Cedar)

Where there was a suspicion of abuse, and despite well intentioned efforts to get women to return to the practice, there was, in essence, some degree of naivety of the complexity of domestic violence and how women seek to live out their lives within such circumstances, not least that for some finding the resources to return was not possible¹⁰¹:

If the doctor twigged anything and they just asked the question, if it was more out there ...Money is an issue, but you have to pay for his [GP's] time. I couldn't justify talking about domestic violence and not have messages [groceries] for the week. (Quartz)

In summary, investing time in clinical consultations was a critical step in the choreography of discovery and disclosure of violence against women. Where women lead the way and disclosed their experiences, they felt supported in the clinical interaction. However, the system of compartmentalising the time structures of general practice did not always allow time to be invested at the moment it was needed in consultations. While offering alternative

¹⁰¹ As mentioned in Chapter Six, section 6.2.2 , clinical seeing, women offered cues and signals to health professionals in an attempt to inform them of their circumstances. Chapter Seven, section 7.4 also discusses breaking the silence where women wanted to be asked about their relationship. For some women, several years may have lapsed between deciding, being enabled and taking action to disclose.

appointments was an option, used by some, toward developing a process of engagement, evidence suggests it was not necessarily a suitable substitute to investing time in the moment. Finally, the complexities of time, paying for time, rationing time and investing time within general practice are closely aligned to a medical model of health care and the compartmentalising of health care. The next section discusses the sub-category of working the medical model.

8.8 Working the medical model

The sub-category of working the medical model illustrates how clinical consultations primarily focus on symptoms of illness and disease, with an emphasis on making a diagnosis, and treating patients based on a given set of symptoms. Health professionals frequently, described how their workload was “mad busy” (Nurse Daisy) and how they were “bombarded with paper work” (Dr Oak). Listing the clinical reasons for consultations was an example used by health professionals to illustrate workload pressure:

There is a female GP who would be on a couple of times a week with me and I'd say, 'how was your morning?' [Her reply] “Oh it was one of those mornings, one IVF¹⁰², two newly pregnant, somebody with depression.” (Nurse Rose)

But you have to do all the blood tests and the x-rays, and you don't only do x-rays, you do MRI scans¹⁰³ as well to convince somebody they are well. (Dr Maple)

I suppose we are more inclined to say, could this [headache] be a brain tumour? So you are sending them off for CT scans¹⁰⁴. (Dr Birch)

Clinical interactions with patients were defined by workload, the type of illness and /or symptoms and the list of tasks provided to patients. The priority focus was on the medical reason for the patient’s visit to the surgery. Evidence suggests that each consultation was

¹⁰² IVF = in vitro fertilisation which is a treatment for female infertility.

¹⁰³ MRI Scan = magnetic resonance imaging is an x-ray technique used to investigate the function of the body.

¹⁰⁴ CT Scan = is a computerised tomography which is a process of conducting 2 or 3 dimensional x-ray images.

addressed as a separate entity due to time limitations and the compartmentalised structure of the system:

I think the patient presents with symptoms that they give the doctor, how they are feeling or that they have a sore throat and the GP responds to the information that is given to them. They make a diagnosis. I don't think that they are sitting there looking for something that isn't obvious [and it is] the same for nurses. If a patient comes in for a smear or an antenatal visit that is what the patient has presented for so therefore that is what the nurse is focused on. We are not focused on looking for something that isn't there or that we perceive to not be there. (Nurse Rose)

Maybe we are trained to look for if somebody comes in with a sore throat, we treat the sore throat but not to look beyond that... On a busy day you may just not think about it [domestic violence] or you are focusing just on what they [patients] are coming in with. (Dr Birch)

Compartmentalising the reason for a consultation, by isolating body parts and concentrating on physical symptoms, does not allow for the clinical gaze to extend beyond what may not be visible, or the experiences behind the stated signs and symptoms. The social and emotional concerns of patients (in the case of this study, women who experience domestic violence) may not be observed. In essence, compartmentalised consultations, within a medical model, and as described by health professionals in this study, involved “[not]sitting there looking for something” (Nurse Rose) and “not look[ing] beyond [presenting symptoms]” (Dr Birch). In other words, consultations were taken at face value, and were based on an instant choreography:

If someone comes into you, you can't say straight away, “oh this is psychological.” You have got to make sure first, or, “oh this is a hidden agenda,” you have got to take it on face value first. (Dr Maple)

The process of compartmentalising clinical consultations involved more than “focusing just on what they [patients] are coming in with” (Dr Birch); it involved decisions around who takes responsibility for managing what in consultations:

Every time the patient comes into me, they're here for a reason. When you go to the doctor, it could be for this or that. They [women] are looking for what the doctor thinks out of that and when they come into me they are coming with a specific task in hand to be seen, to be done. (Nurse Heather)

An emphasis on specific tasks is also about a medical model of practice, where expectations that tasks will “be done” may leave little room for engaging in a consultation toward enabling disclosing violence against women:

It’s [domestic violence] not on my radar. (Nurse Rose)

However, within the system of general practice, women who attended, wishing to have their circumstances of domestic violence recognised, were “looking for something” (Ruby) and seeking help:

I was there a lot with migraines, earaches, sore throat. I was never asked about home. I had a lot of ear infections and I am not surprised now - because your ear is one of the places that is vulnerable if you are a victim of domestic violence. (Ruby)

I never really went with depression. Although I didn’t present with depression, I wouldn’t say I was far off it. I would just go. I would go if I had a mole here [pointing to her arm]. (Pearl)

Evidence suggests that the compartmentalised approach to general practice and the inherent hierarchical role performances within it were not conducive to a dance of instinctive engagement toward discovery and disclosure of women’s circumstances of domestic violence. Rather than making the connections between repeat consultations, the reason for clinical encounters appeared to be addressed at face value, with each interaction a separate entity. Noteworthy too was how women engaged with a medical model of care, at least in terms of what was considered as acceptable for a GP consultation:

You went to the doctor if you were sick, not if you’re beaten at home. It seemed a separate issue. (Ruby)

The separation of being sick and the being beaten into discrete issues is in essence a compartmentalising of the self as a woman in circumstances of domestic violence. By being sick, the woman has an identity; she owns an illness, or a medical ailment; she is a patient. Domestic violence, on the other hand, compartmentalises women in terms of their vulnerability, loyalty (to husband/partner) and their need to disclose. In other words, issues

that do not fit (at least initially) within a medical model of care, are not presented to general practice.

Data emphasise the disconnect by both women and health professionals of the consequences of domestic violence with health and wellbeing. An inability to make connections between illness patterns and symptoms with circumstances of domestic violence, toward viewing it as a health issue, is problematic, and contributes, in part, to the conspicuous invisibility of domestic violence, within general practice:

If I walked in with a black eye, a broken bone, a bruise, something like that, and he [GP] didn't cop that I think that might mean a serious health problem - people are at serious risk when the obvious is ignored. (Pearl)

She [GP] had never seen such injuries in all her years working as the refuge doctor. She had never seen such injuries. I was bruised everywhere except on my face. I had a crown of thorns [bruises] on my head. (Amber)

I presume that a lot of physical violence can be done in such a way that it is part of the woman's body that isn't visible. I know that mental violence; well you can't see the scars. (Nurse Rose)

Working the medical model means health circumstances that do not fit neatly within a medical model of care are likely to be missed. Focusing on medical conditions in isolation influences what is visible in consultations and how medical facts are addressed with little acknowledgement of the emotional impact. Injuries are foregrounded, and the woman as a recipient of abuse, is lost. Findings indicate that health professionals need to engage empathetically with women to elicit information about domestic violence. The need to elicit information and to seek explanations necessitates health professionals demonstrating a sense of seeing and of knowing through reading the person in the clinical choreography:

I mean I have picked up at that time¹⁰⁵ strangulation in the neck, abuse in terms of vulval bruising... bruises on the breast, bites on the breast, bruising on the arms. or when there is absolutely no visible signs, it is just how somebody feels. (Nurse Ivy)

¹⁰⁵ “at that time” refers to the practice nurse conducting intimate procedures on women. These include cervical smear examinations or demonstrating breast awareness education.

The category working the medical model is linked with the sub-category of seeing and not-seeing (see Chapter Six section 6.2).

The findings of this study suggest that consultations, where patients need to “talk out their issues,” do not fit with a medical model of general practice consultations where there is an emphasis on diagnosis, cure, repair and tasks. Furthermore, talking and more importantly listening cannot be accommodated within tight 10 minute time schedule and where the work load is “mad busy.” While the system of referring patients on to others within the practice or pointing them in the direction of other services was common, the, inability to engage, within the consultation, meant missed opportunities for women to disclose and health professionals to discover circumstances of domestic violence. Furthermore, referring women on to other professionals, as opposed to engaging in a collaborative programme of care, was potentially risky, at least for some women:

It’s acceptable to go to the doctor, you could be killed [by partner suggesting vulnerability to further abuse] if you said you were going to a counsellor. You could be going to a GP for so many hidden things. (Sapphire)

In summary, engaging a medical model of care in general practice has limitations for discovering violence against women. It focuses on illnesses and treatment, prioritising a clinical lens that does not extend to an emotional level of understanding. The choreographic style of engagement of clinical seeing, focuses on defined symptoms, diagnosis and treatment, misses the steps of cognitive seeing, as in understanding, where connections are made with underpinning contributing factors to the reason for the consultation – women’s circumstances of domestic violence. Further illumination of the sub-category working the medical model is provided by analyses of data referring to the treatment of symptoms of domestic violence, or what is referred to in this study as medicalising.

8.8.1 Medicalising

The property of medicalising builds on our understanding of the sub-category working the medical model. In essence, it describes how health professionals respond to the presenting consequences of domestic violence, their use of technical language and their principal focus of repairing or treating the person, or the condition. Several GPs spoke of “being trained” to treat or fix things as a method of managing clinical consultations, while a GP from a training workshop stated: “we can’t help it; we are conditioned to fix things.” The notion of fixing things foregrounds physical symptoms and the notion that a cure can be found, or at least some form of alleviation. Both the women and the health professionals embraced the choreography of medicalising:

You are just seen as the illness to disclose, anything further than that illness it’s like - what’s the problem today, earache - how long have you got it, take this - you’ll be better... You always got the tablet. (Ruby)

They [women] would report [to the GP] being hit. They’d just come in and say, “Any painkillers? He hit me last night.” (Dr Ash)

Medications were given for pain, antibiotics for infection and anti-depressants where signs of abuse were present. Fixing things in this fashion failed to deal with the core issue of violence against women and in many ways masked women’s reality by medicalising the consultation. The issuing of prescriptions was part of the process of compartmentalising the clinical interaction, in that prescriptions dealt with symptoms, but not always as part of a response to the issue itself. In other words, injuries became the conspicuous manifestations of violence against women, but without the cause being made visible. Medicalising is also linked with the property accepting and normalising (see Chapter Seven section 7.2.1). Viewed within the choreography of the consultation, medicalising is about a dance to the tune of physical ailments, or other ailments for which a pill can be prescribed, but not one that takes steps toward seeing or exploring possible causes:

They [GPs] are not trained in counselling. They are trained in giving a prescription and diagnosing, or fixing things, or giving you a tablet, or sending you on. But they fix nothing really. They bypass it, or write prescriptions, that's what doctors are about. (Garnet)

But it is so easy to pick up a pad and write a script for whatever they want or have whatever you think would get them out of this depressed state [of depression]. Tablets aren't always the answer... Because you can take all the Valium¹⁰⁶ you want, and this symptom of what is there doesn't go away. (Nurse Violet)

Where time limitations existed, and there was an expectation to take action to “whatever you think [is the diagnosis]” (Nurse Violet), the chief complaint or symptom appeared to be addressed with the use of medication. Ease of action took precedence over time for discovery and disclosure. Sometimes women did not understand the reason why medication was prescribed:

I went [to see] the GP and he starts treating me [with anti-depressants]. “Why?” I asked him later and he says, “Because you are the person who came to see me.” (Opal)

Data suggest that rather than being seen, and understood, as a woman in an abusive relationship, being medicalised placed women in a sick role, where the rules of engagement were influenced by a medical model. Medicalising practices were part of “provid[ing] a solution to them [patients]” (Dr Birch), because some women were seen as “suffering” (Nurse Heather) domestic violence. Medicalising involves a choreography of prescriber and conformer, where solutions offered may not always correlate with the needs of women in abusive relationships and may even mitigate opportunities of discovery and disclosure:

[I was] taking pills of different shapes and colours and all sorts of bullshit and realising this [circumstances of domestic violence] is not getting better. (Opal)

They [women] may start on a tablet, on an anti-depressant, but you [practice nurse] need to say [to the women] “Look, that's not going to [help]...it's only going to mask [it]. It's not going to solve it.” (Nurse Daisy)

Women [in the refuge] were less capable of dealing with [their situation] and less likely to see the abuse as bad as it was, as someone who was not on an anti

¹⁰⁶ Valium is benzodiazepine drug used for treating anxiety or panic disorders.

depressants. Somebody who wasn't on an anti-depressant would be in a worse state emotionally. They [women on medication] were numbed by the Xanax¹⁰⁷ and didn't see the seriousness of their situation...Sometimes they would just head off home, toddle on home, cos it's like, "ah sure I'm ok really" and it was very clear they were going around in a numbed state. Sometimes they weren't even seeing the children's responses fully, because they were so numbed up with medication. (Amber)

In circumstances where symptoms, experienced by women in violent relationships, were medicalised, there existed the potential for a choreography of obscurity. Women were expected to take their medication, while at the same time being advised that it was not a solution to their problem, and indeed could mask it or affect their ability to seek a resolution for their circumstances. Their reasons to attend the surgery were dictated by the need for repeat prescriptions also.

In summary, the property medicalising illuminates the challenges that exist in the compartmentalised, medical model of general practice consultations. Medicalising women's symptoms placed a personal burden on some women and added to their distress. It diminished the potential for engagement with the complexity of issues of domestic violence that underpinned the symptoms experienced by women. Rules of engagement within a medical model foreground the need to find solutions, in other words, to provide treatment for the consequences of presenting symptoms. In such circumstances, physical and psychological problems may be treated with medication, but with no reference to, or understanding of, the complex aetiology of violence against women. In other words, the choreography of engagement is underpinned by a reality of conspicuous invisibility.

¹⁰⁷ Xanax tablets are used for the management of generalised anxiety and panic disorders.

8.9 Chapter summary of compartmentalising

The core category compartmentalising and the sub-categories time and working the medical model were presented and explored in this chapter. Compartmentalisation is a process of simultaneously partitioning many factors: including patterns of engagement, organisational structures and areas of life for example, family life and living in (or departing from) an abusive relationship. It describes a way of managing time and how managed time influences the discovery (or not) by health professionals of circumstances of domestic violence against women. Where time is rationed and women feel the pressure of “clock time”, opportunities to disclose their experience of living in an abusive relationship diminish, or are absent. Furthermore, limitations of the suitability of general practice as a location for the discovery and disclosure of violence against women are discussed. Where there is an emphasis on efficiency, managing workload, and a compartmentalised organisational structure, the opportunity to lift the stones and see the slugs beneath is reduced. However, where health professionals invest time in empathetic engagement and extend their clinical gaze beyond a medical model of care opportunities for the discovery and disclosure of domestic violence are enhanced. When working the medical model health professionals seek solutions to the symptoms experienced by women in circumstances of domestic violence, often without fully understanding the underpinning aetiology. Finding solutions by prescribing treatments further medicalises women’s experience of domestic violence but without adequately dealing with it. Therefore, compartmentalisation illuminates an understanding of the organisational structures of general practice and how it influences the process of engagement for both health professionals and women in abusive relationships who attend general practice. The next chapter presents a discussion of the findings.

Chapter Nine: Discussion

Conspicuous Invisibility: toward an understanding of the process of engagement

9.0 Introduction

The previous four chapters (including the prologue) presented the research findings which are grounded in the voices of the general practice team (GPT) and the voices of women who have experienced domestic violence; they included codes and categories generated by data analyses. This chapter provides an in-depth exploration of the findings toward the development of a middle range theory of conspicuous invisibility. The findings are distilled under two key concepts - engagement and conspicuous invisibility. Firstly, general practice health professionals provide a service and women in abusive relationships engage with the service through attending clinical consultations. Secondly, the theory of conspicuous invisibility informs the complexities of engagement or non-engagement with the substantive issue of women's circumstances of domestic violence. Engagement is discussed with reference to three levels: level one, non-engagement; level two, first impression engagement; and level three, purposeful engagement.

9.1 Revisiting the research question

This study explored the complexities of how general practice health professionals discover, and how women are enabled to disclose, domestic violence in the course of the clinical interaction. In accordance with the research question, the definition of the disclosure and discovery of domestic violence that was used is outlined by Liebschutz et al. (2008). When the topic of domestic violence is voluntarily spoken about, or women initiate the conversation, it is termed 'disclosed' (Ibid). Domestic violence is labelled as 'discovered'

when it becomes apparent in the course of a clinical consultation with a general practitioner, or practice nurse, that violence exists, and when the patient has not made an explicit disclosure of an abusive relationship (Ibid).

9.2 Development of a middle range theory: Conspicuous Invisibility

Grounded theory builds inductive middle-range theories through successive levels of data analysis and conceptual development (Charmaz 2005). According to Charmaz (2006:7) “middle-range theories consisted of abstract renderings of specific social phenomena that were grounded in data.” The challenge in determining a middle range theory as ‘middle’ is that it needs to be sufficiently abstract to allow a breadth of application yet narrow enough to permit guidance in research and practice (Liehr and Smith 1999). Conspicuous invisibility, the theory identified in this study refers to the experience of the GPT being physically present, within the practice, and available for the consultation, but not being wholly present, i.e. not looking and therefore not seeing or enquiring about issues of domestic violence in the course of the clinical consultation. The theory of conspicuous invisibility aims to construct an understanding between the GPT discovering violence against women and enabling women to disclose their experiences of abuse. The theory also illuminates understanding of women’s abilities and opportunities to disclose their circumstances of abuse when attending clinical consultations. Underpinning the theory of conspicuous invisibility is the choreography of engagement. This choreography of engagement provides an important explanatory framework that explains the interactions in clinical consultations between the members of the GPT and women who experienced abusive relationships. According to Liehr and Smith (1999:88), even when not stated explicitly, there are implicit indications that every theory refers to published research when generating theory (see also Chapter Three, section 3.4 and Chapter Four, section 4.5.3). Furthermore, they (Ibid:87) noted how theorists often combine

nursing and non-nursing theories in building theory research, as in this study, where the generation of the theory of conspicuous invisibility illuminates understanding of a process of actions within, as well as the dynamics of, the clinical consultation choreographed between women in abusive relationships and the GPT.

Using a symbolic interactionist perspective, grounded theory provides a way to study human behaviour and interaction and is particularly useful to conceptualise behaviour in complex situations where there is a desire to understand unresolved emerging social situations or how health care problems are managed by clients (Chenitz and Swanson 1986). In the case of this study, domestic violence is a social situation and health care problem, where women are seen as conspicuous attendees for general practice consultations while their background experiences of abuse mostly remains invisible. Blumer (1969) argued that symbolic interactionism, is based on interpretation between a stimulus and a response, and the meaning human beings attach to such behaviours. In the clinical setting of this study, where women experiencing domestic violence attended for general practice consultations, the process or behaviour of the consultation suggested a pattern of not seeing the needs of women, of taking the presentation of the woman at face value and not seeing the underlying or invisible factors contributing to her circumstances. Factors that competed with the discovery of violence against women included organisational factors, environmental factors and factors concerning the person. The complexity of this human behaviour and the associated contextual situations can best be understood from a theoretical perspective grounded in the reality of this study, a middle-range theory of conspicuous invisibility. Each of the contributions are explored in more detail throughout this chapter.

9.3 Foregrounding engagement - the importance of context

General practice health professionals are prominent health service providers within a community setting. The service is also known as family practice because the GPT provide care to all age groups. Patients access the service through self-referral via an appointment or by attending a walk-in clinic. Knowledge of the organisational and environmental setting of general practice is key to understanding the choreography of communication toward a process that facilitates (or not) the discovery and disclosure of violence against women. The environmental setting implies the physical structure as well as the surrounding influences and set of conditions that affect communication; they set the scene toward enabling (or not) participants' ability to engage. Principal elements of engagement (or not) include structural aspects, context and opportunities (Stanhope 2012). Findings from this study enhance understanding of what (Lequerica and Kortte 2010; Walsh et al. 2005) refer to as the interface between the environment and the participant in circumstances of health professionals' discovering and women disclosing domestic violence.

Although structures such as the physical building and space of the surgery were outside of the control of the participants, the set of conditions - rapport and friendliness of frontline staff (receptionists); the chaos of the waiting room; the number of patients waiting to be seen; and the presence, or absence, of posters and health education leaflets on domestic violence - were adjudicated before the face-to-face encounter with the health professional. Sets of conditions are best understood as evidence of the extent of concern for the welfare of patients (Chan and Goh 1995). Most critically, they can tip the economy of power toward empowerment, to disclose, or disempowerment, not to disclose. Adjudication in this context illustrated in the findings is about judgment and decision making, a process of weighing things up toward a consideration to disclose (or not). This is essentially an internal discourse with the self, which

is influenced in a moment in time, in this case the individual's experience of the structural ambience of the general practice waiting area. Thus, the dynamics of engagement toward enabling disclosure (or not) are sown prior to the choreography of the consultation. While others (Gignon et al. 2012; McKie, Fennell and Mildorf 2002) have noted the stressful nature of the waiting period during a general practice consultation, the findings of this study illuminate the nature and complexity of what clients and patients may experience. Although a positive relationship between an environment, which creates an impression of calm and helps to alleviate anxiety, supports engagement (Rice, Ingram and Mizan 2008), the findings of this study found this was not always possible in a general practice waiting room. The waiting time, in and of itself, was stressful. Adjudication of the characteristics of the environment of the waiting room set the scene for the next phase of engagement within a general practice clinical consultation, described by Simmons-Mackie and Kovarsky (2009) as the purpose of interaction, and the roles participants take to influence the engagement of individuals in particular situations. The findings of this study indicate that women judged their surroundings while waiting to be seen by clinicians and perceived that an absence of information, posters and support material, on domestic violence implied that the practice was not disclosure friendly, or that the health professionals were unaware of the issues of violence against women. Therefore, the conspicuous invisibility of support material influenced *inter alia* their decision whether to disclose (or not) their experiences of abuse in some instances.

As well as the environmental structures, organisational structures influence the context for engagement. General practice is compartmentalised into a system that tightly controls time management and expects efficiency. The findings of this study corroborate with Van Roy, Vanheule and Deveugele (2013) who suggested that organisational challenges, such as managing time and the need to have a good flow of patient throughput, influence the process of engagement. Time management defines how general practice consultations are structured.

The findings of this study demonstrate that general practice as a service is dominated by time limitations, compartmentalised in time rationed 'slots' which, in turn, can influence health professionals capacity to discover violence against women. The reasons time influences the process of engagement, as identified in this study, relate to the length of the consultation; the perception being that health professionals are busy and that communicating with them during the consultation should be limited to the main symptom only (discussed later in first impression engagement). Being conscious of time and its availability is a factor that facilitates or impedes discovery and disclosure of domestic violence within the general practice consultation, a factor also noted by Djikanovic et al. (2011) and Buetow (2004).

The findings in this study concur with a large body of literature that acknowledges health professionals are pressed for time and experience workload issues (Staudt, Lodato and Hickman 2012; Krueger and Reilly 2011; Holmstrom and Dall'Alba 2002), which in turn influences the content of the clinical interaction. The theory of conspicuous invisibility acknowledges how time-burdened health professionals contribute to women concealing their experiences of abuse and health professionals not seeking to discover the issue. In this research, some women participants had waited months or in some cases years to build up the confidence to talk to health professionals about their abusive situation but due to the time constraints or the environmental and organisational context of the general practice setting, disclosure did not happen. Where there was a perception that some women needed longer consultations, and health professionals were not in a position to exceed the allotted time, a reluctance to engage with women's circumstances of domestic violence occurred. Similarly, women were not enabled to disclose under such circumstances.

Creating time to facilitate disclosure and thus, to make visible women's circumstances of domestic violence, requires an investment of resources within general practice where the speed of the consultation and what needs to be achieved within the timeframe is of greater

importance than the rhythm of the consultation. Since time is a finite resource within general practice, attempts at making more time requires rationing, which according to Tormey (2003), requires a sharing of a scarce resource equally, or in accordance with need. Where health professionals were able to see need and ration time accordingly, the choreography of the consultation became one of knowing:

Time is not merely an external yardstick with given units; time flows and folds into medical practice in a variety of ways, and the doctor's handling of time becomes an opportunity to influence other important issues. (Jespersen and Jensen 2012:347).

While time and the lack of it was foregrounded as an issue by participants, there was also the notion of the myth of time and whether health professionals believed they had enough of it, or not. Similarly, Mc Kie, Fennell and Mildorf (2002:327) observed that "GPs mythologised time by asserting they did not have enough time to see women who present with domestic violence, yet they revealed their ability to control and suspend time in the consultation if they consider it to be appropriate." Values around time, how it might be used and how much is available are critical to how the choreography of a consultation is controlled. Time is linked to seeing or not seeing, but not exclusively. Along with time, findings indicate health professionals' absence of education and training, and concerns about misjudging women's situations regarding domestic violence, as reasons for their lack of engagement. Education and training are closely linked with knowledge and skills and are key issues in understanding models of engagement. Specific models of engagement underpin the iterative process of the choreography of the general practice consultation toward the discovery and disclosure of women's circumstances of domestic violence. These are presented and debated as characteristics of the theory of conspicuous invisibility.

The notion of time and how it was used and referred to by health professionals provided insight into the structures of general practice. Time was compartmentalised and so too were tasks and roles, suggesting an assembly-line mode of efficiency. Although working in an

assembly-line is more akin to the manufacturing world, within general practice, the analogy provides a lens through which the business approach to managing consultations can be examined. The compartmentalised role boundaries of health professionals and how they approach their work by “performing single tasks” suggested assembly-line efficiency (Fogarty 2011:2206). For example, women presented to the practice nurse for a specific procedure or to the GP for a clinical opinion, diagnosis or medical prescription. According to Toussaint and Berry (2013) the growing need to be efficient in health and to work in an assembly-line manufacturing system, creates a fertile ground for rushing something that cannot be rushed, misunderstanding something that is not easily understood and under investing in something that requires a multifaceted investment. Part of the rushing through meant that women’s circumstances of domestic violence remained invisible and despite some receiving medication and treatment and making return visits, their conspicuousness often went unnoticed too, at least in terms of making connections beyond the initial diagnosis. While health professionals did not engage in a tick box system of care *per se* (though some viewed a tick box screening tool as having potential in the identification of domestic violence) the potential for possible engagement with a ten minute slot mirrored somewhat the brevity of ticking boxes. Doctor-patient relationships were compromised and women experienced a sense of being dehumanised as they described being “only a number” or getting “in and out” of a consultation. The association between tick box engagement and dehumanised practice has been described also by McCartney (2012). It is argued that the challenge of an assembly-line approach with its emphasis on efficiency and productivity within general practice can be illuminated through a theoretical perspective of conspicuous invisibility which is underpinned by engagement and non-engagement.

In summary, foregrounding the environmental and organisational context of general practice sets the scene for presenting a theoretical perspective on engagement, between women who

experience abuse and health professionals toward the discovery and disclosure of women's circumstances of domestic violence. Key environmental and organisation factor include; time management, the level of training for health professionals, patterns of work and the drive for efficiency. Other factors beyond the clinical setting, but nonetheless relevant to the process of engagement relate to women's sense of the self. Women's need to convey a persona that emanates not being seen "as a victim," loyalty to her partner and family, contribute to the theory of conspicuous invisibility. The next section discusses models of engagement.

9.4 Models of engagement relevant to this study

The dynamics of the clinical consultations in this study were explored through an iterative performance of choreography. Using the image of dance, patterns of initial engagement are described through a series of backwards and forwards steps between the general practice team and women. Participants' process of engaging with the discovery or disclosure of violence against women, within the consultation, are conceptualised as lifting the stones and seeing the slugs beneath. Engagement is central to any human interaction where the object is to understand another, develop a relationship, communicate effectively, solve a problem, or bring about change (Walsh et al. 2005). Engagement is defined as an ongoing process that is necessary to sustain therapeutic alliance (Staudt 2007). According to Higgins and Scholer (2009) engagement is a state of being involved, occupied, fully absorbed, or engrossed in something—*sustained attention* [original italics]. Although several definitions for engagement emerge in the literature, according to Walsh et al. (2005), engagement is under theorised and under explored. Findings from this study address the dearth of theorising in relation to engagement and add to our understanding of the complexity of engagement within a therapeutic alliance. The notion of sustained attention, as proposed by Higgins and Scholer (2009) is problematic, since the achievement of such

attention cannot be seen independent of the context, for example, in general practice consultations where time limitations and feelings of an over-burdening workload are an issue. The relevance of the context of the person and the environment towards successful engagement was forwarded by Lequerica and Kortte (2010), who described four key factors to successful engagement: willingness, capacity, social and physical (see Figure 9.1). Although these factors were identified in the context of medical rehabilitation treatment, findings of this study suggest their usefulness when looking at engagement within the context of general practice consultations. For the process of engagement to occur successfully, there must be a willingness and capacity to engage with the substantive issue (circumstances of violence against women) and in an environment conducive to communication where there is an ability to see, or observe the concerns of women, beyond what is presented in the consultation. In other words, members of the GPT need to take notice of (as in observe, become aware of) women who attend for consultations, thus, determining the need to ask women about experiences of domestic violence. Likewise, women's perspective of the person and environment are critical to their process of engagement. They need to feel the setting is disclosure friendly and that health professionals are willing to listen to their narratives of disclosure, should they decide to disclose.

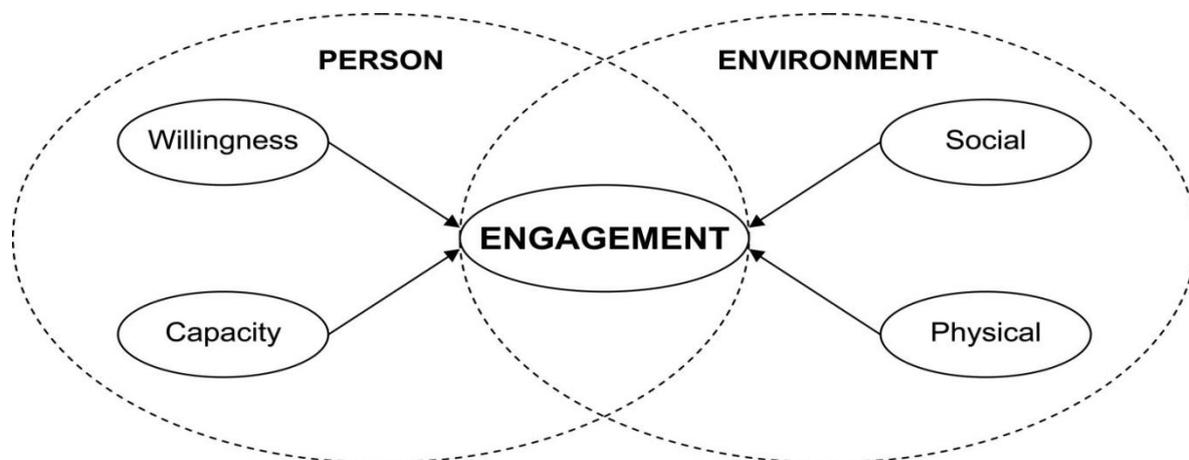


Figure 9.1 Factors contributing to the process of engagement (Lequerica and Kortte 2010)

However, while Lequerica and Kortte's (2010) model is useful, it is also limiting in its ability to explain the whole process of engagement in clinical consultations between general practice health professionals and women who experienced domestic violence. The model does not allow for explanations of the process of non-engagement. Findings from this study indicate that engagement is not fixed or linear, but fluid, and variable. In other words, strengths of engagement and styles of interaction toward successful engagement can fluctuate leading to a process of engagement or non-engagement. Therefore, an alternative model of engagement and non-engagement is advised (see Figure 9.2) to illuminate the ongoing and iterative process of both in complex circumstances of conspicuous invisibility.

CONSPICUOUS INVISIBILITY



[Non] Engage – meant – [not] looking
[Non] Engage – meant – [not] seeing
[Non] Engage – meant – [not] asking
[Non] Engage – meant – [not] telling

[Non] Engagement
is a
PROCESS
that
[dis] (en)ables

DISCOVERY and DISCLOSURE
of
VIOLENCE AGAINST WOMEN

Figure 9.2: The model of engagement and non-engagement of the discovery and disclosure of violence against women underpinning the theory of conspicuous invisibility

The model illustrated in figure 9.2 presents an overview of the complexities of engaging and non-engaging with the discovery and disclosure of violence against women. Substantiating the process of engagement is the middle range theory of conspicuous invisibility where health professionals are present ('being there') in consultations to see patients, but are not looking for, are not seeing and therefore, are not present ('not being there') to engage with a woman's circumstance of domestic violence. Conspicuous invisibility is also an account of women's ability or opportunity to disclose an abusive relationship or not (discussed further in this chapter in levels of engagement). In other words, successful engagement toward building a therapeutic alliance (Staudt 2007) is much more than a clinical encounter; it is about making connections between signs and symptoms and the narratives of the circumstances of both. Successful engagement is also about the other – how women (bringing with them the complexity of themselves and their environment) relate within the overall process of engagement. Clinical encounters are complex circumstances, they need to provide opportunities for discovery and disclosure, which include personal willingness and capacity, and an enabling social and physical environment that enhances engagement. The complex social and physical environment of violence against women, as well as the complex social and physical environment of general practice, underpins the conspicuous invisibility of domestic violence specific to a general practice setting. The association between socio-cultural factors and engagement patterns in clinical interactions was also noted by Simmons-Mackie and Kovarsky (2009). Thus, an understanding of the capacity and willingness of the health professional and the woman to use the clinical encounter toward a therapeutic alliance of successful engagement, where issues of domestic violence are either discovered, or disclosed, is critical.

In summary, the theoretical model of conspicuous invisibility presents a sequence of actions to illuminate understanding a process of engagement and non-engagement thus, the model

enhances our knowledge and understanding of the relationship between visibility and invisibility, and the disclosure and non-disclosure of sensitive issues within general practice. These actions are illustrated in Chapter Six, where examples relating to invisibility are identified in the choreography of the consultation through a process of visual engagement (or not) through reading the person and the environment.

In Chapter Seven, examples relating to invisibility include health professionals non-discovery and women's non-disclosure illustrated through methods of strategic and cultivating silencing. In Chapter Eight, conspicuous invisibility occurs where the medical model focuses on clinical diagnosis and treatment but not on seeing beyond the illness profile of the woman. The next section explores levels of engagement relevant to this study.

9.5 Levels of engagement

This study conceptualised three levels of engagement in clinical consultations, described as: level one, non-engagement; level two, first impression engagement and level three, purposeful engagement. While each level can stand independent of each other, engagement between the three levels is an iterative process. Participants may be more inclined towards one level than another, depending on predisposing factors such as time, understanding, level of comfort with the issue, workload, or opportunities to enquire/disclose during the consultation. Engagement is about being willing to see and speak, during the clinical consultation, about the circumstances of violence against women. The processes described in this study concur with those of Simmons-Mackie and Kovarsky (2009) who stated that during social interactions participants demonstrate levels of engagement via various signals, including both spoken and unspoken signals. The process of engagement is deeper than gazing, as it takes into consideration the visual and cognitive (Lequerica and Kortte 2010); it is a process that involves being motivated to move beyond the mechanical tasks of the

consultation, toward a labour of wanting to know and taking risks to know - a willingness to lift the stones and see the slugs beneath. The notion of uniqueness within the consultation is critical to successful engagement for, as others have found, in trying to understand the significance of violence against women (Natan and Rais 2010) and accepting the need to engage and communicate with patients (Taylor et al. 2013), health professionals can overlook the unique needs of patients (BurrIDGE et al. 2011).

Critically, successful engagement in general practice consultations moves beyond observation alone; it requires knowing the woman (as in this study) by developing what Hudon et al. (2013) described as a partnership toward enablement between patient and family physician. Through “demonstrating engagement” (Ibid:4) within the partnership, the needs of patients with chronic conditions were identified. Evidence from this study illustrates that engagement is demonstrated when the invisible becomes conspicuous and is acknowledged within the consultation. Women were enabled to disclose their circumstances of abuse when health professionals asked about the matter. The process of developing a partnership involved recognising the uniqueness of the other and employing a level of intuitive knowing that gazed toward seeing the unseen, or barely visible, and hearing what is often not articulated, but maybe gestured. While engagement in such circumstances can be both cautious and tentative, in that dealing with the uniqueness of the other takes the health professional beyond the comfort space of a medical model of health care, women in circumstances of domestic violence do have an expectation that general practice health professionals will engage toward enabling the discovery and disclosure of their abusive relationships.¹⁰⁸ In other words, they want the invisible to be conspicuous. Conspicuous invisibility is also about what is obvious

¹⁰⁸ Difficulties experienced by health professionals, in this study, in addressing the matter of violence against women concur with the finding of (Usta et al. 2012) and (Taylor et al. 2013).

(health professionals' presence and the woman's presence), but what is not easily recognised (women's circumstances of abuse and the limitations of the medical model of practice). The theoretical model of conspicuous invisibility (see Figure 9.2) is underpinned by three patterns or levels of engagement which occur at different times and to varying degrees. These levels are described in the next sections: Level one, non-engagement; Level two, first impression engagement; and Level three, purposeful engagement.

9.5.1 Level One: Non-engagement

Non-engagement describes a reluctance, or absence of effort, during a general practice consultation, to address the subject of violence against women. Being reluctant to engage can be a consequence of being closed, or oblivious to the possibility that domestic violence might be an issue. In other words, the subject is not part of the cognitive process associated with what might or might not be a diagnosis. A reluctance to engage can also reflect an unwillingness "to go there", because going there, in circumstances of violence against women, would involve being ready and willing to listen to sensitive issues¹⁰⁹ being prepared to delve into the issue and to search around for clues, and finally, being available to women to do something for them. Non-engagement can occur when parties to a consultation deem it inappropriate to consider discovery or to disclose circumstances of domestic violence due to the status of the role of the other within the general practice setting (in the case of this study, the practice administrator).

¹⁰⁹Reluctance to engage with the emotional and social needs of patients living with psoriasis (a conspicuous skin disorder), evidenced in a "mismatch between the impact of psoriasis on daily living for patients and the failure of practitioners to engage with its management" was reported by Nelson et al. (2013:359). Of interest is the failure to see the emotional and social needs for these patients, suggesting that as with the findings of this study, engagement beyond a medical model of cure and repair is difficult for GPs.

A reluctance to engage is also about choice, where some women, chose not to engage; where they took a stance to remain private about their circumstances of experiencing or living in an abusive relationship. This style of reluctance was planned; it involved a conscious effort to remain silent and not to disclose circumstances of abuse. Kenny (2011:176) articulated the reality of the complexity of choosing to tell or not to tell:

There are occasions when the pain of past events is simply too searing to acknowledge and so people deny, even to themselves the reality of their experiences.

In this study, women's decisions to conceal their situation, contributed to the invisibility of their reality. This stance was not influenced by the dynamic within the consultation, in the sense of feeling a balance of power toward disclosure or non-disclosure. Rather, decisions not to engage were influenced from beyond the consultation where women had learned to cultivate silence about their circumstances as a way of protecting themselves and others.

Choosing not to engage with their experiences of domestic violence was a form of empowerment, of keeping an image of the self (albeit a misleading one) and keeping out of sight particular happenings in their lives. In other words, women took a position of conspicuous invisibility by not exposing a side of themselves they did not want the other to see. Such tactics may be likened to Goffman's (1959) notion of impression management strategies where concerns over the presentation of the self and identity determine how the person is read or understood. Women exerted their own authority and power from within, and in so doing, demonstrated at least some existence of power in their lives. In other words, their strategies embodied the notion that "power only exists when it is put into action" (Foucault 1982:788).

Non-engagement is a complex process involving issues of loyalty, self-protection, power and confidence. For women in this study, loyalty was essentially about a feeling of duty to another and to the family. It involved a strategy toward suppressing evidence of her real situation in an attempt to portray an appearance of normality. In other words, there is a

conspicuous invisibility in the presentation of the public self and how it was experienced as the private self. The conspicuousness of normality was a front for what lay beyond the invisible but all too real fear of what might happen if silences were broken. Putting forward one's best protects the self in terms of others - partner, children, community and health professionals. The association between the presentation of the self as "one's best" and the protection of others concurs with the findings of Knickmeyer, Levitt and Horne (2010). Goffman's (1982) notion of 'saving face' is also illuminating here. The ritual of saving face is principally about projecting a particular image of the self to the other. Saving face is a useful concept to describe what Pollock (2007) referred to as the social etiquette of communication between patients and health professionals, conceptualised in this study as a performance demonstrated through the iterative process of choreography, and within the choreography of non-engagement, a politeness for saying little or nothing and of asking nothing.

The notion of self-protection implicit within women's presentation of their 'best self' was mirrored somewhat by health professionals sense of oblivion to the potential of hidden issues such as violence against women (identified in this study as "not on my radar"), their sense of a professional self and their need to protect their professional image. Just as the women desired to save face, health professionals were fearful of losing face, of being out of their depth, manifested as a concern about not being able to deal with the issue of domestic violence should it arise, as well being unable to deal with the anticipated emotional state of the woman. Thus, the notion of oblivion needs to be considered in terms of self-protection. Self-protection is also about maintaining a sense of confidence within one's role, where the risk of engagement toward discovery is associated with acknowledging potential incompetence, of either not knowing, or not having the capacity to do something about it. These findings surrounding the notion of self-protection, discomfort and reluctance to engage

with the issue of violence against women are reflected by nurses in primary care (Sundborg et al. 2012; Haggblom and Moller 2006; Lynch 2006), nurses and physicians in family practice, emergency medicine, obstetrics/gynaecology and public health (Gutmanis et al. 2007). Thus, like women, health professionals' process of non-engagement was a protective technique, to avoid issues perceived as emotionally challenging or potentially confrontational. Hence, they were agreeable partners in the choreography of non-engagement.

Non-engagement was also about distancing oneself from potential discomfort around emotional issues, a fear of misjudging another and a fear of being judged by another. Health professionals' engaged patterns of distancing, out of fear of insulting the woman and to avoid getting it wrong. Their sense of the professional self was in being accurate in their diagnosis, while their sense of the personal self was to distance themselves from the emotionally charged nature of the doctor-nurse-patient relationship in circumstances of domestic violence. Likewise, Beynon et al. (2012) have reported on the complexity of the emotionally charged nature of professional-patient relationships in circumstances of intimate partner violence. Women's strategy of distancing was a strategy of avoidance or side-stepping being labelled as a 'victim' of abuse. In essence, strategies of distancing employed by women allowed for a sense of self as a "thrivers," of succeeding in circumstances of adversity, of being in some sort of control. Distancing also protected the emotional self and allowed for a sense of denial around the harshness and brutality of their circumstances. The corollary of non-engagement was engagement and with it the naming of their circumstances; which some did not acknowledge. Findings from this study in relation to patterns of distancing as strategies for coping emotionally are supported in the research literature on hospital nurses (Schulz et al. 2011). Noteworthy here is Menzies (1960) original work on detachment and denial of feelings as learned behaviours toward "minimising mutual interaction" (p102) and protecting and maintaining professional independence by student nurses. Similarly, women and health

professionals in this study were minimising mutual interaction as part of a strategy of self-protection and, in so doing, they engaged a choreography of distancing and in some circumstances oblivion.

Conspicuous invisibility is bound to self-protection, where the emphasis is on portraying normality in either clinical consultations, or in women's lives, through a process of non-engagement with matters of discomfort, those perceived as causing discomfort or those viewed as breaching loyalty. Furthermore, the theory of conspicuous invisibility highlights what Kvale (2006:483) terms "power asymmetry" within the clinical consultation; that is where women decide who to tell and health professionals decide who to ask about violence against women. The asymmetry of non-engagement is closely aligned to the notion of selectivity and the discernment of one's needs - for women, fear for the self and for others, as well as maintaining a sense of self, and for health professionals, fear for a sense of self and other, as well as maintaining a sense of the professional self.

The notion of self-protection is illuminated by Goffman (1982:12), where he argued for a moral right to protection and to avoid hostility:

He may want to save the others' face because of his emotional attachment to an image of them, or because he feels that his co participants have a moral right to this protection, or because he wants to avoid the hostility that may be directed toward him if they lost their face. He may feel that an assumption has been made that he is the sort of person who shows compassion and sympathy toward others, so that to retain his own face, he may feel obliged to be considerate of the line taken by the other participants.

Choreography in the context of the protective self is a dance of the unspoken message, where, rather than drawing attention to their situation, health professionals and women engaged in a choreography of avoidance, or what Goffman (1982:13) termed "a repertoire of face-saving practices." Once a person chanced an encounter, toward an attempt at engagement, other avoidance practices or defence measures emerged. Such practices involved steering clear of topics or activities that could lead to the expression of information that might threaten the line

of self-protection. Essentially it was a choreography of avoidance, a process that is illuminated by the following quote from Goffman (1982:41)

Much of the activity occurring during an encounter can be understood as an effort on everyone's part to get through the occasion and all the unanticipated and unintentional events that can cast participants in an undesirable light, without disrupting the relationships of the participants.

Goffman (1982) proposed that each person, subculture and society seem to have their own characteristic repertoire of face-saving practices. Evidence from this study describes a repertoire of face saving practices in the doctor- nurse-patient relationship in circumstances of the complex and sensitive issue of intimate partner violence. These include a choreography of steering clear of the other, of not looking at the other, or the avoidance of direct questions in response to cues and selective narratives.

The corollary of face-saving practices and self-protection is risk taking, which are a key element of the therapeutic relationship (Eusden 2011). Risk taking challenges health professionals; it involves moving beyond one's personal fears of being misjudged, or of getting things wrong, toward a wisdom of discernment that allows one to openly engage, both deliberately and opportunistically, with difficult and sensitive issues - in the case of this study the substantive issue of violence against women. Risk taking toward open engagement with the other was also necessary for women, where the legitimisation of their circumstance of domestic violence was necessary in order to receive help and support, including, legal, social and medical. While non-engagement and self-protection are principally disempowering, albeit with tenets of perceived power, risk taking toward a more open style of engagement is a move toward a more distributed economy of power, both within the doctor – nurse – patient relationship and within the relationship of the woman with herself. Bjorklund (2004:112) noted, “those placed with the power and authority to represent or make claims for others can render the knowledge of others unintelligible, trivial or, worse yet, invisible.” Findings from

this study suggest in circumstances of domestic violence that power can be social, where women seek to protect others, or within the doctor-nurse-patient relationship where the legitimacy of one's circumstance is afforded by a diagnosis.

The theory of conspicuous invisibility that emerges in this study finds resonance with the findings by Cunningham, Silvia and Cheatham's (2007) of the experience of invisibility by Black staff¹¹⁰ involved in academic research at predominately White universities, USA. The experience of being invisible was one of not being considered or, of not being seen, or valued, in the workplace:

People see all around them; yet they somehow see through and miss the individual standing or sitting directly before them, as if the individual is not there at all. Some of the Black staff participants in this study who felt invisible likewise felt that their contributions did not matter (Ibid:68)

Similarly, in this study, women's experience of non-engagement underpinned circumstances of conspicuous invisibility within the choreography of the general practice consultation, by not being seen or understood as a woman in an abusive relationship and by not being given an opportunity to engage with the matter. Likewise, some women can be in an abusive relationship and were not always aware of it. Circumstances of conspicuous invisibility, regarding a woman's understanding of her relationship of abuse, can also mean that engagement is problematic, since engagement about one's circumstances implies some level of self-labeling as a victim of abuse. Labelling oneself by disclosing chronic illness was noted by Charmaz (1991). She reported on how reluctance by people with long term illness to disclose their illness circumstances, was seen as a risk because participants were forced to "acknowledge hardships" (Ibid:116). Resistance to self-labelling has been recorded by Rodriguez-Franco et al. (2012) in their study of dating abuse amongst Spanish adolescents while Barter et al. (2009) reported on a study of 14 year olds' experiences of partner violence

¹¹⁰ The authors use the term Black staff to describe the participants of the study. Black researchers on the team conducted in-depth interviews of Black university staff employees.

in the United Kingdom and their normalisation of violent behaviour. The employment of strategies toward concealing circumstances of abuse as part of a pattern of non-engagement concur with the findings of this study-namely, acceptance and strategic silencing (see Chapter Seven sections 7.2.1 and 7.3 respectively).

In summary, non-engagement during a clinical consultation is about reluctance or inability to engage, or a choice, not to engage with the issues of violence against women. Level one, non-engagement is one of the key elements of the theory of conspicuous invisibility which explicates the dynamic of discovery (or not) and disclosure (or not) of domestic violence within the general practice consultation. Non-engagement is supported by principles of protection - protecting the self, protecting the other and protecting one's professional image. Non-engagement is part of the totality of "engagement" and how it needs to be understood in order to explore the process of discovery and disclosure, of violence against women. The next section will explore level two engagement, a style of clinical engagement, which I term 'first impression engagement'.

9.5.2 Level Two: First impression engagement

First impression engagement is a style of clinical consultation where the focus is on conducting clinical procedures or addressing physical ailments. Failing to grasp opportunities to explore potential underpinning issues, leading to the reason for the clinical procedure, means circumstances that are not physical in nature can be missed. First impression engagement supports the theory of conspicuous invisibility where this style of engagement addresses issues presented 'on the face of it,' while at the same time, ignoring (wittingly or unwittingly) underpinning and potentially pertinent factors, which could illuminate a women's true circumstances of domestic violence. First impression engagement is essentially superficial where the chief complaint, or reason for the visit to general practice, as stated by

the patient and visible within the consultation, becomes the dominant focus, in other words, where the medical story becomes the (my emphasis) story¹¹¹. First impression engagement focuses on the seemingly obvious symptoms and misses the cues and signals of deeper and more complex issues. It involves going on appearances, but not adequately seeing or reading the person for underlying complex circumstances that may be camouflaged or may not be overtly present. This process of engagement equates with Olivola and Todorov's (2010:315) notion of "appearance based inferences" which describes a process where, relying on appearances, one can be "fooled by first impressions" which, in turn, can be detrimental to sound judgment and decision making.

Further illumination of first impression engagement and the process of conspicuous invisibility are possible by drawing on Foucault's (2003) notion of the clinical gaze. The use of the clinical gaze indicates ways of knowing and perceiving a particular stance toward the world (Lawlor 2003). The clinical gaze clarifies what we observe, monitor and survey in clinical consultations. On this basis, the clinical gaze (Foucault 2003) in first impression engagement is instant, and is based on the duration of the consultation, which may in fact, be an observational gaze:

The observing gaze refrains from intervening: it is silent and gestureless. Observation leaves things as they are. (Ibid:131).

Gazing and reading the woman without 'delving' into the underlying reasons, for the consultation, is a process of superficial interpretation. While knowledge generated through the gaze is essential to inform the direction of the consultation, gazing in a consultation that is conducted at a level of first impression engagement (conspicuous issues only), which does not explore underpinning issues is limiting. It does not enhance discovery of the nuances of

¹¹¹ Within a clinical setting Frank (1995:58) argues that until recently the medical story was considered to be the story.

invisible or silent issues, such as violence against women, as evidenced in this study. My findings demonstrate how seeing and not seeing, and medicalising in consultations, within a clinical lens can dominate consultations, but dominate without understanding women's circumstances of domestic violence.

According to Malterud (1999) visual and auditory perceptions are limiting in the absence of listening to the voice of the patient, which suggests, as did the findings of this study, that in the absence of listening, cues or signals are likely to be missed. Hence, interpretation is a complex process of listening to and hearing voice, cues and signals; it is beyond what is possible in an 'on the face of it' or first impression engagement. Deducing women's circumstances of abuse are dependent *inter alia* on health professional's awareness and insight, and their ability and capacity to move beyond a first impression engagement.

First impression engagement in general practice consultations is problematic as it foregrounds a biomedical discourse where, according to Van Roy, Vanheule and Deveugele (2013), the language is usually technical, disease focused and relates to a medical world, rather than taking the necessary biopsychosocial¹¹² approach. Technically driven consultations emphasise conducting procedures or in the words of Iedema et al. (2006:1607) the "technical-instrumental objective." In this study, the task of seeing patients in ten minute slots was a factor for general practitioners, while practice nurses spoke of the tasks associated with their role in providing a service to women within the practice. Women spoke of attending general practice to have something 'done' to them and although they wished to "be

¹¹² The biopsychosocial model of medicine includes assessment of the psychological or social dimensions of health. This approach requires a change from the biomedical to the biopsychosocial model "which takes into account a wider spectrum of the factors influencing health and the healing process and, in turn, demands greater knowledge and time investment. The holism of the biopsychosocial model requires a style of patient-doctor relationship, which enables, among other things, the doctor's attention to the patient's psychosocial circumstances, in order to better manage his or her situation, and not only his or her illness."(Alonso 2004).

seen” they too got into the rhythm of the task, from reading the busyness of the waiting room to collecting repeat prescriptions, A consequence of communication toward the completion of a task is that interaction becomes service driven and does not extend beyond the procedural requirements of the patient. Women found it difficult to share their experiences of domestic violence in this environment, a finding which concurs with that of Beynon et al. (2012).

Where first impression engagement is the style of consultation, women who experience domestic violence are viewed from the perspective of their medical reason for attending the practice. The emphasis of the clinical interaction then focuses on solving the medical problems, screening for disease or biochemical abnormalities. Consultations which foreground a biomedical discourse are problematic as they do not consider the social predicament, which is critical if women are experiencing domestic violence. However, attempts to solve bigger problems can only occur once they are discovered or women are enabled to disclose their concerns. Although the conspicuous problem may be identified, communication in the consultation does not extend to include invisible or social issues. Consequently engagement is insufficient to see beyond the “impression management” (Goffman 1959) of the “best self” (this study) or, to use a phrase from Barsky (1981:494), “non-biomedical reasons may be explicit or they may be hidden behind the mask of physical complaints.”

A consequence of first impression engagement, in circumstances of violence against women is the potential for classification in what Parsons (1975:262) described as the sick role¹¹³. He conceptualised three criteria for accepting the social role of being sick. Firstly, “being in a

¹¹³ While classification within the sick role is problematic, women in abusive relationships, who may not be affected by an illness, may need medical support either for treatment or to an injury. In addition they may need medical assistance to enable disclosure by clinicians enquiring about domestic violence. Furthermore, they may need an illness label and medical certification to aid their legal rights. Only a physician has the power to authorise the sick role.

state of illness is not the sick person's own fault.” Secondly, “a social-structural feature of the sick role is the claim of exemption from ordinary daily obligations and expectations, for example, staying at home in bed instead of going to school or office.” Thirdly, “if the case is sufficiently severe, it is legitimate to seek help from some kind of institutionalised health service agency.” According to Parsons the role of the doctor is to legitimise the patient as actually sick and hence, his/her entitlement to the ‘permissive’ aspect of the sick role (Frank 2013). However, legitimacy within the sick role requires an underlying medical condition, which in circumstances of domestic violence is problematic, as it will reflect the conspicuous or visible, but not usually, or not at all, the invisible reality of what is a complex social issue. Thus, while women in this study did seek and received help from general practice services, including treatment for associated conditions, as with the findings of Hegarty et al. (2013ba) the response was not always what was needed. The conspicuous was treated while the invisible remained invisible.

The theory of conspicuous invisibility illuminates how even when women frequently attend general practice for medical consultations, their narratives of abuse are not explored beyond the medical model that emphasises a diagnosis or label, and the task, toward treatment and a cure. Where women’s stories of abuse are pathologised into a medical discourse, or a sequence of medical terminologies, the potential, for some, is to personalise their symptoms; for example, being known as “the ache¹¹⁴.” Hence, in circumstances of ‘on the face of it’ engagement women defined themselves by their physical symptoms and health professionals know them based on the clinical treatment they provided. Furthermore, where non-medical conditions are addressed with medical language and medication, the process of engagement becomes a medical one of treating women (in this study) as if they have an illness. According to Parsons (1975) the “institutionalisation of the sick role” is a measure of being ill; “if it is

¹¹⁴ Due to frequently attending the practice and the repeated presentation of her symptoms, Ruby felt that she was known as “the ache” by the staff in the surgery.

genuine and not malingering” (p259), that is, where it is a real observable illness and not one that goes beyond physical conditions. Vague symptoms, on the other hand may be disputable. Thus, a problem with first impression engagement is the potential to label one as sick or ill, to misread or dismiss vague symptoms and consequently to think no more of the potential biopsychosocial dimensions of the circumstances of the woman’s need for a general practice consultation.

Further illumination of the limitations of what I term first impression engagement is offered by Frank (1995:5) in what he terms the ‘*modern*’ [original italics] experience of illness. According to Frank (1995) one of the dangers for ill people is that they are often taught how to be ill by professionals. Indeed, as this study has shown, one does not need to be ill, but to be considered ill, to be treated as if an illness exists and to learn how to be ill (ref notion of becoming the ache above). Domestic violence is not an illness, yet evidence from this study illustrates how women frequently attend general practice consultations as patients and, while not having their unseen needs met, their choreography was clinically structured by the need for regular prescriptions, medication and a requirement to attend the surgery often. First impression engagement is problematic; it leads to women being seen as requiring treatment but, without the discovery or disclosure of the invisible abusive relationship, without the underpinning aetiology of their circumstances being known. The choreography of the consultation is performed by addressing the obvious but not exploring the hidden. Others (Morris et al. 2012; Salmon et al. 2004) reported similar findings where patients presenting for general practice consultations with vague or medically unexplained symptoms were more likely to have their symptoms legitimised by a medical diagnosis and treatment, but without having the opportunity to discuss psychological issues. Critiques of the limitations of the medical model are not new; for example, Balint’s (1969) appraisal of the medical model and

its need for change, including the issue of understanding patients over time and addressing their emotional and psychological problems, was first published in 1957.

Findings from this study illuminate how the compartmentalised structure of general practice consultations and the dominance of the medical model foreground first impression engagement and impede opportunities for understanding. Taking things at face value is essentially about focussing on the conspicuous and being satisfied that there is nothing else to be addressed. However, as the findings of this study demonstrate the conspicuous can be underpinned by the invisible, manifested in women's presentation of physical ailments such as an earache. Furthermore, circumstances of the conspicuous – physical disease, are closely aligned to psychological wellbeing (Davidsen 2010; Barsky 1981), regardless of the circumstances initiating a general practice consultation. Thus, 'on the face of it' or first impression engagement is limiting at best and ineffective at worst when seeking to discover or enable women to disclose circumstances of domestic violence. Much of health professionals' time is absorbed in conducting procedures, illustrating the prominence of the medical model in general practice. Exploring women's circumstances, which can be invisible reasons for the clinical interaction are not easily discovered.

Clinical interaction, on a level of first impression engagement, contributes to the maintenance of silence about circumstances of domestic violence. In other words, attending to the conspicuous may prompt further invisibility. Foucault (2003) provided a critique of medicine that can further illuminate the element of first impression engagement within the theoretical framework of conspicuous invisibility. What he proposed as the antithesis to the confined body of techniques for curing ills and the knowledge of disease and illness, a move toward a practice of medicine that would embrace knowledge of the *healthy man*, and a study of the

non sick man [original italics], is essentially about moving from the conspicuous (what is known, familiar, comfortable and what health professionals are trained for¹¹⁵ to the invisible (the other, the unfamiliar, the shared experience).¹¹⁶

Findings from this study demonstrate that women's experiences of abusive relationships are on-going: they occur over time. A consequence of first impression engagement and the non-discovery of domestic violence is that women do not disclose their experiences of abuse in the clinical choreography. Disclosure was not a once off single event for women but a process where they planned for an opportunity to make known their situation, or, where an 'a emotional outburst'¹¹⁷ created an opening for disclosure. Disclosure was a slow process often taking very many visits and over many years, a circumstance of disclosure also noted by MacNeil et al. (2004, referring to Henderson 1997). Findings in relation to the time and manner in which women disclosed within the general practice consultation (and some never did) further supports the limitations of first impression engagement. First impression engagement is not just a once off event, but rather a style of engagement that can occur over an extended period of time. For example, in this study¹¹⁸ women recalled doctor-patient relationships (including interactions with the GPT) extending in excess of twenty years where, despite frequently offering cues and signals during their repetitive visits, the discovery of domestic violence did not occur, nor were women enabled to disclose their experiences of abusive relationships. What was conspicuous to women, that is, their personal circumstances

¹¹⁵ Persaud (2005:276) argued that much of medical training is about how to deal with "things" rather than how to cope with people, or what Macnaughton (2011) described as a highly positivist view of medicine.

¹¹⁶ Evidence from health psychologists and mental health services working collaboratively in primary care show both physical and mental health problems are better addressed, due to sharing knowledge (Thielke, Thompson and Stuart 2011). (Integrating purposeful behaviours to discovering violence against women are discussed in level three engagement, see section 9.5.3).

¹¹⁷ This refers to Coral's comments about having an "emotional outburst" and becoming upset in the waiting room of the surgery prior to attending the GP.

¹¹⁸ Findings from this study identified that some women in abusive relationships visited general practice weekly over a twelve month period amounting to approximately 50 visits to the surgery per year.

of domestic violence, remained invisible to health professionals, due to patterns of the medical model, which focuses on clinical matter; the absence of opportunities to disclose and, for some women, their decision not to disclose.

When patterns of first impression engagement become engrained as a routine style of consultation, breaking the silence and moving from the conspicuous toward making the invisible visible becomes more difficult. Findings indicate that it is health professionals that need to make the move toward enabling disclosure, even in circumstances where women fear breaking their silence. Coupled with women's fear is a desire to disclose but they need to be helped to do so, a finding that is supported by others (Spangaro, Poulos and Zwi 2011; Taket 2004; Belknap and Sayeed 2003; Bradley et al. 2002). More than asking about the issues, women want health professionals to initiate enquiring, for reasons of loyalty and self-protection:

It is not enough to simply wait for women to disclose violence on their own. Experience has shown that many women are willing to talk about violence, but it is usually necessary for health personnel to take the initiative and open the discussion.
(Women's Health Council 2007:23)

To summarise, level two - first impression engagement focuses solely on clinical reasons for attending the general practice consultation. Physical reasons, discovered by health professionals or disclosed by women are prioritised and set the agenda for the consultation. 'On the face of it' or conspicuous clinical issues are dealt with, but without exploring beneath the surface. Engaging with clinical issues is limiting, particularly in circumstances of domestic violence where they are underpinned by complex social phenomenon usually unacknowledged in consultations. The complexity of first-impression engagement is illuminated from a theoretical perspective of conspicuous invisibility where a dominant medical model of health care both legitimises and provides entitlement to the permissive aspect of the sick-role. In other words, being sick foregrounds the conspicuous while not necessarily exploring beyond what lies beneath the surface or any unseen reason for the

consultation that may not be readily witnessed. First impression engagement is enabled by structural and procedural processes within the general practice setting and by women's reluctance to make visible, without being asked, the invisible circumstances of their experience of domestic violence.

Both level one and level two styles of engagement are essentially non-engagement, at least when it comes to reading and seeing circumstances beyond the visible surface. However, these processes of non-engagement are not stationary. While non-engagement, or first impression engagement, can be an iterative process of repeated steps of not seeing and failing to acknowledge circumstances of domestic violence, other processes within the choreography of communication, they can allow for a movement toward what Sheridan et al. (2012:1) refers to as respectful listening and questioning. Viewed within a theoretical perspective of conspicuous invisibility this final process is described as purposeful engagement.

9.5.3 Level Three – Purposeful Engagement

Purposeful engagement describes a process of communication where hidden depths and aspects of the patient's experience that are not immediately obvious, are explored. This style of engagement involves a process of seeing beyond the obvious or the description of symptoms and experiences. It requires enquiry beyond the cursory toward a detailed and meticulous quest to identify the complexity of issues associated with sensitive health circumstances such as domestic violence. Level three engagement involves health professionals making connections between clinical presentations and possible underpinning covert reasons for a general practice visit, toward an awareness of the true reasons for a consultation. In circumstances of domestic violence, level three, or purposeful engagement involves a shift in perception by women where the role of the health professional is seen beyond a clinical role within a medical model toward an understanding of the health

professional as someone to whom she can tell her story. Through a process of disclosure of experiences of abuse, the dynamic of engagement between women and health professionals changes to one of awareness, knowing and seeing with understanding. Knowing in this instance, is a process whereby health professionals reflect on how they frame their consultations, engage with what they know and enable women (in this study) to disclose, so that they can support women in abusive relationships. Critical to knowing from a Foucauldian perspective, is the link between knowledge and power. Power in this sense is linked the with production of truth, a truth to the self:

Power cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it. (Foucault 1982:783)

The concept of knowing, emerging from this study involves reading the person beyond visual appearances, beyond the sick role Parsons (1975), outlined in level two engagement, and extending the discourse to developing connections between what is and is not presented. Purposeful engagement is about connecting the invisible to the conspicuous, it is a level of communication that illustrates empathy, recognition and meaningful understanding. It begins a process of communication that engages with appearance - making visible the invisible, rather than going by appearances and missing what lies beneath-conspicuous invisibility. Engagement at this level is about lifting the stones to see the slugs beneath and, in so doing, indicates the commencement of a process of focussed and decisive communication. The findings in this study illustrate that women accepted and wanted to be asked about their intimate relationships; they welcomed the opportunity to discuss in an upfront and direct manner where seeing with understanding occurred as identified in the findings. Health professionals' belief of causing insult was in direct contrast with women's desire to engage. Taking a conspicuous approach to name the situation and being up front removed the invisibility and/ or the secrecy associated with the issue. The findings of this study are

consistent with other international studies which found that women want health professionals to break the silence by purposefully engaging with the substantive issue of abuse and do not see such questioning as offensive (Taylor et al. 2013).

In circumstances of purposeful engagement, two people (in the case of this study the health professional and the woman) begin circling around each other to engage in what Armstrong (2002) describes as a process of “mutual constitution.” Mutual constitution in this study denotes a reciprocal method of organising consultations or, preparing for the clinical interaction where actions and behaviours support the doctor-nurse-patient encounter in general practice consultations to enable the discovery and disclosure of women’s circumstance of domestic violence. In this regard, acts of seeing evolve into actions of asking, discovering and disclosing.

Essentially, purposeful engagement moves beyond the observational stage of the consultation, as in first impression engagement. Instead, and regardless of whether there is evidence of abuse, or not, the silence is broken and women are asked about circumstances of domestic violence. It involves what Naef (2006:146) describes as “bearing witness [and] being present and attentive to the truth of another’s experiences.” It involves a technique of “conscious identification” (Korner 1993:115) to demonstrate empathic skills by attempting to place oneself in the patient’s position. Styles of conscious identification in this study included both direct and indirect questioning: “How is the relationship?” and “Would you like to tell me anything else?” Communication at this level, involves being aware, being reflective and being prepared to give support following disclosure. Rather, than taking at face value the context of the consultation, the choreography of purposeful engagement is both reflective, by standing back and considering the content of the interaction and exploratory, by analysing the details further. Findings indicate that once women disclosed, health professionals’ attitudes

changed to one of knowing the woman's situation. They consciously identified with her circumstances and the context of the consultation changed to one of empathetic engagement. Women responded when health professionals engaged with the issue of domestic violence (illustrated in the findings as seeing with understanding), extended the length of consultations, and offered referral to support services. A mutual knowing occurred when the invisible circumstances of women's experience of domestic violence became visible, they were enabled to make conspicuous their circumstances of abuse, and in doing so, health professionals were also conspicuous in understanding women's experiences of intimate partner violence.

Purposeful engagement, in circumstances where there is "something to show" through the presence of injuries, was a two way process. For women the invisibility of their situation became visible, initially to the self and then to others. In essence, the conspicuousness of their injury and their need for medical attention compelled a move toward disclosure and hence toward purposeful engagement and visibility. Their sick role was validated; it was "genuine and not malingering" (Parsons 1975:259). However, they needed to be seen as more than a patient with an illness or a set of symptoms to declare (Frank 1995). While the clinical lens of the medical model was necessary in these circumstances, so too was the extended lens that could ask the question, "would you like to tell me anything else?" The asking of such questions, allowed for a consideration of the social circumstances of the conspicuous; it provided an opening for making visible the invisible. Thus, while the silence was broken in the presentation of the injury by women, purposeful engagement involved not just breaking the silence but also activating the next steps of communication. These steps were identified in the findings as naming the matter of violence against women and openly discussing their circumstances of abusive relationships. Purposeful engagement means lifting the stones and examining or, in the case of some women showing the slugs beneath. In such circumstances

the general practice consultation becomes the venue and the process for recognising and acknowledging the conspicuous and making it visible.

The process of purposeful engagement outlined in this reflects the notion of expert practice and proficiency in clinical practice (Benner, Tanner and Chelsa 1997), which involves: being “comfortable with your emotional involvement with patients,” (p17), being able to “read a situation” (p16), the capacity and ability to “recognise changing relevance” (p16) and finally, the capability to “shift one’s perspective on the situation”(p16). Purposeful engagement encompasses health professionals observing and practicing with an extended lens in order to see and interpret the patient’s circumstances at a visual and cognitive level. However, ability and capacity for expert practice, toward purposeful engagement (or not), is not independent of context. Contextual factors, in this study included time management, an individual’s perceived competency to engage and the availability (or not) of education and training in matters relating to circumstances of domestic violence. Contextual factors have also been highlighted by others: time management (Van Roy, Vanheule and Deveugele 2013; McKie, Fennell and Mildorf 2002; Sugg and Inui 1992) the ability to enquire about domestic violence issues (Williston and Lafreniere 2013; Rose et al. 2011) and the need for training (Jaffee et al. 2005; Ramsay et al. 2002; Hegarty and Taft 2001). Purposeful engagement by women toward a process of disclosure was enhanced of necessity:- by either their own need to have an injury dealt with, or the need for medical evidence to support a legal case; or in an unprecedented or ‘an emotional outburst’ moment, attracting attention through the showing of tears and upset; or through empathetic understanding demonstrated in the provision of time to talk in extended consultation slots.

Principally, purposeful engagement allows the dynamics of the doctor-nurse-patient relationship to extend beyond the clinical reason for the consultation, toward a greater

knowing of the patient, or what Liaschenko and Fisher (1999) described as patient knowledge, person knowledge and case knowledge. Although the authors described knowledge and how it is reflected in nurses' methods of working, the model of knowledge is also transferrable to physician's ways of working, as identified in general practice. Case knowledge is akin to the medical model. It is generalised knowledge of physiology, diagnosis and treatment possibilities. Knowledge at this level is "knowing the case" where the individual is the passive object on which the nurse acts (Liaschenko 1997). Evidence of case knowledge occurs in level two engagement (first impression or 'on the face of it' style), where tasks or procedures are completed. Engaging with the topic of violence against women is limited when case knowledge is used to conduct work. In level three engagement, case knowledge is transferred into patient knowledge. "Knowing the patient" occurs with awareness of a patient's biography, marital status, emotional and physical response to treatment (Ibid:25). Patient knowledge is unique to the recipient of care and over time allows nurses to make comparisons between patients receiving care and as a result to recognise atypical responses (Stein-Parbury and Liaschenko 2007). Findings from this study demonstrate that through a process of purposeful engagement to get to know the patient health professionals grew their knowledge of the patient beyond the conspicuous and, in doing so, identified "a map to guide their actions" and their practice (Liaschenko and Fisher 1999:35). Patient knowledge enabled the invisible to become conspicuous through a process of knowing the patient. However, critical to the process of making the invisible visible for women in circumstances of domestic violence was person knowledge, or getting to know something about the person as an individual, with a personal biography (Liaschenko 1997). Where GPs did home visits, as identified in this study, they developed person knowledge through seeing the happenings of women's lives beyond the clinical setting. Practice nurses were not exposed to developing person knowledge in the same way as they only know

patients in the context of consultations conducted in the surgery and not in the patients' homes. The capacity to know women, as persons, beyond patients is limited in general practice, where time and the context of the medical model (case knowledge) dominate. Person knowledge was critical for women also. Firstly, where some women exhibited a persona of themselves, not indicting their circumstances of abuse (due to fear, loyalty to their partner and/or family), and "act[ed] according to his/her own desires" (Liaschenko and Fisher 1999:38), the reality of getting to know the woman as one in an abusive relationship, was not to see the slugs beneath. Secondly, where some women learnt the reality of their circumstances of domestic violence from a therapist (as in this study), the realisation enabled them to develop an awareness about themselves initially, then decide whether to engage (or not) in disclosing their experiences to the GPT.

Knowing the patient enhances the therapeutic potential of the doctor-nurse-patient relationship, but only if knowledge of the patient replaces knowing the patient just as a service recipient (Shattell, Star and Thomas 2007). Findings from this study indicate that a key factor in the development of a therapeutic relationship with women who experience domestic violence is to enable them to tell their story. While time, understanding and skill are critical to the development of a therapeutic relationship (Shattell, Starr and Thomas 2007), none are straightforward in how they might be explicated. For example, an appreciation of the complexity of time involves notions of time beyond frequency and duration. Instead, as findings from this study illuminated, time and its availability within general practice was closely aligned to tasks and an assembly line model for getting things done. Time in these circumstances is about output rather than outcome. In circumstances where time is needed to move from conspicuous invisibility to conspicuous visibility, making the invisible visible is both an output and outcome. In other words, flexibility around the amount of time needed for a consultation (outcome) is as critical as the frequency of

consultations (output). Purposeful engagement is principally about outcome and the process of achieving an outcome, the discovery and disclosure of domestic violence within the general practice consultation. A critical element of purposeful engagement is about hearing narratives. Hearing narratives according to Frank (1995:160) involves providing the space to *allow the story to lead in certain directions* [original italics].

Storytelling requires an interactive audience. Interaction is a key element to purposeful engagement. It involves an ability by health professionals to broach the subject of domestic violence through the extension of an invitation to women to disclose, and where they give time to hear their story, listen with interest and are aware that there is a story in the first instance. Nonetheless, disclosure by women was not guaranteed. However, knowing how to elicit the story or broach the subject¹¹⁹ emerged in this research as a difficulty for several health professionals. Many felt ill-prepared to do so, believing their knowledge and skills in the substantive area was deficient. Thus, it is argued, purposeful engagement is more than the achievement of an interactive audience toward discovery and disclosure, for, as in circumstances of time, complexities relating to skills and understanding are about know-how and know-that, both multifaceted contextual issues for general practice health professionals in relation to education and training (see Chapter Ten section 10.5).

Women used opportunities with an interactive audience to weigh things up and to consider telling their stories (or not). For them, time, meaning an opportunity to disclose (maybe) may not be used as such, but put aside, hoping for an opening on another occasion. Thus, evidence within the literature that patients are ready to “tell their stories when they are allowed to do so” (Undeland and Malterud 2008:226) needs to be reviewed in the light of the findings from

¹¹⁹ Broaching the subject (see Chapter Seven section 7.4.1) was described as health professionals being prepared to ask women questions about the well-being of their relationship, not the details of the relationship.

this study which indicated that in circumstances of domestic violence the notion of readiness to disclose is complex. As well as being enabled to tell their stories by others, women also need to allow themselves to tell their story. In other words story telling is about space within the general practice setting (time, understanding and skills) and space for women (a time, and sense of self, when they are ready to tell).

Principally purposeful engagement toward the discovery and disclosure of domestic violence is a process of development, of getting to know the self, and of getting to know the other-for a woman acknowledging she is in a domestic violence situation, “I need to tell someone” and “I can tell the general practice team”; for health professional, acknowledging that domestic violence is an issue for general practice, that it is hidden, “I need to directly ask about it” and “I need knowledge and skills to do so.” Evidence from the findings demonstrate that in circumstances of a shared narrative and a willingness to delve beneath the surface, and where efforts were made to achieve specific aims, then, a process of purposeful engagement between health professionals and women in abusive relationships followed. Another researcher Charon (2001) described the ability to listen to the narratives of patients and to grasp and honour their meanings as a key component of action on behalf of individual patients.

In summary, purposeful engagement is about being open, being aware and being willing to broach the subject of domestic violence. Key components of purposeful engagement are time, understanding and skills, all of which are complex issues that need to be understood both from the woman’s perspective and the health professional’s perspective. Critically, purposeful engagement is a move beyond non-engagement, taking a protective stance toward the self, and first impression engagement - where the medical history becomes the story (Frank 1995), to a therapeutic relationship of shared interaction toward the discovery and

disclosure of domestic violence. Understanding processes of purposeful engagement from a theoretical perspective of conspicuous invisibility foregrounds the complexity of making visible the invisible, of lifting the stones to see the slugs beneath. In circumstances of domestic violence visibility to the self is necessary first. In other words, women cannot make visible to another without first acknowledging that they are in a circumstance of domestic violence; likewise health professionals can only enable others to talk about their circumstances of domestic violence if they acknowledge it as an issue that is relevant to the consultation. Even in circumstances where physical injury is conspicuous, purposeful engagement is necessary to grasp and honour its meaning, to establish a therapeutic relationship, and to be moved to act on the patient's behalf.

9.5.4 Summary of levels of engagement

The levels of engagement presented in this chapter conceptualise a model of the complexity of engagement toward enabling the discovery and disclosure within general practice, of circumstances of domestic violence experienced by women. Levels of engagement are not linear but rather they involve an iterative process, where persons can transverse between the process of non-engagement, first impression engagement and purposeful engagement. A conceptual model of engagement based on the research findings, illustrates the interconnectedness between the various processes, underpinned by the theory of conspicuous invisibility. Critical to levels of engagement are the dynamics of the clinical interaction between participants, based on an ability to lift the stones and see the slugs beneath. These include women breaking the silence on their abusive relationship, health professionals being willing to broach the subject in the clinical consultation, explicitly showing empathy by reading the person beyond a set of signs of symptoms and investing time in the consultation.

Women's ability to engage with domestic violence issues are enhanced when they are asked about the issues, rather than being expected to take the first step in the dance of disclosure.

9.6 Chapter summary of the process of engagement

This chapter discussed the theory of conspicuous invisibility and presented a model of the process of engagement based on the findings of this study. The use of the metaphor 'lifting the stones and seeing the slugs beneath' illuminates the process of engagement that occurs in general practice consultations. This describes health professionals' ability to discover (or not) and women's ability to disclose (or not), in the course of the clinical consultation, circumstances of domestic violence. A model that presents an overview of the complexities of the process of engagement with the discovery and disclosure of violence was discussed. Engagement is conceptualised into three levels: level one - non-engagement; level two, - first impression engagement; and level three-purposeful engagement, to illuminate an understanding of the intricacies of the process. The major challenge in writing the chapter was not to partition engagement into boxed sections but to present the complexities of the findings as overlapping, multidimensional and interrelated. The study highlights how the flexibility of the process of engagement is dependent on personal and environmental influences.

The discussion focused on the complexities of general practice as a setting for enabling the discovery and disclosure of circumstances of violence against women. In particular, a critique of the limitations of the medical model, including the restricted scope of the clinical lens, as a suitable framework for engagement, was presented. The aim of the study was twofold, to determine: how the general practice team discovered women who experience domestic violence from an intimate partner and, how women were enabled (or not) to disclose their experiences of domestic violence in the general practice consultation. Grounded theory

methodology was used to inform this study. As a consequence of grounded theory, I developed a middle range theory of conspicuous invisibility, as presented here, which illuminated how health professionals are present in general practice to attend to women but do not always see their issues concerning domestic violence. Likewise, women attended general practice clinicians but did not always disclose their experiences of domestic violence. The three level process of engagement presented offers some insights into the strategies used by women and health professionals, in the context of Irish general practice consultations. The concept of conspicuous invisibility provides an important theoretical lens for addressing the key issues within this study.

Chapter Ten: Conclusions, Implications and Recommendations

10.0 Introduction

The aim of this study was twofold: the study provided an analysis of the clinical interaction between the GPT and women who experience domestic violence from intimate partners; and it explored the social process of the disclosure by women and discovery by health professionals of domestic violence specifically within a general practice setting. The methodology chosen for the study was grounded theory and analyses was guided by Charmaz (2006) constructivist approach. In this chapter I draw on Charmaz's (2006:182-183) criteria of credibility, originality, resonance and usefulness to evaluate the contribution of this study to the body of knowledge on processes for the discovery and disclosure of violence against women within a general practice consultation. The implications of the study for clinical education, the limitations of the present study, and the recommendations for future research follow. A review of the thesis chapters situates this, the final chapter.

10.1 Review of the thesis

Chapter 1 set the scene for the study using an excerpt from a novel and outlined the structure of the thesis. Chapter 2 focused on the complexities of defining violence against women. Women's experience of living in a gendered world explored the historical beginnings of bringing domestic violence into the public domain and illustrated how it is an ongoing issue for women today. The merits of screening and case finding tools used by health professionals to discover the issue and enable women to disclose their experiences of abuse were debated. The clinical gaze and the emphasis on how the body part requiring attention predominately determined the contexts of the therapeutic relationship in general practice consultations were discussed. Chapter 3 outlined the methodological approach used in the study, the rationale

for using grounded theory and the key characteristics of the methodology. Chapter 4 mapped the procedure employed in executing this study, including accessing the research site, interviewing participants and the iterative process of data analysis. Chapter 5 presented an prologue to the findings chapter by outlining the theme of lifting stones and seeing the slugs beneath. This theme, which is recurring and weaves throughout the study sets the scene for the findings of the study. It describes how the process of engaging (or not) with the discovery and disclosure of violence against women emerges. Chapters 6, 7 and 8 presented the findings of the study. The findings are the voice of the participants, which were analysed using a process of constant comparative analysis. Analytical categories and concepts from the data emerged to inform how the process of discovery and disclosure of violence against women occurs, or not, specifically in general practice consultations. Each chapter used the conceptual framework of a core category, sub-core category and properties to support the findings. The findings demonstrated that health professionals witnessed women attend for medical consultations but due to factors such as time, workload and unawareness of the signs of violence, domestic violence issues were not discovered. Women were not enabled to disclose the circumstances of their abusive relationships where the emphasis of the consultation was medical or disease focused. The findings demonstrated that women and health professionals mirrored a performance of avoidance of the issues in such circumstances. Chapter 9 revisited the research question and discussed the findings in the preceding chapters. This chapter introduced a middle range theory of conspicuous invisibility. A model of the process of engagement that underpins the theory was discussed where engagement is both person and environment specific. Discussion of the research findings at a theoretical level illuminated an in-depth understanding of the research question.

10.2 Contributions of the study

This study contributes to research in the area of general practice and practice nursing by highlighting how the GPT engage with women who experience intimate partner violence. It also informs an understanding of how women who experience abusive relationships from intimate partners engage with general practice health professionals in the course of clinical consultations. Data in this study demonstrated that engagement is not a linear or a once off event but rather an iterative process involving repetitive interactions between the key actors. Factors both within and beyond the substantive issue of violence against women contributed to the complexities of the process of engagement. These factors relate to the person and the environment¹²⁰ of general practice (see Chapter Nine). The research provides a model for understanding engagement for the discovery and disclosure of violence against women, which underpins the theory of conspicuous invisibility.

This study also shows how the theory of conspicuous invisibility contributed to understanding how the GPT were physically present within the practice and available for the consultation, but not *wholly* present, as in, not looking and therefore not seeing or enquiring about issues of domestic violence in the course of the clinical consultation. Women were also present in the consultation but their circumstances of domestic violence remained invisible, due to not being enabled or not being given an opportunity to disclose their situation. In some circumstances women choose not to take the opportunity to disclose. This contributed to patterns of ongoing invisibility and silence about the phenomenon. Both parties were a

¹²⁰ As a reminder to the reader, some of the factors identified in this study that inhibit the process of engagement include time, workload, and “chaos” in the waiting room, lack of education or training (general practice): fear, loyalty and saving face (women).

conspicuous presence in the consultation but the substantive issue of violence against women remained invisible.

10.3 Implications of the study

This is the first Irish study of its kind, conducted in a general practice setting, to include four cohorts of participants, that explored how the GPT discovered (or not) violence against women and how women attending general practice consultations were enabled to disclose (or not) their experiences of abusive relationships. The emergent theory of conspicuous invisibility has important implications for practitioners, clinical educators and future research. While they are presented in a linear fashion, the implications overlap to some extent.

10.4 Implications for practice and education

The findings identified the complexities of working in general practice where the emphasis is on diagnosing illness and completing procedures or tasks, all within a narrow timeframe. Women's conspicuous reasons for attending the consultation were acknowledged with a clinical lens, an illness framework or the need for repeat prescriptions. This study demonstrated that women's emotional needs remained invisible (wittingly or unwittingly) in the context of clinical interactions. Where the process of engagement was pitched at a 'first impression' or 'on the face of it' level two engagement, the scope of broadening the consultation beyond the clinical reason meant emotional needs were not addressed. Currently, the process of the health professionals discovering and women disclosing domestic violence is ad-hoc. The absence of the use of screening tools meant that there was not a culture amongst health professionals to enquire about the phenomenon in a standardised, structured manner. Hence, discovery of the phenomenon was not a priority in the midst of working the

medical model (see Chapter Eight section 8.8). Likewise, women were not expecting to be asked about the issue because general practice health professionals do not routinely enquire about the matter. As a result, there was widespread absence of engagement with the issue by all actors. In addition, the study identified that women's frequent attendance (see Chapter Six section 6.2.1) to general practice was intertwined with their need for medical attention. Nonetheless, the connection between the repeat visits and the medical reason for the consultations were not linked to the invisible presence of intimate partner violence where the process of non-discovery by health professionals mirrored the non-disclosure by women.

Previous research identified that general practice health professionals are well placed to enquire from women whether they were experiencing problems with domestic violence (Hegarty et al. 2012; Watson and Parsons 2005; Bradley et al. 2002). One reason why this may be so, is to the prominent position and access of general practice as a health service. However, the findings from this study acknowledge that being in a position to enquire about violence against women did not actually mean that the process of purposefully engaging with the issue followed. Rather, the findings of this study argue to some extent that general practice, as a setting is not well placed to enquire about women's circumstances of domestic violence, given that the issues remained frequently invisible and health professionals were unsure how to engage with the matter. The unpreparedness of the general practice setting for the disclosure or discovery of domestic violence was reflected in the absence of posters or support material on the topic in surgeries and waiting rooms and the issue was absent from the health promotion materials on display (see Chapter Six section 6.3.3).

This research reveals several implications for clinical education. The findings identified that many GPs and practice nurses did not have any training in the area of violence against

women which contributed to their discomfort in dealing with the issues. Inadequate knowledge in knowing how to broach to subject with women (see Chapter Seven section 7.4.1) or fear of “getting it wrong” (see Chapter Six section 6.3.2) meant an absence of addressing the subject in consultations, which contributed to the theory of conspicuous invisibility. The discourse did not occur because of a lack of confidence in engaging with the topic, which was largely due to insufficient training. One interpretation of the pattern of not seeing, (Chapter 6) spiralling silences (Chapter 7) and not engaging (Chapter 8) revealed a cyclical process of invisibility. Evidence from the study identified that where practice nurses ‘avoided’ engaging with the issues because it was outside of their scope of practice (see Chapter Seven section 7.3.1), they had no prior training in the area. Instead of being proactive in discovering violence against women, health professionals did not engage or adopted a level one style of consultation (non-engagement) (see Chapter Nine section 9.5.1). Similarly, a public awareness campaign to inform women that health professionals can have a role in supporting them before disclosing or following disclosure would also be required if more women were to see the GP setting as a viable option for them to disclose.

10.5 Recommendations for practice and education

It is recommended that GPs and practice nurses extend their clinical lens from a medical model to include a biopsychosocial model. Instead of seeing a woman with an illness, or as a person needing a prescription, for example, anti-depressants, it is essential to delve beneath the surface and explore any silent, but contributing factors for the consultation. Opportunities such as the re-issuing of repeat prescriptions for medications may be a time for health professionals to enquire about the welfare of intimate relationships and other lifestyle issues. This is not to imply that all patients requiring repeat prescriptions are in an abusive relationship. Rather, it is to evaluate the need for ongoing medication in light of the findings

of this study where women were ‘medicalised’ for the consequence of a phenomenon, without, in some instances the issue being disclosed.

The research reveals the compartmentalised structure of general practice consultations. Practice nurses need to expand their focus beyond the clinical task on hand and see women as more than simply requiring a procedure. Were this approach to be adopted, consultations would need to be less service driven by procedures and more therapeutic driven. This is not to say that health professionals and women do not have a therapeutic relationship. However, where the emphasis is on the clinical prerogative, women’s narratives of domestic violence may not be heard. Hence, there is a need to engage with women beyond what Foucault (2003) describes as the clinical gaze. One way to initiate the process of engagement is ‘building opportunities to ask’ (see Chapter Seven section 7.4.2) by including the question as part of a health and lifestyle screen (Hegarty et al. 2012) with specific cohorts of women (case finding), in specific services for example: women’s health clinics, ante natal clinics or those with a history of abuse. The development of tools for enquiring about the phenomenon would go some way toward developing a standardised approach to enquiring about circumstances of domestic violence. Screening programmes will not and should not, happen without the collaboration of those who are to use them (GPs, practice nurses and women, such as those in this study); and strategies for their use in clinical practice cannot happen in isolation, or without training. Nevertheless, the introduction of systematic screening or a case finding system could go some way toward the identification of violence against women. The expertise of women in the development of screening tools is necessary, as it is they, who can best identify what is acceptable for women to be asked within an Irish general practice consultation.

Enhancing awareness can also occur through the displaying of posters and information. This would allow women to find out how to access domestic violence support services in a way that may involve not engaging in the GP setting. General practice surgeries could help in this regard by being more proactive and publicly displaying information on the support services which are available.

Finally, the study highlights the need for training and education in dealing with what health professionals perceive as emotive issues in consultations. By incorporating training in undergraduate and postgraduate medical and nursing programmes, the ambiguity of addressing such issues may be removed and strategies for dealing with difficult situations provided. Research by Lo Fo Wong (2007) conducted in the Netherlands, found that GPs who attended training programmes were more confident in addressing domestic violence issues with women. In the disciplines of general practice or practice nursing where clinical issues are to the fore, the development of the necessary skills to help women to disclose and health professionals to discover domestic violence might be seen as a lower order priority. However, as this study highlighted, women who are experiencing domestic violence attended general practice frequently and were observed with a clinical lens which resulted in their real needs remaining conspicuously invisible partially due to health professionals' insufficient training in discovering the issues. Areas for ongoing education from a generic perspective for all general practice health professionals should include skills training and role play in how to broach the subject of sensitive issues, including domestic violence when engaging with patients.

10.6 Implications and Recommendations for future research

Implicit in this study was health professionals' process of discovering women who experienced domestic violence and how women were enabled to disclose (or not) their

experiences, specifically in general practice settings. As there is a dearth of research within this area in an Irish context, the scope for future research is far reaching. The study demonstrated that engagement is context specific. As this research took place in an urban setting, future research could include rural populations or a mixed population of urban and rural. Likewise, using quantitative methods would expand the data collected.

One of the key findings from this study was a belief that there was insufficient time in consultations (see Chapter 8) to assign to the topic of violence against women. There were less opportunities to engage with the subject of violence of against women in consultations which were scheduled within a tight time frame, with a need for efficiency and driven by a business agenda. Consequently, there is a need for further investigations with health professionals to gauge how much time they actually allocate or could allocate to an issue that is not in the forefront of consultations in the first instance, as the findings of this study demonstrate. Further studies on the suitability of general practice as a setting and what may be a more appropriate location for women to disclose needs to be addressed. One consideration may be the greater use of counselling and/or therapy services situated within general practices as standard health care providers. The co-location of services would be an opportunity for greater collaboration between disciplines and women could have a choice who to attend without the difficulty of going to a separate site for consultations.

As the study only looked at three actors of the GPT, there is scope for expanding the study to include other community health professionals who engage with female patients in primary care, for example; public health nurses, allied health professionals and midwifery services.

GPs and practice nurses identified difficulties communicating about domestic violence issues with non-Irish women. Hence, there is a need for education and training with health professionals on how to engage with sensitive issues with women from other cultures.

Furthermore, there is also a need to explore what is the experience of non-Irish women attending the GPT and how they are enabled (or not) to disclose domestic violence.

Because women who experienced abusive relationships are a particularly rich source of information to guide health professionals on practice, education and future research, it is recommended that future research should collaborate with persons who use the health services, in a patient-centred approach. In short, women's voices (as in this study) should be included in the development of future research on violence against women.

10.7 Evaluating the theory

This research shows that violence against women is a phenomenon that frequently is not identified in general practice consultations. The theory of conspicuous invisibility is adjudicated in terms of Charmaz (2006:182-183) criteria of credibility, originality, resonance and usefulness. Chapter 3, table 3.1 outlines specific questions for each of these criteria.

Credibility: the study identifies a familiarity with the research setting. Once coding commenced, the analysis process was both rigorous and thorough. My engagement in the analysis process largely described in chapter 4 and supporting appendices provide an audit trail where the emergence of concepts continued through a process of constant comparative analysis before being condensed. Diagrammatic representation of the core categories, sub-categories and properties are also provided.

Evidence of originality is demonstrated as the study is the first of its kind to explore general practitioners', practice nurses' and practice administrators' processes of engaging with women who experience intimate partner violence and women's experience of attending general practice within an Irish context. The multiplicity of categories and concepts provide an in-depth understanding of a process of engagement within the clinical consultation.

Describing the interaction between health professionals and women as the choreography of the consultation offers new insights into a process of engagement in a clinical setting. The research shows the initial interaction of the consultation, is often adjudicated from a visual perspective only.

Resonance: the theory of conspicuous invisibility has meaning for this study, but also finds identity in other areas where there is a culture of not looking, then not seeing and not addressing what is present. The richness of the data, grounded in the participants' own voices, and the development of categories contributes to a broad understanding of the phenomenon under study. The contribution to knowledge and the applicability of the findings informs further research and has implications for other healthcare settings where the issues of domestic violence may not easily be discovered or disclosed. These include mental health services, men's health, or teenage health.

Usefulness: The theory of conspicuous invisibility does have transferability properties. It is likely to find elements of applicability in other clinical settings and with other populations where sensitive issues relating to health and social matters may not be simply emerge; for example; mental health, sexual health, the detection of addiction issues or the discovery of eating disorders. The model of engagement developed in this study is transferable to illuminate an understanding of the process of communication in areas where issues may not be immediately visible or articulated. In addition, the study highlighted the usefulness of grounded theory as a methodology for studying "social justice issues" (Charmaz 2005:508).

10.8 Limitations of the study

The study was conducted in an Irish general practice setting. Confining health professionals to GPs, practice nurses and administrators did not include the wider context of Primary Care health professionals that attend to women's health needs. The inclusion of other disciplines,

for example, psychologists or social workers may well have resulted in different findings that would otherwise have been uncovered. The small number of GP administrators interviewed is a consideration. Saturation is determined when no new data emerges relevant to particular categories and subcategories (McCann and Clark 2003b). However, there is a possibility that if I interviewed more administrators I may have encountered a number who met women who disclosed their experiences of abusive relationships. One of the limitations of using interviews is that participants give a retrospective account of their experiences; when conducting interviews which are dependent on recalled narratives. The process “allows participants to reflect” (Leslie and McAllister 2002:703) on their experiences of engaging in the consultation. While I have no reason to doubt the honesty and the candidness of the participants, reflecting in this way means that participants may chose what they want to tell the researcher. Furthermore, qualitative research is interpretative. Although there is a rigorous coding process in grounded theory methodology, analysing data by the researcher is interpretative where the researcher provides an explanation for the behaviours of the participants. In the words of Charmaz (2006:43) “we make interpreted renderings of studied life” which occurred in the study through a process of constant comparative analysis of the data and the of sorting memos.

All the women participants were Irish. Some will argue that as the health professionals made reference to the difficulty of discovering violence against women in non-Irish women (see Chapter Six section 6.3.1) these groups should have been inducted in the cohort. Women from non-Irish communities may reveal different experiences of disclosing domestic violence to general practice health professionals. In this study, however, engaging with women from non-Irish groups did not occur because the main emphasis of the study was about the process of discovery and disclosure of violence against women. This study could be used to inform a

similar study for women of other ethnic origins, as this is an area that warrant's further research in its own right.

10.9 Summary

The goal of this study was to explore health professionals process of discovering women in abusive relationships and women's ability to disclose their experiences of abuse in the context of general practice consultations. The research findings have highlighted the complexities of the process of engagement within a clinical interaction where violence against women is a principal factor, while remaining silent and invisible. It is important that an issue which is frequently invisible or silent is given a voice and in doing so, there is an opportunity to contribute to knowledge for service providers and service users. I argue that understanding the complexity of the discovery and disclosure of violence against women from both perspectives provides a more rounded, better informed and a more reliable basis for the development of the necessary supports to help women to address the issue of domestic violence in their lives and the development of the necessary education, understanding and skills by health professionals to respond to the needs of women and others who experience domestic violence.

References:

- Abbott, P. and Williamson, E. 1999. Women, health and domestic violence. *Journal of Gender Studies*, 8(1), pp.84-102.
- Al-Busaidi, Z. 2010. A qualitative study on the attitudes and beliefs towards help seeking for emotional distress in Omani women and Omani general practitioners: Implications for post-graduate training. *Oman Medical Journal*, 25(3), pp.190-198.
- Alonso, Y. 2004. The biopsychosocial model in medical research: The evolution of the health concept over the last two decades. *Patient Education and Counseling*, 53(2), pp.239-244.
- An Bord Altranais. 2000. *Scope of nursing and midwifery practice framework*. An Bord Altranais. Dublin.
- Anderson, K.L. 2009. Gendering coercive control. *Violence Against Women*, 15(12), pp.1444-1457.
- Armstrong, D. 2002. *A new history of identity: a sociology of medical knowledge*. Houndmills, Basingstoke, Hampshire; New York: Palgrave.
- Ashcraft, C. 2000. Naming knowledge: A language for reconstructing domestic violence and systemic gender inequity. *Women & Language*, 23(1), pp.3-10.
- Augustyn, M. and Groves, B.M. 2005. Training clinicians to identify the hidden victims: Children and adolescents who witness violence. *American Journal of Preventive Medicine*, 29(5), pp.272-278.
- Bacchus, L., Mezey, G. and Bewley, S. 2003. Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health & Social Care in the Community*, 11(1), pp.10-18.
- Bailey, C., White, C. and Pain, R. 1999. Evaluating qualitative research: Dealing with the tension between science and creativity. *Area*, 31(2), pp.169-178.
- Baird, K. and Salmon, D. 2006. Identifying domestic abuse against women and children. *Primary Health Care*, 16(5), pp.27-31.
- Balint, E. 1969. The possibilities of patient-centered medicine. *The Journal of the Royal College of General Practitioners*, 17(82), pp.269-276.
- Balint, M. 1957. *The doctor, the patient and his illness*. London: Tavistock.
- Barnish, M. 2004. *Domestic violence: A literature review*. London: HM Inspectorate of Probation.
- Barry, A.M. and Yuill, C. 2002. *Understanding health*. London: Sage Publications.

- Barry, C.A., Bradley, C.P., Britten, N., Stevenson, F.A. and Barber, N. 2000. Patients' unvoiced agendas in general practice consultations: Qualitative study. *British Medical Journal*, 320(7244), pp.1246.
- Barsky, A.J. 1981. Hidden reasons some patients visit doctors. *Annals Internal Medicine*, 94(4), pp.492-498.
- Barter, C., McCarry, M., Berridge, D., and Evans, K. 2009. *Partner exploitation and violence in teenage intimate relationships*. London: NSPCC.
- Battaglia, T., Finley, E. and Liebschutz, J. 2003. Survivors of intimate partner violence speak out. *Journal of General Internal Medicine*, 18(8), pp.617-623.
- Beaulaurier, R.L., Seff, L.R. and Newman, F.L. 2008. Barriers to help-seeking for older women who experience intimate partner violence: A descriptive model. *Journal of Women & Aging*, 20(3-4), pp.231-248.
- Belknap, R.A. and Sayeed, P. 2003. Te contaria mi vida: I would tell you my life, if only you would ask. *Health Care for Women International*, 24(8), pp.723-737.
- Ben-Ari, A. and Enosh, G. 2013. Power relations and reciprocity dialectics of knowledge construction. *Qualitative Health Research*, 23(3), pp.422-429.
- Benner, P., Tanner, C.A. and Chesla, C.A. 1997. Becoming an expert nurse. *The American Journal of Nursing*, 97(6), pp. 16BBB+16CCC.
- Bergin, M. 2011. NVivo 8 and consistency in data analysis: Reflecting on the use of a qualitative data analysis program. *Nurse Researcher*, 18(3), pp.6-12.
- Bettman, C. 2009. Patriarchy: The predominant discourse and fount of domestic violence. *Australian and New Zealand Journal of Family Therapy*, 30(1), pp.15-28.
- Beynon, C., E., Gutmanis, I., A., Tutty, L., M., Wathen., C, Nadine and Macmillan, H., L. 2012. Why physicians and nurses ask (or don't) about partner violence: A qualitative analysis. *BMC Public Health*, 12pp.473-473.
- Bjorklund, P. 2004. Invisibility, moral knowledge and nursing work in the writings of Joan Liaschenko and Patricia Rodney. *Nursing Ethics*, 11(2), pp.110-121.
- Blumer, H. 1969. *Symbolic interactionism*. Prentice-Hall, New Jersey: Englewood Cliffs.
- Blumer, H. 1986. *Symbolic interactionism: Perspective and method*. Berkley:University of California Press.
- Bonds, D., Ellis, S., Weeks, E., Palla, S. and Lichstein, P. 2006. A practice-centered intervention to increase screening for domestic violence in primary care practices. *BMC Family Practice*, 7,pp.63-72.
- Borbasi, S., Jackson, D. and Wilkes, L. 2005. Fieldwork in nursing research: Positionality, practicalities and predicaments. *Journal of Advanced Nursing*, 51(5), pp.493-501.

- Bostock, J., Plumpton, M. and Pratt, R. 2009. Domestic violence against women: Understanding social processes and women's experiences. *Journal of Community & Applied Social Psychology*, 19(2), pp.95-110.
- Bradley, F., Smith, M., Long, J. and O'Dowd, T. 2002. Reported frequency of domestic violence: Cross sectional survey of women attending general practice. *British Medical Journal*, 324(7332), pp.271-277.
- Brownmiller, S. 1975. *Against our will: Men, women and rape*. New York: Secker and Warburg.
- Bruce, A., Schreiber, R., Petrovskaya, O. and Boston, P. 2011. Longing for ground in a ground(less) world: A qualitative inquiry of existential suffering. *BMC Nursing*, 10(1), pp.2.
- Bryant, A. and Charmaz, K. 2007. Grounded Theory in Historical Perspective: An Epistemological Account IN: Bryant, A. and Charmaz, K. (eds.) *The Sage handbook of grounded theory*. London: Sage Publications Ltd, pp.31-57.
- Buetow, S. 2004. Patient experience of time duration: Strategies for 'slowing time' and 'accelerating time' in general practices. *Journal of Evaluation in Clinical Practice*, 10(1), pp.21-25.
- Buresh, B. and Gordon, S. 2000. *From silence to voice*. Ontario: Canadian Nurses Association.
- Burman, M.E., Stepan, M.B., Jansa, N. and Steiner, S. 2002. How do NPs make clinical decisions? *The Nurse Practitioner*, 27(5), pp.57-64.
- Burrige, L., Mitchell, G., Jiwa, M. and Girgis, A. 2011. Consultation etiquette in general practice: A qualitative study of what makes it different for lay cancer caregivers. *BMC Family Practice*, 12(1), pp.110.
- Chan, P. and Goh, L. G. 1995. Towards an effective therapeutic alliance in general practice *The Singapore Family Physician*. [Online]. Available from: <http://cfps.org.sg/publications/the-singapore-family-physician> [Accessed 14 June 2013].
- Chan, E.A., Jones, A. and Wong, K. 2013. The relationships between communication, care and time are intertwined: A narrative inquiry exploring the impact of time on registered nurses' work. *Journal of Advanced Nursing*, 69(9), pp.2020-2029.
- Charmaz, K. 2006. *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.
- Charmaz, K. 2005. Grounded Theory in the 21st Century – Applications for Advancing Social Justice Studies IN: Denzin, N. and Lincoln, Y. (ed.) *The Sage Handbook of Qualitative Research*. 3rd ed. California: Sage Publications, pp.507-536.
- Charmaz, K. 2002. Stories and silences: Disclosures and self in chronic illness. *Qualitative Inquiry*, 8(3), pp.302-328.

Charmaz, K. 1991. *Good days, bad days: The self and chronic illness in time*. New Jersey: Rutgers University Press.

Charmaz, K. 1999. Stories of suffering: Subjective tales and research narratives. *Qualitative Health Research*, 9(3), pp.362-383.

Charon, R. 2001. Narrative medicine. *JAMA: The Journal of the American Medical Association*, 286(15), pp.1897-1902.

Chaudoir, S.R. and Fisher, J.D. 2010. The disclosure processes model: Understanding disclosure decision making and post disclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin*, 136(2), pp.236.

Chenitz, W.C. and Swanson, J.M. 1986. *From practice to grounded theory: Qualitative research in nursing*. California: Addison-Wesley, Health Sciences Division.

Clark, D.W. 2001. Domestic violence screening, policies, and procedures in indian health service facilities. *The Journal of the American Board of Family Practice*, 14(4), pp.252-258.

Clark, F. 2003. Partner abuse-recognition and management in general practice. *New Zealand Family Physician*, 30(4), pp.273-278.

Coker, A.L., Bethea, L., Smith, P.H., Fadden, M.K. and Brandt, H.M. 2002. Missed opportunities: Intimate partner violence in family practice settings. *Preventive Medicine*, 34(4), pp.445-454.

Coker, A.L., Flerx, V.C., Smith, P.H., Whitaker, D.J., Fadden, M.K. and Williams, M. 2007. Intimate partner violence incidence and continuation in a primary care screening program. *American Journal of Epidemiology*, 165(7), pp.821-827.

Coker, A.L., Smith, P.H., Bethea, L., King, M.R. and McKeown, R.E. 2000. Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine*, 9(5), pp.451-457.

Cooney, A. 2011. Rigour and grounded theory. *Nurse Researcher*, 18(4), pp.17-22.

Corbally, M. 2001. Factors affecting nurses' attitudes towards the screening and care of battered women in Dublin A&E departments: A literature review. *Accident and Emergency Nursing*, 9(1), pp.27-37.

Corbin, J.M. and Strauss, A.L. 2008. *Basics of qualitative research*. 3rd ed. Los Angeles: Sage Publications.

Corbin, J. and Morse, J.M. 2003. The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative Inquiry*, 9(3), pp.335-354.

Cosc, 2010. *National strategy on domestic, sexual and gender-based violence 2010-2014*. Dublin: Stationary Office.

Covan, E. 2007. The discovery of grounded theory in practice: The legacy of multiple mentors *IN*: Bryant, A. and Charmaz, K. (eds.) *The Sage Handbook of Grounded Theory*. California: Sage Publications, pp. 58-74.

Coyne, I. and Cowley, S. 2006. Using grounded theory to research parent participation. *Journal of Research in Nursing*, 11(6), pp.501-515.

Crenshaw, C. 1996. The normality of man and female otherness:(re) producing patriarchal lines of argument in the law and the news. *Argumentation and Advocacy*, 32(4), pp.170-185.

Creswell, J.W. 2007. *Qualitative inquiry & research design: Choosing among five approaches*. 2nd ed. California: Sage Publications, Inc.

Cunningham, V., D Silva, M. and Cheatham, K. 2007. Invisibility of black staff in academia: A qualitative analysis. *International Communication Studies XVI*, 16(3), pp.66-71.

Cutcliffe, J.R. 2000. Methodological issues in grounded theory. *Journal of Advanced Nursing*, 31(6), pp.1476-1484.

Dahlberg, L.L. and Krug, E.G. 2002. Violence - a global public health problem *IN*: Krug, E.G., Dahlberg, L.L., Mercy J.A., Zwi. A.B. and Lozano, R. (eds.) *World report of violence and health*. 2nd ed. Geneva: World Health Organisation, pp.1-22.

Davenport, B.A. 2000. Witnessing and the medical gaze: How medical students learn to see at a free clinic for the homeless. *Medical Anthropology Quarterly*, 14(3), pp.310-327.

Davidson, A.S. and Reventlow, S. 2010. 'It takes some time to get into the rhythm-and to slow the flow of thought': A qualitative study about experience of time and narrative in psychological interventions in general practice. *Health:(London)*, 14(4), pp.348-368.

Davidson, A.S. 2010. To survive, general practice needs to reintroduce the psychodynamic dimension. *Psychodynamic Practice*, 16(4), pp.451-461.

Davies, D. and Dodd, J. 2002. Qualitative research and the question of rigor. *Qualitative Health Research*, 12(2), pp.279-289.

Dearnley, C. 2005. A reflection on the use of semi-structured interviews. *Nurse Researcher*, 13(1), pp.19-28.

Denzin, N.K. 2010. Grounded and indigenous theories and the politics of pragmatism. *Sociological Inquiry*, 80(2), pp.296-312.

Department of Health and Children 2001. *Primary Care: A new direction*. Dublin: Stationary Office.

Department of Health and Children 2001a. *Quality and Fairness: A health system for you*. Dublin: Stationary Office.

Department of Health and Children. 2008. *Tackling chronic disease*. Dublin: Stationary Office.

- Dhai, A. and Payne-James, J. 2013. Problems of capacity, consent and confidentiality. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 27(1), pp.59-75.
- DiCicco-Bloom, B. and Crabtree, B.F. 2006. The qualitative research interview. *Medical Education*, 40(4), pp.314-321.
- Dienemann, J., Glass, N. and Hyman, R. 2005. Survivor preferences for response to IPV disclosure. *Clinical Nursing Research*, 14(3), pp.215-233.
- Djikanovic, B., Sylvie, Stevanovic, S., Celik, H. and Lagro–Janssen, A. 2011. Women's expectations of healthcare professionals in case of intimate partner violence in Serbia. *Women & Health*, 51(7), pp.693-708.
- Doyle, R. 1996. *The Woman Who Walked into Doors*. London: Jonathan Cape.
- Draucker, C.B., Martsof, D.S., Ross, R. and Rusk, T.B. 2007. Theoretical sampling and category development in grounded theory. *Qualitative Health Research*, 17(8), pp.1137-1148.
- Dunlap, R.K. 2013. Nursing theory and the clinical gaze discovery in teaching theory across a cultural divide. *Nursing Science Quarterly*, 26(2), pp.176-180.
- Dunne, C. 2010. The place of the literature review in grounded theory research. *International Journal of Social Research Methodology*, iFirstpp.1-14.
- Eaves, Y.D. 2001. A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing*, 35(5), pp.654-663.
- Elkins, D.N. 2009. The medical model in psychotherapy its limitations and failures. *Journal of Humanistic Psychology*, 49(1), pp.66-84.
- Elliott, A., McAteer, A. and Hannaford, P. 2011. Revisiting the symptom iceberg in today's primary care: Results from a UK population survey. *BMC Family Practice*, 12(1), pp.16.
- European Institute for Gender Equality, 2012. *Review of the implementation of the Beijing platform for action in the EU member states: Violence against women – victim support*. Luxembourg: Publications Office of the European Union.
- Eusden, S. 2011. Minding the gap: Ethical considerations for therapeutic engagement. *Transactional Analysis Journal*, 41(2), pp.101-113.
- Ewles, E. and Simnett, I. 2003. *Promoting Health: a practical guide*. 5th ed. England: Bailliere Tindall.
- Finfgeld-Connett, D. and Johnson, E.D. 2013. Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews. *Journal of Advanced Nursing*, 69(1), pp.194-204.
- Finlay, L. 2002. “Outing” the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), pp.531-545.

- Fogarty, C.T. 2011. Call it 'Jiffy boob': What's lacking when care has assembly-line efficiency. *Health Affairs*, 30(11), pp.2204-2207.
- Foucault, M. and Rabinow, P. 1984. *The Foucault Reader*. Random House Inc.
- Foucault, M. 2003. *The birth of the clinic*. London: Routledge.
- Foucault, M. 1982. The subject and power. *Critical Inquiry*, 8(4), pp.777-795.
- Frank, A. 1995. *The Wounded Storyteller*. Chicago: University of Chicago Press.
- Frank, A.W. 2013. From sick role to practices of health and illness. *Medical Education*, 47(1), pp.18-25.
- Gadow, S. 2000. Philosophy as falling: Aiming for grace. *Nursing Philosophy*, 1(2), pp.89-97.
- Gaglio, B., Nelson, C.C. and King, D. 2006. The role of rapport: Lessons learned from conducting research in a primary care setting. *Qualitative Health Research*, 16(5), pp.723-734.
- Garcia-Moreno, C., Jansen, H.A., Ellsberg, M., Heise, L. and Watts, C.H. 2006. Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *Lancet*, 368(9543), pp.1260-1269.
- Geneau, R., Lehoux, P., Pineault, R. and Lamarche, P. 2008. Understanding the work of general practitioners: A social science perspective on the context of medical decision making in primary care. *BMC Family Practice*, 9(1), pp.12.
- Gerbert, B., Caspers, N., Bronstone, A., Moe, J. and Abercrombie, P. 1999. A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Annals of Internal Medicine*, 131(8), pp.578-584.
- Ghezaljah, T.N. and Emami, A. 2009. Grounded theory: Methodology and philosophical perspective. *Nurse Researcher*, 17(1), pp.15-23.
- Gignon, M., Idris, H., Manaouil, C. and Ganry, O. 2012. The waiting room: Vector for health education? the general practitioner's point of view. *BMC Research Notes*, 5(1), pp.511.
- Gilgun, J. 2006. The four cornerstones of qualitative research. *Qualitative Health Research*, 16(3), pp.436-443.
- Glaser, B. 1978. *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. California: The Sociology Press.
- Glaser, B. G. 2002. Constructivist grounded theory *Forum: Qualitative Social Research* [Online]. 3(3). Available from: <http://www.qualitative-research.net/fqs/fqs-eng.htm> [Accessed on 16 February 2008].
- Glaser, B. G. and Strauss, A. L. 1965. *Awareness of Dying*. New York: Aldine.

- Glaser, B.G. and Strauss, A.L. 1967. *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Glaser, B.G. 2002. Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1(2), pp.1-31.
- Glaser, B.G. 1998. *Doing grounded theory : issues and discussions*. Mill Valley, CA: Sociology Press.
- Goffman, E. 1982. *Interaction ritual*. New York: Pantheon Books.
- Goffman, E. 1959. *The Presentation of Self in Everyday Life*. New York: Doubleday.
- Goodyear-Smith, F., Coupe, N.M., Arroll, B., Elley, C.R., Sullivan, S. and McGill, A. 2008. Case finding of lifestyle and mental health disorders in primary care: Validation of the 'CHAT' tool. *The British Journal of General Practice*, 58(546), pp.26-31.
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C.N. and MacMillan, H.L. 2007. Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health*, 7, pp.12.
- Hagglom, A.M.E. and Moller, A.R. 2006. On a life-saving mission: Nurses' willingness to encounter with intimate partner abuse. *Qualitative Health Research*, 16(8), pp.1075.
- Hague, G. and Wilson, C. 2000. The silenced pain: Domestic violence 1945-1970. *Journal of Gender Studies*, 9(2), pp.157-169.
- Hapke, H.M. 2013. Theorizing patriarchy: Development paradoxes and the geography of gender in south Asia. *Gender, Technology and Development*, 17(1), pp.1-29.
- Hathaway, J., Willis, G. and Zimmer, B. 2002. Listening to survivors' voices : Addressing partner abuse in the health care setting. *Violence Against Women*, 8(6), pp.687-719.
- Health Service Executive, 2010. *HSE policy on domestic, sexual and gender based violence*. Dublin: HSE.
- Hearn, J. 2013. The sociological significance of domestic violence: Tensions, paradoxes and implications. *Current Sociology*, 61(2), pp.152-170.
- Heath, H. 2006. Exploring the influences and use of the literature during a grounded theory study. *Journal of Research in Nursing*, 11(6), pp.519.
- Heckathorn, D.D. 2011. Snowball versus respondent-driven sampling. *Sociological Methodology*, 41(1), pp.355-366.
- Hegarty, K.L. and Bush, R. 2007. Prevalence and associations of partner abuse in women attending general practice: A cross-sectional survey. *Australian and New Zealand Journal of Public Health*, 26(5), pp.437-442.

Hegarty, K.L. and Taft, A.J. 2001. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Australian and New Zealand Journal of Public Health*, 25(5), pp.433-437.

Hegarty, K.L., O'Doherty, L.J., Chondros, P., Valpied, J., Taft, A.J., Astbury, J., Brown, S.J., Gold, L., Taket, A. and Feder, G.S. 2013a. Effect of type and severity of intimate partner violence on Women's health and service use findings from a primary care trial of women afraid of their partners. *Journal of Interpersonal Violence*, 28(2), pp.273-294.

Hegarty, K., O'Doherty, L., Taft, A., Chondros, P., Brown, S., Valpied, J., Astbury, J., Taket, A., Gold, L. and Feder, G. 2013b. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): A cluster randomised controlled trial *The Lancet* [Online]. Available from: www.thelancet.com [Accessed 22 April 2013].

Hegarty, K., Hindmarsh, E.D. and Gilles, M.T. 2000. Domestic violence in Australia: Definition, prevalence and nature of presentation in clinical practice. *The Medical Journal of Australia*, 173(7), pp.363-367.

Hegarty, K., L., O'Doherty, L., Astbury, J. and Gunn, J. 2012. Identifying intimate partner violence when screening for health and lifestyle issues among women attending general practice. *Australian Journal of Primary Health*, 18(4), pp.327-331.

Heise, L. and Garcia-Moreno, C. 2002. Violence by intimate partners *IN*: Krug, E.G., Dahlberg, L.L., Mercy, J.A., and Zwi, R.L. (eds.) *World report of violence and health*. Geneva: World Health Organisation, pp.87-121.

Higgins, E.T. and Scholer, A.A. 2009. Engaging the consumer: The science and art of the value creation process. *Journal of Consumer Psychology*, 19(2), pp.100-114.

Holloway, I. and Biley, F.C. 2011. Being a qualitative researcher. *Qualitative Health Research*, 21(7), pp.968-975.

Holmstrom, I. and Dall'Alba, G. 2002. 'Carer and gatekeeper' -- conflicting demands in nurses' experiences of telephone advisory services. *Scandinavian Journal of Caring Sciences*, 16(2), pp.142-148.

Holton, J.A. 2010. The coding process and its challenges. *Grounded Theory Review*, 9(1), pp.21-40.

Houghton, C.E., Casey, D., Shaw, D. and Murphy, K. 2010. Ethical challenges in qualitative research: Examples from practice. *Nurse Researcher*, 18(1), pp.15-25.

Howard, J. 2008. Domestic violence screening: Findings of a pilot project conducted by allied health staff in community health. *Australian Journal of Primary Health*, 14(1), pp.43-51.

Hudon, C., Tribble, D.S.C., Bravo, G., Hogg, W., Lambert, M. and Poitras, M.E. 2013. Family physician enabling attitudes: A qualitative study of patient perceptions. *BMC Family Practice*, 14(1), pp.8.

- Hunnicut, G. 2009. Varieties of patriarchy and violence against women. *Violence Against Women*, 15(5), pp.553-573.
- Hunter, A., Murphy, K., Grealish, A., Casey, D. and Keady, J. 2011. Navigating the grounded theory terrain. part 1. *Nurse Researcher*, 18(4), pp.6-10.
- Hyde, A., Lohan, M. and McDonnell, O. 2004. *Sociology for health professionals in Ireland*. Dublin: Institute of Public Administration.
- Iedema, R.A.M., Jorm, C., Long, D., Braithwaite, J., Travaglia, J. and Westbrook, M. 2006. Turning the medical gaze in upon itself: Root cause analysis and the investigation of clinical error. *Social Science & Medicine*, 62(7), pp.1605-1615.
- Illich, I. 1995. Death undefeated. *BMJ: British Medical Journal*, 311(7021), pp.1652.
- Iphofen, R. 2011. Ethical decision making in qualitative research. *Qualitative Research*, 11(4), pp.443-446.
- Jaffee, K., Epling, J., Grant, W., Ghandour, R. and Callendar, E. 2005. Physician-identified barriers to intimate partner violence screening. *Journal of Women's Health*, 14(8), pp.713-720.
- Jeon, Y. 2004. The application of grounded theory and symbolic interactionism. *Scandinavian Journal of Caring Sciences*, 18(3), pp.249-256.
- Jespersen, A.P. and Jensen, T.E. 2012. Making consultations run smoothly: An analysis of doctors' skilful use of time inspired by science and technology studies. *Time & Society*, 21(3), pp.330-350.
- Jewkes, R. 2013. Intimate partner violence: The end of routine screening. *The Lancet*, 382(9888), pp.190-191.
- Jones, J.W. 2009. Selection of grounded theory as an appropriate research methodology for a dissertation: One student's perspective. *Grounded Theory Review*, 8(2), pp.23-34.
- Kandiyoti, D. 1988. Bargaining with patriarchy. *Gender and Society*, 2(3), pp.274-290.
- Kearney, M.H. 2001. Enduring love: A grounded formal theory of women's experience of domestic violence. *Research in Nursing & Health*, 24(4), pp.270-282.
- Kearney, M.H. 1998. Ready-to-wear: Discovering grounded formal theory. *Research in Nursing & Health*, 21(2), pp.179-186.
- Kelle, U. 2005. Emergence vs. forcing of empirical data? A crucial problem of grounded theory reconsidered. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 6(2), [Online]. Available from: <http://www.qualitative-research.net/fqs> [Accessed 8 October 2010].
- Kelleher, P. and O Connor, M. 1995. *Making the Links*. Dublin: Women's Aid.

Kenny, C. 2011. *The Power of Silence: Silent Communication in Daily Life*. London: Karnac Books.

Kelly, M. 2010. The role of theory in qualitative health research. *Family Practice*, 27(3), pp.285-290.

Kelly, U. 2006. "What will happen if I tell you?" battered Latina women's experiences of health care. *CJNR (Canadian Journal of Nursing Research)*, 38(4), pp.78-95.

Kenny, N. and Riain, N.A. 2008. *Domestic violence a guide for general practice*. Dublin: Irish College of General Practitioners (ICGP).

Khalifeh, H., Hargreaves, J., Howard, L.M. and Birdthistle, I. 2013. Intimate partner violence and socioeconomic deprivation in England: Findings from a national cross-sectional survey. *American Journal of Public Health*, 103(3), pp.462-472.

Kimberg, L. 2001. Addressing intimate partner violence in primary care practice *Medscape General Medicine* [Online]. 3(1), Available from: <http://www.medscape.com> [Accessed: 7 April 2007].

Kirby, S. 2007. The contextual researcher: Celebrating 'experiential alertness' in grounded theory in prison research. *Nurse Researcher*, 14(2), pp.51-65.

Knickmeyer, N., Levitt, H. and Horne, S. 2010. Putting on sunday best: The silencing of battered women within Christian faith communities. *Feminism & Psychology*, 20(1), pp.94-113.

Korner, T. 1993. Making conscious identifications: A means of promoting empathic contact. *Australian and New Zealand Journal of Psychiatry*, 27(1), pp.115-126.

Kress, V.E., Hoffman, R.M., Adamson, N. and Eriksen, K. 2013. Informed consent, confidentiality, and diagnosing: Ethical guidelines for counselor practice. *Journal of Mental Health Counseling*, 35(1), pp.15-28.

Krueger, E. and Reilly, D. 2011. The "cash or care" conflict in general practice – A cautionary tale with methodological reflections. *Patient Education and Counseling*, 82(3), pp.479-481.

Krug, E.G., Dahlberg, L., Mercy, J.A., Zwi, A.B. and Lozano, R. 2002. *World report on violence and health*. Geneva: World Health Organization.

Kvale, S. 1996. *Interviews: An Introduction to Qualitative Research Interviewing*, California: Sage Publications.

Kvale, S. 2006. Dominance through interviews and dialogues. *Qualitative Inquiry*, 12(3), pp.480-500.

Laffoy, M., Health Service Executive., Department of Health and Children. and National Council on Ageing and Older People. 2008. *Strategy to prevent falls and fractures*. Dublin: HSE.

- Landenburger, K. 1989. A process of entrapment in and recovery from an abusive relationship. *Issues in Mental Health Nursing*, 10(3-4), pp.209-227.
- Lavis, V., Horrock, C. and Kelly, N. and Barker, V. 2005. Domestic violence and health care: Opening Pandora's box - challenges and dilemmas. *Feminism & Psychology*, 15(4), pp.441-460.
- Lawlor, M.C. 2003. Gazing anew: The shift from a clinical gaze to an ethnographic lens. *The American Journal of Occupational Therapy*, 57(1), pp.29-39.
- Lazenbatt, A., Taylor, J. and Cree, L. 2009. A healthy settings framework: An evaluation and comparison of midwives' responses to addressing domestic violence. *Midwifery*, 25(6), pp.622-636.
- Lee, R.M. 1993. *Doing research on sensitive topics*. London: Sage Publications.
- Lempert, L. 2007. Asking questions of the data; memo writing in the grounded theory tradition IN: Bryant, A. and Charmaz, K. (eds.) *The Sage Handbook of Grounded Theory*. California: Sage Publications, pp.254-264.
- Lequerica, A.H. and Kortte, K. 2010. Therapeutic engagement: A proposed model of engagement in medical rehabilitation. *American Journal of Physical Medicine & Rehabilitation*, 89(5), pp.415.
- Leslie, H. and McAllister, M. 2002. The benefits of being a nurse in critical social research practice. *Qualitative Health Research*, 12(5), pp.700-712.
- Liaschenko, J. 1997. Knowing the patient IN: Thorne, S. and Hayes, V. (eds.) *Nursing praxis: knowledge and action*. California: Sage Publications, pp.23-38.
- Liaschenko, J. and Fisher, A. 1999. Theorizing the knowledge that nurses use in the conduct of their work. *Research and Theory for Nursing Practice*, 13(1), pp.29-41.
- Iverson, K., King, M., Resick, P., Gerber, M., Kimerling, R. and Vogt, D. 2013. Clinical utility of an intimate partner violence screening tool for female VHA patients. *Journal of General Internal Medicine*, pp.1-6.
- Lichtenstein, B. 2006. Domestic violence in barriers to health care for HIV-positive women. *AIDS Patient Care & STDs*, 20(2), pp.122-132.
- Liebschutz, J., Battaglia, T., Finley, E. and Averbuch, T. 2008. Disclosing intimate partner violence to health care clinicians - what a difference the setting makes: A qualitative study. *BMC Public Health*, 8 pp.229.
- Liehr, P. and Smith, M.J. 1999. Middle range theory: Spinning research and practice to create knowledge for the new millennium. *Advances in Nursing Science*, 21(4), pp.81-91.
- Lo Fo Wong, S., Wester, F., Mol, S. and Lagro-Janssen, T. 2007. "I am not frustrated anymore" family doctors' evaluation of a comprehensive training on partner abuse. *Patient Education & Counseling*, 66(2), pp.129-137.

- Lombard, N. 2013. Young People's temporal and spatial accounts of gendered violence. *Sociology* [Online]. Available from: <http://soc.sagepub.com/content/early/2013>. [Accessed 30 March 2013].
- Lutenbacher, M., Cohen, A. and Conner, N.M. 2004. Breaking the cycle of family violence: Understanding the perceptions of battered women. *Journal of Pediatric Health Care*, 18(5), pp.236-243.
- Lynch, L. 2006. Domestic violence: Asking the question. *Practice Nursing*, 17(12), pp.598-601.
- Macnaughton, J. 2011. Medical humanities' challenge to medicine. *Journal of Evaluation in Clinical Practice*, 17(5), pp.927-932.
- Maiter, S., Joseph, A.J., Shan, N. and Saeid, A. 2013. Doing participatory qualitative research: Development of a shared critical consciousness with racial minority research advisory group members. *Qualitative Research*, 13(2), pp.198-213.
- Malterud, K. 1999. The (gendered) construction of diagnosis interpretation of medical signs in women patients. *Theoretical Medicine and Bioethics*, 20(3), pp.275-286.
- Manderson, L., Bennett, E. and Andajani-Sutjahjo, S. 2006. The social dynamics of the interview: Age, class, and gender. *Qualitative Health Research*, 16(10), pp.1317-1334.
- McCabe, J.L. and Holmes, D. 2009. Reflexivity, critical qualitative research and emancipation: A foucauldian perspective. *Journal of Advanced Nursing*, 65(7), pp.1518-1526.
- McCallin, A.M. 2003. Designing a grounded theory study: Some practicalities. *Nursing in Critical Care*, 8(5), pp.203-208.
- McCann, T. and Clark, E. 2003a. Grounded theory in nursing research: Part 2 -- critique. *Nurse Researcher*, 11(2), pp.19-28.
- McCann, T.V. and Clark, E. 2003b. Grounded theory in nursing research: Part 1-- methodology. *Nurse Researcher*, 11(2), pp.7-18.
- McCauley, J., Kern, D.E., Kolodner, K., Dill, L., Schroeder, A.F., DeChant, H.K., Ryden, J., Bass, E.B. and Derogatis, L.R. 1995. The "battering syndrome": Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Annals of Internal Medicine*, 123(10), pp.737-746.
- McCartney, M. 2012. The doctor won't see you now: Online consulting and prescribing. *BMJ: British Medical Journal*, 345.
- McCreddie, M., Lyons, I., Watt, D., Ewing, E., Croft, J., Smith, M. and Tocher, J. 2010. Routines and rituals: A grounded theory of the pain management of drug users in acute care settings. *Journal of Clinical Nursing*, 19(19-20), pp.2730-2740.

- McEvoy, P. 2000. Gatekeeping access to services at the primary/secondary care interface. *Journal of Psychiatric and Mental Health Nursing*, 7(3), pp.241-247.
- McGee, H., Garavan, R., de Barra, M., Byrne, J. and Conroy, R. 2002. The SAVI report: Sexual abuse and violence in Ireland-A national study of Irish experiences, beliefs and attitudes concerning sexual violence. Dublin: The Liffey Press.
- McIlfatrick, S., Sullivan, K. and McKenna, H. 2006. Exploring the ethical issues of the research interview in the cancer context. *European Journal of Oncology Nursing*, 10(1), pp.39-47.
- McKie, L., Fennell, B. and Mildorf, J. 2002. Time to disclose, timing disclosure: GPs? discourses on disclosing domestic abuse in primary care. *Sociology of Health & Illness*, 24(3), pp.327-346.
- MacNeil, M., Stradling, B., MacNeil, C.A., Bethune, A. and MacDonald, B. 2004. *Preventing domestic abuse in the Western Isles: The community perspective*. Scotland: Scottish Executive.
- McPhail, B.A., Busch, N.B., Kulkarni, S. and Rice, G. 2007. An integrative feminist model: The evolving feminist perspective on intimate partner violence. *Violence Against Women*, 13(8), pp.817-841.
- McWilliams, M. 1997. Violence against women and political conflict: The northern Ireland experience. *Critical Criminology*, 8(1), pp.78-92.
- Menzies, I. 1960. A case study in the functioning of social systems as a defence against anxiety. *Human Relations*, 13 pp.95-121.
- Mildorf, J. 2004. Narratives of Domestic Violence Cases: GPs Defining Their Professional Role IN: Twohig, P. and Kaitzkus, V. (eds.) *Making sense of health, illness and disease*. Amsterdam: Rodopi, pp177-200.
- Mildorf, J. 2006. Sociolinguistic implications of narratology: Focalization and 'Double deixis' in conversational storytelling. *The Travelling Concept of Narrative*, pp.42-59.
- Mildorf, J. 2002. "Opening up a can of worms": Physicians narrative construction of knowledge about domestic violence. *Narrative Inquiry*, 12(2), pp.233-260.
- Miller, D. and Jaye, C. 2007. GPs' perception of their role in the identification and management of family violence. *Family Practice*, 24(2), pp.95-101.
- Mills, J., Bonner, A. and Francis, K. 2008. The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5(1), pp.25-35.
- Moracco, K.E. and Cole, T.B. 2009. Preventing intimate partner violence. *JAMA: The Journal of the American Medical Association*, 302(5), pp.568-570.
- Morier-Genoud, C., Bodenmann, P., Favrat, B. and Vannotti, M. 2006. Violence in primary care: Prevalence and follow-up of victims. *BMC Family Practice*, 7(1), pp.15.

- Morrall, P. 2009. *Sociology and Health*. 2nd ed. Dublin: Routledge.
- Morris, R., Kai, J., Atha, C., Avery, A., Bayes, S., Franklin, M., George, T., James, M., Malins, S. and McDonald, R. 2012. Persistent frequent attenders in primary care: Costs, reasons for attendance, organisation of care and potential for cognitive behavioural therapeutic intervention. *BMC Family Practice*, 13(1), pp.39.
- Morse, J.M. 2008. Confusing categories and themes. *Qualitative Health Research*, 18(6), pp.727-728.
- Morse, J.M. 2001. Situating grounded theory within qualitative inquiry. *Using Grounded Theory in Nursing*, pp.1-15.
- Mruck, K. and Mey, G. 2007. Grounded theory and reflexivity IN: Bryant, A. and Charmaz, K. (eds.) *The Sage Handbook of Grounded Theory*. Los Angeles: Sage Publications, pp.515-538.
- Mulhall, A. 2003. In the field: Notes on observation in qualitative research. *Journal of Advanced Nursing*, 41(3), pp.306-313.
- Mullender, A. and Hague, G. 2005. Giving a voice to women survivors of domestic violence through recognition as a service user group. *British Journal of Social Work*, 35(8), pp.1321-1341.
- Naef, R. 2006. Bearing witness: A moral way of engaging in the nurse-person relationship. *Nursing Philosophy*, 7(3), pp.146-156.
- Nair, S. and Osman, M.M. 2012. Singaporean adolescents' perceptions of violence: Implications for practice. *Qualitative Social Work*, 12(4), pp.490-506.
- Natan, M.B. and Rais, I. 2010. Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. *Journal of Trauma Nursing*, 17(2), pp.112-117.
- National Cancer Screening Service 2010. *Cervical check programme report 2008-2009*. Dublin: National Cancer Control Programme.
- Naumann, P., Langford, D., Torres, S., Campbell, J. and Glass, N. 1999. Women battering in primary care practice. *Family Practice*, 16(4), pp.343-352.
- Naved, R. and Persson, A. 2010. Dowry and spousal physical violence against women in bangladesh. *Journal of Family Issues*, 3(6), pp.830-856.
- Nelson, P.A., Chew-Graham, C.A., Griffiths, C.E.M., Cordingley, L. and on behalf of the IMPACT Team. 2013. Recognition of need in health care consultations: A qualitative study of people with psoriasis. *British Journal of Dermatology*, 168(2), pp.354-361.
- Nelson, H.D., Bougatsos, C. and Blazina, I. 2012. Screening women for intimate partner violence: A systematic review to update the U.S. preventive services task force recommendation. *Annals of Internal Medicine*, 156(11), pp.796-808.

Nortvedt, P. 2003. Immersed subjectivity and engaged narratives: Clinical epistemology and normative intricacy. *Nursing Philosophy*, 4(2), pp.129-136.

Nunkoosing, K. 2005. The problems with interviews. *Qualitative Health Research*, 15(5), pp.698-706.

Ogden, J., Bavalia, K., Bull, M., Frankum, S., Goldie, C., Gossiau, M., Jones, A., Kumar, S. and Vasant, K. 2004. "I want more time with my doctor": A quantitative study of time and the consultation. *Family Practice*, 21(5), pp.479.

Oifig an Tánaiste, 1997. *Report of the task force on violence against women*. Dublin: Government Publications.

Olesen, V. 2005. Early millennial feminist qualitative research: Challenges and contours *IN*: Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage Handbook of Qualitative Research*. 3rd ed. London: Sage Thousand Oaks, pp.235-278.

Olivola, C.Y. and Todorov, A. 2010. Fooled by first impressions? reexamining the diagnostic value of appearance-based inferences. *Journal of Experimental Social Psychology*, 46(2), pp.315-324.

Parahoo, K. 2006. *Nursing research: principles, process and issues*. New York: Palgrave Macmillan.

Parsons, T. 1975. The sick role and the role of the physician reconsidered. *The Milbank Memorial Fund Quarterly. Health and Society*, 53(3), pp.257-264.

Paul, G., Smith, S.M. and Long, J. 2006. Experience of intimate partner violence among women and men attending general practices in Dublin, Ireland: A cross-sectional survey. *European Journal of General Practice*, 12(2), pp.66-69.

Pergert, P. 2009. Methodological learning-by-doing: Challenges, lessons learned and rewards. *Grounded Theory Review*, 8(2), pp 65-75.

Persaud, R. 2005. The drama of being a doctor. *Postgraduate Medical Journal*, 81(955), pp.276-277.

Peters, S., Rogers, A., Salmon, P., Gask, L., Dowrick, C., Towey, M., Clifford, R. and Morris, R. 2009. What do patients choose to tell their doctors? Qualitative analysis of potential barriers to re-attributing medically unexplained symptoms. *J Gen Intern Med*, 24(4), pp.443-449.

Polit, D. and Beck, C. 2001. *Essentials of Nursing Research*. 6th ed. Philadelphia: Lippincott Williams & Wilkins.

Polkinghorne, D.E. 2005. Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52(2), pp.137-145.

Pollock, K. 2007. Maintaining face in the presentation of depression: Constraining the therapeutic potential of the consultation. *Health: (London)*, 11(2), pp.163-182.

- Quinlan, E. 2008. Conspicuous invisibility: Shadowing as a data collection strategy. *Qualitative Inquiry*, 14(8), pp.1480-1499.
- Ramsay, J., Richardson, J., Carter, Y.H., Davidson, L.L. and Feder, G. 2002. Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal*, 325(7359), pp.314.
- Reeves, C. 2010. A difficult negotiation: Fieldwork relations with gatekeepers. *Qualitative Research*, 10(3), pp.315-331.
- Relva, I.C., Fernandes, O.M. and Costa, R. 2013. Psychometric properties of revised conflict tactics scales: Portuguese sibling version (CTS2-SP). *Journal of Family Violence*, pp.1-9.
- Rhodes, K., Cerulli, C., Dichter, M., Kothari, C. and Barg, F. 2010. "I Didn't want to put them through that": The influence of children on victim decision-making in intimate partner violence cases. *Journal of Family Violence*, 25(5), pp.485-493.
- Rice, G., Ingram, J. and Mizan, J. 2008. Enhancing a primary care environment: A case study of effects on patients and staff in a single general practice. *British Journal of General Practice*, 58(552), pp.465-470.
- Richardson, J., Coid, J., Petruckevitch, A., Chung, W.S., Moorey, S. and Feder, G. 2002. Identifying domestic violence: Cross sectional study in primary care. *British Medical Journal*, 324(7332), pp.274.
- Ridd, M., Shaw, A., Lewis, G. and Salisbury, C. 2009. The patient–doctor relationship: A synthesis of the qualitative literature on patients' perspectives. *The British Journal of General Practice*, 59(561), pp.268-275.
- Rodriguez, M.A., Bauer, H.M., McLoughlin, E. and Grumbach, K. 1999. Screening and intervention for intimate partner abuse: Practices and attitudes of primary care physicians. *JAMA*, 282(5), pp.468-474.
- Rodríguez-Franco, L., Borrego, J.L., Rodríguez-Díaz, F.J., Molleda, C.B., Pineda, C.E., Bellerín, M.Á.A. and Quevedo-Blasco, R. 2012. Labeling dating abuse: Undetected abuse among Spanish adolescents and young adults. *International Journal of Clinical Health & Psychology*, 12(1), pp.55-67.
- Romito, P. 2008. *A Deafening Silence: hidden violence against women and children*. Bristol: The Policy Press.
- Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G. and Howard, L. 2011. Barriers and facilitators of disclosures of domestic violence by mental health service users: Qualitative study. *The British Journal of Psychiatry*, 198(3), pp.189-194.
- Roush, K. 2012. Domestic violence screening: When will we get it right? *International Nursing Review*, 59(1), pp.115-116.
- Ryan, G.W. and Bernard, H.R. 2003. Techniques to identify themes. *Field Methods*, 15(1), pp.85-109.

- Salmon, P., Dowrick, C.F., Ring, A. and Humphris, G.M. 2004. Voiced but unheard agendas: Qualitative analysis of the psychosocial cues that patients with unexplained symptoms present to general practitioners. *The British Journal of General Practice*, 54(500), pp.171-175.
- Schoening, A.M., Greenwood, J.L., McNichols, J.A., Heermann, J.A. and Agrawal, S. 2004. Effect of an intimate partner violence educational program on the attitudes of nurses. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 33(5), pp.572-579.
- Schulz, M., DamkrÖGer, A., Voltmer, E., LÖWe, B., Driessen, M., Ward, M. and Wingenfeld, K. 2011. Work-related behaviour and experience pattern in nurses: Impact on physical and mental health. *Journal of Psychiatric & Mental Health Nursing*, 18(5), pp.411-417.
- Shattell, M.M., Starr, S.S. and Thomas, S.P. 2007. 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing*, 16(4), pp.274-284.
- Sheridan, N.F., Kenealy, T.W., Kidd, J.D., Schmidt-Busby, J.I.G., Hand, J.E., Raphael, D.L., McKillop, A.M. and Rea, H.H. 2012. Patients' engagement in primary care: Powerlessness and compounding jeopardy. A qualitative study. *Health Expectations*, pp.1-12.
- Sherin, K.M., Sinacore, J.M., Li, X.Q., Zitter, R.E. and Shakil, A. 1998. HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine*. 30(7), pp.508-512.
- Simmons-Mackie, N. and Kovarsky, D. 2009. Engagement in clinical interaction: An introduction. *IN: Engagement in clinical interaction: An introduction. Seminars in Speech and Language*. Thieme Medical Publishers, pp.005-010.
- Sixsmith, J., Boneham, M. and Goldring, J. E. 2003. Accessing the community: Gaining insider perspectives from the outside. *Qualitative Health Research*, 13(4), pp.578-589.
- Smith, D. 1987. *The everyday world as problematic*. Boston: Northeastern University Press.
- Smith, K.R. and Britain, G. 2012. *Homicides, firearm offences and intimate violence 2010/11: Supplementary volume 2 to crime in England and Wales 2010/11*. London: Home Office.
- Smits, F.T., Brouwer, H.J., Zwinderman, A.H., van, d.A., van Steenkiste, B., Mohrs, J., Schene, A.H., van Weert, H.C. and Riet, G.t. 2013. Predictability of persistent frequent attendance in primary care: A temporal and geographical validation study. *PLoS ONE*, 8(9), pp.1-8.
- Sohal, H., Eldridge, S. and Feder, G. 2007. The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: A diagnostic accuracy study in general practice. *BMC Family Practice*, 8(1), pp.49.
- Spangaro, J., Zwi, A.B. and Poulos, R. 2009. The elusive search for definitive evidence on routine screening for intimate partner violence. *Trauma, Violence, & Abuse*, 10(1), pp.55-68.

- Spangaro, J., Poulos, R.G. and Zwi, A.B. 2011. Pandora doesn't live here anymore: Normalization of screening for intimate partner violence in Australian antenatal, mental health, and substance abuse services. *Violence & Victims*, 26(1), pp.130-144.
- Speziale, H.S. and Carpenter, D.R. 2007. *Qualitative research in nursing: Advancing the humanistic imperative*. 4th ed. Philadelphia: Lippincott Williams & Wilkins.
- Stanhope, V. 2012. The ties that bind: Using ethnographic methods to understand service engagement. *Qualitative Social Work*, 11(4), pp.412-430.
- Stark, E. 2004. The response of health systems to violence against women: Lessons learned and models of good practice. *IN: The response of health systems to violence against women: Lessons learned and models of good practice. Women's Aid. Casualties of Violence Conference 2002*. Dublin: Women's Aid.
- Staudt, M. 2007. Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. *Journal of Child & Family Studies*, 16(2), pp.183-196.
- Staudt, M., Lodato, G. and Hickman, C. 2012. Therapists talk about the engagement process. *Community Mental Health Journal*, 48(2), pp.212-218.
- Stein-Parbury, J. and Liaschenko, J. 2007. Understanding collaboration between nurses and physicians as knowledge at work. *American Journal of Critical Care*, 16(5), pp.470.
- Stevenson, H.C. 2003. Commentary: The conspicuous invisibility of black ways of being: Missing data in new models of children's mental health. *School Psychology Review*, 32(4), pp.520-524.
- Suchman, A.L., Markakis, K., Beckman, H.B. and Frankel, R. 1997. A model of empathic communication in the medical interview. *Journal of the American Medical Association*, 277pp.678-682.
- Sugg, N.K. and Inui, T. 1992. Primary care physicians' response to domestic violence. *JAMA: The Journal of the American Medical Association*, 267(23), pp.3157-3160.
- Sundborg, E.M., Stattin, N.S., Wandell, P. and Tornkvist, L. 2012. Nurses' preparedness to care for women exposed to intimate partner violence: A quantitative study in primary health care. *BMC Nursing*, 11(1), pp.1.
- Sykes, J.B. 1982. *The concise Oxford dictionary*. 7th ed. Oxford: Oxford Clarendon Press.
- Taft, A., O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. and Feder, G. 2013. Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews*, Issue (4), pp1-67.
- Taket, A., Nurse, J., Smith, K., Watson, J., Shakespeare, J., Lavis, V., Cosgrove, K., Mulley, K. and Feder, G. 2003. Routinely asking women about domestic violence in health settings. *BMJ*, 327(7416), pp.673-676.

- Taket, A., Wathen, C.N. and MacMillan, H. 2004. Should health professionals screen all women for domestic violence? *Plos Medicine*, 1(1), pp.e4.
- Taket, A. 2004. *Tackling Domestic Violence: the role of health professionals*. 2nd ed. United Kingdom: Home Office Research, Development and Statistics Directorate.
- Taylor, J., Bradbury-Jones, C., Kroll, T. and Duncan, F. 2013. Health professionals beliefs about domestic abuse and the issue of disclosure: A critical incident technique study. *Health & Social Care in the Community*, 21(5), pp.489-499.
- Thielke, S., Thompson, A. and Stuart, R. 2011. Health psychology in primary care: Recent research and future directions. *Psychology Research and Behavior Management*, 4pp.59-68.
- Thistlethwaite, J. 2009. Patient–doctor interactions: Emotional cues and discussing prognosis. *InnovAiT*, 2(10), pp.598-604.
- Thomas, S. and Layte, R. 2009. General Practitioner Care IN: Layte, R. (ed.) *The Impact of Demographic Change on the Demand for and Delivery of Healthcare in Ireland to 2021*. Dublin: ESRI,
- Tichy, L.L., Becker, J.V. and Sisco, M.M. 2009. The downside of patriarchal benevolence: Ambivalence in addressing domestic violence and socio-economic considerations for women of Tamil Nadu, India. *Journal of Family Violence*, 24(8), pp.547-558.
- Tormey, W. 2003. *A Cure for the Crisis-Irish Health Care in Context*. Dublin: Blackwater Press.
- Toussaint, J.S. and Berry, L.L. 2013. The promise of lean in health care. IN: The promise of lean in health care. *Mayo Clinic Proceedings*. Elsevier, pp.74-82.
- Troy, M. 2007. Helping victims of domestic violence. *Forum*, 24(1), pp.53.
- Undeland, M. and Malterud, K. 2008. Diagnostic interaction: The patient as a source of knowledge? A qualitative case study from general practice. *Scandinavian Journal of Primary Health Care*, 26(4), pp.222-227.
- Usta, J., Antoun, J., Ambuel, B. and Khawaja, M. 2012. Involving the health care system in domestic violence: What women want. *The Annals of Family Medicine*, 10(3), pp.213-220.
- Van Roy, K., Vanheule, S. and Deveugele, M. 2013. What makes up good consultations? A qualitative study of GPs' discourses. *BMC Family Practice*, 14(1), pp.62.
- Vandello, J.A., Cohen, D., Grandon, R. and Franiuk, R. 2009. Stand by your man indirect prescriptions for honorable violence and feminine loyalty in Canada, Chile, and the United States. *Journal of Cross-Cultural Psychology*, 40(1), pp.81-104.
- Walby, S. 1989. Theorising patriarchy. *Sociology*, 23(2), pp.213-234.
- Walker, D. and Myrick, F. 2006. Grounded theory: An exploration of process and procedure. *Qualitative Health Research*, 16(4), pp.547-559.

- Walliman, N. 2006. *Social research methods*. London: Sage Publications.
- Walsh, K., Lawless, J., Moss, C. and Allbon, C. 2005. The development of an engagement tool for practice development. *Practice Development in Health Care*, 4(3), pp.124-130.
- Ward, J. and McMurray, R. 2011. The unspoken work of general practitioner receptionists: A re-examination of emotion management in primary care. *Social Science & Medicine*, 72(10), pp.1583-1587.
- Warshaw, C. 1993. Domestic violence: Challenges to medical practice. *Journal of Women's Health*, 2(1), pp.73-80.
- Watson, D. and Parsons, S. 2005. Domestic abuse of women and men in Ireland. *Report on the National Study of Domestic Abuse*. National Crime Council, Dublin: Stationary Office.
- Westmarland, N., Hester, M. and Reid, P. 2004. *Routine enquiry about domestic violence in general practices: A pilot project*. Bristol: School for Policy Studies, University of Bristol.
- Wiklund-Gustin, L. 2011. To intend to but not being able to frequent attenders' experiences of suffering and of their encounter with the health care system. *Journal of Holistic Nursing*, 29(3), pp.211-220.
- Williston, C.J. and Lafreniere, K.D. 2013. "Holy cow, does that ever open up a can of worms": Health care providers' experiences of inquiring about intimate partner violence. *Health Care for Women International*, 34 (9), pp.814-831.
- Women's Aid *Women's aid national and international statistics* [Online]. Available from: <http://www.womensaid.ie/policy/natintstats.html> [Accessed 22 July 2013].
- Women's Health Council 2007. *Violence against women and health*. Dublin: Women's Health Council.
- World Health Organization. 1997. *Violence against women: A priority health issue*. Geneva: World Health Organization.
- Wuest, J. 2000. Negotiating with helping systems: An example of grounded theory evolving through emergent fit. *Qualitative Health Research*, 10(1), pp.51-70.
- y Garcia, E.F., Duberstein, P., Paterniti, D.A., Cipri, C.S., Kravitz, R.L. and Epstein, R.M. 2012. Feeling labeled, judged, lectured, and rejected by family and friends over depression: Cautionary results for primary care clinicians from a multi-centered, qualitative study. *BMC Family Practice*, 13(1), pp.64.
- Yearnshire, S. 1997. Analysis of cohort. *Violence Against Women*. London: Royal College of Obstetricians and Gynaecologists (RCOG).
- Zwiech, P. 2009. Discrimination against women in professional life in chosen pro-feminist theories. *Economics and Sociology*, 2(1), pp.96-104.

Appendix One Conflict Tactic Scale Screening Tool

Conflict Tactic Scale

CTS (38 items)	CTS2 (78 items)
Reasoning (3)	Negotiation (6)
	Cognitive (3)
	Emotional (3)
Verbal aggression (7)	Psychological aggression (8)
	Minor (4)
	Severe (4)
Physical assault (9)	Physical assault (12)
Minor (3)	Minor (5)
Severe (6)	Severe (7)
	Injury (6)
	Minor (2)
	Severe (4)
	Sexual coercion (7)
	Minor (3)
	Severe (4)

The numbers in the brackets indicate the number of items grouped per section. (1) Reasoning (3 items), (2) Verbal Aggression (7 items), and (3) Physical Assault (9 items), in which each item is asked twice, once about the respondent's behaviour toward a target, and then about the target's behaviour toward the respondent. The original CTS classified items in the physical assault scale into the categories minor and severe, the CTS2 provides a better greater distinction between minor and severe acts and can be divided into cognitive and emotional scales.

(Relva, Fernandes and Costa 2013).

Appendix Two

HITS Screening tool

Over the last 12 months, how often did your partner:	Never 1	Rarely 2	Sometimes 3	Fairly often 4	Frequently 5
Physically HURT you					
INSULT you or talk down to you					
THREATEN you with physical harm					
SCREAM or curse at you Total Score					
Total Score					

(Sherin et al. 1998)

Appendix Three HARK Screening tool

HARK questions – one point is given for every yes answer

H HUMILIATION

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?

A AFRAID

Within the last year, have you been afraid of your partner or ex-partner?

R RAPE

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex partner?

K KICK

Within the last year, have you been kicked, hit, slapped or other wise physically hurt by your partner or ex-partner?

(Sohal, Eldridge and Feder 2007)

Appendix Four CHAT = Case-finding and Help Assessment Tool.

Risk factor	CHAT questions	Positive CHAT	Gold standard tool
Smoking	How many cigarettes do you smoke every day? Do ever feel the need to cut down or stop your smoking?	Yes >10 cigarettes/day or Yes to second question	Heavy Smoking Index
Alcohol	Do you feel the need to cut down on your drinking alcohol? In the past year, have you drunk more alcohol than you meant to?	Yes to either question	Alcohol Use Disorders than to? Identification Test
Other drugs	Do you ever feel the need to cut down on your non-prescription or recreational drug use? In the past year, have you ever used non-prescription or recreational drugs more than you meant to?	Yes to either question	Drug Abuse Screening Test
Gambling	Do you sometimes feel unhappy or worried after a session of gambling? Does gambling sometimes cause you problems?	Yes to either question	South Oaks Gambling Screen
Depression	During the past month have you often been bothered by feeling down, depressed, or hopeless? During the past month have you often been bothered by having little interest or pleasure in doing things?	Yes to either question	Patient Health Questionnaire depression scale
Anxiety	During the past month have you been worrying about a lot of different things?	Yes	Hospital Anxiety and Depression Scale
Abuse/violence	Is there anyone in your life of whom you are afraid or who hurts you in any way? Is there anyone in your life who controls you and prevents you from doing what you want?	Yes to either question	Conflict Tactics Scale (CTS-1) and Hurts, Insults, Threatens, Screams tool
Anger	Is controlling your anger sometimes a problem for you?	Yes	CTS-1
Physical inactivity	As a rule, do you do at least 30 minutes of moderate or vigorous exercise (such as walking or a sport) on 5 or more days of the week?	No	Aerobics Center Longitudinal Study — physical activity questionnaire
Eating disorders	Do you often feel that you can't control One, (anorexia nervosa,) what or how much you eat? bulimia, or bingeing) Does your weight affect the way you feel about yourself?	Yes to either question	'Sick, Control, Fat, Food' questionnaire Eating Disorder Screen for Primary Care

For each item, patients are asked: 'If yes, do you want help with this?', with the options 'Yes', 'Yes but not today', or 'No'; except for the exercise question, which asks: 'If no, do you want help with this?'. CHAT = Case-finding and Help Assessment Tool.

(Goodyear-Smith et al. 2008)

Appendix Five

Recruitment letter for health professionals

01/01/2008.

Dear Colleague,

I am currently undertaking a research study in the area of domestic violence in Primary Care. The purpose of the study is to identify how the general practice team recognise and respond to issues of domestic violence in their clinical setting. The members of the team included in the study are general practitioners, practice nurses and administrative staff. I hope this work will assist in improving patient care.

The data will be gathered by interviewing those who wish to partake in the study.

The information will be completely anonymous and strictly confidentiality will be adhered to at all times. The findings will constitute part of my undertaking a Masters by research at Dublin City University (DCU) and will not be used for any purpose other than the aforementioned research. A tape recorder will be used to record the interviews to ensure accuracy in recording the data.

If you are interested in participating in the study I would be grateful if you would complete the return slip below in return it in the stamped address provided before2008.

If your require any further details or would like to discuss the study further please do not hesitate to contact me at 08..... If you decide not to partake in the study, thank you for taking the time to read this letter. Ethical approval for this study has been granted by the DCU ethics committees.

Yours sincerely,

Rita Lawlor

I wish to participate in the research study on domestic violence.

Name: _____

Address for correspondence: _____

Tel no: _____

Signature: _____

Thank you

Appendix Six

Recruitment letter for women participants

Letter to Domestic Violence Support Organisation

Dear

I am currently undertaking a PhD at Dublin City University (DCU) in the area of domestic violence within Primary Care. The purpose of the study is to identify how the general practice team discover issues of domestic violence amongst women and enable the disclosure of abuse within a clinical consultation. The members of the team included in the study are general practitioners, practice nurses and administrative staff. However, it imperative that the voice of women are heard in the study in order to give a complete understanding of the phenomena of domestic violence within a general practice setting. I hope this work will assist in improving patient care. This is the first time such a study has been conducted within an Irish context.

As a researcher it is necessary to select a service or a site that can purposefully enlighten our understanding of the research problem. Therefore, to inform the process of disclosure of domestic violence from a women's perspective, it is necessary to interview approximately five women who have already disclosed their experience to a support service. Participants will be invited to take part in one to one interviews which will involve sharing with the researcher what prompts disclosure by an individual who has experienced domestic violence from an intimate partner. The interviews will be semi structured with open-ended questions and will last approximately 45-60 minutes. All interviews will be tape recorded so that accurate analysis of the data can occur.

Confidentiality and anonymity of participants will be maintained throughout the study. Those who participate in the study and the location of the agency will **NOT** be identifiable. All data relating to the study will be kept in a locked filing cabinet which is only accessible by the researcher and will be held until the study is completed.

The findings will not be used for any purpose other than the aforementioned research. This study will be subject to stringent ethical approval by DCU ethics committees.

The decision to participate in the study is entirely voluntary and participants may withdraw at any point in advance of data processing and formal analyses of contributions.

If you require any further details or would like to discuss the study further please do not hesitate to contact me.

Rita Lawlor - researcher (rlawlor@gofree.indigo.ie), ph 087 XXXXXX

Dr Jean Clarke – academic supervisor (jean.clarke@dcu.ie) ph 7005838

Dr Vera Sheridan – academic supervisor (vera.sheridan@dcu.ie) 7005048

Yours sincerely

Appendix Seven Email to radio show

From: **Rita Lawlor** <XXXXXXXXXXXX>
Date: Mon, Apr 23, 2012 at 10:42 PM
Subject: domestic violence research
To: XXXXXX

Hi XXX

I listened with interest to your programme of the XXth March 2012 on women's experiences of living in violent relationships. Currently, I am a nurse who is undertaking a PhD research study in the School of Nursing, Dublin City University (DCU) entitled "The discovery and disclosure of domestic violence within a general practice setting".

The purpose of the study is to identify how the general practice team discover issues of violence against women and enable the disclosure of abuse within a clinical consultation.

To date I have interviewed general practitioners, practice nurses and administrators.

However, I believe it imperative that the voice of women who have been in difficult relationships are heard in the study in order to give a complete understanding of the phenomena of domestic violence within a general practice setting. I hope this work will assist in improving care for women in the future. This is the first time such a study has been conducted within an Irish context.

Therefore, to inform the process of disclosure of domestic violence from a women's perspective, it is necessary to interview approximately five women who have been in abusive relationships for the study.

In order to enlighten our understanding of the research problem I need to speak with women **REGARDLESS IF THEY HAVE SHARED THEIR EXPERIENCES WITH THEIR GP OR NOT.**

I am inviting participants to take part in one to one interviews which will involve sharing with me their experience of GP services if they attended them or not. The interviews will last approximately 30 minutes. All interviews will be tape recorded so that accurate analysis of the data can occur.

Confidentiality and anonymity of participants will be maintained throughout the study. Those who participate in the study and the location of the interview will **NOT** be identifiable. All data relating to the study will be kept in a locked filing cabinet which is only accessible by me (the researcher) and will be held until the study is complete.

The findings will not be used for any purpose other than the aforementioned research. This study has obtained ethical approval by DCU ethics committees.

The decision to participate in the study is entirely voluntary and participants may withdraw at any point in advance of data processing and formal analyses of contributions.

If you require any further details or would like to discuss the study further please do not hesitate to contact me.

XXXX, I would be grateful if you would pass my details on to XXXXXXX, XXXX, XXXX or any of your female callers that contacted you at the time 'YYYY YYYYYY' aired the subject of domestic violence.

My supervisors are Dr Jean Clarke – DCU, Dr Vera Sheridan – DCU, Dr Anne Matthews - DCU (if you need to contact the college)

Looking forward to hearing from you.

Yours sincerely

Rita Lawlor
Ph 087 XXXXXXX

Appendix Eight Interview Guide

Sample prompt questions for the interviews:

Opening Question: I am interested in the issue of domestic violence in relation to the general practice population and how it is discovered by members of the general practice team.

Tell me how you go about identifying female patients whom you suspect may be experiencing domestic violence? Subsequent prompts:

- What prompts you toward a suspicion of domestic violence?
- If you suspect domestic violence, how do you approach the issue with your patient?
- Do you ask about domestic violence only when you suspect it?
- If not, when else might you ask about it?
- What are the most difficult issues for you regarding questions of domestic violence?
- What group(s) of patients are you most likely to ask if they experience domestic violence?
- Are there any groups of patients where you would not enquire if they had experienced domestic violence?
- Are there any groups of patients where you would routinely enquire if they had experienced domestic violence?
- How do you respond when you identify a case of domestic violence?
- What is your opinion on whether all patients should be screened for domestic violence?
- Has there ever been a time where you suspected that there may be a case of domestic violence but you chose not to ask/enquire/explore the issue?

- **Administrative Staff**
- When a patient requests an appointment, do they ever mention domestic violence?
 - If yes, how do you respond within your role as ...?
- Have you ever suspected that a patient might be experiencing domestic violence?
 - If yes, how did you respond
 - Did you experience any difficulties around what you wanted/needed to do?

Women participants

- Can you tell me about your experience of being able to talk about domestic violence to your general practitioner or practice nurse?

Appendix Nine Open coding

Open codes

Name	Sources	References	Created On	Created By	Modified On
avoiding issues	31	107	05/01/2011 00:17	RL	18/07/2012 16:53
broaching the subject	26	123	16/01/2011 14:01	RL	17/07/2012 12:00
busyness, under pressure	19	49	14/01/2011 11:59	RL	17/07/2012 12:23
Changing family dynamics	14	28	09/01/2011 22:54	RL	18/07/2012 16:20
Choreographing the consultat	30	100	10/04/2011 21:47	RL	18/02/2013 16:05
Complexities of abuse	23	81	05/01/2011 22:09	RL	15/07/2012 20:14
Conscious raising	21	55	05/01/2011 22:57	RL	22/02/2013 17:30
Coping with abuse	22	62	04/01/2011 23:38	RL	18/07/2012 17:18
Cultural diversity	13	38	06/01/2011 23:29	RL	06/07/2012 18:17
Dealing with the present onl	26	118	12/01/2011 22:21	RL	18/07/2012 19:42
Disclosing	24	144	16/08/2010 23:12	RL	14/07/2012 21:48
Discovering DV	33	347	04/01/2011 23:25	RL	22/02/2013 17:30
Domestic oppression	11	49	09/01/2011 22:03	RL	13/07/2012 18:29
empathising	20	48	14/01/2011 11:44	RL	16/07/2012 11:37
explaining it away	31	113	05/01/2011 21:04	RL	18/07/2012 17:19
Familiarity with pts	21	94	05/01/2011 20:42	RL	16/07/2012 21:48
fear and anxieties	24	60	05/01/2011 22:06	RL	16/07/2012 21:48
feeling helpless	22	56	17/01/2011 20:19	RL	22/02/2013 17:30
Fixing things	8	14	06/07/2012 23:45	RL	04/08/2012 20:01
Frequencies	14	56	16/08/2010 23:09	RL	14/07/2012 21:48
Frequenting	12	26	04/07/2012 15:25	RL	18/07/2012 19:46
gatekeeping	16	70	16/01/2011 14:55	RL	16/07/2012 14:49
Gendering issues	16	54	05/01/2011 21:40	RL	18/07/2012 16:49
Health Prof dilem	20	100	04/01/2011 22:41	RL	18/07/2012 16:47

Open codes

Name	Sources	References	Created On	Created By	Modified On
avoiding issues	31	107	05/01/2011 00:17	RL	18/07/2012 16:53
broaching the subject	26	123	16/01/2011 14:01	RL	17/07/2012 12:00
busyness, under pressure	19	49	14/01/2011 11:59	RL	17/07/2012 12:23
Changing family dynamics	14	28	09/01/2011 22:54	RL	18/07/2012 16:20
Choreographing the consultat	30	100	10/04/2011 21:47	RL	18/02/2013 16:05
Complexities of abuse	23	81	05/01/2011 22:09	RL	15/07/2012 20:14
Conscious raising	21	55	05/01/2011 22:57	RL	22/02/2013 17:30
Coping with abuse	22	62	04/01/2011 23:38	RL	18/07/2012 17:18
Cultural diversity	13	38	06/01/2011 23:29	RL	06/07/2012 18:17
Dealing with the present onl	26	118	12/01/2011 22:21	RL	18/07/2012 19:42
Disclosing	24	144	16/08/2010 23:12	RL	14/07/2012 21:48
Discovering DV	33	347	04/01/2011 23:25	RL	22/02/2013 17:30
Domestic oppression	11	49	09/01/2011 22:03	RL	13/07/2012 18:29
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explaining it away	31	113	05/01/2011 21:04	RL	18/07/2012 17:19
Familiarity with pts	21	94	05/01/2011 20:42	RL	16/07/2012 21:48
fear and anxieties	24	60	05/01/2011 22:06	RL	16/07/2012 21:48
feeling helpless	22	56	17/01/2011 20:19	RL	22/02/2013 17:30
Fixing things	8	14	06/07/2012 23:45	RL	04/08/2012 20:01
Frequencies	14	56	16/08/2010 23:09	RL	14/07/2012 21:48
Frequenting	12	26	04/07/2012 15:25	RL	18/07/2012 19:46
gatekeeping	16	70	16/01/2011 14:55	RL	16/07/2012 14:49
Gendering issues	16	54	05/01/2011 21:40	RL	18/07/2012 16:49
Health Prof dilem	20	100	04/01/2011 22:41	RL	18/07/2012 16:47

Appendix Ten Selective coding from women’s interviews

Selective Coding	Open Coding			Core Category
Realising there is a problem	Not aware of DV			“Lifting the stones and seeing the slugs beneath”
	Repeating behaviour “being bent to accept that”			
	Testing boundaries			
	Damaging invisible places			
Wanting to be heard	Stigma and taboo	Heard by another prof		
	Ready to disclose			
	Never being asked			
Wanting to be seen	When the obvious is ignored			
	Seen as the illness or ache			
	In case of legal case			
	Before bruising disappears			
	Attending GP frequently			
	Dying for him to look up			
Fooling self and others	Hiding DV from every one	Invisible	Protecting privacy	Feeling invisible? Invisibility
	Different persona in community			
	Acting normal			
Self preserving	Putting on a “good			

strategies	front” outside			
	Closing boxes in my head			
	Building picture that all is fine			
	Not seeing yourself as victim			
	Not a victim, not survivor - thriver			
Reading the person	Chest x ray, pneumonia,			
	Hiding injuries			
	GP not seeing hidden places			
	As woman with a problem			
	Not connecting signs of physical and emotional health			
	Not enquiring about home			
clarifying roles	Not GP’s area, “fixes things”			
	Practice nurse doing tasks			
	Needing a therapist in practice			
	GP “clueless”			
Medicalising	Medication			
	Frequent visits			
	Being diagnosed (“as the ache”)			
	Labelled with illness to disclose			

	Talking their language			
	Trying to get through			
	Medical power			
	“Classified” for life (labelling)			
	Discontinuing treatment			
	Collaborating with psychiatrists			
	Always getting tablets			
	Writing script as come in the door			
	Ignoring signs			
	Not making connections between visits			
GP setting [dis]abling	Waiting room full			
	Patients complaining, delay			
	Asking too much of GP’s			
	Apologising to other pts for delay			
	Never felt a place to talk about dv			
	Big queues – in and out			
	No posters or information – nothing to indicate knowledge of DV			
	GP’s not delving enough			

	Deal with dv by not dealing with it			
Wanting to be asked	If Gp noticed "me" - make it easier		Cultivating silences	Choreographing the consultation

Appendix Eleven Memo Example

Memo - Asking or telling

14/07/2012

telling is almost like sharing. how does it happen? Generally telling following questioning or being questioned. That means that someone, perhaps the HP has seen something to ask or the woman is compelled to tell of her situation.

the interaction between Telling + Naming mean that there is a recognition that needs to be explored. This is an example¹²¹ of disclosing but it doesn't show how the woman is enabled to reach the point of disclosure in the general practice setting.

'telling' is a method going public on the issue of domestic violence. By telling there is an expectation that the woman may want something done or not. she may only want to share her experience with 'another'.

The consequences of not telling anyone maintain the privacy, and the secrecy surrounding the issues. Not telling may also be due to denying, not wanting to admit what is happening. Deciding not to tell anyone including the GP suggests that the GP is not seen as the person in whom to confide matters of an intimate nature.

The thing about mental abuse or intimacy abuse, if you keep your mouth shut it gets ignored. And there was some physical abuse but you could not tell [because the marks are hidden], you didn't know, they weren't going to find it. it's easier to hide. I can't blame him [GP], I didn't know myself. [Pearl]

Again the concept of TELLING emerges but there is a differentiation* between telling about mental and physical abuse. greater control appears to exist over whether to disclose mental abuse as there are no physical signs. "it gets ignored" by the woman, blocked out as such.

See the codes of covering up and SEEING/NOT SEEING.

¹²¹ The typographical errors throughout this memo are from the original, free style of writing indicating the flow of ideas at the time.

Appendix Twelve Ethical Approval to interview health professionals

DCU

Dublin City University
Ollscoil Chathair Bhaile Átha Cliath

Office of the Vice-President for Research
Dublin 9, Ireland

Dr. Jean Clarke
School of Nursing

27th May 2008

REC Reference: DCUREC/2008/57

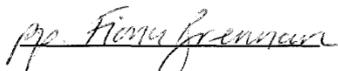
Proposal Title: **The General Practice Teams understanding of domestic violence and how disclosure is enabled within general practice**

Applicants: Dr. Jean Clarke, Ms. Rita Lawlor

Dear Jean,

This research proposal qualifies under our Notification Procedure, as a low-risk social research project. Therefore, the DCU Research Ethics Committee approves this research proposal. Should substantial modifications to the research protocol be required at a later stage, a further submission should be made to the REC.

Yours sincerely,



Mr. Brian Trench
Chair
DCU Research Ethics Committee



Telephone 353 (0)1 700 8000
Facsimile 353 (0)1 700 8002
Email research@dcu.ie
Website www.dcu.ie

Appendix Thirteen Modification to Ethical Approval (to interview women)

DCU

Dr. Jean Clarke
School of Nursing

23rd March 2011

REC Reference: DCUREC/2011/027

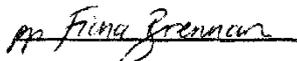
Proposal Title: **The discovery and disclosure of domestic violence within a general practice setting – a grounded theory study**

Applicants: Dr. Jean Clarke, Ms. Rita Lawlor

Dear Jean,

Further to expedited review, the DCU Research Ethics Committee approves this research proposal. Should substantial modifications to the research protocol be required at a later stage, a further submission should be made to the REC.

Yours sincerely,



Dr. Donal O'Mathuna
Chair
DCU Research Ethics Committee



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Dublin 9, Ireland

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Appendix Fourteen Plain Language Statement

The General Practice Teams understanding of domestic violence and how disclosure is enabled within general practice

This study will be carried out by Rita Lawlor as part of a PhD which I am undertaking in Dublin City University. The purpose of the study is two fold. Firstly, it is to determine how the general practice team, which primarily consists of general practitioners, practice nurses and administrative staff, discover those who experience or have experienced domestic violence from an intimate partner in the course of a clinical consultation and secondly how the disclosure of violence against women is enabled within general practice. I invite you to participate in the study and I will outline below what is involved.

You will be invited to participate in a one to one interview. This will involve sharing with the researcher what prompts you to enquire if an individual has experienced domestic violence from an intimate partner and how disclosure is enabled within general practice. Women participants will be invited to discuss with the researcher their experience of disclosing (or not) of domestic violence to a health professional within general practice. The interviews will be semi structured with open-ended questions. The interviews will be conducted by the researcher and will last approximately 30 minutes. All interviews will be tape recorded so that accurate analysis of the data can occur.

While there will be no direct benefit to you from participating in the study, the findings will assist in the development of future educational opportunities for health care professionals. Confidentiality and anonymity of participants will be maintained throughout the study. Those who participate in the study and the location of the general practice site will **NOT** be identifiable. All data relating to the study will be kept in a locked filing cabinet which is only accessible to the researcher and will be held until the study is completed. It will be held for a period of 3 years thereafter, when it will be destroyed. The decision to participate in the study is entirely voluntary and participants may withdraw at any point in advance of data processing and formal analyses of contributions.

If you require any further details about the study please contact

Rita Lawlor - researcher (rita.lawlor7@mail.dcu.ie), ph 087 XXXXXX

Dr Jean Clarke – academic supervisor (jean.clarke@dcu.ie) ph 7005838

Dr Vera Sheridan - academic supervisor (vera.sheridan@dcu.ie) ph 7005048

Appendix Fifteen Informed Consent Form [health professionals]

Researcher Rita Lawlor, rita.lawlor7@mail.dcu.ie ph 087

Academic supervisors Dr Jean Clarke, jean.clarke@dcu.ie ph 7008533

Dr Vera Sheridan, vera.sheridan@dcu.ie ph 7005048

The purpose of this study is to identify how the general practice team discover domestic violence issues as part of a clinical consultation. For the purpose of the research, the core general practice team consists of the general practitioner, practice nurse and administrator staff. The research will be used as part of a Doctoral study which the researcher is undertaking in Dublin City University.

Due to my **clinical experience** and **familiarity of the general practice workplace** I understand that I will be asked questions regarding my knowledge of recognising and responding to domestic violence in the general practice setting.

I understand that participation in the study is voluntary and that I can withdraw from the project at any time in advance of the data processing or analysis stage. I understand that the information is totally confidential and that my anonymity will be maintained at all times. No names or identifying details will appear in the final study.

I understand that the taped interviews will be stored in a secure environment until the study is completed and for a period of three years thereafter, when they will be destroyed by the researcher.

I have been informed that a copy of the final study will be available to me should I request it.

I have read and understand the information in this form. My questions and concerns have been answered by the researcher. I understand that I can withdraw from the study in advance of data processing and formal analysis of contributions. I have been given a copy of this consent form.

I am willing to take part in this research project.

Participant's signature: _____ Date _____

Appendix Sixteen Informed Consent Form [women participants]

Researcher Rita Lawlor, rita.lawlor7@mail.dcu.ie ph

Academic supervisors Dr Jean Clarke, jean.clarke@dcu.ie ph 7008533

Dr Vera Sheridan, vera.sheridan@dcu.ie ph 7005048

The purpose of this study is to identify how women who experience or have experienced domestic violence disclose [or not] their encounters of abuse while attending the general practice. For the purpose of the research, the core general practice team consists of the general practitioner, practice nurse and administrator staff. The research will be used as part of a Doctoral study which the researcher is undertaking in Dublin City University.

I am being asked to participate in this study to provide a woman's insight into how the disclosure of domestic violence is enabled [or not] by the general practice team for women who live or have lived in an abusive relationship. I understand that I will be asked questions regarding my knowledge of recognising and responding to domestic violence in the general practice setting.

I understand that participation in the study is voluntary and that I can withdraw from the project at any time in advance of the data processing or analysis stage. I understand that the information is totally confidential and that my anonymity will be maintained at all times. No names or identifying details will appear in the final study.

I understand that the taped interviews will be stored in a secure environment until the study is completed and for a period of three years thereafter, when they will be destroyed by the researcher.

I have been informed that a copy of the final study will be available to me should I request it.

I have read and understand the information in this form. My questions and concerns have been answered by the researcher. I understand that I can withdraw from the study in advance of data processing and formal analysis of contributions. I have been given a copy of this consent form.

I am willing to take part in this research project.

Participant's signature: _____ Date _____

Researcher's signature: _____