POSITIONS CONSTRUCTED IN SPECIALIST HEALTH CARE FOR PATIENTS EXPERIENCING INTIMATE PARTNER VIOLENCE

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ABSTRACT

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The aim of this study was to examine the positions that health personnel in specialist health care construct for patients experiencing intimate partner violence. It was also studied whether these constructed positions were challenged by other health care professionals and if so, how. The method of analysis chosen was discourse analysis.

The data in this study was part of a larger development and research project Violence Intervention in Specialist Health Care (VISH), which was funded by the EU Daphne III Program in 2009–2010. The data consisted of six focus group interviews collected in 2006 in Jyväskylä, Finland. In these interviews specialist health care personnel discussed how they encounter and intervene in intimate partner violence. There were 30 participants altogether: physicians, nurses, social workers and psychologists. The health care professionals worked in VISH pilot departments in specialist health care in Central Finland Health Care District: the maternity, psychiatric ward and emergency department.

The patients experiencing intimate partner violence were positioned in diverse ways. The positions were constructed in three dimensions, each of them having three to four subcategories. The patient was positioned as a visible and easily recognisable "victim"; latently damaged by the violence; and participating in and supporting the violence. The patient was perceived as possessing the classic characteristics of a "victim": physical injuries, visible emotional expressions and obvious relationship problems. The patient was also perceived as damaged or disturbed in a way that their victimisation becomes hidden behind some secondary symptoms, such as psychological problems, substance abuse, becoming violent oneself or turning into a "time bomb". The patients were perceived as participating in and supporting the violence when they were positioned responsible for ending the violence. It was thought that the patients did not leave the relationship because of their weakness, participation as an accomplice or guilt for the violence. Almost all the constructed positions were challenged by the other health care professionals, although most often in a very discreet way, through tones and gestures.

The results of this study support the common notion that health personnel often have stereotypical and even distorted perceptions about people experiencing intimate partner violence. This is why a mere suspicion of abuse based on a health care professional's intuition is unable to detect most of these patients. The health personnel's perception of intimate partner violence as a rare phenomenon that only relates to certain types of people can be considered a valid argument for universal screening of violence. The education of health personnel is imperative in order to implement screening policies and change the attitudes about patients experiencing intimate partner violence.

Key words: intimate partner violence, specialist health care, health personnel attitudes, crime victims, positions

TIIVISTELMÄ

JYVÄSKYLÄN YLIOPISTO
Psykologian laitos

KOISTINEN, INKA: Lähisuhdeväkivaltaa kokeneille rakennetut positiot erikoissairaanhoidossa
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Tämän tutkimuksen tarkoituksena oli tarkastella lähisuhdeväkivaltaa kokeneille potilaille erikoissairaanhoidossa rakennettuja positioita. Tutkittiin myös sitä, haastavatko toiset terveydenhuollon ammattilaiset näitä rakennettuja positioita ja jos haastavat, niin miten. Valittu analyysimenetelmä oli diskurssianalyysi.

Tutkimusaineisto oli osa suurempaa kehittämis- ja tutkimusprojektia Violence Intervention in Specialist Health Care (VISH), jota EU:n Daphne III -ohjelma rahoitti vuosina 2009–2010. Tutkimusaineisto koostui kuudesta fokusryhmähaastattelusta, jotka kerättiin vuonna 2006 Jyväskylässä. Näissä haastatteluissa erikoissairaanhoidon henkilöstö keskustelee siitä, kuinka he kohtaavat lähisuhdeväkivaltaa ja puuttuvat siihen työssään. Osallistujia oli yhteensä 30. Terveydenhuollon ammattilaiset – lääkärit, hoitajat, sosiaalityöntekijät ja psykologit – työskentelivät VISH-pilottiyksiköissä Keski-Suomen sairaanhoitopiirin erikoissairaanhoidossa: synnytysosastolla, psykiatrisella osastolla ja päivystysalueella.

Lähisuhdeväkivaltaa kokeneelle rakennettiin monia eri positioita. Näitä voidaan tarkastella kolmella eri ulottuvuudella, jolla jokaisella on kolmesta neljään alakategoriaa. Potilas positioitiin näkyväksi ja helposti tunnistettavaksi ”uhriksi”; latentisti väkivallasta vaurioituneeksi; ja väkivaltaan osalliseksi ja sitä kannattelevaksi. Potilasta kuvattiin klassisilla ”uhrin” tunnusmerkeillä: fyysisillä vammoilla, näkyvillä tunneilmaisuilla ja selkeillä parisuhdeongelmilla. Potilaiden nähtiin myös vaurioituneen väkivallasta siten, että heidän uhriutumisensa piiloutuu sekundaaristen oireiden, kuten psyykkisten ongelmien, päihteiden väärinkäytön, oman väkivaltaisuuden ja ”aikapommiksi” muuttumisen taakse. Potilas nähtiin väkivaltaan osallisena ja sitä kannattelevana silloin, kun hänet positioitiin vastuuseen väkivallan lopettamisesta. Ajateltiin, että potilas ei lähtenyt väkivaltaisesta parisuhteesta heikkoutensa, rikoskumppanuutensa tai syyllisyytensä vuoksi. Lähes kaikki rakennetut positiot haastettiin muun terveydenhuoltohenkilöstön toimesta, vaikkakin usein hyvin hienovaraisella tavalla, äänensävyjen ja eleiden kautta.

Tämän tutkimuksen tulokset vahvistavat sitä yleistä huomiota, että terveydenhuollon henkilöstöllä on usein stereotyyppiset ja jopa vääristyneet käsitykset lähisuhdeväkivaltaa kokevista. Tästä syystä pelkkä terveydenhuollon ammattilaisen intuitioon perustuva väkivallan epäily ei pysty tunnistamaan suurinta osaa tällaisista potilaista. Terveydenhuoltohenkilöstön käsitystä lähisuhdeväkivallasta harvinaisena ilmiönä, joka koskettaa vain tietyn tyyppisiä ihmisiä voidaan pitää pätevänä perusteluna kaikille potilaille tehtävälle väkivallan seulonnalle. Terveydenhuollon henkilöstön koulutus on välttämätöntä seulontakäytäntöjen toimeenpanemiseksi ja lähisuhdeväkivaltaa kokevia potilaita koskevien asenteiden muuttamiseksi.

Avainsanat: lähisuhdeväkivalta, erikoissairaanhoito, terveydenhuoltohenkilöstö, asenteet, positiot

TABLE OF CONTENTS

1. INTRODUCTION

Intimate partner violence can be defined in several ways. In this research it is defined as violence in close relationships: between spouses, family members, relatives, friends and dating partners (see Appendix A). The violence can be physical, such as hitting, strangling and pushing; sexual, such as verbally forcing one into sexual interaction, sexual abuse and rape; or emotional, such as criticising, threatening and financial controlling. Intimate partner violence is a phenomenon that often remains private and thus hidden, although it greatly affects the health and wellbeing of those living in abusive relationships (Notko et al., 2011; Taket et al., 2003). In addition, intervening in intimate partner violence has historically been constructed as an exclusively social care issue (Lavis, Horrocks, & Barker, 2005). Only recently has attention begun to focus on the lack of knowledge health care personnel have about intimate partner violence, its prevalence and the health consequences associated with it.

For example, health professionals believe intimate partner violence to be a rather rare phenomenon, affecting less than one per cent or even less than one per mill of their patients (Miller & Jaye, 2007; Roelens, Verstaelen, Egmond, & Temmerman, 2006). They also feel sufficiently capable of recognising intimate partner violence among their patients, which is why they oppose routine violence interventions, such as screening. Hence, the professionals' beliefs have a direct impact on the health care practices employed and thereby affect the way patients are being treated. The purpose of this study is to examine the positions that health personnel in specialist health care construct for patients experiencing intimate partner violence.

1.1. Health personnel's views about patients experiencing intimate partner violence

1.1.1. Features associated with patients experiencing intimate partner violence

Health care professionals commonly feel that they are capable of recognising intimate partner violence among their patients (Roelens et al., 2006): this indicates that they must have some kind of belief about what these patients are like. The most common sign by which health personnel state

they recognise the violence 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). Intimate partner violence is suspected if the location or the type of the injury does not correspond to what the patient is telling, or if the injuries are typical of intimate partner violence (such as a black eye, a swollen lip, or many bruises of various age) (Leppäkoski, 2007).

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

The ethnical background and socio-economic status of the patients also influence the probability that they are believed to be encountering intimate partner violence (Baig, Shadigian, & Heisler, 2006; Sugg & Inui, 1992). For instance, thirty-seven per cent of American residents falsely thought that intimate partner violence is more prevalent among African-American than Caucasian Americans (Baig et al., 2006). Sixty-six per cent of the studied physicians also incorrectly reckoned that the violence is more prevalent among patients of lower socio-economic status. These beliefs may serve the health personnel's need to protect themselves: it can be emotionally less straining to think that patients very similar to the studied professionals (Caucasian and middle-class) cannot be at risk of encountering intimate partner violence (Sugg & Inui, 1992).

1.1.2. Blame distribution attitudes towards intimate partner violence

Intimate partner violence is often seen as a medical problem in health care. For example, ninety-one per cent of South African physicians felt that intimate partner violence should be treated as a medical syndrome (Peltzer et al., 2003). This medicalization can however displace the responsibility for violence from the perpetrator to the target: the abused can be seen as mentally ill or substance dependent without the comprehension that these are the consequences, not the causes for the violence (Harne & Radford, 2008). For instance, fifty-nine per cent of the South African physicians believed that intimate partner violence is caused by the battered person's psychological

problems (Peltzer et al., 2003). This kind of thinking borders on blaming the person experiencing intimate partner violence.

It has been studied that almost a third (30 %) of American physicians have attitudes that put the blame on the target of the violence (Garimella, Plichta, Houseman, & Garzon, 2000). It is believed that the individual's personality, such as passivity or dependency, leads to their abuse. It is also thought that the person must be getting something out of the relationship, or otherwise they would leave. Health personnel can believe that people getting abused subconsciously gravitate towards violent relationships (Jackson, Witte, & Petretic-Jackson, 2001) or that they stay 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 these kinds of blame distribution attitudes are significantly more widespread among men than women (Garimella et al., 2000).

1.1.3. ”A victim” or ”a survivor”?

People experiencing intimate partner 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 this dominant convention however changed in so that the targets of the violence were no longer considered victims but survivors (Johnson & Ferraro, 2000). It has been a conscious decision not to use either of these terms in this thesis because of their problematic nature, although replacing them has occasionally lead to clumsy expressions. Nevertheless, the impacts of perceiving the person experiencing violence as “a victim” or as “a survivor” are considered next.

The victim discourse can be seen as including the idea of a weak, helpless, incapable and uncontrollable nuisance that is considered at least partly responsible for their own victimisation (Browne, 1991; Buchbinder & Birnbaum, 2010). A victim minimises, denies and forgets the experienced violence or is so anxious and agonised that is making others uncomfortable and ends up being avoided. They can also react to the experienced violence in extreme measures, such as being violent towards their own children. Victims are perceived not only as passive objects of abuse but as incompetent to act on their own behalf (Profitt, 1996). Therefore, agency and victimisation appear mutually exclusive, and leaving the violent relationship is considered as the only evidence of the victim's agency.

This is why many abused people find it difficult to utilise available victim discourses to articulate their experiences and construct meaningful self-images (Leisenring, 2006). It is especially

hard for them to understand being wronged but not perceive themselves as passive or helpless. Particularly for abused men the identification as a victim is stigmatising because of the feminine stereotypes associated with the victimisation (Browne, 1991). Defining oneself as a victim can thus require some significant and painful alterations in the ways that a person views oneself and the abuser, which is why the victim discourse is often rejected.

Identification as a survivor is not nearly as stigmatising as victimhood and it also dispels some of the problems inherent in the dichotomy of victim versus agent (Leisenring, 2006). The conceptualisation of patients encountering intimate partner 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). Survivors actively and rationally seek help and safety for themselves and their children while, at the same time, fight against the oppressive patriarchal society.

The problem with the survivor discourse can however lie in the inhumane expectations of strength and resilience, which can generate feelings of shame in the presence of potential 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.

1.2. Positioning

This study aims to understand the positions constructed in specialist health care group discussions for patients experiencing intimate partner violence. A conversation arises through joint action of all the participants (Davies & Harré, 1990). The words that each speaker chooses inevitably contain images and metaphors which hold assumptions and beliefs about other people. An individual and in fact the whole world emerges through the process of social interaction, not as a fixed end product but as one that is constructed and reconstructed over and over again: thus, speech can be understood as actions (van Langenhove & Harré, 2003).

Position can be defined as a pattern of beliefs in 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, in a way that positions are dynamic and fluid, not fixed (van Langenhove & Harré, 2003). Positions determine what actions are socially possible and appropriate for a person by defining a loose set of rights and duties. For example, positioning someone as unreliable excludes

the person from certain duties, such as handling the finances. This sort of attribution of traits to position someone is called indirect positioning.

Therefore, individual's behaviour is understood and explained in terms of what is culturally assumed to be typical for persons who share the particular category membership (Harré & Moghaddam, 2003). The positioning can be interactive in a way that the speech of one person positions another, or reflexive when a person positions oneself (Davies & Harré, 1990): it can thus be defined as a way in which people dynamically produce and explain the everyday behaviour of themselves and others (van Langenhove & Harré, 2003). Positioning can be planned and executed deliberately like the apartheid laws in South Africa, or subconsciously, as "a part of the natural order of things" (Harré & Moghaddam, 2003: 7).

Sometimes a speech-action can become determinate to the extent that it is taken up as such by all the conversationalists (Davies & Harré, 1990). A person with a dominant role in a conversation will then force the others to use positions they would not have used voluntarily (van Langenhove & Harré, 2003). The 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 positions can be challenged and people repositioned (Harré & Moghaddam, 2003).

1.3. Aim of the study and research questions

The aim of this study is to make visible the positions that health personnel in specialist health care construct for patients experiencing intimate partner violence. It is also studied how these positions are potentially challenged.

The research questions are the following:

- What kinds of positions are constructed in specialist health care for patients experiencing intimate partner violence?
- Are the constructed positions challenged by other professionals? If so, how?

2. METHODOLOGY

2.1. Data and participants

The data in this study is part of a larger development and research project Violence Intervention in Specialist Health Care (VISH), which was funded by the EU Daphne III Program in 2009–2010. The aim of the project is to create an evidence-based model for intervening in intimate partner 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 data was collected in 2009 in Jyväskylä, Finland and it comprises of six focus group interviews. Focus group interview is a group discussion conducted by an interviewer (Mäntyranta & Kaila, 2008). The discussion has a predefined frame and its aim is to understand the studied phenomenon through discovering the participants' diverse perceptions and opinions. Therefore, the emphasis is on the explicit use of the group interaction to produce insights that could not have been revealed with direct interview questions (Morgan, 1997). Focus groups allow the researcher to study the dynamic interactions that take place during the interviews, as well as the construction, maintenance and transformation of socially shared knowledge (Marková, Linell, Grossen, & Salazar Orvig, 2007). The use of focus groups generates a versatile and rich data that cannot be attained with other methods (Mäntyranta & Kaila, 2008).

In the research interviews in this study specialist health care personnel discuss how they encounter and intervene in intimate partner violence at their work. The frame of the interviews described in Appendix A was given to all participants. The aim of the focus groups was to discover what kinds of attitudes health personnel have towards intimate partner violence and patients seeking help for it. Each focus group consisted of three to six professionals (physicians, nurses, social workers and psychologists), and there were 30 participants altogether. The health professionals worked in VISH pilot departments in specialist health care in Central Finland Health Care District: the maternity, psychiatric ward and emergency department. Twenty-two participants were women and eight were men. Two of the six groups were multidisciplinary, the other four groups contained participants from only one profession. Each interview took up approximately one and a half hours and they were all videotaped, recorded and transcribed to text form.

2.2. Method and research process

The primary objective of all qualitative research is to develop understanding of how the world is constructed (McLeod, 2001). Of course, we all intuitively know how the world works: this ability to take certain aspects of social life for granted and not to require constant explanations for the phenomena surrounding us makes everyday life possible. In scientific research, however, systematic examination is needed to expose and dismantle these taken-for-granted structures.

The method chosen for analysing the data in this study was discourse analysis. Discourse analysis is not just a method, though; it is a wider perspective on the nature of language stating that speech is actions and thus constructs, not merely reflects, the psychological and social reality (Coyle, 2007; Wood & Kroger, 2000). Consequently, it is not assumed that some objective truths exist "out there" (Coyle, 2007). Instead, the language user is seen as choosing from the array of linguistic resources available to them and using these resources to construct a version of events, although not necessarily in an intentional way. This social constructionist approach guided the analysis as well as the whole research process.

Discourse can be defined as a relatively whole system of meaning relationships that is both constructed in social conventions and at the same time constructing the social reality (Jokinen, Juhila, & Suoninen, 1993). Discourse is thus action-oriented, situated and constructed (Potter, 2004). The social reality takes shape as a diverse entity, full of varied, competing discourses (Jokinen et al., 1993). Discourses are also entwined with power in a way that there are certain socially shared, taken-for-granted "truths" that silence and smother the other, alternative discourses. These strong, hegemonic discourses are usually the ones that recur most often in the data. It is therefore obvious that the statements people make in a conversation are not autonomous but constructed as the rules of the discussion become clearer. In a sense the conversationalists are not "free" to express their minds, and can renew and support some old constructions and dichotomies without even noticing it.

There are no specific coding strategies or research manuals by which discourse analysis should be done. Hence, doing discourse analysis has less to do with following some particular steps than with developing a confidence in the use of analytic concepts and the reporting of the analysis in terms that are consistent with the ideology of discourse analysis (Coyle, 2007). The analysis should be guided by what works in that particular case (McLeod, 2001).

This research process was started by exploring the VISH-project's research plan and previous publications. Soon it became clear that there were many unanswered questions that could be answered, also in the limits of a master's thesis. After discussing these potential research

questions with the thesis supervisor, one of them rose above the rest and was chosen. The original research question was phrased: “How do the health care professionals talk about targets of intimate partner violence?” With this question in mind the actual analysis began. The transcribed interviews (142 pages) were thoroughly read through and all the extracts that seemed to focus around the patient experiencing intimate partner violence were copied to a new text file. These selected text extracts comprised of 38 pages, and it was clear that there truly was enough material for studying the issue chosen.

After repeatedly reading the selected text extracts and discussing with the thesis supervisor the interpersonal nature of the data became obvious. This is why the original research question was defined more accurately. ”The ways of talking” sharpened as “positions” and the interactive negotiation of these positions was attached to be a part of the final research question. On the basis of these research questions the initial positioning categories were created by reading the transcribed extracts recurrently and labelling them under one or more themes that arose from the text. At first there were 39 overlapping, uncombined categories. Gradually these initially separate themes blended into one another (Potter, 2004), forming three main categories with each one having three to four subcategories. The original text data was thus organised into meaningful extracts, coded and categorised in order to reveal concealed themes and patterns (McLeod, 2001).

In the beginning it seemed that these constructed positions were not challenged at all or were very rarely challenged by the other health care professionals. This was one of the reasons why the information given by the transcribed text extracts was supplemented by watching the original videotaped interviews. After all, it must be remembered that the transcription and the videotape are not exactly the same (Wood & Kroger, 2000). Both verbal and nonverbal data must be taken into consideration, not only because they are both important, but because they are truly intertwined and cannot thus be separated. Although the researcher already had a strong opinion about the data, she still had to be open-minded and ready to change her mind.

Watching the videotaped interviews was at times tedious. At these times strategy of reversal was introduced (Wood & Kroger, 2000). The strategy entails turning the problem into a topic; in this case the researcher pondered what it was that made the discussions tiresome. What was not there? Eventually, while watching the tapes, some discrepancies between the professionals started to show. The differing opinions were sometimes expressed in such a discreet way that they could only be recognised through tones and gestures. Suddenly it seemed that almost every constructed position was challenged at one point or another. Watching the tapes did not change the already created three main categories, but it clarified many of the subcategories, making them more coherent.

Lastly, text extracts that would best describe the three main categories and the eleven subcategories were chosen. The extracts were selected from different focus groups and participants to best cover the data.

3. RESULTS

The specialist health care professionals positioned the patients experiencing intimate partner violence in numerous ways. These constructed positions were divided into three categories, each of them having three to four subcategories. The patient was positioned as *a visible and easily recognisable "victim"*; *latently damaged by the violence*; and *participating in and supporting the violence*. These categories are presented with illustrative text extracts from the transcribed data. The data is cited by marking the focus groups (e.g. FG1), interviewed health care professionals (e.g. P1) and the interviewers (I1 or I2) with an abbreviation. Numbers inside brackets (e.g. (2)) are used to mark pauses and their duration in seconds. (Brackets) are used when the words said are too ambiguous or silent to hear properly. Notes made by the transcriber are given inside ((double brackets)). Overlapping speech is marked with [square brackets]. The original text extracts in Finnish are attached to Appendix B.

3.1. A visible and easily recognisable "victim"

The patient experiencing intimate partner violence was perceived as possessing the classic characteristics of a "victim" and was thus positioned as easily recognisable. These characteristics make the patient stand out and deviate from the "normal" patients, thus raising suspicions among the health care professionals. If the target of intimate partner violence cannot be identified, it is explained to be due to the health professional's inexperience.

Extract 1 (FG3)

> P1: But like such, the nurse should be able to notice and that knowledge, the expertise should be like that you recognise that person from the rest. But you shouldn't automatically ask everybody, to me that's terribly insulting (2) to ask a perfectly normal person who comes to treatment for some injury
> P4: [because of a tooth ache]
> P1: yeah and you pop, say that did somebody hit you, it's like an irrelevant question. You should be able to choose, thanks to your professional skill, those things that are important.

The easy recognition of intimate partner violence was also challenged by referring to the individuality of every patient and situation.

Extract 2 (FG2)

> P4: And then this, do you ask at the front disk so, the purpose is now to ponder that is there like some symptoms, signs from which you could like notice and then you would ask. But then on the other hand they are like very diverse. And then what happens like with the nurses there, do they remember those things, some list of for example ten symptoms that all of these must be asked about this intimate partner violence (2) in contrast to this kind of routine question. I wonder whether the inquiry is forgotten, I think there's such a risk.
> P5: True.

3.1.1. Physical injuries

A patient experiencing intimate partner violence was most often positioned as easily recognisable because of their visible physical injuries or recurrent "accidents". Attention to the injury mechanisms typical to intimate partner violence was considered important. The possibility of victimisation was thus accepted and noticed only in the presence of bruises and cuts.

Extract 3 (FG3)

> P4: Well they are mostly these kinds of external signs that you have to sense before you start to ask 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
> P3: Yeah not like that.

3.1.2. Visible emotional expressions

The targets of intimate partner 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 to be very low. Emotion of fear was mentioned many times, referring to for example fear of childbirth or difficulty to interact with health care professionals representing the same sex as the offender.

Extract 4 (FG2)

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

3.1.3. Obvious relationship problems

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

Extract 5 (FG1)

> P5: That you would have more of that skill to smell it from for instance that relationship problem or jealousy and start to like map out from there (2) I don't know if I'm drivelling but you probably understood like what I'm saying.

3.1.4. Other ways to recognise the signs of intimate partner violence

The health care professionals also positioned the patients experiencing intimate partner violence as easily recognisable in a more vague fashion. The professionals seem to rely heavily on their intuition as they try to pick up clues suggesting that "something's wrong". Intimate partner violence was suspected for example when a pregnant woman felt uncomfortable with gynaecological examinations or when the reason for seeking medical attention was considered to be vague, diffuse or even bogus.

Extract 6 (FG2)

> I1: How about in your work, do you usually ask always or according to the situation or?
> P5: Well at least I, it comes a situation, like if you get that kind of feeling for some reason. These patients do usually communicate it, it can be like read between the lines. Sometimes you can read it, unfortunately maybe not always. (2) But at least I don't automatically ask it at first that.

3.2. Latently damaged by the violence

The patients experiencing intimate partner violence were also positioned as **not** presenting the classic characteristics of a "victim". Instead, the target was perceived as damaged or disturbed in a way that their victimisation becomes hidden behind some secondary symptoms, such as physical pain.

Extract 7 (FG5)

> P5: We actually had in the children's' ward this kind of (.) case last summer (2) an appendix was operated in vain

I1: hm hm
P5: from this child (.) who because of domestic violence (1) came there (.) some nurse then (.) later asked then that how are you doing like some time in the evening beside the child's bed and then it came out that.

3.2.1. Psychological problems

The patients experiencing intimate partner violence were positioned as being at risk for psychological distress, such as anxiety, depression, insomnia and self-harm.

Extract 8 (FG2)

P6: Somehow it feels like when yeah psychiatric patients that come to us and such like that emotional violence is very common in almost every case then either in childhood, youth or present stage of life there's some sort of emotional abuse they have faced or (2) experienced at least.

The psychological symptoms were also seen as a possibility or an authorisation for the patient to disclose the violence.

Extract 9 (FG1)

P2: Also in here they may develop a little mania so that they become more open ((laughter)) and then then they can tell.

3.2.2. Substance abuse

The health care professionals positioned the patients experiencing intimate partner violence as susceptible to turn to alcohol and drugs in order to cope with the violence. Especially pregnant women using drugs and patients seeking medical attention intoxicated were perceived as very likely targets of intimate partner violence.

Extract 10 (FG4)

P1: Oh well this is based on this kind of intuition or this kind of implicit (1) like po-pondering this issue and I can be totally wrong too, but like such (.) and like (2) 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 (.) at drunk huts to each other well there's not I think these intoxicants and such influence in there like (.) in the background but of course this intimate (.) partner 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 intimate partner violence as mainly people with substance dependencies was however challenged. The professionals acknowledged that the perceived

connection between substance abuse and intimate partner violence might be based more on the professionals' attitudes than reality.

Extract 11 (FG6)

> I2: So do you think that this intimate partner violence rises especially from their ((substance dependent mothers)) background or?
> 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 those contacts to other places, too like in the emergency room they have more visits than so called normal pregnant- or like they have these already several, and then they have social care and there can be rehab like they come to our knowledge 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, expecting woman like it's not like you go and ask.

3.2.3. Becoming violent oneself

Abused patients were also positioned to be potential assaulters themselves. The health care professionals described how the victimisation can hide in a way that the person who originally was the target of violence becomes the perpetrator. Several possible situations were showcased. The patient might have been abused as a child and as an adult becomes violent towards their own children. Abused women can turn against their batterers and even kill them. The patients experiencing intimate partner violence can also be so distressed that they attack the professionals treating them.

Extract 12 (FG6)

> P1: And then with women it can be targeted at that child, which is also that 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,] somewhere it passes
> P5: Somewhere it goes.

3.2.4. Targets as time bombs

Patients experiencing intimate partner violence were also positioned as not having any visible symptoms, unless forcefully confronted with the violence. They were thus positioned as time bombs: not currently problematic, but potentially severely challenging in the future. This is why it was not considered 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 traumatising the patient further.

Extract 13 (FG1)

> P5: That molestation of children is just such like (.) as a trauma somehow (.) somehow I feel that it's that it is SO deep that from that you are left kind of helpless and you don't really have the courage not to like (2) .hhh traumatise even more (.) yeah because of that intervention that something would remain unfinished and then those wounds are completely open there (.) which they might have closed with some other mechanism.

It was also discussed how difficult it would be for a health care professional to face these issues if they themselves were targets of intimate partner violence. The abused were thus positioned as able and competent to the extent of being capable of working in health care. This competence was however thought to vanish the moment they were "forced" to confront the violence. The interviewees pondered, is it ethical to oblige the abused professionals to work with battered patients and what kind of reactions this might evoke.

Extract 14 (FG3)

> P2: And then of course always in these situations you can't help but wonder, in whatever health care unit the thing that what if the employee who has to like bring this thing up then is themselves a victim of these?
> I2: Yeah that's an important point to be made.
> P2: Then if we in a way, how could we know, we are so many here
> I2: Yeah this is totally normal this group we have here, everyone has
> P2: [Yeah, we too have by percentage] most certainly we have them.
> I1: Victims and perpetrators, both.
> P2: I'm thinking it from a manager's point of view that at what stage it comes to the picture. Do I have to as a manager somehow intervene in it like how it, how is this person now potentially somehow more anxious or something like.

3.3. Participating in and supporting the violence

The patient experiencing intimate partner violence was perceived as participating in and supporting the violence when they were positioned responsible for ending the violence. The health care professionals believed that it was the abused patient's own choice to stay in a violent relationship, and that it is the targets' job to become stronger and braver in order to seek help and leave their batterers.

Extract 15 (FG2)

> P1: Like from my point of view when I think about it then the biggest obstacle to somehow doing this work are those own emotions and that own cynicism and that frustration. And somehow when there are no involuntary treatment resources and nothing that damn, they are just going back there to be beaten. I can't do anything. (3)

> Like these are that sort of things, that you would always like to get the help there pretty fast, somehow to stop and think about the situation and. Then they will evoke emotions. And then you get that kind of rejection, like 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 patient cannot be helped if they do not leave their violent partner. Intimate partner 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 16 this position was however challenged by stressing that every step towards the patient's well-being is important.

Extract 16 (FG1)

> P5: That 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 that like
> P5: Yeah right but that – but you can't create follow-up contact like that it would be ready
> P2: [Yeah right create but not yes yes].

3.3.1. Weak and thus unable to understand one's best interests

The patients experiencing intimate partner violence were positioned as somehow mentally weaker than the rest of the people. This weakness was attributed to be due to ethnicity, pregnancy, former experiences of violence, low socio-economic status or the female sex.

Extract 17 (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 fine.
> P3: It's this, somehow the interpretation (how they are seeing it)
> P1: [It's so hard to interpret]
> P3: The other one doesn't mind at all and then another is totally anxious.
> P1: Yeah.

The low socio-economic status of the patients experiencing intimate partner violence was indicated for instance by stating that they don't watch documentaries or magazines on TV. Also, violence was often described by quite vulgar terms and expressions, such as "the hubby beats her up / thrashes / bruises". The sex of the patient experiencing intimate partner violence was most often indicated by referring to the target as "she". It was also mentioned that the professionals may have never

encountered a man seeking help as a target of violence. This positioning, that abused patients are predominantly women of low socio-economic status, was nevertheless often challenged.

Extract 18 (FG4)

> P2: I can now open up, no but here is for real soon that one horrible (example was) a few years back this kind of (1) doctor colleague who (.) was burned ALIVE (.) by his wife (2) the violence had been going on for years (.) and then she ignited her husband on fire and he died the cardiologist from that ((laughing)) thing like (.) then like (2) yeah (.) a working person
> ?: awful
> P3: it happens in all walks of life ((vigorously)) you shouldn't then people so that
> P2: no but like in a way kind of
> P3: yeah.

The sex of the abused patient was however most often challenged in a dismissive manner. It was recognised that men can be targets of intimate partner violence, too, but men's victimisation was somehow ridiculed.

Extract 19 (FG3)

> P4: I think that that emotional violence is the most difficult one from these. That one meets totally normal relationship criteria
> ((P2 and P1 are laughing))
> P4: Based on that every Finnish drunk man that comes to the hospital then has experienced emotional abuse.

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

Extract 20 (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 however describes these features of emotional abuse it's full of (1) there might even be something physical breaking objects et cetera but the person doesn't perceive it as violence (1) 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.

3.3.2. Accomplice to the violence

The abused patient was positioned as an accomplice to the intimate partner 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 repetitively returning to the violent relationship and refusing the offered help in the health care was also disapproved.

Extract 21 (FG3)

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

3.3.3. Guilty for the violence

The patient experiencing intimate partner violence was also positioned as somehow guilty for their own maltreatment. This was done by suggesting that the target had in some way provoked the abuser, perhaps by being violent oneself or by threatening to leave the relationship.

Extract 22 (FG2)

> P4: Haven't they been studying it in Finland too that in the same wa- 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 that are they always like merely the victims after all. Then like what's the other side and what's happening there.

This position of "victim" blame was challenged by acknowledging the distinctive, dependent nature of a violent relationship. Blaming the abused was recognised to be common in every-day speech, but it was considered not acceptable in the health care context.

Extract 23 (FG1)

> P2: Yeah (.) in a situation where that person has already been controlled then like at least I come across some situations where like specifically that if you're say a victim (2) who now doesn't quite for example for psychiatric illness like that it can of course lower the capability to take care of oneself but if there's not (.) so in a way that like that in what extent like that when when we all do condemn intimate partner violence we condemn hopefully more the perpetrators but a little bit also in the side those victims why is that 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 anyways 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 moralised and condemned in a way that why do you smart person let someone do this to you.

In addition, some groups of people, mainly children and seniors, were considered not to be guilty for their own victimisation. Their assumed helplessness, passivity and inability to make choices exonerated them from the blame.

Extract 24 (FG3)

> P3: And especially with kids it is highlighted because there's that helplessness, because they can't defend for themselves.
> P1: Kids and then of course there among adults then such, so sick, already elderly people, who can't defend for themselves, they have no ability to speech for example anymore. They can't themselves in any way. In my opinion it's purely the health care's business, or thus other's business, those people can't defend for themselves.

4. DISCUSSION

The aim of this study was to make visible the positions that health personnel in specialist health care construct for patients experiencing intimate partner violence. It was also studied how these positions are potentially challenged. The research method chosen was discourse analysis. The research findings indicate that health care professionals position the patients experiencing intimate partner violence in diverse ways that can be classified into three categories: a visible and easily recognisable "victim"; latently damaged by the violence; and participating in and supporting the violence.

The patient experiencing intimate partner violence was perceived as possessing the classic characteristics of a "victim" and was thus positioned as easily recognisable. The patients were most often positioned as easily recognisable because of their visible physical injuries or 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 to be very low. The health care professionals thus believed that the routinely used safety question is an effective means to identify patients experiencing intimate partner violence. However, it has been studied that up to 43 % of those patients that 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 experiencing physical violence reported feeling safe at home.

The patients experiencing intimate partner violence were also positioned as easily recognisable because of their obvious relationship problems, such as jealousy. In addition, the health care professionals seemed to rely heavily on their intuition in recognising the targets of violence, as they described that there was just "something wrong" with the patient. These classical characteristics of a "victim" make the targets stand out and cause them to deviate from the "normal" patients.

This sort of marginalisation was also evident in the way that the targets of intimate partner violence were perceived as latently damaged, that means damaged or disturbed in a way that their victimisation hides behind some secondary symptoms. Abused patients were seen as having psychological problems, being substance dependent, becoming violent themselves or turning into "time bombs" – this means positioning the patient as not having any visible symptoms unless forcefully confronted with the violence. Describing the targets of intimate partner violence in this way makes it possible to bypass the violence as a present problem and to perceive it merely as a random deviation: it becomes the problem of others, the abnormal (Husso, 2003). The trap of wellbeing generates a thought that a person that is normal and healthy needs not to be abused, which consequently inhibits from seeing the big picture surrounding the violence (Notko, 2000).

The targets of intimate partner violence were perceived as participating in and supporting the violence when they were positioned responsible for ending the violence. The health care professionals believed that it was the abused patients' own choice to stay in a violent relationship and that they could not be helped if they did not leave their violent partners. The patient did not however leave the relationship because they were positioned weak due to ethnicity, pregnancy, former experiences of violence, low socio-economic status or the female sex. The abused patient was positioned as an accomplice to the intimate partner violence when they were described as repeatedly acting in a way that benefits the perpetrator, for example covering up the violence. This concealment was therefore interpreted as a choice, which demonstrates the target's approval and co-partnership (Husso, 2003). The patient experiencing intimate partner violence was also positioned as somehow guilty for their own maltreatment. This was done by for instance suggesting that the target had in some way provoked the abuser.

It is still common to charge the responsibility for violence and its' termination to the target (Husso & Virkki, 2008). For instance, it is rare to demand that it is the abuser that should leave the relationship (Notko, 2000). Therefore, it is clear that encountering patients experiencing intimate partner violence in an appropriate, empathetic and therapeutically efficient manner requires examination of the health professionals' own blame attitudes (Jackson et al., 2001).

After all, there are numerous characteristics in a violent relationship that make it distinct from other relationships. Firstly, it is common that the expressions of violence and hostility are altered with expressions of love and warmth (Husso, 2003). It is not easy to abandon a person you love, no matter how they behave. Secondly, the constant fear the abused people experience paralyses and makes them turn to important people for care. In most cases these important people are the perpetrators, which makes leaving even more difficult. In addition, separation can also be difficult because of threats of custody battles and even death. By acknowledging these aspects, the

view that targets of intimate partner violence are mindless and irrational can be questioned (Husso & Virkki, 2008). Also, it must be remembered that these kinds of target blaming attitudes have a significant impact on behaviours and practices employed by the health professionals: for example, the more target blaming views health personnel have, the less protection plans and referrals to other agencies they will make (Jackson et al., 2001).

Almost all the constructed positions were challenged by the other health care professionals at some point of the conversations. However, these differing opinions were often expressed in such a discreet way that they could only be recognised through tones and gestures. Challenging the already constructed positions must have been quite difficult for the health care professionals, because all the other conversationalists were close colleagues or even managers. This might have also been why the group discussions seemed at times tedious: the interviewees were probably in a "working mode" which inhibited emotional and private ways of speaking.

The researcher strived to make the research process transparent by keeping a research diary and describing the steps of the study in detail according to that. Transparency was also achieved by providing the reader with multiple direct text extracts (Wood & Kroger, 2000). The data from the focus group interviews can be considered authentic in the context in which it was acquired: the basic discourse analytic premise is that the social world does not exist independently of our constructions of it, so it makes no sense to ask if our analyses are valid in the sense that they are true. Also, criteria such as reliability and validity are based on the assumption of scientific objectivity, which in turn assumes that the researcher and the researched are independent of each other – with discourse analysis, this cannot be the case (Coyle, 2007). This is because factors related to the researcher, such as training and personal experiences, influence the ideological framework that is brought to the analysis.

The study had some limitations, too. The lack of triangulation, that is usage of more than one method, researcher or science, can be counted as one. However, the researcher strived to improve the quality of the research by analysing both data from the transcribed texts as well as the original video tapes. The master's thesis seminars were also utilised in order to gain new insight. One of the biggest limitations of this study might have been the fact that the researcher was no able to transcribe the interviews herself: it can be in the phase of transcription when the most revealing realisations are made (Potter, 2004). Nevertheless, it must be remembered that often the researcher, too, becomes blind to the most powerful discourses in the data (Jokinen et al., 1993).

The results of this study support the common notion that health personnel often have stereotypical and even distorted perceptions about people experiencing intimate partner violence and the prevalence of violence (Miller & Jaye, 2007; Roelens et al., 2006). In another study in the

Violence Intervention in Specialist Health Care (VISH) -research project, it was discovered that 2,6–29,3 % of the patients visiting the Central Finland Health Care District pilot departments were experiencing intimate partner violence at the time, and 20,4–51,2 % of the patients reported experiencing abuse in the past (Notko et al., 2011). Intimate partner violence is thus not just a marginalised problem of "the others". After all, the core of recognising intimate partner violence is that 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 unable to detect most patients experiencing intimate partner violence.

The health personnel's perception of intimate partner violence as a rare phenomenon that only relates to certain types of people can be considered a valid argument for universal screening of violence. The screening should be conducted specifically in health care because it has the widest and most frequent contact with the population among all public services (Taket et al., 2003). In addition, abused people use health services more frequently than others. Screening is a cost-effective method that would give the society a message that intimate partner violence is an issue that is the health care's responsibility and that should be condemned (Daugherty & Houry, 2008; Taket et al., 2003).

Of course, mere screening is not sufficient – a proper response is also imperative (Lavis et al., 2005). The patients should for example be informed about the resources available to them, since they find it difficult to find out about services specialised in intimate partner violence (Garimella et al., 2000; Taket et al., 2003). If the abused patients feel they have not been treated appropriately, it is unlikely that they will seek help in the future (Harne & Radford, 2008). This is why it would be so important to educate health personnel about the dynamics of intimate partner violence. Health personnel training has been found to be the strongest predictor of positive attitudes towards screening (Roelens et al., 2006). In addition, health care professionals that have training in intimate partner violence are less likely to have target blaming attitudes (Jackson et al., 2001). Education could also create a space for the health personnel to talk about the criteria of a successful violence intervention: it would be important to realise that it may not result in the patient leaving the abuser (Garimella et al., 2000).

We all share the responsibility for intimate partner violence through attitudes that bypass abuse and thereby make its recurrence possible (Husso, 2003). The only thing that is certain is that silence helps nobody; this is why health care agencies should awake and take intimate partner violence openly on their visiting agenda, simultaneously contributing to the dismantling of the taboo surrounding the violence (Peckover, 2003).

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APPENDICES

Appendix A: The frame of the focus group interviews (translated from Finnish)

Intimate partner violence -project

FOCUS GROUP INTERVIEWS
Fall 2009

THE DEFINITION OF INTIMATE PARTNER VIOLENCE

Every participant is handed a paper, which has a definition of intimate partner violence used in this project.

Key question:
How do you feel about this kind of definition of intimate partner violence and what kind of thoughts arise from the definition of intimate partner violence also more generally?

INTIMATE PARTNER VIOLENCE MEANS:

physical violence = hitting (with an object or fists), strangling, kicking, restriction of physical movement, shooting, hitting with an edged weapon, throwing a damaging object, pushing, haling

sexual violence = forcing one into sexual interaction verbally or with threats of violence, sexual abuse, rape

emotional violence = continuous, long-term non-physical damaging, such as criticising, annulment, recklessness, induction of danger, controlling, threatening, restriction of life circle, financial exploitation or controlling, spiritual violence, persecution

Intimate partner violence can occur between:

- spouses
- parents, grandparents or other adults in the family and children
- siblings
- relatives, such as parents-in-law and children-in-law
- friends and dating partners

THE FRAME OF THE CONVERSATION

1. Why is intimate partner violence **not** screened automatically from every client, although studies show that it's one of the biggest problems in the Finnish society and therefore produces many such health care visits whose actual cause for arrival ergo intimate partner violence stays unidentified?

2. How should intervening in intimate partner violence be handled in your department?

3. What prerequisites are needed in so that the service model under development will be a functional and established practice in your work?

4. What risks do you see in intervening with intimate partner violence (its recognition, bringing up, handling and referring to the services needed)?

* * *

THE INTERVIEW ENDS

Thank you to all the participants!
The research done on the basis of this interview material will be informed later on the Intimate partner violence -project's website (www.ksshp.fi)

Appendix B: The original text extracts in Finnish

Extract 1 (FG3)

P1: Mutta sitten semmoset, jotka ni täytyis olla hoitajalla silmää huomioia ja se tieto, ammattitaidon olla semmonen että tunnistaa sen ihmisen sieltä seasta. Mut ei automaattisesti kaikilta ihmisiltä kysellä, minusta se on hirveen loukkaavaa (2) kysellä ihan tavallinen ihminen tulis hoitoon jonkun vammansa takia
P4: [hammassäryn takia]
P1: niin sä pamautat, sanot että löikö sua joku, niin se on niinku epäoleellinen kysymys. Kyllä pitäis niinku osata valkata ammattitaidollisesti ne asiat mitkä on tärkeitä.

Extract 2 (FG2)

P4: Ja sitten tätä, kysytäänkö tossa triasissa niin, nythän on tarkotus miettiä että onko niinku oireita, merkkejä mistä se olis niinku havaittavissa ja sitten kysyttäis. Sit toisaalta taas ne on hyvin monimuotosia. Ja mitä sitten tapahtuu niinku tossa sairaanhoitajille että muistaako he ne asiat, joku lista vaikka kymmenen oiretta et nyt näiltä kaikilta pitää kysyä tästä lähisuhdeväkivallasta (2) kuin että se olis tämmönen rutiinikysymys. Mä mietin jääkö sit se kysyminen että musta tässä on se riski olemassa.
P5: Totta.

Extract 3 (FG3)

P4: Kyl lähinnä ne on semmosia ulkosia merkkejä, mitä sieltä pitää haistaa ennen kun rupee mitään kyselee. Useita vanhoja pieniä mustelmia siellä täällä ja nyt on sit haava tullu jostain syystä kaiken lisäksi. Enemmän tällasten kautta ku
P3: Joo ei semmosta.

Extract 4 (FG2)

P3: Onhan se tossa se yks, mikä oli, mikä mullekin se ensimmäinen raiskauksen uhri mikä tuli terveyskeskuspäivystyksessä. Ja miespuolinen psykiatri meni tekemään sitte sitä haastattelua ni eihän se nainen puhunu tälle sitten yhtikäs mittään. Ja lääkäri tuli sitten ja mietittiin et jos joku nainen menis et jos vaikka kertois. Ja kyllähän se nainen sitten rupes kertomaan niitä tapahtumia tällain näin. Mut ei sille mieslääkärille ruveta sitten puhumaan.

Extract 5 (FG1)

P5: Että olis niinku sitä taitoa enemmän haistaa se vaikka siitä parisuhdeongelmasta tai mustasukkaisuudesta ja lähtee sitä kautta kartottamaan sitä enemmän (2) en mä tiiä puhunko mä puuta heinää mut ymmärsitte varmaan mitä niinku tarkoitan.

Extract 6 (FG2)

I1: Mites teidän työssä, tuleeko se kysyttyä aina vai tilanteen mukasesti tai?
P5: No ite ainakin se tulee tilanne, et jos tulee semmonen olo syystä tai toisesta. Kyllähän nää potilaat yleensä viestii sen, se niinkun on siellä luettavissa rivien välistä. Joskus sen osaa lukea, ikävä kyllä aina ehkä ei. (2) Mut en mä ainakaan automaattisesti kysy ensimmäisenä että.

Extract 7 (FG5)

P5: Meille itseasiassa lastenpuolella oli semmonen (.) keissi kesällä (2) leikattiin turhaan umpisuoli
I1: mm mm
P5: semmoselta lapselta (.) joka oli perheväkivallan (1) tilanteesta tullu siihen (.) joku hoitaja sitte (.) myöhemmin kysy sitten että (.) mitähän sulle kuuluu sillai niinku joskus illalla sen lapsen sängyn ääressä ni sillon se tuli esille että.

Extract 8 (FG2)

P6: Jotenki tuntuu että ku tota, niin psykiatrisissa potilaissa mitä meille tulee ja muuten ni toi henkinen väkivalta on hyvin yleinen lähes kaikissa tapauksissa niin joko lapsuudessa, nuoruudessa tai nykyisessä elämänvaiheessa niin jonkin sortin henkistä väkivaltaa kohdannneet taikka (2) kokeneet ainakin.

Extract 9 (FG1)

P2: Täälläkin pientä maniaa kehittää että tulee avoimemmaksi ((naurua)) ja sitten sitten voi kertoo.

Extract 10 (FG4)

P1: No tota täähän on tämmöseen niinku mutututuntumaan ja tämmöstä implisiittistä (1) siis po pohdintaa tämä asia ja voi olla ihan väärässäkin mut tota noinniin (.) ja tota (2) kyllä musta tää yhteiskunta tai siis suomihan on niinku maailman väkivaltasimpia maita mutta suurin osa väkivallan teoista tehään (.) juoppokämpillä keskenään toisille tota ei siinä mun vaikuttaa niinku tää päihteet ja tämmöset siin tota (.) taustalla mutta tietysti tää lähi (.) suhdeväkivalta voi niinkun johtaa myös tämmösiin päihteiden käyttöihin ja niistä (.) piireistä sikiää varmaan ehkä kuitenkin enempi kun (.) sitte niinku tää.

Extract 11 (FG6)

I2: Nouseeks heidän ((HAL-äitien)) taustalta siis erityisesti tää lähisuhdeväkivalta teiän mielestä?
P1: Kyllä mun mielestä kyl nousee, mut se voi myös johtua siitä et heil on niinkun tarkempi seulonta raskauden aikana ja synnytyksen jälkeenkin kuin muilla synnyttäjillä
P4: Ja sit just et niil on niitä kontakteja muuallekin et ensiavussa usein paljon enemmän käyntejä ku ns. tavallisilla raskaana- tai olevilla et heil on näitä jo useampia, ja sit on sosiaalipuolelle ja katkasuhoitoo voi olla niin ne tulee jo sieltä tietoon.
P6: Sit mä luulen et heiltä tulee kysyttyä helpommin tämmösestä asiasta, kun että keneltä tahansa kaduntallaajasta, raskaana olevalta ni ei tuu tolleen mentyä kysymään.

Extract 12 (FG6)

P1: Ja sitte just naisilla saattaa kohdistua siihen lapseen, et mikä on se yks alue kanssa
P4: [aivan]
P5: Ja sit jos on perheessä potkittu koira ni sitte tietää et pitää ( ). lapset potki sitte sen koiran ( )
P1: [Nimenomaan,] jonnekin siirtyy
P5: Jonnekin se menee.

Extract 13 (FG1)

P5: Se lapsen hyväksikäyttö on vaan jotenkin niinku (.) traumana jotenki si (.) si jotenkin mä koen sen et sen on NIIN syvä että siittä jää niinku aseettomaksi eikä oikein uskalla ettei jäisi niinku (2) .hhh tulisi vielä traumatisoi-tuneemmaks (.) ni sen työskentelyn kautta että jäiskin joku kesken ja sitten ne haavat on ihan auki siellä (.) mitkä ehkä jollakin toisella mekanismilla on saanu kiinni.

Extract 14 (FG3)

P2: Ja sit tietysti aina näissä tulee mieleen, missä tahansa terveydenhuollon yksikössä se et entäs sit jos se työntekijä joka joutuu ottamaan asian puheeks ni on itse joutunut näitten uhriks?
I2: Niin tuohan on tärkee pointti kyllä että.
P2: Et jos me tavallaan, mistäs me tiedetään, meitäkin on paljon täällä
I2: Niin täähän on ihan tavallista porukkaa tämä sairaalan henkilökunta, kaikil on
P2: [Niin, meilläkin prosentuaalisesti] aivan varmasti löytyy niitä.
I1: Uhreja ja tekijöitä, sekä että.
P2: Mä aattelen siinä esimiehen roolissa missä vaiheessa sitten tulee se kuvaan. Pitääks mun ruveta jotenkin esimiehenä puuttumaan siihen että mitenkä se, mitenkä nyt mahdollisesti tää ihminen on jotenkin ahdistuneempi tai jotakin muuta että.

Extract 15 (FG2)

P1: Et omalta kannalta ku mietin ni kyllähän suurin este jotenki tän työn tekemiselle on ne omat tunteet ja se oma kyynisyys ja se turhautuminen. Ja jotenki kun ei oo pakkohoitokeinoja eikä mitään että hitsi että se menee vaan sinne takas hakattavaksi. Mä en voi mitään. (3) Et nää on jotenkin semmosii juttuja, että siihen haluis aika nopeestikin aina apua, jotenkin semmosta pysähtymistä ja miettimistä ja. Et ne kyl nostaa kyllä tunteita. ja sit tulee semmonen torjunta, ihan selkee et mä en, me ei voida hoitaa tätä.
P2: Nii onkii.
P5: Mitäs sä tänne tuut josset sä kerta haluu sitä.
P1: Niin mitä sä tänne tuut jos et sä ota mitään vastaan mitä täs yritetään ja.

Extract 16 (FG1)

P5: Ettei pysty auttaa sitten tietää että meidän hoito päättyy vaikka ens tiistaina mut sä et pysty siirtää sitä
P2: Mut ethän sä voi tietää jos se on jo auttanu sitä johonkin asiaan että että tavallaan se että
P5: Niin joo mutta että – mut ei pysty jatkokontaktia luomaan niinku et olis valmiiks
P2: [Niin joo luomaan mut et niin niin].

Extract 17 (FG3)

P4: Onhan se tilannesidonnainen, subjektiivinen kokemus
P1: [Nii] on.
P4: et joissain tilanteissa jotkut asiat tuntuu loukkaavalle ja alisteiselle tai käskevälle, toisissa tilanteissa se on ihan jees.
P3: Se on tää, jotenkin se tulkitseminen (mitenkä he kokee)
P1: [Se on hirveen vaikea tulkita.]
P3: Toinen ei oo moksiskaan ja toinen on ihan ahdistunu.
P1: Nii.

Extract 18 (FG4)

P2: Mä voin nyt avautua ei mut tässä on ihan oikeesti kohta et se karmee (esimerkki oli) joittekin vuosien takaa sellanen (1) lääkärikollega joka (.) poltettiin HENGILTÄ (.) vaimon toimesta (2) väkivaltaa oli jatkunut vuosia (.) ja sit se tuikkas sen miehensä palamaan ja se kuoli se kardiologi siihen ((naurahtaen)) asiaan että (.) et tota (2) niin (.) työssäkäyvä ihminen
?: kauheeta
P3:sitä sattuu kaikissa piireissä ((ponnekkaasti)) ei sitä pitäis sitten ihmisiä niin että
P2: ei mut että tavallaan tavallaan niinku
P3: niin.

Extract 19 (FG3)

P4: Kyl toi henkinen väkivalta musta kaikkein vaikein näistä. Toihan täyttää ihan normaalit parisuhdekriteerit ((P2 ja P1 naureskelee))
P4: Sillä perusteella jokainen suomalainen humalainen mies joka tulee sairaalaan niin on kokenu henkistä väkivaltaa.

Extract 20 (FG1)

P1: Ei aina ku (.) jos potilaalta kysyy (.) et onko välivaltaa vaikka nyt ajatellaan parisuhdetta niin usein potilaat vastaa että EI OLE mutta sitten kun sitä suhdetta potilas kuvaa ni potilas kuvaa kuitenkin sit näitä henkisen väkivallan piirteitä se on täynnä (1) saattaa jopa olla jotakin fyysistäkin esineitten rikkomista ynnä muuta muuta mutta ihminen ei miellä sitä väkivallaksi (1) et kun me kysytään siitä vastaus on ei ja sitten kuvaelma tulee tämän (.) määritelmän mukaan (.) et se on aika tyypillistä.

Extract 21 (FG3)

P4: [Heiän] heiän parisuhde ei ollu pitkä. että se oli muutaman vuoden tuttuus. Mä kysyin sitä et ”ooks sä ihan varma et sä lähet sinne samaan kyytiin?” Sano että kyllä hän, et täs on niin paljon stressiä takana et hän

ymmärtää ihan täysin et näin toimi. Et se nainen niinku meni siihen tavallaan sitä varten mukaan et hän ymmärtää jos vähän stressaa ni häntä saa sit mopsasta jos vähän vituttaa.

Extract 22 (FG2)

P4: Eiks sitä oo tutkittu Suomessakin että yhtä lail- yhtä paljon naiset tappaa yhtä paljon kuin miehet, siis niinku parisuhteessa kumppaninsa. Et niinku jotenkin, siis myös uhrin, ite ainakin mietin et onko hän aina niinku pelkkä uhri kuitenkaan. Et mikä se sitten on se toinen puoli ja mitä siellä tapahtuu.

Extract 23 (FG1)

P2: Niin (.) tilanteessa missä ihmistä on jo kontrolloitu että niinku mä ainakin koen joitakin tilanteita missä niinku nimenomaan se että jos on vaikka uhri (2) joka nyt ei hirveästi oo vaikka psyykkisen sairauden niinkun et sehän voi tietysti alentaa kykyä pitää huolta itestään mutta jos ei oo (.) nii tavallaan se että et et missä määrin niinkun et ku ku mehän paheksutaan kaikki mehän paheksutaan lähisuhdeväkivaltaa me paheksutaan toivottavasti enemmän tekijöitä mutta vähän myös jossakin sivulauseessa niitä uhreja miksi tuo on vielä naimisissa tuon tyypin kanssa ku se on semmonen ja tämmönen ja sehän on myös se minkä nää uhrit varmasti haistaa ja vaistoaa ja tietää ne on ehkä jos on puhunut jollekin ni ne on saanut semmosia vastauksia jo elikkä he on yleensä kuitenkin aika semmosessa ALISTETUSSA ja myös niinku herkässä tilanteessa sen suhteen että MILLÄ LAILLA mua autetaan ja minkä mää koen avuksi eikä siksi että mua moralisoidaan tai paheksutaan siitä että miksi sä annat fiksu ihminen itselles tehdä.

Extract 24 (FG3)

P3: Ja erityisesti lasten kohdalla se korostuu koska siin on se avuttomuus, koska se ei voi puolustaa itseään.
P1: Lapset ja sitte tietysti tuolla aikuisten puolella sitten semmonen, niin sairas, jo iäkkäämpi ihminen, joka ei pysty itseänsä millään tavalla puolustamaan, ei oo puhekykyä esimerkiks tallella. Ei pysty itseänsä millään tavalla. Mielestäni se on puhtaasti terveydenhuollon asia, tai siis muitten asia, ei se ihminen voi ite itseänsä puolustaa.