

**DOMESTIC VIOLENCE AND SOCIAL NORMS: ATTITUDES
AND PRACTICES OF CRIMINAL JUSTICE AND HEALTH
WORKERS IN NORWAY AND BRAZIL**

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ABSTRACT

Background: In recent years, gender-based domestic violence has gained significant visibility and is currently considered a priority in the field of public health.

Research objective: To explore how professional and social norms and regulations impact the attitudes and practices of health and criminal justice professionals regarding domestic violence against women in Brazil and Norway.

Methods: I selected a qualitative approach and gathered data through individual, semi-structured interviews with professionals from the health and criminal justice departments. I conducted 16 in-depth interviews (eight in Brazil and eight in Norway, with four health professionals and four criminal justice professionals in each country). I focused on their perceptions of existing workflows between identifying cases of violence and dealing with these cases. I analyzed the transcribed interviews using a focused open coding process. I assigned codes to statements through a line-by-line, cross-interview analysis of the raw data.

Findings: The participants ranged in age from 32 to 59. All of them work with domestic violence victims both with and without supervision. According to the opinions of some participants, violence against women is a historical problem rooted in: a society that accepts the superiority of men and imposes a submissive role for women; the subordination of women; and the domination of men over decision-making and women's lives. This problem is aggravated by women's social, cultural, and economic dependence. Some respondents recognized and linked patriarchy to violence against women, while others seemed unaware of the concept. Both countries have regulations to provide professionals with guidance on navigating services related to domestic violence cases; and their governments try to give professionals some rules to follow when helping domestic violence victims. For many reasons, professionals do not always follow these regulations, but the situation is more complicated in Brazil, where service providers face several challenges in comparison to the circumstances in Norway.

Conclusion: Personal beliefs and observed norms concerning the acceptability of domestic violence are critical risk factors for women. Individual characteristics, family, the environment, and even one's professional profile can affect the way health or criminal justice workers perceive and deal with domestic violence cases.

Keywords: domestic violence, health professionals, criminal justice professionals, Brazil, Norway

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LIST OF ACRONYMS

CEDAW - Convention on the Elimination of All Forms of Discrimination Against Women

DEAMs - Delegacias Especializadas de Atendimento à Mulher (Special Police Stations for Women)

FRA - European Union Agency for Fundamental Rights

IPV - Intimate Partner Violence

NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress (Norwegian Center for Violence and Traumatic Stress Studies)

NSD - Norwegian Social Science Data Services

OECD - Organization for Economic Co-operation and Development

SARA - Spousal Assault Risk Assessment

SPM - Secretaria de Políticas para Mulheres (Secretariat of Policies for Women)

SUS – Sistema Unico de Saúde (Unified Health System)

UiB – University of Bergen

UN – United Nations

WHO – World Health Organization

1 INTRODUCTION

1.1 Background

In recent years, gender-based domestic violence has gained visibility and is currently considered an urgent matter in public health (Dahlberg & Mercy, 2009; United Nations, 2015; WHO, 2013). Domestic violence occurs globally and affects people of all cultures, ethnicities, and economic status. Women are the victims in the majority of cases (WHO, 2013). Domestic violence against women represents not only one of the most extreme expressions of gender inequality, as it is a violation of women's human rights and fundamental freedoms; it is also a major obstacle to societies' development.

Violence against women caused by an intimate partner is an important factor of harmful conditions for women's health. The proportion of women who have reported being physically abused by an intimate partner varies from 15% to 71%, depending on the country (WHO, 2013). Despite the alarming number of female victims of violence worldwide by a partner or ex-partner, most crimes against women are not even registered. Domestic violence is very difficult to measure with absolute precision due to numerous complications, including the social stigma that inhibits victims from disclosing their abuse (Garcia-Moreno et al., 2006; WHO, 2013).

Health and criminal justice systems can play a fundamental role in preventing violence against women, helping victims to identify violence at a premature stage, providing them with essential care, and referring women to proper and informed resources. Health and criminal justice services should be spaces where women feel safe, are treated with respect, are not stigmatized, and where they can obtain quality care.

1.2 Problem statement

Domestic violence requires multidisciplinary coordination from bodies such as the criminal justice system (e.g., police officers, prosecutors, and the court system), the social system (e.g., legal aid, social services, and shelters), the community at large (e.g., neighbors, families, friends, schools, and churches), and health professionals (e.g., physicians, nurses, counselors, and social workers) (McClure, 1996). Nevertheless, coordination has not always been

successful, as many health professionals do not recognize victims, and some police departments are not prepared and can embarrass them (Capaldi et al., 2009).

Female victims of domestic violence do not always denounce their aggressor; therefore, most remain anonymous, and the violence stays invisible (Reuland, Morabito, Preston & Cheney, 2006). However, when they suffer severe injuries that impair their physical health, they receive aid from health services. In other cases, to a lesser extent, the violence does not cause physical harm and women turn to police stations in order to press charges against the perpetrator (Payne & Gainey, 2009). It is vital that public policymakers understand how professionals, who are part of the network of care for female victims, comprehend their role in health clinics and police stations.

Investigators in the field of domestic violence have recognized some barriers that affect the ability of both health professionals and patients to address the topic. Obstacles to physician inquiry include time restrictions, absence of training for dealing with domestic violence, embarrassment about this kind of harm, fear of upsetting patients, and feelings of ineffectiveness (McLeer & Anwar, 1989; Sugg & Inui, 1992). The reluctance of abused women to reveal violence to health or criminal justice professionals is based on fear of revenge by the abuser, embarrassment, humiliation, low self-esteem, and family devotion (Rodriguez, Quiroga, Bauer, 1996). As the health community works to improve identification and intervention by healthcare professionals, lawmakers have created and enacted various pieces of legislation. Most countries require healthcare workers to report all cases of injured patients to police, and there are specific rules to include adult victims in care services (Hyman, Schillinger & Lo, 1995).

1.3 Relevance of the study

This study focuses on domestic violence in Brazil and Norway, which are very socio-economically and culturally different. Despite having the largest economy in Latin America, Brazil has high levels of social inequality (Meyer, 2010). When it comes to domestic violence issues, one woman is killed every two hours, with an average of 4,500 women killed every year. The reported number of women murdered increased by 230% from 1980 to 2010 (Moloney, 2015). In contrast, Norway is a prosperous country recognized for its social

welfare, equality, and social justice (Alestalo, Hort & Kuhnle, 2009). As for domestic violence, the situation in Norway is not as bad as in Brazil, but is still alarming. A nationwide, public educational campaign by the human rights group Amnesty International Norway, carried out in 2005, showed that one in four Norwegian women has experienced domestic violence, and every year, at least 20,000 women are exposed to (threats of) violence by someone with whom they share an intimate relationship (Amnesty International Norway, 2015). Less than half of these women contact public services, doctors, or hospitals for help (Neroien & Chei, 2008). Table 1 shows World Bank data that describe the two countries.

Table 1. World Bank indicators data, 2016

Indicators	Brazil	Norway
Continent location	South America	Europe
Legislation on domestic violence	Yes	Yes
Population, total (millions)	207.65	5.24
Population growth (annual %)	0.8	0.9
Surface area (sq. km) (thousands)	8,515.8	385.2
Population density (people per sq. km of land area)	24.8	14.3
Poverty headcount ratio at national poverty lines (% of population)	8.7	-
Income share held by lowest 20%	3.6	9.0
Life expectancy at birth, total (years)	76	83
Fertility rate, total (births per woman)	1.7	1.7
Mortality rate, under-5 (per 1,000 live births)	15	3
Physicians (per 1,000 people)	1.9	4.4
School enrollment, primary and secondary (gross), gender parity index (GPI)	1	1
Inflation, GDP deflator (annual %)	8.3	-1.1
Military expenditure (% of GDP)	1.3	1.6
Mobile cellular subscriptions (per 100 people)	117.5	109.0
Individuals using the Internet (% of population)	60.9	97.3

Source: World Development Indicators database: <https://data.worldbank.org>

1.4 Objectives and research questions

This study aims to describe the involvement of criminal justice and healthcare workers handling cases of domestic violence, as well as their attitudes and practices, in the Brazilian and Norwegian contexts. My main objective is to explore how social norms and professional rules, as well as national regulations, impact professionals' attitudes towards domestic violence in each country. I intend to answer the following research question:

How do professional and social norms and regulations impact health and criminal justice professionals' attitudes and practices regarding domestic violence against women in Brazil and Norway?

1.5. Organization of the thesis

This thesis is organized into eight chapters. The first chapter introduces the topic. In the second chapter, I present the theoretical framework that I used to guide my analysis of the data. The third chapter includes a literature review. In the fourth chapter, I describe the problem statement and research questions. In the fifth chapter, I explain the research methods, as well as my experience conducting the interviews and understanding the process of work among criminal justice and health professionals. In the sixth chapter, I report my findings. The last two chapters comprise the discussion and conclusions.

2 THEORETICAL FRAMEWORK

2.1 Introduction

In this chapter I present the theoretical framework that I utilized in this study. I start by describing patriarchy, which has established itself in the social, legal, political, religious and economic realms in many different nations. Even if not clearly stated as being present in countries' constitutions and laws, most modern societies are, in practice, patriarchal. I also include the concept of hegemonic masculinity, which aims to explain how and why men remain socially dominant over women, and over other subgroups of gender identities in different cultural contexts. After addressing these notions and how they can influence the approach of domestic violence cases, I explore social norms, which are unwritten rules about how to behave. These norms offer an expected idea of how to act in a specific social group or culture. After reviewing these concepts, which comprise the theoretical framework of my project, I examine government regulations, which exist to control the way something is done or how people should behave; I am including this notion because it can influence peoples' attitudes and practices. I also discuss professional rules, which are standards that criminal justice and healthcare workers follow with regard to ethics.

2.2 Patriarchal theory and hegemonic masculinity

An American sociologist, Allan Johnson, defined "patriarchy" as a male-centered, male-identified, male-dominated social structure. Johnson recognized male suspicion and apprehension of other men as patriarchy's core force. Patriarchal values are based on the control and domination of other men, which ensure a man's safety from the threat of other males. Patriarchy causes men to: seek security and prestige through control; fear other men's ability to hold power over and damage them; and recognize being in control as the greatest protection against harm and humiliation, in addition to the most efficient way to fulfill their needs and desires (Johnson, 1997). Following Johnson's thoughts, while we frequently think of patriarchy in terms of women and men, it is more about what happens among men. The domination of women is undoubtedly an important part of patriarchy, but, unexpectedly, it might not be the cornerstone (Becker, 1999; Johnson, 1997). Although domination of women is not the main point of patriarchy, a society centered on male identification and control will

certainly value masculinity over femininity. In such a context, men and women will be influenced to view females as objects meant to satisfy male desires (Becker, 1999).

In light of the magnitude and impact of domestic violence, unsurprisingly, considerable attention has been paid to the etiology of this phenomenon. Much of the discourse focuses on the causal relationship between patriarchy and domestic violence. This calls for exploring the relationship between patriarchy and domestic violence more precisely, starting with traditional feminist views (Tracy, 2007, p. 576). According to some of the earliest feminist theorizing, domestic violence against women is primarily the result of a patriarchal system, which exerts male domination over women (Dobash & Dobash, 1979). Bell Hooks emphasizes that women can be “wedded to patriarchal thinking” and defines patriarchy as:

A political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence (...) Patriarchy requires male dominance by any means necessary, hence it supports, promotes, and condones sexist violence (...) Despite the contemporary visionary feminist thinking that makes clear that a patriarchal thinker need not be a male, most folks continue to see men as the problem of patriarchy. This is simply not the case. Women can be as wedded to patriarchal thinking and action as [much as] men. (1979, pp. 1-2)

Patriarchy cannot be ignored as a factor that contributes to domestic violence. Furthermore, we cannot push aside the neglect with which this issue has been dealt in the social and legal realms, or deny the invisibility of cases in the health system, since even key professionals in this field practice social norms established by patriarchy. However, despite the belief of secular feminists and many egalitarians that patriarchy is the ultimate cause of all abuse against women, the etiology of domestic violence is far too complex to support any single hypothesis (Tracy, 2007).

In his work, “Patriarchy and Domestic Violence: Challenging Common Misconceptions,” Steven R. Tracy quotes Cynthia Ezell, who asserts a strong causal link between domestic violence and patriarchy, but does not perceive it as the ultimate cause of abuse:

Patriarchy is not responsible for an individual husband’s violent action toward his wife. It does, however, create an environment ripe for abuse. A weakened immune system does not create the virus that leads to deadly infection, but it

provides the environment in which the virus can thrive and do its killing. Patriarchal beliefs weaken the marital system so that the deadly virus of violence can gain a stronghold. (2007, p. 578)

In contrast to this perspective, where the link between patriarchy and abuse leads to the understanding that domestic violence is gender-based, there are other views that understand domestic violence and intimate partner violence (IPV) as a gender symmetric phenomenon. Also, imbalance in relationships can be reinforced by society's patriarchal preconceptions (Messerschmidt, 2012). The present study is based on theories that support the idea that domestic violence and IPV are a gendered phenomenon reinforced by patriarchy.

Hilde Jakobsen (2014) believes that to disregard the impact of gender on domestic violence harms people of any gender. Jakobsen (2014) insists that the objective must be to establish gender-informed prevention and to elicit reactions to domestic violence. In order to understand what is gendered about domestic violence against women it is essential to have a comprehension of gender is. In Western civilizations, the accepted cultural perspective on gender sees women and men as instinctively, and undeniably, defined categories of being (Garfinkel 1967, pp. 116-118, *apud* Jakobsen, 2014). According to the "Doing Gender" theory, proposed by West and Zimmerman (1987), gender is not simply what an individual is, but something that an individual does, in interaction with others, is not an individual attribute, but rather a performance of each. It is a product of social interaction. It involves a complex of socially guided perceptual, interactional, and micro political activities that cast particular pursuits as expressions of masculine and feminine "natures" (p. 126). Jakobsen (2014) brought an interesting discussion to the topic:

The idea that violence is important as part of an unequal gender order – the subordination of women to men – is central to feminist understandings of violence against women. Both feminists and their critics, however, have pointed out that the exact role of violence against women in the gender order remains unclear. Which causes which between the subordination of women and violence against women? Do men abuse their wives because power inequality means they can? Or is power inequality a result of their ability to abuse their wives? Is the violence facilitated by women's subordination? Or is it provoked by their lack of it? Is violence against women a last resort for those men who lack the means that more powerful men have of dominating women? (Jakobsen, p. 28)

The transformation of gender stereotypes and implicit patriarchal normative shifts can generate insecurities in men's lives, causing feelings of low self-esteem and inadequacy. The demonstration of this insecurity could be perceived as sexual control, aggressiveness, and violence against women in an attempt to reestablish male dominance (Silberschmidt, 2001). There are implications for policies concerning men and women's economic empowerment, and how it can influence the construction of alliances for transformative social change toward gender equality.

In gender studies, hegemonic masculinity comprises a portion of the gender theory that was originally proposed as an analytical instrument to recognize attitudes and practices among men who disseminate gender inequality (Connell, 1987); this philosophy distinguishes multiple masculinities that differ across time, culture, and individuals. Hegemonic masculinity is a practice that legitimizes men's dominant position in society and explains women's subservience (Connell & Messerschmidt, 2005). Theoretically, hegemonic masculinity elucidates how and why men remain socially dominant over women, in addition to shedding light on minority gender identities. The theory has been broadly used and debated, including the notion that hegemonic masculinity is "a culturally idealized form" and "is both a personal and a collective project" (Donaldson 1993, 645; Jewkes et al., 2015). A review published by Jewkes and Morrell describes the concept of hegemonic masculinity as:

(...) a set of values, established by men in power that functions to include and exclude, and to organize society in gender unequal ways. It combines several features: a hierarchy of masculinities, differential access among men to power (over women and other men), and the interplay between men's identity, men's ideals, interactions, power, and patriarchy. (Jewkes & Morrell 2012, p. 40)

This concept shows that masculine identities are not constructed merely in relation – of opposition or complementarity – to feminine identities, but also to other masculine identities. Hegemonic and subaltern masculinities are formed by social hierarchies, taking into account factors such as age, generation, class, race, and sexual orientation. Hegemonic masculinity is a structured, theoretical-conceptual ideal of patriarchy; it deals quite extensively with hierarchical relationships between men and women. Due to its similarity with the notion of patriarchy, this concept receives a lot of criticism from some academics who do not understand the need for a new theory to approach the same matter (Matthews, 2016; Messerschmidt, 2012).

When comparing hegemonic masculinity in Brazil and Norway, it is possible to see significant cultural differences between Latin America and Scandinavia. The culture of “machismo” is very common and can be found everywhere in Latin America, including Brazil. However, the region has undergone social changes over the last 20 years, such as reduced fertility rates and the increasing presence of women in the workforce, which are not suitable for the notion of a male-dominated society (Hausmann et al., 2015; The Economist, 2015). Is women’s acceptance limited to the public sphere, or does it reflect a change in attitudes appropriate to the private scope as well? The response to this question could affect the region’s future and fixed gender prejudices that have long damaged economic growth in Latin America.

In Brazil, we find the figure of the sexual predator in the context of hegemonic masculinity. There is a sense that a man must have courage, physical strength, and the ability to provide for his household. Yet among young people, full access to masculinity occurs by initiating sexual activity with a woman; thus, it is assumed that a man should be heterosexual. In this way, men in Brazil take on the role dictated by hegemonic masculinity (Caulfield & Schettini, 2017). Other types of masculinity are subalternized in relation to this model. When a woman leaves a man, his honor is tarnished, which in Brazil generates the most classic cases of domestic violence, eventually leading to murders. There is a cultural development in the male psychic structure that is not prepared to receive female rejection. According to this model, only men can reject women.

In several ways, there is gender equality in the Nordic countries, which has helped the region become one of the most solid economic and socially developed areas in the world. Investments in education, childcare, elder care, and parental leave have guaranteed women’s participation in the labor market, which is considerably higher than the figure proposed by the Organization for Economic Co-operation and Development (OECD). Despite the abovementioned investments, the region is still concerned about gender equality. In 2017, delegates from Nordic corporations and governments, as well as masculinity researchers, met in Copenhagen to encourage men to participate in promoting gender equality. While 61% of individuals with advanced degrees are female, men hold the majority of top business positions. Nordic women still spend more time on housework and parental leave than men, and are more likely to work part-time (Rosenberg, 2017). Yet Norway has one of the highest

rates of women's participation in the workplace worldwide. There are discussions in the country about how to reduce gender imbalances in many professions and workplaces – the armed forces included – as well as in leadership positions. Often, cultural predetermination in some workplaces is not particularly favorable to women, and much work remains to be done in order to decrease gender inequality (Dalaaker, 2017).

2.3 Social norms and professional rules

Social norms are motley of informal, often unspoken rules and standards of behavior. Their source of authority is not obtuse, and communal sanctions for violating them can be swift and harsh. They are highly influential in modeling individual behavior, including the use of violence. Some social norms are universal, while others are more localized (O'Donnell, 2007). Social norms are neither good nor bad; they can protect against violence, but can also support and inspire its use. The cultural tolerance of violence, either as a normal method of solving conflict or a usual part of educating a child, is a risk factor for all interpersonal violence (Kaur & Garg, 2008; WHO, 2002). This can help explain why countries undergoing elevated levels of one type of violence also experience high levels of other kinds (Lansford & Dodge, 2008). Social acceptance of violent behavior is probably absorbed in childhood through the use of corporal punishment (Lansford & Dodge, 2008), or by witnessing violence in one's family (Abrahams & Jewkes, 2005; Brookmeyer, Henrich, & Schwab-Stone, 2005) or the media (Johnson et al., 2002). Interventions that confront cultural and social norms that encourage violence can help diminish and prevent violent behavior.

Norms are developed in specific areas of social life and frequently instilled in formal institutions. An unconscious process about what is "socially acceptable" should not justify continued discriminatory norms. Norms can be altered in multiple ways, both in response to general socio-economic modifications and from the angle of the dynamics of gender relations. Rearranging gender orders, diversity, and paradoxes of gender norms offers the opportunity to discuss gender (Pearse & Connell, 2016).

The conventional belief that men have the right to control or punish women physically makes women vulnerable to violence at the hands of their intimate partners (Ilika, 2005; Mitra & Singh, 2007) and exposes them to the risk of sexual abuse (Jewkes, Penn-Kekana, & Rose-

Junius, 2005; Kaur & Garg, 2008). In the same way, cultural tolerance of violence in the private sphere impedes outside interventions, and prevents those affected from speaking out and receiving help (Hussain & Khan, 2008). Furthermore, evidence of the association between alcohol/drug abuse and violent behavior means that cultural and social norms surrounding alcohol/drug use – and the subsequent predictable effects – can also support and justify violent acts (Rossow, 2001; Kaur & Garg, 2008). Health and criminal justice professionals working on cases of domestic violence belong to patriarchal societies and are exposed to the same cultural and social norms as their fellow citizens. In addition to the professional practices that naturally take place due to personal characteristics molded by the environment in which they were raised and the individuals they socialize with, criminal justice and health professionals learn during their university education about professional conduct and ethical behavior, which guide their attitudes and practices in relation to their commitment to their clients.

Cross-cultural research indicates that societies with stronger ideologies of male dominance experience more violence (Kaur & Garg, 2008; Levinson, 1989). According to feminist theories, violence against women is rooted in male patriarchal roles and cultural norms that view women as subordinate (Dobash & Dobash, 1979; Kalokhe et al., 2016). Violence against women is also linked to income inequality; a crisis in male identity can be triggered when men are unable to meet the social expectations of manhood due to poverty. Men may use violence to resolve this identity crisis since violence against women allows men to express power that they otherwise lack (Jewkes, 2002). This type of violence may be higher in areas where income inequality is growing, such as the peri-urban areas of large cities (Brook & Dávila, 2000; Silberschmidt, 2001; Tacoli, 2012).

Patriarchy and social norms intersect in some realms and can influence one another. The theoretical approach to norms tends to underestimate the power and impact of gender socialization. An alternate conceptualization proposed by Pearse and Connell (2016) states that gender norms imply different rules of behavior for women and men, including rules that guide interactions between them. The idea of consensus might not reflect real social understanding in terms of symbolic power, but rather, the operation of dominance (Pearse & Connell, 2016). It is important for researchers to understand how profoundly beliefs, attitudes, and norms can justify masculine supremacy, and reinforce conduct and organizations that discriminate against women. Despite this acknowledgment, there has been little theoretical

clarity about the differences between these concepts, or how they relate to actual practices (such as domestic violence).

One's behavior is molded by perceptions of how one should behave (Salancik & Pfeffer 1978). From this angle, a wide range of factors can influence professionals' practices, including individual motivational predispositions to change as well as social, economic, political, and organizational contexts. Although some theoretical standpoints could be used to discover the determinants of healthcare professionals' behaviors, many clinical procedures consist of professionals' individual decisions (Grol, Bosch, Hulscher, Eccles, & Wensing, 2007). When a professional makes a decision in her/his daily work, his/her attitude and practice are especially related to social norms, including past behavior and in terms of others' opinions. Social norms also affect criminal justice professionals. Law is the realm most linked to the political sphere and media, and consequently, the area in which professionals are exposed to and can be affected by communal influence (Weisberg, 2003).

In this project, I intend to explore whether criminal justice and health professionals from two countries with opposite social and economic backgrounds act differently when handling cases of domestic violence. Do criminal justice and health professionals in Brazil and Norway behave differently? Or rather, despite the distinct traits of the two countries, do they present similar attitudes and practices?

3 LITERATURE REVIEW

In this section, I review the literature related to the main concept and the research question. First, I briefly summarize the history and definition of domestic violence in order to provide an overall understanding of this phenomenon. Subsequently, I present literature in relation to social norms and the network of services for victims. How can social norms influence criminal justice and healthcare professionals and services? Several studies have been conducted on health professionals' perspectives, but few have examined criminal justice professionals' perspectives at the individual and societal levels. At the end of the chapter, I describe the situation of domestic violence in Brazil and Norway.

3.1 Domestic violence

The United Nations defines violence against women as any act of “gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of acts such as coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (United Nations, 1993). The scope of this kind of violence includes physical, sexual, psychological and economic violence in the family or community, and violence committed or tolerated by the state.

Violence against women includes domestic violence, child marriage, forced pregnancy, honor crimes, female genital mutilation, femicide, sexual and other violence executed by someone other than an intimate partner (i.e., non-partner violence), sexual harassment, trafficking, and violence in conflict situations (United Nations, 2015).

In this study, I focus on physical and psychological violence against women caused by an intimate partner (i.e., domestic violence). Domestic violence results from power, control, and coercive behavior of one individual over another in a relationship. This relationship may include marital, non-marital, and dating partnerships. The abuse often involves repetitive battering and injuries, psychological abuse, financial abuse, sexual assault, progressive social isolation, and intimidation (Flitcraft, Hadley, Hendricks-Matthews, McLeer, & Warshaw, 1992; Piosiadlo, Fonseca, & Gessner, 2014). Approximately 90% of victims are female (Buel, 1995; United Nations, 2015) and come from all socio-economic, educational, and ethnic backgrounds. Globally, about one in three women have experienced physical and/or sexual

domestic violence or non-partner sexual violence (United Nations, 2015; WHO, 2013). Violence against women can lead to injury, depression, psychosocial stress, sexually transmitted diseases, and death, as well as adverse pregnancy outcomes (Ahmed, Koenig & Stephenson, 2006; WHO, 2013).

Figure 1 shows the prevalence data on violence against women published by the World Health Organization (WHO) in 2013. Violence against women occurs throughout the world and has severe effects on women’s health; therefore, it is considered a major public health problem.

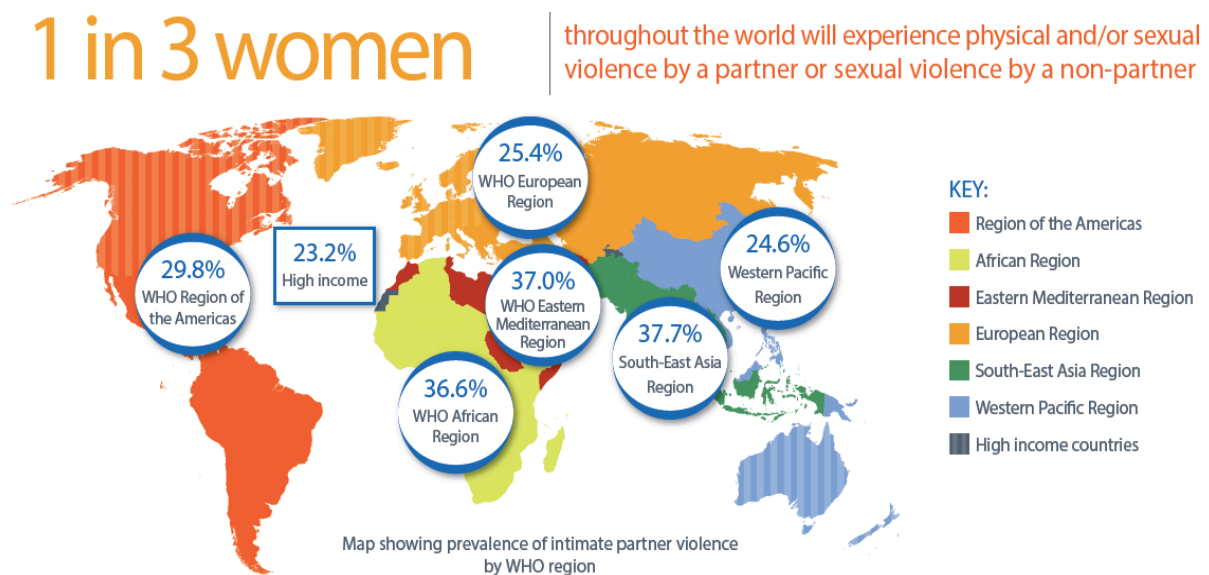


Figure 1. Global WHO prevalence data about violence against women

Source: http://www.who.int/reproductivehealth/publications/violence/VAW_infographic.pdf?ua=1

Several health complications are more frequent among women who have been physically or sexually abused by their partners. They are more than twice as likely to have a miscarriage or abortion, nearly twice as likely to have depression, and in some regions, 1.5 times more likely to contract HIV, when compared to women who have not experienced violence (WHO, 2013). While few data are accessible and enormous disparities have been shown in terms of how psychological violence is measured across countries and cultures, the evidence reveals high prevalence rates worldwide. Forty-three percent of women across the European Union’s 28 member nations have experienced some form of psychological violence by an intimate partner (European Union Agency for Fundamental Rights, 2014).

3.2 Social norms and professionals' behavior

Social capital is a broad term that encompasses social relationships, social networks, and values that facilitate collective action for mutual benefits. Researchers have linked social capital to a number of health behaviors and outcomes (Islam, Merlo, Kawachi, Lindström, & Gerdtham 2006; Kim, Subramanian & Kawachi, 2008), including domestic violence (Kirst, Lazgare, Zhang, & O'Campo, 2015). The relationship between social capital and domestic violence can be both positive and negative. For example, some aspects of social capital – such as social support and cohesion – can promote safer environments. In communities where social organization is strong and violence is socially unacceptable, the incidence of violent behaviors is likely to be lower (Kirst et al., 2015). Conversely, where social networks are supportive and network members share the same values, men may experience social pressure to behave in ways that are consistent with traditional gender norms and views of masculinity, which has the potential to perpetuate injurious attitudes and actions toward women (Portes, 1998). In some cultures, men have strong networks and might also share views that accept violence against women; knowledge about how social capital can be addressed to change these normative views could inform successful violence prevention interventions.

Cultural and social norms are highly influential in terms of modeling individual behavior, including the use of violence. Norms can protect against violence, but can also encourage its use. The cultural acceptance of violence, either as a normal method of resolving conflict or as a regular part of child rearing, is a risk factor for all types of interpersonal violence (WHO, 2002). As described previously, this might also explain why countries experiencing high rates of one kind of violence also have increased levels of other types (Lansford & Dodge, 2008).

Wilson, Jackson, and Nichols (2013) noted that human factors and ergonomics generally fail to address “the social aspects of performance” (Wilson et al. 2003, p. 83). Furthermore, they promote the comprehension of “the way in which we come to understand other people, and the way that others, and our relationships with them, may affect how we act” (p. 86). Recently, other authors have stressed that there is increasing acknowledgement of “the social” side of human factors (Farrington-Darby & Wilson, 2009). These elements are important to consider when we evaluate criminal justice and health professionals' attitudes and practices, since they are exposed to the same social norms as society in general.

3.3 The network of services for victims: The criminal justice system and healthcare services

Domestic violence is a multidisciplinary problem that requires coordination among the criminal justice and social systems, the community, and health professionals (McClure, 1996). Sometimes it is not easy to arrange communication among different sectors or even between the same ones. Low rates of injuries in medical records suggest that this phenomenon does not have the necessary visibility. Important professionals involved in the care system for victims need special training to adequately address all relevant sensitive issues. Lack of knowledge and training might contribute to providers' inability to recognize and correctly interpret behaviors associated with domestic violence. Many health professionals have not consistently identified victims, and some police departments linked to the criminal justice system have hindered victims from seeking help (McClure, 1996; Capaldi et al., 2009).

This study focuses on criminal justice and health professionals at the frontlines of domestic violence services and addresses specific, critical approaches to help female victims. In the next two sections, I mention the techniques that professionals employ and the challenges they face.

3.3.1 Health professionals

Health workers play a vital role in helping women suffering from violence. Those working in community health centers and clinics might hear rumors that a woman is being beaten or abused, or notice evidence of violence when women seek treatment for other conditions. Those working in hospital emergency departments might be the first to examine women injured by rape or domestic violence. However, despite the high magnitude of domestic violence against women, this phenomenon does not have the necessary visibility (Piosiadlo et al., 2014). In order for health services to cope with injuries and health complications originating from domestic violence, it is essential that health professionals understand women's vulnerability as an indicator of social discrimination and inequality, which surpasses the concept of risk (Piosiadlo et al., 2014). They need to be sensitive to victims' problems and receive training not only to notice signs of violence but also to be able to address this subject with the victim.

It is important to grasp these ideas because female victims are more likely to seek health services than women in general, and health professionals can provide prevention and assistance. Health professionals also play a role in recognizing and accompanying women before dealing with sequelae at future doctors' appointments (Kronbauer & Meneghel, 2005; Moreira, Galvão, Melo, de Azevedo, 2008). The responsibility of healthcare facilities in dealing with violence against women comprises a broader definition of health that includes understanding and modifying attitudes, beliefs, and practices. This responsibility goes beyond offering diagnoses and treatment for patients' injuries (Minayo & Souza, 1999). The main responsibility of healthcare systems for women facing the health effects of domestic violence is to offer adequate care. Sympathetic care can stop violence from recurring and alleviate its consequences. This approach can also help professionals manage related problems, such as alcohol/drug abuse and depression, in addition to delivering immediate and ongoing care.

Health professionals also have an impact in primary care units, where they can work on stopping violence before it gets to a more advanced stage. They can do so by recording cases of domestic violence, highlighting the associated health problems, and encouraging action in the social and criminal sectors. Establishing health policies, including training agendas for health professionals, can help employees address domestic violence in terms of individual and organizational obstacles (Sprage et al., 2012; Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999). Previous research suggests that distributing data or training performed in an isolated way does not facilitate a steady and sustainable transformation (Fanslow, Norton, Robinson, 1999; McCaw, Berman, Syme, & Hunkeler, 2001) and that an inclusive approach is necessary (Fanslow, et al., 1999; McCaw et al., 2001; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). Adequate reactions from healthcare professionals will differ depending on the victim's level of perception or recognition of violence, the type of violence, and the admissions point or level of care where the victim is acknowledged. Actions taken by healthcare professionals include identification, initial response to admission or identification, and the delivery of clinical care, follow-up, referral, and clinical support for victims.

3.3.2 Criminal justice professionals

The criminal justice system is not always prepared to offer quality services regarding individualized care. Consequently, women can fall through the gaps because of insufficient finances, poor training, lack of liability, or negative opinions about certain kinds of victims (Paine & Gainey, 2009). The justice system is failing to respond to most of the needs of domestic violence victims. Certainly, some researchers might claim that the first focus of criminal justice should not be working with domestic violence victims. In general, criminal justice participation in domestic violence cases intends to (1) prevent future transgressions on the part of the offender; (2) protect the victim and society; (3) hold the offender responsible; (4) treat the offender; and (5) offer compensation to the victim (Formby, 1992; Heisler, 1991; Heisler & Quinn, 1995; Paine & Gainey, 2009). Criminal justice participation can occasionally lead to increased domestic violence cases, it does not always defend the victim, might not hold the offender responsible or offer satisfactory treatment to the offender, and does not provide suitable compensation to the victim. Despite all this, criminal justice is important to assist victims of domestic violence and several improvements have been made in police stations to meet victims' needs.

Female victims call the police when they think they have no other choice and want to stop the violence. A study of women in four domestic violence shelters in the U.S. found that women who called the police felt more at risk of future violence than those who did not call (Harding & Helweg-Larsen, 2009). Another investigation conducted in the same country found that domestic violence victims – more so than other kinds of victims – tend to call the police for self-preservation and because they recognize domestic attacks as being more severe than other transgressions (Felson, Messner, Hoskin, & Deane, 2002). Women feel more secure – at least temporarily – if the offender is detained (Miller, 2003). When women decide to involve the police, they are confident in the police's role to offer them safety. Moreover, if criminal justice professionals meet their expectations, these women will call the police more frequently in future cases of domestic violence (Fleury-Steiner, Baybee, & Sullivan, 2006).

As mediators, police officers try to carry out crisis interventions by reestablishing order and bringing the parties together in a peaceful way. Crisis interventions should not replace arrest, but can be used when arrest is not possible. In such cases, officers will attempt to mediate (Payne & Gainey, 2009). As advisors, police may inform the victims of their legal rights

(Dakis, 1995; Saunders, 1995). Some police officers provide more helpful advice, such as encouraging the woman to stay near a phone or keep her court date (Caputo, 1988; Finn, 1991; Paine & Gainey, 2009). Police officers might also recommend that victims go to a local domestic violence service or obtain an order of protection. Police will apply the law and detain the offender or, in some cases, the offender and the victim. As said before, domestic violence is a complex problem and police officers and criminal justice officials cannot deal with cases alone (Mignon & Holmes, 1995; Rodriguez, McLoughlin, Bauer, Paredes, & Grumbach, 1999). Countries prosper when collaboration among criminal justice, the healthcare system, and social services runs smoothly, without barriers or complications. In order for this collaboration to be successful, it is also important for the system to count with the victim's collaboration. Women might not always receive the police response they need, and gaps remain in terms of whether some victims receive adequate service. Nevertheless, despite criticism, the police remain a key frontline service that victims can use to prevent and end domestic violence. The role of the police in domestic violence cases is crucial, although some investigation data have been critical of field officers' response (Reuland et al., 2006).

3.4 The Brazilian context

Brazil has one of the highest rates of violence against women in Latin America, ranking 11th in the list of 32 American countries with female homicide rates, and fourth in Latin America, only behind El Salvador, Guatemala and Honduras – all countries with much lower levels of economic development and recent histories of violent civil conflict. In 2012, 5,496 women were hospitalized in Brazil's Unified Health System (SUS) due to aggressions. In addition to hospitalized victims, 37,800 women between 20 and 59 years of age needed care in the SUS due to having experienced some type of violence. This figure is almost 2.5 times higher than the number of men in the same age group who were treated for the same reason, according to data from the Brazilian Ministry of Health (Agência Brasil, 2012). Despite that unequal reality, Brazilian health professionals still have difficulties to address women's needs. A study carried out in São Paulo (Brazil) shown that professionals from the Family Health Program¹ identified different kinds of violence in the families visited by the program, but the actions of the teams were focused mainly on the child abuse related situations. The teams did not

¹ Family Health Program is one of the national public health programs in Brazil, which implements a national policy for primary care settings.

address domestic violence against women, which revealed invisibility among the different types of violence. In this attempt to provide assistance to child victims of domestic violence, the health professionals were able to perceive that the violence suffered by women were alarming and also needed special care. Thanks to this program, many strategies were taken to prepare these professionals to focus also on violence against women (Moreira et al, 2014). Conditions for women have been slowly improving, a woman is still attacked every 15 seconds and murdered every two hours. In the past three decades, at least 92,000 women have been killed, many at the hands of their partners, according to a 2012 survey (Agência Brasil, 2012).

Domestic violence received visibility in Brazil in 2001 when the Inter-American Commission on Human Rights (hereafter referred to as the Commission) heard a complaint from a woman called Maria da Penha Maia Fernandes, alleging that the Brazilian government had implicitly condoned the violence perpetrated against her by her husband by failing to adequately protect her or punish her husband for his crimes. By that point it had been more than 15 years since the attack with no judicial resolution. The Commission looked at several controlling documents and found that Brazil had failed to exercise due diligence in responding to the plight of Mrs. Fernandes. Among other legal sources, the Commission relied on the American Declaration of the Rights and Duties of Man and the Convention of Belém do Pará². In its report, the Commission found that the violence suffered by Mrs. Fernandes was “part of a general pattern of negligence and lack of effective action by the State in prosecuting and convicting aggressors” and that “general and discriminatory judicial ineffectiveness” creates a climate that is “conducive to domestic violence” (OEA, 2001).

In 2006, Congress presented the Maria da Penha Law, an internationally lauded piece of legislation aimed at curbing domestic violence, which introduced special courts for victims and established assistance and protection measures for them. A Brazilian study analyzed the correlation between the Maria da Penha Law and domestic violence in two Brazilian states (São Paulo and Pernambuco) and observed an increase in physical violence prevalence when compared to the previous informed data, and a decrease in the prevalence of sexual and psychological violence. This increase could be due to intensified physical violence, or greater

² The Convention of Belém do Pará (1994) is an Inter-American convention on the prevention, punishment, and eradication of violence against women.

awareness of the problem by health professionals, or a combination of both factors. Furthermore, the analysis revealed that in São Paulo's urban area, physical violence tends to be more severe and happen at home; while in the rural zone of Pernambuco (Brazil's northeast), physical violence was more likely to be moderate and occur in public areas (Gattegno, Wilkins, & Evans, 2016).

The Maria da Penha Law led to mechanisms to prevent and curb domestic violence in Brazil. The law was written in accordance with the Brazilian Constitution, the Convention of Bélem do Pará, and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The law established special courts for domestic violence, as well as assistance and protection measures for victims. The law also provided an additional impetus to expand the *Delegacias Especializadas de Atendimento à Mulher* (DEAMs), which are special police stations for women (referred to earlier) and an important part of the infrastructure needed to implement the Maria da Penha Law; despite their growing popularity, little is known about their genuine effectiveness (Perova & Reynolds, 2015).

The Brazilian government has been actively trying to address this issue: in 2003, the creation of a new ministry, the *Secretaria de Políticas para Mulheres* (SPM), triggered an increase in government funding for services aimed at preventing and treating domestic violence, including DEAMs (Perova & Reynolds, 2015).

According to by Perova and Reynolds:

DEAMs, literally translated as “specialized police services for women,” constitute a part of the Civil Police and are focused on crimes such as rape and domestic violence that target women. Although not a legal requirement, the units are primarily staffed with women. Among other responsibilities, similar to those of a regular police station, DEAMs are charged with requesting urgent protective measures from the judge in case of domestic violence. (2015, p. 5)

After all these efforts, domestic violence in Brazil is now legally defined in Article 5 of the Domestic Violence Law of 2006, Law Number 11,340, known as the Maria da Penha Law (Brasil, 2006). Although the legal definition is widely explained in the law, familiarity with domestic violence is the responsibility of the victims or close relatives or friends, or anyone in the community who knows about it. In November 2017, the Congress passed a new law to offer specialized, ongoing and expert police assistance to women facing situations of domestic and family violence. This law complements the 2006 legislation (Brasil, 2017).

In 2013, as an innovative attempt to improve the combat and prevention of domestic violence and reduce the dramatic number of femicide in the State of Espírito Santo (southeastern Brazil), a judge called Herminia Maria Silveira Azoury created an electronic security device with a GPS tracker called the “Panic Button”. The initiative is a joint measure between the municipal government of Vitória (State capital) and the Espírito Santo State Supreme Court. Women victims of domestic violence, who have received a protective measure by the Maria da Penha Law, receive the "Panic Button" from the justice system to be used when they are at risk of noncompliance of the protective measure by the aggressor. According to the Judge Azoury, when a woman receives the "Panic Button", she is guided on how the device should be used, and becomes aware of all actions that will take place when the safety device is activated. When the woman, who is under a protective measure, activates the "Panic Button", immediately the Monitoring Center for the device receives the geographical coordinates indicating where the victim has activated it from and then the process of recording the environment begins to locate the victim. The Panic Button Center sends to the Maria da Penha Patrol the coordinates of where the victim is. Once contacted, the Maria da Penha Patrol goes straight away to the place where the protective measure was violated and possibly catch in the act and arrest the aggressor. In the beginning, the “Panic Button” was created to be used in the State of Espírito Santo, but now it has gained popularity in other Brazilian states (Rodrigues, 2016).

Despite all the improvements, the system still has many flaws. First, the few police stations for women prevent them from receiving assistance in a vast number of cases. The lack of women’s police stations in some districts causes victims to search for help at regular police stations. Second, female police departments are not open 24 hours a day, and are closed on the weekends. Health professionals are obliged to notify the municipal or state health departments of any case of domestic or sexual violence that they identify. This obligation is contained in the Ordinance of the Ministry of Health and was established in 2011 (Brasil, 2011); however, it is not upheld in many situations. When women are brave enough to press charges against their aggressors, how are they being received in police departments? What are the links between Brazil’s criminal justice and health systems? Many questions remain to be answered.

3.5 The Norwegian context

According to the Global Peace Index, Norway is one of the safest countries in the world, as well as among the wealthiest. Surprisingly, it is not the safest country for women (Neroien & Chei, 2008). In 2005, a campaign by Amnesty International Norway alerted the society to the invisible violence that has been occurring. The number of women murdered by their partners or ex-partners is not shocking if compared that of Brazil; however it is still alarming, especially when referring to Norway as one of the safest countries globally. Every year, at least 20,000 women experience (threats of) violence from someone with whom they share an intimate relationship, and seven out of ten rapes are committed in private homes. Annually, more than 3,000 women spend the night in a shelter. In 2008, 60% of these women were immigrants, of whom 28% were married to Norwegian men (Amnesty International Norway, 2015).

The Norwegian Center for Violence and Traumatic Stress Studies (NKVTS) conducted a nationwide survey on domestic violence and presented the results in 2014. They reported severe partner violence among 8.2% of women and 2% of men (life-threatening violence, attempted strangulation, use of weapons, and beating one's head against an object or wall). In 2013, there were 45 murder victims in Norway, 15 of whom were women murdered by their partners. From 1991 to 2011, 152 women were killed by their intimate partners (this number comprises between 20% and 30% of the murders that happen every year). Domestic violence increased by 32% between 2009 and 2013, and a total of 2,500 women received care in shelters during this period (Thoresen & Hjemdal, 2014).

Domestic violence in Norway is officially referred to as *vold i nære relasjoner* (violence in close relationships) and is defined as: "Violence or threats of violence against persons who are or have been married or who live or have lived in marriage-like relationships. It also applies to siblings, children, parents, grandparents and others in a straight ascending or descending line, as well as adoptive-, foster- and step-relationships." Furthermore, the act of violence is considered independent of location (Norwegian Ministry of Justice, 2004). The Norwegian government has taken many steps to combat violence against women. These actions have mainly been guided by the government's Action Plans to Combat Violence

Against Women. The first was the National Action Plan from 2000-2003, and in 2004, a support center for victims of crime was established as a three-year pilot project in Trondheim (Norwegian Government, 2013).

Norway addressed domestic violence in the 2007 *Handlingsplan mot vold i nære relasjoner* (Action Plan to Combat Domestic Violence). This plan was drafted as collaboration between the Ministry of Children and Family Affairs, the Ministry of Health, the Ministry of Justice, and the Ministry of Social Affairs (Norwegian Ministry of Justice and Public Security, 2004). Since January 2006, domestic violence has been considered an offense. Violent attacks in the private sphere fall under the provisions of the Norwegian Penal Code, Article § 219. As part of policy initiatives to stop violence against women, in 2007, the Norwegian government proposed Action Plan 2008-2011, titled “The Turning Point” (Action Plan, 2008). Many initiatives have been launched to increase awareness and implement prevention jointly with non-governmental organizations and the production sector.

Since 2000, the government has presented three action plans that address violence against women. These include action plans on genital mutilation and forced marriage, against the sexual and physical abuse of children, and against rape. These action plans are important for highlighting violence against women as a problem to be fought, and show that it is a high priority for the government.

Norwegian healthcare professionals’ practice of identifying and treating victims in close relationships is regulated by two important laws: the Act relating to Healthcare Personnel (Helsepersonelloven; LOV-1999-07-02-64) and the Patients’ Rights Act (Pasient- og brukerrettighetsloven; LOV-1999-07-02-63), established by the Ministry of Health and Care Services. Victims of violence and abuse in close relationships must receive professional healthcare (Meld. St. 15 *Forebygging og bekjempelse av vold i nære relasjoner. Det handler om å leve* (2012–2013) [Preventing and Combating Violence in Intimate Relationships - A Matter of Life]). When necessary, they are referred to specialist health services. Health and care services for persons subjected to violence and abuse are part of the responsibility imposed on municipalities and regional health authorities.

In Norway, there is a crisis center facility called *krisesenter*, which is a low-threshold facility offering protection to victims and their children during a transitional phase. The aim of a

crisis center facility is to offer support to victims so they may contact other kinds of public services. The facility includes a 24-hour helpline, residential accommodations, daycare, and follow-up during the re-establishment phase. Housing accommodations for women and men are maintained separately. Persons exposed to threats of, or actual, domestic violence can make direct contact with the facility without an appointment or referral, and service is free of charge. The Norwegian municipalities have had a statutory responsibility to provide such crisis centers since 2010. The Act of 19 June 2009 relating to municipal crisis center facilities compels all Norwegian municipalities to have an available crisis center for their inhabitants, either inside the municipality or in collaboration with nearby municipalities (Norwegian Ministry of Children and Equality, 2015).

Norway uses the Spousal Assault Risk Assessment (SARA) to identify and protect victims. The SARA is a professional risk assessment and management tool for IPV that facilitates screening for risk factors of spousal assault, so that preventive measures can be taken (Kropp, 2008). It comprises 20 standard risk factors in four domains: (1) general criminality, (2) psychosocial adjustment, (3) spousal assault history, and (4) index offense (Kropp et al., 1994, 1995, 1999). The SARA is an important tool to protect victims and help control domestic violence in the country. The Norwegian police force has implemented the tool and is still in the process of doing so.

3.6 Brazil versus Norway

Brazil and Norway have great socio-economic and cultural differences. They are located on different continents and have unique backgrounds. While Brazil has high levels of social inequality (Meyer, 2010), Norway is recognized for its social welfare, equality, and social justice. Norwegian society is known for its high educational levels, social trust, and gender equality (Alestalo et al., 2009). Instead of separating police departments for women, as Brazil has done, each police district has its own Coordinator for Family Violence and Sexual Abuse. This is a police officer with special knowledge and expertise in matters related to domestic violence and sexual assault (Norge Politiet, 2009). Despite all this, after analyzing a small number of studies on domestic violence against women in Norway, it is possible to see that violence against woman is far more widespread than initially thought (Neroien & Chei, 2008).

This study aims to determine how criminal justice and health professionals in Brazil and Norway act based on different perspectives regarding domestic violence. Despite the great differences between them, professionals in both nations have similar attitudes and practices. Table 1 presents the main definition of domestic violence, legislation, and police institutions that deal with domestic violence in each country.

Table 2. Approach to domestic violence in Brazil and Norway

Domestic violence	Brazil	Norway	Comments
Main definition	The country uses the United Nations definition	The country uses the United Nations definition	It applies to siblings, children, parents, grandparents, and other family relationships in both countries
Main legislation/ or main policy	The Maria da Penha Law (Brazilian law to control domestic violence)	<i>Handlingsplan mot vold i nære relasjoner</i> (Action Plan to combat domestic violence)	First attempt of both governments to specifically punish perpetrators. In Norway, legislation was passed in 2004. In Brazil, legislation was passed in 2006.
Police institution	Special police stations called DEAMs help female victims. A help center attends to victims.	Every police station has a division to deal with domestic violence issues. A crisis center (<i>krisesenter</i>) helps victims.	In Brazil, DEAMs are police stations exclusively for women, and in Norway, every police center has a division for women's care.

4 PROBLEM STATEMENTS AND RESEARCH QUESTION

Historically, intrafamilial relations and spaces have been interpreted as restricted and private, generating impunity for the perpetrators of violence committed in the family environment. The naturalness with which violence against women in private relations has been dealt obscures the visibility of the problem and trivializes its occurrence. The basis for other forms of harm lies in domestic violence; it produces experiences of violence in childhood and adolescence that eventually lead to aggressive behavior and severe psychic deviations (Moylan et al, 2010). These facts highlight a multifaceted problem and show how difficult it can be for professionals involved in criminal justice and healthcare to handle domestic violence cases.

Domestic violence is a multidisciplinary problem because victims are concurrently involved with the police, the courts, emergency medical services, shelter providers, and counselors. For example, victims might request that the courts implement a restraining order, rely on the police to apply it, and depend on social service workers to help them find a safe place to live. Sometimes they also need medical care. To avoid gaps in obtaining assistance, these tasks require coordination among agency leaders and field personnel. Consequently, addressing domestic violence effectively must be a shared priority for criminal justice specialists, healthcare professionals, and social service workers (Payne & Gainey, 2009; Reuland et al., 2006). It is important to have a well-coordinated, multi-professional approach to solve cases.

Domestic violence research can be approached using quantitative or qualitative studies. Quantitative studies have recognized predictors and mechanisms that provoke violence and its categories, and offered support for hypothetically resulting hypotheses. Meanwhile, qualitative research has offered important perceptions into the subjective understanding of violence, and knowledge of the context and connotations associated with it. Independently of the choices made, quantitative and qualitative studies enhance our understanding of domestic violence. I chose a qualitative approach because I would like to examine personal views of health and criminal justice professionals.

My main objective is to explore how social norms, professional rules, and national regulations impact professionals' attitudes and practices in relation to domestic violence in Brazil and in Norway. As stated in the introduction, I intend to answer the following research question:

How do professional and social norms and regulations impact health and criminal justice professionals' attitudes and practices regarding domestic violence against women in Brazil and Norway?

5 METHODOLOGY

5.1 Research design

I selected qualitative research with the aim to acquire an in-depth understanding of the phenomenon through exploration instead of measurement (Creswell, 2014). The focus of qualitative research is to find explanations for questions such as “what,” “how” or “why” (Green & Thorogood, 2014, pp. 5-25).

An interview is a quick method for obtaining qualitative data, especially about personal or sensitive issues, as with domestic violence. Interviews are suitable for this project considering that they are advantageous when participants have little available time, which is the case of the informants (i.e., health and criminal justice professionals in Brazil and in Norway). Moreover, interviews allow people to talk on their own terms. With this technique, I had the opportunity to learn about the words they use, their priorities, and concerns (Skovdal & Cornish, 2015).

I adapted the questions from ones found in the Virtual Knowledge Centre to End Violence against Women and Girls, published by United Nations Women (United Nations, 2011). The interview guide is listed in Appendix 1. Although social norms were not explicitly mentioned in the questions I used, it was possible to identify their presence through the participants' responses. The questions were:

- (1) Can you briefly describe your work and area of responsibility?
- (2) Do you treat victims who sustain injuries as a result of violence in the home? Is this frequent?
- (3) What are your primary concerns in serving these women?
- (4) Do you see injuries that you suspect are the result of violence in the home, but the woman gives another reason? How do you handle these cases?
- (5) If a woman tells you that her injuries were caused by violence in the home at the hands of her husband/boyfriend, what do you do? Do you document the injuries in a particular way? Do you refer her to other services?
- (6) How would you describe the level of coordination between hospitals and clinics and community groups, legal professionals, and the government?

- (7) Have you or your staff received any training related to documenting, for legal purposes, injuries resulting from violence in the home? What kind of training?
- (8) Has anyone close to you – family members, friends, or colleagues – ever experienced domestic violence?
- (9) Do you believe that having someone close with a history of domestic violence would affect the way you deal with these cases?

5.2 Study area

The current project addressed violence against women through interviews with criminal justice and health professionals working in the network of services, whether directly or indirectly focused on women. I carried out the interviews in two cities in Brazil and two in Norway. The cities in Brazil were in the southeastern state of Espírito Santo, with a population of a little over 4 million. The cities in Norway were in Hordaland, the third largest county in the country with 484,000 inhabitants (almost 10% of Norway’s population). The countries are shown in the world map below. Brazil is located in South America and Norway in Europe (Figure 2).



Figure 2. Political map of the world showing Brazil (South America) and Norway (Europe)

Source: <https://geology.com/world/world-map.shtml>

5.3 Participants (inclusion/exclusion criteria, recruitment, gatekeepers)

Using purposive sampling, I identified potential respondents by visiting clinics and hospitals, as well as police departments. To aid with recruiting, I created a protocol that included a quota for each subsample for in-depth interviews. I conducted 16 in-depth interviews (eight in Brazil and eight in Norway, with four health professionals and four criminal justice professionals in each country). It was not easy to recruit participants. The interviewees were always busy and not willing to schedule an appointment with a Master's student. I used a network of known people that helped introduce me to criminal justice and health professionals in both countries. I first needed to explain the project and its importance to my network, and later on to the professionals to convince them to participate. It was important to do this before scheduling appointments.

I collected data through individual, semi-structured interviews. The selection of professionals privileged those directly involved in the process: medical doctors and nurses in the healthcare system, and police officers and prosecutors in the criminal justice system. The interviews focused on their perceptions of the women's care network and the existing workflows between dealing with cases of violence and managing these cases. The distribution of the selected participants is listed in Table 2.

Table 3. Number of selected participants in the study by country

	Brazil	Norway	Grand total
Healthcare professionals	4	4	8
Criminal justice professionals	4	4	8
Total	8	8	16

5.4 Methods of data collection and accumulation

I conducted the interviews in Portuguese in Brazil, while in Norway there were five in English and three in Norwegian. The interviews lasted 30–40 minutes; most lasted 35 minutes, mainly because health and criminal justice professionals have a very busy workday. The interviews took place in a private area in the chosen health clinics and police stations, or in another location in which the professional felt more comfortable, like coffee shops. I requested written consent from all participants, informing them that the interviews would be

de-identified using a pseudonym. I audio-recorded all interviews, which I then transcribed and translated into English for analysis using Atlas.ti, Version 8.

5.5 Data management plan and analysis

I analyzed the transcribed interviews using a focused open coding process (Strauss & Corbin, 1988). I assigned in vivo codes (i.e., codes using the respondent's words) to restatements through a line-by-line, cross-interview analysis of the raw data. Since I conducted some interviews in Portuguese and Norwegian, the process included two steps. The first step was transcribing directly from the native language, and the second step was translating into English.

The data analyses included the following steps:

(1) *Understanding the transcriptions.* The transcribed data were carefully protected by a password on my personal computer, which were only accessible to my supervisor and myself during the study period. I saved a copy of the transcribed data on a memory stick and kept the data in a place that only I could access. After performing data transcription, I continually read the interviews and listened to the audio recordings. I also reviewed my notes that I took during data collection. This step helped me to reach the required overall understanding of the interviews before coding the data.

(2) *Coding data.* After becoming acquainted with the data, I started coding them, which included categorizing the results into significant fragments of text. I coded the interviews with a colleague, which allowed me to acquire another perspective. Initially, we examined and individually codified each interview; next, in a second round of analysis, I compared my findings and selected the outcomes that best fit each interview. From the in vivo codes, I identified focused code categories that exemplify specific themes of patriarchy, the formation and influence of gender norms, as well as specific role models appropriate for use in interventions.

(3) *Identifying themes linked to the theoretical framework.* After coding the data, I identified relevant concepts. I began by extracting basic ideas out of the coded data. In pinpointing these fundamental issues, I grouped concepts mentioned repetitively into basic themes. I listed these

in a table and organized them for the next phase of the analysis. I used thematic network analysis (Attride-Stirling, 2001). In this step, I grouped similar topics that emerged in the basic concepts under a theme that condenses the ideas into a systematized procedure. This was important to obtain an advanced level of information by establishing pieces of assumptions found in the fundamental notions. The final process in identifying themes involved classifying the organized ideas into global ones.

(4) *Building the thematic network.* I identified organized topics and global themes, and prepared the thematic network to explore the interface between themes. The thematic network was critical for providing a better understanding of the procedure.

5.6 Development of global themes from organizing themes, basic themes, and primary codes

Table 3 describes the development of the global themes from organizing and basic themes, as well as primary codes.

Table 3. Thematic Analysis: From codes to global themes

Basic themes	Organizing themes	Global themes
Treat victims who sustain injuries due to domestic violence	Professional/personal perceptions, attitudes and practices surrounding domestic violence	The influence of a patriarchal society and social norms on different professionals' perceptions in their encounters with domestic violence victims
Document injuries and refer cases that result from violence		
Primary concerns in serving these women		
Handling injuries that you suspect result from domestic violence		
Personal experience – family, friend or colleague – with domestic violence	Health and criminal justice professionals' past experience as behavior modifiers	
Personal experience can affect the		

way you deal with domestic violence cases		
Work and area of responsibility	Education and training for health and criminal justice professionals	The influence of institutions' regulations and norms regarding the attitudes and practices of healthcare and criminal justice professionals
Training related to documenting, for legal purposes, injuries resulting from domestic violence		
Level of coordination between hospital or clinic and community groups, legal professionals, or the government	Multi-professional approach and supporting staff	
Approach to cases of violence and professional perspectives		
Socio-economic and psychological dependence, and the male-female relationship	Barriers women face when pressing charges and/or leaving the aggressor	

5.7 Trustworthiness of the research

Although many critics are reluctant to accept the trustworthiness of qualitative research, frameworks for ensuring rigor in this form of work have been used for many years. It is possible to assess the trustworthiness of qualitative research through specific criteria, as described below (Guba, 1981; Shenton, 2004):

- a) **Credibility:** This is the first benchmark that must be established in qualitative research. It is the main yardstick for establishing trustworthiness because credibility asks the researcher to clearly connect the study's findings with reality in order to reveal the truth of the results.
- b) **Transferability:** In qualitative research, transferability is equal to generalizability in quantitative research, and is demonstrated by giving evidence to readers that findings could apply to other circumstances, conditions, times, or populations.

- c) **Dependability:** This criterion shows that the findings are consistent and replicable. Researchers target an outcome to confirm that their findings are consistent, and they want to ensure that if other investigators decide to reproduce their research, they will obtain comparable outcomes, interpretations, and conclusions about the data.
- d) **Confirmability:** This is the last measure; it is related to the level of confidence whereby findings are based on the narratives and words of participants, rather than potential researcher biases.

5.8 The role of the researcher

I personally performed all the interviews. I was aware that questions linking social norms with attitudes and practices towards domestic violence could lead to biased answers (Questions 4, 5 and 9) due to the general tendency to give socially acceptable replies in face-to-face interviews. These responses required special analysis, as there certainly could have been a contrast between the participant's attitudes as a professional and as an individual. I also transcribed and translated the findings into English for analysis and examined the collected data.

The researcher's characteristics, such as gender and personal experiences, may have had an impact on the study in terms of qualitative research. The researcher's background and experience affects data collection and interpretation, which can be reflected on them during the final phases of the study (Berger, 2015). The researcher can look at the role he/she has in the study, remaining aware of how personal positions could influence the investigation. This awareness plays a key role in demonstrating how the researcher complements the value of the study and addresses his/her limits of knowledge. Therefore, clear communication of personal roles improves the quality of research (Guillemin & Gillam, 2004).

5.9 Challenges and limitations

An important challenge was Question 8, which asked the professionals about their personal experience with domestic violence *"Has anyone close to you – family members, friends, or colleagues – ever experienced domestic violence?"* I needed to work on my shyness to

prepare for the interviews and before asking the respondents personal questions. Another challenge was that during the first couple of interviews in Brazil, I was too eager to participate, which I came to realize was a mistake, as it could impact the subjects' answers or simply distract them. After realizing this, I limited the next interviews to simply following the interview guide, and let the respondents answer naturally.

An important limitation of the interviews in Norway was the fact that I do not have a Scandinavian background, which made me insecure when approaching the participants. As my Norwegian language proficiency is only intermediate, I was slightly nervous about conducting the interviews in Norwegian, which was unfortunate since I believe that communicating with people in their language is key to establishing strong connections with them. This helps us to integrate every other aspect of social and academic life. However, I am reasonably satisfied with the results and the positive feedback from the interviewees, and for being able to overcome my challenges and conduct some interviews in Norwegian.

Since I am from Brazil, it was easier to carry out the interviews there than in Norway. I experienced various difficulties in each country. In Norway, the obstacles were more related to language and the culture; in the beginning, I was a little embarrassed to apply the interviews, and insecure about being misunderstood due to language barriers. In Brazil I was comfortable with the language and culture, but once I felt awkward for sitting in the waiting room of a women's police station. People passed by and looked at me as if I were a domestic violence victim looking for help. It was an interesting experience because I felt what I imagined victims must feel when they go there to seek assistance.

5.10 Ethical considerations

I held all interviews in private places away from other people and distractions, at a time that was convenient for the respondent. I invited all selected professionals to take part voluntarily in the study. Those who accepted signed a written consent form. I submitted this project for approval to Ethical Clearance from Norwegian Social Science Data Services (NSD). The NSD approved the study (Appendix 1).

5.11 List of the participants in the interviews

I gave the participants pseudonyms. I assigned Norwegian names to the Norwegian respondents, and Brazilian names to the Brazilian participants in order to preserve their anonymity and confidentiality. Table 4 presents the distribution.

Table 5. Characteristics of interviewees included in the study analysis

PARTICIPANT #	COUNTRY	AGE	GENDER	SECTOR
1 - Sofia	Brazil	52	Male	Criminal Justice
2 - Fernando		57	Female	
3 - Thiago		41	Male	
4 - Maria		47	Female	
5 - Elizabete		55	Female	Healthcare
6 - Pedro		42	Male	
7 - Ana		38	Female	
8 - Julia		32	Female	
9 - Dagfinn	Norway	42	Male	Criminal Justice
10 - Fredrik		47	Male	
11 - Einar		58	Male	
12 - Birgitta		34	Female	
13 - Agnes		32	Female	Healthcare
14 - Arnt		41	Male	
15 - Kristin		36	Female	
16 - Hanna		59	Female	

6. FINDINGS

6.1 Introduction

This chapter is structured based on my findings from the interviews with health and criminal justice professionals in Brazil and Norway, in order to understand if and in what ways social and professional norms influence how these professionals cope with domestic violence cases. Some of the elements to be analyzed include health promotion, and treatment or planning actions. What is important is the characterization of the values, attitudes and beliefs of a population, including professionals involved in their care.

Criminal justice and health professionals from Brazil and Norway participated in the study. They ranged in age from 32 to 59. All of them were directly or indirectly working with domestic violence victims.

6.2 Health and criminal justice professionals' own experiences

The question about cases of domestic violence among close friends and family members was a very sensitive inquiry. I could have assumed that some participants were not comfortable answering it. However, other professionals were very confident and open regarding this matter.

Yes, I hardly believe there is anyone that does not know a relative, a friend, or coworker who has not been a victim of domestic violence. I know women from inside and outside my family who were victims of domestic violence – gender violence from their partners, and many opted for to stay silent. A criticism that I always point out when I talk to people about this issue, especially those close to me, is that silence potentializes the aggressor's next action. If you decide not to talk today, and you can be silenced forever. (Thiago, Brazil)

It was common for professionals in both countries to report that they knew someone who has experienced domestic violence.

Yes. A cousin who was living next door to me suffered violence at the hands of her husband. He hit her and it was a complicated situation. It was not easy to have it so close. (Ana, Brazil)

Yes. It was a very bad experience and I needed to learn how to help her. It is more difficult when we are emotionally involved. (Kristin, Norway).

Interestingly, in Brazil, most of the participants linked domestic violence with physical violence, but the Norwegian professionals also recognized psychological violence as being a problem in Norway.

Yes, [in] some cases (...) unfortunately it is common. I already had it in my close family and among friends. It is sad! But don't forget that when I say that, I mean psychological violence, which here in Norway is also considered as serious as physical violence. I don't know how the situation in Brazil is. (Birgitta, Norway)

When I asked them if having someone close with a history of domestic violence would affect the way they handle these issues, the answers were diverse, but no significant differences appeared between the countries.

I cannot say no (...) because you can experience domestic violence and be emotionally worn out, and not receive the appropriate treatment to heal. Yet as professionals, we cannot be personally involved. I say this because when investigating violence, we have to explore all the hypotheses. (Maria, Brazil)

Professionals mentioned the importance of remaining impartial and professional while working with domestic violence victims, despite having someone close to them that shared the same issue.

Look, I think that the crime of violence against women is very serious. I am particularly touched by the fact that I have had experiences like this in my family, so maybe it will lead to repercussions in my analysis. Because of it [cases of violence in the family], I can be very strict in cases of domestic violence. Yet I can tell you, I always try to be impartial and avoid becoming involved. (Pedro, Brazil)

Fernando, a criminal justice professional from Brazil who has been working at a regular police station for 14 years, also emphasized the importance of remaining impartial.

No, I don't think so. We work here, right? We have to be neutral, we cannot take sides, and we always have to use the law. We have to be impartial. Mainly, we need to be fair and try to make the person who committed the crime pay for it, while also encouraging the victim to make that person take

responsibility for the crime, and to realize that domestic violence is a crime.
(Fernando, Brazil)

Einar, a criminal justice worker from Norway, emphasized the importance of being professional and investigating cases without subjective impressions.

No, I am not affected [by cases of domestic violence]. We need to be professional. The important thing is to investigate the fact itself. Subjective impressions cannot hinder the search for the real truth. We cannot be personally involved in the situation (...) (Einar, Norway)

Birgitta, a police officer, and Arnt, a general doctor from Norway, agreed about the importance of not becoming personally entangled in a case.

Being involved? What is the premise on which the police have to act? A case is not truth, it is not a lie; a case...needs to be investigated. If we are not trained with the equity to identify, refer and investigate these cases, it may be that a previous experience with domestic violence can hinder our case management and referrals. We cannot allow this to happen. (Birgitta, Norway)

Arnt stressed that he had been trained to avoid becoming involved, because doing so could interfere with his professional approach.

No. I was trained to not allow this [case involvement] to happen. We need to be professional to provide good care. (Arnt, Norway)

To Tiago, a Brazilian police officer, police training was the reason why he would not let himself get emotionally involved in domestic violence cases.

Years ago I was trained by the Giraldi method³. This method shows the cop the importance of always use reason and to not get carried away by emotions. We must apply this concept in the domestic violence context as well. Matter fact, we must apply the method especially in sensitive cases like that. (Tiago, Brazil)

There were no significant differences between the countries. The findings showed that some attitudes are globalized. However, the importance of being professional and not getting personally involved in a case of domestic violence was considered unanimous in both

³ Giraldi Method consists of a set of techniques and norms to train police officers. It was created by Nilson Giraldi and it is used in the State of São Paulo (Brazil) since 1998.

professional groups. This demonstrated that professional concepts in healthcare and criminal justice share similarities independently of the country.

6.3 Perceptions of domestic violence cases

According to some participants, violence against women is a historical problem rooted in the following: a society that accepts the superiority of men and imposes a submissive role for women; the subordination of women; and men's control over women's lives and their decisions. This problem is aggravated by women's social, cultural, and economic conditions. Some participants in both countries recognized and linked patriarchy to violence against women, while others seemed to ignore this idea. Through the interviews, I noticed how much patriarchy is rooted in society in such a way that some violent behaviors toward women are considered normal, or at least justifiable.

Sofia, a Brazilian sheriff who currently works in a regular police station but previously worked at a women's police station and dealt with many domestic violence cases, expressed the belief that males should not take all the blame for patriarchy:

It's not a matter of only educating men. Once I dealt with a case of violence against a woman who had been beaten since the third day of her marriage. She was married for 25 years, and her mother-in-law, a woman, told her son to beat her; not only that, she told him to beat her in the intimate areas because she would be ashamed to show her body to someone. That way, he would not be denounced. It was an act made by a woman - but she is just a regular person who was raised in the same society as men. There are men and women with deeply sexist behaviors, because the society they live in is the same. We are all villains and victims of ourselves. Men are raised by women. You see? (Sofia, Brazil)

What this participant told me about women with sexist behaviors was, unfortunately, exemplified in my next interview with another professional from Brazil's criminal justice system. Maria works directly with victims, who seek free assistance at the police station.

Many women come back here to withdraw charges against their husbands. Once a woman came here and told me she wanted to withdraw the charges against her husband because she believed she was the one to blame for what he had done to her. I asked her to explain the case better. She said her husband had lost his job, and because of that, he started drinking a lot every night and

coming home very late. She said one night she had had enough and locked the house, not letting him in. I asked her why she would do something like that. I asked her if she understood that she really did contribute to the aggression. (Maria, Brazil)

Maria continued, trying to convince me of how women's behavior could somehow justify an aggression towards them:

A man loses his job, so he drinks because he lost his job. One thing leads to another. You see? And sometimes women don't have the maturity to accept that, and they start a discussion that leads to the aggression. This happens very, very, very frequently. (Maria, Brazil)

Agnes, a Norwegian doctor who works in an emergency unit, somehow has a constructive view of the situation. She believed that the number of domestic violence cases is rising because the number of women who recognize aggressions toward them is also increasing due to societal changes. Plus, if the cases become visible, there could be a possible end to the violence.

One thing is the taboo, of course, but I think that previously, a lot of women did not know that it was abuse. They thought: "Oh, but he is my husband – or boyfriend – so it is fine, he did not really hurt me or tear me apart, it is not a big deal (...) Nowadays, we are more focused on the importance of consent (...) By May 2017, they [women] had filled the yearly quota for 2016. Cases of violence are not increasing by 10% or 20%; rather, this is like 50% per year. It implies a shift in society, which is very good. (Agnes, Norway)

In Norway, none of the interviewed police officers expressed sexist attitudes, but Dagfinn, a police officer from a station in Norway, showed concern for the patriarchal and sexist mentality of some professionals in the criminal justice system:

Look, to me, the crime of violence against women is very serious. It affects me a lot because I have had experiences like this in my family, so maybe this has repercussions for my analysis. I am very strict in cases of domestic violence. However, I will tell you that some cops and judges think differently. The trend of placing blame on the woman remains, and/or that the woman causes the events (...) Perhaps this also happens because it is very common for female victims, who can receive protective measures, to call their husbands to encourage them to return home. That is, women ask for protective measures and afterward ask their husbands to come back home. (Dagfinn, Norway)

Another concern shown by Fredrik, a police officer from Norway, was the fact that women often give up to press charges against the aggressor. The aggression seems to be justified by alcohol consumption.

We often get calls regarding domestic violence during the weekends when people have been consuming alcohol in excess. It's common that the women say they had enough and want to move out from the house. But when Monday comes and they are sober, they give up and do not want to cooperate with the police anymore. (Fredrik, Norway)

I noticed similarities between Brazil and Norway regarding concerns with possible patriarchal behaviors. However, professionals in Norway claim that things are changing and have a more proactive approach to the problem. Unlike what happened in Brazil, none of the Norwegian professionals believed that women were in some way responsible for the aggressions. However, male criminal justice professionals from both countries were indignant at the fact that women break restraining orders themselves. This was mentioned as a dangerous behavior and seen as a barrier to police work.

6.4 Education and training

Regarding the training to prepare these professionals to deal with cases of domestic violence, I noted that there is no unique protocol. Below, I describe the different perspectives of two Brazilian criminal justice professionals in regards to training.

Yes, we have received several trainings. We have our own training regarding the victims' approach: (1) identify cases of violence; (2) make referrals; and (3) know the health system. You know that many cops are still unaware of how care for women in health units works. Furthermore, in partnership with regional prosecutors, the Center for Confronting Domestic and Family Violence lies at the core of domestic violence, and provides training throughout the state, both for civilian and military police. (Maria, Brazil)

Even though both professionals work in the same city, one of them received training, while the other did not.

No, I never received any training on domestic violence. It is really up to the sheriff or police officer, or to the professional in charge, to discuss and decide what to do. We need to seek the most current information regarding this matter and talk to other colleagues, because there is no systematic training for how to deal with this type of crime or this kind of victim. (Fernando, Brazil)

As for the health professionals, almost of them declared to have had lectures regarding violence when in the university, however, only a few of them were trained to deal with domestic violence cases, in order to be able to address the violence with their patients.

I have been trained to deal with domestic violence cases when I start to work in the Family Health Program. They taught us to recognize and face complex situations (...) and to deal with them. It [the course] was very important for me as a professional! (Pedro, Brazil)

Yes, I received training in my previous work. I participated in local courses in the hospital, as well as through medical education I was trained to take care of the physical injuries caused by violence cases and how to behave in these situations. (Hanna, Norway)

Some of the professionals who did not receive training stated to have had some challenging episodes regarding domestic violence cases.

Of course, we all go through basic courses at university where we are taught how to recognize violence against women, and kids. To be honest with you, I have never taken another course on that after I graduated from medical school. It would have been interesting to receive a course on that. It can be very challenging sometimes. (Kristin, Norway)

I have never been trained to deal with domestic violence cases. I do not know anyone who has had this kind of training in this hospital. We have to learn how to deal with these cases where they come to us, which can be tricky. (Ana, Brazil)

There was no significant difference between Brazil and Norway in terms of training professionals to deal with domestic violence, despite that health and criminal justice professionals comprise the frontline social institution for dealing with domestic violence, and are often the desired point of disclosure for victims. However, Fredrik, a police officer from Norway, emphasized his training:

Yes, I received training in Oslo. I also took local courses in the police force, as well as during my police education, when I was trained to take care of the legal aspects of injuries caused by domestic violence and how to proceed in such circumstances. (Fredrik, Norway)

I noted heterogeneous reports and realized that trainings are not offered on a regular basis in Brazil or Norway, especially not for professionals who work in smaller municipalities.

6.5 Regulations and laws

As shown in Table 1, both countries have laws to provide guidance on services related to domestic violence cases. For many reasons, professionals do not always follow these rules, but the situation is more complex in Brazil, where the structure of services faces several challenges.

In both countries where the study was conducted, the law guarantees that violence against women is a crime that does not require one's permission or representation in order for the police to enforce the law and criminally charge the offender. When a woman suffers violence by her partner, that action becomes responsibility of the State, and the police has the duty to open a case and assure victims protection despite their will to press charges. Fredrik, a Norwegian police officer, explained this to me:

In the cases where we are sure that the woman is being abused in her home or relationship, according to the Norwegian law, the police must open a case despite the victims will. It applies for all family cases related to physical violence. But the cases where we can act without the victims cooperation are minority. (Fredrik, Norway)

In Brazil, a high percentage of women still fear pressing charges against the aggressor and making the act of violence public, which seemed to concern criminal justice professionals when they told me:

We currently have the so-called hidden cifra. What is this? It means that many women do not turn to police stations or public services for help or to report their problems. This is because they do not think they will receive assistance from public services. They are afraid of being re-victimized, of being blamed for the event. This is very common. Today, 20% to 30% of women do not use public services for their protection because they are afraid. We realize that this number is much higher than statistics reveal. (Sofia, Brazil)

It was interesting how Maria, another Brazilian police officer, who works at a police department specialized in women, identified the "hidden cifra" mentioned by her colleague, without naming it. She believes that some revolting police behaviors regarding domestic violence victims showed by the media, like criminal justice professionals giving low priority

to domestic violence cases and blaming the victims, might be one of the reasons why there is such a high percentage of women who avoid the police stations. This police officer also seemed to have to have a lot of faith on the Maria da Penha law.

The Maria da Penha law has the potential for being a watershed in our women's lives. I just pray that they will be more and more empowered by the law and let us help them. I am sure that you must have seen in the newspapers about how some sheriffs disrespect women victims of their husband's violence. There are men, and possibly women as well, working in the police who still believe women must obey their husbands and respect the family as an institution that is above them. There is a high number of women who avoid the police stations for fear of being judge, or if they come here, we can feel they are extremely uncomfortable because they expect we do not care. They do not think they are a priority for us. (Maria, Brazil)

I perceived the connection between social norms and the importance they give to regulations in professionals' statements from both countries. Thiago, from the Brazilian criminal justice system, linked domestic violence with gender issues.

We have a much more serious problem than statistics show. There is no doubt. How many women are beaten daily? Are they not violated in terms of their morals and heritage? These women do not turn to police units due to the challenges of recording an incident, which in turn is due to the difficulty of obtaining protective measures because of swift hearings. Today we still have a very serious problem regarding gender violence. This worries us. (Thiago, Brazil)

Fredrik, who has worked in the same police station in Norway for 15 years, demonstrated impressive knowledge about Norwegian legislation for domestic violence cases.

In 2010, the government approved a new piece of legislation that includes a statutory, municipal responsibility to provide shelter services to the local population, regardless of gender. (...) I believe that the law went into effect in 2010. The main purpose for providing a statutory shelter service is to show that public authorities are responsible for safeguarding people, that individual users of women's shelters have synchronized, and individuals are following up with other support services. (Fredrik, Norway)

A Norwegian criminal justice professional mentioned SARA – an important tool that has been implemented in Norway to protect victims – as useful in helping women fight violence.

The implementation of the risk assessment tool SARA in the police force was a very important government initiative to assist victims and prevent criminal recidivism. (Einar, Norway)

Both countries have regulations on domestic violence assistance, and criminal justice professionals seem to value and follow them. The situation seems more complex for health professionals because they need to find a balance between following the ethical medical code and ensuring patient safety. Health professionals also face the difficulty of identifying violence suffered by the patient, even when this is not obvious, while police usually help women who are somehow ready to reveal their situation. As for criminal justice professionals, the ones from Brazil have to work with the fact that some victims might be skeptical to approach them because of previous cases of police misconduct toward women based on patriarchal beliefs. This was not mentioned by any participant in Norway

6.6 Confidentiality

Some participants, mainly from the field of healthcare, mentioned the fear of becoming involved with cases of domestic violence for fear of retaliation at the hands of aggressors; the lack of support in health units; the lack of commitment from victims' relatives and acquaintances, who would rather not get involved; and not pressing charges against the aggressors (a behavior that hides the violence and allows it to continue). Clearly, the problem of domestic violence against women is not easy to handle. My first observation was that most participants seemed to not feel empowered to deal with the problem.

Since the crime scene in domestic violence cases is private, I also noticed that some health professionals would rather keep it that way and focus on the physical injuries. The health professionals explained that excess eagerness to ensure confidentiality somehow implies trying to conceal the fear of becoming involved in complications due to a private relationship, and possible revenge at the hands of the aggressor. Thus, upon feeling threatened when it comes to decisive involvement in situations of detected violence, most health professionals end up deciding not to take on such cases. Interestingly, participants from both countries frequently mentioned this, but for different reasons.

Pedro is a gynecologist who has been working in a public hospital in Brazil since 1998. He told me he has never seen or suspected that any of his patients had been through a case of

domestic violence. I found such testimony very shocking, considering that the hospital where Pedro works – which is also where I held the interview – is located in a poor part of the city in Brazil where there are many reports of domestic violence. I found it quite unlikely that the women who attended that hospital – for almost twenty years – never showed up with any signs of physical or psychological aggression. During the interview, however, I was able to understand why the doctor had not been so attentive to the possible assaults suffered by his patients. The “apparent” lack of sensibility in this case could have been fear of exposure, caused by a failure of the system:

(...) when we [health professionals] make the notification, we already know who will provide answers in the justice system, or who will receive an intimation to go to the police station; it will not be the hospital, municipality or the government. Rather, the physician will do it. Thus, those who will be exposed and will need to participate in the situation will be each one of us [professionals] individually (...) We become very exposed, we do not know the character of the alleged aggressors. Not just us, but our families, too, you see? Our name appears publicly during the process; the entire population has access to our names, our work schedules, and on the Internet you can find the rest of the information about us. I think our team fears that. (Pedro, Brazil)

In Norway, the participants were not afraid of retaliation from the aggressor, as in Brazil, but healthcare professionals feared becoming involved in a patient’s private life beyond what is considered acceptable in society, as well as of breaking doctor-patient confidentiality. There were many reasons besides fear as to why health professionals in Brazil and Norway do not become involved in private cases of domestic violence. The number of similar cases somehow banalized the violence in both countries.

To be honest, I think when I started in Oslo as a medical student – I don’t know if I was naïve or hadn’t been exposed to this before – but I was more concerned about the psychological part. I was worried about the children of these women and their security. A lot of women showed up with severe injuries. I asked them if they were going to file a report with the police against the aggressor, and they would say no. My primary concern was to try to make them understand that there is an end to this and we can try to help them. I don’t know if it’s good or bad, though. Well, of course it’s a bad thing, but I think that nowadays, I kind of stopped caring so much in this sense, like, I think it took me a while to understand that it is not my life. You just see it so much, more and more I feel like I am just treating an object, so my primary concerns are the physical injuries (...) (Kristin, Norway)

In addition to the fear of violating patients' privacy, I observed a sense of detachment related to the importance of professionals' confidentiality in both countries. Hanna, a doctor from Norway, talked about the difficulties of dealing with the problem, despite that she has been working in the same clinic for 25 years. Sometimes she feels there is something wrong; she tries to help but she cannot do anything if the woman does not want to talk about the situation.

You can never know for sure, because if you ask them they say no. Yet you kind of feel that there is something there. You can tell that these injuries don't result from falling down the stairs. For instance, if they have bruises internally, you don't get that if you injure yourself on the stairs or something like that. It's very difficult to get bruises internally unless somebody held you down or did something bad to you. So of course with these cases, you kind of think, right? If you ask them, they say no, but if you ask a bit more you gradually see that they start shaking. However, at the same time, I think it's important to remember that we want to help, we want to do something about it; but it is not about us, it is about them, and if they don't want help, we don't have anything to say. (Hanna, Norway)

Elizabete has been a gynecologist in Brazil for 30 years. She told me about the doctor-patient relationship. She thinks it is important to respect the patient's will, even when she knows the patient is lying.

Most of the time they [women] deny it, no matter how much you realize it. You realize that the person is not telling you the truth, but you respect them because you will not be able to intervene. I'm not going to tell her [a woman] that she's lying, that her injuries actually resulted from getting beaten up. I know she's lying, but I cannot tell her she's lying. We need to respect the other person because I cannot distort information that the patient is giving me. I will not confront her, right? Yet I realize that the story is false. (Elizabete, Brazil)

Arnt, a Norwegian doctor, also said he does not insist if the patient does not want to tell him:

In the beginning I would try to dig more, but nowadays I ask, and if they say no, I might ask again differently, but if they still say no, I am like, well, ok. That is none of my business. (Arnt, Norway)

The majority of health professionals reported how challenging it is to deal with multifaceted circumstances, and how frustrating it is not to have all the answers their patients desire and need. The participants said they think that a social situation can influence a patient's decision in terms of whether to alert the police.

We cannot report these cases [domestic violence] to the police. We are not allowed to go to the police, but if we see that the patient is in immediate, life-threatening danger, then we can go to the police, but that is so unusual. Even if the woman is badly injured – for example, if her uterus is ruptured – even then it is not enough. Even if the abuser has threatened to kill her, it is not enough. She has to be nearly dying. I have been so surprised by this. If a person tries to strangle someone else, it is not enough. I don't know any cases where the doctor could break confidentiality. I know it is for a good reason; sometimes you really feel like doing it...but you can't. (Hanna, Norway)

Surprisingly, doctor-patient confidentiality was mentioned several times as the main reason why health professionals sometimes do not report cases. They were consistent in underscoring the importance of respecting the patient's will.

It depends if she [the woman] allows me to report it. In general, they do not tell us. I think the biggest difficulty is fear, right? So what prevents her from disclosing is the fear that the violence will get worse, and this can get to a point from which she cannot return. Because of that, I always respect the patient's desire to report the incident or not... (Elizabete, Brazil)

Domestic violence is not common in my daily clinic, but it appears sometimes. I have personally treated a few cases. I still feel uncomfortable with these kinds of cases. I am uncomfortable interfering in these family affairs (...). I cannot help them when they do not want me to call the police (...) I need to respect their will and this is very frustrating. (Kristin, Norway)

Criminal justice professionals from both countries insisted that all cases should be reported to the police station because this is the law, and they know that health professionals sometimes do not do so based on doctor-patient confidentiality.

(...) when an individual is shot and enters the hospital, health professionals have, as a protocol, reported cases like that to the police. In the case of female victims, sometimes they do not give this information to the police, which I think is a big mistake. When a woman who was attacked by her husband arrives at the hospital, the police station should be informed so that police can take the necessary steps. Domestic violence is a crime, and it is the police's duty to investigate it, regardless of the woman's will. In most instances, health professionals do not call the police. (Fernando, Brazil)

Participants discussed the extent of confidentiality. If patients are at risk, health professionals should not avoid becoming involved.

Confidentiality between the doctor and patient is not supposed to be that strict anymore. If the doctor sees that the patient is facing any kind of risk, they have

to notify the police immediately. Cooperation with hospitals has become much better now. (Dagfinn, Norway)

It was interesting to note how doctor-patient confidentiality was present in the health professionals' responses in both countries. In addition, I observed that criminal professionals in both nations complained about the links between hospitals and police stations, and about the gaps in terms of reporting incidents, even though reporting violence is compulsory. I could understand how complex the situation is for health professionals since the law mandates that cases be reported, but the ethical code states that doctor-patient confidentiality needs to be respected.

6.7 A multi-professional approach

Two questions in the interview helped me to determine the relationship between the approaches of professionals, institutions, and violence. Respectively, Questions 5, 6 and 7 covered how to document injuries and refer the victim to other services; the level of coordination between hospitals/clinics and criminal justice professionals; and if the institution provided specific training related to documenting injuries resulting from violence in the home, for legal purposes. I perceived that integration between the different institutions involved in women's care is complex due to several aspects.

The link between criminal justice and health professionals is not as strong as it should be, and the fact that women count on health professionals for confidentiality makes the situation even more challenging. I observed this standpoint in the responses of both categories of professionals in Norway. According to a Norwegian police officer:

The cooperation between hospitals or clinics and police stations is very complex! There is no perfection. It is public knowledge that a gap remains regarding victim care (...) (Einar, Norway)

Below are the words of a young Norwegian doctor who always tries to follow protocol. She has been working in a hospital for a few years. She felt pressure to attend to domestic violence cases.

If someone says that the injury resulted from domestic violence caused by the husband/boyfriend, I try to offer the victim help and a safe alternative to

returning home. I ask if she wants to report the harm to the police. If the case involves an extensive amount of damage, I consider filing a report with the police. I describe the damage carefully in the medical record, take measurements/check sores on the body, and possibly document the injuries with pictures if the victim allows it. I might refer the victim to a crisis center, sexual crimes reception in the hospital, police, psychiatric services, or child welfare – depending on what is relevant to the situation and the woman's wishes. (Agnes, Norway)

The circumstances were not much different in Brazil. The health and criminal justice professionals know about each other and recognize the importance of working in partnership, but it seemed that they do this simply to follow protocol.

...we have our Forensic Department and legally have to be processed through this department, with the forensic medical report, right? (...) in order to attach it [the forensic medical report] to the inquiry, which is a duty of the civil police branch. In terms of the Forensic Department, which is a department of the police (...) all victims with injuries are sent there. There are other cases, of course, in which the victims suffer many injuries, so they are taken to the hospitals. Then, we request the report from the general hospital as well, but it is not common. We are on the right track, yes? [We have] a good connection with the hospitals in the region; it flows very well in that sense. (Sofia, Brazil)

In the words of Julia, a Brazilian nurse, I saw that cooperation is almost performed automatically. They send the information that they are supposed to send to the police.

What is the level of collaboration between the hospital and police? I provide them with the written medical record if the patient gives consent. The government does not cooperate with me. I collaborate with the police office; there is a standing agreement for me to obtain help from police when I need it and when they need me, if the patient agrees. (Julia, Brazil)

Health and criminal justice professionals in both countries attributed the limitations of their work to a lack of support from mental and social health professionals, and how they could do their job better if they could count on these staff to cooperate with the police and hospitals. They expressed concern over the lack of psychological professionals, which was thought to be essential to complement multidisciplinary work.

The specialized women's police stations, as I have told you before, have social workers as part of their structure – but they do not yet have psychologists. They usually do this work to receive the women in the first place, and if it is necessary, to send them somewhere for more in-depth psychological

assistance. This is the job of social workers, right? I am very happy to count on them to help me! (Thiago, Brazil)

(...) It [domestic violence] is a complicated topic and...[that is] why we need a psychologist to help us conduct these cases. (Dagfinn, Norway)

In a Brazilian clinic where they added a social worker to the multi-professional team, the doctor was relieved to know she could count on this professional.

We have some cases where the women are very emotional. Domestic violence really affects them emotionally, and this is challenging to deal with. We send them to the social worker or the psychologist to be listened to, right? We have an excellent social worker working with us, thank God! It was a wonderful acquisition for our clinic (...) She solves the emotional part of the problem! (Ana, Brazil)

Interestingly, most of the professionals from both countries felt they were not prepared to lead in terms of the social and psychological aspects of domestic violence.

I took local courses at the hospital, as well as through my medical education. I was trained to take care of physical injuries caused by violence, and how to proceed in these situations. Still, I do not always feel prepared to take care of psychological problems. We need help from professionals. Some nurses are good at that though. (Agnes, Norway)

My primary concern as a health professional would be the physical injuries, because the number of domestic violence victims is increasing, and we don't have time to provide psychological support to all of them. (Hanna, Norway)

Both health and criminal justice professionals from both countries talked about the difficulties of leading regarding the social and psychological aspects. The need for extra support was unanimous. They are trained and used to working on concrete problems. They feel insecure (or are too busy) to spend time on emotional issues.

6.8 Perceptions about barriers women face in terms of pressing charges and/or leaving the aggressor

In Brazil, when speaking about the barriers women face in terms of pressing charges and/or leaving the aggressor, the importance of women's economic independence is underscored as

an element of a possible transformation in the male-female relationship, the end goal being for victims to achieve positions of equality and freedom. Such positions allow them to build new partnerships to overcome violence. Two of the interviewees from Brazil's criminal justice service viewed financial independence as a way for women to escape violence:

In 70% of the cases here, women depend on men financially. Thus, they give up on pressing charges since they have children to raise and husbands who work to give money to them. (Fernando, Brazil)

Thiago, a Brazilian police officer, talked about women's circumstances from the angle of disadvantages, and affirmed that economics plays an important role in women staying in violent relationships.

As I said, it's a patrimonial issue. This [problem] has obviously been shrinking over the years as women are becoming increasingly more independent. The most disadvantaged classes face the greatest number of demands. We have great indications of women depending on their husbands, and generally, we also see that many victims have a large number of children. (...) I am sure there are other things that keep a woman in a toxic relationship. However, I believe that being financially dependent on one's husband is the biggest factor. (Thiago, Brazil)

In contrast to the almost unanimous belief that what keeps a woman in a violent relationship in Brazil is economic dependence, a participant from the Brazilian criminal justice system believed that what kept a woman in a violent relationship was not only economic dependence, but rather psychological dependency.

...especially the psychological dependence. Many people think that financial dependence is the biggest factor, but financial dependence happens because of psychological dependence, and psychological dependence does not happen overnight. Everyone has a hard time understanding, but why does she submit to her husband? This is a construction, it starts with a small amount of violence until it reaches a level whereby the victim can no longer leave the relationship, and both aggressor and victim become sick. (Maria, Brazil)

One of the Norwegian criminal justice professionals also reported psychological dependence as a barrier for women to leave their abusers.

My concern is that they [women] usually go back to the same man and the abuse continues. Some women do not have the courage to make the decision to leave the aggressor and frequently go back to those men. They feel they might regret abandoning their home. (Birgitta, Norway)

Kristin, a Norwegian nurse, worried about the fact that even women who decide to leave their partners for a period of time usually come back.

My primary concern is that they often return to me in the same conditions that they were in the first time, and they usually need to leave the municipality. We know that it is very common for them to return to their partners (...) (Kristin, Norway)

In some cases, professionals thought that that the woman dependence was a greater problem than only psychological issues. This was also linked to social norms about maintaining the family structure. They care about having a family for their children.

I am concerned about doing my job and ending the abuse these women suffer. The problem is that when we have one case of family abuse per month at the police station, there are at least ten other cases we do not know about. When they [women] come to press charges, it is because the violence has happened many times already. For the sake of the family, women here decide to forgive their partners. (Dagfinn, Norway)

Largely in Brazil, the importance of women's economic and psychological independence was clear in the process of breaking free from domestic violence. Regarding Norway, in the participants' responses, psychological dependence and social norms were obvious barriers to ending violence; for example, psychological dependence and social norms caused women to return to the same men for the sake of the family – even after being abused. They do not want to break up the family and expose their children to divorce.

In this chapter, I presented the data collected from the interviews. I tried to include the most relevant parts without being repetitive. The goal was to describe health and criminal justice professionals' answers regarding this topic. In the next chapter, I will discuss these findings in light of the relevant literature.

7 DISCUSSION

My findings showed that most criminal justice and health professionals from both countries face a complex situation when dealing with domestic violence. Not only do they find it challenging to identify possible occurrences, but once they do, they find it difficult to help women solve the problem. This chapter discusses the impact of regulations and social norms on professionals' attitudes and practices towards domestic violence cases in Brazil and Norway.

This study had some limitations. For example, the relatively low number of participants within each category; or the possibility of partial answers, which cannot be ruled out due to the overall tendency to give socially acceptable answers in face-to-face interviews. Another potential bias is the fact that I am from one of the countries that I studied, which makes it impossible for me to deny preconceptions and presumptions about certain topics. Despite these restrictions, I managed to demonstrate the importance of including criminal justice and health professionals' perspectives when we approach domestic violence in both countries.

Despite my insistent attempts to find similarities in the care system for female victims, the great social and economic differences between the two countries have a deep impact on professionals' practices and behaviors. Values and behaviors ought to vary when the cultures are so distinct; therefore, so is the way that people deal with certain phenomena. The health and criminal justice interviewees in Brazil and Norway reflected on social aspects of their own country, as well as traces of what they are exposed to in their daily lives. In addition to the importance of training activities, it is essential to consider professionals' personal beliefs and family backgrounds. Professionals' attitudes concerning domestic violence against women, and beliefs that place the responsibility of the violence with the victim, prevent us from seeing that domestic violence must be urgently addressed (Aksan & Aksu, 2007; Zakar, Zakar, & Kraemer, 2011). If for one side, the "machismo" in Brazil collaborates to the tolerance regarding domestic violence in the country, the acceptance of exacerbated alcohol consumption, during the weekends, in Norway conceals people's violent actions and it could justify them somehow (Bye & Rossow, 2008). Domestic violence is a complex topic, and a professional's personal experience of violence can affect his/her capacity to respond to cases, even if they believe otherwise (Aksan & Aksu, 2007; Kim & Motsei, 2002; WHO, 2014).

My personal experience during an interview in a women's police station was also significant. While waiting outside to be seen by the sheriff, I realized that people could see me from the street, and that friends or family members could see me, as the police station was in the neighborhood where I used to live before moving to Norway. In that moment, I panicked and thought about leaving the police station. I felt extremely uncomfortable and exposed there – not because the woman in the reception made me feel this way; on the contrary, she was lovely and welcoming. I felt extremely uncomfortable and exposed there – not because the woman in the reception made me feel this way; on the contrary, she was lovely and welcoming – but what help would I be if someone were to see me in that place? What would people think of me? I felt ashamed, and at that moment I understood in a small way what women that suffered violence and are brave enough to enter a police station must truly feel. However, I was not there for any drastic reason, so I only shared the feeling of shame, not the humiliation, which they certainly feel on top of shame. It was an interesting experience, and I asked myself if professionals consider women's feelings when they receive them at the police station, and how important that is for them not to give up on the complaint.

It is also important to note my personal bias and preconceptions. As someone who grew up in Brazil, I expected a positive answer from the Brazilian participants when I asked them if they had anyone close – friends or family members – with a story of domestic violence. In contrast, I expected a negative answer from the majority of Norwegian participants. In Brazil, everything was going the way I expected: all of the Brazilian respondents mentioned someone (close to them or not) who had suffered physical assault at the hands of her partner. I was surprised in Norway when nearly half of the participants said they knew someone who had been through domestic violence. I could not hide my surprised expression when the first respondent answered my question with “Yes.” She added that she was talking about psychological violence, that she did not know how it worked in Brazil, but that in Norway, psychological abuse was also considered domestic violence. Then it hit me: Why is it that the Brazilian participants – including myself, tended to link domestic violence mostly to physical assault, and did not seem to pay much attention to the psychological side? These two forms encompass the concept of domestic violence in each country, as they both follow the WHO definition (WHO, 2014). I wondered if Brazilian people had a higher tolerance for psychological abuse and could only perceive violence when it appeared in an extreme form? Or rather, is it because Norway is more committed to fighting domestic violence and abuse

against women in all its forms, and Norwegians can therefore recognize abuse earlier than Brazilians?

In the interviews, even when professionals did not feel prepared to manage situations of domestic violence, they said they try to conduct cases with impartiality and to follow protocol. They also emphasized the importance of not allowing personal experiences to interfere with their jobs. Health professionals are expected to act in their patients' best interests, even when those interests might conflict with their own (Rodwin, 1993). However, personal beliefs can interfere with the doctor-patient relationship. Better training and more knowledge about domestic violence can improve professionals' trust in themselves to manage the circumstances at hand and make health workers more confident about the case.

Whether they are working in the criminal, civil, or family courts, criminal justice professionals have fundamental functions in domestic violence cases. These functions often meet conventional expectations that society has for them. For example, criminal justice professionals might be expected to also provide social services for female victims, despite that they are not trained to do so and do not see themselves playing the roles of social workers (Page, 1993; Payne and Gainey, 2009). Very often, criminal justice professionals are criticized for giving low priority to domestic violence cases and for sometimes blaming the victims (Hart, 1993; Payne & Gainey, 2009).

A study in United States (U.S.) found that judicial monitoring failed to reduce the re-arrest rate for any offense, for domestic violence in general, or for domestic violence with the same victim. The effectiveness of monitoring has barely been examined among the members of this population (Rempel, Labriola, & Davis, 2008). Critics of criminal justice professionals can influence their attitudes to some extent because they can try to offer better assistance to erase prejudice, or can be insensitive to such comments for feeling too criticized. My findings revealed that criminal justice professionals had a sense of responsibility toward the effects of the law, as well as the desire to resolve cases. Despite the suggestion that these professionals view domestic violence cases and their victims in a critical light, research has shown that judges favor increased training in arbitrating domestic violence cases (Crowley, Sigler, & Johnson, 1990; Payne & Gainey, 2009). There is a need to improve judicial training and preparation for domestic violence cases so that criminal justice professionals are not obliged to learn how to respond to them spontaneously in their daily job activities (Knepper & Barton,

1997; Payne & Gainey, 2009). In this study, the criminal justice professionals from both countries complained about the lack of training and not feeling prepared to deal with the social or psychological aspects of domestic violence cases.

Some health professionals limit themselves to concentrating strictly on the physical aspects of health (Kalra, Di Tanna, & García-Moreno, 2017; Moreira et al., 2008). The expectations of health professionals do not always match the expectations of the women, who envision comprehensive services, versus merely addressing symptomatic problems (Garcia-Moreno et al., 2015; Moreira et al., 2008). The relative “hiddenness” of domestic violence is emphasized due to the complexity and sensitivity of this kind of harm, making interventions more challenging. Consequently, many women do not disclose abuse and many health professionals do not ask about violence during clinical consultations. This may be because sometimes, the period of time available for the appointment is very short, and other times, simply because the matter is difficult to deal with. There is a general belief that domestic violence is a private issue and can only be resolved in a private setting; the problem is that, in many cases, doctors and patients share this belief. The need to change this situation and provide better assistance to these women is urgent.

An important problem disclosed by health professionals, mostly in Norway, but also often in Brazil, was the fear of interfering in someone’s private life when help was not requested. Two other impressive topics that appeared only in the Brazilian interviews were fear of retaliation by the aggressor, as hospitals could not guarantee that the professional’s name would be kept anonymous (in case they wanted to denounce a violent incident). This was recognized as a deep flaw in the Brazilian medical system that promotes the under-notification of violence. In addition, patriarchal beliefs and behaviors were expressed in some interviews that did not favor the victim; on the contrary, it blamed them for the violence.

Regarding the situation among criminal justice professionals, some of the difficulties described by those I interviewed were also described in the article “The Challenges of Domestic Violence Investigations” by Jeremy Nikolow (2015), a police officer from the Daytona Beach Police Department in Florida in the U.S., who believes that domestic violence investigations differ from any other type of police investigation, as officers face the threat of potential violence not only from the offenders, but also from victims. He affirms that victims and witnesses often do not cooperate, even if they were the ones to contact the police in the

first place. He believes this is partly caused by the fear of retaliation, and that in other cases, victims merely want the police to de-escalate the situation, but not take the offender to jail.

One of the participants, a sheriff from Brazil, shared the same belief when he stated that many women call the police about a case of violence. The police go to the crime scene and take both offender and victim to the police station, but once they arrive, the woman refuses to press charges. One example was a case where the woman said she did not want the police to arrest her husband; she only wanted to scare him a bit. He mentioned other reasons like economic dependence and the victim's belief that the criminal justice system would not be able to solve their problem. A police officer from Norway who participated reported many cases where alcohol consumption was involved when the call to police was made, and how delicate it was to approach the crime scene. However, once things calmed down and both parties were sober, the woman did not want to press charges anymore, which made the situation challenging.

This topic is complex because there are different meanings of gender, and diverse perspectives on violence depending on where one lives. For example, Jakobsen (2014) examined the relationship between intimate partner violence and gender – versus with biological sex – as conceptualized in feminist theory in Tanzania. The views of women from countries in the Global South differ from the perceptions of women who live in the Global North. The findings from Tanzania present some similarities to the Brazilian situation, but are very far from the circumstances of Norway. All these differences are also reflected in professionals' attitudes and beliefs.

In general, the findings show that most of these professionals seem to be doing the best they can within their responsibilities; however, they did not feel well trained or empowered enough to deal with domestic violence cases, which is understandable since many of the participants had never even been trained to deal with this issue. Training and education of criminal justice and healthcare professionals to identify and address domestic violence has been proposed to resolve the many related obstacles. This could improve health outcomes for victims (Huisman, Martinez, Kalra et al., 2017; Wilson, 2005).

Domestic violence training and support programs for primary care have been predicted to be cost-effective from the angle of community (Devine, Spencer, Eldridge, Norman, & Feder,

2012; WHO, 2014). A society's perception of domestic violence is molded by culture. In Norway, psychological abuse was mentioned several times, while in Brazil, domestic violence was automatically linked to physical assault most of the time. This happened despite that both countries use the United Nations definition of domestic violence (United Nations, 1993).

The importance of adequate training is linked with decreasing the stigma associated with domestic violence. Regarding the health system, a major barrier to asking questions in domestic violence cases includes healthcare professionals' belief that by screening for domestic violence, they will invade a private and complicated situation that they are not sure they are prepared to handle, since they feel they have not been satisfactorily trained (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Davidson et al., 2001; Djikanovic, Celik, Simic, Matejic, & Cucic, 2010). Some health professionals that I interviewed thought they should not get involved in cases of violence because they do not have the proper instruments at health facilities to enable them to deal with such a complex situation. Many mentioned their duty of confidentiality between doctor and patient to prevent them from assisting the patient in deeper ways, such as by contacting the police.

With that said, I reaffirm my first perception of this project that some participants did not seem to feel empowered to deal with the problem. This reinforces the need to invest in training professionals and increasing their awareness and sensitivity to detect violence, not only in extreme cases, but especially in its veiled forms. Despite understanding the role that healthcare workers can play in addressing domestic violence, many difficulties can inhibit them from effectively identifying and acting with female victims. Furthermore, lenience toward cases of violence against women can result in low rates of reporting. Health professionals who lack appropriate training to investigate cases can cause more harm than benefits; they might advocate leaving an abusive relationship while failing to provide women with a safety strategy or to consider the woman's perspective (Morse, Lafleur, Fogarty, Mittal, & Cerulli, 2012). Training and education for healthcare professionals to identify domestic violence have been proposed to address the many obstacles of domestic violence care and can improve health outcomes for victims.

Regarding the influence of institutions' regulations on the attitudes and practices of health and criminal justice professionals, they find ethical codes and institutions regulations' to be very important; the former group is very concerned about ethical codes, while the latter is

concerned about laws and regulations. These concepts appeared very frequently in the interviews.

The notion of a professional ethical code was very present when the health professionals talked about the importance of confidentiality. To my surprise, they described their exacerbated worry about confidentiality as a barrier to helping patients end physical abuse. An ethical code should not be proposed to transform subjective aspects of care into more objective ones. When there is a deeper reflection in daily situations, personal moral rules and judgments play a central role and are crucial in most cases (Limentani, 1998). More than commanding specific actions, a code should explain the ethical environment for the provision of healthcare and reproduce its character and general approach.

Nevertheless, ethical codes can provide form and structure to a moral background and summarize an ethical opinion; however, each health professional has ethical responsibilities. Personal differences and individual issues need to be taken into account. An ethical code provides general rules and proposes professional conduct in difficult situations to facilitate the exercise of ethical issues. The significance of an ethical code is the description of shared ethical positions, developed over the years by healthcare professionals, and can be used as a model to guide professional behavior and prevent patient damages (Limentani, 1998).

Interestingly, when asked about the link between hospitals and police stations, the criminal justice professionals recognized confidentiality as a problem that would, in many cases, expose the patient to further risk, which interferes in the police's capability to help and protect the victim. This is a real possibility. However, it is important to consider cases where physician involvement can expose the victim even more. This is a complex situation. In addition to concerns about confidentiality and the presence of professional codes, there are also government regulations on caring for victims (Berwick et al., 1997; Center for professional responsibility, 2018; Limentani, 1998). Laws in Brazil and Norway state that all cases of domestic violence should be investigated and reported to the police despite the victims will (Brasil, 2006; Helsepersonelloven; LOV-1999-07-02-64; Hyman et al., 1995; Pasient- og brukerrettighetsloven; LOV-1999-07-02-63). Health professionals are obliged by law to report cases, but even so, they sometimes do not do so in Brazil or in Norway. Criminal justice professionals expressed concern about this situation and how to deal with it.

The article “Intimate partner violence and the Nordic paradox,” written by Enrique Gracia and Juan Merlo in 2016, remarks on a 2014 survey by the European Union Agency for Fundamental Rights (FRA). The findings demonstrated how a higher prevalence of domestic violence rates in countries with high gender equality, like Norway, might simply indicate that women in these countries feel more empowered and encouraged to talk about their victimization (Garcia & Merlo, 2016). A Norwegian doctor I interviewed also mentioned this possibility. The increase in violence does not reflect an actual higher prevalence, but rather higher levels of disclosure in comparison to less egalitarian countries, like Brazil, which are still fighting against the high “hidden *cifra*” – mentioned by one of the criminal justice professionals – which refers to the high number of female victims who do not press charges. It is not possible, however, to presume that countries with a higher degree of gender equality do not have a significant “hidden *cifra*”. With the establishment of the Maria da Penha Law in Brazil, the number of reports on domestic abuse increased by 600% between 2006 (when the law was passed) and 2013. This shows that the law encouraged victims to report assault; therefore, the latest data does not necessarily signal higher levels of abuse against women, but instead might reflect higher levels of empowerment (Mendonça, 2015).

Despite all the reasons that keep professionals from both areas (criminal justice and healthcare) in assisting female victims, there was no distinction among views on the importance of controlling domestic violence across the different occupations or countries analyzed in this study. However, the perspective on domestic violence statistics differed between Brazil and Norway, which was an eye-opener to another possible reality. While in Brazil there is a great concern for the “hidden *cifra*,” in Norway, the increase in the number of cases could be seen as positive, since it is believed that women are recognizing and reporting violence, as stated by a Norwegian physician who participated in the present study. Recognition of the importance of laws and regulations to help control domestic violence in both countries was unanimous.

Despite the significance of legislation, health professionals in both countries mentioned doctor-patient confidentiality as one of the barriers to working on domestic violence cases, and as the reason for not reporting cases to authorities. In the present study, some health professionals said they were not comfortable notifying authorities if the victim asked them not to do so. A good physician-patient relationship includes understanding, confidence, encouragement, reassurance, and confidentiality, which can help women with violent

experiences overcome obstacles and feel safe enough to talk about the problem with the relevant authorities (Othman, Goddard, & Piterman, 2014). Confidentiality during healthcare should be used to empower women to become free of the vicious cycle of violence. In domestic violence cases, confidentiality should be focused on protecting the victim, but could be used as an excuse for the professional not to get involved in an uncomfortable incident.

I can see how such circumstances are not simple for health professionals, because the law stipulates that they need to report cases, while the ethical code states that they need to respect doctor-patient confidentiality. Although confidentiality is sometimes viewed as a barrier that professionals face in helping victims, confidentiality between doctor and patient can be critical in order to create trust between them. Professionals must have a sense of when to apply or break the ethical code in order to meet the patient's needs.

During the interviews, many health professionals discussed the importance of confidentiality in the doctor-patient relationship. They showed how ethics are an essential and integral part of healthcare. Berwick et al. (1997) proposed a common ethical code for professionals involved in healthcare; it is considered potentially valuable and welcomed by health professionals, but the role and limitations of this code need to be recognized. For example, a recent study from the U.S. revealed that despite almost all states and provinces having laws requiring licensed healthcare professionals to report worries and claims to law enforcement regarding the abuse of children, the elderly, and the disabled, as well as all episodes of violence with use of a lethal weapon, only a few states in the country also require health professionals to notify authorities of damages caused by reported or suspected domestic violence (Walker, 2017). These data demonstrate that there are some places, even in developed nations, where notification is not mandatory and it could influence the follow-up of cases. On the other hand, this could also be a way to let professionals decide to protect the victim from exposure and further violence.

A frequent comment in this study was the need for psychological support. The interviewed professionals who could count on social and psychological support in their workplaces reported more safety while managing cases. On the other hand, those who did not have this kind of support described difficulties. Their remarks emphasize the importance of having a multidisciplinary team, which should be formed by several professionals of different specialties who act as a group. Moreover, there is a need for a good relationship between the

team and recognition of the patient as a whole, from a humanized angle (García-Moreno et al., 2015). Professionals who work with the phenomenon of violence must position themselves as facilitators of therapy, building strategies that contemplate and respect the social context and singularities of victims. To boost this process, it is necessary to approach the realities experienced by victims and to make the conflicts presented during the complaints visible, from a multidisciplinary perspective (García-Moreno et al., 2015; Payne & Gainey, 2009). One strategy used to support women in situations of violence should be to break its cycle and build citizenship through global actions and multi-professional care (e.g., the psychological, social, legal, and health fields).

In Brazil, the fifth article of the Maria da Penha law that deals with domestic violence foresees the formation of a multidisciplinary care team, to consist of professionals that specialize in the psychosocial, legal, and healthcare fields (Brasil, 2017). This is because the procedural response to cases will not always provide women with what they need to break the cycle of violence and restructure their daily lives. In order to deal with domestic and family violence, it is necessary to understand that violence is a complex problem and that many people have to be involved in the response. For example, the law reinforces the importance of dialogue by indicating the joint work of criminal justice and healthcare professionals with psychologists and social workers. Despite creating possibilities for greater communication and integration of the teams, this action has not yet been implemented universally in care services for victims of violence.

In Norway, the multi-professional approach is also recommended in cases of domestic violence. Health and criminal justice professionals can refer victims to social and psychological resources using the *krisersenter* facilities (Norwegian Ministry of Children and Equality, 2015). Psychological and social work support is also available in the health system, as well as a specialized professional at some police stations. Yet as I observed in the interviews, there are still some gaps in the connections among them.

Besides having an interdisciplinary team working on domestic violence cases, it is also important to build a network. Networking among relevant professionals and institutions is an appropriate way to improve victims' circumstances and the efficiency of the approach (United Nations, 2011; WHO, 2014). Exchanging knowledge and experience, being well-informed of

what others are working on, having direct streams to other organizations, and knowing about training possibilities are great advantages of these cooperative networks.

The ecological perspective, adopted by Yoshioka and Noguchi (2009) and guided by Bronfenbrenner's (1979) ecological model, helped me understand how culture shapes a woman's experience of domestic violence, and therefore, people's experience in general. Bronfenbrenner described the three primary systems within which a woman defines what is abusive and what will be helpful. The "micro-system" represents elements of the woman's environment that directly influence, or are influenced by her; for instance, her immediate and extended family, and her informal support network. The second system mentioned by Yoshioka and Noguchi (2009) is the "exo-system" which symbolizes aspects of a woman's environment that indirectly affect her functioning and resources; for example, characteristics of her cultural community (e.g., its size, how well established it is, whether there are culturally specific resources available to her), and her relationship with the host country in terms of citizenship status. Finally, the "macro-system" comprises cultural beliefs and values that influence women's perceptions and choices through the impact of elements of other systems. This system may include culturally informed beliefs and attitudes about gender, marital roles, and partner violence. Yoshioka and Noguchi (2009) believe that within these three systems, a woman ascribes meaning to her experiences and choices.

Regarding the fight against domestic violence, the situation in Norway appeared to be better than in Brazil. Brazil suffers more from patriarchy, which was indicated by different professionals' behaviors and perceptions of their approach to victims. The idea of the "macho man" – strong, powerful, desirable and seductive – is still prevalent in Brazilian society. Men strive to be like this image, and women want their men to be like that. How fine is the line between the protector and provider "macho man" and the possessive controller, and finally, the aggressor "macho man?" As this patriarchal system is still present in Brazilian society, it is more difficult to tackle domestic violence cases and to get women to go to police stations. Brazil has protective laws (Brasil, 2006), but women need to be convinced that legislation will be effective in order to press charges against their aggressors. Although Norway is far ahead of Brazil regarding gender equality and the quality of the care system, the Norwegian system still has some gaps, but there is definitely less focus on the "macho man." A criminal justice professional reported the challenges of collecting information and solving cases, despite the existence of crisis centers and the implementation of the SARA tool. In the past

few decades, the Norwegian government has taken a large number of steps to fight domestic violence. These efforts have mainly been channeled through the government's action plans to combat violence against women (Action Plan, 2008).

In sum, over the past few decades, there has been a significant development in elaborating and approving international norms to address domestic violence in Brazil and Norway. These countries' governments have passed laws to stop domestic violence, to investigate and prosecute cases, and to punish the perpetrators. However, there is still a long way to go because it is important to improve the quantity and quality of domestic violence training to give health and criminal justice professionals the chance to be prepared, so they can discuss the topic with women and adequately answer their demands. Most of all, the social belief that domestic violence is a private matter must be extinguished.

8 CONCLUSIONS

Disclosing domestic violence to health and criminal justice professionals is not easy for those experiencing the problem. Even if women manage to arrive at health facilities and/or police stations, they face several barriers in discussing abuse with care professionals. These professionals must be aware of obstacles in order to identify their omission and provide empathy and culturally sensitive help to female victims.

Personal beliefs and social norms concerning the acceptability of domestic violence are critical risk factors. It is important to point out that individual traits, family and environmental contexts, and even professional profiles, can affect the way a health or criminal justice professional views and deals with cases.

Health professionals play an important role in accessing domestic violence cases because they are often the first point of contact, and frequently the preferred point of admissions for domestic violence victims. They are present during the ideal moment to identify and provide adequate care to female victims. Additionally, the health division offers a probable pathway to criminal justice professionals, with whom women will need to be in contact to press charges. The pathway is not limited to legal aid, but also extends to social and psychosocial support. It is vital to establish a multi-professional network to provide good assistance to victims. The professionals involved in domestic violence assistance need to receive specific training on a regular basis to give them a sense of safety and autonomy to deal with this complex topic.

The introduction of regulations has not been sufficient to decrease domestic violence in Brazil or Norway, but they have proven to empower women, giving them strength to press charges against their aggressors. It is important to remember that health and criminal justice professionals are ordinary citizens who fit into their societies and are influenced by the community. In order to improve the circumstances surrounding domestic violence in Brazil, it is necessary to improve the population's quality of life, guaranteeing access to education and work. This is a basic responsibility of the state and an important condition for facing structural violence, which is directly linked to domestic violence, since regions with high rates of domestic violence are also regions with high amounts of violence in general (United Nations, 2014). On the other hand, Norway, despite having very low rates of structural

violence, could improve the fight against domestic violence if the excessive eagerness not to enter a person's private sphere were controlled in professional environments. The fear of "stepping on people's toes" is a cultural characteristic of Norwegians that must be tackled and neutralized in a professional context, so that health professionals can help potential victims of domestic or sexual violence. Due to the high rate of domestic violence against women in both countries, further substantial actions are needed in order to change their reality.

Health and criminal justice professionals accept that they have responsibility in terms of offering help to female victims. They know it can be difficult to maintain a professional detachment and limit interventions when faced with women asking for help in the hospital or in a police office. This can be a problem, as they do not believe that they have the time or skills to deal with the issue. At the same time, however, they felt that it was somewhat insensitive to discourage a woman from talking through her difficulties, having raised the subject. The fact that some women who have been through violence in Norway are immigrants can add to health professionals' feelings of detachment, as the approach becomes even more challenging.

Talking about gender violence entails analyzing issues related to: gender and gender roles; the relationship between men and women; the hierarchy of power; values and attitudes that are established to shape and regulate affectivity, sexuality, and individual life; women's economic conditions; and the domination and privilege of men over women. These issues are rooted in the psychology of the victim, the aggressor, and health and criminal justice professionals, who are responsible for ending the tragic reality experienced by thousands of women, not only in Brazil and in Norway, but all over the whole world as well.

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10. APPENDICES

10.1 Interviews guide in English

Project: Domestic violence and Social Norms: Attitudes and Practices of Criminal Justice and Health Workers in Norway and Brazil

- (1) Can you briefly describe your work and area of responsibility?

- (2) Do you treat victims who sustain injuries as a result of violence in the home? Is this frequent?

- (3) What are your primary concerns in serving these women?

- (4) Do you see injuries that you suspect are the result of violence in the home, but the woman gives another reason? How do you handle these cases?

- (5) If a woman tells you that her injuries were caused by violence in the home at the hands of her husband/boyfriend, what do you do? Do you document the injuries in a particular way? Do you refer her to other services?

- (6) How would you describe the level of coordination between hospitals and clinics and community groups, legal professionals, and the government?

- (7) Have you or your staff received any training related to documenting, for legal purposes, injuries resulting from violence in the home? What kind of training?

- (8) Has anyone close to you – family members, friends, or colleagues – ever experienced domestic violence?

- (9) Do you believe that having someone close with a history of domestic violence would affect the way you deal with these cases?

10.2 Inform consent in English

Project: Domestic violence and Social Norms: Attitudes and Practices of Criminal Justice and Health Workers in Norway and Brazil

Informed Consent Form

Information and Purpose: The interview, for which you are being asked to participate in, is a part of a research study that is focused on explores how social norms and regulations impact professional's attitudes towards domestic violence in Brazil and in Norway. The purpose of this study is to evaluate Brazilian and Norwegian criminal justice system (e.g. police departments) and health care worker's involvement in women's care and their attitudes and practices.

Your Participation: Your participation in this study will consist of an interview lasting approximately one hour. You will be asked questions about your life and work experiences. You are not required to answer the questions if they make you feel uncomfortable. At any time, you may notify the researcher that you would like to stop the interview and your participation in the study. There is no penalty for discontinuing participation.

Benefits and Risks: The benefit of your participation is to contribute information to the academy regarding the attitudes and practices of professionals involved in the care system for domestic violence in Brazil and in Norway. By comparing the strategies used to tackle domestic violence in both countries, and the professionals perceptions we will be able to elaborate startegies to improve the quality of provided care for these women. There are no risks associated with participating in the study.

Confidentiality: The interview will be tape-recorded; however, your name will not be recorded on the tape. Your name and identifying information will not be associated with any part of the written report of the research. All of your information and interview responses will be kept confidential. The researcher will not share your individual responses with anyone other than the research supervisor.

If you have any questions or concerns, please contact the researcher or her supervisor at Faculty of Psychology, University of Bergen (Christies gate 13, 5015 Bergen).

Researcher: Raquel Miranda (raquelbmiranda@outlook.com)

Supervisor: Dr. Siri Lange (Siri.Lange@uib.no)

By signing below I acknowledge that I have read and understood the above information. I am aware that I can discontinue my participation in the study at any time.

Signature _____

Date ____/____/____

10.3 Ethical clearance from Norwegian Social Science Data Services (NSD)

Siri Lange
Christiesgt. 13
5015 BERGEN

Vår dato: 06.09.2017

Vår ref: 55285 / 3 / AH

Deres dato:

Deres ref:

Tilbakemelding på melding om behandling av personopplysninger

Vi viser til melding om behandling av personopplysninger, mottatt 09.08.2017.

Meldingen gjelder prosjektet:

<i>55285</i>	<i>Domestic violence and Social Norms: The Brazilian and Norwegian Legal and Health Workers Attitudes and Practices</i>
<i>Behandlingsansvarlig</i>	<i>Universitetet i Bergen, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Siri Lange</i>
<i>Student</i>	<i>Raquel Miranda</i>

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget [skjema](#). Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet

Personvernombudet har lagt ut opplysninger om prosjektet i en [offentlig database](#).

Personvernombudet vil ved prosjektets avslutning, 29.06.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Dersom noe er uklart ta gjerne kontakt over telefon.

Vennlig hilsen

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.