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Finnish Health Care Professionals' Views of Patients Who Experience Family Violence

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Abstract

The aim of this study was to examine the beliefs health care personnel have about patients who experience family violence. This was done by analyzing the positions constructed for such patients using content analysis. The data comprise six focus groups conducted with physicians, nurses, social workers, and psychologists working in a maternity unit, a psychiatric ward, and an emergency department. The research team collected the data in 2006 in Finland. Three main positions were constructed for these patients: as a “victim,” with the classic characteristics of such; as a person damaged or disturbed in such a way that his or her victimization has become hidden behind secondary symptoms; and, as responsible for ending the violence and thus as an active contributor to and supporter of the violence. The results support the notion that health care personnel often have stereotypical beliefs about people experiencing family violence. It would be important to educate personnel about the dynamics of family violence.

Keywords

intimate partner violence, domestic violence, abuse, victimization, attitudes, positioning

Historically, intervening in family violence has been constructed as an exclusively social care issue. A health care provider is, however, likely to be the first professional contact for people who experience physical, psychological, or sexual violence and abuse in family and other close relationships. Patients frequently report difficulties in disclosing their experiences with family violence to health care personnel (Yam, 2000). Thus, attention has been focused on the lack of knowledge health care personnel have about family violence, its prevalence, and the health consequences associated with it. Health care professionals commonly feel that they are able to recognize family violence among their patients (Roelens, Verstraelen, Van Egmond, & Temmerman, 2006). In addition, health professionals believe family violence to be a rather rare phenomenon, affecting less than 1% or even less than 1% of their patients (Miller & Jaye, 2007; Roelens et al., 2006). Research shows that most patients experiencing family violence who visit health care agencies do not receive any intervention (Furniss, McCaffrey, Parnell, & Rovi, 2007; Owen-Smith et al., 2008).

The most common signs of violence, as reported by health care personnel, are visible physical injuries (García-Moreno, 2002; Gerbert, Caspers, Bronstone, Moe, & Abercombie, 1999; Leppäkoski, 2007; Miller & Jaye, 2007; Peltzer, Mashego, & Mabeba, 2003; Roelens et al., 2006). Family violence is suspected if the location or type of injury does not correspond to the patient's story, or if the injuries are typical

consequences of family violence (such as a black eye, a swollen lip, or multiple bruises of various age; Leppäkoski, 2007). However, health care professionals often do not recognize violence even in cases in which the signs of physical violence are clearly evident (Bacchus, Mezey, & Bewley, 2003; Leppäkoski, 2007).

Health care personnel also believe that they can detect signs of violence by the patients' behavior (García-Moreno, 2002; Leppäkoski, 2007). People experiencing family violence are seen as fearful and excessively vigilant, distressed and tearful, or nervous and hostile (Leppäkoski, 2007). They can also be seen as evasive and reluctant to explain how they came by their injuries (García-Moreno, 2002; Leppäkoski, 2007). In addition to these behavioral clues, professionals report becoming suspicious of family violence if the patient visits the health care agency regularly, arrives at the appointment intoxicated, or complains of vague symptoms such as headache or chest pain.

Ethnic background and socioeconomic status also influence the probability that patients are believed to be

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encountering family violence (Baig, Shadigian, & Heisler, 2006; Sugg & Inui, 1992). For instance, 37% of American residents falsely thought that family violence is more prevalent among African American than Caucasian Americans (Baig et al., 2006). Sixty-six percent of the physicians studied also incorrectly assumed that violence is more prevalent among patients of lower socioeconomic status. These beliefs may serve the need of health care personnel to protect themselves: It may be less of an emotional strain to think that patients very similar to themselves (Caucasian and middle class) cannot be at risk of encountering violence (Sugg & Inui, 1992).

Attributions of Blame for Family Violence

Family violence is often seen as a medical problem in health care. For example, 91% of South African physicians felt that family violence should be treated as a medical syndrome (Peltzer et al., 2003). Medicalization, however, can displace the responsibility for violence from the perpetrator to the abused patient: The patient can be seen as mentally ill or substance dependent, obscuring comprehension of the likelihood that these are the consequences, not the causes, for the violence (Harne & Radford, 2008). For instance, 59% of the same sample of South African physicians believed that family violence is caused by the battered person's psychological problems (Peltzer et al., 2003). This kind of thinking can be seen as blaming the abused person.

It has been estimated that almost a third (30%) of American physicians have attitudes that put the blame on the patient experiencing family violence (Garimella, Plichta, Houseman, & Garzon, 2000). It is believed that the abuse is caused by characteristics of the individual's personality, such as passivity or dependency. It is also thought that the person must be getting something out of the relationship, or otherwise they would leave. Health care personnel may even believe that abused people subconsciously gravitate toward violent relationships (Jackson, Witte, & Petretic-Jackson, 2001) or that they remain in them because of their masochism (Peltzer et al., 2003). Hence, the most common reason for blaming the abused person is that they are not able to leave the relationship. It has been observed that attributing blame in this way is significantly more widespread among men than women (Garimella et al., 2000).

Victim or Survivor?

Patients experiencing family violence have traditionally been called victims: This is because it has been considered important to highlight the suffering inflicted by the violence. In the 1990s, however, this dominant convention changed; these patients were no longer being considered victims but instead as survivors (Johnson & Ferraro, 2000). The victim

discourse can be seen as encompassing the idea of a weak, helpless, incapable, and uncontrollable nuisance who is considered at least partly responsible for her or his victimization (Browne, 1991; Buchbinder & Birnbaum, 2010). Victims are perceived not only as passive objects of abuse but also as incompetent to act on their own behalf (Profitt, 1996). Therefore, agency and victimization are seen as mutually exclusive, with the result that leaving the violent relationship is considered as the only evidence of the victim's agency.

Identifying oneself as a survivor removes some of the problems inherent in the dichotomy of victim versus agent (Leisenring, 2006). The conceptualization of patients encountering violence as survivors acknowledges their tremendous strengths and coping skills, as well as their pain and loss (Profitt, 1996). The survivor discourse portrays the abused person as proactive, competent, and heroic (Buchbinder & Birnbaum, 2010). The problem with the survivor discourse lies, however, in the expectations of strength and resilience implicit in the term, which can generate feelings of shame in the presence of one's own weakness and exhaustion. Furthermore, the expression "survivor" still refers to people primarily in terms of the effects that violence and abuse has had on them (Profitt, 1996). In the move from victim to survivor, the focus has not thus actually shifted from representing the person as an object of oppressive forces. In this article, it has been a conscious decision not to use either of these terms because of their problematic nature. Instead, people experiencing family violence are simply referred to as patients.

Positioning

Position can be defined as a pattern of beliefs current among the members of a relatively coherent speech community (Harré & Moghaddam, 2003). It can be seen as a replacement for traditional, static concepts such as role. Unlike roles, positions are dynamic and fluid, not fixed (van Langenhove & Harré, 2003). Positioning determines what actions are socially possible and appropriate for a person by defining a loose set of rights and duties. Therefore, an individual's behavior is understood and explained in terms of what is culturally assumed to be typical for persons who are perceived as members of the category in question (Harré & Moghaddam, 2003). Positioning can be interactive, as when the speech of one person positions another, or reflexive when a person positions oneself (Davies & Harré, 1990): It can thus be defined as the way in which people dynamically produce and explain the everyday behavior of themselves and others (van Langenhove & Harré, 2003). Others are required to conform if they want to continue to converse with the first speaker in a way that contributes to that person's story line (Davies & Harré, 1990). Of course, the others may not wish to do so for various reasons: in such a case, positionings can be challenged and people repositioned (Harré & Moghaddam, 2003).

In this study, the concept of positioning was used to render visible the beliefs and responsibilities that personnel in specialist health care, or secondary care, construct concerning patients experiencing family violence. Beliefs and knowledge about people experiencing family violence are crucial for identification of these patients. Positioning is an interactive process and the positions constructed may be challenged by other group members. When constructing positions for these patients, health care professionals are at the same time constructing expectations regarding the actions of not only the patients but also themselves, thus attributing responsibility. The research questions are (a) What positions are constructed in specialist health care for patients experiencing family violence? (b) What are the implications of these positions for identification of violence and the actions expected of these patients and of health care personnel?

Method

Data

The data in this study form part of a larger development and research project, Violence Intervention in Specialist Health Care (VISH), which was funded by the European Union (EU) Daphne III Program in 2009 through 2010. The aim of the project is to create an evidence-based model for intervening in family violence and to strengthen the channels for offering help to all the parties involved in the violence. The study has been approved by the Ethics Committee of the Central Finland Health Care District.

The research team collected the data in 2006 via six focus groups (FGs). A FG is guided and supported by researchers, and focus on a particular topic to be discussed in a group setting (Marková, Linell, Grossen, & Salazar Orvig, 2007). The FG is often used as a means for studying participants' opinions about and attitudes toward the phenomenon of interest (Barbour & Kitzinger, 1999; Fern, 2001; Stewart, Shamdasani, & Rook, 2007). In this study, the use of FGs allowed the researchers to study the dynamic interactions that took place during the interviews, as well as the construction, maintenance, and transformation of socially shared knowledge (Marková et al., 2007).

In the research interviews conducted in this study, specialist health care personnel discussed how they encounter and intervene in family violence in the course of their work. Family violence was explicitly determined as physical, psychological, or sexual abuse between spouses, family members, relatives, friends, or dating partners. This definition was given to the participants in an information letter prior to the interviews. Each FG consisted of three to six professionals (physicians, nurses, social workers, and psychologists), and there were 30 volunteering participants altogether. The health professionals worked in VISH pilot departments: a maternity, a psychiatric ward, and an emergency department. Twenty-two of the participants were women and 8 were men.

Two of the six groups were multiprofessional, whereas in the other four groups all the participants were drawn from the same profession. Each interview took approximately 1.5 hr, and they were all videotaped, recorded, and transcribed to text form.

Analysis

The data were analyzed using content analysis, which is a method used to analyze transcription data or other data in textual form (Brewerton & Millward, 2001). In qualitative content analysis, the emphasis is not on quantification but rather on meanings. The analysis started by a thorough reading of the transcribed interviews (142 pp.), after which all the extracts that seemed to focus around the patient's experience of family violence were copied to a new text file. These extracts comprised 38 pages. The initial positioning categories emerged by reading the transcribed extracts recurrently and labeling them under one or more themes that arose from the text. This resulted in 39 overlapping, uncombined categories. Gradually, these initially separate themes blended into one another, forming three main categories with three to four subcategories in each. The original transcribed data were thus organized into meaningful extracts, coded and categorized to reveal concealed themes and patterns (McLeod, 2001). The transcribed text extracts were supplemented by viewing the original videotaped interviews to find out whether and, if so, how the positions constructed by participants for abused patients were challenged by others in the group. Lastly, text extracts that were considered to best illustrate the three main categories and the 11 subcategories were chosen. The extracts were selected from different FGs and participants to best cover the data.

Results

The constructed positions were divided into three categories, each with three to four subcategories. The patient was positioned as a visible and easily recognizable "victim," as latently damaged by the violence, and as contributing to and supporting the violence. These categories are presented with examples from the transcribed data. The data are cited by referring to the FG (e.g., FG1) and the interviewee in question (e.g., P1) with an abbreviation. (Parentheses) are used when the words said are too ambiguous or silent to be properly heard. Notes made by the transcriber are given inside ((double parentheses)). Overlapping speech is marked with [square brackets].

A Visible and Easily Recognizable "Victim"

A patient thought to be experiencing family violence was perceived as possessing the classic characteristics of a "victim" and was thus positioned as easily recognizable. These characteristics, physical, emotional, or relational, clearly

differentiate the patient from “normal” patients, thus arousing suspicions among the health care professionals.

A patient experiencing family violence was most often positioned as easily recognizable because of his or her visible physical injuries or recurrent “accidents.” Attention to the injury mechanisms typical of family violence was considered important. The possibility of victimization was thus accepted and noticed only in the presence of bruises and cuts.

(FG3)

P4: Well they are mostly sorts of external signs that you have to notice before you start asking any questions. Multiple old small bruises all over and now there’s a cut then from somewhere on top of that. More like through these things than.

The patients experiencing family violence were positioned as displaying strong, readily noticeable emotions, such as shame, sadness, exhaustion, and loss of self-esteem or dignity. The patients’ sense of security was portrayed as very low. The emotion of fear, for example, in relation to childbirth or to difficulty interacting with health care professionals representing the same sex as the offender, was frequently mentioned.

(FG2)

P3: But there was that one, who was, who came to me the first rape victim that came to the medical center emergency care. And a male psychiatrist went to interview her but the woman wouldn’t say anything to him. And then the doctor came and we wondered what if a woman went maybe she would tell her. And then the woman did in fact start to tell about events like this. But they won’t open up to a male doctor.

The health care professionals positioned patients experiencing family violence as living in troublesome relationships. Problems such as jealousy, controlling behavior, strange relationship chemistry, or the desire to end the relationship were considered to indicate the possibility of abuse.

(FG1)

P5: You would have more skill to sus it out from for instance a relationship problem or jealousy and start to like map it out from there I don’t know if I’m driveling on but you probably understood like what I’m saying.

The health care professionals also positioned patients experiencing family violence as easily recognizable in a more nebulous fashion. They seem to rely heavily on their intuition as they try to pick up clues suggesting that “something’s wrong.” Family violence was suspected, for example, when a pregnant woman felt uncomfortable with a gynecological examination or when the reason for seeking medical attention was considered to be vague, diffuse, or even bogus.

In the next extract, a participant is sharing his view on family violence screening.

(FG2)

P5: Well at least I, a situation comes, like if you get that kind of feeling for some reason. These patients usually communicate it, it can be like read between the lines. Sometimes you can read it, unfortunately maybe not always. But at least I don’t automatically ask about it first off.

Latently Damaged by Family Violence

Patients experiencing family violence were also positioned as not presenting the classic characteristics of a “victim.” Instead, such patients were perceived as damaged or disturbed, to the point where their victimization becomes concealed behind secondary symptoms, such as psychological problems, substance abuse, or physical pain, as the next extract shows.

(FG5)

P5: We actually had in the children’s ward this kind of case last summer an appendix was operated on unnecessarily.

P5: In this child who because of family violence came in some nurse then later asked how are you doing like some time in the evening beside the child’s bed and then it came out.

Patients experiencing family violence were also positioned as being at risk for psychological distress, such as anxiety, depression, insomnia, and self-harm.

(FG2)

P6: Somehow it feels like when yeah psychiatric patients that come to us and such like emotional violence is very common in almost every case either in childhood, youth or the present stage of life there’s some sort of emotional abuse they have faced or experienced at least.

The health care professionals positioned patients experiencing family violence as liable to turn to alcohol and drugs to cope with the violence. In particular, pregnant women using drugs and intoxicated patients seeking medical attention were perceived as very likely to be experiencing family violence.

(FG4)

P1: Oh well this is based on this kind of intuition or this kind of implicit like po-pondering the issue and I can be totally wrong too, but like such and like I do think this society or like Finland is like one of the most violent countries in the world but most of the violence is done where drunks hang out to each other well there’s not I think these intoxicants and such influence like in the

background but of course this family violence can like lead to this substance abuse and from those circles breeds probably maybe more than than like this.

This positioning of patients experiencing family violence as mainly people with substance dependencies was however challenged. The professionals acknowledged that the perceived connection between substance abuse and family violence might be based more on their own attitudes than reality. This is evident in the next extract, in which the participants discuss whether or not family violence is more prevalent among substance-dependent mothers.

(FG6)

P1: Well I think so yeah, but it can also be because they have like this more rigorous screening during pregnancy and after the births also compared to others giving birth.

P4: And then like they have these contacts to other places, too like in the emergency room they have more visits than the so called normal pregnant—or like they already have several of these, and then they have social care and there can be rehab like they are known to us from there already.

P6: Then I think that it is easier to ask them about this sort of issue, compared to just someone walking down the street, an expectant woman like it's not like you go and ask.

Abused patients were also positioned as potential assaulters themselves. The health care professionals described how victimization can be concealed in cases where a perpetrator turns out to have originally been abused. Several possible situations were showcased. The patient might have been abused as a child, and as an adult becomes violent toward their own children. Abused women can turn against their batterers and even kill them. Patients experiencing family violence can also be so distressed that they attack the professionals treating them.

(FG6)

P1: And then with women it can be targeted at the child, which is also one area.

P4: [indeed].

P5: And then, if there's a kicked dog in the family, then you know that you have to, the children kicked the dog then.

P1: [Exactly,] it goes somewhere.

P5: It goes somewhere.

Patients experiencing family violence were also positioned as not having any visible symptoms, unless forcefully

confronted with the issue of receiving violence. They were thus positioned as time bombs: not currently problematic but representing a potentially severe challenge in the future. This is why the health care professionals did not consider it wise to start “poking” at the issue and cause the patient to “explode.” For instance, asking about childhood molestation or bullying was deemed dangerous because of the possibility of traumatizing the patient further.

(FG1)

P5: Child abuse is just somehow like as a trauma somehow somehow I feel that it's that it is SO deep that you are left kind of helpless and you don't really have the courage to like hhh traumatize even more yeah because of that intervention something would remain unfinished and then those wounds are completely open which might have been closed with some other mechanism.

Contributing to and Supporting the Violence

Patients were also positioned as responsible for ending the violence directed toward them. This positioning indicates that they were perceived as contributing to and supporting the violence. The health care professionals believed that whether or not to stay in a violent relationship was the abused patient's own choice and that it is these patients' job to become stronger and braver to seek help and leave their batterers.

(FG2)

P1: Like from my point of view when I think about it then the biggest obstacle to somehow doing this work are my own emotions and my own cynicism and frustration. And somehow when there are no involuntary treatment resources and nothing that dammit, they are just going back home to be beaten. I can't do anything. Like these are the sort of things, you would always like to get help there pretty quick, somehow to stop and think about the situation and. Then they evoke emotions. And then you feel kind of rejected, like it's totally clear that I can't, we can't treat this.

P2: That's true.

P5: What do you come here for if you don't want it.

P1: Yeah why are you coming here if you don't take anything we're offering here and.

It was commonly agreed that the abused patients cannot be helped if they do not leave their violent partner. Family violence was thus considered to be a somehow distinct issue, where the generally accepted response to treatment (“two steps forward and one step back”) is not valid. In Extract 12, this position was however challenged by one participant (P2)

who stressed that every step toward the patient's well-being is important.

(FG1)

P5: You can't help then you know that our treatment ends say next Tuesday but you can't transfer it

P2: But you can't tell whether it has already helped them with something like in a way like.

Patients experiencing family violence were positioned as somehow mentally weaker than others. This weakness was attributed to ethnicity, pregnancy, former experiences of violence, low socioeconomic status or being female.

(FG3)

P4: It is a situational, subjective experience.

P1: [That's] right.

P4: Like in some situations some things feel offensive and oppressive or authoritative, in some situations it's quite all right.

P3: It's this, somehow the interpretation (how they are seeing it).

P1: [It's so hard to interpret].

P3: One doesn't mind at all and then another one is totally anxious.

P1: Yeah.

The perceived low socioeconomic status of patients experiencing family violence was indicated, for instance, by stating that they do not watch documentaries or current affairs programs on TV. Also, violence was often described in rather vulgar terms and expressions, such as "her hubby beats her up/thrashes/bruises." The sex of the patient experiencing family violence was most often indicated by referring to them as "she." It was also mentioned that health professionals may never have encountered a man seeking help as a patient experiencing family violence. This positioning, that abused patients are predominantly women of low socioeconomic status, was nevertheless often challenged.

(FG4)

P2: I can now open up, no but here it's for real one horrible (example was) a few years back this kind of doctor colleague who was burned ALIVE by his wife the violence had been going on for years and then she set her husband on fire and he died the cardiologist from that ((laughing)) thing like then like yeah a working person.

?: Awful

P3: It happens in all walks of life ((vigorously)) you shouldn't then people so that.

It was also recognized that men can be experiencing family violence, too, but men's victimization was often somehow ridiculed.

(FG3)

P4: I think that that emotional violence is the most difficult of these. One can see it as a part of a normal relationship.

((P2 and P1 are laughing))

P4: Based on that every Finnish male drunk that comes to the hospital then has experienced emotional abuse.

Because of this perceived weakness, abused patients were positioned as unable to recognize the violence they had suffered and understand their own best interests. These patients were described as falsely understanding violence as merely a bad relationship, for example. This is why they need to be "awakened" and guided.

(FG1)

P1: It's not always when if you ask a patient if there's violence say like in a relationship then often the patients reply that NO THERE'S NOT but then when the patient describes that relationship like the patient anyway describes these features of emotional abuse it's full of there might even be something physical breaking objects et cetera but the person doesn't perceive it as violence so that when we ask about it the answer is no and then the description comes like according to this definition like that's pretty typical.

The abused patient was positioned as an accomplice to the family violence when they were described as repeatedly acting in a way that benefits the perpetrator. This is done by accepting, forgetting, or covering up the experienced violence, keeping up appearances or otherwise protecting the batterer and blaming oneself for the violence. The patients' custom of repeatedly returning to the violent relationship and refusing the help offered in the health care system was also regarded with disapproval.

(FG3)

P4: [Their] their relationship hadn't been long it was a few years' acquaintance. I asked are you completely sure that you're going to share a ride with him? She said yes she, that there has been so much stress in the background that she totally understands that he acted this way. It's like the woman went with

him in a way because she understands that if you're a little stressed out then you can whack her if you're a little pissed off.

Patients experiencing family violence were also positioned as somehow to be blamed for their own maltreatment. This was done by suggesting that these patients had in some way provoked the abuser, perhaps by being violent themselves or by threatening to end the relationship.

(FG2)

P4: Hasn't it been studied in Finland too that in the same way as many women kill as men, like their partner in a relationship. So that like somehow, then also the victims, at least I always wonder are they always like only the victims after all. Then like what's the other side and what's happening there.

The distinctive, dependent nature of a violent relationship was, however, acknowledged and the positioning of blame challenged. Blaming the abused was recognized as common in everyday speech, but it was considered unacceptable in the health care context.

(FG1)

P2: Yeah in a situation where the person has already been controlled then like at least I come across some situations where like specifically that if you're say a victim who now doesn't quite for example have a psychiatric illness like it can of course lower one's ability to take care of oneself but if there's not so in a way that like to what extent like when when we all condemn family violence hopefully we condemn more the perpetrators but also a little bit on the side the victims why is she still married to that guy when he's like that and that and that's also the thing that these victims surely can smell and sense and know that they are maybe if they have spoken to someone then they have received these sorts of answers already so that they are usually anyway in a quite like OPPRESSED and also like vulnerable situation in relation to IN WHAT WAY am I being helped and what I experience as help and not as being moralized at and condemned in a way that why do you a smart person let someone do this to you.

In addition, some groups of people, mainly children and seniors, were considered not to be guilty of their own victimization. Their assumed helplessness, passivity, and inability to make choices exonerated them from blame, in contrast to adults experiencing family violence.

(FG3)

P3: And especially with kids it is highlighted because there's that helplessness, because they can't defend themselves.

P1: Kids and then of course among adults there are such, so sick, already elderly people, who can't defend themselves, they have no ability to speak for example anymore. They can't do it themselves in any way. In my opinion it's wholly the business of

healthcare, or others' business, those people can't defend themselves.

Discussion

The findings indicate that health care professionals position patients experiencing family violence in diverse ways that can be grouped into three categories: a visible and easily recognizable "victim," a person latently damaged by the experience of violence, and as a contributor to and supporter of the violence. These patients, perceived as possessing the classic characteristics of a "victim," were thus positioned as easily recognizable, most often because of visible physical injuries or a history of recurrent "accidents." They were also positioned as displaying strong, readily noticeable emotions, such as fear, shame, sadness, exhaustion, and loss of self-esteem or dignity. In addition, the patients' sense of security was portrayed as very low. The health care professionals in this study thus believed that the routinely used question asking patients about their personal safety is an effective way to identify patients experiencing family violence. However, it has been found that up to 43% of patients who report feeling safe at home are currently being physically or emotionally abused (Peralta & Fleming, 2003). Even more startling was the result that up to 80% of patients who were actually experiencing physical violence reported feeling safe at home.

Patients experiencing family violence were also positioned as easily recognizable because of obvious relationship problems, such as jealousy. In addition, the health care professionals seemed to rely heavily on their intuition in recognizing such patients, as they described them as having "something wrong." It was perceived that these classical characteristics of a "victim" cause these patients to stand out and thus to deviate from "normal" patients.

This sort of marginalization was also evident in the way that the patients experiencing family violence were perceived as latently damaged, meaning damaged or disturbed such that their victimization is hidden behind secondary symptoms. Abused patients were seen as having psychological problems, being substance dependent, becoming violent themselves, or turning into "time bombs"—that is, positioning the patient as not having any visible symptoms until forcefully confronted with the fact of having experienced violence. Describing these patients in this way makes it possible to bypass the violence as a pressing societal problem and instead to perceive it as merely a random deviation: It becomes the problem of the Other, the abnormal (Husso, 2003). The trap of well-being generates the notion that a person who is normal and healthy does not need to be abused, which consequently inhibits the observer from seeing the bigger picture regarding family violence (Notko, 2000).

The patients experiencing family violence were positioned as responsible for ending the violence and thus as contributing to and supporting the violence. The health care professionals believed that remaining in a violent relationship was a

choice made by the abused patient, and hence such patients could not be helped if they did not leave their violent partners. The patient did not however end the relationship because they were positioned weak due to ethnicity, pregnancy, former experiences of violence, low socioeconomic status, or female sex. The abused patients were positioned as an accomplice in the family violence when they were described as repeatedly acting in a way that is in the interests of the perpetrator, for example, covering up the violence. Such acts of concealment were therefore interpreted as a choice, which demonstrates the abused patient's approval and cooperation (Husso, 2003). These patients were also positioned as somehow guilty of their own maltreatment, for example, in suggestions that they had in some way provoked the abuser.

It is still common practice to attribute the responsibility for family violence and its termination to the abused patient (Husso & Virkki, 2008). For instance, it is rare to demand that the abuser should be the one to leave the relationship (Notko, 2000). It is clear, therefore, that to be able to encounter patients experiencing family violence in an appropriate, empathetic, and therapeutically efficient manner requires that health personnel reflect on their own attitudes for any tendency to blame the abused patient (Jackson et al., 2001). A health care professional blaming and judging the patient who is trying to reach for help does clearly more harm than help.

It should be remembered that a violent relationship has several characteristics that distinguish it from nonviolent relationships. First, expressions of violence and hostility commonly alternate with expressions of love and warmth (Husso, 2003). It is not easy to abandon a person you love, no matter how they behave. Second, the constant fear that abused people experience weakens their agency, leading them to rely on significant others for care. Paradoxically, in most cases, these significant others are the perpetrators of the violence against them, which makes leaving even more difficult. In addition, separation can also be difficult because of threats such as custody battles and even death. It should be possible to question the view that the patients experiencing family violence are weak and irrational (Husso & Virkki, 2008). It should also be remembered that the tendency to blame these patients has a significant hindering impact on the behaviors and practices of health professionals: For example, the more commonly health care personnel attribute blame to the abused patient, the less likely they will be to arrange protection plans or make referrals to other agencies (Jackson et al., 2001).

The results of this study support the common notion that health care personnel often have stereotypical and even distorted perceptions, that is, cultural or socioeconomic status concerning people who experience family violence and about the prevalence of violence (Miller & Jaye, 2007; Roelens et al., 2006). In another study in the VISH research project, it was discovered that 2.6% to 29.3% of the patients visiting the Central Finland Health Care District pilot

departments were experiencing family violence at the time and that 20.4% to 51.2% of the patients reported experiencing abuse in the past (Notko et al., 2011). It is important to remember that the majority of those experiencing abuse do not show any overt signs of it, but rather a wide variety of vague symptoms, if any (Roelens et al., 2006). A suspicion of abuse based on a health care professional's intuition is thus insufficient to detect experiences of family violence in most patients.

The dominant positions constructed in the FGs in this study were, however, challenged by other health care professionals at some point during the interviews. This can be seen as evidence for the gradual attitudinal shift from "victim" to "survivor" (Johnson & Ferraro, 2000), described in the introduction. Nevertheless, these dissident views were often expressed in such a discreet way that they were only recognized through tone of voice and by gestures. Challenging already constructed positions must have been rather difficult for the participants, as the other group members were close colleagues, sometimes even managers. Also, during the analysis, there was no attempt to differentiate the constructed positions between patients of different age or sex, which can lead to overly generic results. This must be acknowledged as a limitation.

The study had some other limitations, too. Much of the analysis was done by the first author in the initial phases of the qualitative analysis. After that, however, regular research meetings with a research group were arranged. The coding of the initial phase analysis was checked and evaluated by the research team, and some changes were made accordingly. By this consensus for coding and assessment, adequate screening for research credibility and a sufficient level of triangulation was obtained. However, no calculation of the rates of consensus between coders was made. Transparency of the research process was maintained by providing multiple extracts from the transcriptions. Also, the quality of the research was improved by analyzing data both from the transcribed texts and original videotapes. It must be noted that the research was carried out in a specific setting, in a particular country. As the data and the research team were Finnish, there could be some cultural specificity in these findings.

The stereotypical perception by the present health care personnel of family violence as a rare phenomenon that only relates to certain types of people can be considered a valid argument for the universal screening for violence. Such screening is still not a common practice in Finland (Notko et al., 2011). Screening should be conducted specifically in the health care sector because, of all the public services, it has the widest and most frequent contact with the general population (Taket et al., 2003). In addition, abused people use health services more frequently than others. Screening is a cost-effective method that would convey the message that family violence is an issue that is the specific responsibility of health care and is to be condemned (Daugherty & Houry, 2008; Taket et al., 2003).

Of course, screening alone is not sufficient—also imperative is a proper response (Lavis, Horrocks, & Barker, 2005). Patients should, for example, be informed about the resources available to them, as they may find it difficult to find out about services specialized in family violence (Garimella et al., 2000; Taket et al., 2003). If abused patients feel they have not been treated appropriately, it is unlikely that they will seek help in the future (Harne & Radford, 2008). For this reason, it would be important to educate health care personnel about the dynamics of family violence. Health care personnel training has been found to be the strongest predictor of positive attitudes toward screening (Roelens et al., 2006). In addition, health care professionals who have training in family violence are less likely to attribute blame to the abused patient (Jackson et al., 2001). Education could also create a space for health care personnel to talk about the criteria for a successful violence intervention: It would be important to understand that this may not require that the patient leave the abuser (Garimella et al., 2000).

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