

It is apparent from the findings that there are points of tension in the provision of healthcare for women whose health is affected because of living in a violent relationship. These intersect with and further influence turning points in women's lives. I re-constructed these in order to reconceptualise discourse in a way that will provide a fresh and alternate lens from which to view women's needs and that can better inform policy, nursing, and other health professionals' practice, in order that women's health issues and needs may be better understood and addressed.

In the first reading of healthcare experiences I argue that there is a clear and dominant healthcare trajectory, informed by bio-medical discourse and practice. However, I argue that there is a need to examine women's health issues from a substantially different framework, also evident in the findings, named Biographical Disruption (Bury, 1982), which is apparent in the experiences described by women in this study yet is overlooked in the literature and in practice.

Examining Dances of Disclosure

Recall the early phases of healthcare encounters set out in Chapter 4. These were named a 'dance of disclosure' in the chapter and they show characteristics of a critical part of the encounter, a turning point, and one from which women's health, healthcare and sense of self can be tracked and where conflicting discourse is evident. Recall for example how Ange presented to a psychiatrist to seek help for her mental health issues. She described how she sat in his office crying and the psychiatrist responded by focussing on her symptoms. They were named, 'depression', and a trajectory of treatment for her symptoms was offered, one which should return her to normality. She related how she was frustrated that the psychiatrist failed to look for the reason as to why she might be crying. She had lived in a violent relationship for seven years. She did not directly disclose the source of her issues, nor did the psychiatrist facilitate such a disclosure. Any disclosure of her underlying problems is covert and subverted to the treatment of symptoms with the ambition to return her to a normal state of health, that is, one without the symptoms of emotional distress. While this covert process as a response to obvious signs and symptoms of abuse has been presented and the analogy critiqued in the literature (Gerbert, 1999; McCauley et al., 1998) it has not received attention with regard to how it impacts on the care trajectories or the ways the dance may take shape over time, or end. That is, a point of disclosure, or end

point, is assumed and becomes the focus of attention, rather than the process, that is, the dance. This in turn sheds light on the treatment approaches currently adopted, that is the care trajectory, and the assumptions that underpin healthcare within this framework. To bring light to understanding the 'dance' I turn now to discussing how women's health issues and needs that result from domestic violence are constructed. The healthcare encounters described in Chapter 4 evidence the dominant dance, one underpinned by the thinking and practice of biomedical discourse.

Bio-medical Discourse and Practice

Biomedical discourse has prevailed in healthcare language and influenced healthcare policies and practices for many years. Arguably it is the dominant framework in contemporary healthcare generally and I argue that it was the dominant approach to the healthcare encounters of women in the present study. Applying this lens to healthcare, health problems or issues are diagnosable, discrete entities, ills suffered by individuals that affect 'normal' function. These are examined by professionals, medical officers, supported by nurses and allied health professionals, who guide the process to recovery through a trajectory based on treatment interventions (Ballard & Elston, 2005). Through this lens, not only physical symptoms but also personal and social phenomena are defined as illness and treated in predictable and discernible ways (Ballard & Elston, 2005). Bio-medical discourse is linear. Health concerns are discrete and categorised within definitive diagnoses that are attributable to specific and intrinsic causes or deviations from normal function. Normal function separates health from ill health, dysfunction or abnormality from function and normality. These are each understood as individual pathology (Fisher & Goodley, 2007).

The individual is responsible for seeing the trajectory through and being guided by the proffered expertise. Thus, one would expect Ange to accept that symptomatic treatment of her emotional distress was the ideal and sufficient treatment trajectory and to be responsible for complying with its rigors.

Bio-medical discourse is framed and frames healthcare, across three tiers. First, discourse is apparent at a conceptual level where medical language constructs and defines presenting problems. Second, it is apparent at institutional level where collaboration with other authorities is used to legitimate the problem or issue as a

medical problem. Third, biomedical discourse influences healthcare at the interactional level between health professionals and individuals in which individuals are assumed to acquiesce to direction from 'experts'.

Healthcare trajectories are built through a lens of practice that supports 'good practice' as that which affords primacy to prioritising physical emergencies and favours individual, biological or psychiatric causes of ill health which are amenable to categorisation, over socially or externally constructed experiences which are less so (Kurz & Stark, 1988).

I also argue here that that the structured bureaucracy of healthcare settings influences the response of health professionals in a way that inhibits women centred care and complements the dominant healthcare trajectory of diagnosis and cure. For nurses there is a further issue in that they are at times challenged by blurred professional boundaries. Carmel (2006) has described how non-medical health professionals who work closely with medical practitioners adopt discursive practices whose values and attributes reflect the dominant biomedical discourse (Carmel, 1992). Whilst nurses claim to practice in a different relationship with patients from their medical colleagues, they often work closely with their medical colleagues and in such environments nurses may take on characteristics associated with medical dominance such as applying diagnosis to symptoms and affording priority to physical care trajectories (Carmel, 2006; May, 1992).

In this study Emergency Department nurse participants struggled to accept their workplaces, as appropriate places to care for women affected by domestic violence once their physical needs were met. Nurses organised women's health issues that resulted from domestic violence around reductive knowledges and practices that categorised them as body types. In the study, nurses described attempting to 'babysit' women or pass them on to services they deemed were more appropriate. The women's stories included accounts of medical personnel also deflecting them as patients, for instance to parenting courses. They related being referred to social workers when there was a question of child safety, community nurses when there was an issue of mothering, and ED nurses when there was physical injury.

Fragmented care is a dominant trait in the literature which has a strong focus on individual responses (Pierret, 2003). That is, nurses' responses, doctors responses, social worker's responses, police responses, support services and broader legal responses.

Women in this study described a form of 'game playing' that they undertook with health professionals when they sought care, and as they attempted to negotiate or change the trajectory of their care. This suggests that women attempted to maintain autonomy over their needs; however the approach had a deleterious effect on their care. This form of game playing has not been conceptualised with regard to domestic violence however, it has been described by McKeever & Miller (2004) who investigated medical professionals' pressure on mothers' of disabled children to conform to biomedical paths of healthcare for their children. Fearing retribution these women "acquiesced and played the rules of a healthcare game" (p. 1183) by appearing to conform publicly to expectations. Women in the present study related how they read health professionals' body language to determine what type of care they would receive and reacted accordingly. For example, Edwina described her response to being referred to a parenting programme, for the third time. She nodded and said 'OK' whilst believing that her needs had been ignored and discounted.

The women in this study clearly contested the meanings and labels that were being attached to their health needs by healthcare providers. They demonstrated this by adopting measures of suspicion and defensiveness, or at worst by refusing to re-engage with healthcare. Andrea for example, described her experience in an ED where she felt judged for her situation because she smelled of alcohol. She walked out and refused to return to the ED in the future.

The process reveals non-compliance and disillusionment on women's parts, acts of resistance and despair. But, as discussed earlier the process also reveals a rejection of women and their health issues by healthcare services. Women's needs when non-responsive become constructed as being outside the scope of healthcare environments. An imperative of a bio-medical discourse lens is treatment and treatment responsiveness. Contrary expectations may be set up for women to meet such as attending relationship counselling but also being expected to cease being in a violent

relationship as the 'fix it' or cure to stop the physical injuries and mental ills. Rittmayer and Roux (1999) argue that until health professionals cease attempting to 'fix' women's health problems, administering care will continue to be a source of frustration that exacerbates women's negative experiences. I argue that the approach also sanctions health professionals' disengagement from women's health needs as they re-define them as social needs. The links between the two are not maintained but rather sectioned off as one or the other.

The findings revealed women who present for healthcare as vulnerable and uncertain about how to disclose their health issues and the underlying social realities that generate these. In response to the healthcare approach proffered women feel judged for their presentations and for their life situations. They found themselves waiting, 'stood over', ignored or abandoned.

The findings revealed the direction of the healthcare trajectory. For the most part women's needs were quickly re-defined as 'social needs', evidenced in nurses expressions such as '[there] wasn't much they could do for them' and they were referred on, to social workers. These sorts of actions signal the disengagement of healthcare services and its care providers. Women's health issues are at best only partially addressed and at worst, overlooked as the very system they seek help from determines them to be outside the scope of practice.

Judged and punished, women interpret these responses and look to themselves, feeling shame and guilt. They blame, question themselves and struggle to find themselves worthy. These are feelings similar to those generated within their violent relationships. Here they are generated in the healthcare that they seek out.

Clearly this situation exemplifies poor healthcare and contributes to poor outcomes for women. No one is to blame. Rather it is as a result of a sophisticated and well established discourse, embedded in everyday life as healthcare practice. However I wish to move beyond the status quo. In order for the dance of disclosure to be re-shaped requires responses that adopt different shapes, ones that are helpful, responsive care trajectories, which provide new ways of understanding women's health issues. An alternate response is needed, one informed by a lens that can be

make women's health issues accessible and clearer and that can alter the dominant discourse and its practices. I argue that a way of doing this is apparent in the findings. It is discussed below.

Biographical Disruption – An Alternative Reading

The key concepts here are disruption and self concept. The concept of biographical disruption evolved from Bury's (1982) work in which he developed a theoretical understanding of chronic illness. It is usefully applied to examining these concepts. Bury argued that the diagnosis of chronic illness acted as a disruptive experience that challenged the taken for granted assumptions in an individual's life and particularly a cognitive understanding of self. At the heart of the theory is the assumption that a major disruptive experience leads to a fundamental re-think of a person's biography and self-concept (Bury, 1982; Lawton, 2003). Lonardi (2007) argues that biographical disruption may be experienced by people when their health issues impact on daily life, self identity, self reliance and social relationships. The theory has been widely applied in studies of chronic illness. Biographical disruption has been used to describe the diverse experiences of people who suffer for example, Rheumatoid Arthritis (Bury, 1982), Chronic Fatigue Syndrome (Travers & Lawler, 2008), chronic headaches (Lonardi, 2007), Human Immunodeficiency Virus (HIV) (Carricaburu & Pierret, 2002) and mothers of children with disabilities (McKeever & Miller, 2004).

Bury (1982) theorised biographical disruption as a trajectory through which the course of an illness could be examined as it impacts on self-concept. Three phases are identified in this trajectory; biographical disruption, biographical re-evaluation and biographical re-construction. Disruption is the phase in which the person experiences a major disruptive experience that leads to re-examination of their biography and self-concept (Bury, 1982; Lawton, 2003). Re-evaluation is concerned with a re-think of the person's biography and self concept when they attempt to make sense of their situations and what is happening in their lives. During this phase of disruption Bury (1982) suggests that intervention is important however limited in procuring an outcome as management is based on trial and error. As a result individuals fall back on their own knowledge and biographical experiences. Re-construction is concerned with mobilising resources and attempts to normalise the situation. The person is drawn into re-arranging their sense of self and place in society. The presence or

absence of a supportive network has profound implications for movement through this phase of disruption. As Bury (1982, p. 176) says “The erstwhile taken-for-granted world of everyday life becomes a burden of conscious and deliberate action”.

Biographical disruption is a new lens through which to examine health issues and healthcare for women affected by domestic violence, and more specifically through which to see the relationship between their health, health issues and sense of self as these relate to their healthcare. It illuminates points of tension in relationships that women have with health professionals thus offering direction in which intervention can occur to repair the ruptures in relationships and in order that women’s interests and needs are met when they seek healthcare. It has the potential to place women centre-stage, linking and mediating their health to personal troubles and wider public and social and political issues (Williams, 2000).

Three aspects of Biographical Disruption as a framework require clarification in order to apply this theoretical lens to the work of re-constructing and re-conceptualising health and healthcare in the context of the present study. The theory was first developed and applied to chronic illness. Thus the first issue concerns the term ‘illness’. The context of Bury’s and much of the work that has followed has been that of discrete illnesses or syndromes with fairly fixed turning points constituted in the initial assessment and diagnosis of an illness entity. Further, the context has been primarily applied to conditions where physical symptoms form the primary health concern (Williams, 2000). One of the difficulties with effective healthcare as outlined in the previous section of this discussion is the difficulty that arises from the efforts of professionals to buttonhole women’s ills, or to put it another way, to provide neat medical diagnoses of physical or mental abnormalities. In the context of the health issues experienced by women who live in violent relationships, the health issues and the symptoms women embody are more disparate, not discrete and certainly do not, nor should not, be contained in a discrete diagnosis. However, looking back at the narrative ‘fragments’ presented in the findings it is apparent that there are quite recognisable turning points or epiphanies for women as they live in violent relationships – where they recognise that their health is suffering and their ability to function in their everyday world in ways that they know is less taken-for-granted. At these turning points, I argue, they begin to seek out healthcare. These recognisable

turning points also support the application of the framework to the context of the present study.

The second issue concerns chronicity. For the most part Bury's framework has been applied to and contested within the context of individuals living with chronic conditions. In the context of the current study, it is clear that while women do not have, nor want to be labelled with a syndrome or discrete illness, the effects of their situation on their health are ongoing and some aspects of their health change, and deteriorate over time, and may be permanently altered in the face of their experience. Thus there is an element of chronicity in their health issues.

The third issue arises in debate from within the research literature on chronic illness and forms a critique of the framework. This relates primarily to the insistence on a diagnosis of chronic illness being a significant disruption to an individual's sense of self and biography. Williams (2000) argues that whilst it may appear that the lives of people are disrupted it is possible that rather than experience a disruption to their biographies they may experience as shift or continuity of their biography. He further argues that what may be experienced as a biographical disruption for some may be experienced as a 'normal' crisis to others. He cites the case of stroke in London East Enders who believed it to be a normal part of ageing or expected due to co-morbidities they experienced. Carricaburu and Pierret (1995) introduced the notion of biographical reinforcement. In their study of men who had contracted HIV (Human Immunodeficiency Virus) they found that for this population interpretation of their infection entailed reconstructing their individual and collective pasts as haemophiliacs or homosexuals in a way that gave continuity to their biographies of lifetime illness or struggle with identity. Similarly, Faircloth, Boylstein, Rittman, Young & Gubrium, (2004) describe how people who suffered strokes did not necessarily view it as biographically disruptive, that their conceptualisation was also related to biographical contingencies, such as their age when the stroke happened, whether they suffered co-morbidities such as diabetes and also what their pre-existing knowledge was with relation to stroke. Contingencies resulted in biographical continuity or flow where the stroke event was bracketed and normalised as part of a flow of life events.

To address the issue of biographical disruption versus continuity / shift or flow I turn to women's experiences. The women who took part in the present study clearly endured disruption to their sense of self or known biography. Their stories revealed that many epiphanies or turning points occurred over the course of their violent relationships and their perceptions of health and what health meant for them changed over the course of their relationships. The turning points in their relationships and their understandings of self were related in their stories and reflections about their changing health, stories of inner turmoil, self-doubt and self-blame. Further their health and their sense of self remained fragile and contested even when their relationships ended. Their understanding of what being healthy meant changed irrevocably.

Williams (2000) raises the issue of anticipation; that if some life events can be anticipated and moderated by social support and self esteem they may not be biographically disruptive. In the present study women did not anticipate that there would be violence in their relationships. Indeed for all the women in this study the violence in their relationships began following marriage or following cohabitation. Further, one of the tactics that violent partners employed was to isolate women from systems that could have provided social support, for example, their families and friends. There is little evidence to suggest anything other than biographical disruption for women in this study.

Thus the necessary premises of the framework, disruption of self concept related to disruption of known and anticipated life and living, marked in identifiable turning points or epiphanies are established in the context of the participants' experiences in this study. Women witnessed deterioration in their health, increasing health issues and increasing needs for healthcare as a result of living in violent relationships. I now turn to the analytic utility of biographical disruption as a lens from which to view healthcare and to better understand healthcare trajectories.

Disruption

Bury (1982) describes how disruption is insidious, when the person becomes aware that 'something is wrong' but then looks to common sense to furnish the answer. This rang true for the participants of this study who spoke clearly about how their

relationships with violent partners did not live up to their expectations, that they had envisaged long and loving relationships with their partners and that they were prepared to examine their own actions within the relationship to try to address what they perceived to be relationship problems. They described how early in their relationships they experienced domestic violence as they knew ‘something was wrong’ with their relationships, but rationalised it as being associated with their partner’s stress, consumption of alcohol or that something they had done had caused the situation. However, as Bury (1982) describes this approach of rationalisation becomes more problematic over time when it fails to fix the problem and the person enters a “new social arena where common sense guidelines are no longer sufficient” (p. 170). As their relationships progressed the process of rationalism transgressed women’s sense of “common-sense boundaries” (Bury, 1982, p. 169) and women were no longer able to distinguish internal and external reality of their situations and feelings but were not yet able to present themselves with an alternative explanation. This is due in part to their confusion due to the insidious nature of ‘symptoms’ (Bury, 1982). In their confusion as they sought ways to externalise what was happening and sought meaning for their situations.

Bury (1982) describes the end point or turning point of this phase of biographical disruption as one that is marked with relief when problems are disclosed as it signals that complaints are justifiable and behaviour is warranted. Women in this study had presented to health professionals hoping they would help them and seeking validation of their feelings. However, many women never experienced a sense of relief. When they presented to health professionals without disclosing their violent relationships or health professionals failed to attribute their complaints as possible evidence of violence, their needs were prescribed a care trajectory that re-characterised their confusion within a biomedical discourse played out in its attendant practices, as previously described.

Conversely, when women did disclose that they lived with domestic violence they felt they were stigmatised, discredited and ignored by health professionals. Stigma occurs at two levels – enacted and felt stigma (Pierret, 2003). Enacted discrimination occurred in the discrimination women described. The shame they expressed represents felt stigma. This stigmatisation compounded women’s feelings of

transience or liminal being. This is associated with what Pierret (2003) describes as a redefined self, reconstructed personal biographies requiring a renegotiation of identity. This experience, in turn further exacerbated their mounting and unaddressed health issues.

Re-evaluation

Bury (1982) presents a second phase in the trajectory of biographical disruption, a period of re-evaluation. The phases are not easily distinguished or traversed. However, this phase involves a fundamental re-think of the person's biography and self concept. Clearly women in this research spent much time trying to make sense of their situations and what was happening to them and attempting to construct meaning within their lives and incorporate their changing sense of self. Indeed at times they questioned life itself. In this phase Bury (1982) suggests that intervention is important however limited in procuring an outcome as management is based on trial and error. As a result individuals fall back on their own knowledge and biographical experiences. This is a particularly important point to make when examining the care trajectory women in this study experienced as it suggests that in the face of unresponsive healthcare that also stigmatises, women's knowledge contributes to a biography that is further fragmenting and confusing.

At this point it is important to examine reciprocity and how it may function in shaping the healthcare encounter and women's experiences and understandings of self. Relationships of reciprocity and mutual support are 'normal' in healthcare relationships where patients are expected to be honest and forthcoming and in return health professionals are expected to behave in ways that demonstrate respect and which validate their complaints (Bury, 1982). The challenges to these rules were apparent when women spoke about how they danced around the issue of disclosing the violence that so disrupted their health and sense of self. They were not forthcoming with information but still expected health professionals to see their situation and respond in a way that addressed their complaints and respected their autonomy. Bury (1982) iterates that at this stage when seeking help, perceptions and expectations may not necessarily coincide with those of health professionals and that as a result recognition and legitimation are problematic. This was clearly evident in women's stories when they began to seek help without disclosing or only hinting at

the nature of their problems or when they presented with non-specific physical symptoms or psychological distress. Their confusion, inability to name their situation and turmoil of trying to make sense of their disrupted sense of self is clearly evident in the findings. The dance of disclosure is not about women's uncertainty in disclosing domestic violence but about them voicing the experience of disruption to their sense of self that they recognise, if only partially.

Women's stories of presenting for healthcare, their underlying angst and conflict about how to present were in clear contrast to nurses' stories that relied heavily on descriptions of physical symptoms and diagnoses that were attributable to violence, that characterised their health issues and which set in place a prescribed care trajectory and an expectation that women comply in appropriate ways. The effect of this response is that it fails to recognise the sense of disruption women experience, and effectively silences women's efforts to voice this disruption. Validating the more ambiguous presentation or addressing a disrupted sense of self begins a dance that may be indeterminate, without discrete, linear solutions. This does not fit within the healthcare framework which surrounds women as they present for care. Such open ended interpretive assessment is not prioritised as it may expose the limitations of interventions aimed at curing or fixing presenting symptoms. Acknowledging women's confusion and turmoil and understanding that women are not trying to hide the violence that underpins their ill health but that they are trying to present a disrupted self is an important point of departure in healthcare trajectories, one from which nurses and other health professionals may be more able to support women. Nurses may be able to abandon the moral taxonomy of good and bad patient, good and bad woman (Lupton, 2003).

The findings provide further depth to the potential issues regarding disruption to self and the ways that early interventions might shape the course of disruption as individuals attempt to re-evaluate their experience and sense of self. In this case the rite of passage away from the transience of liminal being is not necessarily progressed in the approach to responding to the presenting health issues of women. The evidence of these findings is that in fact the disrupted sense of self may deepen at the hands of healthcare.

The findings showed the way some of the women resisted the thinking and treatments offered but the findings have also shown that their resistance was in part to having to face the disclosure of their disrupted sense of self. It is posited here that if health professionals viewed women's resistance as 'expected' rather than their compliance when they are traversing through journeys of disruption and disputed sense of self it might allow new ways of constructing and supporting women's needs when they present for healthcare. They may need to negotiate the healthcare relationship from a different set of premises and thus be able to act in ways that do not increase the sense of shame and guilt experienced by women, actions which may thus prevent women's further disruption. Bury (1982) has argued that compliance is a pathway to normative views of self. However the picture drawn in this study suggests that identifying and negotiating and working with resistance may be more productive in leading a more successful dance of disclosure or healthcare trajectory.

Re-construction

In the third phase of the trajectory of biographical disruption Bury (1982) he describes a response to disruption that involves mobilising resources. He adds that the presence or absence of a supportive network has profound implications for the progress or course of individuals. This is an issue of importance for health professionals as a potential resource. It may be that a supportive network of health professionals who inform their practice from a woman-centred approach to care, that acknowledges and values their experiences may fundamentally impact, positively, on women's lives when they experience domestic violence. In this study, women attempted to mobilise many resources, in particular they approached health professionals. However their attempts were met by health professionals who they believed had no understanding of how violence impacted on their lives and who undertook very limited roles in responding to their needs.

Bury (1982) adds that at this stage when individuals attempt to normalise their experiences their behaviour may depart from what is deemed 'normal' or acceptable' and that flexibility must be allowed in formal and informal relationships. It was evident that health professionals perceived that women's behaviour was not 'normal' or 'acceptable' and they were not afforded flexibility in their relationships with health professionals. They were afforded a set path through which to traverse the healthcare

system and when they transgressed their behaviour was deemed to be inappropriate. Women, as a result, became labelled as not credible patients and felt unworthy of care. Labelling of women who present as a result of domestic violence has been discussed in the literature for many years and it is recognised as problematic by some authors (Kurz & Stark, 1988; Stark et al., 1979). However the dominant discourse in the literature that addresses healthcare responses to domestic violence is informed by medically oriented opinions. Further, responses are often focussed on screening for the presence of domestic violence in women's lives and services are intervention and outcome directed rather than support and process focussed.

For women, identifying coping resources was the result of a long process through which they sought assistance, in particular help within healthcare systems to facilitate identification of and initiate a response to the 'problem'. They attempted to continue to engage with healthcare by working with the various diagnoses of mental illness that they were labelled with, such as depression, anxiety or stress. However these diagnoses and the treatments that accompanied them did not act as resources for women, the findings suggest that they worked instead to exacerbate their feelings of unworthiness and shame. Women engaged in selective concealment and disclosure of information to health professionals and within personal relationships. Sometimes disclosure of domestic violence was carefully thought out and staged by women when they sought help and healthcare. They sometimes had a plan of disclosure and used selective strategies to disclose information. This included not reporting the presence of domestic violence in their relationship or minimising the severity of the violence. It is thought that this process of minimisation is aimed at protecting the self from situations that may ultimately bring them discredit (Bury, 2001; Pierret, 2003). These represent efforts to normalise, cope and manage.

Normalisation as a concept involves two processes (Bury, 2001). On the one hand women tried to normalise their experiences by attempting to maintain their pre-violent relationships and keep their identity intact. This involved maintaining as many activities as possible and disguising and minimising of the impacts of violence on their health. When this strategy failed women attempted to incorporate their deteriorating health and sense of self concept into their changed lifestyles. They were unable to reintegrate their previously held understandings of self concept that had

departed from their fixed point over the course of their violent relationships and thus were unable to traverse their sense of liminal being as they sought to incorporate changing health into their altered self concept and their place within the social world. Navon & Morag (2004) describe liminal individuals as those who struggle with nullification of their identities and whose sense of understanding of the world around them becomes ambiguous. Turner (1967) argues that this experience results in a struggle to integrate new meaning to life and sense of personhood. Until meaning is found liminal beings regard themselves as “neither this nor that, but both” (p. 99). Situated in this enduring period of liminality women described their struggle and turmoil as they grappled with their disrupted sense of self concept. Their new meanings were at worst despair, situating themselves as unworthy.

Using the theory of Biographical Disruption helps to illuminate what underpins women’s thinking and experience as they present for healthcare for their emerging health issues. It provides an alternate and illuminative reading of the effects of the dominant available care trajectory as described by participants in the current study and finally it helps to provide an alternate understanding in an effort to re-direct the dance of disclosure and alter healthcare trajectories. It is the central thesis of this discussion that a disrupted sense of self is at the heart of healthcare issues that are experienced by women who present for healthcare as a consequence of living in violent relationships. Failure to recognise, acknowledge, accommodate or direct care based on this understanding fails to provide responsive healthcare. Further it may further disrupt and harm women in this situation. I argue that in currently available healthcare, exemplified in the accounts provided by affected women and nurses in this study, it is evident that this failure is the norm. Additionally it is an expression of a discourse of healthcare that is enacted as the norm which has little facility to acknowledge and focus care on this type of health issue. Without accepting, negotiating and enacting healthcare in a field of complexity and resistance, suggested by the presence of such disruption to a sense of self, the outcomes for affected individuals will at best act as bandaids. At worst they act to deepen the disruption and despair, to isolate and remove potential sources of help and support.

This assertion is confronting, however to finalise this discussion I wish to investigate evidence in the findings of care that suggests that there is an alternate dance, or trajectory that needs to be given credibility beyond the actions of individuals.

Locating Alternate Voices

Women who participated in the study provided evidence of an alternate voice when they related details of encounters in which they felt 'cared for'. The traits that were named as demonstrating caring were also related by nurses when they spoke about what would make a woman feel that she was being cared for, such as calling her by her name, offering a warm blanket or listening while she tells her story. These are the actions of validation and acceptance. They may help to turn resistance into openness. The value of communication was also supported by women who engaged in healthcare. They described wanting to be treated as they believed other patients were treated and went to lengths to emphasise the 'ordinariness' of what they expected. This supports the small body of qualitative research that has previously investigated what women expect from health professionals when they approach health services, which emphasises the importance of appropriate communication that makes women feel believed and not being judged for their situation (Chang et al., 2005; Gerbert et al., 1999; McCauley et al., 1998; Yam, 2000).

It was clear that nurses do want to help and they emphasised the importance of encounters in which communication made women feel valued and safe. Importantly, it has been described in the literature that having a health professional who responds appropriately helps to plant the seed for women so that they can begin to see themselves and their relationships differently and in some cases it assists them in making the decision to leave a violent relationship (Gerbert et al., 1996). In the current study Ashley described presenting in ED with signs of physical abuse that were evident on her injured body. As she embarked upon a dance of disclosure she told the physician that she had fallen. The doctor suggested that maybe she hadn't fallen and gave her a card for a domestic violence service which she accepted. At no time in the encounter was the true source of her injuries openly discussed however Ashley related how she kept the card which had 'planted a seed' in her mind about how to understand her situation.

Nurses also highlighted the importance of communication to demonstrate compassion and respect for women's situation and autonomy in their decision making. These stories contrast with the main story told by nurses about their encounters with women and indicate that nurses struggle to know how to respond appropriately when working in healthcare environments that may constrain their responses. There is little evidence in the findings that nurses' responses that demonstrate compassion are supported at institutional or conceptual level and therefore these examples may be exceptions in responses. Whilst there is much written about the therapeutic benefit of communication in health professional-patient interactions it remains problematic and at times can become destructive in responding to the needs of women affected by domestic violence (Stenius & Veysey, 2005). Whilst this finding complements current literature (Bacchus et al., 2003; Chang et al., 2004; Yoshihama, 2002) it also highlights an area of struggle for nurses who clearly know how to demonstrate caring approaches but fail to use them in their practice. Yet importantly, therapeutic communication plays a significant role in helping women to move beyond their disrupted, fragmented, liminal self (Gerbert et al., 1999; McCauley et al., 1998).

Summary

In this chapter I have discussed the significance of the research findings constraining the process of reconstructing healthcare for women whose health is affected by living with domestic violence and have re-contextualised the findings. The findings show that clearly, healthcare encounters with women affected by domestic violence are problematic. The women who participated in this study were clear about what they expected from health professionals and using this information provided a useful platform from which to re-conceptualise healthcare.

Women affected by domestic violence believe health professionals have a role in responding to their needs when they seek help yet they have negative experiences during their healthcare encounters and perceive that their health needs are not met, and indeed at times their health issues are made worse. In contrast health professionals, whose practice is informed by the dominant biomedical paradigm, believe they respond well to women by prescribing care trajectories that diagnose their ills, and set treatment approaches to afford them a cure.

I have attempted here to outline how current healthcare responses and health professionals' practices are informed and underpinned by biomedical discourse. I have used the dance of disclosure as an analogy to illuminate aspects of healthcare, its processes and outcomes. Biomedical discourse currently constructs women's health needs and sets them on a trajectory of care that is outcome focussed and embraces therapeutic values of diagnosis, treatment and cure. I have argued that current responses fail to acknowledge the complexity and needs of women affected by domestic violence. I have highlighted how a predominantly biomedical lens currently constricts women's health issues and needs that result from domestic violence and frames the relationships and roles on health professionals and of women who engage in a complex dance of disclosure. It is clear that the treatment approaches and expectations of health professionals who practice using a biomedical lens have negative outcomes for women whom they encounter. I have suggested here that for the most part health professionals do not recognise how living in a violent relationship so profoundly disrupts women's lives and sense of self.

I have provided a new lens from which to view women's health and health issues. Biographical disruption was presented as an alternate lens from which to view women's health issues and needs. This framework highlights how, as a result of living with domestic violence, women experience significant fracturing of their sense of self and attempt to traverse a liminal space in which their personal biographies and identities are shaped not only by their experiences of living in violent relationships, their emerging health issues, but also by the healthcare that responds to their issues. I have indicated that there are critical points at which health professionals can support women, particularly on presentation. I have also argued that the 'symptoms' that health professionals seek to respond to are only part of the 'symptom' of their health issues.

Biographical disruption is an important framework which helps to illuminate aspects of healthcare, oft overlooked, to understand what is happening to women's self concept. This framework also highlights important issues for health services to acknowledge and be responsive to if care is to be responsive and more helpful to women affected by domestic violence. The following chapter will expand on these key points and offer recommendations for future healthcare and practice.

Conclusion

The purpose of this study was to develop knowledge of women's health and health issues that arise as a result of living with domestic violence and of healthcare experiences when they seek healthcare.

Domestic violence is already recognised as a major and costly public health issue and it has previously been acknowledged that its effects on women's health are devastating (Access Economics, 2004; Fraser, 2003; Parker & Lee, 2002). However, current responses to domestic violence are focussed on epidemiology of domestic violence and identification or presence of violence in women's lives, stretched thinly across social, legal and health service departments and are uncoordinated.

For this study an interpretive interactionist approach, informed by both a feminist and postmodern lens, was used, that placed women centre stage and took into account the social context of their experiences. Women shared their stories of health issues related to domestic violence and subsequent healthcare encounters. The stories were then analysed using narrative techniques to highlight key elements of their health issues and healthcare experiences. In completing the study I tried to move beyond deconstructing to re-conceptualising health and have begun to unravel complex factors that impact on healthcare responses to women.

Women's health and health issues that result from domestic violence are constructed from two diametrically opposed lens. Women told stories of disrupted sense of self, of inner turmoil and negotiation and renegotiation of their sense of self. Their sense of living 'betwixt and between' highlighted the liminal state of their being as they struggled to make meaning of every day life. For women health encompassed their being and was an integral part of their personhood, defining their existence and forming their life biography. Whilst they lived with domestic violence their health was expressed through their bodies in the form of physical, mental and emotional difficulties and ills. The findings of the study illuminated important issues and turning points in women's health as they lived with domestic violence and when they sought healthcare. I have argued that these turning points remained overlooked by health

professionals when they sought healthcare and women remained suspended in their liminal state.

I conclude that the dominant paradigm on which healthcare responses are currently built values medical models of healthcare that focus on disease, illness, diagnosis and treatment and in which health professionals are experts and women are amateurs. Characteristics of the medical model of healthcare prevail at conceptual, institutional and interactional levels of healthcare delivery and are deeply entrenched in healthcare settings. Its dominance makes it difficult to challenge because of the bureaucratic structure of health services and the dominance of medical doctors as the perceived experts in healthcare.

Implications for Practice

The challenge is for nurses to dare to be different.

Rather than conceptualising women presenting for healthcare with characteristics such as 'badly' behaved, non-complaint or consciously involved in a 'dance' of disclosure, which suggests game playing, the nature of their presentations and the characteristics of confusion and resistance that women exhibit should be expected, accepted and celebrated as an opportunity to afford support as opposed to treatment. Accepting that women present for healthcare whilst living with a disrupted, liminal sense of self and that their behaviours indicate they are searching for meaning and support allows nurses and other health professionals opportunity to understand the turmoil in women's lives.

It is important to understand that when women present for healthcare they are traversing processes of disruption, re-evaluation and re-construction of their sense of self in which their health is inextricably intertwined with their personhood. A fresh lens from which to view this issue may allay some of nurses' and other health professionals' anxieties in responding to women because it highlights that what women present with is to be expected, accepted and supported rather than treated or fixed.