

Old Dominion University

## ODU Digital Commons

---

Counseling & Human Services Theses & Dissertations

Counseling & Human Services

---

Summer 2015

# An Exploration of Health Providers' Responses to Intimate Partner Violence (IPV) in Malaysia

Kee Pau

*Old Dominion University*

Follow this and additional works at: [https://digitalcommons.odu.edu/chs\\_etds](https://digitalcommons.odu.edu/chs_etds)



Part of the [Counseling Psychology Commons](#), [Domestic and Intimate Partner Violence Commons](#), [Public Health Commons](#), and the [Women's Studies Commons](#)

---

### Recommended Citation

Pau, Kee. "An Exploration of Health Providers' Responses to Intimate Partner Violence (IPV) in Malaysia" (2015). Doctor of Philosophy (PhD), Dissertation, Counseling & Human Services, Old Dominion University, DOI: 10.25777/t5pn-ds22  
[https://digitalcommons.odu.edu/chs\\_etds/76](https://digitalcommons.odu.edu/chs_etds/76)

This Dissertation is brought to you for free and open access by the Counseling & Human Services at ODU Digital Commons. It has been accepted for inclusion in Counseling & Human Services Theses & Dissertations by an authorized administrator of ODU Digital Commons. For more information, please contact [digitalcommons@odu.edu](mailto:digitalcommons@odu.edu).

**AN EXPLORATION OF HEALTH PROVIDERS' RESPONSES TO INTIMATE  
PARTNER VIOLENCE (IPV) IN MALAYSIA**

by

Kee Pau

B.Ed., Sultan Idris University of Education, Malaysia, 2007  
M.Ed., Universiti Sains Malaysia, 2011

A Dissertation Submitted to the Graduate Faculty of  
Old Dominion University in Partial Fulfillment of the  
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELING

OLD DOMINION UNIVERSITY  
August 2015

Approved by:

---

Danica G. Hays (Director)

---

Jeffrey Moe (Member)

---

Rebecca Earhart Michel (Member)

## ABSTRACT

### AN EXPLORATION OF HEALTH PROVIDERS' RESPONSES TO INTIMATE PARTNER VIOLENCE (IPV) IN MALAYSIA

Kee Pau

Old Dominion University, 2015

Director: Dr. Danica G. Hays

This grounded theory study aimed to examine factors that influence Malaysian health providers' attitudes, knowledge, and responses to IPV survivors, including health providers' perceptions of IPV, factors that influenced the ways they work with IPV survivors, factors they perceived toward influencing IPV survivors' help-seeking behaviors, and their recommendations for improving IPV training. Seventeen ( $N = 17$ ) participants were recruited using snowball sampling and theoretical sampling was utilized to ensure the data was saturated. The results found nine superordinate themes that highlights health providers' perceptions of IPV in general, conceptualization of IPV, institutional factors, health providers' personal factors, sociocultural factors, IPV survivors' resistance, and professional responsibilities, as well as recommendations for improving IPV training and services. Twenty-three themes and 71 subthemes were identified to further describe the superordinate themes. Implications of the findings for health providers and counselor training were presented. This study concluded with recommendations for further research directions.

*Keywords:* intimate partner violence, health provider, grounded theory, Malaysia

## **DEDICATION**

I dedicate this dissertation to my husband, Siong, for his inexhaustible patience and unwavering love and support during graduate school, and for his unconditional love and care for our two beautiful kids, Kingsley and Celine. This work is also dedicated to my beloved Pau's family and Phee's family who have always encouraged and inspired me to pursue my career in the helping profession.

## ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to several important people for the tremendous assistance they have provided to me throughout the research process.

Without them, I would not have been able to complete this dissertation in the least.

**To Dr. Danica G. Hays:** A special thanks goes to you for the guidance, support, and scholarly challenges that you have given to me during the past three years. Your patience, careful review of my works, and constructive feedback have stimulated me to conceive and carry out research projects of the highest quality, this one in particular. Furthermore, your understanding of my situations and the various roles that I play in my daily life has meant a great deal to me. You are my greatest mentor and an inspiration to my career as a clinical practitioner and educator. Thank you, Danica, for sharing your wisdom with me during our wonderful academic experience together.

**To Dr. Jeffry Moe:** To all of your students, especially your international ones, you are a caring, understanding, multiculturally sensitive teacher. Thank you for your willingness to put yourself in my shoes, as well as for your care toward my capacity to negotiate multiple challenges at once. I could not have asked for a better professor to be involved with my dissertation. I have appreciated your support and guidance beyond what words can express.

**To Dr. Rebecca Earhart Michel:** I truly appreciate the feedback and suggestions that you gave to me throughout my research. Your support and understanding of Asian cultures have been particularly invaluable.

**To my father and mother, the late Mr. Pau Ngi Kui and Mrs. Lu Ding Hua:** Thank you for your unconditional love and faith in me. Your inspiration, encouragement, and

sense of rigor have shaped the person I am now. If you could see me at this moment, then I know you would be incredibly proud of me. I promise to keep your advice and teachings deep in my heart. Thank you for being such a lovely mom and dad to me. I love both of you so much.

**To my siblings:** Thank you for supporting me and listening to me whenever I have needed you. I will never forget how you have taken care of me, both emotionally and financially, during the past three years. I hope that our siblingship will everlasting, and I love each of you very much. To my late sisters, Choo and Yieng: You are always in my heart.

**To the Phee family:** I could never have found anyone who has been as supportive of and patient with me. Your philosophy about life, compassion, and love of family have motivated me in my career as a helping professional. Thank you for being a big tree to all of us!

**To my lovely husband, Siong:** Thank you for being my life partner, friend, and husband. I could not have asked for a better soulmate and companion. You have shown truly amazing effort during the past three years in taking care of me and our children. Now, all of our hard work has paid off, and you deserve the credit! You are amazing!

**To my beautiful children, Kingsley and Celine:** I feel as though I have won some sort of prize by having the two of you in my life. Kingsley, I learned so much from you by being a first-time mom. I know that I could have sometimes done a better job, but you have always been there to say, "It's okay!" Thank you for being such a sweet boy to me. Celine, you are the sunshine of our family. I could not have gotten through this critical time without your being there for me. Thanks, my little sweetheart!

**To my best friend, Hsin-Ya and Ugyen:** Thank you for accompanying me on this journey. Without you, my story in the United States would never have been as fruitful or colorful. I look forward to having you near me to share many more amazing stories about counseling. Thank you for your friendship. I hope that it lasts forever!

**To my research team:** Eric, Jamie, and Katey, thank you for devoting so much time in helping me during data analysis. The opinions, thoughts, and feelings that you shared with me during the research have been greatly appreciated, and I look forward to further collaborating with you in the future.

**To all faculty members:** Each of you has played an important role in my formation as a professional, as well as challenged me to discover my potential and true capacity to carry out diverse tasks under pressure. Without you, I would have never learned to push myself beyond the limits I assumed were impassible. I would like to especially thank Dr. Tim Grothaus for his support and understanding during my second and third years of study. I would never forget the critical semester we shared and your sound advice: “Kee, don’t look at how other people have done! Remove all the obstacles that can prevent you to achieve your goal - to graduate.” Thanks to you, Dr. Grothaus, I have achieved that goal. I also wish to thank Dr. Ed Neukrug for teaching me to scrutinize all knowledge with curiosity. This practice has allowed me to explore topics and questions in greater depth and from various perspectives. Thank you as well to Dr. Nina Brown for teaching me how to be a good faculty member. I will always remember your cool, engaging teaching style, and how you have handled different complicated issues throughout your career. Being in your advance counseling and psychotherapy group was a valuable, unforgettable experience. Thanks also to Dr. Wood and Dr. Parker for being great supervisors for me

over the course of several semesters.

**To my fellow doctoral students:** I would like to thank my cohort members Kevin, Brett, Andrea, Heather, Krystal, Gina, Rebecca, Norton, Rob, and Davide for their friendship and support during the past three years. It has meant more than you know to me, and I do not think that I could have asked for better friends and classmates. I am satisfied in seeing each of you grow and strive for success. I wish all the best to you. I also wish to thank the junior cohort members Maddie, Chuck, Caroline, Mary, Marla, Kristy, Marina, Sandy, Sonia, Tracia, Zach, Mike, and Amber, all of whom offered me tireless support and love during my third year in the program. Thank you for your friendship and for being there for me when I needed you. I hope that all of you find happiness and success.

**To my scholarship sponsor:** A special thank you to the Malaysian Ministry of Higher Education for sponsoring my pursuit of doctoral study. Without your financial support, my America dream would not have come to fruition. Thank you also to Sultan Idris Education University for offering such a fantastic position to me and for supporting me during the past three years.

**To my research participants:** Thank you for your willingness to participate in my study and to share your valuable experience with me during interviews. Your words, insights, and encouragements have navigated me toward completing this research and returning to serve my country.

## TABLE OF CONTENTS

	Page
<b>ABSTRACT .....</b>	<b>ii</b>
<b>DEDICATION .....</b>	<b>iv</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>v</b>
<b>LIST OF TABLES .....</b>	<b>xii</b>
<b>LIST OF FIGURES .....</b>	<b>xiii</b>
<b>CHAPTER I: INTRODUCTION .....</b>	<b>1</b>
STATEMENT OF THE PROBLEMS .....	1
PREVALENCE OF IPV .....	5
HEALTH PROVIDERS' RESPONSES TO IPV .....	12
MALAYSIA AND IPV .....	14
TERMINOLOGY OF DOMESTIC VIOLENCE AND IPV .....	16
PURPOSE OF THE STUDY .....	21
RESEARCH QUESTIONS .....	22
DEFINITION OF KEY TERMS .....	23
STUDY DELIMITATIONS .....	25
<b>CHAPTER II: LITERATURE REVIEW .....</b>	<b>27</b>
HISTORICAL OVERVIEW OF IPV .....	27
INTERNATIONAL HISTORICAL PERSPECTIVES OF IPV .....	34
TYPES OF IPV .....	49
PHYSICAL VIOLENCE .....	50
SEXUAL VIOLENCE .....	51
EMOTIONAL ABUSE .....	53
IPV-RELATED THEORIES .....	59
FEMINIST THEORY .....	59
FAMILY VIOLENCE PERSPECTIVE .....	62
ATTACHMENT THEORY .....	63
CULTURE OF VIOLENCE THEORY .....	65
LEARNED HELPLESSNESS THEORY .....	67
CYCLE OF VIOLENCE .....	69
CORRELATES OF IPV .....	71
SOCIOECONOMIC STATUS .....	72
EDUCATION STATUS .....	73
SUBSTANCE ABUSE .....	74
HISTORY OF VIOLENCE .....	76
IPV AS NORMATIVE .....	77
COLLECTIVISM .....	78

TRADITIONAL GENDER ROLES.....	80
RELIGION.....	81
IMMIGRATION STATUS.....	83
ACCESS TO FIREARMS .....	84
HEALTH PROVIDERS AND IPV .....	85
CONCLUSION.....	88
<b>CHAPTER III: METHODOLOGY.....</b>	<b>90</b>
RATIONALE FOR USING QUALITATIVE METHODOLOGY .....	90
SOCIAL CONSTRUCTIVISM .....	92
GROUNDED THEORY .....	93
PURPOSE STATEMENT AND RESEARCH QUESTIONS .....	94
ROLE OF THE RESEARCHER .....	95
RESEARCHER ASSUMPTIONS AND BIASES .....	96
RESEARCHER SENSITIVITY .....	98
RESEARCH PLAN .....	104
SAMPLING PROCEDURES .....	104
SPECIFIC PARTICIPANT PROCEDURES .....	105
GAINING ENTRY .....	106
PARTICIPANT PROFILES .....	107
MEASURE TO ENSURE PARTICIPANT CONFIDENTIALITY AND SAFETY.....	110
DATA SOURCES .....	110
DATA ANALYSIS.....	113
STRATEGIES FOR TRUSTWORTHINESS .....	120
<b>CHAPTER IV: FINDINGS.....</b>	<b>123</b>
SUPERORDINATE THEME ONE: PERCEPTIONS OF MEN AND WOMEN IN GENERAL .....	126
SUPERORDINATE THEME TWO: CONCEPTUALIZE OF IPV .....	130
SUPERORDINATE THEME THREE: TRAINING.....	139
SUPERORDINATE THEME FOUR: INSTITUTIONAL FACTORS.....	147
SUPERORDINATE THEME FIVE: PROVIDERS' PERSONAL FACTORS. ....	159
SUPERORDINATE THEME SIX: SOCIOCULTURAL FACTORS.....	168
SUPERORDINATE THEME SEVEN: IPV SURVIVORS' RESISTANCE .....	178
SUPERORDINATE THEME EIGHT: PROFESSIONAL RESPONSIBILITIES .....	183
SUPERORDINATE THEME NINE: RECOMMENDATIONS FOR IMPROVING TRAINING AND SERVICES .....	197
OVERVIEW OF THE EMERGENT THEORY .....	211
<b>CHAPTER V: DISCUSSION .....</b>	<b>218</b>
SUMMARY OF FINDINGS .....	218
RESEARCH QUESTION 1: HOW DO HEALTH PROVIDER CONCEPTUALIZE IPV FOR MALAYSIANS?.....	218
RESEARCH QUESTION 2: WHAT FACTORS INFLUENCE	

THE WAYS HEALTH PROVIDERS WORK WITH IPV SURVIVORS?.....	223
RESEARCH QUESTION 3: WHAT FACTORS DO HEALTH PROVIDERS PERCEIVE TOWARD INFLUENCING MALAYSIAN IPV SURVIVORS' HELP-SEEKING BEHAVIORS? .....	235
RESEARCH QUESTION 4: WHAT RECOMMENDATIONS DO HEALTH PROVIDERS HAVE TO IMPROVE TRAINING TO WORK WITH IPV SURVIVORS IN MALAYSIA?.....	244
IMPLICATIONS FOR HEALTH PROVIDERS .....	250
IMPLICATIONS FOR COUNSELOR TRAINING .....	253
LIMITATIONS.....	255
FUTURE RESEARCH DIRECTIONS .....	257
CONCLUSION.....	260
<b>CHAPTER VI: MANUSCRIPT .....</b>	<b>261</b>
ABSTRACT.....	262
INTRODUCTION .....	263
METHODS .....	265
FINDINGS.....	269
DISCUSSION .....	281
STUDY LIMITATIONS .....	285
FUTURE RESEARCH DIRECTIONS .....	286
REFERENCES .....	287
APPENDIX.....	293
<b>REFERENCES.....</b>	<b>297</b>
<b>APPENDICES</b>	
A. DESCRIPTIVE DATA QUESTIONNAIRE (FOR RESEARCH TEAM) ....	363
B. IRB APPROVED LETTER .....	364
C. INFORMED CONSENT FORM .....	365
D. DESCRIPTIVE DATA QUESTIONNAIRE (FOR PARTICIPANT) .....	368
E. INTERVIEW QUESTIONS.....	370
E. FINAL CODEBOOK .....	374
<b>VITA.....</b>	<b>383</b>

## LIST OF TABLES

Table	Page
1. Summary of the History of IPV in the United States.....	32
2. Summary of the History of IPV at the International Level.....	47
3. Participant Demographic Data.....	108
4. Superordinate Themes, Themes, and Subthemes by Research Question .....	124
5. Perceptions of Men and Women in General .....	126
6. Conceptualization of IPV.....	131
7. Training .....	140
8. Institutional Factors .....	147
9. Providers' Personal Factors .....	159
10. Sociocultural Factors .....	168
11. IPV Survivors' Resistance .....	179
12. Professional Responsibilities .....	184
13. Recommendations for Improving IPV Training .....	198

**LIST OF FIGURES**

<b>Figure</b>	<b>Page</b>
1. A Theoretical Model for Understanding Factors Influencing Health Providers’ Knowledge, Attitudes, and Responses to IPV Survivors .....	212

## **CHAPTER I**

### **INTRODUCTION**

This chapter provides a statement of the problem that includes an examination of the prevalence of intimate partner violence (IPV) in the United States, internationally, and Malaysia specifically. This chapter also includes an examination of the underreporting issues regarding IPV in the United States and across cultural groups, as well as a discussion of health providers' responses to IPV. A brief introduction of how IPV manifests in Malaysia is presented. This chapter also further clarifies the terminology of domestic violence and IPV that have been used interchangeably in the literature. Finally, this chapter provides the purpose of intended research project, research questions, and a definition of terms for this study. The delimitations of the study are included at the end of this chapter.

#### **Statement of the Problems**

Intimate partner violence is a pervasive, yet underrecognized human rights violation in all societies around the globe (Browne-Miller, 2012; Heise, Ellsberg, & Gottmoeller, 2002; CARE International Report, 2013). It is estimated that at least 1 of 3 females and 1 of 4 men have experienced some form of IPV during their lifetime (Centers for Disease Control and Prevention [CDC], 2010). Globally, approximately 1.8 million women are victimized each year by their intimate male partners (Fife, Ebersole, Bigatti, Lane, & Brunner Huber, 2008). This social concern affects both men and women, regardless of their social, economic, religious, or cultural groups (Awang & Hariharan, 2011; Howard et al., 2010).

The critical aspects of IPV are not only its causes, but also the consequences

borne by its survivors. Research on addressing risk factors and IPV outcomes has been conducted for many decades. Ambramsky et al. (2011) assessed the factors associated with IPV behavior for 24,097 women from 11 countries and found three protective factors to be: a high socio-economic status (SES), secondary education, and a formal marriage that protected participants against being violent in a relationship. Factors such as age, cohabitation, alcohol abuse, attitudes of supporting wife beating, and previous history of IPV or family violence were found to correlate to IPV. These factors were similar to those found by Hassan and Malik (2011), who identified that low levels of education, unemployment, previous history of IPV or family violence, and the lack of parental support were also risk factors for IPV. Other related risk factors included lower SES (Cunradi, 2009; World Health Organization [WHO], 2013), immigrant status (Caetano, Vaeth, & Ramisetty-Mikler, 2008; Raj & Silverman, 2002), and firearm access (Center for Gun Policy and Research [CGPR], 2011; Catalano, 2013). Devries et al. (2013) found that depression and low self-esteem were co-occurring factors for IPV.

Cunradi, Caetano, and Schafer (2002) investigated 1635 couples and found that SES appears to contribute more to the probability of IPV than education or employment status. Lower SES individuals may have greater exposure to childhood violence, high depression, alcohol-related issues, and involvement in physical abuse (Cunradi et al., 2002). Similarly, unemployment and financial disadvantage create stress and thus, strain intimate relationships (Stark, 2007). However, Walton-Moss, Manganello, Frye, and Campbell (2005) argued that fair or poor mental health, pet abuse, and drug or alcohol use were the main risk factors for IPV. Women who had children by the age of 21 were twice as likely to be victims of IPV and men who became fathers by age 21 were three

times more likely to be abusers (Moffitt & Caspi, 1999). This result was consistent with the study by Rennison and Welchans (2000) that younger women were more likely to be abused compared to older women.

Additionally, culture is known to be associated with IPV. It is a critical component that needs to be explored since the meaning ascribed to different acts may differ depending on cultural differences (Heise et al., 1999). Malaysia, as a patriarchal society with unequal gender relations supported by both deeply social and cultural norms, as well as economic problems, is no exception to these statics (Colombini, Mayhew, Ali, Shuib, & Watts, 2013). Women tend to accept violence as normal. This can be related to several factors: filial piety, collectivism, the concept of face-saving and religious orientation that are still deeply rooted in the cultures of the community (Jamal, 2006). Intangibly, social norms and cultural concepts have restricted IPV survivors from reaching out for help (WHO, 2009) in Malaysia and other countries.

The outcomes of IPV for the survivors mainly occur in the form of mental and physical health issues. Several studies suggested increased physical violence and more severe physical injuries result in severe health and mental health outcomes for IPV survivors (Campbell, 2002; Nathanson, Shorey, Tirone, & Rhatigan, 2012; Whitaker, Haileyesus, Swahn, & Saltzman, 2007). For example, Nathanson et al. (2012) found 101 women had experienced high levels of physical, psychological, and sexual injury in the previous six months. In the same study, 57.4% of women had met the criteria for post-traumatic stress disorder (PTSD), 56.4% for depression, 18.1% for alcohol dependence, 3.2% for alcohol abuse, 6.4% for substance dependence, and 6.4% substance abuse (Nathanson et al., 2012). The findings were consistent with the study by Golding (1999)

that women with frequent IPV experiences reported a 3 to 5 times greater likelihood of depression, suicide, PTSD, and substance abuse. Other mental health outcomes included anxiety (Helfrich, Fijiura, & Rutkowski-Kmitta, 2008), sleep disorders (Lowe, Humprey, & Williams, 2007), and poor self-perceived mental health (Roche, Moracco, Dixon, Stern, & Bowling, 2007). These collective risks experienced by IPV survivors remain under-researched.

Moreover, the WHO (2012) stated that IPV has a profound impact on the health of women by exhausting their energy, as well as eroding their self-esteem. Several studies reported that IPV survivors may sustain physical harm to their body, such as bruises, knife wounds, broken bones, traumatic brain injury, back or pelvic pain, and headaches (Black, 2011; Breiding, Black, & Ryan, 2008). Some of these physical damages can affect the functioning of the gastrointestinal system or the neurological system (Kendall-Tackett, 2009). Intimate partner violence was also related to long-term health problems, such as chronic pain, physical disability, and drug and alcohol use (WHO, 2002). The risks of unintended pregnancy, sexually transmitted diseases, and miscarriages were also associated with IPV (Campbell, 2002; Campbell, Garcia-Moreno, & Sharps, 2004). These impacts were linked with IPV survivors' feelings of inadequacy, such as self-blaming, sexual frigidity, and marital friction that lead to poor self-concept, lack of self-confidence, and feelings of worthlessness (Campbell et al., 2004).

As a result, many women sought medical treatment in hospital emergency rooms, clinics, and social departments for injuries they had received from physical or sexual assaults (CDC, 2013; Colombini et al., 2013). Some of women sought help from other available support centers (CDC, 2013). The CDC (2013) found that 24% to 54% of

women who visit emergency rooms have been abused during their lifetime. Victims utilized the health care system as much as 2.5 times more often than non-abused patients. Health providers have many points of contact with IPV survivors. That could create opportunities for them to help file a police report and offer support to IPV survivors (Robinson & Spilsbury, 2008). Unfortunately, not all providers inquire about IPV when working with the survivors (Boyle & Jones, 2006). Thus, this study will explore factors that influence health providers' knowledge, attitudes, and responses to IPV survivors within a Malaysian cultural context.

### **Prevalence of IPV**

Research indicates that women in the United States are more likely to be victimized compared to men, even though the problem tends to affect both genders (Catalano, 2007; Langhinrichsen-Rohling, 2010; Moore, Frohwirth, & Miller, 2010). The proportion of women experiencing IPV in the United States was around 35.6%, while men were 28.5% (Black et al., 2011). Women between the ages of 20 and 24 were more predisposed to IPV compared to other age groups (Jordan, Campbell, & Follingstad, 2009), while women aged 18 to 19 years were predisposed to stalking, specifically (Catalano, 2012).

Male victims were found to have rarely reported their physical injuries compared to women (Hines & Douglas, 2011). More recently male victimization is secondary to IPV and has become a major concern in the United States (Shuler, 2010). The ratio of IPV victimization between women and men was 3.9:1.3 per every 1,000 victims (Catalano, 2007; Menard, Anderson, & Godbolt, 2008). The IPV policy and available resources have protective limits to male victims (Barber, 2008; Shuler, 2010).

The National Center for Injury Prevention and Control [NCIPC] reported that on the average 24 people per minute were victims of rape, physical violence, or stalking by an intimate partner in the United States (NCIPC, 2012). Women and men were victims of 5.3 million and 3.2 million incidents, respectively, each year (Burke, Mahoney, Gielen, McDonnell, & Campo, 2009). According to the United Nations (UN, 2014), around 7 million women have reported being raped or assaulted by their intimate partners. The worst case reported was violence resulting in murder. The National Intimate Partner and Sexual Violence Survey has estimated that more than 12 million people in the United States experience various forms of IPV including physical abuse, sexual abuse, and stalking in the previous 12 months (Smith, Fowler, & Niolon, 2014).

Among the different ethnicities, Potera (2014) found that Alaska Natives women or other Tribal Native American women were 2.5 times more likely to be raped or become victims of other sexual violence than other ethnicities of women living in the United States. In the most recent national survey, data indicates that 27% of Alaska Natives or American Indians women admitted to having been raped compared to the rates of African Americans (22%), Whites (19%) or Hispanics (15%) (Sapra, Jubinski, Tanaka, & Gershon, 2014). Bonomi, Anderson, Cannon, Slesnick, and Rodriguez (2009) also reported that the prevalence of IPV among Latina women was higher (20.1%) compared to the non-Latina women during the past five years. However, among Asian American groups, Leung and Cheung (2008) found that 22.4% of Vietnamese, 21.8% of Filipinos, 19.5% of Indians, 19.5% of Koreans, 9.7% of Chinese, and 9.7% of Japanese were reported to having been abused by their current or former partners. These numbers did not include immigrant women in the United States. Hass, Dutton, and Orloff (2000)

established that among a sample of 280 immigrant Latinas, 49.8% of them admitted to being abused. There was a higher prevalence noted among immigrant Latinas who were currently married or had previously been married (59.5%). A comparable result was also found by Raj and Silverman (2002) that 40% of South Asian women in Boston have experienced IPV. Erez and Ammar (2003) added that 65% of the 157 immigrant women had experienced some form of abuse after they arrived in the United States. These statistics show that IPV rates are varied contingent on race in American.

On a global scale, 35% of the women have at one point in their lives experienced IPV or non-partner sexual violence (UN Women, 2014; WHO, 2013). The WHO (2013) reported that for over 79 countries and two territories, the highest IPV prevalence occurred in Africa (45.6%), followed by South East Asia (40.2%), Eastern Mediterranean (36.4%), the United States (36.1%), Western Pacific (27.9%), and Europe (27.2%). Moreover, the UN Women (2014) indicated that in Canada, Australia, United States, Israel, and South Africa, IPV accounted for 40% to 70% of the female murder cases.

Findings from the 2010-2011 British Crime Survey estimated that 1.2 million females and 0.8 million males experienced violence by an intimate partner or family member in the past 12 months (Smith, Lader, Hoare, & Lau, 2012). In European countries, IPV seriously undermined females' mental, social, and physical well-being (Gracia, 2014). In most of the studies, the specific IPV lifetime prevalence in Western Europe was around 19.3%. The prevalence was higher in Eastern and Central Europe at 27%. Indeed, this was not so different from the worldwide statistics that showed the prevalence of IPV averaged between 30% and 23% in the high-income nations (WHO, 2013).

In other countries such as Uganda, the 2011 Uganda Demographic and Health Survey findings indicated that 25% of women experienced physical abuse and 21% experienced sexual violence from an intimate partner within 12 months (Kwagala, Wandera, Ndugga, & Kabagenyi, 2013). In the South East Asia, especially Thailand and Vietnam, IPV is a threat to women's well-being (Tyson, Herting, & Randell, 2007). Garcia-Moreno et al. (2006) found that 41% at one urban site and 47% at one rural site reported to have experienced physical and/or sexual partner violence. The Government of Vietnam reported 34% of ever-married women aged 18 to 60 experienced physical or sexual partner violence (Rasanathan & Bhushan, 2011).

In Malaysia, IPV is a silent pandemic that happens in families. Since 1996, the implementation of the Domestic Violence Act in Malaysia has not been seen to lower the number of IPV effectively; instead IPV has risen from year to year. Studies on IPV were also relatively limited with only a small amount of research being done in Malaysia. The first study of violence against women was conducted by Rashidah, Rita, and Schmitt (1995) with the collaboration from the Women's Aids Organization (WAO) of Malaysia. This study indicated that for 1221 respondents, there was 36% physical IPV in both married and unmarried couples, and 15% of the women respondents claimed that they deserved the abuse if they failed to serve their husbands' needs. The WHO study also reported that the respondents' husbands were allowed to use some form of violence on their wives if infidelity was involved (72%), being disobedient to the husband (58%), refusal to have sex (4%), and other reasons, such as arguing and nagging (1%). Following by the first study, Shuib et al. (2013) reported that for 3427 respondents in Malaysia, an estimated 8% of women have been abused intimate partners. This result indicated that

fewer women reported IPV experiences when compared to the first study due to the different research designs being used for both studies.

According to Subramaniam and Abdullah (2003), the state of Selangor recorded the highest rate of IPV every year at 30%. This rate is followed by the federal territory of Kuala Lumpur (20%), and Penang (13%). The majority of IPV survivors are Malays (43.8%), Indians (28.3%), and Chinese (20.7%). The latest statistics distributed by the Royal Malaysian Police (2013) show that there were 3,488 cases of IPV reported in 2012. However, this number only represents a small portion of IPV. The unreported rate of IPV is high due to the privacy of the family and the intimacy of the marital relationships (Colombini, Ali, Watts, & Mayhew, 2011; Lees, Phiminister, Broughan, Dignon, & Brown, 2013).

The prevalence of IPV transcends boundaries of race, ethnicity, or nationality, and also involves specific cultural group memberships. Many studies noted that a larger proportion of individuals who identified themselves as lesbians, gays, bisexuals, transgenders, and queers (LGBTQ) couples had been widely affected (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2014; National Coalition of Anti-Violence Programs [NCAVP], 2014). The National Violence Against Women [NVAW] survey found that 21.5% of men and 35.4% of women with a history of cohabitation with same-sex partners have experienced physical abuse in their lifetimes (Tjaden & Thoennes, 2000). Murray and Mobley (2009) reported that 25% and 50% of IPV occurred in gay and lesbian relationships. A study authored by Bimbi, Palmadessa, and Parsons (2008) found that 38% of gay, lesbian, or bisexual samples reported IPV, with 22% reporting physical abuse and 34% reporting nonphysical abuse. Other groups, particularly

transgendered individuals, have suffered from an even larger amount of IPV (Golberg, Matte, MacMillan, & Hudspith, 2003). In a survey conducted of 1,600 people in Massachusetts by Landers and Gilsanz's (2011) found that 34.6% of transgendered respondents and 14% of gay or lesbian respondents reported lifetime physical abuse. This population was less likely to seek help when they experienced IPV (Ard & Makadon, 2011). Intimate partner violence also occurred among HIV-affected couples who were in the same-sex relationships or heterosexual relationships. The CDC (2014) found LGBTQ couples were accounted for 54% of all people living with HIV infection in the United States and globally HIV transmission were more common among women with high risk heterosexual contact (CDC, 2013).

Intimate partner violence can also traced its roots to adolescents' dating relationships (Craigien, Sikes, Healey, & Hays, 2009; Exner-Cortens, Eckenrode, & Rothman, 2013; Hays et al., 2011). Mulford and Giordano (2008) learned that 1 in 10 teens experienced dating violence, and most of the cases were unreported. In the European nations, 1 out of 3 adolescents around 15 years-old reported dating violence (European Union Agency for Fundamental Rights [EUAFR], 2014). Several cross-sectional studies indicated that between 9% and 38% of adolescents were victimized in the past year in their dating relationships (Ackard, Eisenberg, & Neumark-Sztainer, 2007; Temple & Freeman, 2011). Young adolescents between the ages of 10 to 19, who experienced mild forms of dating violence were 2.4 times more likely than their non-victimized peers to become victims of serious physical dating violence, and 1.3 times more likely to become victims of sexual dating violence (Foshee, Benefield, Ennett, Bauman, & Suchindran, 2005). Specifically, in the national representative samples, 20%

of adolescents reported some kind of psychological violence victimization, and 0.8% to 12% reported physical violence victimization (CDC, 2012). Consequently, such violence leads to depression, suicide, poor educational outcomes, or early pregnancies, among other effects (Banyard & Cross, 2008).

Unfortunately, the trend of IPV reporting may become an issue even though the statistics and the related consequences of IPV are alarming (McLeod, Muldoon, & Hays, 2014). According to the U. S. Department of Justice (2005), IPV was one of the most chronically under-reported crimes and it is estimated that 2 in 5 incidents from 1998 to 2002 were not reported to the police. These under-reported cases were related to different definitions and degrees of tolerance towards IPV across cultural groups, as well as various cultural factors that influence IPV survivors' help-seeking behaviors. Moreover, other reasons, such as data often collected in the emergency room and other data sources were excluded from various related settings. The lack of resources for lower SES from the communities of colors was some of the reasons that prevented reporting and help-seeking behaviors (Hays & Emeliachik, 2009). Among South Asian women, the unreported cases were related to the financial dependence on a spouse (Merali, 2009), the lack of knowledge of rights, lack of supportive social networks, and lack of knowledge about community resources (Dasgupta, 2000). Additionally, fear of retaliation from the perpetrator, shame, perceived stigma of being an IPV victim, making what the victim assumed to be a private matter, and the belief that no help would come out of reporting were frequently related to the reasons for not reporting across cultural groups (Bachman, 1998).

Thus, IPV was not only a serious human rights violation, but also a growing public health issue for many decades (Garcia-Moreno et al., 2006). This phenomenon gathered global attention due to the consequences of IPV being clearly noted from the survivors' physical, mental health, psychological, and interpersonal outcomes. In order to gain a better understanding of IPV, learning the different terminologies used in the literature and differentiating the meaning of each term was necessary for researchers to provide a clear justification of using the term IPV throughout this study.

### **Health Providers' Responses to IPV**

It is critical for health providers to assist the survivors in safety planning and provide preventive health care, follow-up consultations, and information sharing about legal options and supportive community resources (Hart & Klein, 2013). A health provider is likely to be the first professional contact for IPV survivors as IPV survivors seek health providers more often than non-abused women (WHO, 2013). According to Kramer, Lorenzon, and Mueller (2004), 1 in 3 women who went to emergency rooms, experienced physical or sexual abuse at some point in their lifetime, and 1 in 7 women in emergency rooms reported physical violence in the past year.

Studies indicated that a high percentage of U.S. adult women (Littleton, Berenson, & Breitkopf, 2007) and adolescent females (Zeitler et al., 2006) stated they did want to be asked about their present or past experiences of IPV by their health providers. They stressed that therapeutic factors, such as trust, caring, and sensitivity of the health provider could be helpful. In 2010, the Joint Commission (TJC) mandated an initial and annual training of health providers regarding guidelines for identification and response to IPV. This was also endorsed by the Institute of Medicine (TJC, 2010). However, Rhodes

et al. (2011) indicated that nearly 80% out of 993 female victims visiting emergency rooms, 72% were never identified as victims of IPV, even though these women visited the emergency rooms seven times on the average over the study period. Many health providers still followed the traditional role of treating and solving IPV as a “medical problem.” They treated the injuries without addressing the underlying root of the problem (Colombini et al., 2013; WHO, 2012). This approach might have discouraged IPV survivors from seeking help when they encountered providers who appear “uninterested, uncaring, or uncomfortable” about IPV (Gerbert et al., 1996, p.15).

Additionally, some health care providers admitted that they did not screen for IPV because they lacked the necessary training, time, tools, and resources. Health care providers did not feel they could make a difference (Borowsky & Ireland, 2002; Tjaden & Thoennes, 2002). Kass-Bartelmess (2004) suggested that it was necessary for health care providers to be able to identify the signs and symptoms of IPV, document the evidence, provide treatment for survivors, and refer them to counseling and social agencies that could provide assistance. However, the United States Preventive Services Task Force (2004) argued that numerous screening methods and multiple training sessions and interventions had been developed for IPV, but with no standard definition or evidence to support them.

There were some broad gaps in the literature concerning health providers’ competency with respect to their knowledge, attitudes, and responses when identifying IPV survivors. Thus, it is important for this study to further explore these three core elements of health providers in order to provide a comprehensive training for improving providers’ skills and overcoming unhelpful factors by encouraging the facilitating factors.

## **Malaysia and IPV**

Malaysia, originally called Malaya, was founded in the fourteenth century by a prince, Parameswara, of the former Srivijayan Empire. Malacca was the first independent state in the peninsular area of Malaya. Due to the strategic location of Malacca, it became a commercial center for trade with primarily Arabian countries, China, and India. These commercial exchanges resulted in mixed-marriages between local people and the outsiders, as well as led to the immersion of these outside cultures. The prosperity of Malaya attracted other countries such as Britain, Portugal, and the Netherlands to show their interest in Malacca during the sixteenth to eighteenth century. Islam became an official religion after Malaya became independent in 1957.

Malaya became one of the British colonies in the eighteenth century. Under British rule, many immigrants from China and India were employed to serve as laborers. During the Second World War the Japanese army occupied Malaya, North Borneo, Sarawak, and Singapore for three years. The presence of the Japanese army created ethnic tensions. The Malayan Union was established in 1946 between British and Malay Peninsula, not including Singapore. It was replaced by the Federation of Malaya two years later and Malaya achieved its independence from Great Britain in 1957. A new constitution was instituted in 1963 and the name Malaya was changed to Malaysia.

From the time Malaya was founded throughout the time it gained its independence, Malaysia experienced economic, religious, cultural, and political transformation. First, the economics of the country evolved from the agricultural era to the industrialized era. Today, Malaysia has implemented a constitutional monarchy with a parliamentary democracy system. The Yang di-Pertuan Agong (king) is the head of the

country. The patriarchal system demonstrated that only males would be selected for governing positions, including the Prime Minister and Malaysian state leaders. The Prime Minister is the leader of the government. The 222 members (state leaders) of the House of Representatives are elected every five years. However, only 10% of the seats were held by women, suggesting that the involvement of women in governance was minimal.

Gender inequality is a critical issue in Malaysia due to the patriarchal structure in the family system, workforce, and political structures. According to Noor and Mahudin (2014), the Malaysian cultural perception is that men should be the head of the family and women seen as the caregivers. This traditional gender role is still practiced by Malaysians up to the present day. In the Global Gender Gap Report in 2011, Malaysia was ranked 97 out of 134 countries with a score of 0.65. This gender gap index indicated the distinctions between female to male ratios in many aspects, such as economic participation and opportunity, political empowerment, basic rights and social institutions were drawn (Hausmann, Tyson, & Zahidi, 2011).

Malaysia is located in the Southeast Asia, which comprises 13 states including three federal territories. It is divided into two distinct parts known as Peninsular Malaysia (West Malaysia) and Island of Borneo (East Malaysia). They are separated by the South China Sea. Peninsular Malaysia consists of the states of Kedah, Pulau Pinang, Perlis, Terengganu, Kelantan, Perak, Negeri Sembilan, Johor, Pahang, Selangor, Melaka, and the federal territories of Kuala Lumpur and Putrajaya. The Island of Borneo includes the states of Sabah, Sarawak, and the federal territory of Labuan. Currently, the population of Malaysia is 30,267,367 with 50.1% Malays, 22.6% Chinese, 11.8% indigenous, 6.7% Indians, 0.7% others, and 8.2% non-citizen. The religious demographics in Malaysia

include Muslim (61.3%), Buddhist (19.8%), Christian (9.2%), Hindu (6.3%), and other religions (3.5%). Bahasa Malaysia is the national language in Malaysia, however, other languages are also spoken which include English, Chinese (Cantonese, Mandarin, Hokkien, Hakka, Hainan, Foochow), Tamil (Telugu, Malayalam, Panjabi), as well as the indigenous dialects of Iban and Kadazan.

### **Terminology of Domestic Violence and IPV**

Historically, there have been various terminologies in the legal system used to describe violence against women, some of which were also used by researchers, scholars, or women advocates (Allen, 2013; Bloom, 2009). For example, studies in the United States illustrated varying definitions of domestic violence and IPV, nationally and internationally (Breiding, Ziembroski, & Black, 2009; Gover, Paul, & Dodge, 2011; Hines & Douglas, 2011). Currently, there is no universally agreed upon definition on domestic violence and IPV (Hamberger, 2005). The term *domestic violence* has been used interchangeably with family violence, wife abuse, battered women, spouse abuse, marital assault, IPV, and violence against women (Bloom, 2009).

In 1979, Walker introduced the cycle of violence by using the term *battered women* to explain her model (Walker, 2009). The term battered women was derived from the criminal violation known as “battery.” Battery is defined as an individual’s intention to physically, sexually, or emotionally control another person (Bloom, 2009). This term has been widely used in the United States and Europe to describe women who experience a pattern of systematic domination and physical assault by their male partners (Walker, 2009). However, the term failed to identify the various ways in which diverse genders of

intimate partners could be manipulated and abused. As a result the term was replaced by the more generic term that included family violence, domestic violence, and IPV.

Family sociologists studied violence in families and between intimate partners. They used the term *family violence* to refer to violence that takes place between immediate family members: husbands, wives, children, and parents (Barnett, Miller-Perrin, & Perrin, 2010). Levesque (2001) identified family violence as family members' acts of omission or commission resulting in physical abuse, sexual abuse, emotional abuse, neglect, or other forms of maltreatment that hampers individuals' healthy development (p. 13). Burnette and Adeler (2006) extended the definition by including family members who were living or have lived in the same household and who have a close connection with the perpetrator. Although family violence was a broad term that included all types of violence that occur in family, it did not include interpersonal violence outside the bounds of the traditional family. Thus, cases that involved victims within the intimate relationship between cohabiting, ex-spouses, and dating violence were not entitled to get any legal protection.

According to Ellsberg and Heise (2005), the United Nations considered gender-based violence as a broad term to be used internationally. The term took into consideration women's subordinate status across cultural groups. This new term was first presented in 1993 when the General Assembly passed the Declaration on the Elimination of Violence Against Women (DEVAW). This definition included any harmful behaviors that were directed at women and girls because of their gender, including wife abuse, sexual assault, dowry-related murder, marital rape, selective malnourishment of female

children, forced prostitution, female genital mutilation, and sexual abuse of female children (UN, 1993).

In the United States and many parts of the world, people have generally viewed the term *domestic violence* as the subset of family violence between intimates (Family Violence Prevention Fund [FVPPF], 2004). The term domestic violence was adopted by women advocates describing the risk of women within their own family and household (Kelly & Johnson, 2008). According to the CDC (2013), domestic violence is a pattern of coercive behaviors, used by a perpetrator to gain or maintain power and control over another person with whom the perpetrator is in an intimate, dating, or family relationship. However, the WHO (2005) also identified domestic violence as violence against women. This included physical and sexual violence, emotional abuse, and controlling behaviors by current partners or ex-partners.

In the United Kingdom, the term domestic violence or domestic abuse was the most commonly used term that described all forms of abuse in the family (Lees, Phimister, Broughan, Dignon, & Brown, 2013). This description was changed to a new definition that was announced by the UK Deputy Prime Minister, Nick Clegg, which was:

Any incident or pattern of incidents of controlling, coercive or threatening behavior, violence, or abuse among those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional. (Birmingham Violence Against Women Board, 2012, p.17)

On the other hand, the term *violence against women* has been used over the centuries and across cultures when describing the condoned, denied, stigmatized, and criminalizing behaviors against women (Allen, 2013). Due to the notions that the term domestic violence emphasized actions of violence among family members, including adult and adolescent partners, a parent and a child, between caretakers or partners against elders, and between siblings, the term IPV appeared to replace domestic violence for the sake of definition clarity (O' Brien, 2009). However, Furlow (2010) argued that domestic violence included child abuse, elder abuse, and IPV, which were tailored to the original definition of family violence. In 2009, the American Psychological Association (APA) supported the use of the term domestic violence to describe survivors or women who experienced IPV in the past to avoid the likelihood of offending readers or using language that may be read as biased. Thus, the violence that occurred between same-sex, mixed-sex partners, or ex-partners, whether they were cohabiting or not, was categorized as IPV (Kernback-Wighton, 2014).

However, many scholars and community activists preferred the term IPV as any form of abuse among individuals who was currently or had previously been abused in intimate relationships (Belknap, 2007). The U.S. Bureau of Justice and the CDC used the term IPV to refer to violence between spouses, ex-spouses, or separated spouses; between cohabiters, or ex-cohabiters; between boyfriends, or ex-boyfriends and girlfriends; and between same-sex partners or ex-partners (Barnett & Miller-Perrin, & Dale-Perrin, 2010).

The WHO (2005) first recognized intimate partner violence as the most common form of violence in women's lives. They defined IPV as any behaviors adopted by an intimate partner or ex-partner that caused physical, sexual, or psychological harm,

including physical aggression, sexual coercion, psychological abuse, and controlling behaviors. This definition was associated with the power. Intentionality this covers a broad range of outcomes, including psychological harm, deprivation, and maldevelopment (WHO, 2013). This term and definition of IPV has been widely used in many other countries that are the members of the WHO, including Malaysia, Thailand, Nepal, Philippines, and India.

*Intimate partner violence* is a popular term used to refer to a pattern of abusive behavior, hindering women from exercising freedom of choice. It is also known as wife beating, battering, or domestic violence (Chuemchitt & Perngpam, 2014; Colombini et al., 2011; Yoshikawa, Shakya, Poudel, & Jimba, 2014). Specifically, in Malaysia, the term IPV has been used interchangeably with domestic violence to accommodate the cases that may involve children, siblings, or elders (Saddki, Suhaimi, & Daud, 2010). Thus, the definition includes any actions that cause the victim to have a fear of physical injury, causing physical injury, forces, or threat to engage in any conduct, sexual, or otherwise, detaining against the victim's will, and causing destruction to property (Domestic Violence Collection of Laws, 2003).

Concisely, family violence is an umbrella term that has been adopted for use to characterize a wide variety of violence and IPV is one type of them (CDC, 2013). For the purposes of this study, the term IPV refers to the full range of violence that is related to a pattern of assaultive and/or coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion that occurs between same-sex or heterosexual partners, or ex-partners, which can include cohabitation or not (Kembach-Wighton, 2014).

### **Purpose of the Study**

Given the prevalence of IPV that involved women and men in the United States, Malaysia, and internationally, and the inadequacy of health providers' responses to IPV described in the current literature, this study aims to examine factors that influence how health providers work with IPV survivors in Malaysia and specifically their views on IPV, the IPV experiences of women, and factors that influenced IPV survivors' help-seeking behaviors. Additionally, to understand the factors that influence health providers' services, this study will also examine Malaysian health providers' recommendations to improve training to work with IPV survivors. Understanding the factors and the needs of health providers in working with IPV survivors may provide a better grasp of the barriers and facilitating factors, as well as the components that need to be included in the training program within Malaysian health providers' context.

Current literature focuses primarily on the barriers of health providers in providing services to IPV survivors, such as the discomfort in asking IPV-related questions due to running the risk of offending patients and a failure to identify IPV survivors' history of abuse or even worse, blaming the victims (Colombini et al., 2013; Humphreys & Thiara, 2003). However, there was a paucity of research that explored more deeply the factors that could be barriers and facilitators when working with IPV survivors. Moreover, several U.S states have enacted mandatory reporting laws, which required the reporting of specific injuries and wounds, and suspected abuse by health providers (FVPPF, 2010). Thus, the role of the health provider as a mandated reporter and primary resource for IPV survivors became extremely important. The attention turned to how health providers could best assist IPV survivors who come to seek help and provide

quality services to them by offering routine assessment, documentation, intervention, and referral. By understanding factors that influenced health providers' knowledge, attitudes, and responses to IPV, this study can offer an insight to better assist health providers when working with the survivors.

Furthermore, IPV is a sensitive topic in Malaysia due to cultural factors and values that are deeply rooted in Malaysians' daily lives (Talib, 2010). Both health providers and survivors were exposed to the Malaysian cultures, and may have intangibly affected their attitudes and responses to IPV. Furthermore, while many scholars included cultural factors in studying IPV survivors (Campbell, 2002; Gullum, 2009; Montalvo-Liendo, 2009; Rodriguez, Valentine, Son, & Muhammad, 2009), there is limited research that includes cultural factors in investigating health providers' knowledge, attitudes, and responses to IPV. This is a critical gap in the research on IPV as health providers were the primary resource for women when seeking help (WHO, 2013). Thus, there is a need for research that is exploratory in nature to investigate this topic. Such knowledge might generate ideas about unique skills and training necessary for health providers working with IPV survivors.

### **Research Questions**

The central question for this grounded theory study was: What factors influence Malaysian health providers' attitudes, knowledge, and responses to IPV survivors? The sub-questions for this study were:

1. How do health providers conceptualize IPV for Malaysians?
2. What factors influence the ways health providers work with IPV survivors?

3. What factors do health providers perceive toward influencing Malaysian IPV survivors' help-seeking behaviors?
4. What recommendations do health providers have to improve training for working with IPV survivors in Malaysia?

### **Definitions of Key Terms**

For the purposes of the study, the following terms were defined to illuminate the understanding of the topic under study:

*Health providers* refers to individuals who were categorized within the five groups that were listed in the International Classification of Health Workers (2008): (a) health professionals, (b) health associate professionals, (c) personal care workers in health services, (d) health management and support personnel, and (e) other health service providers not elsewhere classified. They often work in hospitals, health care centers, and other service delivery points that directly or indirectly work with patients. Each field of expertise was classified according to skill level and specialization, and usually required extensive knowledge including higher qualification.

*Intimate partner violence* is defined as a form of violence that involved dominating and controlling behaviors through physical, sexual or psychological means, threats, financial deprivation, stalking, or results in physical, sexual and/or psychological damages that could place women in fear (CDC, 2013; Colombini et al., 2011).

*Intimate partner* can be a spouse, ex-spouse, current or former boyfriend or girlfriend, or dating partner (Saltzman, Fanslow, McMahon, & Shelley, 2002), as well as involving the same sex partner (NCAVP, 2012), irrespective of gender, history of sexual involvement, or cohabitation status (CDC, 2006).

*Perpetrator* is a term that was often used to describe a man or a woman who perpetuated violence against his or her current or former boyfriend, girlfriend, spouse, or ex-a spouse. The CDC (2010) defined a perpetrator as a person who inflicted the violence or abuse or causes the violence or abuse to be inflicted on the victim.

*Survivors* refer to individuals who were being targeted for abuse and have experienced intimate partner violence (CDC, 2010).

*Physical violence* refers to “the intentional use of physical force with the potential of causing death, disability, injury or harm (CDC, 2010). Physical violence included, but was not limited to scratching, shoving, pushing, grabbing, biting, choking, shaking, slapping, punching, burning, use of a weapon, and use of restraints or one’s body, size, or strength against another person (Saltzman et al., 2002, p. 11-12). This type of violence included coercing other people to commit any violent acts.

*Sexual violence* refers to the use of physical force to compel a person to engage in a sexual act; an attempted or completed sex act involving a person who was unable to understand the nature of the condition of the act, or abusive sexual contact (CDC, 2010).

*Psychological/emotional violence* involves the use of verbal and nonverbal acts which symbolically hurts the other or the use of threats to hurt the other (Straus, 1979, p.77). This type of violence includes yelling, insulting, belittling or ridiculing the partner, name calling, humiliating or demeaning things, acting jealous and suspicious of the partners, friends, and social contacts (Jones, Davidson, Bogat, Levendosky, & Von, 2005).

*Stalking* refers to a repeated harassing or threatening behavior, such as following a person, appearing at a person’s home or place of business, making harassing phone

calls, leaving written messages or objects, or vandalizing a person's property (Tjaden & Thoennes, 2000).

*Malaysia's cultural values and tradition* refers to the country itself with a multi-ethnic, multi-religious, and multi-languages that encompassed a majority of Malays (62.3%), Chinese (22%), Indians (6.7%), and other ethnicities (9%). Cultural values and traditions have been deeply rooted in the cultures of the community and they play an important role in the lives of Malaysians. The cultural values and traditions include respecting elders, having a sense of collectivism, succumbing to patriarchal norms and the role of male privilege, and preserving of family honors in order to prevent the idea of 'losing face.'

### **Study Delimitations**

The study did not include a substantial number of health providers from emergency rooms in general hospitals, social welfare departments, and non-governmental organizations (NGOs). The study was focused on health providers who formerly worked or currently working in more developed health systems and did not include providers from less organized systems and rural areas. Moreover, only health providers who had current or former direct experiences working with IPV survivors were recruited. IPV survivors sought health services as often as others but they were less likely to receive adequate services than they deserved (Plichta, 2007). Thus, this study focused on exploring health providers' knowledge, attitudes, and responses to IPV, and looking into factors that might influence health providers' services, particularly from the Malaysian cultural context.

Additionally, this study only focused on five states of Malaysia for two primary reasons. First, the states of Selangor, Penang, and the territory of Kuala Lumpur are located in the West of Malaysia, and have had a high prevalence of IPV for many years (Subramanian & Abdullah, 2003). Second, there were no studies that reported about the IPV in the East of Malaysia of Sabah and Sarawak. Through this study, the under-represented groups of health providers' voices were in order to construct a comprehensive training for health providers in the future.

This study did not provide any training to health providers. Instead it focuses on health providers' experiences when working with IPV survivors, the factors that influenced the way they provided services, and their recommendations to improve training to work with IPV survivors. Health providers may benefit from the results of this study as they seek to understand both the inhibiting factors and facilitating factors through recounting their own experiences working with the survivors. However, the study did not include the survivors' experiences of seeking help from health providers due to the nature of the topic, which indicated that issues of safety, confidentiality, and training were more important in research (WHO, 1999). The time frame of the study limited the researcher's ability to provide counseling services or training to IPV survivors during the study. Thus, the perspectives of the survivors were excluded from the study.

## **CHAPTER II**

### **LITERATURE REVIEW**

This chapter begins with a historical overview of IPV in the United States and internationally. A detailed description of the types of IPV is based on three primary types of IPV: physical violence, sexual violence, and emotional abuse. The chapter also presents information about IPV related theories and cycle of violence IPV that impacted intimate partner relationships. In order to understand the root problems of IPV, an outline of correlates of IPV is discussed. This chapter then focuses on health providers and IPV, particularly in Malaysia context. Finally, this chapter concludes with a summary of previous research regarding IPV.

#### **Historical Overview of IPV**

Intimate partner violence (or domestic violence) is an endemic, universal, and multifaceted nature of gender related violence that has had a significant historical context internationally (Aghtaie & Gangoli, 2014). It has been a problem in American society for many decades (Shuler, 2010). The early history of violence against women dated back to the nomadic period of the ancient Hebrews, the early Greeks, and Romans that allowed “wife beating” as one of the valid exercises or practices of the husband’s necessary to have authority over the wife (Schelong, 1994). Early European settlers in Colonial America developed judicial systems based on Judeo-Christian values and English Common Law (Daniels, 1997) that tolerated abusive husbands. The popular ruling known as the “rule of thumb” was a legal principle allowing a husband to beat his wife with a stick no thicker than his thumb (Rhode, 1989; Davidson, 1978). Early marriage licenses became “hitting licenses” as men had the legal right to beat their wives (Straus, 1983).

For example, in 1824 the Supreme Court of Mississippi affirmed the English Common Law by accepting that a husband had the right to chastise his wife (Erez, 2002). The court supported that family arguments or conflict between a husband and a wife should remain private and were not proper matters for which the court to intervene. Similarly, a New Hampshire court held that a wife who failed to submit to the legitimate authority of her husband could not obtain a divorce (*Poor v. Poor*, 8 N. H. 307, 316) in 1836 (Schelong, 1994). Many scholars believed the historical inequality of women and gender socialization of females and males have greatly contributed to the root causes of domestic violence or IPV (Pence & Paymar, 1993; Schechter, 1982).

A husband's right to beat his wife had judicial approval until the late 1800s. The terms assault, battery, and neglect of a spouse were not common in the United States until the states of Alabama and Massachusetts became the first to rescind the legal right of men to beat their wives (*Fulgrahm v. State*) in 1875 (Barner & Carney, 2011). This phenomenon still remains quite common. Intimate partner violence was not treated as a crime until 1882 when the state of Maryland passed a law to make IPV punishable by 40 lashes or a year in jail (Schornstein, 1997). Furthermore, political agitation and protests in the 19<sup>th</sup> century brought about changes in legislation and popular opinion regarding IPV in the United States, as well as other countries such as the United Kingdom.

Starting in 1960, various feminists documented the pervasive nature of IPV across social classes, including cases of husbands who abused their spouses. In this way, they were able to substantiate their argument that wife-beating served as a tool for helping men to dominate women (Hunnicut, 2009). In this fashion, grassroots feminists brought the problem of violence against women to the attention of the public that triggered a

flood of media attention for IPV (Dobash & Dobash, 1992). These efforts also gained momentum when the first shelter to serve victims of IPV was established in the United States in 1967. Other shelters were developed, such as Women's Advocates in Minnesota and Haven House in California. The shelters offered IPV survivors refuge and support before reporting the incidents of abuse to police officers. In addition, the shelters offered advocacy in court for IPV survivors. Thus, the feminist movement reformed the way in which IPV in general was recognized and understood in society (Welsh, 2008).

The emergence of the women's shelter movement and the advocacy organizations such as the National Coalition Against Domestic Violence (NCADV), the National Organization for Victim Assistance (NOVA), and the National Council on Child Abuse and Family Violence (NCCAFV) called for legal and practical solutions to IPV survivors (Barnett et al., 2010). The transformation of IPV from a private issue to a public concern warranted legal attention. Additionally, IPV among immigrants was addressed when an abused woman, Amita Vadlamudi, killed her abusive husband in New Jersey in 1981 (Abraham, 2000). As a result, shelters for immigrants were established and the Family Violence Prevention and Services Act (FVPSA) were first authorized in the United States. The FVPSA served as part of the Child Abuse Amendments of 1984 (PL 98-457) that provided funding to help victims and their dependent children of domestic violence (Fernandes-Alcantara, 2014). In 2010, the FVPSA was revised to include critical improvements of the needs of underserved populations, and provided needed funding for this cost effective and life-saving program.

Furthermore, the Violence Against Women Act (VAWA) was passed in 1994 to provide funding for battered women's shelters and outreach education, as well as training

for police and court personnel. Its reauthorization in 2000 and again in 2005 has included additional related crimes of dating violence and stalking, as well as to further protect immigrants and provide legal assistance program for victims in the United States (Conyers, 2007). The latest revision of VAWA in 2013 reauthorized and improved upon “lifesaving services for all victims of domestic violence, sexual assault, dating violence, and stalking, including Native women, immigrants, LGBT victims, college students and youth, and public housing residents” (National Network To End Domestic Violence [NNEDV], 2013, p. 1). It also authorized funding for VAWA’s programs and protections for victims. Several protections for immigrant survivors that are clearly stated in VAWA 2013 include strengthening the International Marriage Broker Regulation Act and the provisions around self-petition and US visas (NNEDV, 2013). The implementation of VAWA reduced the number of IPV or domestic violence in the United States (NNEDV, 2013). The 1994 VAWA Act was incorporated with the Gun Control Act of 1994, which was amended in 1996 to include illegality for individuals who were convicted of a misdemeanor domestic assault to possess a firearm. The introduction of FVPSA and VAWA were the milestones in eliminating violence against women in the United States.

While violence against women became a common social problem in the United States, the number of male victims also increased, which consisted of 1.3 men per 1,000 are victims of IPV each year (Menard et al., 2008). Because America’s social norms around gender were rooted in the idea that men are the stronger and more dominating gender in the society, male victims chose not show the public that they were victims of IPV (Shuler, 2010). However, with the rise of the men’s movement of the 1990s, the

problem of violence against men gained significant attention from scholars and jurisdictions (Hines, Brown, & Dunning, 2007; Menard et al., 2008).

On the other hand, little attention was directed towards the needs of LGBT groups. The Minnesota Coalition for Battered Women reported that same sex relationships were not routinely afforded the same protections as those heterosexual victims of IPV (National Resource Center on Domestic Violence [NRCDV], 2007). Specifically, the early VAWA Act did not include same sex couples in its definition of IPV. However, the reauthorization of VAWA 2013 prohibited discrimination to ensure LGBT victims had access to the same services and protection to overcome trauma and find safety (NNEDV, 2013).

Women's crisis centers and battered women's shelters have been the cornerstone of programs for victims of IPV. Health providers and health care settings were closely engaged in the helping process by providing medical and counseling services to victims. However, health providers encountered issues in that insurers did not have to pay for preventive care, including domestic violence screening. The Affordable Care Act (ACA) signed by President Obama in 2010 made this possible. Consistent with other efforts originating in the 20<sup>th</sup> century, the violence against women became a fundamental national and international human rights issue.

Efforts to combat IPV were a continuous process throughout the historical development in the history of IPV. The system response to IPV significantly changed to include criminal justice response, women's shelters and other services, and political and social advocacy. However, efforts to train health providers were still in the formative stage (Bloom, 2009). Thus, it became crucial to ensure the comprehensiveness of health

care systems, as well as the preparedness of health providers to work with IPV survivors in the United States and internationally.

Table 1

*Summary of the History of IPV in the United States*

Period	Events
Before 753 B.C.	During the nomadic period of the ancient Hebrews, the early Greek, and Romans, 'wife beating' is allowed as one of the valid exercises or practices of the husband's necessary authority over the wife (Daniel, 1997).
1400s	Early European settlers in Colonial America developed judicial systems based on Judeo-Christian values and English Common Law that tolerated abusive husbands (Daniel, 1997).
1500s	The "rule of thumb" was used as a legal principle that allowing a husband to beat his wife with a stick no thicker than his thumbs (Rhode, 1989). Early marriage licenses became 'hitting licenses' as men had the legal right to beat their wives (Straus, 1983).
1824	The Supreme Court of Mississippi affirmed the English Common Law by accepting that a husband had the right to chastise his wife (Erez, 2002).
1836	A New Hampshire court held that a wife who failed to submit to the legitimate authority of her husband could not obtain a divorce (Poor v. Poor, 8 N. H. 307, 316).
1875	The states of Alabama and Massachusetts became the first to rescind the legal right of men to beat their wives (Fulgrahm v. State) (Barner & Carney, 2011).
1882	IPV was not treated as a crime until 1882 when the state of Maryland passed a law to make it punishable by 40 lashes or a year in jail (Schornstein, 1997).
1900s	The involvement of political agitation and protest in changing legislation of IPV.
1960	Various feminists documented the pervasiveness of IPV across social classes, and in this fashion, grassroots feminists brought the IPV issues to the public attention.
1967	The first shelter to serve victims of IPV was established in the United States in 1967 (Lernon, 2009): Women's Advocates in Minnesota, and Haven House in California.
1970	The emergence of the women's shelter movement and the advocacy organizations

(continued)

Table 1: *Summary of the History of IPV in the United States (continued)*

Period	Events
1981	Shelters for immigrants were first developed and the Family Violence Prevention and Services Act (FVPSA) was first authorized in the United States after an abused woman, Amita Vadlamudi killed her abusive husband in New Jersey.
1984	The FVPSA served as part of the Child Abuse Amendments of 1984 (PL 98-457). Then, the FVPSA was revised in 2010.
1990	The rise of the men's movement to make others aware of the problem of violence against men.
1994	The Violence Against Women Act (VAWA) was passed to improve the criminal justice system by strengthening federal penalties for IPV offenders, provide funding for battered women's shelters, outreach education, training for police, and court personnel.
1996	The VAWA was incorporated with the Gun Control Act of 1994. Individuals who have been convicted of a misdemeanor domestic assault were illegal possessing a firearm.
2000	Reauthorization of the VAWA by creating a victim legal assistance program and expanding the definition of crime to include dating violence and stalking.
2005	Reauthorization of the VAWA by creating new programs to meet the emerging needs of communities working to end violence.
2013	The latest revision of VAWA to improve upon "lifesaving services for all victims of domestic violence, sexual assault, dating violence, and stalking, including Native Women, immigrants, LGBT victims, college students and youth, and public housing" (National Network to End Domestic Violence [NNEDV], p. 1).
2014	The Affordable Care Act (ACA) signed by President Obama in 2010 and its full implementation in 2014 to overcome the issues encountered by health providers for insurers who did not have to pay for preventive care, including domestic violence screening.

## **International Historical Perspectives of IPV**

Since the United States initiated the efforts to eliminate IPV at the public level, the actions also called for more international attention to be given to IPV that occurred in other countries, such as Europe, Africa, and Asia. An increasing number of newspapers and electronic media published the issue of IPV trying to enhance public awareness toward IPV. Because IPV was a hidden issue deeply embedded in the human life history, it became a part of the human experience. Thus, the historical development of IPV played a pivotal role in shaping IPV trends internationally – a concept demonstrated when IPV was accepted as a norm in many communities in Africa (Chakwana, 2004) and Asia (Yoshihama, Bybee, Dabby, & Blazeovski, 2010).

The early English Common Law that supported the husbands' rights to discipline their wives impacted the legal system, as well as cultural practices in Europe, Africa, and Asia. Woodman (1996) called this phenomenon as 'legal pluralism,' which includes multiple sets of norms and legal practices, such as customary law, indigenous law, religious law, or law connected to distinct ethnic or cultural groups within a society. However, Gebeye (2013) argued that the principle of legal pluralism had the potential of eroding the constitutional guarantees given to women. As most customary and religious laws were developed based on a patriarchal society, Okin (1999) noted that legal pluralism did not advance the rights of women. As a result, many agencies of criminal justice tended to situate IPV policy statements within a human rights framework in order to highlight all kinds of IPV as a human rights violation that every public people should proactively prevent (Barnish, 2004).

The UN was the first international institution that framed the protection of human rights and agreed on a definition of violence against women (Blanchfield, 2011). The General Assembly 1993 adopted the Declaration on the Elimination of Violence Against Women (DEVAW) and clarified the terms of *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 such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life*” (UN, 1993, Article 1). This declaration was the first international human rights instrument that specifically and exclusively to identify violence against women (Montoya, 2013). All 185 member countries that were involved with the UN were asked to participate with DEVAW. Moreover, this declaration also served as a platform in fostering the women’s movement and the involvement of NGOs, as well as international and regional cooperation in combating violence (Blanchfield, 2011). However, the focus of the UN General Assembly in 2000 emphasized gender equality, development, and peace for the 21<sup>st</sup> century. In 2005, the General Assembly called on member states to strengthen their legal framework and addressed specific forms of violence against women, including trafficking, traditional or customary practices affecting the health of women and girls, and crime against women committed in the name of ‘honor’ (UN, 2010).

Similarly, in 1995, the Beijing Platform for Action, adopted at the Fourth World Conference on Women in Beijing had called on governments to enact in domestic legislation to punish the perpetrator and ensure its effectiveness in eliminating violence against women (Kelly, 2008). The objectives of this platform were to uphold CEDAW and achieved the empowerment of women through the gender equality and human rights.

As a result of this conference, 45 nations had laws that explicitly prohibit IPV and 21 more were drafting new laws to do so by amending criminal assault laws to cover IPV (Carillo, Connor, Fried, Sandler, & Waldorf, 2000). Accordingly, in 2000, 118 countries had constructed national action plans to combat violence against women (Carillo et al., 2000). Both the CEDAW and the Beijing Platform for Action were emerging from the global negotiating process and agreed upon by all the world's governments. Thus, the UN designated November 25 as International Day for the Elimination of Violence Against Women (UN, 2013). This effort positioned violence against women as a human rights violation. The Universal Declaration of Human Rights (UDHR) guaranteed that every state needed to offer effective remedies for persons whose rights were seemingly violated.

Furthermore, the WHO was established in 1948 as a specialized body of the UN to serve international public health matters. The involvement of WHO as an expert consultant on VAW in 1996 served to connect all researchers, health care providers, and women's health advocates from different countries in order to address IPV comprehensively. The WHO multi-country study of violence against women also considered cultural as one of the factors that contributed to IPV (WHO, 2005).

**IPV in Europe.** In European countries IPV had occurred since the Medieval and Modern Europe in which husbands had the right to 'chastise' their wives, servants, and apprentices (Fee, Brown, Lazarus, & Theerman, 2002). Several records from church courts, the London Consistory Court, London records, and Connecticut court records proved that chastisement often triggered wife beating during the 16<sup>th</sup>, 17<sup>th</sup>, and 18<sup>th</sup> centuries (Fox, 2002). The records revealed that male dominance in the household was infiltrated with relationship of violence and subservience. For example, one of the cases

that documented in the London Consistory Court from 1711 to 1713 was Thomas Hull, a barber who wanted his wife to give him the record of the separate settlement that she brought into marriage. His wife refused and he beat her until she miscarried, threatened to send her to the madhouse, threw her clothes into the fire and tried to burn her (Ibid, p. 195, cited in Burguiere, Klapisch-Zuber, Segalen, & Zonabend, 1996). Many women suffered in silence as they were afraid they would receive punishment such as having a bridle on their head, paraded through the village, and not released until they repented (Fox, 2002). Additionally, Fox (2002) pointed out that society accepted these forms of punishment due to the laws in several countries such as England and Geneva, that Puritans rejected the physical infliction of harm by a husband to his wife. Consequently, the patriarchal domination of the husband was deeply rooted in the European cultures for many centuries.

Until 1829, the first legal rejection of the right of 'chastisement' happened in England (Dobash & Dobash, 1979). However, this principle was found in court in 1840 when the case of Cecelia Maria Cochrane, who ran away from her husband, was judged with the statement that "the husband bath by law power and dominion over his wife, and may keep her by force, within the bounds of duty, and may beat her, but not in violent or cruel manner..." (Dowling, 1841, p. 630). Accordingly, in 1915, the similar statement was found in a London magistrate that "the husband of a nagging wife... could beat her at home provided the stick he used was no thicker than a man's thumb" (Dobash & Dobash, 1979, p. 74). This traditional legal principle was not removed until 1981 when the shelter movement and feminist women became active in eliminating violence against women.

Furthermore, marital rape was also a common problem that occurred in many European countries. Conjugal exemption, which was rape committed by a husband against his wife, was not considered an offense (Fox, 2002). The statement of English Chief Justice Mathew Hale in his *History of the Pleas of the Crown* regarding the marital rape adopted into the English Law of many other commonwealth countries:

The husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual matrimonial consent and the contract the wife hath give up herself in this kind unto her husband, which she cannot retract... In marriage she hath given up her body to her husband.... (Hale, 1736, pp. 628-629, as cited in Estrich, 1987)

The rape of a wife by her husband was not prohibited by law. This problem was outlawed in several countries in Eastern Europe and Scandinavia before 1970 and in other countries in Western Europe until the 1980s and 1990s (Gelsthorpe & Larrauri, 2013). This issue was repealed in Holland in 1991, in the United Kingdom in 1994, and in Germany in 1997 (Romito, 2008).

In 1971, the first emergency women's shelter was established in England by Erin Pizzey (Jackson, 2007). Followed by the shelter movement, there were many other women's voluntary organizations established across the world. They provided practical and emotional support to women survivors and their children. In the mid-1970s, women survivors and feminists began to advocate for the physical abuse in intimate relationships. The feminist movement acknowledged the origins of IPV within the traditional and patriarchal family structures of domination and subordination, within a global framework of discrimination against women and denial of women's human rights (Fox, 2002).

Simultaneously, feminist groups also built the women's NGOs in order to fulfill the conditions of public financing they had to formalize and establish the issue and their expertise on national and international agendas (Kelly, 2008). They provided refuges, helplines, self-help groups, and advocacy as grassroots responses to IPV (Bevacqua, 2000; Dobash & Dobash, 1992).

In the mid-1990s, the European Union (EU) became involved with women's international activism in combating violence against women (Montoya, 2009). Due to the effort of the CEDAW and the Beijing Platform of Action, the EU became actively engaged to support the adoption of new policy and providing IPV advocacy organizations with valuable resources, as well as facilitated transnational cooperation and networking (Montoya, 2009). The efforts of the EU through the "Campaign for Zero Tolerance for Violence against Women" successfully called the European Parliament's attention to prevent and eliminate all forms of violence (Montoya, 2009).

In 1997, the European Commission reported that male violence was the most common form of violence against women (Kane, 2008). After the communication was put into place, the Daphne Program was formed by the Swedish organization to support a wide range of projects related to violence against women. This program provided funding to 47 NGOs to support and promote cooperation between advocacy organizations (Montoya, 2009). Through the Daphne program, many scholars were also involved in researching health sector responses to IPV (Bacchus et al., 2012). In the same year, the Women Against Violence Europe (WAVE) Network was funded by the European Commission to promote feminist analyses of violence against women and to develop criteria and guidelines to legislation, services, and prevention strategies.

The effort of combating IPV continued through several resolutions on trafficking of women, the elimination of domestic violence against women, the elimination of honor crimes against women, and recommendations on combating violence against women (Montoya, 2009). The Parliamentary Assembly of EU repeatedly called for legally binding standards for preventing, protecting against the most widespread forms of IPV. The collaboration between Parliament, EU, and NGOs pushed IPV to the public attention and promoted zero tolerance to violence against women.

**IPV in Africa.** Although IPV received more attention globally over the last three decades, in Africa, particularly, it was still largely hidden (Burrill, Roberts, & Thornberry, 2010). Traditionally, women were obliged to surrender their entirety to their husbands and be domestically available to gratify their male partner's psychological, physical, and sexual desires (Oyediran & Isiugo-Abanihe, 2005; Tenkorang, Nwabunike, & Sedziafa, 2014). Further, the African customary law accepted women as akin to property and marriage was a property transaction in traditional communities (Bowman, 2003).

According to Klein (1998), the slave trade also impacted the household dynamics and deepened the commoditization of rights of persons. This system was a tendency to retain female slaves and exported men consolidated ideologies of patriarchy gender systems (Burill et al., 2010). Moreover, the continuity of cultural structures that carried a sense of deep tradition and national essence had seriously discriminated and violated women's rights (Burrill et al., 2010). For example, in the Ikwerre culture of Rivers State required that a woman needed to remain single in order to inherit her father's property. However, in the Tiv culture of Benue State, as a way to pay respect to a guest, men offered their guests who visited them in August to have sex relations with their wives in

his house (Regina & Patrick, 2011). The society appeared to be more favorable to men. Thus, women were largely seen as problems when they brought complaints to the police. They were told to 'go home and be a good wife' (Eze-Anaba, 2010, p. 10).

Additionally, legal pluralism in which multiple systems of normative beliefs and legal practices coexist from pre-colonial to the post-colonial eras provided opportunities for males to consolidate their power (Burrill et al., 2010). The integration of normative beliefs into legal practices had created confusion to judges to be fair between law, culture, and gender, as well as the contents of African custom. Thus, women have never been adequately protected by both culture and law (Eze-Anaba, 2010; Burrill et al., 2010). In fact, some existing laws encourage and condone IPV. The rules of procedures in courts were not friendly to IPV survivors (Eze-Anaba, 2010).

No significant changes have been made before mid-1990 until the UN Declaration on Elimination of Discrimination Against Women and the Beijing Platform for Action were held in 1993 and 1995. Since then, the African government has attempted to deal with the problem of IPV primarily through law reform and the criminal justice system. In 1993, South Africa was first enacted the Domestic Violence Act as a legislation in the country. However, the introduction of the Act was questioned by attorneys who insisted to protect men's rights (Vetten, 2005). The Domestic Violence Act was officially implemented in South Africa in 1998 (Abrahams, Mathews, Martin, Lombard, & Jewkes, 2013). The implementation of the Domestic Violence Act marked a distinct shift in South Africa as the Act served to protect women from abuse. Nevertheless, the involvement of women's groups, social, and legal activists in combating IPV in Africa brought public attention.

By 2004, the African Government had integrated the Domestic Violence Training Program Manual in guiding police officers, prosecutors, magistrates, counselors, and victim assistant officers to deal adequately with IPV (Bendall, 2010). Four years later, the Justice and Constitutional Development implemented a set of guidelines to assist magistrates in dealing effectively with IPV cases.

**IPV in Asia.** Asia had the second highest prevalence rate of IPV in the world, particularly in Southeast Asia (WHO, 2013). The pervasive culture of IPV in Asia had eroded women's fundamental rights to life, health, security, bodily integrity, political participation, food, work, and shelter (Mohajan, 2012). Many histories and ethnographies indicated sensational and stereotypical accounts of foot-binding, widow burning child marriage, forced marriage, female infanticide, polygamous unions without consent, genital mutilation, and corporal punishment, as violence against women (Bernett & Manderson, 2003; Niaz, 2003).

Since the 1950s, many countries in Asia have experienced rapid economic growth, which has increased the rate of women in clerical and light manufacturing jobs. However, the identity of males became threatened when women became empowered through wage-earning and better education (Hensengerth, 2011). On the other hand, the indigenous religions in Asian countries impacted the status of women. The actual practice of polygamy, allowing a man to have four wives, still occurs in societies with codified laws and institutions based on Islam (Niaz, 2003). Moreover, Hindu culture was patriarchal and upheld values supportive of sexism (Segala, 1999), and Buddhism encouraged women to be subservient to men (Niaz, 2003). Hensengerth (2011) stressed women tend to occupy low socioeconomic positions, lack of education, and financial dependence on

their husbands in conservative Islamic areas in Malaysia, Indonesia, and minority areas of the Philippines (Foley, 2003). Other affected areas include conservative Catholic regions in the Philippines (Ansara & Hindin, 2009), Confucianism in China, Japan, South Korea, and Vietnam (Yoshihama et al., 2010), and in general patriarchal societies in Thailand and Cambodia (Brickell, 2008).

The traditions and customs in Asia made it difficult for women to seek justice, even in cases where a woman had a clear legal right. There were no formal laws discriminating against women, but the common culture or tradition contributed to disempowering attitudes toward them (Niaz, 2003). In order to combat IPV in Asian countries, women's rights NGOs formed regional networks to advocate for women's education and enhanced their awareness about their rights under international human rights treaties (Hensengerth, 2011). The Fourth UN World Conference on women was held in Asia in 1995, attracting over 40, 000 women to speak out (Matsui, 2001). This Beijing conference served as the platform for action as over 189 government representatives and the NGOs attending the conference. Twenty critical areas of concerns were included in their platform for action, such as poverty, education, health, violence against women, armed conflict, economic participation, decision making, the advancement of women, women's human rights, the media, the environment, and the girl child (Matsui, 2001). This small step of discussion set as a fundamental and milestone of changes on eliminating IPV in Asia. Accordingly, the fifth UN World Conference on Women emphasized the reality of the lives for millions of women worldwide.

Specifically, in China, feminist activists implemented new knowledge drawn from international discourses on women's rights to form an epistemic community in order to

overcome local notions of masculinity (Milwertz & Bu, 2007). However, this approach had not effectively changed the basic pattern of male domination in the household. Moreover, the patriarchal political system in China rarely allowed women to hold top positions in politics (Hensengerth, 2011). The same phenomenon occurred in South Korea, where patriarchal social values allowed men to dominate women (Doe, 2000). As a result, the husband often physically abused their wives to maintain hierarchical order in the family. A law for preventing domestic violence was passed in South Korea in 1997 and the Basic Act on Healthy Family of 2004 was implemented to increase women's participation in the labor force (Park, 2008). Feminist scholars saw the direct involvement of the government with family life as a positive attempt to improve women's status.

Furthermore, in Japan, the history of IPV was fundamental to the patriarchal social structure and focused on shame rather than justice (Hensengerth, 2011). Victim blaming attitudes among the Japanese society made the victims fearful to seek help from others (Yoshihama, 2002). The rates of IPV began to receive attention from the public in Japan when the World Conference on Human Rights in Vienna in 1993 promoted women's rights through the Asian Women's Human Rights Council (Hensengerth, 2011).

Unfortunately, IPV was still treated as a private matter in Vietnam. The patriarchal family and gender norms, as well as a culture of shame, often discouraged women from reporting their abuse and seeking help (Vung, Ostergren, & Krantz, 2009). However, no law or statute was implemented in Vietnam for combating IPV. In contrast, the Domestic Violence Act was integrated into the laws of Thailand in 2007 as an effort to eliminate IPV; studies indicated that many police officers refused to provide help to IPV survivors. Moreover, One Stop Crisis Center (OCCS) that was formed in general

hospitals did not provide adequate services to the survivors (Hindin & Adair, 2002). A similar situation happened in Cambodia when the Cambodian judges viewed IPV as a criminal act only if the victim was severely injured by her partner (Zimmerman, 1994).

In Indonesia, the government established the National Commission on Violence Against Women to respond to the crisis that occurred on the May 1998, when there was a mass rape of Chinese Indonesian and other ethnic minority women after the fall of the Suharto regime (Wandita, 1998). The initiative taken by the government was heralded as a major policy step, but concrete outcomes were lacking (Tan, 2006). In Singapore, the efforts to combat IPV focused on the organizational responses of the police force (Ganapathy, 2008). The first Association of Women for Action and Research (AWARE) was established to advertise the campaign of domestic violence in 1985. This effort eventually had to fight for approval of the proposals in the Family Violence Bill (Amirthalingam, 2003), which unfortunately, was rejected. Other alternatives were taken to include developing the Family Violence Dialogue Group in 2001. This incorporated a multidisciplinary approach to domestic violence.

In Malaysia, IPV was formally recognized as a problem when the Malaysia refuge for women victims was first established in 1982. The purpose of the shelter was to provide assistance to female victims of domestic violence through counseling, safe places to stay, and support from social and welfare services department (WAO, 2000). Various NGOs and individuals who came to join a Joint Action Group (JAG) took primary role in assisting the survivors during the shelter movement. They provided workshops to educate the public to relate to rape, domestic violence, sexual harassment, prostitution, and the women images in the media (Amirthalingam, 2003). In order to help women get

protection legally, Domestic Violence Act 521 was first adopted in the legal system in Malaysia. Many viewed the language in the act as contracting Muslims' values that women needed to obey to their husbands. The implementation of the Act was reconsidered and delayed until 1996. The integration of the Domestic Violence Act increased women's awareness and encouraged them to report any form of violence (Amirthalingam, 2003).

Alignment with the implementation of the Domestic Violence Act, the government also established the OSCC in the primary hospitals (Colombini et al., 2012). The purpose of the centers was to provide medical treatment and other related assistance to IPV survivors. Until recently, 90% of the government hospitals had the OSCC based in the emergency rooms (Colombini et al., 2012). Additionally, the women's right movement marked it as a beginning in 2001 when the Federal Constitution Government was amended to eliminate gender discrimination in the country.

Overall, the high acceptance and tolerance of violence among Asian women placed them at the risk for multiple forms of violence. Research findings of IPV in Asia were limited due to the internal political pressure and lack of resources for researchers to publically publish their findings (Bernett & Manderson, 2003). As a result, women experienced chronic IPV in many Asian communities, which were slowly acknowledged as a social problem in these patriarchal societies. However, the severity of violence against women caught public attention when the United Nation Development Fund for Women (UNIFEM) estimated that one-quarter of all women world-wide were subjected to rape during their lifetime (Heise, Pitanguy, & Germaine, 1994).

Table 2

*Summary of the History of IPV at the international Level*

Period	Events
1400s	<ul style="list-style-type: none"> <li>• The early English Common Law supported the husband's rights to discipline their wives</li> <li>• Implemented 'legal pluralism' in Europe, Africa, and Asia.</li> </ul>
1600s – 1800s	<ul style="list-style-type: none"> <li>• Several records from church courts' records proved that chastisement often triggered wife beating</li> </ul>
1829	<ul style="list-style-type: none"> <li>• The first legal rejection of the right of 'chastisement' occurred in England.</li> </ul>
1840 - 1981	<ul style="list-style-type: none"> <li>• The principle of 'chastisement' still existed until 1981.</li> </ul>
1945	<ul style="list-style-type: none"> <li>• The UN officially became the first international institution that framed the protection of human rights and agreed on a definition of violence against women. (Blanchfield, 2011).</li> </ul>
1948	<ul style="list-style-type: none"> <li>• The UDHR was adopted to offer effective remedies for persons whose rights are seemingly violated.</li> <li>• The WHO was established as a specialized body of the UN to serve international health matters and public health</li> </ul>
1971	<ul style="list-style-type: none"> <li>• The first emergency women's shelter was established in England by Erin Pizzey (Jackson, 2007).</li> <li>• Women survivors and feminists began to advocate for the physical abuse in intimate relationships.</li> </ul>
1982	<ul style="list-style-type: none"> <li>• The refuge for women victims was first established in Malaysia.</li> </ul>
1985	<ul style="list-style-type: none"> <li>• Singapore first established the Association of Women for Action and Research (AWARE) to advertise a campaign about domestic violence.</li> </ul>
1987	<ul style="list-style-type: none"> <li>• The statement of English Chief Justice Mathew Hale in his History of the Pleas of the Crown regarding the marital rape was adopted into the English Law in many other commonwealth countries.</li> </ul>
1990	<ul style="list-style-type: none"> <li>• The EU began involved with women's international activism in combating violence against women.</li> </ul>
1993	<ul style="list-style-type: none"> <li>• The General Assembly adopted the DEVAW and clarified the terms of violence against women.</li> </ul>

(continued)

Table 2: *Summary of the History of IPV at the international Level (continued)*

Period	Events
1994	<ul style="list-style-type: none"> <li>The first OSCC established in Kuala Lumpur, Malaysia.</li> </ul>
1996	<ul style="list-style-type: none"> <li>The Domestic violence Act 521 was implemented in Malaysia.</li> </ul>
1997	<ul style="list-style-type: none"> <li>The Daphne program was formed for supporting IPV projects.</li> <li>South Korea implemented Domestic Violence Act.</li> </ul>
1998	<ul style="list-style-type: none"> <li>The Domestic Violence Act was officially implemented in South Africa in 1998.</li> </ul>
1995	<ul style="list-style-type: none"> <li>The Beijing Platform for Action, adopted by the Fourth World Conference on Women in Beijing, had called governments to enact in domestic legislation.</li> </ul>
1998	<ul style="list-style-type: none"> <li>The Indonesia government established the National Commission on violence against women (Wandita, 1998).</li> </ul>
1999	<ul style="list-style-type: none"> <li>The UN designated November 25 as International Day for the elimination of violence against women.</li> </ul>
2000	<ul style="list-style-type: none"> <li>The UN General Assembly had emphasized gender equality, development for the 21st century.</li> <li>118 countries had constructed national action plans to combat violence against women (Carillo et al., 2000).</li> </ul>
2001	<ul style="list-style-type: none"> <li>Women's right movement in Malaysia to eliminate gender discrimination.</li> </ul>
2004	<ul style="list-style-type: none"> <li>The African Government had integrated the Domestic Violence Training Program Manual into system.</li> <li>South Korea implemented the Basic Act on Healthy Family.</li> </ul>
2005	<ul style="list-style-type: none"> <li>The General Assembly called on member states to strengthen their legal framework and addressed a specific form of violence against women.</li> <li>The WHO conducted a multi-country study of violence against women also considered culture as one of the factors that contributed to IPV</li> </ul>
2007	<ul style="list-style-type: none"> <li>The Domestic Violence Act was integrated into the legal systems in Thailand.</li> </ul>
2008	<ul style="list-style-type: none"> <li>The Justice and Constitutional Development in Africa implemented a set of guidelines to assist magistrates in dealing effectively with IPV cases.</li> </ul>

## **Types of IPV**

Research on IPV expanded over the past several decades to include different types of victimization, even in different regions. A comprehensive model regarding IPV that developed based on the survivors' perspectives was called the Power and Control Wheel (Pence & Paymer, 1993). The Power and Control Wheel illustrated eight tactics a perpetrator uses to maintain power and control over his partners: (a) coercion and threats, (b) intimidation, (c) emotional abuse, (d) isolation, (e) using children, (f) male privilege, (g) economic abuse, and (h) minimizing, denying, and blaming. These eight tactics were reinforced by the actual use of physical and sexual violence. Several scholars argued that the wheel was tender to emphasize on physical violence to the exclusion of the other control tactics (Barnish, 2004; Stark, 2007). However, other studies supported that the wheel served as fundamental to other researchers and government bodies to begin paying attention to economic abuse (Adams, Sullivan, Bybeen, & Greeson, 2008; Wilcox, 2006), particularly the UN Secretary-General acknowledged economic abuse and exploitation as a form of violence.

According to Pence and Paymer (1993), one or more violent incidents were accompanied by other types of abuse that listed on the wheel and they were less easily identifiable. These experiences have threatened women primarily and established a pattern of intimidation and control in an intimate relationship. Chavis and Hill (2009) related these hidden types of abuse with multiple oppressions inevitably shaped the experience of IPV survivors. Thus, it was important to recognize the intentionality of using the power and control tactics from a cultural lens.

## **Physical Violence**

Physical violence was the most common form of violence experienced by women. Usually, the perpetrator used physical force or power with the possibility for causing injury, harm, disability, or death (Saltzman et al., 2002). It also included behaviors like hitting, slapping, biting, beating, pushing, kicking, throwing objects, using weapons against the partner, or pulling the partner's hair (CDC, 2013; Stewart, MacMillan, & Wathen, 2012). In addition, according to Ganley (2008), physical assault included grabbing, restraining, shaking, scratching, punching, burning, or choking a partner among other misconducts. However, in Asian nations such as Malaysia, Cambodia, and Bangladesh, physical abuse can also include acid attacks, in which the perpetrator throws acid on a victim's face, burns him or her, and damages skin tissues, resulting in long term blindness and permanent scarring (Bandyopadhyay & Khan, 2003). Moreover, hot water poured on the back and iron burns on thighs or back were the common types of physical abuse in Malaysia (Chelliah & John, 2003).

The data indicated that 1 in every 3 females or 1 in every 4 males experienced pushing, shoving, or slapping from the intimate partner in the United States (Breiding et al., 2014). A more specific number provided by the National Coalition against Domestic Violence indicated that 30.3% of women have been slapped, pushed, or shoved by an intimate partner, and 3.2 million women experienced severe physical violence (Black et al., 2011). Additionally, an average of 18% of females and 11% of males were medically treated for injuries sustained in 2002 to 2011 due to physical violence (Catalano, 2013). Truman and Morgan (2014) revealed that 19% of IPV involved a weapon. An NCADW report showed that in 70% to 80% of intimate partner homicides, no matter which partner

was killed, the man physically abused the women before the murder (Campbell et al., 2004).

Globally, 35% of women have experienced either physical and/or sexual IPV or non-partner sexual violence; 4% to 49% reported having experienced severe physical violence by a partner (WHO, 2012). In Europe between 15% and 76% of women are targeted for physical and/or sexual violence in their lifetime (European Union Agency for Fundamental Rights, 2014). However, in other parts of the world, the UN Statistics Division (2010) reported 6% women in China, 7% in Canada, to over 48% in Zambia, Ethiopia, and Peru suffered physical violence perpetrated by a current or former intimate partner. Bazargan-Hejazi, Mederios, Mohammadi, Lin, and Dalal (2013) examined the lifetime prevalence of different types of IPV among Malawi women age 15 to 49, and found that 20% out of 8291 participants reported being pushed, shaken, slapped or punched, and 3% reported severe violence, such as being strangled or burned, or threatened with a knife, gun, or with another weapon. Similarly, a 22% rate of occurrence was reported by the women in Tanzania (McCloskey, Williams, & Larsen, 2005). In Thailand, 41% of women in Bangkok and 47% of women in rural areas experienced physical or sexual abuse by a partner (United Nations Population Fund [UNFPA], 2009). In Malaysia, 22% of women experienced physical abuse and 68% of them were beaten while pregnant (WAO, 1992).

### **Sexual Violence**

Sexual violence is violence comprised of various expressions, including coerced sex through threat or manipulation, pressured sex, physically compelled sex or even sexual assault that is accompanied by some violence (Krebs, Breiding, Browne, &

Warner, 2011). The survivor may actually sustain injuries in the genital area, secondary to the use of weapons or blows by a partner. Alternatively, the survivor can be prevented from using protection or contraceptives, leading to unwanted pregnancy or sexually transmitted diseases (Miller et al., 2013).

In the United States, nearly 1 in 5 women and 1 in 71 men have been raped in their lifetime (CDC, 2010). This translates to almost 22 million women and 1.6 million men in the United States, respectively. Based on the National Intimate Partner and Sexual Violence Survey, 43.9% of women and 23.4% of men experienced other forms of sexual violence, to include being made to penetrate, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences (Breiding et al., 2014). Among the cultural groups, the CDC reported lifetime prevalence of sexual violence at 41% of African Americans, 47.6% of White Americans, and 36.1 of Hispanics (CDC, 2010).

Worldwide, around 120 million females experienced forced intercourse or other forced sexual acts at some point in their lives (UNICEF, 2014). This sexual violence occurred between the ages of 10 and 14 in Eastern and Southern Africa. The European Union's Fundamental Rights Agency interviewed 42,000 women aged 18-74 across Europe to gauge the extent of sexual violence and harassment experienced by women in the EU's 28 nations. The results revealed that 1 in 10 of the women interviewed indicated that they experienced some form of sexual violence before they were 15 years old; 55% of women experienced some form of sexual harassment in their lives. The study also reported 52% of women in Denmark, 47% in Finland, and 46% in Sweden suffered sexual and/or physical abuse (FRA, 2014).

In Asian countries, sexual violence was pervasive in India, Pakistan, and the Philippines. Yoshihama et al. (2010) interviewed 143 women and the results indicated 56% of Filipinas and 64% of Indian and Pakistani women experienced sexual violence by an intimate partner. Moreover, Jewkes, Sen, and Garcia-Moreno (2002) conducted a study in six Asian countries (i.e., Bangladesh, China, Cambodia, Indonesia, Sri Lanka, and Papua New Guinea) and found the prevalence of non-partner single perpetrator rape varied between 2.5% (rural Bangladesh) and 26.6% (Papua New Guinea), multiple perpetrator rape between 1.4% (urban Bangladesh) and 14.1% (Papua New Guinea), and rape of a man between 1.5% (Indonesia), and 7.7% (Papua New Guinea). Indirectly, this result reflected women were at high-risk of being victims of sexual abuse, regardless of geographical, race, and gender (Jewkes et al., 2002). Malaysia also reported 3595 rape cases in 2010. This number did not include marital rape or underreported cases (Royal Police Malaysia, 2014). Considering the fact that some Asian nations still practice forced marriages and early marriages, it was easy to find IPV in many families as a form of sexual violence (UN, 2009). For example, in Malaysia, women were reluctant to make their problem public and seek assistance due to shame, fear of retaliation from their husbands, and cultural factors, particularly sexual violence, which was also believed to be a private matter in the cultural context (Awang & Hariharan, 2011)

### **Emotional Abuse**

Emotional abuse, also known as psychological abuse, was categorized as non-physical violence. It referred to threatened behaviors such as “the use of verbal and nonverbal acts which symbolically hurt the other or the use of threats to hurt the other” (Straus, 1979, p. 77). Normally, the perpetrator used various tactics to manipulate or

control a partner through verbal attacks or humiliations (CDC, 2012). Through emotional abuse, the victim's self-worth was highly damaged. According to Outlaw (2009), all forms of non-physical abuse were the same, with respect to intensity, frequency, or co-existence with physical violence. Examples of emotionally abusive behaviors included intimidation, name-calling, or denying the partner to meet with friends or relatives (Anderson & Kobek-Pezzarossi, 2011; Zamorski & Wiens-Kinkaid, 2013). Alternatively, the abuser may humiliate, degrade, or emotionally manipulate his or her partner (Steward et al., 2012). This hidden abuse was more common than physical violence. There was strong evidence that some types of non-physical abuse may increase risk of more frequent violence among IPV victims (Outlaw, 2009; Sims, 2008).

In the United States about 48.4% of females and 48.8% of men were victims of emotional abuse (Breiding, Chen, & Black, 2014). Coker, Derrick, Lumpkin, Aldrich, and Oldendick (2000) found that of 556 participants, men (7.4%) were as likely as women (8.3%) to report perceived emotional abuse 'alone.' Baynyard, Potter, and Turner (2011) found that of 1079 women, more than half (54.5%) reported emotional abuse from their partners.

With a wide range of statistics reported globally, a ten-country WHO survey and other research consistently showed that emotional abuse could have a more profound and negative effect than physical violence. The WHO (2005) survey indicated that between 20% and 75% of women experienced one or more types of emotional abuse within the past 12 months across all countries. Thapa-Oli, Dulal, and Baba (2009) studied 45 Nepali immigrant women in New York and found that 75.6% of women had been verbally insulted by their current partners, and 62.2% had to seek permission from their partners to

go to their friends' or relatives' houses. Studies conducted in Australia, through telephone surveys, indicated that verbal and mental abuse ranged from 47.1% to 88% among the survivors (Alexander, 1993). In the United Kingdom, Keeling and Birch (2004) investigated 316 females in hospital settings and they found that 26.3% reported experiencing severe emotional IPV. However, in Nepal, studies indicated 81% of respondents ( $N=200$ ) were victims of psychological abuse by their husbands and 32.5% by family members (Chetri et al., 2007). Specifically, in Malaysia, the WAO (2011) reported that 71 of 110 women who sought help from shelters had reported being psychologically abused by their partners.

**Coercive control violence.** Coercive control included intimidating, minimizing, denying, and blaming, using children, using male privilege, isolating, and abusing economically (Pence & Parmer, 1993). All of them entailed the use of force or threats to compel or dispel a particular response from an individual (Stark, 2007).

In the United States there was little research on coercive controlling violence, but there were few qualitative studies that clearly identified this type of violence in same-sex (Renzetti, 1998) and heterosexual relationships (Hines, Brown, & Dunning, 2007). Renzetti (1998) found that for lesbian relationships partners tried to control a partner through all the tactics identified in the Power and Control Wheel, as well as the threats of outing. However, Hines et al. (2007) reported 95% of the men calling to the Domestic Violence Helpline due to their partners' coercive controlling behaviors. Johnson (2008) also found that 68% of women who filed for protection from abuse orders and 79% of women who contacted shelters experienced coercive controlling violence.

Graham-Kevan and Archer (2003) found 87% of the coercive controlling behavior in their British sample was male-perpetrated. Rees, Agnew-Davies, and Barkham (2006) found that 60% of refugee men threatened to have the children taken away at least once; 36% threatened to hurt the children; 63% threatened their friends and family; and 82% threatened to destroy things they cared about. On the other hand, Johnson (2008) argued that women could show a similar degree of controlling behavior to their partners in the relationship. In the Maldives, 72% of women reported that their partner displayed at least one act of controlling behaviors in their relationships (Fulu, 2014). Unfortunately, in Malaysia, no data has been documented regarding coercive controlling behaviors.

***Stalking.*** Stalking is a form of surveillance used in coercive control. According to the CDC (2010), stalking refers to harassing or threatening behavior that was repeatedly performed by an individual, such as following a person, appearing at a person's home or workplace, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property. It included a range of surveillance tactics such as letting a partner know he or she was being watched or overheard, insisting on 'check-ins', listening to his or her phone messages, and going through mail, handbags, bank records, and email or Facebook (Rees et al., 2006).

The CDC (2007) reported 50% stalking was against women. This result was consistent with Breiding et al. (2014) who estimated that 53.8% of females and 47.7% of males were first stalked before the age 25 of years. However, Black et al. (2011) found that 19.3 million women and 5.1 million men in the United States experienced stalking in their lifetimes; 66.2% of stalking victims reported stalking by a current or former

intimate partner. This phenomenon also occurred on college campuses as Fisher, Cullen, and Tunner (2002) reported that 13% of college women were stalked during six-to-nine month period and 80% of them knew their stalkers. The National Asian Women's Health Organization (NAWHO, 2002) conducted telephone interviews with a random sample of 336 Asian American women aged 18 to 34 in the Western United States and found that 14% of women reported that someone repeatedly followed or spied on them, appeared at unexpected locations, or stood outside their home, school, or place of work.

In Australia, Purcell, Pathe, and Mullen (2002) investigated the prevalence and nature of stalking in the Australian community among 3700 participants and found that 4.4% reported ongoing harassment; on average, victims were subjected to 2.8% methods of intimidation, and for 29% of victims stalking was accompanied by explicit threats (Purcell et al., 2002). On the other hand, Yoshihama et al. (2010) reported 67.8% of Filipinas and 50.0% of Indian or Pakistani women experienced stalking in their lifetimes. Ghani (2014) found that 17 out of 25 participants reported having experienced stalking, or controlling behaviors of the partner.

***Technology abuse.*** Technology abuse was very similar to the cyber stalking, in which the stalkers used the internet, email, or other electronic communications devices to stalk another person (Cruz & Bair-Merritt, 2013). This type of abuse received little attention from scholars because the reported rate was low (26.1%) (Baum, Catalano, Rand, & Rose, 2009). Consistently, Botuck et al. (2009) also reported 15% of their sample of partner stalking victims reported contact through the email or internet, and 12.5% reported other technology use. None used GPS. Wolak, Mitchell, and Finkelhor (2006) stressed that youth were the targeted internet users that received unwanted sexual

solicitations (13%) and 47% of them reported themselves as the internet-initiated sex crime victim.

***Economic abuse.*** Economic abuse was part of the control tactics used by a partner. It involved an intention of a partner who denied the other funds, declined from contributing finances to maintain the family, or refused to give food to the spouse (CDC, 2010). In addition, the abusive partner may have denied the other access to important basic needs or control the access to employment or health care (Khan, 2000). This means that most of the cases of the economic abuse revolved around finances, although not all of them had a direct link to money. According to NNEDV (2013), economic abuse usually along with emotional, physical, and sexual abuse, manipulation, intimidation, and threats, were all intentional tactics used by a perpetrator aimed to control the partner.

In both the U.S., as well as Asian nations, economic abuse was common, especially among young couples who are developing their relationship. According to Matthews (2004), women were cut off socially and not allowed to work. Their partners may have been their only means of financial support. The NNEDV (2013) reported that 98% of IPV survivors reflected concerns regarding their ability to provide financially for themselves and their children. This became the top reason for staying in the relationship. The same result was found by Women's Aid Federation UK (2002), 77% of women cited economic dependence as the main barrier to leaving. Additionally, Thapa et al. (2007) found that 79% out of 200 female victims interviewed in Nepal were found to have been economically abused by their male counterparts. Moreover, McDonald (2012) stated a majority of women (80 to 90%) seeking support for IPV or domestic violence in Australia experienced financial abuse. In Malaysia, financial abuse was a hidden agenda

in the family and it became an inhibiting factor for women to leave their partners (Othman & Adenan, 2010).

***Isolation.*** This control tactic involved the controllers isolating their partners from their friends and family, preventing disclosure of IPV, monopolizing available resources, and keeping them from getting help or support (Stark, 2009). In order to protect friends or family from being harmed by their partners, IPV survivors may have isolated themselves. Partners also involved other tactics such as denying women access to the phones or cars, locking them up, or forcing survivors to make hard decisions between their family members and the partners (Stark, 2009). There was a lack of specific data that indicated the number of IPV survivors being isolated; however, the United Kingdom Refuge Survey indicated 81% of women reported they had been kept from leaving the house and 47% reported this happened ‘often’ or ‘all the time’ (Rees et al., 2006)

### **IPV-Related Theories**

By the turn of the 19<sup>th</sup> century, complex theories about male domination and female victimization were developed to help individuals learn about domestic violence or IPV (McGregor, 1990). Several theories or perspectives emerged as a result of the IPV historical trends in the United States, such as Feminist Theory, Family Violence Perspective, Attachment Theory, Culture of Violence Theory, and Learned Helplessness.

#### **Feminist Theory**

Feminist theory was a common theoretical perspective used to analyze IPV. This theory drew on the accounts of abused women and an understanding of how patriarchal dynamics in intimate relationships and at the societal level, as well as gender power differentials, have fostered inequality and male privilege. Specifically, feminists defined

IPV as a matter of control rooted in patriarchal conditions of male dominance in intimate relationships (Stark & Flitcraft, 1996). Men were purported to abuse their wives mainly because of their desires to have control over “their women” and to show they have the power to subordinate women (Bograd, 1988).

However, Dutton (2006) stressed that women’s ways of living indicated that they were vulnerable and dependent on their husbands; their attitudes regained men’s authorities and power over women. This phenomenon not only occurred at the relational level, but also existed on the societal level. Society supported the patriarchal structure of the United States family, with men in the primary control of the economy, education, and political realm, which prevented the equal participation of women and perpetuated the male dominance of the systems (O’Leary & Woodin, 2009). In fact, the domination at the societal level may be the contributing factor when maintaining IPV at the relational level, as society views patriarchal structure as normal and acceptable (Dobash & Dobash, 1992).

Furthermore, feminist theory also suggested that men used various tactics, such as physical, psychological, sexual, coercive, and economic abuse to gain or maintain control over a partner (Walker, 1984). These behaviors occurred due to power struggles among men, particularly when their position was threatened (Tracy, 2007). For example, women were at a greater risk of experiencing IPV when husbands held traditional sex-role attitudes and when the husbands and wives’ acceptance of patriarchal values were different (Leonard & Senchak, 1996; Smith, 1990). Though the feminist theory has explicitly included the concept of patriarchy and gender power differential to explain the phenomenon of IPV, there are multiple criticisms of this theory due to its limited focus on within-group gender difference, racial/ethnic minority, and sexual minority. Dutton

(2006) argued that feminists only focus on a single factor explanation of women abuse by paying too much attention on male in general. They de-emphasized differences among men as well as ignored female pathology. In fact, women used violence in intimate relationships to the same extent as men in Canada and the United States (Dutton, 2006; Straus, 2006). Additionally, the difference in male groups in their attitudes and acceptance of violence could be different (Dutton & Nicholls, 2005). Thus, many scholars contended that feminists should integrate some other factors, such as unemployment, globalization, life events stress, intimate relationship status, substance use, and so forth in their perspectives on IPV.

Other critics of the feminist perspective argued that in both lesbian and heterosexual relationships, there was evidence to suggest that women were as violent or more violent than men (Straus & Gelles, 1990). Studies indicated that lesbian and heterosexual rates of abuse were similarly high for all forms of abuse (Dutton & Nicholls, 2005). Although there were many similarities of abuse between heterosexual and same-sex relationships, Renzetti (1998) argued that the two phenomena were not the same due to the assertion of power and control over their partners. For instance, the tactic of threat was often used by perpetrators in same-sex relationships. Hence, IPV was closely related to power rather than gender. This had been proven in past studies that IPV occurred regardless of gender, social economic, and cultural (Conroy, 2014). Thus, IPV was not specific to men and it could not explained on the basis of gender except when men used sexist attitudes as rationale IPV cases; for same-sex women, internalized patriarchal values, minority stress, and heterosexism colluded to reinforce domination and control attitudes. In the later of studies, feminist analysis focused on intersectionality, power, and

socially constructed gender roles in order to expand the understanding of IPV through other lens (Sokoloff & Pratt, 2005).

On the other hand, feminist theorists used self-defensive behaviors, which were known as mutual violence, to clarify the high prevalence of women's perpetrators (Dutton & Nicholls, 2005). This claim was contradicted by Stuart et al. (2006), who noted reasons other than self-defense were endorsed by females as motives for their violence perpetration. Thus, it was important for future research to further clarify the utility of feminist theory as it pertains to violence behaviors in intimate relationships.

### **Family Violence Perspective**

A family violence perspective was developed by sociologists Richard Gelles and Murray Straus (Lawson, 2012). They focused more generally on spousal abuse or family violence rather than solely IPV. The family violence perspective viewed conflict among family members as part of the social interaction and internal violence as a mechanism to resolve the conflict. This type of family violence was accepted as a normal part of family life in most societies (Straus & Gelles, 1979). Hence, this approach assumed family members solved their own conflicts.

Barnish (2004) stressed that poor communication and ineffective resolution in family produce dysfunctional family systems that reinforced conflict and problem behaviors, particularly in children. Barnes, Hoffman, Welte, Farrell, and Dintcheff (2006) found that poor communication was associated with poor family management, such as unclear expectations for children's behavior, insufficient monitoring, loose family boundaries, and substance abuse. However, Dutton (2006) argued that violent behavior within an intimate relationship was perceived as inherited through poor

parenting. This poor early relationship with a primary caregiver produced a sense of insecurity within perpetrators or victims of IPV. Ineffective parenting also affected immediate family, particularly children who tended to be impulsive, aggressive, and engaged in maladaptive behaviors (Steward, Simons, Conger, & Scaramella, 2002). Other researchers argued that the parents' characteristics often reflected in children, which resulted in violent behavior.

Moreover, family violence theorists noted that the complex role-sets formed from tension and stress in relationships. In dual-career families, the man tried to share some domestic chores with his wife; women had to balance identity, power, and status with family roles and responsibilities resulting conflict in relationships (Panda, 2011). However, Hunnicutt (2009) found that there was no impact of societal institutions on women and men in their inherent nature of gendered roles within the family. Babcock, Waltz, Jacobson, and Gottman (1993) found husbands who had less power were more physically abusive toward their wives. Thus, family violence research broadly focused on various causal factors that created conflict in the family systems and its impact on family members who lived in the systems.

### **Attachment theory**

Attachment theory was originally formulated by a British psychiatrist, John Bowlby, in 1969 to explain children form mental prototypes of relationships based on their early experiences with primary caregivers (Fife & Schrager, 2012). The primary bond between mother and infant created beliefs that led to the development of different attachment styles, and was an extension of object relations theory, which was pioneered by Melanie Klein. For example, Bowlby (1973) investigated an importance of healthy

and unhealthy development based on the sensitivity and responsiveness of parents toward their children. He found that the higher parental sensitivity and responsiveness were to the children's needs, the more secure and healthy the attachment was that developed. In contrast, insecure attachment led to a lack of feeling safe and rejection, which increased the likelihood of entering into an abusive relationship (Bartholomew, Henderson, & Dutton, 2001). This relationship was relatively consistent over time and served as a foundation for future relationships.

Ainsworth, Blehar, Waters, and Wall (1978) brought this theory to the United States and developed a method for assessing infant attachment known as the "strange situation." This experiment involved a year old infants' responses to the brief absence of their mothers and followed by a reunion. They identified three types of attachment behavior: secure, avoidant, and anxious-ambivalent. Secure children were happy at their mothers' return. Avoidance children did not indicate to be seriously upset when being separated from their mothers, but they avoided when they reunited. However, anxious-ambivalent children strongly indicated their separation anxiety, and exhibited confusion when reunited with their mothers (Ainsworth et al., 1978).

The link between early attachment experiences on adult attachment was confirmed by many researchers (Dumas, Pearson, Elgin, & McKinley, 2008; Fraley & Shaver, 2000). Main et al. (1985) found three attachment patterns: secure, preoccupied, and missing through prior familial experiences. Specifically, Hazan and Shaver (1987) found three patterns of attachment: security, ambivalent, and avoidance in intimate relationships. Other studies suggested that the category of insecure, anxious, or preoccupied was a significant predictor of IPV for both genders (Dumas et al., 2008).

Henderson, Bartholomew, and Dutton (1997) found 88% of 63 IPV victims reported as anxious attachment style and admitted having a shorter relationship period, more frequent separations, continued emotional engagement with ex-partners, and frequent sexual relations with ex-partner. Implicitly, these discoveries also explained that anxious attachment was a risk factor for victimization and challenge for victims leaving the intimate relationships. Additionally, Doumas et al. (2008) stated that IPV rates were higher for males and females with insecure attachment styles and this 'mispairing' contributed to a high risk factor for IPV perpetration and victimization. However, Pistole (1994) indicated that the combination of any attachment style can also lead to IPV experiences. Further, Bowlby (1988) determined that intergenerational transmission of attachment style had implications for the intergenerational transmission of IPV as well.

### **Culture of Violence Theory**

The culture of violence theory was developed by Marvin Wolfgang and Franco Ferracuti in 1967. This theory explained that the differential of cultural norms and values concerning violence can influence the distribution of violence. Culture of violence theory viewed violence as a learned response that occurred within a cultural or subcultural group. The concept of subculture pertained to the knowledge, belief, art, morals, laws, customs, and any other capabilities and habits that developed as separate norms in the particular society (Wolfgang & Ferracuti, 1967).

With regard to exploring the influence of subcultures on violence, Wolfgang and Ferracuti (1967) pointed out that subculture was in direct conflict with the dominant culture; however, it may not have been in total conflict with the societies of which they are a part. They suggested subcultures that perceived violence as acceptable and helped to

explain the occurrence of IPV in our society. This theoretical framework was applied and evaluated in relation to a variety of other demographic and locales, such as the American South (Nisbett & Cohen, 1996; Hayes & Matthew, 2005), athletes (Smith, 1979), and middle schools and high schools within the United States (Berburg & Thorlindsson, 2005; Ousey & Wilcox, 2005).

Wolfgang and Ferracuti (1967) reported that subculture of African American men was more violent than its white counterparts. However, Cao, Adams, and Jensen (1997) disagreed with the premise as their findings indicated that white males were considerably more likely to be violent in a “defensive situation” and both African American males and white males were equally violent in an “offensive situation.” Moreover, Felson, Liska, South, and McNutty (1994) found support for a link between group norms and values permissive of violence and violent behavior. Specifically, Felson et al. (1994) conducted a study with 2, 213 sophomore males and reported male violence and delinquency were related to the values in schools. Males engaged in violence to maintain their reputation within their school peer groups. These results found by Goff and Goddard (1999) also suggested that the membership of a group could contribute to their tendency to be violent and gain their friendship and pleasure. This finding was supported by an earlier study by Wolfgang and Ferracuti (1967) regarding a sense of belonging to the subculture.

Ousey and Wilcox (2005) suggested the importance of considering additional factors such as impulsivity and exposure to violent peers in the study. They stated that the impact of violent values was somewhat exaggerated when violent peers and low self-control were excluded. These findings contradicted the conclusions of Felson et al. (1994); however, Berburg and Thorlindsson (2005) found support for Felson’s et al.

(1994) findings regarding the significance of social control processes in perpetuating subcultural violence. Clarke (1998) further discussed subculture by integrating the historical context of an individual needs and the needs to understand the hardships of certain subcultures face and to address these difficulties in society.

As a conclusion, research indicated that high concentrations of violence amongst specific populations and geographic locations can be connected with a variety of social and cultural forces. Unfortunately, there was a paucity of research using culture of violence theory's lens to explain the IPV phenomenon in the Asian context, particularly in Malaysia.

### **Learned Helplessness Theory**

The learned helplessness theory was developed by Martin Seligman to explain women's psychological and behavioral responses to abuse (Walker, 1984) and explore the reasons why victims of IPV often chose to stay in the violent relationships. Seligman first observed "learned helplessness" in experiments with animals and noticed that when animals were placed in an aversive situation without an ability to escape, they appeared to be helpless (Miller & Seligman, 1975). However, this theory was reformulated in terms of human reactions and was applied to victimization (Abramson, Seligman, & Teasdale, 1978). Women who experienced repeated abuse by their partners may develop negative beliefs about their future and feel helpless being in relationships (Walker, 2009).

Walker (1984) proposed the theory of learned helplessness and the battered women syndrome to posit that abused women were passive victims in IPV (Walker, 1984). She argued that IPV survivors often become "paralyzed" and vulnerable to the situation over which they believe to have no control. However, Peterson, Maier, and

Seligman (1993) refuted Walker's statements and argued that passivity may be instrumental behaviors that functioned to minimize the risk of violence, instead of reflecting learned helplessness as it was originally conceptualized.

Based on the argument, several studies were conducted to examine learned helplessness and passivity of IPV survivors. Goodman, Dutton, Weinfurt, and Cook (2003) explored low-income African American women who experienced IPV or domestic violence, found that they used both passive and active strategies for dealing with violence. Furthermore, Dobash and Dobash (1992) agreed with the concept of learned helplessness, but they argued that abused women did not live in a state of 'learned helplessness'; they often engaged in a process of staying, leaving, and returning. Thus, abused women's characteristics, such as low self-esteem, a tendency to withdraw, perceptions of loss of control, and reaction to the violence were the signs of being in the process of an abusive relationship.

Given a thorough review of IPV-related theories allows a closer examination of the need of establishing a theory from health providers' perspectives of IPV in the Malaysian cultural context. Though feminist theory acknowledged the patriarchal dynamics, intersectionality, power, and social constructed gender roles when analyzing IPV, these inclusions were not enough to fully express the cultural background of Malaysian people. The variation of ethnic groups, religion, SES, and collectivism must be considered when addressing IPV in Malaysia (Yusoff, 2010). The need for understanding cultural intricacies within a given society was required for this study. Moreover, family violence perspective and attachment theory that focused more on family conflict and attachment style that developed during childhood threatened the intimate relationships.

Their perspectives were ignorant of the social-cultural factors and centered on the internal factors that occurred within the family and developmental process. As family systems in Malaysia were influenced by the patriarchal structure in society and traditional values that held from generation to generation, the cultural itself intangibly shaped the family communication and attachment style. Thus, viewing IPV from one lens was not enough to conclude IPV phenomenon in the context of this study.

Zannettino (2012) concluded that culturally specific factors had an impact on IPV as well as how it was perceived, understood, and dealt with. The culture of violence theory explained IPV from cultural norms and values perspectives, however, the examples given in studies mostly focused on African Americans, athletes, middle schools, and high schools within the United States. The study perspectives did not take into account the cultural complexity of violence and dynamics impacting on Asian communities, particularly in Malaysia. On the other hand, learned helplessness theory focused on analysis of the help-seeking behaviors exhibited by IPV survivors that were learned from the aversive situation. This theory emphasized IPV survivors' psychological and behavioral responses without considering the contextual factors that impacted IPV survivors' help-seeking behaviors. The limitations of the theories, which included specific cultural factors was one of the research gaps. Hence, it was critical for this study to construct a theory that was grounded in data to reflect health providers' perspective of IPV in Malaysian cultural context.

### **Cycle of Violence**

Intimate partner violence occurred as a cycle and was first identified by Lenora Walker in 1979. The cycle of violence contained three phases: tension-building, acute

battering incident, and loving-contrition. This cycle did not start immediately after the beginning of the relationship due to the partners still having a lot of interest towards each other and it was usually filled with loving behavior (Walker, 2009). By the time abuse happens, the survivor may have already made a commitment to the perpetrator and did not have the desire to break off the relationship.

The first phase, *tension building*, was mainly characterized by emotional abuse. The perpetrator expressed dissatisfaction and hostility to the other, but not in an extreme explosive form (Walker, 2009). The survivor tried to please the perpetrator by doing whatever the perpetrator asked with the hope that the survivor could restore equilibrium in the relationship (Durant, Kephart, & McGowan, 2014). Moreover, stress seemed to build, its intensity increased and communication started to break down. The abusive incidents increased in frequency and perpetrators denied the abusive acts by blaming some external factors, while the survivor kept hoping that things would change at some point. According to Walker (2009), this unrealistic belief also became part of the unpredictable outcome pattern that created the learned helplessness.

In the second phase of the cycle, *acute battering incident*, tension became unbearable (Walker, 1979) and may have been followed by minor occasional assaults or a major single assault (Durant et al., 2014). The survivor was exhausted from the constant stress and tended to withdraw from the perpetrator, fearing he or she will accidentally set off an explosion. According to Walker (2009), the acute battering phase was wrapped up when the perpetrator stopped and brought with its cessation a physiological reduction in tension.

In the third phase of the cycle, *loving contrition*, the perpetrator may have apologized profusely and attempted to convince the survivor to accept the apology or to stay by giving gifts or making promises, showing kindness and remorse (Walker, 2009); this behavior may have remind the survivor of the initial loving relationship. The perpetrator may have also believed that violence would never occur again. At this phase, both partners felt relieved that the conflict was over, even though the survivor may have feel exhausted. However, the acceptance of the promises only occurred if the victim believed that the abuser would change (Anderson et al., 2003). When the third phase was over, a phase of calmness began, which was characterized by the perpetrator's tendency to think that even if the violence were to be repeated, the would always be forgiveness (Durant et al., 2014). When this happened, tension began to build up and the IPV cycle began again.

### **Correlates of IPV**

Many scholars researched factors that affected the risk of IPV for perpetrators and survivors. Most of the risk factors, such as low socioeconomic status, substance abuse, low education level, and a history of some sort of violent experience in the past have been correlated to both the perpetrators and the survivors (Breiding et al., 2008; Capaldi, Knoble, Shortt, & Kim, 2012). Other risk factors discussed in the literature included cultural factors, immigration status, access to firearms, and formal marriage. All those factors emerged as significant risk factors for IPV, but may not have been uniform across countries.

## **Socioeconomic Status**

An individual who was economically disadvantaged in the country encounters higher rates of IPV than other groups. Research over the past 30 years showed a consistent pattern of IPV caused by SES factor (Gelles, 1997). This factor contained three indicators: income, employment status, and educational level that demonstrated a direct association with the occurrence of IPV in intimate relationships. Jewkes (2002) stated that IPV occurred more frequently and was more severe in lower SES groups across the United States, Nicaragua, and India. Women or men who had low incomes were regularly confronted with the economic hardship and stressful life that triggered their risks to become aggressive and violent. Specifically, women who were economically dependent on their partner correlated with the severity of the abuse they suffered (Weaver, Sanders, Campbell, & Schnabel, 2009).

Browne, Salomon, and Bassuk (1999) found American women who lived in households with incomes less than \$10,000 annually were four times greater at risk of experiencing IPV when compared to high-income households. A National Crime Victimization Survey data indicated that the prevalence of IPV increased with the decrease of household income (Rennison & Welchans, 2000). Among African American women, SES was one of the significant factors that increased risk of exposure to IPV (Alim, Charney, & Mellman, 2006). Similar results were found by Malcoe, Duran, and Montgomery (2004). Their study found that 42.8% of Native American women who had experienced IPV reported were in low socioeconomic levels. Additionally, unemployment or employment instability could have created frustration and stress in relationships and increased alcohol use and violence (DeMaris, Benson, Fox, Hill, &

Wyk, 2003). Certainly, the low education levels have limited the employment opportunities and indirectly contribute to the risk of IPV.

In New Zealand, studies found that family poverty in childhood and adolescence, low educational levels, and aggressive delinquency at the age of 15 were strongly predicted male violent behaviors (Moffitt & Caspi, 1999). In Europe, 80% of people viewed SES as a cause of IPV and 70% of people in member states admitted poverty or SES as one of the reasons for IPV, including those in Luxembourg (58%), Bulgaria (63%), Austria (65%), and Spain (65%) (European Commission, 2010). In Southeast Asia, particularly India, the highest prevalence of IPV occurred amongst the working class and the lower middle SES (Nagassar et al., 2010; Sekhri & Storeygard, 2011). However, Bamiwuye and Odimegwu (2014) noted that IPV was higher among women from rich households than those from poor and middle household in Zambia and Mozambique. No correlation was reported by Hindin and Adair (2002) for Filipinos in earnings and employment; by contrast, the male as the primary decision maker in family predicted IPV. Dora and Abd Halim (2011) reported financial problems as the most common cause of violence between partners. The dual career family became more common in order to improve their economic condition, but also the indirect factor for IPV.

### **Education Status**

The association between individual educational background and IPV was common in the literature (Ackerson, Kawachi, Barbeau, & Subramanian, 2008; Dalal, Rahman, & Johnson, 2009). Lower levels of education, however, consistently related to both perpetrators and survivors. According to Dalal et al. (2009), women who reported

lower levels of education had 2 to 5 fold increased risk of being involved in IPV when compared to higher educated women. However, the WHO (2010) showed that higher numbers of educated women reported lower levels of IPV; in contrast, lower educational levels reduced chances for women to gain access to resources, increased their tolerance for IPV, and tended to perpetuate unequal gender norms. On the other hand, Lussier, Farrington, and Moffitt (2009) noted that low verbal IQ among men was a developmental risk factor predictive of IPV. Education also influenced in lifetime and recent IPV as stated by Ackerson et al. (2008), who asserted that higher educational levels for perpetrators were associated with lower rates of IPV. However, women married to husbands with no formal education were more likely to report lifetime IPV.

Moreover, Costa et al. (2013) discovered that European women with primary school or less are likely to be physically and psychologically abuse compared to university level in blue collar workers. In contrast, Kamimura, Ganta, Myers, and Thomas (2014) noted that Indian women who had more than secondary education were at lower risk of IPV when compared to women with no education. Individuals with low education levels assumed to have poor communication skills and lack of problem resolution skills to resolve conflicts in the relationships (Dutton, 2006). There was no research in Malaysia that indicated educational levels were related to IPV.

### **Substance Abuse**

Literature documented the link between alcohol and drug use and the occurrence of IPV in many countries. Often times, people believed that male abuse of drugs or alcohol resulted in the tendency to act aggressively to their partners. Others argued that substance abuse was co-occurrence in IPV. For example, Moore and Stuart (2004) found

that substance abuse was reported in 40% to 60% of IPV. Specifically, Fals-Stewart (2003) noted that on days of heavy drug use, physical violence was 11 times more likely to occur. In fact, the relationship between substance abuse and IPV was commonly identified in primary health care settings.

Roche et al. (2007) investigated 321 adult female patients who reported at least one form of IPV in their lifetime and found that alcohol or drugs were significantly related to IPV. Similarly, Caetano, Nelson, and Cunradi (2001) stated alcohol-related issues remained the strongest predictors of IPV for African American partners, but not for Caucasian and Hispanic partners. The involvement of the male in drinking was associated with an eight-fold increase in IPV. Hankin, Smith, Daugherty, and Houry (2010) identified 20% of women reported being abused in the past, 56% with positive for tobacco abuse, 47.1% with alcohol abuse, and 44.7% with drug abuse. However, Foran and O' Leary (2008) emphasized that alcohol and IPV were associated with both males and females.

In Europe, a study indicated that 95% of respondents admitted that alcohol use was a cause of IPV, followed by 92% who regarded drug addiction as a risk factor for IPV (European Commission, 2010). Furthermore, a multi-country study in Chile, Egypt, India, and the Philippines found that regular alcohol use by the husband or partner led to lifetime IPV across their countries (Garcia-Moreno et al., 2006). Other countries strongly linked substance abuse to IPV, including Africa and Vietnam. In South Africa, violence after drinking was perceived as a socially expected behavior and it also facilitated individuals to act violently to others (WHO, 2006). Although, the harmful use of alcohol

was identified among Malaysians through the WHO research, there was a lack of empirical studies focusing on substance abuse and IPV specifically.

### **History of Violence**

The early exposure of violence or experience of being abused was the factor of IPV consistently cited in the literature. The previous experience of violence, especially during childhood, increased the likelihood of IPV perpetration among men by three or four-fold when compared to men without past violence experience (Gil-Gonzalez, Vives-Cases, Ruiz, Carrasco-Portino, & Alvarez-Dardet, 2007; Schafer et al., 2004).

Meanwhile, DiLillo, Giuffre, Tremblay, and Peterson (2001) reported women who experienced childhood sexual abuse were more likely involved several forms of violence in intimate relationships, such as physical, sexual, and psychological abuses.

During adulthood, women who were previously abused by partners or non-partners were more likely to experience IPV in the future when compared to those without prior exposure to violence. For example, Abramsky et al. (2011) noted that women who engaged in current abusive relationships reported that their mothers and their partners' mothers had been abused in the past (Abramsky et al., 2011). Similarly, men with a prior history of abuse were more likely to show this behavior in their later relationships (Chan, 2009).

A study by Gage (2005) examined the female population in Haiti and found that IPV was significantly associated with all forms of violence, including history of violence within women's families of origin either witnessing the violence between parents or direct experience of physical abuse by family members, or a former partner. Consistently, Boyle, Georgiades, Cullen, and Racine (2009) showed that women who reported previous

IPV were 3.8 times more likely to be abused when compared to those without prior violence experience. The prior history of violence was also related to other issues such as depression, suicide attempts, low self-esteem, and withdrawal.

### **IPV as Normative**

Intimate partner violence has been a social and health problem for many decades and the efforts of combating IPV still continue until today. Public perceptions and toleration toward IPV make the issue more complex. In the United States, Simon et al. (2001) examined 5,238 adults and found the acceptance of IPV was higher among male participants who were younger than 35, with other specific characteristics including non-white, divorced, or separated, or never had married; had not completed high school; had a low SES; or were victims of violence in the past. The similar phenomenon occurred in Europe, where the acceptance of IPV was prevalent in society and victim blaming attitudes were high, both of which contributed to a climate of social acceptability (Garcia & Herrero, 2006). The European Union (2010) conducted a survey in the 27 countries and found that opinions of agreement that women's provocative behavior was a cause of IPV averaged 52% and ranged from 33% to 86% across countries.

Furthermore, Asian cultural beliefs and attitudes perpetrated IPV, especially against the women (Lee & Hadeed, 2009). This was because the members of the Asian community were expected to adhere to the beliefs that males must dominate the household even when it came to making decisions that affected the wife. Actually, in several studies on IPV among minority groups in the United States, some Asian females in intimate relationships claimed that they normally attempted to persevere or cope with

domestic violence through endurance and tolerance as a way of avoiding sentiments of shame (Center for Research on Violence Against Women [CRVAW], 2010).

Yoshioka, DiNoia, and Ullah (2002) found that most Southeast Asian female participants claimed to support the attitudes that gave males privilege over females and allowed males to utilize violence in certain situations such as a wife nag, refusing to clean and cook, or became unfaithful. The WHO (2012) stressed that the man must have a right of asserting power and control over the woman in Asian cultures. In fact, Asians have an attitude that a female's freedom needs to be restricted. Moreover, the association of cultural attitude to Asian women was very commonly focused on the adult heterosexual relationship, but lack of studies focused on dating violence or LGBTQ populations.

### **Collectivism**

Collectivism was a cultural pattern that existed in most Asian countries, as well as in some Eastern European countries (Haj-Yahia & Sadan, 2008). Hui and Triandis (1986) defined *collectivism* as the person's own feelings, beliefs, ideologies, actions, and that constituted collectivism. The family village orientation and religions were the biggest components that contributed to collectivism (Mohan & Sorooshian, 2012). Collectivists tended to give priority to the goals of the group, had a strong sense of involvement in others' lives, behaved on the principle of collective responsibility, and made decisions by consensus (Bagshaw & Porter, 2009; Hui & Triandis, 1986).

According to Haj-Yahia and Sadan (2008), women from collectivist societies believed they represented not only themselves, but their whole community. Some traditions and values such as respect for elders, collectivism, and the concept of face saving were still deeply rooted in the cultures of the community, particularly in Malaysia

(Jamal, 2006). There were several myths about IPV that still existed in Asian culture and tradition: (a) only poor and uneducated men abuse their wives; (b) men have a right to beat their wives; (c) IPV is a private matter; (d) alcohol and drug use cause battering behavior; and (e) women deserve being beaten (Chelliah & John, 2003). Religious, traditional cultures and values, and patriarchal attitudes shaped the mindset and personalities of men, which devalued the role of women (Amirthalingam, 2003; Mohamad & Wieringa, 2014; Niaz, 2003).

Shouts, Magnussen, Manzano, Arias, and Spencer (2010) investigated ten Filipino women regarding their perceptions, responses, and needs towards IPV, and found that the women believed it was their responsibility to keep the family intact at all costs, particularly if they have children, regardless of IPV being present. Adherence to the collectivism values, Triandis (2013) stressed that domestic violence was higher in collectivist cultures.

On the other hand, Asians were concerned with 'face saving', especially to maintain dignity and family honor. Ho (1976) defined face saving from Asian perspective as:

The respectability and/or deference that a person can claim for him/herself from others, by virtue of the relative position he occupies in the social network and the degree to which he is judged to have functioned adequately in the position as well as acceptably in his social conduct. (p. 883)

This concept of maintaining face and avoiding shame both in public and private was vital in the Malays, Chinese, and Indian communities (Kim & Nam, 1998). "Shame" based cultures were inclusively associated with the collectivism and substantial of

harmonious relationship within the family and the society (Hofstede, 2001). Due to the family unit playing a crucial role in the life of every Malaysian, individual's behavior was seen as a reflection of the family's worth in society, particularly among the Chinese people. According to Midlarsky, Venkataramani-Kothari, and Plante (2006), Chinese people did not conceive of separate from the community and they perceived loss of face as the penalty for deviating from cultural values.

Yoshioka and Choi (2005) conducted a survey on the importance of culture in the context of IPV and found that 18% of Chinese women said an abused wife should not report or tell her abuse. This attitude was related to cultural values of preserving harmony in relationships. Asian women did not want to bring attention to their problems for fear of stigmatizing their family and communities (Yick, 2007) and losing face (Lee & Lawy, 2001). Therefore, keeping family harmony and saving family face was highly emphasized in Malaysia.

### **Traditional Gender Roles**

The patriarchal concept was deeply embedded in the traditional gender roles within the family systems. Men were perceived as superior, were valued, controlled the family, and all resources; women were subordinates, reproducers, nurturers of children, and performed domestic chores (Daniel & Milligan, 2013; Lee & Hadeed, 2009). These gender norms placed women in the vulnerable position to extricate their individual rights from the needs and demands of their families and spouses. In the United States, gender roles have been clearly defined since the early of American history. The husbands held the role of the breadwinner; the wives took the role as a caregiver. These traditional

gender roles intangibly have given more power to men and shaped the concept of patriarchy within family systems.

According to Ho (1990), the high value placed on female willingness to endure suffering by Asian cultures often prevents women from disclosing family problems to the outsiders. Additionally, the patriarchal societies may foster IPV due to men being perceived 'appropriately' correcting and disciplining the behavior of their partners in the family (Araji & Carlson, 2001). Specifically, looking into the Chinese family, most of the families still practiced the Confucian social principles, which were a hierarchical authority structure (Archer, 2006). Social order and role assignments were the core elements in the Chinese family. For instance, a girl had to obey her father before she was married, and be subordinate towards her husband and in-laws once married (Yusoff, 2010). In patriarchal Chinese culture, a woman was not supposed to voice or act against her husband's will, and should conform to all his demands (Shen, 2011).

The patriarchal ideology was very similar to the Indian and Malay cultures where a husband was perceived as the primary person to whom a wife must always obey irrespective of his unruly behavior (Yusoff, 2010). This dynamic produced inequitable gender relationships and maintained women's acceptability of male violence (Yusoff, 2010). This patriarchal relationship between husband and wife in the family was part of the wider inequality male and female relationships in Malaysia.

### **Religion**

Religion was another factor that contributed to the risk of IPV in general, particularly when religious concepts were favored to certain groups of people. This phenomenon became a landmark in the history of IPV when most of the churches were

supported by men's right to chastise their wives through the 'rule of thumb.' The NRC DV found that 15% to 25% of all Jewish households experienced IPV (Giller & Goldsmith, 1980). However, Fortune, Abugideri, and Dratch (2010) argued that religious concerns could be roadblocks or resources for those dealing with IPV. The roadblocks or resources depended on the individuals or families in how they handled it. Ross (2013) examined the relationships between Judeo-Christian religion and IPV and noted elements of male patriarchy were integrated in Judeo-Christian scripture and some perpetrators misinterpreted certain scripture to rationalize and defend violence toward their partners. Sixty-six percent of people in Europe also started to see religious beliefs as a factor that affected risk of IPV (European Commission, 2010).

On the other hand, in Indian communities, the beliefs that wives were the property of their husbands and were handed over by the father to her husband were upheld. This transferring process was seen by males as a barter system, in which they had a right to control their wives. By contrast, Indian women believed that it was her 'karma' and she needed to pay back what she deserved. Due to this belief, Indian women tended to stay in an IPV relationship much longer than women of other races (Chelliah & John, 2003).

Specifically, in Malaysia, the Islamic Family Law (also known as the Sharia Law) played an important role in maintaining and strengthening the structure of Malay families. Muslim women were not permitted to contact men outside their immediate family or date male friends alone (Keddie, 2009). Gender discrimination continued to occur, particularly through the practice of polygamy (Hensengerth, 2011; Niaz, 2003). Traditional customs and the Islamic religion permitted the practice of polygamy, in which a man could marry more than one woman but not more than four at any one time.

Alexander and Welzel (2011) indicated that patriarchal values were also an inherent element of the Muslim identity as the wife must obey the husband's words or she would be committing a sin. The family structure was largely based on the principle of Islam as it was written in the 'Qur'an.' Moreover, in the legal context, there was no recognition of women's rights or individual autonomy thus, marital rape was not considered an offense in Malaysia (Amirthalingam, 2003).

As a result, some cultural practices and traditions in Asia reflected and perpetuated gender discrimination and literally allowed the violence against women. It is possible that adherence to the Malaysian values of collectivism over individualism, patriarchy in the gender roles, and religions could have impacted individual attitudes toward IPV survivors, as well as health providers who are in the frontline to serve this population. Hence, health providers needed to be culturally competent by understanding ways of valuing the survivors' cultural beliefs, and coordinating the care with other relevant agencies in order to provide comprehensive care for them.

### **Immigration Status**

Immigration was an issue that received much attention from scholars due to the drastic increase of immigrants since 2012, which was 40.8 million in the United States (U. S. Department of Homeland Security, 2013). According to Bui and Morash (1999), "immigrant women arrive with disadvantages in social status and basic human capital resources relative to immigrant men" (p. 774). Ingram (2007) studied 12,039 participants and compared Latinos and non-Latinos on socio-demographic factors for IPV; he found that non-Latinos reported greater IPV than Latinos at educational levels and at family incomes. However, Latino immigrants were less likely to seek help from formal agencies

than non-Latinos due to their undocumented status, which could lead to their deportation (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Flicker et al., 2011).

Other related factors such as language and cultural barriers, lack of resources, lack of education, and so forth put Latinos in a disadvantageous position (Ramos, Green, Booker, & Nelson, 2011). Ramos et al. (2011) found that immigrant Hispanic girls who were non-English-dominant were one-fourth as likely to have experienced dating violence as those immigrant girls who were English-dominant. In contrast, Sampson (2008) argued that immigrants might have had their own cultural perspectives regarding the acceptability of violence that were different from the United States. The process of acculturation can create stress and frustration, which may prevent them from establishing strong social networks with local people. Consistently, Wright and Benson (2010) supported that cultural differences and strong social networks among immigrants inhibited lower violence rates.

### **Access to Firearms**

Research also found access to firearms was correlated to the risk factors of IPV. The current information regarding IPV in the United States was that firearm access in a family increased the rates of homicides secondary to IPV. The risk related to gun ownership increased to eight fold when the perpetrator was an intimate partner or relative of the victim and was 20 times higher when previous IPV exists (CGPR, 2011). The federal police department indicated 40% of victims ages 15-50 were killed by either a current or former intimate partner and 55% of them were killed by a gun (Fox & Zawitz, 2006). Richardson and Hemenway (2011) and argued that of the women killed with a firearm, nearly two-thirds were murdered by male intimates. Other studies found that

perpetrators who had access to guns tended to inflict the most severe abuse on their partners (Campbell et al., 2003).

### **Health Providers and IPV**

With regard to health providers or health management on IPV, several studies focused on health sector response to IPV, factors behind the development and the national scale-up of the OSCC policy, knowledge, attitudes, and practices of health provider teams. Wong and Othman (2008) identified domestic violence among female adult patients ( $N=710$ ) at eight Malaysian health centers to determine the relationship between social correlates and domestic violence screening. Results indicated that 58% of 40 female patients who reported being abused were Indian, followed by Malay (32.5%), and Chinese (10%). Specifically, 72.5% of those screened positive for domestic violence were from low-income groups compared to middle (22.5%) and high-income groups (5%). One third of the women patients reported that they would not voluntarily tell the doctor about their violent relationships. The results also revealed that primary care had an important role in the identification of IPV. The factors that inhibited or facilitated patients from disclosing their abuse, as well as health providers' services provided were not been included in the study.

Similarly, another study by Othman and Adenan (2008) focused on the health care management in Malaysia assessed the knowledge, attitudes, and practices of primary health care providers. This cross-sectional study used 108 participants. Sixty-eight percent of clinicians reported that they asked their patients regarding IPV at times, but 26.2% admitted they had never asked at all. Time constraints, fear of offending the patients, and uncertainty of how to ask about IPV were reported by 66%, 52.5%, and 32.8%

of the clinicians, respectively. Further, 28% of clinicians and 51.5% of nursing staff had victim blaming attitudes. Less than 3% of participants reported knowing any written protocol for domestic violence management, 20% of clinicians, and 6.8% of nursing staff received some training related to domestic violence. This quantitative study did not present factors that influenced clinicians' attitudes and how they could impact the ways they work with IPV survivors. The study did not include the association between non-physical injuries and symptoms with the respondents' confidence level in asking their patients about IPV problems. Additionally, validity and reliability of the cross-cultural adoption of the instrument were unknown.

Colombini et al. (2011) conducted a policy analysis of the Malaysian response to IPV in the OSCC. The purpose of the study was to investigate the processes, actors, and other influencing factors behind the development and the national scale-up of the OSCC policy. Content analysis and in-depth interviews indicated that a strong partnership between NGOs and government health officer led to the establishment of the OSCC. However, for the long-term implementation, the NGO-health coalition was subsequently broken down due to lack financial resources and clear guidance from the Ministry of Health. Thus, it was a challenge to sustain support from the government to properly implementing OSCCs in the country. However, the researchers did not include the impact of policy makers and government on health providers, as they were the respondents in the front line to serve IPV survivors.

Colombini et al. (2012) explored quantitatively the strengths and challenges encountered during the scaling up of the OSCC model and identified lessons for supporting successful scale-up. Interviews were conducted with 74 participants who were

health care providers, policy makers, and key informants in seven hospital facilities in two states. Three main themes were found (health policy, health care delivery, and provider) with 12 subthemes (low priority to VAW, limited internal coordination at Ministry of Health on VAW, limited inter-ministerial collaboration, lack of national monitoring on VAW, lack of training on IPV, lack of specific protocol on IPV, limited referral to counseling and other support services, poor collaboration within hospitals and between agencies, lack of knowledge/awareness of VAW, confusion on role when dealing with VAW cases, and lack of time) that interconnected at each stage. The research suggested the OSCC model provided a potentially important source of support for IPV survivors. However, cultural factors embedded in health providers, health care delivery level, and policy makers were not counted as the contributing factors for the implementation of OSCC model.

Furthermore, Colombini et al. (2013) explored the views and attitudes of health providers in Malaysia toward IPV. This study involved 54 health care providers in health care facilities in two Northern States in Malaysia. In-depth interviews showed that Malaysian health providers tended to focus on the physical abuse by utilizing the medical model in their treatment. Lack of training and sensitivity of health providers toward IPV survivors minimized the underlying cause of the problem and ignored the emotional care of patients. However, this study did not emphasize how health provider's lack of training and insensitivity impacted on service quality as well as IPV survivors' help-seeking behaviors. Additionally, all of their research was done in the states of Pulau Pinang and Kelantan, where the rates of IPV were not prominent compared to other states, such as Selangor and the federal territory of Kuala Lumpur (Subramaniam & Abdullah, 2003).

Throughout the intensive literature review of health providers and IPV in Malaysia, clearly, there was a paucity of research on how the health providers in Malaysia conceptualized the IPV, what they viewed as risk factors for Malaysian women, what they perceived as the IPV experiences of women, and the factors that influenced Malaysian IPV survivors' help-seeking behaviors. In fact, for many Malaysian women who have been abused, health providers were the main and often the only people being contacted (Wong & Othman, 2008). Phillips, Rosen, Zoellner, and Feeny (2006) suggested the need for further study of Malaysian IPV survivors and the appropriateness of therapeutic services, but there was no research in Malaysia regarding the training on serving IPV survivors. Therefore, the sensitivity and well-trained health providers were crucial to serve the frontline for IPV survivors in Malaysia. This study served to fill these gaps and create a training model that may fit for health providers' needs when working with the Malaysian IPV survivors.

### **Conclusion**

This chapter provided an overview of the literature regarding the history of IPV both nationally and internationally; discussed types of IPV and IPV related theories, cycle of violence, and correlates of IPV, as well as health providers and IPV in specific. Most of the literature indicated that IPV survivors tended to seek help from health providers, but many health providers did not have adequate training, failed to identify IPV survivors' history of abuse, or tended to blame the victims (Colombia et al., 2013; Humphreys & Thiara, 2003). There was a dearth of research that included cultural factors, such as SES, educational status, IPV as normative, collectivism, traditional gender roles,

religion, and immigrant status that directly influenced health providers' service quality, and IPV survivors' help-seeking behaviors.

Specifically, Malaysian health providers' views of IPV for Malaysian women were pivotal because they associated their knowledge, attitudes, and responses to IPV survivors. Thus, the limitations in Colombini et al. (2013) qualitative study that focused specifically on health providers' issues of dealing with IPV survivors did not include environmental factors, as well as cultural factors in the study. Wong and Othman (2008) adapted the WAST as a screening tool for health providers to get information from the survivors. However, factors that inhibited and factors that facilitated health providers to provide a quality service have not yet been explored.

Furthermore, the OSCC was developed since 1994 in most of the emergency and trauma departments, in general hospitals in Malaysia as an effort to combat IPV. The effectiveness of OSCC in helping prepare health providers to work with the survivors is unknown and no study has been conducted to exclusively integrate health providers' recommendations for improving IPV training.

Thus, this study attempted to fill in the gaps by explicitly including inhibiting factors and facilitating factors that influence health providers to work with the survivors; and by taking cultural factors and environmental factors into consideration in order to understand health providers' perspectives of IPV as a whole. Health providers' recommendations for improving IPV training was another focus for this study that may help health providers better understand their needs, and develop awareness and sensitivity in serving the survivors.

## **CHAPTER III**

### **METHODOLOGY**

This chapter provides a description of the methodological approach for this study. It begins with a rationale for using qualitative research methodology, a brief discussion of the selected research paradigm and research tradition, a purpose statement, and the research questions for this study. An in-depth review of the researcher role and the research team, as well as researcher bias, are addressed. This chapter also includes an explanation of participants and sampling procedures that were employed for the study. Additionally, data sources, procedures for data collection, and data analysis are described. Finally, strategies for trustworthiness are outlined.

#### **Rationale for Using Qualitative Methodology**

Qualitative research is the study of a phenomenon in its natural setting and is useful for understanding the meanings people have constructed for an experience and how they make sense of their world and their experiences (Merriam, 2009). The focus on the meaning and process of the study are the cornerstones of qualitative study (Creswell, 2009). This study was concerned with interviewing health providers and learning about their experiences and perceptions of the services and support they provide to IPV survivors. Qualitative research allowed them to tell their perspectives and experiences in depth.

In addition, due to the lack of previous research on IPV in Malaysia, this approach was deemed appropriate and allowed me as a researcher to identify new constructs specific to Malaysian culture. It also helped to develop an understanding of IPV and provide a detailed description of factors that influence health providers' provision of

services as well as IPV survivors' help-seeking behaviors. Moreover, health providers encounter various challenges linked to personal factors such as the lack of competence, time, resources, and training, as well as external factors that include institutional barriers, lack of commitment from police departments, and legislative issues (Rodriguez, Valentine, Son, & Muhammad, 2009). Those factors can best be comprehended through qualitative approach. Thus, by immersing myself into a setting and eschewing any expert role, I was able to better understand the participants' stories. According to Hays and Singh (2012), to understand from the context of the participant is imperative for the researchers to attend to their thoughts, feelings, beliefs, and assumptions that might influence the research process and the researcher-participant relationship.

According to Griffin (2007), qualitative methods allow researchers a degree of flexibility in the conduct of a particular study and facilitate the examination of sensitive or difficult topics through relationship-building between researchers and participants. Because IPV is a sensitive topic that has not been researched in depth in Malaysia, the researcher-participant relationship is instrumental in gathering data related to the research questions.

In addition, qualitative research was linked to the interpretivist's epistemological position where reality and knowledge are seen as being constructed through complex interactions between the researcher and participants (Charmaz, 2008; Mendlinger & Cwiker, 2008; Stake, 2010). A respected qualitative way of moving from individual knowledge to collective knowledge was grounded theory (Strauss & Corbin, 2008).

## **Social Constructivism**

Constructivism is a research paradigm that emphasizes multiple realities, which are constructed through the interactions of researchers and participants to produce and interpret data (Hays & Singh, 2012). As a co-producer, this approach allows the researchers to address why and how questions, go beyond the surface in seeking meaning in data, and explore the complexity of social life within the participant's context. Charmaz (2008) stated that "a social constructionist approach encourages innovation and researchers can develop new understandings and novel theoretical interpretations of studied life" (p. 398). This process contains an abstract understanding of empirical phenomena and constructs meaning and actions in specific circumstances.

For this study, the constructivist approach allowed for discovery as to how health providers make meaning of their experiences in working with IPV survivors and uncover any factors that influence the ways they work with IPV survivors, as well as factors they perceive toward influencing IPV survivors' help seeking behaviors. Ontologically, multiple contextual perspectives and subjective voices from health providers helped me to capture the complexity of the phenomenon under study. Epistemologically, these experiences were socially constructed through my interaction with participants who had direct experiences working with IPV survivors. Values of the participants were accounted for along within different cultural experiences and identities in order to develop a shared understanding of the study. Thus, a social constructivism approach was vital for this study as the experiences of health providers are subjective and can be understood through in-depth conversation between participants and researchers.

## **Grounded Theory**

Grounded theory serves as a methodology of developing inductive theories that are grounded in data regarding participants' perspectives for a particular phenomenon (Glaser, 1978; Corbin & Strauss, 2008). Data are systematically collected and analyzed to generate a theory of the patterns of human behavior in social contexts (Engward, 2013). This exploratory study utilized grounded theory because it sought to move beyond describing experiences to provide an insight into factors influencing Malaysian health providers' services and factors they perceived as IPV survivors' help-seeking behaviors. This insight included their conceptualization of IPV and recommendations to improve training for working with IPV survivors. Moreover, Corbin and Strauss (2008) stressed that grounded theory was useful for analyzing data in exploratory studies.

Furthermore, grounded theory also emphasizes the importance of participant voice and researcher subjectivity (Corbin & Strauss, 2008). Using grounded theory permitted the development of a substantive theory, which increased the understanding of factors that influenced health providers' practices and IPV survivors' help-seeking behaviors. The central aim of grounded theory was to produce a theory to guide action and practice (Glaser & Strauss, 1967).

In this constructivist grounded theory, data and analysis were created from my shared experiences and relationships with participants and other data sources (Charmaz, 2006). I embraced the multiple realities and allowed myself to seek full meaning of the data by paying attention to what participants did not say and sought clarification about what participants did say. Constructivist grounded theory required the researcher to be aware of biases and assumptions throughout the data collection and data analysis

(Welsman, 2007). Bracketing my own biases helped me to identify concepts, thoughts, feelings, and beliefs that needed clarification. Thus, a constructivist grounded theory approach was well-suited for this study and enabled me to explore health providers' competency with respect to knowledge, attitudes, and responses to IPV to develop a theory or conceptual framework about health providers' perspectives of IPV.

### **Purpose Statement and Research Questions**

The primary purpose of this grounded theory was to examine factors that influenced how health providers delivered services to IPV survivors as well as the factors they perceived as affecting IPV survivors' help-seeking behaviors, their views on IPV, and the IPV experiences of women. Thus, I sought to develop a theory to explain the factors that influenced health providers' attitudes, knowledge, and responses to IPV survivors, as well as those factors they perceived to have influenced IPV survivors' help-seeking behaviors. The secondary purpose of this study was to examine their recommendations to improve training to working with IPV survivors. The findings may help improve training and IPV interventions by providing health providers a theoretical framework to develop their self-awareness, and IPV survivors' needs or barriers when seeking help.

The central question for this grounded theory study was as follows: What factors influence Malaysian health providers' attitudes, knowledge, and responses towards IPV survivors? The sub-questions for this study were:

1. How do health providers conceptualize IPV for Malaysians?
2. What factors influence the ways health providers work with IPV survivors?

3. What factors do health providers perceive toward influencing Malaysian IPV survivors' help-seeking behaviors?
4. What recommendations do health providers have to improve training for working with IPV survivors in Malaysia?

### **Role of the Researcher**

The primary researcher's roles in this study were reflexive other than being an insider-researcher. According to Denzin and Lincoln (2003), the qualitative researcher was the primary 'instrument' of the data collection and analysis thus, reflexivity was deemed essential for facilitating understanding of both the phenomenon under study and the research process itself. Being reflexivity allows researchers to use their personal interpretive framework consciously as the basis for developing new understandings (Morrow, 2007). This mechanism was integrated into the guidelines underpinning grounded theory (Dunne, 2011).

During this process, my role was to reflect on my personal experiences regarding IPV and acknowledge any difficult personal reactions that I had encountered throughout the study. I was accountable to how my various reactions to participants' data shaped the interpretation of data (Hays & Singh, 2012). By doing this, I was able to address my subjectivity as a researcher as related to participants that I encountered in the field. Moreover, reflexivity enhanced the quality of research through its ability to extend my understanding of how my position and interest as researcher affected all stages of the research process (Primeau, 2003).

Furthermore, I disregarded traditional definitions of objectivity taken and adopted a researcher's sensitivity towards the participants' meanings (Hays & Singh, 2012). Thus,

I presented the view of participants through the immersion in data and understood the data intimately (Corbin & Strauss, 2008). Corbin and Strauss (2008) asserted, “Sensitivity is required to perceive the subtle nuances and meanings in data and to recognize the connections between concepts” (p. 32). Perhaps, my personal and professional experiences, which I had acquired during years of practice in the field as a practitioner and educator in Malaysia, were the sources of my sensitivity. My knowledge and experiences about IPV allowed me to remain open and sensitive to participants’ perceptions and responses. On the other hand, I was also expected to experience some tension and struggle due to the discrepancies between my previous knowledge, experiences, and values on IPV compared to the participants’ data. Being sensitive and acknowledging its impact on the study helped me remain aligned with the data and interpret it based on the participants’ ways of understanding.

In addition, being an insider researcher allowed me to bring a breadth of understanding about the culture being studied in the natural flow of social interaction, and establish trust relationships with participants that could encourage them to tell me experiences that did not deviate from truth (Unluer, 2012). Through this insider role, I was aware of the possible effects of perceived bias in the data collection and analysis, as well as my insider role on coercion, compliance, and access to privileged information at each stage of the research (Hays & Singh, 2012; Smyth & Holian, 2008).

### **Researcher Assumptions and Biases**

For the purpose of this study, I acknowledged my background knowledge regarding the population of IPV survivors and Malaysian health providers. Both my personal and professional experiences influenced the direction of this study. Personally, I

was raised in an abusive family environment and I witnessed much physical and verbal abuse within my family, as well as in my neighborhood. I empathized with how victims of IPV suffered from their relationships, but they still chose to stay in those relationships in order to retain the wholeness of the family. No one reported violence to the police due to several factors that I observed from the people around me, such as fear of 'losing face', fear of being abused, fear of losing custody of their children, and perceptions of IPV as a private family matter and acceptable cultural norm. Victims' vulnerability to advocate for themselves exacerbated the situation. This experience deeply impacted my perception towards IPV and my professional work with IPV survivors. I believed cultural norms allowed violence to prevail in society and people accepted IPV as a normal phenomenon in Malaysia. This may be considered a bias as some cultural norms and value can affect the process and the outcomes of IPV survivors' help-seeking behaviors, as well as the responses from health providers.

My professional experience in working with IPV survivors for several months provided me with another perspective of treating IPV survivors. As there was scant training provided to health providers working with IPV survivors, most of the health providers only focused on the physical injury that could be found on survivors' bodies. However, I believed the internal injury was far more painful than external injury as it had a long-term impact on IPV survivors. In fact, many IPV survivors chose to seek help in the emergency rooms in hospitals for their physical injury (Colombini et al., 2013; Rodriguez & Battaglia, 2003). As expected, during the interviews and data analysis, I found a strong evidence that treating external injury was the primary response of health providers to the survivors. Thus, I may be more likely to advocate for the survivors

whom I believed should get further treatment from health providers. I expected and found that health providers did not have adequate IPV training that led to their lack of competence in providing services to the survivors.

Additionally, I had several connections with health providers who served IPV survivors in hospitals, social departments, and NGOs. I understood the different service systems that they adopted in serving IPV survivors. My knowledge about the health providers' working environment and their service systems may have affected my research questions and interpretation of the results. I expected that the OSCC that was set up in the emergency and trauma department in hospitals may have provided a more comprehensive treatment for the survivors. I found OSCC is a team-work based service and the survivors could be mistreated during the referral process.

### **Researcher Sensitivity**

Sensitivity is an awareness of researchers' subjectivity and understanding of what is being described in data by immersing in data (Glaser, 2002). The researchers' active self-reflection on the research process becomes a lens into the research process itself (Hays & Singh, 2012; Charmaz, 2008). My previous knowledge and experiences with respect to IPV survivors and health providers, as well as the health care system in Malaysia, could create such sensitivity. By identifying my own authentic thoughts and feelings about IPV throughout the research process, I examined my expectations and convictions about the topic, which I had not acknowledged previously. It was also pivotal for me to be unconditionally accepted by participants during the research process and I took into consideration how these reactions shaped my interpretation of the data. Thus, I

utilized four strategies that included a reflexive journal, research team, independent auditor, and member checking to maintain my sensitivity.

**Reflexive journal.** Reflexive journal is a crucial method in grounded theory that prompts to analyze data and codes early in the research process (Charmaz, 2006). This process helps the researchers increase the level of abstraction of their ideas and capture any thoughts, feelings, or reactions toward the interview and the data. To maintain my sensitivity, I used a journal to record all my personal reactions and perceptions throughout the process of data collection and analysis. I then shared my journal with my research team to help me monitor my personal biases, values, or assumptions that I expected to influence my interpretation and my research questions. The reflexive journal was included in the final analyses as it provided a documented first-hand account of my biases and the preconceptions that may influence my findings.

**Research team.** In order to help minimize researcher bias, I employed a research team of three members to assist with the data analysis process. Using a research team was a crucial component of developing rigor in qualitative research (Hays & Singh, 2012) and examines the results of the data that have been collected and analyzed (Creswell, 2009). The members of the research team were recruited from among the doctoral students and doctoral graduates in Counselor Education and Supervision program at Old Dominion University, who had completed the qualitative research methods training and who had an interest in topics surrounding IPV. For this study, I recruited the diverse backgrounds of research team members with respect to race, ethnicity, and gender. According to Greem, Creswell, Shope, and Plano-Clark (2007), the diversity of research team members can

lead to equal status and authority to impact in the data analysis, interpretation, and validation process.

The first research team member was 32-year-old Caucasian/Hispanic American female. She completed her doctoral degree and was a Licensed Associate Counselor (New Jersey), National Certified Counselor (NCC), and Approved Clinical Supervisor (ACS). She had over 10 years of experience in the mental health counseling field, with expertise in children's behavioral and emotional issues. She worked with children who witnessed and/or were the victims of domestic violence. The second research team member was a 27-year-old European American Female. Currently, she is a doctoral student and a clinical supervisor. She had four years of experience working with clients from diverse backgrounds at the time of the study. She was interested in enhancing her awareness on IPV by getting involved in research and IPV training. The third research team member was a 38-year-old African American male. He was a current doctoral student and had two years of experience working as a college counselor and substance abuse counselor. IPV was an issue that he encountered in his work as a pastor in the past eight years and wanted to learn more about the topic in order to help other people who sought help from him.

In order to gather descriptive data from the research team members, I sent them a descriptive data questionnaire (Appendix A), which consisted of questions regarding race/ethnicity, gender, educational background, professional background, number of years delivering services to clients in general, research interest, and perspectives on IPV. These pieces of information helped me to understand their backgrounds and perspectives. Furthermore, I provided an hour of training to my research team concerning of study

topic and data analysis procedure, checked on their biases and assumptions on the topic, and given a thorough information about Malaysian cultures, as well as how the health care system accepting IPV survivors. I then discussed with them the coding process and subsequently, a line-by-line coding approach was employed. This coding approach was highly recommended by Charmaz (2008) and Corbin and Strauss (2008) for grounded theory studies. I communicated with the research team members four times independently and two group meetings through face to face and/or via adobe connect or face time throughout the research process. We also communicated constantly through email to share our thoughts, feelings, and reactions to the coding and agreed upon consensus coding.

Although the research team members did not involve themselves in the data collection process or interview transcription, they provided feedback and checked the appropriateness of the development and revision of the interview protocols, assisted in coding the collected data, and became involved in the data triangulation process to ensure the themes and theory were grounded in data. They also reminded me about my biases and developed memos about reactions that may have influenced their interpretations of data. This process was crucial to refine themes or categories and to make sure the outcomes successfully reflected the participants' voices (Corbin & Strauss, 2008).

**Independent auditor.** An independent auditor was utilized in this study to examine the process and the product of the study, as well as assessing the accuracy of the study procedures that fit the grounded theory (Creswell, 2009). According to Hays and Singh (2012), the independent auditor should have no connection to the study and be able to review the collection of evidence throughout the research process. In this study I

gathered descriptive data from the independent auditor using the same descriptive data questionnaire (see Appendix A) that I used for the research team members. The independent auditor I selected was a 34-year-old female who identified herself as Taiwanese. She had completed her doctoral degree and was a faculty member in the Psychology and Counseling Program. She was a National Certified Counselor (NCC) and a Licensed Counseling Psychologist in Taiwan. She has worked with Asian clients for over eight years and is familiar with family and women issues in the Asians context.

The role of the independent auditor was to review the data to identify themes and categories that were constructed by the research team and to validate decisions in the final codebook in order to ensure that the results are grounded within the data (Hays & Singh, 2012). The independent auditor reviewed the research team's work and provided detailed feedback at each stage of analysis process: open coding, axial coding, selective coding, and theoretical coding. For example, the independent auditor provided feedback on accuracy of codes based on cultural context and she reminded the research team to keep personal biases on check. She also traced the initial codebook to the original sources in the transcripts, included priori codebook from the pilot study for this dissertation. She provided written and oral feedback on themes or subthemes that need to remove or add on. She reviewed conceptual labels assigned to the themes, and suggested the placement of themes into higher order domains/categories. In particular, she suggested IPV survivors' resistance should move as superordinate theme as it was one of the important factor that influenced both health providers and IPV survivors. She also suggested the research team to think about three levels of changes that were reflected on participants' needs of training. She checked for consistency, redundancy, clarity, and accuracy

between the domains, chunks of data and core ideas by thoroughly reviewing the raw data and the codebook. She also offered input into the actual model demonstrating factors that influencing health providers' knowledge, attitudes, and responses to IPV. The validation of the independent auditor was an important stage to enhance the quality of the study and is helpful for constructing a theory that is accurately reflected in the data. The research team considered the auditor's comments carefully and this auditing process was repeated until all were satisfied that the data have been captured as faithfully as possible.

**Member checking.** Member checking was a strategy used in qualitative research as a quality control process by including participant verification, informant feedback, and research team members' feedback throughout the research process (Harper & Cole, 2012). This process also involved sharing interview transcripts, analytical thoughts, and interpretations with the participants to ensure their ideas were reflected in data (Strauss & Corbin, 2008). The participants had an opportunity to clarify the information that they had given early and pointed out any misinterpretations of their perceptions and experiences. This also allowed the researcher to verify the authenticity and completeness of the work in order to improve the rigor of the study (Cohen & Crabtree, 2006).

In this study, member checking was done via email after each interview. I emailed the full interview transcripts to each participant and asked them to check if the transcriptions were accurately reflected their voices. All participants responded to member checking requests. Only two participants edited their transcripts due to misheard phrase or grammatical errors. PA07 added three clarifications to statements to further explain what he had said. He remarked the changes on the transcript with red color and sent back to me. PA14 also corrected on the transcript with grammatical errors, but no

changes have been made on content of the transcript. At the end of data analysis process, I emailed my results to my participants to verify the accuracy of the themes constructed by the research team and me, and asked for clarification if needed. No additional feedback from participants about the themes.

### **Research Plan**

Prior to data collection, I obtained approval to pursue the investigation on health providers' responses to IPV in Malaysia. I submitted a formal protocol that outlined the proposed investigation to the Human Subjects Committee at Old Dominion University and requested permission to conduct the study. The Institutional Review Board (IRB) approved the study and sent me an exempt letter (see Appendix B).

### **Sampling Procedures**

A purposeful sampling strategy was selected (Palinkas et al., 2013). Participants for this study were recruited using snowball sampling. This method allowed for the inclusion of the typical case for the population under study and permitted the researcher to connect with research participants to locate the additional individuals who met the typical criteria to be interviewed (Sadler, Lee, Lim, & Fullerton, 2010). The inclusion criteria for recruiting participants was as follows: (a) an individual who have formerly worked or currently working in the emergency and trauma departments at general hospitals, NGOs, or the Department of Social Welfare; (b) have had direct experience working with IPV survivors or provide any sort of assistance for IPV survivors; and (c) have formerly worked or currently working within the states of Selangor, Penang, Sabah, Sarawak, and the federal territory of Kuala Lumpur. The states of Selangor, Penang, and the federal territory of Kuala Lumpur were selected for this study because statistics

indicated that these three states had highest rates of IPV cases (Subramaniam & Abdullah, 2003) and no research of IPV had been conducted in Sabah and Sarawak. The differences of geographical locations offered me a new angle of perspectives on IPV for this study. In addition, choosing the participants who work in the particular settings allowed a rich set of data to be extracted from the participants. It gave me a better understanding regarding the phenomenon, research context, and participant context as these aligned with the notion of the grounded theory (Hays & Singh, 2012).

According to Cutcliffe (2000), the selection of participants in the grounded theory was driven by the emerging theory. The sample size was driven by theoretical completeness, which was also known as data saturation. Creswell (2009) and Morse (2000) recommended a sample size of approximately 20 to 30 for grounded theory studies. This number may fluctuate based on the richness of the data collected, but Thomas (2011) stated that it would be wise to anticipate 10 to 30 interviews in order to facilitate pattern, category, and the dimension growth and saturation. Thus, I utilized the theoretical sampling in the recruitment process and constant comparison method to ensure theoretical saturation.

### **Specific Participant Selection Procedures**

For the pilot study, I conducted two interviews with participants. One of these participants was a familiar associate, and the second participant was recommended by a friend who was familiar with the pilot study. Both pilot participants had direct experiences working with IPV survivors within the state of Sabah and the federal territory of Kuala Lumpur. To recruit additional participants for this study, I asked the pilot participants and other known expert informants to connect me to the typical case

participants. After completing each new interview, I asked the participant to help me located the potential participants who meet my research criteria. I then contacted these potential participants requesting their consent to participate in the study. Several participants provided agencies or departments' contact numbers and based on the information given, I able to locate additional participants for this study. Once the participants agreed to participate in this study, I immediately arranged individual interviews with each participant and inquired which video conferencing they preferred.

I recruited 18 participants during the study, including archival data from two previously conducted interviews as part of a pilot study for this dissertation. However, one participant withdrawn after I have scheduled the interview with him because of a busy work schedule. Of 17 participants involved in the semi-structured interviews, all participants were medical doctors, assistant medical officers, nurses, counselors, social workers, or para-counselors who had direct experiences working with IPV survivors.

### **Gaining Entry**

Due to the busy schedules of health providers who work in various settings, initial entry into the field is necessary to help the researcher gains access to research participants (Creswell, 2009; Hays & Singh, 2012). Initial entry into the field was gained through conversations with the pilot study participants who represented typical cases for the study. At the same time, I contacted several individuals who worked in the emergency and trauma departments in general hospitals, NGOs, and department of social welfare in the states of Selangor, Penang, Sabah, Sarawak, and the federal territory of Kuala Lumpur in Malaysia and introduced the study to the potential participants. Once I acquired names of the potential participants, I contacted them to ask if they were interested in participating

in the study. After the participants agreed to voluntarily join the study, I scheduled interview times with each participant and requested them to complete the informed consent form (see Appendix C) and the demographic information (see Appendix D) prior to the interview.

### **Participant Profiles**

The 17 participants included 11 female and 6 male Malaysian adults, who had provided direct services to IPV survivors. Participant ages ranged from 23 to 59 ( $M = 33$ ;  $SD = 9.64$ ). Ethnic identification was Chinese ( $n = 7$ ); Kadazan ( $n = 2$ ); Malay ( $n = 4$ ); Indian ( $n = 2$ ); and Iban ( $n = 2$ ). Participant religion or spiritual affiliation was Buddhist ( $n = 4$ ); Christian ( $n = 7$ ); Islam ( $n = 4$ ); and Hindu ( $n = 2$ ). Participants listed highest degree completed as diploma ( $n = 3$ ), bachelors ( $n = 13$ ), and master's ( $n = 1$ ). Eleven were married and 6 of them were single.

Of the 17 participants, six identified as social workers, 2 medical doctors, 2 medical assistant officers, 3 nurses, 2 counselors, 1 para-counselor, and 1 participant identified herself as a social worker and a counselor. Four participants were recruited from the state of Selangor, Sabah, and Sarawak respectively; three participants from the federal territory of Kuala Lumpur, and two participants from the state of Penang. The participants' year of working experience in their current position ranged from 1 to 39 years ( $md = 3$  years). Furthermore, the total number of years in health settings in general ranged from 1 to 30 years ( $md = 5$  years). Seven participants reported 10% to 20% of their clients had experienced IPV, four participants reported 21% to 30% of their clients had experienced IPV, and five participants reported more than 30% of their clients had experienced IPV. Participants' demographic information is displayed in Table 3.

Table 3

*Participant Demographic Data*

ID	Ethnicity	Gender	Age	Religion/ Spiritual Affiliation	Highest Level of Education	Relationship Status	Current Position	Work Experience <sup>1</sup>	Health Setting <sup>2</sup>	IPV Clients (%)
PA01	Chinese	Female	35	Buddhist	Bachelor Degree	Married	SW	3	5	90
PA02	Kadazan	Male	25	Christian	Bachelor Degree	Single	MAO	2	3	10
PA03	Chinese	Female	33	Buddhist	Bachelor Degree	Married	SW	2	8	15
PA04	Kadazan	Male	23	Christian	Diploma	Single	MAO	1	2	15
PA05	Malay	Male	36	Islam	Bachelor Degree	Married	SW	3	6	25
PA06	Chinese	Female	42	Buddhist	Master Degree	Single	SW/C	10	20	100
PA07	Chinese	Male	45	Christian	Bachelor Degree	Married	MD	15	19	12
PA08	Chinese	Female	37	Christian	Bachelor Degree	Single	SW	1.5	2	60
PA09	Chinese	Female	31	Christian	Bachelor Degree	Married	C	7	7	30
PA10	Chinese	Female	38	Buddhist	Bachelor Degree	Married	C	14	14	30
PA11	Iban	Female	25	Christian	Bachelor Degree	Single	SW	1	1	90
PA12	Iban	Female	59	Christian	Bachelor Degree	Married	P-C	30	30	30

(Continued)

Table 3: Participant Demographic Data (Continued)

ID	Ethnicity	Gender	Age	Religion/ Spiritual Affiliation	Highest Level of Education	Relationship Status	Current Position	Work Experience <sup>1</sup>	Health Setting <sup>2</sup>	IPV Clients (%)
PA13	Malay	Female	25	Islam	Bachelor Degree	Married	N	2	3	10
PA14	Malay	Male	26	Islam	Bachelor Degree	Married	MD	2	4	15
PA15	Indian	Male	42	Hindu	Bachelor Degree	Married	SW	9	15	32
PA16	Indian	Female	29	Hindu	Diploma	Married	N	5	5	15
PA17	Malay	Female	23	Islam	Diploma	Single	N	2	3	20

*Note.* Data presented in Table 3 were reported on the Demographic Questionnaire and reflected participants' data at the time of their interview. SW = Social Worker; MAO = Medical Assistant Officer; N = Nurse; C = Counselor; MD = Medical Doctor; P-C = Para-Counselor; <sup>1</sup> = Years of work experience in current position; <sup>2</sup> = Total number of years in health settings in general.

## **Measures to Ensure Participant Confidentiality and Safety**

Participants' confidentiality and safety were the primary considerations of the study. In order to protect the safety of the participants in this study, I obtained approval of my study from the Darden College of Education's Human Subjects Committee at Old Dominion University (see Appendix B). Prior to the interview, I had each participant review and sign an informed consent form (see Appendix C). I explained to them that their participation was voluntary, and they could withdraw from the study at any time if they felt uncomfortable.

In addition, participants were given the opportunity to member check the interview transcriptions to clarify, modify, or delete any data. I also sent the full report of the results to participants upon written requests. I made sure all participants' identities were masked and replaced with a number. This number applied to all notes, audio-recordings, interviews, contact summary sheets, and transcripts. Furthermore, all identifiable information was removed from study documents. For the security of the documents, I kept all information pertaining to the study in a locked cabinet. All the documents will be destroyed five years after the completion date of the study.

## **Data Sources**

**Descriptive data questionnaire.** A questionnaire was developed for the purposes of gathering demographic information about the participants (see Appendix D). It consisted of items such as: age, gender, ethnicity, religion, relationship status, highest degree completed, work setting, state/region, number of years of work experience in current position, total number of years in health settings in general and percentage of clients who had experienced IPV. Each participant completed the questionnaire prior to

the interview session. A copy of the questionnaire was prepared in Malay language to accommodate participants who had requested to use their native language during the study.

**Individual interviews.** Individual interviews were the primary data collection method for this study. According to Hays and Singh (2012), the interview allowed participants to describe using their own words what was meaningful and important. This method permitted me to further explore the factors that influenced health providers' attitudes, knowledge, and responses on IPV from participants' perspectives and contexts. The interviews were conducted using a semi-structured format. Interviews were 30 to 65 minutes ( $M = 45.70$ ,  $SD = 11.12$ ) in duration; interviews were conducted via Skype or other videoconference software depending on participants' preferences. All interviews were recorded and transcribed verbatim. This close observation of data and carefully listening repetitiously to the recording could contribute to good self-immersion into the data that proved to be important for the data analysis (Bailey, 2008).

**Interview protocol.** There were 17 interview questions and 8 probing questions were used to gather the research data (see Appendix E). A copy of Malay language interview protocol was translated and prepared for participants. I piloted the interview protocol prior to conducting this study. Following the pilot interviews, I asked participants for their feedback about the interview questions. Based on the feedback from participants, question 11 (What, if any, are the interpersonal barriers that you perceive for IPV survivors when seeking help from others?) and question 12 (What, if any, are the intrapersonal barriers that you perceive for IPV survivors when seeking help from others?) were unclear to them. Thus, those questions were modified and question number 9 (How

do those challenges affect the way services are provided to IPV survivors?) was deleted due to its redundancy with question 8. Three questions were added after discussing with the advisor, the research team members, and the independent auditor. For instance, question 7 (How would you determine the presence and history of intimate partner violence for a man who seek treatment?); question 10 (To what degree are these methods or interventions similar to the way you work with other client? Or are they different?); and question 11 (What, if any, resources do you perceive for intimate partner violence survivors who seek help from others).

The Malay language version of interview protocol was used upon the request of participants. I conducted all of the interviews, as I was able to speak both languages. After completing each interview, I did the verbatim transcription and performed member checking with participants to make sure that the content and translation were accurate.

***Validation of the translation process.*** In order to ensure the accuracy of the translation from Malay language to English, I employed a reviewer from Malaysia, who spoke both Malay and English, to check all the accuracy of the translation for demographic data questionnaire, interview protocol, and interview transcripts for participants who requested to speak in their native language. This reviewer had a basic knowledge about IPV and cultural norms in Malaysia and was a 34-year-old Malay female who completed her Master's degree in English and had over four years of proofreading and editing experience. Malay language was her native language. She grew up in Malaysia and understood the cultural and traditional values that were practiced by local people. She was also familiar with the IPV issue that occurred in Malaysia.

The reviewer made some changes on the grammatical errors in Malay language version before I using them for this study. Two participants were requested to use their native language as they felt more comfortable to express themselves. To ensure the interview transcript was reflected participant's intended meaning, I first transcribed the interview based on the original language used by the participants. Then, I performed member checking by emailing the transcript to the participant and asked them to review it to ensure my transcriptions did reflect their voices. I then translated the particular Malay transcripts that were agreed to by the participants into English for the coding and auditing processes. During this validation process, the reviewer compared the original copy of the verbatim transcripts to the English version of transcripts, and provided feedback to me after finishing the review process. A final copy of the English transcriptions was distributed to my research team for the data analysis.

### **Data Analysis**

Data analysis was a core element in grounded theory that served as an 'interplay' between researchers and data (Corbin & Strauss, 2008; Dunne, 2011). It transported the researcher and the data from the transcript to theory (Corbin & Strauss, 2008). In qualitative research, the data analysis process should occur concurrently with the data collection (Hays & Singh, 2012; Gay & Airasian, 2011). This concurrent process provided a few opportunities for the researcher to gather a thick description of the participants' perspectives, as well as contextual information. In the grounded theory, data coding and analysis were based on the method of constant comparison (Corbin & Strauss, 2008; Glaser & Strauss, 1967). This constant comparison served to uncover and explain patterns and variations.

Data analysis in the grounded theory involved four phases: (a) qualitative coding, (b) memo-writing, (c) theoretical sampling, (d) theory reconstruction (Charmaz, 2006; Corbin & Strauss, 1998; Glaser & Strauss, 1967). Coding prompted the researcher of the empirical level by fracturing the data, and conceptual grouping it into conceptual codes that then became the theory that explained what was happening in the data (Glaser, 1978). Memo-writing allowed the researcher to write informal analytical notes about the data and enabled the researcher to move swiftly from description to conceptualizing data (Charmaz, 2011). Through theoretical sampling, the researcher compiled the data to develop and refine theoretical categories until the properties of categories are saturated (Thornberg & Charmaz, 2011). Finally, theory reconstruction synthesized the categories developed in the previous phases to explain the data collected (Charmaz, 2006). Comparative methods were used at all levels of analysis.

**Qualitative coding.** Qualitative coding was the fundamental analytic tool that engages the researcher to define the data into meaningful segments and assign names for the segments, combine the codes into broader categories and construct a theory based on the categories (Creswell, 2009). This coding process is also known as a constructive process according to Charmaz (2006) as it involves theory development at the end of the process. Strauss (1987) and Corbin and Strauss (2008) suggested three phases of coding process in the grounded theory: (a) open coding, (b) axial coding, and (c) selective coding.

**Open coding.** Open coding was the initial step of discovering concepts. It required the researcher to break down the data into discrete parts, to have them closely examined, compared for similarities and differences, and to raise questions about the phenomena reflected in the data (Corbin & Strauss, 2008). Grounded theory coding

involved events, actions, objects, interactions, or statements that were presented in the data. In order to capture all the important categories and ensure the grounding of categorizing the data is beyond impressionism, I utilized a line-by-line coding approach. This approach was recommended by Glaser (1978) and Charmaz (2006). They believed that the detailed consideration of the data could help researchers be free from their preconceptions and enhance their theoretical sensitivity through data immersion.

During an open coding phase, each research team member was given copies of the first two interview transcripts and was engaged in the initial line-by-line coding independently. We then met after we completed the first two transcripts coding for consensus coding. The consensus was reached with the first two sets of interviews, and then the research team members and I compared the consensus codes with a *priori* codebook that was developed during a pilot study. We utilized constant comparison technique by comparing codes found in each subsequent set of the interviews in the first set. Then, each member was given another two copies of the interview transcripts, and they used the same approach for coding. After completing the coding, I scheduled a meeting with each member separately to determine and discuss the existing categories and compare them with the new emerging themes. We also communicated through email and memo-writing about our immediate thoughts, feelings and reactions. In this fashion, all of us reviewing the first four transcripts and agreed upon the codes that emerged in the data. For each additional transcript, at least one of the research team member and I were coded and analyzed the interview transcript. I met each research team member individually after they finished their coding, either through face-to-face or Face time. The same process was repeated for the rest of the interview transcripts until saturation was

achieved. My research team and I met for consensus coding and created an initial codebook collaboratively. The independent auditor reviewed audit trail materials throughout each phase of data analysis and interpretation process. Then, we moved on to the axial coding.

***Axial coding.*** Axial coding involved reassembling data that were fractured during open coding (Corbin & Strauss, 2008). The purpose of axial coding is to recombine the data by making connections between the categories and subcategories and specifying the dimensions and properties of the categories (Rintala, Paavilainen, & Astedt-Kurki, 2014; Corbin & Strauss, 2008). Hays and Singh (2012) stressed that axial coding requires the researcher to refine open coding and examine relationships among the large open codes to understand the theory that emerges from the data. This connection focused on the condition in which the phenomenon occurs, the actions or interactions of the people in response to the situation, and the consequences of the behaviors (Corbin & Strauss, 2008).

During axial coding, my research team members and I took the initial codes and applied them to new data (Charmaz, 2006). This phase focused on developing categories that were identified from constant comparison. This process was not a linear process and required us to revisit earlier data frequently in order to search for variation from the core categories, also to synthesize and explain the codes. For example, after every two or three interviews, the research team members and I independently reviewed and highlighted all materials that emerged by refining the initial codes and starting to conduct a data synthesis. Next, we met to perform consensus coding and refine the codebooks. I also requested research team members to provide feedback on any possible misinterpretation of the data. This process involved a continuous revision of definitions to make sure the

codes were driven by data through the constant comparison method. I then sent the revised codebook to the independent auditor and discussed with her about concerns or insight. She reviewed and provided feedback to me before I moved forward to the next phase. Axial coding led to selective coding.

***Selective coding.*** Selective coding is also known as theoretical coding that is used by many grounded theorists (Charmaz, 2006; Corbin & Strauss, 2008). This phase is the most complex coding process in grounded theory as the researcher needs to identify patterns, processes, and sequences among axial codes to construct a theory about a phenomenon (Hays & Singh, 2012). According to Corbin and Strauss (2008), the grounded theory only emerges after the process of crucial integration of weaving and refining all the major categories into the selection of a core category.

During selective coding, we worked collaboratively to fully explore and analyze all new and existing data to ensure consistency and objectivity in the process of analysis. Moreover, all memos the researchers had written throughout the process of abstraction and reflection, along with the major identified categories, were reviewed. My research team and I created a final codebook after the coding process was completed. As a final step, I reviewed the final codebook and cross-case display with my research team to address the rigor and comprehensiveness of the study. We met through adobe connect and we reviewed the final codebook in detailed by considering personal biases, thoughts, or feelings, as well as participants' statements. This process helped me move from the analytic story towards the theoretical development (Charmaz, 2006). All material then reviewed by the independent auditor to ensure the accuracy of categories that embedded in data.

**Memo-writing.** Memos were the written notes about ideas that further explain the data and the coded categories (Charmaz, 2006). It is used to capture discrepancies, concepts, emerging ideas, and the reactions of researchers, and participants throughout the study (Rich, 2012). This is an important step in theory development to help the researcher connect the analytic framework that provides a broad description of the ideas developed in the final product (Birks & Mills, 2011). Thus, memo-writing started with the first interview until the stage where the study was completed. This process was parallel with all other grounded theory methods and it served as a final source to refine the codes through constant comparison.

I employed memo-writing throughout the research process to systematically move from description to conceptualization of the core category. My research team and I reflected on the data during the coding process and wrote down any feelings, thoughts, reactions, or ideas related to the data in an analytical and personal sense. By doing this, we were able to uncover incomplete categories and gaps in the data analysis. We updated the analysis progress regularly on particular concepts, thus evolved into memos that were of more depth and complexity (Corbin & Strauss, 2008). These notes were included as an important source to compare with the materials gathered in order to generate a theoretical outline that explains about a phenomenon.

**Theoretical sampling.** Theoretical sampling was an integral part of the analytic process of the grounded theory. This data collection method was based on concepts emerged from the data were simultaneously collected, coded, and analyzed using activities and events related to IPV disclosure to saturate the evolving theory and increase its level of abstraction (Schwandt, 2001). According to Corbin and Strauss (2008),

theoretical sampling was used in conjunction with the three levels of the coding process. Continuous comparison between the developing theory and the raw data was important until no new findings or views emerged about a concept or category, a process that was called saturation (Thornberg & Charmaz, 2011).

In order to reach saturation, the research team and I coded the data and compared the initial codes to new categories. I included memos in this constant comparison process and began to tailor them to the categories that had been constructed. I continued the data collection process to gather new insights and refine the concepts until the data were saturated. After every two to three interviews, I met with my research team for consensus coding and constant comparison. I noticed that there was no new data identified for PA15. Then, I collected another two participants to help me verified and ensured the saturation of the data. I stopped data collection after PA17. The utilization of theoretical sampling allowed me to build full and robust categories, as well as clearly explain the relationship among categories. The research team and the independent auditor reviewed and evaluated the data to identify themes and categories were saturated and the results were embedded in data.

**Theoretical reconstruction.** The final stage of the data analysis process involved theoretical reconstruction. According to Charmaz (2011), this stage is a transformation of analytic processes towards producing the grounded theory. Interpretive theory that emphasized on the abstract understanding of the studied phenomenon was used as a guideline to construct a theory. This approach allowed for indeterminacy rather than seeking for causality and aiming to theorize patterns and connections (Charmaz, 2011).

In order to generate a theory grounded in data and to include researchers' subjectivity, the research team and I looked from multiple perspectives, examined the participants' contexts, made comparisons, and built upon ideas. The research team and I decided to choose a theme or subtheme that have been mentioned by at least two participants. We implicitly examined factors that influenced Malaysian health providers' provided services, factors that influenced IPV survivors' help-seeking behaviors, and their recommendations on improving training to work with IPV survivors. By considering the purposes of the study, we then made connections with the data to form relationships between categories.

Further examination was done between main themes and subthemes and main themes and superordinate themes to make sure they fit as subsets of the themes and superordinate themes. Thus, the data were presented as a hierarchy of three levels, including superordinate themes, themes, and subthemes (Attride-Stirling, 2001).

### **Strategies for Trustworthiness**

Trustworthiness is parallel with the criteria of internal validity, external validity, reliability, and objectivity to establish scientific rigor (Guba, 1981). Hays and Singh (2012) described several criteria for trustworthiness and suggested specific strategies to address each criterion. In this study, trustworthiness was defined according to four criteria: credibility, dependability, confirmability, and transferability. Credibility referred to the 'believability' of the study and it was the standard one should use to judge the quality of the study (Creswell, 2009; Lincoln & Guba, 1985). Dependability referred to the consistency of the study results over time and across researchers. Confirmability was the degree of the research findings that represented the genuine reflections of the

participants (Lincoln & Guba, 1985). Transferability in qualitative study was the detailed description of the research process, including participants, settings, and time frame that allowed readers to make decisions about the possible replication of the findings to their own contexts (Hays & Singh, 2012).

In order to maintain the rigor of this study, I employed several strategies of trustworthiness throughout the study. Credibility was established through memo-writing after each interview and throughout the coding process. Thick description was used to provide a detailed account of my research process and outcome, and created an audit trail to provide physical evidence of systematic data collection and analysis procedures. Prolonged engagement was another technique I used throughout the research process by immersing myself in the data, interacting with my research team and participants to help me understand the context and culture of the study.

Dependability is parallel to the concept of reliability that looked into the stability of findings over time (Hays & Singh, 2012). To ensure dependability in this study, I utilized triangulation of researchers and auditor to review that the themes or categories constructed were grounded in data. The auditor reviewed the audit trail to determine if the research team and I have completed a comprehensive and rigorous study and validated the results that were embedded in the data.

To ensure confirmability, I applied member checking, memo-writing, and prolonged engagement techniques to make sure my interpretation of the data was not influenced by my own biases. I bracketed my biases and expectations through memo-writing during the consensus coding process, and revisited the raw data frequently in order to stay as closely aligned with participants' voices as possible. Moreover, I did

member checking with participants after completing the first interview through email checking. I asked any questions that I had regarding the data in order to get further explanation from participants that could help reduce my biases. Prolonged engagement was another way to keep me closer to the data and understand the data from the point of view of the participants and the context.

Thick description allowed readers to make decisions regarding transferability (Lincoln & Guba, 1985). To ensure transferability, I provided a thick description of the participants and research design and method, as well as included the triangulation of researchers in the data analysis to enhance the transferability of the study. Additionally, theoretical sampling was required to be varied to enhance the possibility of transferability. Bitsch (2005) suggested that purposeful sampling is another technique for transferability as a great deal of contextual variation can be integrated in the research; this could provide a database as comprehensive.

## **CHAPTER IV**

### **FINDINGS**

This chapter will present the results of the study that emerged from participants' responses to answer the research questions. This chapter also includes a graphic representation of the theory that was generated from data regarding the factors that influence health providers' responses to IPV survivors, their perceptions of IPV survivors' help-seeking behaviors, and their recommendations for improving training to work with IPV. The central research question for this grounded theory was: What factors influence Malaysian health providers' attitudes, knowledge, and responses to IPV survivors? Four sub-questions guided this study were:

1. How do health providers conceptualize IPV for Malaysians?
2. What factors influence the ways health providers work with IPV survivors?
3. What factors do health providers perceive toward influencing Malaysian IPV survivors' help-seeking behaviors?
4. What recommendations do health providers have to improve training for working with IPV survivors in Malaysia?

The results are organized into three category levels: Superordinate themes, themes, and subthemes. The research team identified 9 superordinate themes, 23 themes, and 71 subthemes that answered the research questions listed above (see Table 4). These categories will be discussed in detail in the remaining section of this chapter.

Table 4

*Superordinate Themes, Themes, and Subthemes by Research Question*

<b>Superordinate Theme</b>	<b>Theme</b>	<b>Subtheme</b>	<b>Research Question</b>
Perceptions of Men and Women in General	IPV gender stereotyping	Women as victims Men as perpetrators Denial of male IPV victims Gender discrimination	Central question & Sub-question 1
Conceptualization of IPV	Types of IPV	Physical abuse Sexual abuse Emotional abuse	Central question & Sub-question 1
	IPV outcomes	Mental health issues Behavioral outcomes	
	Types of relationships	Marital relationship Partner relationship No prior relationship	
	Risk of IPV	History of abuse Substance abuse	
Training	Short-term training	Experiencing in vivo training scenario General counseling skills and interventions Advanced training program	Central question & Sub-question 2
	Inadequate training	Non-specific IPV training Centered on female survivors	
Institutional Factors	Internal factors	The need to collaborate with other departments Protocol in treating IPV survivors Delaying responses to survivors Professional supports Lack of resources Busy working environment Lack of supervision	Central question & Sub-question 2 & 3
	External factors	Police department response Abide by religious principles	
Providers' Personal Factors	Work performance	Lack of competence Lack of self-efficacy Resistance to Professional Roles Victim blaming	Central question & Sub-question 2 & 3
	Self-experience and assumptions	Personal experience of being abused	

(Continued)

Superordinate Theme	Theme	Subtheme	Research Question
Sociocultural Factors	Cultural values	Differences in self-values and beliefs Emotional reactions Traditional gender roles Religious values Accept IPV as normal Collectivism Educational background Socioeconomic status	Central question & Sub-question 3
	Lack of legal awareness	Women's acts and women's rights Child custody	
IPV Survivors' Resistance	Internal factors	Fear of being judged Wanting to repair the relationship	Central question & Sub-question 2 & 3
	External factors	Lack of trust Lack of protection and support	
Professional Responsibilities	Acting as a first responder	Focus on external injuries (medical model) High vigilance	Central question & Sub-question 2 & 4
	Protocol of services	Screening Referral of clients to other departments Involvement in legal process	
	Treatment	Counseling services Crisis management	
	Prevention	Provide psychoeducation to public No direct involvement in prevention	
	Being sensitive	Considering multiculturalism Empowering clients in decision making Respecting client's privacy	
Recommendations for Improving IPV Training and Services	Personal changes	Communication skills Continuing Education Self-awareness	Sub-question 4
	Institutional changes	Practical protocol or guidelines for treating IPV survivors Better referral sources Support team Inter-agency collaboration Provide supervision	
	Societal changes	Psychoeducation for the survivors Legal knowledge Increase public awareness on IPV	

*Note.* The connection between research questions, superordinate themes, themes, and subthemes demonstrates coherence across rounds of data analysis.

### Superordinate Theme One: Perceptions of Men and Women in General

This superordinate theme of health providers' perception of men and women in general refers to health providers' perceptions on how men and women are treated in Malaysia in regard to IPV. This superordinate theme consists of a theme *IPV gender stereotyping*, and four subthemes: *women as victims*, *men as perpetrators*, *denial of male IPV victims*, and *gender discrimination*.

**IPV gender stereotyping.** All participants ( $n = 17$ ) reported gender stereotyping when discussing how men and women are treated in terms of IPV. IPV gender stereotyping refers to pervasive beliefs or stereotypes about women being victims and men being perpetrators in an IPV relationship. These negative perceptions were reported to produce gender discrimination in Malaysia. Table 5 displays the theme and subthemes with the perceptions of men and women in general.

Table 5

#### *Perceptions of Men and Women in General*

Theme & Subtheme	Number of Participants who Endorsed the Theme or Subtheme ( $n$ )	Percentage (%)
IPV Gender Stereotyping	17	100.00
Women as victims	17	100.00
Men as perpetrators	17	100.00
Denial of male IPV survivors	10	58.82
Gender discrimination	11	64.71

***Women as victims.*** All participants ( $n = 17$ ) mentioned that women are the victims in the abusive relationship. Words use to describe women as victims included women as weak, helpless, and vulnerable. In addition, the participants perceived IPV as against women and wives. They used the term 'she' or 'women' to indicate the survivors'

gender throughout the interview process. For example, PA01 stated, “I found that 50%, may be not more than 50% of women were being abused by their partners. However, there were many unreported cases.” PA05 and PA06 had similar perceptions that, “Women have greater potential to be victims than men.” Most of the participants of the study directly assigned, “the man is perpetrator and the woman is the victim” in their statements, and consistently stereotyping men and women’s roles in IPV (i.e., PA12, PA14, PA16, and PA17). Specifically, when the participants shared their professional experiences of working with IPV survivors, almost none of them mentioned male survivor cases.

***Men as perpetrators.*** Men as perpetrators were presented in 100% ( $n = 17$ ) of the study sample. Men as perpetrators refer to the notion that men commit the majority of violent acts against women. This study found that participants described male perpetrators as unemployed, having low self-esteem, a bad temper, experienced some kind of stress at work, and failure to control their emotions. PA03 stated, “Most of the physical abuse is committed by men.” Similarly, PA04 also pointed out that IPV usually involved husbands or partners as perpetrators. This statement was echoed by other participants such as PA02, PA08, PA09, and PA10 to emphasize that male partners or husbands are the perpetrators in an abusive relationship. PA15 further explained IPV phenomenon in Malaysia by stating that, “Most perpetrators are men and that victims are women and children. So, perpetrators didn’t need any assistance from us, unless if they have a mental illness. Then they might be referred to the hospital or a psychiatric department.”

Other situations that described men as perpetrators were noted by PA14, “A lot of instances of sexual harassment, molestation, theft, road rage, and violence toward women are committed by males. Men view females as a weak group who cannot fight others in a violent way.” However, based on the experience working with women survivors, PA09 explained, “Women survivors do not perceive their husband’s violent behaviors as abuse. They might believe that their husbands simply have a bad temper and easily become angry. They don’t see it as violence or abuse.” Thus, health providers’ stereotypes of men as perpetrators might be contradicted to the survivors’ experience of IPV, in particular within their cultural context.

***Denial of male IPV survivors.*** Ten participants denied that there were male survivors. They did not believe men could be victims of IPV, and they had no experience working with male survivors. For instance, PA02 said, “No, I haven’t had any male survivors [chuckled]. I don’t think I can answer you because I have not met any men who were abused by their wives or partners.” He then added, “For me, men will be protected by their egos. They usually don’t tell others that they were scared of their wives [chuckled]”. PA11 also admitted, “I haven’t received any reports or calls regarding women beating their husbands. We don’t have this kind of case.” PA13, PA15, and PA17 also indicated no experience with male survivors. PA12 even expressed that she could not imagine how men could be abused:

No, not that I know of, I don’t remember having any male survivors. I am not sure; I am not sure how true it is because usually they do not come to us to seek help. I don’t know how it could happen – that is, men being abused.

PA16 tried to give a reason for her rejection of male survivors by saying that, “Most male survivors suffer from other types of violence rather than domestic violence or IPV.” On the other hand, seven participants (41.18%) recognized male IPV survivors as possible cases or underreporting cases, but they admitted having had minimal experience of working with male survivors (i.e., PA01, PA03, PA04, PA05, PA06, PA07, PA10, and PA14).

***Gender discrimination.*** Gender discrimination refers to prejudice or discrimination based on a person’s sex or gender. It occurs in many forms, including education, jobs, politics, and economics. Eleven out of 17 participants (64.71%) thought that gender discrimination was a serious issue in Malaysia and inequality among men and women was common in the society. PA05 acknowledged that,

Men have more power than women in most aspects, because people view [that] men can do better than women, and that men can become leaders. Fewer women are involved in high positions or earn more money than men due to society’s perceptions and norms.

PA15 noted a similar situation that occurred for women: “Fewer women [are] involved in politics... they will not be able to gain a higher position due to the patriarchal system and people’s mentalities about women’s roles.” He then elaborated, “A lot of arguments concern how women should behave in public, especially Muslims. Due to societal norms, men seem to have more advantages than women to get good jobs.”

In terms of decision-making, PA06 described, “A lot of time women’s voices are not heard because people feel that women’s opinion cannot convince them.” Further, PA17 noted, “Women struggled to prove themselves as people trust men’s ability to lead

the country more than they do women's." The same pattern of how men and women's statuses can be found in the statement by PA12:

If the job requires decision making, then mostly men will be hired for that position. Based on my observations, private companies and government offices usually hire men as their leaders. Even though there are some opportunities for women, there are not enough. Sometimes, women excel more than men, but when it comes to decision making, women are excluded. So, it continues to be a long process for us to change people's perceptions of the fact that women can make important decisions, too.

In contrast, PA14 spoke that based on male perspective inequality occurs to men in terms of dowry payment for marriage. He stated, "Many men struggle to pay a dowry due to the income they earn. Sometimes, I feel that cultural values have created discrepancies between men and women, as well as between rich people and poor people." Thus, the participants agreed that IPV becomes a complicated issue due to the intersectionality of socially-accepted stereotypes and discrimination of gender in Malaysia.

### **Superordinate Theme Two: Conceptualization of IPV**

The second superordinate theme related to health providers' *conceptualization of IPV*. It refers to health providers' knowledge of IPV, particularly in defining and conceptualizing IPV based on their experiences. Four themes connected to this superordinate theme were *types of IPV*, *IPV outcomes*, *types of relationship*, and *risk of IPV*. Additionally, ten subthemes were found to describe in detail the spectrum of IPV

from the participants' perspectives. Table 6 displays the themes and subthemes for health providers' conceptualization of IPV.

Table 6

*Conceptualization of IPV*

Theme & Subtheme	Number of Participants who Endorsed the Theme or Subtheme ( <i>n</i> )	Percentage (%)
Types of IPV	17	100.00
Physical abuse	17	100.00
Sexual abuse	15	88.24
Emotional abuse	14	82.35
IPV Outcomes	13	76.47
Mental health issues	11	64.71
Behavioral outcomes	6	35.29
Types of Relationships	17	100.00
Marital relationship	17	100.00
Partner relationship	16	94.12
No prior relationship	6	35.29
Risk of IPV	11	64.71
History of abuse	7	41.18
Substance abuse	6	35.29

**Types of IPV.** The term of IPV describes physical, sexual, or psychological abuse by a current or former partner or spouse. All participants ( $n = 17$ ) mentioned some types of IPV when they were asked to define the term in their words. Three subthemes were identified: *physical abuse*, *sexual abuse*, and *emotional abuse*.

**Physical abuse.** Physical abuse refers to the intentional use of physical force with the potential for causing death, disability, injury, or harm. All participants ( $n = 17$ ) acknowledged that physical abuse was the most common type of abuse that was identified during the initial entry of IPV survivors. There are various words associated

with physical abuse, such as beating, hitting, acting aggressively, burning, cutting, or using tools. PA06 shared that, “Many of the survivors have been beaten, hit, kicked, burned with cigarettes, punched in the face, or abused with tools or weapons.” PA01 also asserted, “I can see from their faces, their arms, they got bruises or cut or anything on their bodies.” PA07 as a medical doctor recalled his experience of handling a client’s case:

I had a client who was abused by her husband. She had a physical injury when she came to seek help in the emergency room. At the beginning, she denied being abused, but because her injury was obviously due to her being beaten by someone, through the initial screening we successfully identified her problem.

PA13 shared one of her client’s cases that involved a severe physical abuse:

One case that I handled previously that involved a woman who was being abused badly by her husband. He beat her with hard wood and broke some of her bones. He wanted to kill her, but luckily her neighbor helped by calling the police department. She was sent to us in an unconscious state and with a lot of blood on her head. I couldn’t gather any information from her, but she received immediate physical treatment from a medical doctor.

PA08 reported her client had experienced more than one type of abuse such as being beaten, hit, kicked, or sexually abused by their husbands. She also recognized physical abuse as the most common type of abuse among her clients.

***Sexual abuse.*** Sexual abuse involves molestation, forcing undesired sexual behavior by one person upon another. It can be very difficult for the survivors to express themselves about their sexual abuse experiences to others. Fifteen of 17 participants

(88.24%) indicated sexual abuse as mostly done by husbands, partners, or unknown individuals. PA02 stated, “The guy who liked her actually raped her. When she got pregnant, the family, her parents asked her to marry him.” PA03 also stressed, “IPV involves sexual abuse, rape, and forced involvement in sex activity with other guys.” PA17 reported, “Some of the sexual abuse involved individuals who may not have [had] any prior relationship, but they are being abused or sexually abused by strangers.” This type of abuse was as common as physical abuse due to the physical evidence that can be found on the survivors’ bodies. For example, most of the participants mentioned sexual abuse at least once during the interview, except PA01 and PA09.

***Emotional abuse.*** Emotional abuse is a hidden type of abuse that involves trauma to the victim caused by acts, threats of acts, words, gestures, weapons, or coercive tactics. This type of abuse was reported by 82.35% ( $n = 14$ ) of participants in this study. Some examples of emotional abuse towards survivors included: humiliation (PA03, PA05), degradation, calling or labeling them ‘stupid’ (PA03, PA10), threats (PA06, PA09), financial control (PA03, PA06, PA13), and not allowing them to go out of the house (PA03, PA06).

PA06 further described, “Threatening to kill their family members or children makes the victims feel scared and so they stay in the relationship.” PA03 stated, “At the beginning, husbands may financially control them and create tension in the relationship. Then, at one point, they might act aggressively against their wives.” In addition, PA14 acknowledged that,

Coercive tactics included threatening the other partner, hurting family members, or abusing the partner in any way that scares or harms him or her. Not providing

financial support to the family or humiliating family members can be part of the [emotional] abuse as well.

Due to emotional abuse is difficult to identify by providers, PA14 affirmed, “People tend to hide it as family matter and no one wants to tell others about their family issues or conflicts.”

**IPV outcomes.** IPV outcomes refer to the consequences of IPV towards the survivors in respect to their mental health, physical health, or behavioral outcomes. Thirteen participants (76.47%) agreed that IPV had long-term effects on the survivors that can be both physical and psychological. This theme connected to two subthemes: *mental health issues* and *behavioral outcomes*.

***Mental health issues.*** Mental health issues refer to those such as depression, stress, suicide, post-traumatic stress disorder (PTSD), nightmares, insomnia, and emotional instability. Eleven of 17 participants (64.71%) reported that their clients had experienced some kind of mental health issues after IPV incidents. Common terms mentioned by participants included trauma, depression, suicide ideation, and emotional instability (i.e., PA10, PA12, PA13, PA14, PA15). For example, PA01 admitted her personal IPV experience: “I took other alternatives to help me reduce my depression, where I took medicine to calm my emotions. One time I was rushed to the hospital due to overdose.” PA04 also stated, “The survivors may go through a lot of problems because no people can help them. They might commit suicide or develop depression, emotional problems, and other mental health issues.” PA16 recalled one of her client’s situations and stated, “She was emotionally unstable and we thought she might need to see our counselor or psychiatrist.” In additional, PA17 indicated, “IPV survivors may take a long

time to recover from their traumatic experience, but some may recover quickly depending on the client's situation."

***Behavioral outcomes.*** Behavioral outcomes include the acts of the survivors or perpetrators to end IPV situation. Six participants (35.39%) spoke about behavioral outcomes of IPV during the interviews. In particular, PA06 talked about one of her clients' report after being abused:

A women who had run away from her house with her three children from another state did not have a place to stay. She contacted me, and I provided shelter for her and assisted her to plan out their future lives.

PA02 disclosed one of his severe client's cases by saying, "A pregnant woman who was being abused by her husband had experienced a miscarriage or complications about having a baby. Miscarriages could lead to the death of the mother if the survivor delayed seeking help in the hospital." He then added, "The survivors might run away from home, or the worst is that they might kill their husbands." Additionally, PA11 narrated a client's situation: "She managed to run away from the house and stayed at her neighbor's house, but her husband hunted for her around the neighborhood." Her narration had described behavioral outcomes on both the perpetrator and the survivor and had a high possibility of causing death to both sides.

***Types of relationships.*** The conceptualization of IPV also includes the types of relationships that was described by the participants. It focuses on individuals who are involved in abusive relationships, whether they were married, in a partner relationship, or non-partner relationship. All participants ( $n = 17$ ) related IPV to three types of

relationships, which were also identified as subthemes of this study: *marital relationships*, *partner relationships*, and *no prior relationships*.

***Marital relationship.*** Marital relationship refers to the relationship between a wife and her husband, and they are legally bonded to each other. All participants ( $n = 17$ ) found IPV is embedded in the marital relationship and it was a trigger for marital conflict and divorce. For example, PA04 stated, “A husband had beaten his wife. The wife came to the emergency room to seek treatment for the injury in her eyes.” PA06 and PA07 emphasized, “IPV mostly involved husbands and wives. Because of power differentials, women are abused by their husbands.” All participants were used the term ‘husbands’ and ‘wives’ when retelling the survivors’ stories. Their statements were aligned with the traditional cultural values that marriage is perceived as legal relationship between husbands and wives.

***Partner relationship.*** Partner relationship refers to any couples relationship, or cohabitation relationship between same-sex or heterosexual partners. Sixteen participants (94.12%) mentioned partner relationship when they were defining IPV. However, they specified partner relationship only as heterosexual partners. For example, all of them have utilized the term ‘boyfriend or girlfriend’ to describe a partner relationship. PA01 expressed, “My client had run away from home a couple of times and stayed with her boyfriend. However, her boyfriend had shown his violent behavior and he had beaten her.” PA02 and PA04 uttered, “The survivors are being abused, especially by their husbands or boyfriends.” Other participants have mentioned, “IPV [is] not necessary between a husband and wife, but could also involve a boyfriend and girlfriend,” except PA09 did not include partner relationship in her definition of IPV.

**No prior relationship.** Six of 17 participants (35.29%) associated no prior relationship with IPV. No prior relationship means individuals were not in an intimate partnership. All six participants related sexual abuse with no prior relationship. For example, PA04 stressed, “For the woman who was abused or raped by an unknown man, it could have been a traumatizing experience for her.” Similarly, PA05 stated, “IPV also involves individuals who can be unknown to their abusers, such as the survivors of being raped by someone unknown to them.” Another participant, PA12, who worked as a medical doctor described,

A young girl – I think that she was around the age of 19 – had been raped by her boyfriend’s friend. She was referred by a non-governmental organization (NGO) to the hospital to receive a medical examination. During the process, we categorized her as a cold rape case because she came in after 72 hours after the incident. This process might make it hard for medical doctors to collect samples and write a medical report as evidence for court.

**Risk of IPV.** Risk of IPV refers to risk factors or causes of IPV occur in the relationship. Eleven of 17 participants (64.71%) talked about the risk of IPV based on their experiences of working with the survivors. Two subthemes were identified: *history of abuse* and *substance abuse*.

**History of abuse.** Individual who had been abused or witnessed abuse occurred in the family has a high probability of becoming a victim or perpetrator in their current or future intimate relationships (Cattaneo, 2003). Seven of 17 participants (41.18%) endorsed a history of abuse as a strong predictor of IPV in the relationship. For instance, PA08 said,

I had a female client who had been abused by her husband for a long time. I think that she had been abused for several years. This type of physical abuse can make them fall into a situation in which they can't express themselves because they don't have anyone with which to talk. For this situation, usually the victim has a lot of emotions that accumulate from year to year. When they are in this situation and repeating the cycle over and over again, they will start degrading themselves and feel that they deserve to be abused. They have been in trauma for a long time.

She further described that women in long-term abusive relationships believed they deserved to be abused. PA10 echoed the concern of women being in a long-term abusive relationship and she stated, "They might think all families are the same, and they normalize their experience. Then, they don't feel that they need help from others." This led to the potential of being re-abused by their husbands or partners at a later time. PA09 also shared her client's case, "She had past experience of being abused. Those experiences might have occurred a long time back. However, she currently re-experienced the same situation that caused her to get divorced from her husband." PA13 recalled her client's experience of being abused, and she emphasized, "He had abused her several times in the past, but this time he really lost control and used a tool like a weapon to beat her." This abusive pattern has been carried forward by the survivor or the perpetrator within the relationship or to the new intimate relationship.

***Substance abuse.*** Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Six participants (35.29%) reported substance abuse as a risk factor for IPV. In their statements, they related substance abuse with perpetrators rather than the survivors. Thus, they perceived

perpetrators were under the influence of alcohol or drugs when they acted violently towards their partners. PA02 articulated his client's story of having a husband who was addicted to drugs:

The husband is a former drug addict and he still is taking the drugs until now. Her husband keeps asking her for money. At first, she doesn't know he asks money for what [reason], but later she finds out her husband was use the money to buy drugs. After two years they were married, the husband started beating her because she didn't give him money anymore.

PA07 described a similar situation that occurred to his client by saying, "The husband will demand his wife to hand over her earnings to him, and he seems to have the right to squander all of the money and waste it all on other women, alcohol, and drugs."

Additionally, PA11 felt sympathy towards her client who was stalked by her husband. She stated, "Her husband was actually under the influence of drugs, and she couldn't anticipate what he would do next." The participants also reported that the husbands who were drug or alcohol addicted had caused feelings of fear and insecurity among the wives (i.e., PA11, PA14, PA15). On the other hand, the superordinate theme of sociocultural factors that will be discussed later in the chapter also reported as one of the risk factors in the literature. However, all participants (100%;  $n = 17$ ) only acknowledged the subtheme of *IPV as normal* as one of the risk factors for IPV and excluded other related sociocultural factors.

### **Superordinate Theme Three: Training**

The third superordinate theme is associated to *training* that has been received by health providers to work with IPV survivors in various settings. The training reported by

the participants was categorized into two themes: *short-term training* and *inadequate training*. These two themes were connected with four subthemes: *experiencing in vivo training scenario*, *general counseling skills and interventions*, *comprehensive training program*, *non-specific IPV training*, and *centered on female survivors*. Table 7 displays the themes and subthemes of training that have been received by health providers in working with IPV survivors.

Table 7

*Training*

Theme & Subtheme	Number of Participant who Endorsed the Theme or Subtheme ( <i>n</i> )	Percentage (%)
Short-Term Training	17	100.00
Experiencing in vivo training scenario	5	29.41
General counseling skills and interventions	15	88.24
Comprehensive training program	7	41.18
Inadequate Training	15	88.24
Non-specific IPV training	10	58.82
Centered on female survivors	14	82.35

**Short-term training.** Short-term training refers to a training activity that can be completed within a period of no more than 3 months. It includes seminars, workshops, continuing education classes, or non-credit courses. All participants ( $n = 17$ ) reported having received some short-term training, either specifically focused on IPV training or learned only general counseling skills and interventions. The period of training that reported by the participants ranged from several hours to a week ( $n = 16$ ). Only one

participant (PA12) received 3 months of para-counselor training because she was not from a helping profession background previously. She called herself a para-counselor as she did not have a counselor license. Three subthemes were identified: *experiencing in vivo training scenario*, *general counseling skills and interventions*, and *comprehensive training program*.

***Experiencing in vivo training scenario.*** In vivo training is a practical and work experience training that involved practice while watching a video, or live demonstration from an expert. Five participants (35.39%) noted their training content included learning from victims' experience, observing a live counseling session, sensitizing exercises learned, and watching a video about IPV. For example, PA01 described her training experience:

We had a live session counseling during training. It means they had brought a real victim to the training session. The victim told us her experiences of being abused. Then, a CR – counselor registered [Licensure Professional Counselor] demonstrated to us how to handle the victim.

PA05 recalled his first training experience focused in general about the organization, and some sensitizing exercises to help IPV survivors. He stated,

The first training session that I attended was in October 2000, which was a two-day course. It included an overview of the One Stop Crisis Center (OSCC), the role of NGOs, some sensitizing exercises such as role playing, case studies, the integration of teamwork, and legal perspectives.

PA03 and PA16 reported similar training experiences that involved in-vivo learning, such as watching a video related to IPV and role-playing IPV interventions. All six

participants agreed that in-vivo training provided them a broad sense of how to work with IPV survivors. PA01 shared that, “After I attended the in-vivo training, I used the techniques that I learned to explore my clients’ stories, who were being abused by their partners.”

***General counseling skills and interventions.*** General counseling skills included basic helping skills such as listening, empathizing, paraphrasing, reflecting, and questioning. Interventions could be vary, such as play therapy, art therapy, music therapy, dialectic behavioral therapy, cognitive behavioral therapy and other approaches or interventions. All were reported as helpful for the survivors. Fifteen participants (88.24%) indicated that they at least received basic helping skills training that mostly focused on listening and being empathy to the survivors. PA06 stated,

I have received a lot of different trainings. I learned basic counseling skills and how to approach clients in an appropriate way. I learned different interventions such as play therapy, sand therapy, case management, and emotional management, and to assist my clients.

PA08 informed that she attended two courses. The first one was a five-day course, and the second one was a four-day program. She then further elaborated the content of the training:

These training programs taught us about how to treat people, to be empathic, to infuse hope in our clients, and to trust them. The most important thing was learning to show them that we love them and care about them. The program was an informal program conducted by other organizations to assist individuals who wanted to become involved in volunteer work for helping others.

PA10 spoke about the similar training experience that focused on general counseling skills and intervention: “The training was general counseling skills training—skills such as listening, empathizing, and exploring clients’ stories. There were also taught counseling theories and other models that are relevant to helping different clients.” Furthermore, two participants (i.e., PA07 and PA14) who were from a medical background did not mention any counseling skills or helping skills that they learned during the training.

***Comprehensive training program.*** Comprehensive training program includes IPV or domestic violence specific program that contains knowledge of IPV, protocol or guidelines of handling IPV survivors, resources, organizations or departmental collaboration, and legal perspectives. Seven of 17 participants (41.18%) described the specific IPV training they had attended in the past. All IPV trainings were provided by the organization or center where they currently or formerly worked. PA06 stated,

I also attended specific training on domestic violence and intimate partner violence in other countries. Those courses were more specific about what IPV is, what it looks like, what survivors’ emotional states or reactions in the aftermath are, how to handle them, and what appropriate intervention is needed. I think that it has been helpful for me to help my clients.

PA15 and PA17 also described their comprehensive training experience:

The training focused on building skills to help the survivors such as empathy, listening skills, how to communicate with survivors, protocol or guidelines to handle survivors, and the center policy and procedures for when the survivors seek help. Several advanced training sessions included specific techniques or

interventions such as play therapy, art therapy, sand therapy, and crisis intervention that helped better serve the survivors.

In addition, PA16 explained several short-term trainings she had attended:

I received several short-term trainings through our center – One Stop Crisis Center. The senior doctors have provided some training to junior staff that work in the center. It was internal training. The OSCC training was a full set of trainings that involved many other departments who work as our team members. The initial training that I received focused mostly on basic knowledge of IPV, the role of the provider in assisting clients, domestic violence acts, and some exercises such as role-playing and watching videos. The second training was more intensive and helped me learn the overall function of OSCC and protocol to assist IPV patients. It also involved NGOs, Department of Social Welfare, and the Police Department. It was a teamwork task.

Although these participants ( $n = 7$ ) have received comprehensive training on IPV, but later in the interviews, 5 of 7 of these participants expressed their difficulty when working with IPV survivors (i.e., PA03, PA10, PA12, PA13, PA14). A detailed discussion in the remaining section will be presented in the subtheme of lack of competence.

**Inadequate training.** Inadequate training refers to insufficient or lack of requisite qualities of the training to prepare health providers to work effectively with IPV survivors. Fifteen participants (88.24%) claimed they received inadequate training to work with IPV survivors. Two subthemes were found: *non-specific IPV training* and *centered on female survivors*.

***Non-specific IPV training.*** Ten out of 17 participants (58.82%) reported that the training they received was non-specific IPV training. The training content was not focused on discussing IPV, risk of IPV, IPV or a domestic violence act, interventions for IPV survivors, or any related strategies that could be applied to the survivors during the helping process. They described their experience as ‘having no formal training in IPV or domestic violence issues.’ PA01 and PA03 stated, “We didn’t have any specific training on IPV or domestic violence, and the training was a general training for all types of clients.” PA04 reported, “I don’t really have any training on how to work with IPV survivors. The only thing we had was learning the theories [on] to handle the situation. To apply the theories in real settings, we need to have our own skills.” He then provided a specific example about how he handled his client with his limited skills.

A woman who had been abused by her husband. When she comes in, the first thing I can do based on the theory is ask her questions in order to address the issue and give her treatment. It will be a list of questions provided to us. So, we just followed the list and asked the survivors questions. For example, the first question is, “Who came with you?” Then, “What types of violence have you experienced?”

Due to the inadequate training, PA04 felt it difficult to gather information from the survivors during the initial session. PA08 also stated, “I honestly didn’t receive any specific training for these things [IPV]. I only attended several courses that focused on how to assist clients in general.” PA09 mentioned a similar training that she had received:

The training that I have received is related to counseling skills and theories. We didn’t take specific sections or courses that emphasized domestic violence or

intimate partner violence, but we were taught that if we are ever presented with cases that are beyond our job responsibilities, we needed to refer such cases to other departments or agencies that have the expertise to handle them.

Thus, referring the clients becomes a part of the protocol of helping the survivors due to the inadequate training that resulted in the lack of competence of providers in their services.

*Centered on female survivors.* Fourteen out of 17 participants (82.35%) revealed they only provided services to female survivors. They noted they were not well prepared to work with male survivors, and were referred male survivors to other agencies or departments to get further assistance. For example, PA06 stated, “Since our center focuses only on women survivors, most of our cases are women.” PA17 indicated the same statement: “I have seen and handled many cases, all of them involving women because our center primarily serves women and children.” One participant failing to accept a male survivor (PA08) stated,

When our center just started, we received a young male survivor referred by another department. However, at that time, I did not accept the client. If I had accepted him, then he would have stayed with me. I think it was inconvenient for me, and I did not accept him at the time.

Other participants, PA11 and PA15, only provided shelter for women and children, and they referred male survivors or elderly people to others. In particular, PA15 stressed, “Most perpetrators are men and that victims are women and children. So, perpetrators don’t need any assistance from us.” Her mentality or stereotyping that men cannot be victims made her focus her services on women only.

### Superordinate Theme Four: Institutional Factors

The fourth superordinate theme was related to *institutional factors* that can influence the health providers' ability to respond to IPV survivors, as well as IPV survivors' help-seeking behaviors. Institutional factors were divided into two main themes: *internal factors* and *external factors*. Internal factors were connected to seven subthemes, and external factors were connected two subthemes. Table 8 displays the themes and the subthemes of institutional factors with the number of participants endorsed each of the theme or subthemes.

Table 8

#### *Institutional Factors*

Theme & Subtheme	Number of Participant who Endorsed the Theme or Subtheme ( <i>n</i> )	Percentage (%)
Internal Factors	17	100.00
The need to collaborate with other departments	17	100.00
Protocol in treating IPV survivors	15	88.24
Delaying responses to survivors	11	64.71
Professional supports	7	41.18
Lack of resources	11	64.71
Busy working environment	7	41.18
Lack of supervision	5	29.41
External Factors	9	52.94
Police department responses	7	41.18
Abide by religious principles	5	29.41

**Internal factors.** Internal factors related to the institutional characteristics, such as the purpose or objectives of the institutions, capabilities, relationships, rules, protocol or guidelines, resources, and environment that may influence health providers to provide

adequate services to the survivors. All participants ( $n = 17$ ) emphasized that internal institutional factors were the primary factor that influenced their ability to respond to the survivors. They highlighted seven factors (subthemes) that were related to the theme: *the need to collaborate with other departments, protocol in treating IPV survivors, delaying responses to survivors, professional supports, lack of resources, busy working environment, and lack of supervision.*

***The need to collaborate with other departments.*** This subtheme refers to the needs of health providers to work collaboratively with other departments to serve the survivors adequately. All participants agreed that collaboration with other departments was one of their challenges because it was time-consuming and there was a lack of commitment from other departments. PA05 stated,

If the survivors have experienced physical abuse, then I need to refer them to the emergency and trauma room immediately. I will also advise my client to file a police report. However, if the survivors come to me with an intention to repair their relationship, then I need to use my expertise to assist them to do so.

He then added, “Through the department, the clients are referred to the Syariah Court if needed. This process usually takes several months or years to settle. The whole process involves collaboration with departments or between departments.” PA06 also imparted,

Lack of commitment or collaboration from police department, the Department of Social Welfare, and the court can affect my ability to assist clients because we might have taken a long time, from nine months to several years, depending on the investigation process by the police department.

Furthermore, PA13 informed,

I think that the OSCC does not function well because not all departments are committed to the service. We have difficulty with referring survivors out of the hospital, and this process is exhausting for survivors, as well as for us as first responders.

PA11 shared the challenges that she encountered when she referred her client to the OSCC:

One time when I wanted to refer one of my clients to them, they were not there to help her; they might have been out or no one was there. I don't want to give a negative comment on this situation. The client called me back and asked what she needed to do next. Maybe she did not disclose her problems to them or they did not ask her. So, they thought she had come to the center only to get external treatment. She asked me what to do next and whether she needed to go to the police station.

The need to collaborate with other departments was critical; however, the participants reported that they received a low rate of response from other departments, and that impacted their ability to respond adequately to the survivors. PA 14 stated,

Reaction or response from other departments is also a problem. Sometimes there is no one at the counter to receive patients or they are busy. The teamwork is not effective sometimes. Not all parties take responsibility when we have IPV or DV survivors come in. There is a lack of collaboration from other departments.

***Protocol in treating IPV survivors.*** Protocol in treating IPV survivors refers to the guideline or procedure that use by health providers when working with IPV survivors. Fifteen participants (88.24%) mentioned a protocol for treating survivors; they followed

the protocol or they did not have any guidelines in their organizations. Several of the participants complained that the protocol they used was overly complicated and not client friendly (i.e., PA04, PA07, PA12, PA13, PA14). PA03 asserted,

Sometimes the complicated procedures not only influenced my ability, but also prevented survivors from coming to seek help from us. We might need to think about this aspect by providing an easier procedures and guidelines to help them to get better assistance.

PA04 elaborated that the complicated procedures in the emergency room is process the patients need to go through in order to get treatment. He stated,

In the emergency room, we need to follow the triage process. We have three zones: yellow zone, green zone, and red zone. Medical assistant officers or nurses will first respond to survivors and ask several questions to help us decide to which zone we will send them. Based on the information the survivors give us, we will refer them to the medical doctors in OSCC for further action. Then, we will start the screening process.

PA14 also said, “I think the protocol for handling the survivors might be too complicated. It requires a lot of time for us to walk the clients through the process and that might delay our response to survivors.”

In addition, all 15 participants admitted that they utilized the same methods or protocols for all types of clients, including male survivors and female survivors. PA06 affirmed, “ I think that the protocol or interventions used for male survivors would be the same with female survivors because they also want others to listen to them, respect them, and be sensitive to their stories.” She further explained,

Since our center mostly focuses on helping women who were in danger or having difficulty in their lives, including domestic violence, intimate partner violence, sexual assault, rape, or other issues related to women, we mostly use the same methods and interventions to treat our clients.

PA16 stated, “I would definitely utilize the same protocol to treat male survivors. In the emergency department, the procedures to treat patients are the same; we need to identify the external injuries first before treating other aspects.”

PA07 and PA12 stated that in their opinions that they should use similar protocol or methods to treat all patients, regardless of gender or race. On the other hand, two participants (PA09 and PA10) said,

I think we don’t have any specific guidelines for that. However, if needed, we will refer the clients to other places. If we can’t handle a client, then we will refer him or her to a center that specifically handles IPV cases.

Thus, participants who followed a protocol or did not have any guidelines marked this aspect as important in determining the quality of their service.

***Delaying responses to survivors.*** The factor of delaying response to survivors was closely related to the need for collaboration with other departments, as well as the protocol of treating the survivors. Eleven participants (64.71%) acknowledged that the delay occurred during the helping process due to several conditions. For example, PA03 expressed her feeling of frustration with the wait time of another department:

Since I needed to depend on a lawyer or a social advocate to assist the clients, sometimes it might have taken a long time for me to guide the clients through the process. I felt sympathy for the clients, as they were really depressed with the

situations. Also, the procedures used were not really helpful because a lot of time we needed to refer the clients to other departments before we could start doing our work. This could limit my ability to provide further help to my clients.

PA03 also spoke about the same issue that she had encountered in the past: “Sometimes we need to wait until the clients are done with treatment in the hospital; then we can start our counseling services.” Furthermore, PA15 reported the delay in service is due to lack of shelter facilities:

Sometimes, our shelter is full, and clients might have to wait a long time while I contact other shelters. If there isn’t any room there, then I might not be able to accommodate the clients and have to ask them to stay with their friends or relatives.

She then continued, “The referral process is not easy. Sometimes it takes a long time to get permission or approval from both sides before transferring clients. Clients do not get immediate help from providers.” Other participants (PA13, PA14) reported that delaying process was also caused by the providers, especially when they noticed that no external injury was found on survivors. They tended to delay the time to serve the survivors.

***Professional supports.*** Professional supports is another internal factor that influence health providers in working with the survivors. Seven out of 17 participants (41.18%) in this study reported professional supports could impact them negatively or positively. Only one participant believed that she received positive support from colleagues in the department (PA01). She described, “I think the support of the department is helpful for me. No matter how difficult the cases, all staff will help each other to assist the clients.”

Another six participants reported a negative influence of this subtheme on their ability to perform. For instance, PA13 stated, “I think they influence me mostly negatively. The attitudes of providers and administrators of the departments are not supportive or helpful in assisting me with helping survivors.” PA10 echoed the concern of lack of professional supports due to the insufficient well-trained workers. She said, “Right now, the OSCC is under the Ministry of Health. But they don’t have enough well trained workers—at least not many in the emergency room. Not many medical workers are involved in serving victims.” Specifically, the rural areas still lack sub-teams who can provide services in rural areas (PA11). PA11 emphasized that professional support is important to maintain the quality work of providers as well as support them emotionally since the process of helping is not easy.

***Lack of resources.*** Lack of resources refers to deficiency of shelter facilities and funding of an organization to maintain service to IPV survivors. Eleven out of 17 participants reported that they encountered lack of resources in their centers or organizations, did not have enough space or any at all or adequate funding to accommodate IPV survivors. PA01, PA06, PA15 and PA17 stated that they have a shelter for survivors, but they don’t have enough facilities to accommodate all survivors who come to seek help. PA08 indicated, “A lot of cases are referred from the Department of Social Welfare because they don’t have shelter for some survivors. However, I cannot receive all of them due to the limited space that I have.” PA06 also shared her regret of not being able to assist all survivors. She stated,

Due to the lack of resources and funding, staff members at the center have to handle many different things including food and daily necessities and gather

funding from outside. Thus, lack of funding could be another factor that limits my ability to assist more survivors.

Several participants encountered difficulty due to no shelter facilities for survivors (i.e., PA10, PA11, PA12, PA13, PA16). PA11 expressed,

I think that there is shelter in the Department of Social Welfare, because that is the only shelter that we have in this district. Survivors might need that if they want to get away from the house. Also, certain cases only can be handled by this department. We need to refer some clients to the department. If clients need an IPO [i.e., interim protective order], then they probably need shelter. However, last time when I visited another district that had a shelter, no one was using it, even though there are many out there who need shelter to protect themselves. Now, the Department of Social Welfare has asked us to tell survivors to stay with their relatives as a second option.

PA09 and PA10 tried to accommodate the survivors by saying, “If the survivors want to stay in our center during the daytime, we are okay with that, but we do not provide any shelter for them to stay overnight.” Due to the lack of shelter facilities, survivors might not be able to come out from the abusive relationship as most of them were not financially independent ( $n = 11$ ). Clearly, lack of resources can influence both health providers and IPV survivors.

***Busy working environment.*** Five medical doctors, assistant medical officers, and nurses, and two social workers claimed that busy working environment was one of the internal factors that influence the ways they work with IPV. Busy working environments occurred in hospital settings and NGOs reduce providers’ attention to further inquire

about IPV symptoms or history of abuse. For example, PA04 stated, “A lot of times, I don’t have enough time to fulfill all of the needs of the survivors, and I may not get enough information from them.” PA07 spoke about his busy schedule in the emergency department: “Since the emergency department is a busy working environment, it is too busy for us to spend too much time with patients.” He then acknowledged, “The busy environment can effect doctors’ attention toward patients, and they might neglect to identify IPV cases, or they might see these cases as a hassle to handle because the social part is never as straightforward.” PA11 described her experience of working with survivor in the busy working environment:

A lot of time, due to the busy work environment, I can provide only a list of available resources to patients or I can refer them to the Department of Social Work in the hospital, which helps us to handle patients. I don’t have much time to tell them in detail about each of the resources or assist them in making decisions.

Another two social workers indicated their busyness due to the lack of the number staff working in the center. PA15 said, “Sometimes my schedule is fully booked, and I might not be able to serve clients, so I refer them to other social workers within the department.” PA11 also stated,

I am the only staff worker in the center. Sometimes clients come into the center at the same time that the phone is ringing. I have to handle two cases in one day. I have experienced handling three cases in a day, two of them by phone calls and another that was a walk-in.

***Lack of supervision.*** Five out of 17 participants (29.41%) noticed that a lack of supervision had impacted their ability to respond to IPV survivors. Lack of supervision

includes failure to provide adequate supervision to individuals who needed guidance or monitor. PA15 mentioned,

We don't have anyone to monitor or supervise us after training. So, people may or may not use those skills with clients. Nobody knows if the training was effective for providers or helpful for clients. That is a limitation that I noticed a long time back.

PA13 had also note the attention of the institution as a lack of supervision. She said, "Lack of supervision is a critical issue for us because we don't have that in our system."

PA05 pointed out the same problem that, "There were no long-term training or monitoring given after training." These participants also suggested supervision as part of the training program in the later of the chapter.

**External factors.** There were nine participants (52.94%) who reported that external factors of the institution, such as *the police department's response* and *abide by religious principles* (subthemes) influenced their ability to respond to IPV survivors.

**Police department responses.** Police department responses include survivors seeking help from a police department, filing a police report, the investigation process, and bringing the case to court. Police officers work closely with providers and survivors throughout this process. Unfortunately, seven participants (41.18%) expressed their feelings of dissatisfaction toward police officers' attitudes and their insensitivity when working with survivors. PA06 stated,

A lot of time when women report cases, they will be blamed by the police officer for not being able to remember what was happening to them or what tools the

perpetrator used to hurt them and so forth. For me, this is an insensitive way of handling victims because they don't ask to be abused.

She further explained, "The survivors need to show the police officer strong evidence of abuse." PA05 felt sympathy for the survivors: "The police and court process take clients a long time, which makes them feel stress since they can't solve their problems immediately." PA16 mentioned a similar concern about the inefficiency of police officers: "The inefficiency of police officers and courts in helping survivors might make them doubt if they will be treated fairly if they seek legal help."

PA11 shared her feelings of disappointment when she asked help from police officer to assist her client who was stalked by her husband. She reported, "The victim called the police emergency helpline to seek help, but the police officers did not want to go to her place." Thus, the police officers' attitudes and responses could effect a health providers' ability to respond as they did not get a full commitment from police officers, and could prevent IPV survivors in seeking help from others.

***Abide by religious principles.*** Abide by religious principles referred to health providers' obligations to follow the religious principles that are implemented in the country, in particular when treating Malays IPV survivors. Five participants (29.41%) acknowledged this subtheme as an external factor that limited their ability to assist the survivors. For example, PA01 and PA03 said, "For the Muslim survivors, we need to refer them to the Islamic Religious Department because they have different approaches to handling the Muslim survivors compared to non-Muslims. They will have specific sessions with the survivors and their partners." PA05, who worked as a social worker in the religious body, felt that the integration of religious values in the session was good, but

he also felt it was a limitation for him to provide further treatment for the survivors. He stated,

I feel that my intention to provide counseling is to assist clients to repair their relationships or address situations that they have experienced. However, certain cases have not progressed as I expected in terms of the decisions made by survivors. If the survivors do not want to continue the relationship with their husbands, then divorce would be a solution. But if the survivors want to repair their relationships, then it could become better through our counseling sessions.

He then explained,

If the survivor decides to separate from or divorce her husband; they need to attend three counseling sessions. Then the case will be brought to the Syariah Court. This process usually takes several months or years to settle. Some of the survivors refuse to go to court because there is no guarantee of their right to get what they ultimately want.

PA12 believed religious principles focused more on wanting to rekindle a loving relationship without considering the consequences or that the safety issues of the survivors could bring harm to the survivors. PA05 admitted,

I should not encourage the victim to divorce his or her partner. In the session, I should try my best to persuade the client to find the best solution for the problem by not choosing to divorce. Thus, if the client has requested to divorce her husband, then I cannot encourage her to do it because her religion does not teach us to separate husband and wife or destroy families.

This factor not only effected non-Muslim providers as they need to refer Muslim clients to the religious bodies, but also Muslim providers who might feel the client's welfare was neglected due to the religious principles that they needed to follow.

### **Superordinate Theme Five: Providers' Personal Factors**

The fifth superordinate theme was related to *providers' personal factors* that influence their ability to work with IPV survivors. Based on the participants' data, there were two themes identified: *work performance* and *self-experience and assumptions*. Seven subthemes were connected to these two main areas, which will be discussed in the following section. Table 9 displays the themes and the subthemes of providers' personal factors and the number of endorsement by the participants.

Table 9

#### *Providers' Personal Factors*

<b>Theme &amp; Subtheme</b>	<b>Number of Participant who Endorsed the Theme or Subtheme (<i>n</i>)</b>	<b>Percentage (%)</b>
Work Performance	15	88.24
Lack of competence	15	88.24
Lack of self-efficacy	9	52.94
Resistance to professional roles	8	47.06
Victim blaming	7	41.18
Self-Experience and Assumptions	13	76.47
Personal experience of being abused	3	17.65
Differences in self-values and beliefs	8	47.06
Emotional reactions	7	41.18

**Work performance.** Work performance refers to a health providers' ability to perform when working with IPV survivors. It reflects on health providers' competency,

attitudes, and responses to IPV, in particular to address factors that influence their work performance. Fifteen out of 17 participants (88.24%) spoke about their work performance as one of the biggest factors that determined their service quality. There were four subthemes connected to work performance: *lack of competence*, *lack of self-efficacy*, *resistance to professional roles*, and *victim blaming*.

***Lack of competence.*** Lack of competence includes lack of knowledge, skills, and awareness of serving IPV survivors. This study found 88.24% of the participants ( $n = 15$ ) reported lack of competence to provide service to IPV survivors. PA15 admitted his limitation as a provider: “I am not an expert in handling all of these complicated issues. I haven’t received enough training about IPV, particularly specific interventions that I could use to assist clients.” PA01 and PA13 echoed the similar concern about receiving lack of training that led to lack of competence. PA13 stated,

I have received only several short courses of training. I feel that that is not enough to help me to be a competent provider for survivors. A lot of times, I don’t know how to handle a situation, particularly when survivors come in with critical situations.

PA01 said, “Sometimes it is quite difficult for me to get information from the clients who resist talking about their experiences.” PA04 also stressed, “I think understanding the psychological aspects of survivors is also important to me. Since I didn’t receive any formal training about that, I think basic knowledge about IPV and how survivors’ mental and psychological states are after being abused.” His lack of competence and knowledge could be risky for survivors, as he did not have any skills to

identify IPV. This study also found one participant (PA05) neglected the needs of IPV survivors in her statement,

We would want to maintain the peaceful harmony of the family. If the couple comes to us with the intention of repairing their relationship, then we will do our best to assist them. However, if there is no other way to solve the problem, then we will still need to advise them to think about it before choosing to divorce.

PA12 felt surprised the survivors came in with no IPV symptoms:

Not all survivors who come to us will open up to us directly. Some of them don't have any symptoms that we can see to know whether they are being abused or not.

You know what I mean? So it's hard for me to fulfill each of their needs."

Another participant had no awareness about the importance of being competent when working with the survivors (PA16). She stated,

I basically focus more on medical models and basic helping skills such as communications: questioning and building relationships with clients. Due to the fact that I don't provide treatment to clients – I only conduct screening processes and referral processes – I don't need specific interventions to handle the clients.

Basic helping skills are helpful for me in gathering information from clients and I provide available resources for the survivors. I do not use any specific intervention to assist the survivors.

Health providers' lack of competence resulted in a lack of empathy among health providers. They misunderstood survivors' stories (PA03), forced survivors to report abuse alone (PA09, PA10, PA11), coerced the survivors to disclosing IPV (PA02, PA04), and minimized survivors' experiences (PA13).

***Lack of self-efficacy.*** Lack of self-efficacy refers to health providers' belief in their capacity or ability to handle IPV cases. Nine out of 17 participants (52.94%) reported lack of self-efficacy when working with IPV survivors. PA13 stated, "I think my feeling unprepared to handle survivors reduced my confidence in serving them." PA16 indicated that she did not provide adequate service to survivors: "I feel that I do not provide a good service to them and feel that I am not well prepared to work with the survivors. Those feelings really bother me sometimes." PA09 also expressed her concern about having provided the survivors with enough assistance.

PA02 described his feelings of lack of confidence to work with IPV survivors. He stated,

There are a lot more questions to ask, but without training I find it is quite difficult to ask them because some of the survivors will not disclose that they have been raped or abused by their husbands or other family members.

PA04 also felt he was unprepared and untrained to address IPV issues:

I have no experience in handling this type of client [IPV], but it does occur in the emergency room. I feel uncertain about what kind of questions I need to ask. I worry that my questions might offend them.

***Resistance to professional roles.*** Seven participants (47.06%) mentioned resistance to professional roles in helping IPV survivors. Several terms that reflected their resistance included lack of interest, lack of motivation, perceived IPV as a social workers' job, refused to work beyond the job responsibility, and emphasized their job scopes. For instance, PA09 and PA10 indicated in similar statements regarding their job responsibilities. They said, "I need to refer them if their needs are beyond my ability to

handle. I should not provide services out of my services scopes.” PA16 recalled her experience working in the center:

I do not have many clients because we were on a rotation to respond in the center.

My primary role is to assess the survivors on a regular basis and provide survivors with available resources. Other jobs should be done by other providers.

PA14 described his experience of working with colleagues who were not interested in IPV. He said, “They view IPV as a mild issue, so I can see that the influences of their attitude in working with survivors. Their attitudes have impacted me negatively to treat survivors.” He then added, “I can’t provide many services to survivors since I have many other patients who need to be treated at the same time.” PA12 also denied her role as a provider in giving treatment to the client. She stated,

I do not provide any treatment for survivors. Treatment is provided by medical doctors for their external injuries. So, if this woman came to the emergency room in the hospital, they would go through the process to determine her physical injuries. Then, the case would pass to the OSCC, and I would come involved in providing several counseling sessions with the client.

PA05 also talked about health provider’s resistance to addressing IPV:

A lot of the times, medical doctors might see IPV or domestic violence as the social worker’s job and not a part of a medical doctor’s job. On the other hand, providers’ patience when dealing with IPV patients also influences my ability to identify survivors.”

**Victim blaming.** Victim blaming is identified as a common obstacle for health providers to work with the survivors. This factor also influences IPV survivors’ help-

seeking behaviors. Seven out of 17 participants (41.18%) revealed victim blaming attitudes when they shared their experience in handling IPV cases. For example, PA04 blamed the survivors for putting up with IPV due to perceived lack of options. He said,

They are afraid to seek help because of their husbands. They don't know where to go or they don't know where the hospital is. They don't know how to drive or they have no money. If they go out to tell others about the problem, the husbands will take their children away. Mostly, it involves an emotional and family crisis. Also, most of the women who come to us are housewives. They lack education, and they are so obedient to their husbands. I think that is the reason their husbands find it easy to control them.

Similarly, PA09 also blamed the survivors for putting oneself at risk to get injured:

The survivors will only report to the police if things get worse. If things don't get worse, they will not report it to others. Reporting is their last choice. Because of this mentality, women may get hurt, and they may not be able to resolve the problem.

Other participants, PA8, PA10, PA13, and PA15 put the responsibility on victims to prevent abuse, assigned them to identifying warning signs and avoid abusive situations, and control their emotions to avoid triggering the perpetrator's IPV behavior.

**Self-experience and assumptions.** Self-experience and assumptions refer to health providers' personal experiences with IPV that includes self-beliefs, self-values, and emotional reactions toward IPV. Thirteen participants (76.47%) mentioned some personal experience and assumptions toward IPV during the interviews. Three subthemes

were identified: *personal experience of being abused, differences in self-values and beliefs, and emotional reactions.*

***Personal experience of being abused.*** Health providers' personal experience of being abused was reported by three participants (17.65%). It could bring positive or negative impacts on health providers when working with IPV survivors. PA01 described:

He beat me for a couple times within a six-month period. Um... he punched my face, arms, and legs. I was depressed due to his violent behaviors. However, it did not impact my professional work. I got involved in helping other IPV survivors after I recovered from my own trauma.

However, PA03 noted that she was re-traumatized with the survivors' experiences and easily attached stereotype to survivors' stories. This can be found in her statement when she tried to define IPV. She stated, "IPV is a complicated relationship. Because of certain issues or conflicts, they might act violently against their spouses or partners."

On the other hand, PA13 also indirectly expressed her feelings that, "Many people view IPV as normal, especially when they see violent behavior as a normal phenomenon within families. Everybody has experienced the same situation, so I think it was understandable." She indicated a high potential for being a victim in the past but she never acted on it. Later in the interview she expressed her beliefs that, "Each survivor can extricate her or himself from the cycle of violence and start a new life." She minimized survivors' experiences based on her own personal experience and admitted her attitudes and beliefs had impacted her negatively: "I think my beliefs and attitudes make me overlook their problems."

***Differences in self-values and beliefs.*** Health providers' self-values and beliefs are another subtheme that was highlighted by participants during the study. Eight participants (47.06%) acknowledged they held certain values and beliefs that might be contradictory to IPV survivors, such as divorce as a reasonable solution, prayer and religion could prevent IPV or divorce is bad. PA05 struggled to keep balance between his values and the survivors' desires to divorce:

Most of the clients want me to help them to get out from the problematic situations. They want to divorce with their partners. This will make me feel disappointed because I cannot fulfill the needs of my clients. I should try my best to persuade the client to find the best solution for the problem.

He then added, "Individuals need to practice good religious values and pray, and I believe that can prevent evil behavior or incidents from occurring in the family or intimate relationship." Furthermore, PA13 believed that each survivor can extricate her or himself from the cycle of violence could prevent her from getting further assistance for the survivors. Several participants acknowledged clients perceived marriage is everything for them, which was contradicted to their intention to help survivors to get away from the situations (i.e., PA03, PA08, PA09, PA13).

Another participant spoke about his personal biases on how other ethnicities handling IPV cases could also influence his reaction to survivors (PA14). In contrast, health providers' gender differences also created discomfort to the survivors, as PA15 stated, "My gender can also be a barrier because clients prefer to work with providers of the same gender." PA02 also said, "Most of the survivors are women, and they feel

hesitant to talk to me because I am a man. They will keep sidetracking and refuse to tell me the truth.”

***Emotional reactions.*** Emotional reactions refer to any feelings or emotions that are evoked when working with IPV survivors. Seven participants (41.18%) in this study noticed that their emotional reactions could influence their ability to provide quality service to survivors. For instance, PA06 stated,

Since the cases involve a lot of deep emotions from the victims, indirectly I will also have strong emotions toward the legal system and various parties that are supposed to assist victims but don't. All of these things can influence the way I treat my clients.

PA02 felt challenged by the survivors who didn't disclose personal information. He expressed, “I found it more difficult to handle if she resisted in telling me her problem. I cannot further refer survivors to other departments due to the lack of information I have gathered.” PA07 also shared a same situation, “Health providers need to show their patience and care in order for them to open up.” He then described, “I felt my own patience is a challenge for me as to treat IPV patients. I might need more time and care.”

Two participants said that their emotional reactions occurred due to the survivors' gender and age. For example, PA11 admitted she had experienced discomfort due to client's age. She said, “I feel uncomfortable in talking with someone older than me. So, I will call other volunteer workers or para-counselors who have received more training or have more experience with handling various clients' concerns.” PA02 also noted,

I feel uncomfortable asking survivors about their sexual lives and how their marriage or their relationship with their husbands is. Because I am single, I don't

have any of those experiences. Thus, I feel uncertain about what kind of questions I need to ask. I worry that my questions might offend them.

### **Superordinate Theme Six: Sociocultural Factors**

This superordinate theme described the *sociocultural factors* that were rooted in Malaysians' lives. Those factors are perceived as traditional values and social norms that are practiced in the country. This superordinate theme included two themes that were discussed by participants: *cultural values* and *lack of legal awareness*. Eight subthemes were identified that further described these two main areas. Table 10 displays the themes and subthemes of the superordinate theme of sociocultural factors.

Table 10

#### *Sociocultural Factors*

<b>Theme &amp; Subtheme</b>	<b>Number of Participant who Endorsed the Theme or Subtheme (<i>n</i>)</b>	<b>Percentage (%)</b>
Cultural Values	17	100.00
Traditional gender roles	17	100.00
Religious values	12	70.59
Accept IPV as normal	17	100.00
Collectivism	17	100.00
Education background	8	47.06
Socioeconomic status	17	100.00
Lack of Legal Awareness	17	100.00
Women's acts and women's rights	12	70.59
Child custody	14	82.35

**Cultural values.** Cultural values relate to values, beliefs, norms, or core principles that are shared by the members of a group. All participants agreed that cultural

values are an important factor that influence IPV survivors' help seeking behaviors, as well as health providers' responses. For example, PA16 stressed,

People grow up in this cultural environment and they get used to the system. It is a normal system for them and there is no way for them to change it unless the culture changes. No matter which ethnic group we are from, we have been educated about the system, culture values, and how to behave ourselves.

This statement revealed that both health providers and IPV survivors were attached to the system and culture values, and intangibly these culture values became a part of their daily lives. Six subthemes were identified that are associated to this theme: *traditional gender roles, religious values, accept IPV as normal, collectivism, education background, and socioeconomic status*.

***Traditional gender roles.*** Traditional gender roles refer to a set of societal norms determining how males and females should think, speak, dress, and interact as being considered as acceptable or appropriate. All participants ( $n = 17$ ) mentioned gender roles issues, either within the family system, the political structure, or at the societal level. This factor is recognized as a risk factor for IPV, as well as a factor that could prevent IPV survivors in seeking help from others. For instance, PA06 stated, "The concept of male privilege and female subordination is still practiced in society, and that can lead to IPV and gender inequality." PA13 elaborated gender roles in the past and current changes in society:

We expect women to take responsibility for taking care of their families and men to provide income and food for their families. Due to the evolution of the economy in Malaysia, many families are now dual-career families. However,

women always need to do more than men. Women have their careers, but they also have to take care of their children and families. Because of the different responsibilities held by men and women, domestic violence and IPV easily occurs in the family. Arguments and violent behavior happen commonly among dual-career families.

PA14 spoke from male perspective regarding gender roles:

In terms of gender roles, even though women have careers, they still need to take responsibility for taking care of their children and housekeeping. They contribute to the family income as well. Men probably need to work harder to provide for their families, but a lot of men do not help with cleaning the house or taking care of their children. I think that women have more responsibilities than men.

Interestingly, people perceive the father's role in the family as important but belittle the mother's role in nurturing children and providing for their families, particularly in rural areas.

One the other hand, PA09 believed men and women should act in their roles to maintain harmony in the society:

I think men and women should play their own roles. If women becomes too strong and takes over the responsibilities of men, then that is not seen as a good sign either. In contrast, if men give up their male roles, then the dynamics of a whole society are disrupted.

PA09's responses reflected that she accepted tradition gender roles as a standard for maintaining the peacefulness of the society. In a certain particular ethnic group, PA15 explained, "We are very particular about men's and women's roles in the family. Men

should provide food and income to their families.” The concept of gender roles has shaped the patriarchal system in the family, where men have more power than women.

***Religious values.*** Religious values were another sub-factor that was mentioned by 70.59% of the participants ( $n = 12$ ) in this study. Religious values refer to ethical principles grounded in religious traditions, texts, and beliefs, especially in Malaysia that where there is a multi-religious country in which religious values are integrated into the legal system, as well as Malaysians’ daily lives. PA05 described,

From Islamic perspectives, women and men are the same and need to tolerate each other. Marriage is legally binding by Islamic law. Thus, women need to obey their husbands no matter what they say and also respect elderly family members. Non-Muslims have their principles that they need to follow. Most of the time, husbands have more power than their wives in family matters.

PA01 also pointed a same situation that Malays who were Muslims need to honor religious customs for marriage. She stated, “In Islam, there is a specific counseling session for husbands and wives before they get married or before they get divorced.”

PA02 gave a specific example regarding religion as a barrier for survivors. He said, “I think religion, especially for the Muslims, are bound to respect their husbands. For them, the husbands are their guards to the heaven.” PA16 also indicated, “Religious values [by] obeying the husband could be a barrier for the survivors in seeking help.” As regarding marriage or IPV issues, PA05 received Malay survivors who needed further treatment from religious department. But, he admitted religion could be a barrier for IPV survivors to seek help from others, as they know it was not an easy process for them to get out from

the abusive relationship through religious bodies. PA17 also emphasized Malay survivors should not go against their husbands.

***Accept IPV as normal.*** All participants agreed that society and cultural norms have accepted IPV as a normal phenomenon in Malaysia. People believe that a good woman will not be abused or IPV is not a crime (i.e., PA06, PA11, PA13). In particular, PA06 stated, “The social perception of women’s issues and the high level of acceptance also prevent women from seeking help from others.” The similar statement was given by PA16 regarding the cultural context and Malaysians’ attitudes of downgrading IPV to marital issues. She said,

When survivors tell their families about their abusive experiences, the family members might advise them to be patient and that their husbands might be stressed at work, or give other reasons to convince them to stay in the relationship. They say this is not a crime; that it’s a marital problem.

PA09 also brought up the issues that the survivors tried to minimize their experience:

She denied it because she felt that it was just her husband’s personality or bad temper, and had nothing to do with a violence problem. Although we wanted to explore further the situation and help her to file a report, she refused to do so because she felt that the situation was not bad enough. When families around hers experience the same thing, they normalize the situation and accept it as normal in the community.

She then added her experience regarding male survivors:

I think they don't feel that they are being abused by the wife because they think the term *abuse* only applies to severe cases. They feel that they have just a small problem and that they should not use the term *abuse* to describe their experience.

Several participants (i.e., PA10, PA12, and PA15) emphasized the lack of awareness of survivors regarding IPV symptoms and perceived IPV as a normal behavior in the family and society. PA14 stated, "We perceive it to be normal so survivors have a lack of awareness that what they have experienced was abuse." Furthermore, PA17 related that some relatives or friends of the survivors refused to assist them due to their mentalities. She said, "No relatives or friends may be willing to let them stay in their houses as they perceive IPV as normal family problems and think the women should be able to settle the family problems and not tell others." Due to the high tolerance of society towards IPV, PA15 reported that survivors believe their abusive experience to be normal and common in marital relationships and the situation will return to normal after a few days or weeks.

**Collectivism.** Collectivism refers to the subjugation of the individual to a group, such as focusing on family orientation or community orientation. All participants reported that collectivism is a barrier for survivors in seeking help from others. Words used to describe collectivism by the participants included saving face, preserving family honor or family reputation, protecting significant others, and wanting to maintain the wholeness of the family. For instance, PA02 described his client's experience, "She got pregnant, the family's parents asked her to marry him [even though she] was raped because of the family reputation." PA03 emphasized, "Many survivors feel embarrassed if other people knew about their family issues, and their family reputation might be

effected, especially for women.” However, PA05 pointed out that male survivors also felt ashamed to tell others their experience with abuse because they also want to protect the name of their families. He then added,

In rural areas such as villages, if the cases are reported, then the entire village or community will know your problem. If the husband has a good family background compared to the wife’s, then the wife needs to maintain the reputation of her husband’s family as well as her own family’s reputation. The abuser is her husband, not his family.

PA06 stated, “Family members might not allow them [survivors] to report to others to avoid other people’s knowing about their family issues.” PA13 also shared the concept of family’s wholeness. She indicated,

Another barrier that I can think of is when survivors want to maintain a sense of the family’s wholeness. You know, in our culture, the family is important. We want the best for our families, and the wholeness of the family represents the health of the family. Many people have the wrongheaded perception that healthy families should have both parents and children.

PA17 explained, “Survivors perceive divorce as shameful and think they need to save their husband’s and family’s face.” PA16 reported, “Many clients, even though they are being hurt, still love their family and they might not want to make a police report.” Thus, the strong feelings of protecting the family reputation and saving face are barriers for being collectivists in IPV context, as survivors do not want to go against their families.

***Educational background.*** Eight participants (47.06%) mentioned survivors’ educational background as one of the factors that influence their help-seeking behaviors.

Educational background refers to the level of education that is completed by an individual. Four participants discussed that low education levels could affect survivors. For example, PA09 stated, “In rural areas, educational background could be another factor that prevents clients from seeking help as they don’t know what kind of resources and information are available.” PA17 added, “Many of them don’t have high education, and they are afraid that, after they leave the relationship, they can’t support themselves.” On the other hand, for the male IPV survivors, PA05 mentioned, “Husbands who are less educated than their wives, they need to listen to whatever their wives say.”

Two other participants spoke about highly educated survivors who felt embarrassed to seek help (i.e., PA01, PA03). PA01 and PA03 said, “Some of them are highly educated and feel ashamed to share their experience with being abused by others.” Thus, educational background is a barrier for survivors regardless of their level of accomplishment.

***Socioeconomic status.*** Socioeconomic status refers to social class and economic background of an individual or family. All participants mentioned that socioeconomic status of the survivors was an important factor in preventing them from seeking help. For example, PA07 stated,

Most married women who are in these relationships are unemployed; they are full-time housewives. Thus, they rely heavily on their husbands. At the same time, if the husband is unemployed and the wife is working to feed the family, then the unemployed husband can be abusive to his wife.

PA06 shared a similar situation regarding IPV survivors: “A lot of women don’t have money and depend on their husbands. If they leave the relationship, then, they don’t

know where to go or how to survive, particularly if they have children.” PA02 pointed out the reality that many women are in poverty. He said, “They are very poor and have no money. If they go to tell people, their husbands will not give them money.” PA08 related the financial issue with having children:

Some of the clients don’t have their own career and are dependent on their husbands. Also, they have children. In order to provide the best for their kids, they stay in the relationship. If they leave the relationship, then they might not be able to support themselves financially. Some of them—because of financial issues and not having income, or because of their children—continue the relationship.

PA08 believed this factor also given a big challenge to health providers when they received clients who need financial help and they might not be able to provide long term financial support to the survivors.

**Lack of legal awareness.** Lack of legal awareness refers to unmindfulness of the survivors toward IPV or domestic violence acts, women rights, and child custody issues. All participants acknowledged lack of legal awareness of the survivors as one of the primary concerns. Two subthemes were identified by the research team: *women’s acts and women’s rights* and *child custody*.

***Women’s acts and women’s rights.*** Twelve participants (70.59%) recognized that many survivors were unaware about women’s acts and women’s rights. There is a domestic violence act in Malaysia that protects IPV or domestic violence survivors from getting harmed by their partners. However, the participants reported that many survivors are not aware about the existing of laws and legal services that can help survivors. For instance, PA03 described,

Some of them don't know who can protect them. For example, we have acts or regulations to protect women and an availability of lawyer services for legal advice, and we know how to report to police for further action. I think women have less awareness of what their rights are regarding IPV.

Similarly, PA11 also spoke about her experience of working with IPV survivors: "They don't know their rights or that an IPO (interim protection order) can protect them. They don't know what to do next after they make a police report." PA16, PA08, and PA12 also raised concerns about survivors' lack of legal knowledge and ignored their rights as women. Most of them do not have awareness about IPV in general.

***Child custody.*** Child custody refers to guardians or a parent's right to have a child lives with him or her. Fourteen of 17 participants (82.35%) in this study reported children as a barrier for the survivors in seeking help from others. PA01 stated,

Children could be a barrier that comes from their relationship. They fear losing child custody if they seek help from others. They also fear that if they report the cases and receive no protection from the police department, they still need to go back to their husbands, and they will be abused again by their husbands.

PA16 stressed that survivors have children they need to take care of. They might not be able to find anyone to support them financially and emotionally. PA17 shared with one of her clients who has a child and being abused by her husband:

She was in the relationship for two or three years and her husband had an affair with another woman. She did not seek help at the beginning because she thought that her kid was still young and she didn't have a job.

PA06 reported, “Sometimes the perpetrators threatened the survivors with children and made them feel scared and so that they stay in the relationship.” Additionally, PA05 elaborated the hesitance of women to seek help if they have children. He stated, “If they were to leave their husbands, then they might not be able to support themselves and children financially. They might also lose custody of their children if they lose in court.” As a result, due to the financial issue and child custody issue, IPV survivors in particular women survivors were struggling in making a decision to leave the abusive relationship if they didn’t have enough support from others.

### **Superordinate Theme Seven: IPV Survivors’ Resistance**

This superordinate theme was related to *IPV survivors’ resistance* to seek help from others during the initial treatment with health providers. Resistance is a type of emotional or behavioral reaction toward something that could recall an anxiety-producing experience. It also recognizes a defense mechanism for the survivors to protect themselves. This superordinate theme was connected to two themes: *internal factors* and *external factors*. Each of the themes contained two subthemes that further explain the sources of resistance based on health providers’ perspectives. Table 11 displays the themes and the subthemes of IPV survivors’ resistance.

Table 11

*IPV Survivors' Resistance*

Theme & Subtheme	Number of Participant who Endorsed the Theme or Subtheme ( <i>n</i> )	Percentage (%)
Internal Factors	17	100.00
Fear of being judged	17	100.00
Wanting to repair the relationship	9	52.94
External Factors	14	82.35
Lack of trust	8	47.06
Lack of protection and support	10	58.82

**Internal factors.** Internal factors refer to the survivors' internal reactions toward their experience of being abused. All participants ( $n = 17$ ) recognized that a survivor's self-resistance was an important barrier for them to seek further treatment. Health providers encountered difficulty in gathering information from the survivors during treatment. Two subthemes were identified: *fear of being judged* and *wanting to repair the relationship*.

***Fear of being judged.*** Fear of being judged refers to the survivors' feelings of fear about other people's opinions toward him or her. All participants noted that fear of being judged was a strong factor that contributed to IPV survivors' resistance to seek help or to disclose their stories during the initial session. For example, PA02 described her experience of encountering IPV survivors' resistance: "Sometimes the victims will not tell because they are ashamed of the situation. They are afraid." PA05 and PA07 also shared the same experiences: "After being abused, women should not tell others because it is an embarrassing issue." PA05 then further explained, "Since IPV is a private

problem for families, rarely do people disclose these problems to others. Survivors feel too ashamed to tell others about their experience with abuse, particularly male survivors.”

PA10 provided an example regarding a male survivor who called the crisis helpline:

He felt upset because his wife was very aggressive with him. Sometimes she beat him and verbally abused him. He felt so hurt by her words. When I invited him to come to our center, he refused because he felt embarrassed. He felt his situation was not that bad; he only wanted someone to listen to him.

Furthermore, PA06 shared about some of her clients’ resistance to tell others, including their families regarding their abusive experience. She stated, “Several of them did not want to see their families because they hated to be asked or judged by others.” The survivors’ feeling of embarrassment, fear of telling others, and disguising IPV behind other family issues caused them delay seeking help from others, or were given minimal information during initial session (i.e., PA13, PA14, PA15, PA16).

***Wanting to repair the relationship.*** Nine of 17 participants (52.94%) talked about survivors’ desires to repair their relationship that prevented them from filing a police report or seeking help from others. PA03 recalled her experience of working with a woman who refused to file a police report and went to hospital to get a check-up: “The reason she came in was to find someone to listen to her and help her find a way to repair her relationship with her husband. She wanted their relationship to go back to normal since their children were young.”

PA 17 noted the survivors believe that their partners were another barrier for them to seek help. She said, “They believe their husbands will change if they stay in the relationship, and they believe it is the best for their children.” Additionally, PA10 pointed

out that the survivors' had easily forgiven those who had placed them in a cycle of violence: "The husband always ask for forgiveness after the incident, and women easily get convinced and forgive them. This has become a pattern and cycle of violence to continue to occur in their relationship." Several participants talked about if the survivors would come with the intention of wanting to repair their relationship, they will do their best to assist them to build a good relationship with their partners. They would also invite their husband to come for the counseling session (i.e., PA05, PA08, PA09).

**External factors.** External factors associated to external supports and protection by providers, police officers, court, and media. It also included health providers' ability to keep confidentiality to build trust with the survivors who want to seek help. Fourteen of 17 participants (82.35%) discussed external factors that caused resistance in survivors. They mentioned two external factors during the interview: *lack of trust* and *lack of protection and support* (subthemes).

***Lack of trust.*** We found that lack of trust of survivors was closely related to the confidentiality and safety issues. Eight participants (47.06%) expressed a lack of trust towards others by the survivors as one of the factors that made them feel insecure to seek help or disclose their stories. PA03 identified, "Lack of trust with health providers can influence their [survivors] choices to seek help from us." PA01 articulated the curiosity of survivors toward the confidentiality of the services. She said,

I had clients who came to the center to seek help, but they kept their feelings and [were] scared to tell others about their experiences. They were scared that their problems will be known by others and they questioned about the confidentiality of our services.

Several participants also highlighted confidentiality as a critical element when treating IPV survivors (i.e., PA06, PA09, PA13, PA16 PA17). PA06 also expressed feelings about survivors' concerns, as there was no guarantee they would win the cases if they reported the cases and the cases were brought to court. Thus, health providers' competencies in maintaining confidentiality and services provided by agencies, departments, or court had affected IPV survivors' decisions and trust toward health care and legal systems.

***Lack of protection and support.*** Lack of protection and support associated with health providers, police department, court, and media as well as survivors' family members' attitudes when assisting IPV survivors. Ten participants (58.82%) acknowledged that lack of protection and support from outside was another external factor that contributed to the survivors' resistance. Participants mentioned legal support, the re-victimization through court proceedings, time demands of the divorcing process, and the media to describe a lack of protection and support that they had or may have received by the survivors. For example, PA06 stated,

The legal system in Malaysia does not protect women since the process of reporting cases and bringing them to court is very complicated, and it takes several months or years to settle the cases. For the victims, it is another traumatic experience and pain that they need to go through. In terms of the media role, sometimes the media also cause survivors from seeking help.

She further described, "Once the case is brought to court, the media will publish information about the victim. Even if they have covered the victim's face, her family pictures are included. This is a secondary harm to the victim and her family." PA10 also

noticed the complicated reporting process also contributed to the resistance of survivors, particularly when dealing with the police officer. She said, “The complicated reporting process has caused secondary harm to the survivor.” This may lead to the feelings of fear of re-victimization for survivors when, they would like to seek a compassionate listening and support sources (i.e., PA06 and PA07).

### **Superordinate Theme Eight: Professional Responsibilities**

This superordinate theme was discussed as to health providers’ *professional responsibilities* when working with IPV survivors. It encompasses the duties of medical doctors, assistant medical doctors, nurses, counselors, and social workers to act in a professional manner when providing services to IPV survivors. This superordinate theme is associated to five themes: *acting as a first responder*, *protocol of services*, *treatment*, *prevention*, and *being sensitive*. Based on these five themes, the research team identified twelve subthemes to elaborate further on the health providers’ professional responsibilities in various aspects. Table 12 displays the themes and the subthemes of professional responsibilities for health providers and the number of endorsements for each of the theme or subtheme.

Table 12

*Professional Responsibilities*

Theme & Subtheme	Number of Participant who Endorsed the Theme or Subtheme ( <i>n</i> )	Percentage (%)
Acting as a First Responder	6	35.29
Focusing on external injuries (medical model)	6	35.29
High vigilance	6	35.29
Protocol of Services	17	100.00
Screening	13	76.47
Referral of clients to other departments	17	100.00
Involvement in legal processes	8	47.05
Treatment	14	82.35
Counseling services	12	70.58
Crisis management	11	64.71
Prevention	14	82.35
Provide psychoeducation to public	7	41.18
No direct involvement in prevention	11	64.71
Being Sensitive	16	94.12
Considering multiculturalism	12	70.58
Empowering clients in decision-making	10	58.82
Respecting client's privacy	10	58.82

**Acting as a first responder.** A first responder is a person who is among those responsible for an emergency or who immediately responds to IPV survivors. Six of 17 participants (35.29%) claimed that they acted as a first responder in the emergency and trauma departments in hospitals. All six participants were medical doctors, assistant

medical doctors, and nurses. They emphasized two main areas that were identified as subthemes: *focusing on external injuries (medical model)* and *high vigilance*.

***Focusing on external injuries (medical model).*** Focusing on external injuries is a medical model base that requires health providers to treat patients' injuries or critical disease as a priority. Six participants (35.29%) talked about their responsibilities in treating external injuries of IPV survivors before handed over to other departments. PA02 stated, "We will determine if she has any injury and refer her to a medical doctor. The medical doctor will take over the further responsibility of referring survivors to other departments based on their clinical judgments." PA04 also explained his working protocol by saying, "The wife came to the emergency room to seek treatment for the injury in her eyes. We first gave her treatment for her eyes. Then we brought her to a private room for a screening process." Similarly, PA13 described the steps that she would take when the survivors first enter to the emergency room:

The first step I take is to identify the purpose of her referral to the emergency room—usually any external injury and/or disease that she has experienced and for which she needs immediate treatment from a medical doctor. At the reception counter, we ask several questions to help us identify what services we need to provide to the patient. If the patient indicates any symptoms of being abused, then we first treat her external injuries, if any; then we ask several questions to help us to gather information to make an action plan.

Two others participants also mentioned that their primary roles as a first responder for survivors in the OSCC were to provide external treatment. PA14 and PA16 said, "I provide external treatment and medical examinations for survivors." PA14 further

indicated, “In the emergency department, the procedures to treat patients are the same. We need to identify the external injuries first before treating other aspects. We have a triage process to determine the severity of the patient’s condition and then provide medical treatment if needed.”

**High vigilance.** High vigilance refers to carefully noticing problems or signs of IPV by health providers during the first visit of IPV survivors. Six participants (35.29%) reported the needs to be high vigilance when working in the hospital settings. They noticed that patients do not always tell the truth or do not disclose until the further screening or concern was given to them. PA02 provided a specific example of how he handled a client who refused to disclose her story:

One woman came in and claimed that she had bruises on her body because she fell. However, it did not make sense to us as she had bruises on almost every part of her body. However, we did not force her to tell us. The medical doctor just kept asking her politely about her bruises and tried to explain to her that her bruises did not look like she had fallen down.

PA05 also highlighted the important of being vigilant to patients who were suspected of having been abused:

First and foremost is to outline a good history to determine whether or not the injury fits the story. Doctors must have a high index of suspicion. If her story doesn’t tie in with the injury, then doctors need to probe more.

Another two participants identified IPV based on the survivors’ injuries and symptoms as shown by the survivors and they would further ask the patient to confirm their suspicions (i.e., PA14, PA16).

**Protocol of services.** Protocol of services refers to process or procedures that are taken by health providers when working with IPV survivors. All participants ( $n = 17$ ) agreed that they had followed some procedures when working with IPV survivors. Three subthemes were connected to this theme: *screening*, *referral clients to other departments*, and *involvement in legal processes*.

**Screening.** Screening is an initial step that is taken by health providers to address current or history of IPV that occurred to survivors. Thirteen participants (76.47%) informed the researcher that they conducted an initial screening or assessment to help them identify IPV survivors. The screening process was based on a list of protocol that was provided by the agencies or hospitals to assist providers gather information from the survivors (i.e., PA02, PA04, PA13, PA14). PA06 described,

Usually, when the clients first come to seek help at the center, I listen to them, comfort them, and calm down their feelings of anxiety, fear, or depression. Then, I ask several questions in order to assist them to plan out what we should do for the next step.

PA09 also elaborated the protocol she used during screening process:

If, during the session, the client shared an abuse experience, I would ask her several questions. For example, when was the client abused by her husband? How frequently did he abuse her? What trigger the husband's abusive behavior? In what situations does violence occur in their relationship? How does each partner handle the abusive situation and the relationship after the abuse? I would first try to understand the client's situation in order to determine whether the client is part of an abusive relationship or a violent family.

PA15 admitted that he conducted less screening because most of his clients were referral clients and the initial screening was done by other departments. PA14 claimed that he only performed further screening if the cases involve IPV or domestic violence:

Basically, the screening process is performed by a nurse in the OSCC. I only perform further screening if the cases involve IPV or DV. Also, if it is a police case, then I will perform a detailed screening so that I can write a report to assist the investigation.

Thus, each health provider or department had conducted initial screening during the first visit of the survivors and detailed information would be gathered if the IPV cases were identified. Furthermore, several participants claimed that they would ask direct questions to male survivors (i.e., PA13, PA14, PA16) and less direct questions to women as they would more easily to open up (PA05). Health providers should not ask 'why' questions to both male and female survivors as it might offend the survivors (i.e., PA12, PA13, PA14).

***Referral of clients to other departments.*** A referral is part of the protocol in the health care system in Malaysia if the patient needs further assistance or treatment from the expertise in other departments. All participants discussed that referral clients to other departments was part of the protocol to give further treatment or assistance to the clients. For instance, PA05 who was a social worker in a religious body described, "If the survivors have experienced physical abuse, then I need to refer them to the emergency and trauma room immediately." He then added, "If the clients are Malays, then they need to refer the clients to our department." PA09 and PA10 also indicated that they would refer clients to other places if needed. PA08 stated,

I would either refer the victim to the Department of Social Welfare or a hospital or else file a police report. However, we also accept referral clients from the Department of Social Welfare because they don't have shelter for some survivors. PA01 admitted that she also referred the client if she identified the client had symptoms of being abused and needed medical treatment. Several participants agreed that the referral process occurred in multiple levels depending on clients' needs and conditions (i.e., PA02, PA03, PA09, PA10). PA12 claimed, "A lot of time, if I can't handle clients, I still need to refer them to other departments to get further help."

***Involvement in legal processes.*** Eight of 17 participants (47.05%) revealed they had used the legal processes with IPV survivors. The involvement of legal processes includes accompanying the clients to attend hearings at court, advocate for the clients, assisting clients in the reporting process, and any related legal issues. PA06 emphasized one of her roles as a social worker and counselor is to "accompany survivors at court and stay together with them if needed." PA11 also assisted the survivors by contacting with different agencies or police departments and assisted police in the investigation process. Several participants informed their agencies or centers that they provided legal advice to survivors and had social workers help survivors with the process, even attending hearings at court (i.e., PA05, PA10, PA15, P17). PA08 expressed that she did provide multiple services to survivors: "I do assist survivors to file a police report, but it really depends on the client's situation. I will accompany them, talk to them, provide alternatives to them, and become the mediator between clients and legal authority people." PA02, PA14, and PA16 also offered help in the police investigation process by providing a complete medical report and conducting detailed screening to gather more information from the

survivors. This process was noted as time-consuming and caused both health providers and survivors to become exhausted (PA06).

**Treatment.** Treatment is another theme that emerged as part of the professional responsibilities for health providers when they are working with IPV survivors.

Treatment refers to any care given to a client for their illness, injury, or psychological needs. Fourteen participants (82.35%) mentioned that they had provided some type of treatment to the survivors. The treatment was categorized into two subthemes: *counseling services* and *crisis management*.

**Counseling services.** Twelve of 17 participants (70.58%) claimed that counseling services was one of the treatments they provided to IPV survivors. Counseling services include exploring client's presenting problems, teaching skills, infusing hope, listening to client's needs, and guiding clients through steps of recovery. For example, PA06 said, "I will make sure that she receives counseling services at the center and help her to walk out of the darkness." PA05 also offered counseling services to his clients as well as the clients' partners and he said, "My primary task is to give counseling and be a mediator to couples if the survivor wants to repair her relationship with her husband."

PA08 articulated her objectives of providing counseling services: "I work according to the objective of our center; unconditional acceptance is our primary guideline, regardless of survivors' socioeconomic background, health conditions, and psychological issues, if any." Several other participants also provided support, care, love, and an integrated counseling theory and technique during the session (i.e., PA09, PA10, PA15, PA17). The common advanced interventions that were mentioned by participants were sand therapy and play therapy (i.e., PA06, PA08, PA10).

***Crisis management.*** Crisis management is a process to handle critical and urgent cases from the survivors, and need an immediate response from health providers. Eleven participants (64.71%) claimed that they had conducted crisis management when working with IPV survivors. Various terms the participants used to describe their crisis management, included providing helpline crisis service, providing food and shelter, discussing safety plans, providing crisis counseling, and providing financial assistance. Six participants from NGOs acknowledged that they had provided a crisis helpline for survivors who needed help, and they got staff to take turn in serving at the center for 24 hours. PA15 described his experience of handling crisis client:

This lady was referred by a hospital for counseling service and shelter assistance. She came in with black eyes, volatile emotions, and had suicidal ideation. I provided crisis counseling to her by first ensuring her safety and arranging for her to stay in our shelter.

PA16 shared about her crisis management procedures in the emergency room:

First, we will do a screening. We will document all the information and she will be seen by medical doctors in OSCC. More information will be gathered in OSCC. We will ask the patient if she wants to make a police report. If she agrees, we will call a police officer in the hospital to come file the client's report. The report will be given to the police officers to help the investigation process. If the patient refuses to make a police report, we will ask if she feels safe to go home or if she needs a place to stay. We also can admit the patient if she has experienced severe injuries and needs to be monitored.

Four other participants (i.e., PA09, PA10, PA11, and PA12) reported that they also discussed a safety plan with the client to prepare for if the situation were to get worse. They also provided temporary financial assistance and informed about available resources and options to help the survivors react to the immediate needs.

**Prevention.** Prevention is associated to the act of health providers in hindering IPV from happening. Fourteen participants (82.35%) noted their roles in IPV prevention, either they had direct involvement in prevention or they did not involve in prevention. This theme was connected to two subthemes: *provide psychoeducation to public* and *no direct involvement in prevention*.

***Provide psychoeducation to public.*** Seven of 17 participants (47.05%) acknowledged their roles in IPV prevention and they had provided IPV information and psychoeducation to public. For example, PA06 stated,

I am also involved in prevention by providing training and psychoeducation through the media to share my experience of working with survivors and to call for public awareness of the issue and tell them [who] they can seek help from and what should be the first action they need to take in order to protect evidence on their bodies.

PA07 called his prevention role as secondary prevention as he provided information to survivors during the treatment. He said, “We try to help women to break out of the cycle of violence. We give them advice and provide useful, important information regarding their rights. We discuss with them their options and try to empower them.” Two participants confessed that they had been offered a prevention program by focusing on

promoting the Domestic Violence Act in public (i.e., PA11, PA17). In particular, PA17 described,

We provide psychoeducation to the public and set up violence against women counters, banners, and flyers through the media to educate people that IPV is a crime. We also give a brief talks in schools about domestic violence and IPV and provide information to the public about where they can seek help if they need it.

***No direct involvement in prevention.*** Eleven participants (64.71%) denied they had engaged in any of the prevention programs. Most of them believed prevention were not part of their job responsibilities, and there were other departments take charge of the prevention program (i.e., PA02, PA03, PA08, PA12). For instance, PA16 emphasized,

I work in the emergency room and at OSCC, and I don't think we have any prevention programs. Usually human resources or social workers in the hospital provide information on prevention. No medical doctors or nurses are involved directly with the prevention program unless they are asked to participate in the program.

PA13 also mentioned a similar situation that providers in the emergency room are not involved in prevention programs. She stated,

Regarding prevention, I don't think that I have had a preventing role. Usually in hospital settings, we have a Public Health Department that will provide psychoeducation and information regarding wellness, IPV, DV, and other diseases. I think that they are in charge of prevention programs. In the emergency room, we aren't involved in any prevention programs.

PA14 said that he had not been involved directly in any prevention programs, but he did provide tips about communication, how to treat husbands and wives, how to manage children's behavior, and the responsibilities of husbands and wives. He felt that might be counted as prevention as well. He then explained, "Someone in the department has provided outreach programs, workshops, and campaigns to help the public to learn about symptoms of IPV."

**Being sensitive.** Being sensitive includes a strong tendency to be aware of survivors' feelings, needs, their pains of being abused, and to be more cautious about taking action when working with them. Sixteen of 17 participants (94.12%) talked about being sensitive as a key element to work with IPV survivors. There were three subthemes identified: *considering multiculturalism*, *empowering clients in decision-making*, and *respecting client's privacy*.

**Considering multiculturalism.** Twelve of 17 participants (70.58%) reported multiculturalism issues, such as language, self-values, being nonjudgmental, and avoiding offending clients when working with IPV survivors. This factor was embedded in the Malaysia context, as the country itself is a multi-lingual, multi-racial, and multi-religious society. PA06 as a social worker and counselor shared her experience about the importance of being sensitive especially when asking questions to the survivors or appropriate language used when working with IPV survivors. She stated,

It is important to be sensitive when asking survivors questions because the question "Are you sure?" can bring huge damage to the client because it also means that you do not trust her." She also suggested, "Acceptance is an important

element: Accepting whatever the client brings to you without making any judgment.

PA07 also emphasized being non-judgmental when working with IPV survivors:

One thing that we should not do is be judgmental. We should not be too pushy in trying to impose our own views on patients. We can only advise patients. We should listen to the patient's needs and see how we can try to help her.

He also described, "I want to emphasize that there should not be any difference in terms of the interventions that we use for survivors according to gender." In addition, PA09 and PA13 provided a similar suggestion in working with male survivors. They stated,

Male survivors might feel embarrassed to tell me about their family problems, they need a lot of courage to tell others about their abusive relationship. So, being sensitive to this process can be helpful. What I should not do is judge them or ask questions about why the violence has occurred. They might feel that I am challenging them.

Finally, PA15 noted limitations and avoiding impose self-values to clients were the elements to take into consideration when working with IPV survivors.

***Empowering clients in decision-making.*** Ten participants (58.82%) mentioned that empowering clients in decision making is a critical process in IPV. Empowerment refers to give the clients power to make their decisions and providers as a guide in this process. PA06 stated, "We need to respect the client's decision, not push too much, and let her take her time to calm down before making decisions about what to do next." PA10 and PA11 also felt that they were helpful to the clients by providing alternatives to help them make a right decision for the next step. PA12 stated:

We need to know what options survivors have and to tell them these options and let them make their own decisions. One thing that we should not do is make any decisions for survivors. We can provide information to assist them to make their decisions.

PA15 further described how she empowered her clients in decision-making:

During the initial process, based on the information I've received, I discuss with the client the available resources we have and help her to decide what is best for her. For example, if the client needs a place to stay, then I definitely show her shelter situations and what is available for her. I also calm her down and let her know that I am there to assist her. I do not give her any immediate counseling service, not until she has settled down in our shelter. However, if the client comes in for counseling services or other assistance only, then I directly talk with her about her needs, particularly if she needs an interim protection order. I might need to help her to apply and accompany her through the process.

This empowerment process occurred in a respectful manner as health providers provided options or alternatives to assist the survivors to make their decisions (i.e., PA16, PA17).

***Respecting client's privacy.*** Respecting client's privacy includes keep confidentiality, creating a safe environment, establish a professional relationship, and being respectful in treating clients. Ten of 17 participants (58.82%) in this study recognized respecting client's privacy as critical in building a provider-client relationship, as well as influencing IPV survivors' help-seeking behaviors. For instance, PA01 recalled her experience of working with IPV survivors:

A lot of clients felt scared to tell their experience because they questioned the confidentiality of the services. During the sessions, I will mention about the confidentiality to reassure the clients that our discussion will be kept as confidential.

PA04 also described one of his clients who refused to tell the truth, and he tried his best to talk politely with her: “We kept asking her politely about her bruises and tried to explain to her that her bruises did not look like she had fallen down.” By doing that, he was able to get a confirmation from the client that she had been beaten by her husband. PA13, PA14, and PA16 shared similar actions they took to ensure the privacy of the clients protected. They said, “We take her to a private room for screening where a record is made, and she is examined closely, particularly if she has filed a police report.” PA07 admitted that health providers’ responsibilities to respect clients’ privacy and keep confidentiality could help to establish a good working alliance between providers and survivors.

### **Superordinate Theme Nine: Recommendations for Improving IPV Training and Services**

This superordinate theme focused on the *participants’ recommendations for improving IPV training* in Malaysia. Due to the lack of training that was mentioned by participants, this superordinate theme was constructed based on the suggestions given by participants to meet their needs for improving IPV training and services. Three themes were identified: *personal changes*, *institutional changes*, and *societal changes*.

Participants in this study expressed their hopes that the improvement of IPV training should focus on health providers in person, institutional based, as well as public or

societal awareness towards IPV. Twelve subthemes were connected to these three levels changes and will be discussed in the following section. Table 13 displays the themes and the subthemes of health providers' recommendations for improving IPV training and services, and the number of endorsement by participants for each theme and subtheme.

Table 13

*Recommendations for Improving IPV Training and Services*

Theme & Subtheme	Number of Participant who Endorsed the Theme or Subtheme ( <i>n</i> )	Percentage (%)
Personal Changes	17	100.00
Communication skills	9	52.94
Awareness of professionalism	8	47.06
Continuing education	17	100.00
Self-awareness	8	47.06
Institutional Changes	17	100.00
Practical protocol or guidelines for treating IPV	12	70.59
Better referral sources	17	100.00
Support team	8	47.06
Inter-agency collaboration	5	29.41
Provide supervision	4	23.53
Societal Changes	15	88.24
Psychoeducation for the survivors	11	64.70
Legal knowledge	9	52.94
Increase public awareness on IPV	6	35.29

**Personal changes.** Personal changes refer to health providers' self-improvement in term of their knowledge, skills, attitudes, and awareness on IPV through various trainings. All participants reported that the training should focus on health providers'

personal changes. Four subthemes were identified: *communication skills, awareness of professionalism, continuing education, and self-awareness.*

**Communication skills.** Communication skills refers to interpersonal skills that are required when working with IPV survivors. It includes questioning skills, paraphrasing, showing empathy, utilizing appropriate language, and creating a climate of openness. Nine participants (52.94%) suggested they would like the training to include interpersonal skills to help them to improve their communication skills with IPV survivors. For example, PA07 mentioned, “I think that soft skills are important- for example, understanding what a difference can we make for survivors and counseling skills to help in communicating with IPV survivors.” PA09 pointed out a similar issue that, “It would also need to teach health providers how to communicate with survivors about the prevention of IPV, and how clients can protect themselves from being abused again.”

Another participant claimed that communication was important during assessment (PA11). Thus, the training should include assessment training to help providers assess, and communicate with survivors. PA11 said,

It is important for nurses, medical doctors, and medical officers need to know how to assess clients, what questions they can ask to get information, and how they provide immediate response to clients when they come to seek help.

Furthermore, PA14 emphasized the importance of health providers to be able to communicate with IPV survivors. She stated,

I think that health providers’ communication skills and questioning skills need to be improved. If you can provide us with that kind of training, then it would be

helpful, because we usually ask direct questions and get straight to the point to help us to identify the injured areas of survivors. But I have noticed that it does not always work when I ask direct questions to survivors. I need those skills to help me to gather information and treat patients appropriately.

Thus, verbal communication skills were required when working with survivors and all nine participants wanted the training to include these specific skills to assist them to be able to explore clients' presenting problems, communicate resources, and understanding better the clients' immediate needs.

***Awareness of professionalism.*** Eight of 17 participants (47.06%) highlighted the awareness of professionalism as part of the IPV training. Since many providers have a lack of interest in treating IPV survivors, it was important to help them understand their professional roles in serving the survivors (i.e., PA07, PA14). In particular, PA01 stated, "As a provider, we should do our best to help our clients and understand their problems, and help them to go through the process."

Additionally, PA14 suggested that training should train all providers to be competent and responsible in their jobs. Infusing knowledge of IPV and enhance motivation to work with IPV survivors could be helpful as well for them. PA15 described the reality that health providers lack interest to serve IPV survivors and he called for providers' awareness about their job responsibilities. He said, "I think that to enhance providers' awareness of their professionalism when working with survivors is important. Most of them are in these positions, but they have no intention or even lack interest in assisting survivors." PA06 and PA07 expressed, "All parties involved in helping IPV

survivors should know their responsibilities and aware about personal job scopes in serving the survivors.”

***Continuing education.*** Continuing education consists of short or part-time courses, such as formal courses, seminars, workshops, webinars or any other similar type of educational program designed to help individuals gain new knowledge or skills about the field in which they work. All participants ( $n = 17$ ) recommended continuing education as an important element in enhancing health providers’ knowledge, skills and ability to respond to IPV survivors. Several suggestions were given by participants regarding the content of the continuing education, included provided IPV related skills and interventions, basic IPV knowledge, assessment training, and practical training. For instance, PA01 stated,

I think you should emphasize the techniques, interventions, or strategies that can help health providers in Malaysia to work better with intimate partner violence survivors. Such as counseling techniques or psychology techniques can help health providers to work with intimate partner violence survivors.

PA05 also made a point of health providers who provide services to survivors need to be more sensitive and continue to update themselves to accommodate clients’ needs. PA06 said that various interventions should be included in IPV training. She expressed,

Various interventions could be introduced to health providers for them to have more choices when dealing with different clients. At the same time, to educate health providers on how to play the role of advocate for victims is important because we are the first respondents to victims and need to protect them. In order

to be able to protect them, first we need to have knowledge and skills about how to handle the situation.

Another three participants suggested the training program should include basic knowledge about IPV because they did not receive formal training in the past (i.e., PA01, PA02, PA11, PA13). PA02 described, “I think basic knowledge about IPV and how survivors’ mental or psychological states are after being abused.” Similarly, PA13 also stated,

I think that providing a continuing education program regarding IPV would be important. We have short training, but that training is not comprehensive. I need more comprehensive training that includes a set of protocols for handling survivors, teaches me how to manage survivors’ emotions, and explains what interventions I can use, particularly to treat the emotional aspects.

Thus, the IPV training program should be an on-going training and focus on different areas of knowledge and practical skills. PA11 said, “The availability of the training and the providers’ continuing upgrade themselves through various training programs were be more helpful for the survivors.”

***Self-awareness.*** Self-awareness refers to the ability of health providers to recognize ones strengths, weaknesses, thoughts, beliefs, motivations, and the dynamic between provider-client relationships. Eight participants (47.06%) mentioned health providers’ self-awareness in enhancing IPV services. PA05 requested, “The training should include some practical techniques to help survivors and ways for health providers to avoid projecting their emotions onto the clients and imposing their values upon clients are needed.” Another clear example was given by PA06:

I think that the training program should include health providers' emotional management and interventions for survivors. It involves a prolonged engagement with health providers in the victims' cases, and self-care and emotional management for health providers are important to making sure that they are able to provide a quality service to victims.

She then described:

We have our own emotional involvement in the client's case, and we should be aware about it and walk away to take a break before we come back to continue our work, because a lot of the times, we might be using an inappropriate tone due to anger, or we might offend the clients.

PA15 indicated that sometimes she felt tired from serving the whole day without rest as she only has several staff but many survivors in the shelter. She felt self-care was important for health providers to be able to maintain their wellness. PA03 also spoke about health providers' self-awareness:

Though this process can be extremely emotionally provoking for the health providers, we need to assist them. Emotional control for health providers is important, and we might be the victims' only place to seek help. I just feel there are a lot of aspects that we still can improve on in order to provide a better service for survivors.

Thus, health providers' awareness of their own thoughts, feelings, and reactions when working with the survivors could be helpful to assist IPV survivors to be able to disclose themselves.

**Institutional changes.** All participants agreed that the training should focus on institutional changes since health providers worked closely with various institutions. Institutional changes include the protocol or procedures in handling IPV cases, referral resources, teamwork, and supervision needs. Five subthemes were associated to institutional changes: *practical protocol or guidelines for treating IPV survivors, better referral sources, support team, inter-agency collaboration, and provide supervision.*

***Practical protocol or guidelines for treating IPV survivors.*** Twelve participants (70.59%) acknowledged that a set of protocol or guidelines for treating IPV needs to be provided during the training. The training should assist each institutional in developing their practical protocols or guidelines that were beneficial for both health providers, as well survivors who come to seek help (i.e., PA02, PA13, PA16). For example, PA01 stressed, “The basis protocol to handle the clients’ cases is important. How we should handle the clients if we found the clients were being abused.” PA04 further described the importance of having a set of interview protocol that was multicultural sensitive to different clients:

I think the most important thing should be included is a set of interview questions

I would like to know specifically what kinds of questions I can ask based on different cultures. Then I would be able to fully understand the survivors’ stories.

For example, among the different age groups, I believe I should use different questions to track their stories. By mastering questioning skills, I would feel more comfortable with treating survivors.

PA05 noted the flow charts about the work processes, how other agencies and departments, the referral system, the available law, and counseling skills need to be

cleared for health providers in order to prepare them to be competent providers. Thus, he suggested that the training should provide the information regarding flow charts of work processes. PA09 reflected on her work experience and recommended, “I think the training program needs to include guidelines or procedures for handling IPV survivors, so that we can know what we need to do when working with different clients.” PA12 explained the importance discussing the protocol or procedures use for each organization:

NGOs play an important role in helping survivors, but most of them don’t have formal training for assisting survivors. When they refer clients to us, they might neglect some procedures or fail to get information that they need to give us. I think that it’s good to go through the training program, so we can provide all information and procedures regarding how each organization and department works. That might be more helpful for all of us.

Other participants (i.e., PA11, PA13, PA15, PA16) expressed their needs to have a practical protocol or procedures to handle IPV cases. They believed with a clear, practical, and appropriate procedures to handle IPV cases, they would feel more confident in their jobs.

***Better referral sources.*** All participants pointed out that a list of available resources is needed to help them provide adequate services to the survivors. These sources include agencies or departments who have provided adequate services to the survivors, financial assistance for survivors, shelters, counseling services, and legal advices. PA09 emphasized the lack of referral sources in her agency and she wanted other agencies can shared their resources with her:

I am wondering how they can share resources with us. I believe that in my area, we don't have many agencies or departments who have provided services to IPV survivors, particularly in rural areas. Many families have the same issues, but it is hard for them to get help due to the lack of resources. They also definitely don't want to share their problems with others.

PA13 was concerned if the training could provide a complete list of available resources that could help her to refer her patients:

I think that the training should also provide us a list of available resources, as well as educate other providers who have worked directly with survivors, such as workers from NGOs and the Department of Social Welfare, as well as police officers, to help them to understand better ways to treat survivors.

Another three participants also expressed that the training should provide a correct referral resources for providers in order to help them communicate with survivors about what other resources are available for them (i.e., PA03, PA10, PA12).

***Support team.*** Support team refers to a group of providers who work together as a team to serve IPV survivors based on their expertise. Eight participants (47.06%) claimed that the available support team in the OSCC needs to be improved and well-trained.

PA03 and PA07 acknowledged emotional support is important within a team work and it should be emphasized during the training. One participant spoke about the relationship among helping providers needing to be improved in order to enhance the quality of their services (PA16).

PA09 wanted more competent providers to be recruited to the team to serve rural and urban areas:

We need to train more staff and implement an OSCC in all clinics in Malaysia, both in rural and urban areas. Each OSCC needs to be handled by competent police officers or practitioners who are able to help survivors. We need to gain more knowledge and learn appropriate procedures for handling IPV cases, and then we can work in every part of the rural and urban areas in this state.

PA14 recognized the importance of team work, but he also wondering how training can help to improve team work based service:

If one person or one department does not respond to the survivors, then, there is no way for us to treat survivors quickly. It is a teamwork-based task, because we need different experts and providers from various departments to assist patients.

He then added, “The training should include each agency or department’s role in serving the survivors, as well as infuse a sense of responsibilities on them. Through training, the connection and support among providers would become strong.” Thus, training serves as a platform to provide support to the team work as well as to enhance providers’ ability to respond to IPV.

***Inter-agency collaboration.*** Inter-agency collaboration refers to the collaboration between agencies or departments for the purpose to provide better service for IPV survivors. Five of 17 participants (29.41%) suggested inter-agency collaboration was an important element to change the quality service of institutional. For example, PA05, as a medical doctor who also provided training to junior staff expressed,

I feel that inter-agency collaboration is very important. Thus, the need for regular case discussions and reviews among agencies is necessary. In order to help patients, we need to have good networking with relevant departments so that

things can get done and so that there will be better understanding among all agencies involved.

PA09 also emphasized on making inter-agency connection with other agencies or departments: “The connection between agencies and departments are important as we don’t have enough resources or providers in our areas.” PA15 spoke about IPV training also addressing providers in various settings, because they work collaboratively with other departments. He said, “All of us need to know what we need to do and who we should contact when we have clients who need to be referred out.” PA16 also stated, “I think providers should be aware of their responsibilities if they work in OSCC or on collaborative teams as it is important to success in the referral process. I think reminders can be given during the training.” Thus, the purpose of the training should focus on inter-agency collaboration and help health providers establish connections with other departments.

***Provide supervision.*** Supervision means to review or monitor IPV workers by senior staff or expert of the field. Four participants (23.53%) recommended the need of supervision for health providers, particularly for the beginner providers who are involved in working with IPV survivors. PA11 stated, “I think that I would recommend that the training program includes supervision training, since we need that to monitor our skills and interventions in treating survivors.” Similarly, PA16 also articulated, “Continuing supervision to make sure all providers have utilized the appropriate protocols might be helpful. This can help maintain our services for the survivors.” Another two participants, PA07 and PA13 stressed that “We need expert advice to help us to be competent in handling various IPV cases and we think supervision is important to maintain the quality

of service and ensure the effectiveness of training.” All four participants agreed that supervision should include in the training program and train senior providers to monitor the quality of the IPV services in their departments.

**Societal changes.** Another component that was highlighted by 15 participants (88.24%) was societal changes. They stated that the training program should include psychoeducation for the survivors and increase public awareness IPVs could bring to societal changes. Through the training program, each provider will be trained to be involved in prevention programs and educate public and survivors about their legal rights in IPV. Three subthemes were identified: *psychoeducation for the survivors*, *legal knowledge*, and *increase public awareness on IPV*.

***Psychoeducation for the survivors.*** Eleven of 17 participants (64.70%) in this study claimed that psychoeducation for the survivors is necessary. They reported many survivors had a lack of awareness about IPV and available resources for them if they wanted to seek help (i.e., PA02, PA03, PA04, PA06, PA07, PA08, PA17). For example, PA10 mentioned,

We need to help survivors understand what violence is and what types of violence exist. They might have been in an abusive relationship for a long time, yet they are not aware that it was domestic violence or intimate partner violence. They don't feel that they need help from others; they perceive it as normal and are already used to the situation.

PA05 also spoke about educating children and survivors on how to protect themselves from continually being abused. Furthermore, PA08 suggested it is important to create

awareness among survivors regarding available resources for them if they wanted to seek help. PA02 suggested,

Educate survivors on the need to tell us and let them know it is violence if their husbands beat them. Tell them to talk to us and we are there to support them and to listen to their problems. Make them aware that this is violence and they have a right to report and to advocate for themselves.

Only six participants mentioned increased public awareness on IPV rather than putting fully responsibility on the survivors. Thus, this interesting phenomenon needs to be addressed during the training in order to keep providers' biases in check.

***Legal knowledge.*** Legal knowledge includes Domestic Violence Act, laws, and women rights in term of IPV. Nine participants (52.74%) noted that imparting legal knowledge on IPV survivors as well as public was critical and needs to be included in the training program. For instance, PA09 indicated, "We also need to educate survivors about what IPV and domestic violence are, what IPOs are, and the law, as well as the available resources that they can access in order to get further help." She then added, "I am not an expert in offering legal advice. I think if your training can provide some sort of legal perspective of IPV it could be helpful for us."

PA17 expressed the inclusion of legal knowledge in training is not only good for providers, but also for survivors. PA14 said, "Training programs should focus on the public by educating society about IPV as a crime and the appropriate steps they should take to protect themselves." Additionally, PA05, PA06, and PA07 also agreed that the training should provide the information about available law that can protect survivors and the appropriate steps should be taken by women if they were being abused.

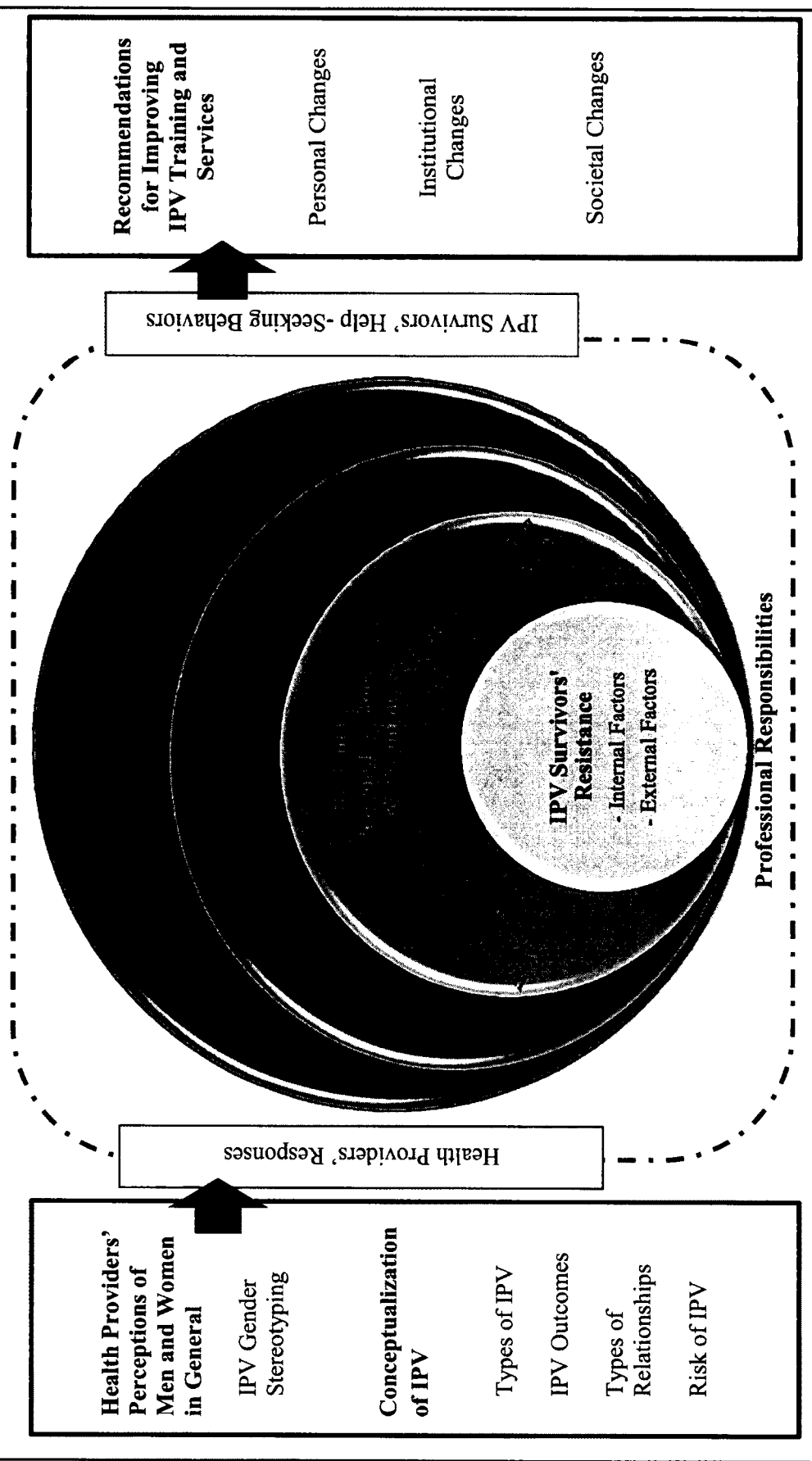
***Increase public awareness on IPV.*** Six of 17 participants (35.29%) recognized the importance of increasing public awareness on IPV. The participants disagreed that the training program only focused on health providers. They would like the training program to be given to the public in order to educate them and enhance their awareness toward IPV. PA13 and PA14 spoke about a need to involve the public in the training program and said, “Increasing public awareness about IPV is important as well. Thus, psychoeducational training is needed for us and for the public.” PA01 also described how to include educating the public as part of the training program. She said, “We can offer outreach programs and some classes to educate public about IPV, domestic violence, and children abuse. We also can provide them the available resources they can use to seek help.” PA02 and PA08 suggested having a campaign or psychoeducation training done in various settings by involving public in the campaign or in a psychoeducation series. Through the training effort to make changes on personal level, institutional level, and societal level, it may increase health providers’ responses to IPV survivors as well as building confidence in survivors regarding the quality services they will receive if they needed.

### **Overview of the Emergent Theory**

Figure 1 shows the relationship between the superordinate themes, themes and subthemes that assist in understanding health providers’ perception of IPV, influencing factors, and recommendations for improving IPV. The emergent theory is represented in Figure 1.

**Figure 1**

*A Theoretical Model for Understanding Factors Influencing Health Providers' Knowledge, Attitudes, and Responses to IPV Survivors*



This figure represents the theoretical model for understanding the factors that influence health providers' knowledge, attitudes, and responses to IPV survivors. The interactions of superordinate themes and themes constructed in this theory occur within the context of a health care system that is depicted by the box the diagram in Figure 1. This process involved medical doctors, assistant medical doctors, nurses, counselors, social workers, and para-counselors who were the participants for this study. The theory proposed that there were many factors that influenced health providers' ability to respond, and IPV survivors' help seeking behaviors, whether within the system and outside of the system. The nine superordinate themes, 23 themes, and 71 subthemes constructed in this study produced the emergent theory that explains health providers' perception on IPV, factors influencing health providers' responses to IPV survivors, and factors they perceived as IPV survivors' help-seeking behaviors, as well as their recommendations for improving IPV training.

The nine superordinate themes included *perceptions of men and women in general, conceptualization of IPV, training, institutional factors, providers' personal factors, sociocultural factors, IPV survivors' resistance, professional responsibilities, and recommendations for improving IPV training*. The first part of the column on the left of the figure describes the first two superordinate themes that answered the research question regarding the perception of how men and women are treated in Malaysia. This column reflected on health providers' knowledge of IPV and their perceptions on IPV based on gender in Malaysia context. One theme was found, *IPV gender stereotyping*. Related to this theme were four subthemes that associated how men and women are treated, including women as victims, men as perpetrators, deny of IPV male victims, and

gender discriminations. The second superordinate theme was related to health providers' *conceptualization of IPV*. An additional four themes and ten subthemes were determined as related to *types of IPV* (including the three subthemes of physical abuse, sexual abuse, and emotional abuse), *IPV outcomes* (including the two subthemes of mental health issues and behavioral outcomes), *types of relationship* (including three subthemes of marital relationship, partner relationship, and no prior relationship) and *risk of IPV* (including two subthemes of history of abuse and substance abuse).

The Venn diagram that is surrounded by a square box located in the center of the figure was the most prominent feature of this model. It was the core components of this study that explored factors that influence the ways health providers responses to IPV and factors they perceived influenced toward IPV survivors' help-seeking behaviors. The square box outside of the Venn diagram represents superordinate theme of *professional responsibilities*. In the spectrum of professional responsibilities, and health providers need to respond to five different roles: Acting as a first responder, protocol of services, treatment, prevention, and being sensitive. The emergent theory postulates that the process of responding to these responsibilities were influenced by the four layers of the Venn diagram that reflected factors that influence health providers' responses ability as well as IPV survivors' help seeking behaviors. These four layers contained five superordinate themes: *IPV survivors' resistance*, *providers' personal factors*, *training*, *institutional factors*, and *sociocultural factors*. *IPV survivors' resistance* was the first layer because they are the target population for health providers to perform their services. The survivors' resistance is affected by *internal factors* (including fear of being judged and wanting to repair the relationship) and *external factors* (including lack of trust and

lack of protection and support). The second layer is the *providers' personal factors* and *training*. These two superordinate themes were the key elements that influenced a health providers' ability to respond adequately. Providers' personal factors consisted of *work performance* and *self-experience and assumptions*. Related to work performance, health providers were reported to have lack of competence, lack of self-efficacy, resistance to professional roles, and victim blaming. Their personal experiences of being abused, differences in self-values and beliefs, and emotional reactions were identified under the theme of self-experience and assumptions. Training that was received by health providers fell into two themes: Short-term training, and inadequate training. Five subthemes emerged including experiencing an in vivo training scenario, general counseling skills and interventions, comprehensive training program (short-term training), non-specific IPV training, and centered on female survivors (inadequate training). The second layer had direct influences on the first layer of IPV survivors' resistance due to the providers' personal factors and the training they received.

The third layer of the Venn diagram represents the superordinate theme of *institutional factors*. Two themes related to internal and external factors; five subthemes found related to *internal institutional factors* (including the need to collaborate with other departments, protocol in treating IPV survivors, delaying responses to survivors, professional support, and lack of resources); and two subthemes were associated to *external institutional factors* (including police department response and abide by religious principles). This theory assumed that institutional factors influenced a provider's ability to respond and indirectly effect IPV survivors help-seeking behaviors. For example, factors such as protocol in treating IPV survivors, delaying responses to

survivors, lack of resources, and police department responses obviously effected IPV survivors' help-seeking behaviors.

The fourth layer of *sociocultural factors* is embedded within Malaysian cultural context, where health providers and IPV survivors lived and grew up. There were two themes found: *cultural values* and *lack of legal awareness*. Associated to these themes were six subthemes related to cultural values, including traditional gender roles, religious values, accept IPV as normal, collectivism, educational background, and socioeconomic status; and two subthemes related to lack of legal awareness, including women acts and women rights, and child custody. These four layers interacted and effected each other within the spectrum of professional responsibilities of health providers. However, the direct influence of these factors on IPV survivors can be seen in the diagram, as IPV survivors are the central persons to be treated by health providers.

Regarding *recommendations for improving IPV training and services*, the constructed model indicates three levels of changes need to be included in the training. The first theme is focused on *personal changes* that including communication skills, awareness of professionalism, continuing education, and self-awareness. The second theme is related to *institutional changes* and includes practical protocol or guidelines for treating IPV survivors, better referral sources, support team, inter-agency collaboration, and provide supervision. The third theme is about *societal changes*, which related to psychoeducation for survivors, legal knowledge, and increase public awareness on IPV. This theory suggests that the focus of the training on health providers may not enough to improve services to IPV survivors, but the inclusion of institutional and societal changes

could make a huge milestone in combating IPV as well as provide a better quality services to IPV survivors.

## **CHAPTER V**

### **DISCUSSION**

The purpose of this study was (a) to examine Malaysian health providers' perceptions of factors that influence their perceptions of IPV and delivery of services to IPV survivors as well as, factors related to IPV survivors' help-seeking behaviors; and (b) to examine health providers' recommendations for improving training in working with IPV survivors. The research team identified 9 superordinate themes, 23 themes, and 71 subthemes in relation to the research questions. This chapter provides an interpretation of these results and compares them to the existing literature. In addition, implications for health providers and for counselor training are discussed. Finally, this chapter concludes with a discussion of the study limitations and possible future research directions.

#### **Summary of Findings**

The central research question of this study was: What factors influence Malaysian health providers' attitudes, knowledge, and responses towards IPV survivors? This central question will be answered through four sub-questions in the following section.

#### **Research Question 1: How Do Health Providers Conceptualize IPV for Malaysians?**

Numerous studies have identified health providers' knowledge of IPV and how it affected their attitudes and responses to IPV survivors and their children (Colombini et al., 2013; Coulter & Mercado-Crespo, 2015; Tower, 2007). Coulter & Mercado-Crespo (2015) found providers in Florida reported that inequitable knowledge of IPV and child protection affected their ability to deal with IPV cases that involved children. Consistently, research conducted in Australia (Tower, 2007) and in Malaysia (Colombini et al., 2013) indicates that health providers' lack of knowledge about IPV could inhibit an

effective response and that they tended to ignore emotional care for patients. These findings were in accordance with survivors' experiences of seeking help from various providers within the health care and social care sectors and reported their experiences as negative because of their health providers' lack of IPV knowledge (Humphreys & Thiara, 2002). Given that previous research on providers' knowledge of IPV is mixed and based on health providers in primary care settings, this research question examined how health providers conceptualize IPV for Malaysians and explored their understanding of IPV in general. The superordinate theme one (*perceptions of men and women in general*) and the superordinate theme two (*conceptualization of IPV*) were reflected by health providers' knowledge of IPV within the Malaysian context.

**Perceptions of men and women in general.** All participants reported having *IPV gender stereotyping*, which related to four subthemes: *women as victims*, *men as perpetrators*, *denial of IPV male survivors*, and *gender discrimination*. They held pervasive beliefs about women being victims and men being perpetrators in an IPV relationship. These findings support data from Tjaden and Thoennes (2000) and Kelly and Johnson (2008), which showed that women are at a significantly greater risk of IPV than men. The same result was found in Kelly and Johnson (2008) showing that most victims of IPV were women.

All participants assigned the term 'she' or 'women' as victims and 'husbands' or 'men' as perpetrators throughout the interviews. In particular, PA03 and PA14 pointed out that most of the physical abuse or related violence such as sexual harassment, molestation, theft, and rage toward women are committed by males. Research indicates that both women and men can be violent, but women who are violent are more likely to

be acting in self-defense to protect themselves (Caldwell, Swan, & Woodbrown, 2012; Dutton & Nicholls, 2005; Downs, Rindels, & Atkinson, 2007). Further, health providers' stereotypes of men's and women's respective roles in IPV can be influenced by their cultural norms and that this diminished their attentions in assessing male survivors (Dutton, 2011). This was evidenced in this study as 10 participants denied the existence of IPV male survivors, as they did not believe men could be victims of IPV. All participants reported minimal experience in working with male survivors and several seemed hesitant to mention male survivors, as if the providers had never thought of this aspect of IPV before.

Additionally, 11 participants thought that gender discrimination was a serious issue in Malaysia and that gender inequality was common in the society, especially in work settings. Women's abilities and statuses were perceived to be degraded due to the patriarchal system and people's mentalities about women's roles. These participants agreed that IPV becomes a complicated issue due to the intersectionality of socially-accepted stereotypes and discrimination based on gender in Malaysia. This finding was echoed with Garcia-Moreno et al. (2015), who noted gender inequality and discrimination are root causes of IPV and IPV cuts across social, economic, cultural, and political rights between men and women. The participants believed men seem to have more power than women in many aspects. For example, PA15 stated, "Perpetrators don't need any assistance from us unless if they have a mental illness." Their perceptions are not only a consequence of gender inequality, but reinforce the inadequacy of services available to IPV survivors; this is consistent with Govender and Penn-Kekana (2008),

who noted that health providers' attitudes and behavior are shaped by the social context in which they live.

**Conceptualization of IPV.** Health providers' identification of IPV was connected to four themes: *types of IPV*, *IPV outcomes*, *types of relationships*, and *risk of IPV*. All participants mentioned types of IPV and types of relationships when defining the term IPV. Physical abuse was the most common type of IPV identified by participants in this study as well as in the literature (see Breiding et al., 2014; CDC, 2013; Saltzman et al., 2002). Fourteen participants recognized emotional abuse as a type of IPV, but only six of them described how emotional abuse manifests itself, such as through humiliation, degradation, name calling or labeling, threats, financial control, and control the person's freedom. No participant perceived emotional abuse as a severe issue; this finding was inconsistent with Outlaw (2009), who found that emotional abuse is as severe as physical abuse regarding the long-term effects that are experienced by IPV survivors.

Fifteen participants noted sexual abuse as a type of IPV. They related sexual abuse to no prior relationship type because they believed most of the sexual abuse was committed by unknown individuals. This finding was inconsistent with the National Crime Victimization Study (U.S. Department of Justice, 2015) showing that 4 of 5 rapes were committed by someone known to the victim, and 82% of sexual assaults were perpetrated by a non-stranger. The participants' perceptions may have been influenced by the Domestic Violence Act, as marital rape is not an offense in Malaysia (Amirthalingam, 2003). Thus, most of the cases that are reported involve attacks by strangers. Furthermore, the most common type of relationship that was listed as being involved in IPV was a marital relationship ( $n = 17$ ). This result is in accordance with the family violence

perspective that dysfunctional family systems reinforce spousal abuse or family violence (Lawson, 2012). Another explanation for this could be related to the fact that marriage is a serious matter in Malaysian culture and both wife and husband are legally bonded to each other. Thus, IPV commonly occurs within a marital relationship. Frias and Angel (2005) noted a different conclusion about married women in that they are less likely to experience violence than their unmarried counterparts. Johnson and Ferraro (2000) explained that this may be because cohabiting and dating couples were not fully committed in their relationships, which led to the high rates of IPV among unmarried couples.

In terms of IPV outcomes and risk factors for IPV, previous research indicates that these two elements sometimes overlap for perpetrators and survivors (Breiding et al., 2008; Capaldi et al., 2012). Similar results were found in the present study that IPV behavioral outcomes were related to both the survivors and the perpetrators as an effort to end IPV situations. Six participants spoke about women survivors running away from their homes and looking for a shelter to stay in. Another participant emphasized that the perpetrator became aggressive after noticing his wife running away from the house. This situation has a large impact on survivors' mental health statuses as 11 participants recognized their clients had trauma, depression, suicidal ideation, and emotional instability. Seven participants noted women who were in long-term abusive relationships believed that they deserved to be abused. This finding was aligned with the notion of learned helplessness theory that when women experience repeated abuse by their partners it may lead them to develop negative beliefs about their future and feel helpless being in the relationship (Walker, 2009). In addition, Abramsky et al. (2011) noted that women

who have previously been abused by partners or non-partners are more likely to experience IPV in the future as compared to those without prior exposure to violence.

On the other hand, another risk factor mentioned by six participants was substance abuse. Literature documents substance abuse as being linked to IPV in many countries for both survivors and perpetrators (see Hankin et al., 2010; Roche et al., 2007; WHO, 2006). However, participants in this study only related substance abuse to perpetrators. PA07 and PA09 described a situation where a client's husband beat her because she failed to give him money to buy drugs. PA11 also expressed her sympathy towards her client, who was stalked by her husband who was addicted to drugs. Interestingly, other risk factors such as low SES, education level, and cultural values that are found in the literature (Abramsky et al., 2011; Cunradi, 2009) were not recognized by participants as risk factors for victimization; they discussed these factors rather as barriers that prevented IPV survivors' help-seeking behaviors.

Therefore, these findings provided a clear picture of how health providers' stereotypes of IPV based on gender influenced their abilities to respond to IPV, as there is a scant research acknowledging this element. In addition, providers' knowledge of IPV has shaped their attitudes and responses to IPV survivors. These predominant perceptions of IPV were linked to other factors that will be discussed further in the next section.

### **Research Question 2: What Factors Influence the Ways Health Providers Work with IPV Survivors?**

Several research studies identify health providers' lack of knowledge and training in the area of IPV (Colombini et al., 2012; Borowsky & Ireland, 2002; Lawoko, Sanz, Helstrom, & Castren, 2011), their attitudes toward IPV (Lawoko et al., 2011), lack of use

of a specific protocol (Colombini et al., 2012), pressure related to time (Colombini et al., 2012), poor collaboration with other departments (Colombini et al., 2012), failure to routinely ask patients about IPV (Kramer et al., 2004; Tjaden & Thoennes, 2002), and insensitivity about patients' needs (Colombini et al., 2013; Gerbert et al., 1996) as influencing factors on health providers' ability to respond adequately to IPV. However, there is a paucity of research focused on discussing underlying issues that may be encountered by health providers, including their personal reactions, survivors' resistance, differences in cultural values among survivors, and institutional issues. This study found 6 superordinate themes: training, institutional factors, providers' personal factors, professional responsibilities; and two indirect factors: IPV survivors' resistance and sociocultural factors, which influenced health providers in working with survivors.

**Training.** Training is the primary factor that influences health providers' ability to work with IPV survivors (Colombini et al., 2012; Borowsky & Ireland, 2002; Lawoko et al., 2011). This study found that all participants had received short-term trainings that ranged from several hours to a week. Only one participant received a three-month training, but she was not eligible for counselor license. The content of the trainings were mostly related to general counseling skills and interventions ( $n = 15$ ), such as listening skills and being empathic. Interestingly, two participants with a medical background did not mention receiving any training on counseling skills or intervention. This is similar to the findings of Rhodes et al., (2007), who noted that provider communication behaviors were a common pitfall in screening patients for abuse. Because of poor communication skills, health providers feel unsure how to screen for IPV and fear offending the survivors (Gutmanis et al., 2007).

Seven participants had received comprehensive training that focused specifically on IPV, as well as protocol or guidelines for handling IPV, resources, legal perspectives, and collaboration sources. However, when it came to serving IPV survivors, 5 of these participants expressed difficulty in working with survivors. The combination of a lack of training and knowledge about IPV has resulted in some health providers' feeling overwhelmed and therefore providing inadequate services to IPV survivors (Colombini et al., 2013; Ramsay et al., 2002; Roelens et al., 2006). Fourteen participants also tended to focus their services on female survivors, and noted they were not well prepared to work with male survivors. Due to lack of inadequate training, the rates of non-identification of IPV survivors remain high (Rhodes et al., 2011).

On the other hand, a new discovery of this study was that five participants believed in-vivo training on IPV issues was helpful in providing an overview of how to work with IPV survivors. This included watching a video, role-playing, demonstrations, or bringing a survivor into the training session to share his or her experiences with abuse. This result has not been discussed in the existing study, however, as in-vivo exposure was always related to survivors, rather than health providers (WHO, 2013; Rakel & Rakel, 2011).

**Institutional factors.** Institutional factors included internal and external factors that affected health providers in working with IPV survivors. The most prominent internal factor that was discussed by all participants was the need to collaborate with other departments. Because the protocol for responding to IPV survivors is teamwork-based, health providers need to work collaboratively with other departments to serve the survivors adequately. The time-consuming nature of this process and a lack of

commitment from other departments became challenging for the participants. Several participants complained that the teamwork-based approach was not helpful; in particular, one participant reported that they received a low rate of response from other departments.

This lack of consensus about integrated services has been discussed in the literature. Mayhew et al. (2000) found that the entrenched medical hierarchies at the provider level might impede one's training on integrated service provision into practice. Although Malaysia has implemented the OSCC model, Colombini et al. (2008) pointed out that this model may result in more limited coverage than interventions implemented at a primary-care level, and that it is dependent upon referring survivors externally to legal or other support services.

Furthermore, most of the participants believed the protocol they used to work with IPV survivors was overly complicated. For instance, PA14 stated, "The protocol for handling the survivors might be too complicated. It requires a lot of time for us to walk the clients through the process, and that might delay our response to survivors." This finding seems to contradict to the report by Colombini et al. (2008) that the integration of policies, protocols and procedures for IPV response helped to institutionalize IPV services and improved the implementation of the Malaysian OSCC model. A similar result was found in Goicolea et al. (2013), which said that responding to IPV was more complex than merely following the steps of a protocol. Additionally, research has found most medical and nursing schools do not offer any form of extensive training in IPV or domestic violence issues (Goicolea et al., 2013; Hendricks-Matthew, 1997).

Two participants did not have any guidelines when working with IPV survivors, and 15 participants performed the same protocols for all types of survivors. This leads to

an inadequate response when they do not know what to ask or how to work with survivors after disclosing (Othman & Adenan, 2008). Thus, the protocol used to serve IPV survivors should be client-centered and time-efficient for both providers and survivors, and in particular for those providers who work in a busy environment. Time constraints may impact providers' ability to identify IPV and may make them provide limited care to the survivors (Colombini et al., 2013; Othman & Adenan, 2008).

Six participants reported that the attitudes of providers and administrators of the departments are not supportive or helpful and had negatively impacted them in performing adequately. In addition, a lack of institutional resources, such as funding and shelter facilities, has made the helping process more difficult. Eleven participants indicated that they did not have enough facilities to accommodate IPV survivors. These findings are in accordance with the findings in Eastman and Bunch (2007) and Garimella et al. (2000) indicating that a lack of available resources for providers could prevent them from responding to IPV survivors. In addition, lack of supervision was recognized by five participants as an addition to the previous literature, as no study has discussed supervision as an important factor for health providers in working with IPV survivors. Especially in Malaysia, there is no sustainability of training in the long term, nor is there supervision and ongoing monitoring. This is a gap that must be filled in through training and inter-agency collaboration.

External institutional factors included police department response and health providers' need to abide by religious principles. Seven participants from NGOs and departments of social welfare expressed their disappointment towards police officers' attitudes and insensitivity to IPV survivors. Police officers require physical evidence

when filing a report and they may blame survivors for not being able to provide more detailed information. This result was consistent with the fact that police officers have historically been criticized for ignoring the seriousness of IPV and for dismissing survivors' needs (Leisenring, 2012). This police department response factor not only influenced health providers in being able to provide immediate responses to survivors, but also became the most common reasons survivors gave for not reporting IPV (Wolf, Ly, Hobart, & Kernie, 2003).

Moreover, five participants noted their obligations to abide by religious principles when working with diverse survivors. For Muslim survivors in particular, participants noted that they needed to refer these survivors to religious bodies. The participants believed it was a limitation for them in providing further treatment for these survivors because they should not encourage these survivors to divorce or go against their husbands or partners. The safety issue and the risk of damages that it might bring to the survivors were highly concerning for the researchers, as the participants did not indicate any discussion with survivors regarding the consequences of their decisions to stay in the relationship. American studies have rarely indicated the influences of religious principles on health providers; however, there have been several researches conducted in Asia and South Africa that show religious institutions as providing additional support for counseling services (Chepuka et al., 2014; Colombini et al., 2011). The effect of integrating religious principles with counseling services for IPV survivors has not been yet broadly discussed in the literature.

**Providers' personal factors.** Providers' personal factors can play a critical role in determining whether the providers screen clients for IPV (Sprague et al., 2012). In this

study, all participants acknowledged their work performance (lack of competence, lack of efficacy, resistance to professional roles, and victim blaming), and self-experience and assumptions (personal experience of IPV, differences in self-values and beliefs, and emotional reactions) as influencing factors for their responses to IPV. Most participants reported a lack of competence when working with IPV survivors ( $n = 15$ ). For example, they had difficulty in gathering clients' information, were unfamiliar with specific interventions, misunderstood survivors' stories, forced the survivors to report abuse alone, gave inaccurate clinical judgment, and minimized survivors' experiences.

The literature shows that health providers' lack of competence is linked to their feelings of discomfort in talking to patients about abuse (Love et al., 2001; Sprague et al., 2012), a fear of offending their patients (Elliot, Nerney, Jones, & Friedmann, 2002; Hamberger et al., 2004), and uncertainty about how to ask about IPV and thus not screening clients for IPV (Elliot et al., 2002; Rose et al., 2011; Sundborg, Saleh-Stattn, Wandell, & Tornkvist, 2012). Harway and Hansen (1993) stressed that many providers could not identify the severity of lethal violence that may later cause worse injuries or death for the survivors. This can be evidenced by one participant who indicated no awareness about the importance of being competent providers. In particular, throughout the research process, the research team noted that there was a lack of empathy shown by the participants due to their lack of competence. This could be risky for survivors as the providers might overlook their hidden IPV experiences.

Lack of competence was also linked to lack of self-efficacy of health providers when assessing IPV. Nine participants expressed their feelings of being unprepared and untrained to address IPV issues; they lacked confidence and experience in helping IPV

survivors, and tended to depend on other providers to help the survivors. This result was consistent with the study of Colombini et al. (2013), which noted that some providers see women as an obstacle in their perceived self-efficacy in the management of IPV.

Providers' lack of self-efficacy included feelings of powerlessness and loss of control when working with the survivors (Gutmanis et al., 2007). A majority of the participants related their lack of self-efficacy to inadequate training; however, Yeung et al. (2012) highlighted that inadequate self-efficacy could be attributed to the lack of professional experience rather than a lack of adequate training. This can be demonstrated by the fact that when most participants did not receive sufficient training on IPV, their immediate needs were focused on training rather than learning about IPV through their own professional experience.

The literature notes that many providers perceived that screening for IPV was not their responsibility (Love et al., 2001). In this study, participants stated they lacked interest and motivation and perceived IPV as a social workers' job, and therefore refused to work beyond their own job responsibility. In particular, seven participants who work a hospital setting reported their unwillingness to screen for IPV. This finding is aligned with Sprague et al. (2012), who noted that 50% of health providers believe screening for IPV is not part of their role, and 9% perceive that the abused women are to blame. Goicolea et al. (2012) stressed that responding to IPV relies strongly on the willingness of health providers.

The lower self-efficacy of health providers and the lack of a sense of responsibility resulted in victim blaming. Seven participants revealed victim blaming attitudes when they shared their experience in handling IPV cases. They put the

responsibility on victims to prevent abuse and to identify warning signs to help them avoid abusive situations. Consistent with this study's result, Othman and Adenan (2008) found victim blaming attitudes existed in 28% of the clinicians and 51.1% of the nursing staff in the study. Health providers' victim blaming attitudes caused a secondary victimization for survivors that could prevent survivors from seeking help from others (Campbell, 2008). The providers' victim blaming attitudes also allows IPV to become an embedded issue in society.

On the other hand, providers' self-experience and assumptions on IPV were also a critical factor identified in this study. Three participants reported that they had been abused previously, but no participant noted their personal experience had affected them in working with IPV survivors. However, the potential for these participants being re-traumatized was reflected in their statements as they felt overly responsible for their clients. Their reactions were consistent with the findings in Iliffe and Steed (2000) who noted, "Secondary or vicarious trauma can affect providers in an array of aspects, such as loss of confidence, sense of responsibility for client's safety, a sense of loss in security, worldview changes, trust, isolation, and powerlessness" (p. 394). Similarly, Gremillion and Evins (1994) showed that a personal history of abuse or gender differences between patient and provider might lead providers to avoid screening for IPV.

Additionally, 11 participants believed their self-values and beliefs also influenced them in serving the survivors, particularly regarding the concept of marriage. Many survivors viewed marriage as being everything to them, which contradicted to the providers' values and beliefs. One participant held the assumption that each survivor can extricate himself or herself from the violence cycle, while another participant believed

prayer and religion can prevent IPV from occurring in the family. The providers' cultural assumptions and biases inhibited from inquiring about IPV (Warshaw, 1998). In particular, many health providers believed that the survivors would not leave the abusive relationship (Love et al., 2001) and they also perceived IPV as being a private and personal issue (Anderson & Aviles, 2006).

Provider-client gender and/or age differences may also create a barrier during treatment. Seven participants reported their emotional reactions towards clients' issues and two of them felt discomfort with gender and age differences. Rhodes et al. (2007) indicated providers' personal distress and discomfort could influence the outcome of the therapeutic encounter. That could lead to almost three-fourths of survivors preferring to disclose and discuss IPV with a woman provider (Hayden et al., 1997). This factor may have affected the IPV survivors' help-seeking behaviors and their satisfaction with treatment from providers (Plichta, 2007).

**Professional responsibilities.** Multiple professional responsibilities that applied to health providers also affected their ability to respond immediately to survivors. The list of professional responsibilities discussed by participants included: acting as a first responder, being involved in protocol of services, providing treatment, preventing, and being sensitive. Most of the existing research emphasizes on screening, identifying and assisting survivors without further describing their actual responsibilities (Chang et al., 2005; Colombini et al., 2013; WHO, 2013). Thus, the findings of the current study provide additional information to the literature regarding providers' responsibilities in serving IPV survivors.

Six participants recognized themselves as first responders as they worked in the emergency and trauma department. However, they utilized a medical model that focused on the physical aspects of injury, which limited their sense of IPV that may occur to their patients (Colombini et al., 2013; Warshaw, 1998). The utilization of this model requires providers' high vigilance about IPV, as this model did not include psychological treatment for survivors.

Another responsibility that was frequently highlighted in this study related to the protocol of services, such as screening, referral of clients to other departments, and involvement in legal processes. This protocol involved various parties within departmental or inter-agency collaboration, but a lack of commitment and support was reported by several participants in this study. Thus, Latta and Goodman (2005) indicated health providers should not rigidly adhere to the protocol, but should revise it based on survivors' immediate needs and situations. Their suggestions were consistent with the needs of participants of this study to have a practical protocol included in training, which will be further explained in research question four.

Riviello (2010) stressed that health providers have a responsibility to patients to do no harm and to provide care. This is what the participants called "being sensitive" when working with the survivors. Being sensitive included considering multiculturalism ( $n = 12$ ), empowering clients in decision-making ( $n = 10$ ), and respecting clients' privacy ( $n = 10$ ). Several studies have inclusively discussed IPV from cross-cultural perspectives and suggested a culturally sensitive model for providers in working with IPV survivors (Anderson, et al., 2008; Shim & Nelson-Becker, 2009). Due to the context of this study, participants' concerns about multicultural sensitivity were closely attached to their

cultural norms and the values that they lived in their daily lives. This can be evidenced as PA16 stressed “people grow up in this cultural environment, and they get used to the system. There are no ways for them to change it unless the culture changes.” This result was consistent with Shim and Nelson-Becker (2009) who stated that culturally competent interventions are needed to identify diverse clients.

Another finding related to empowering clients in decision-making. Ten participants emphasized that health providers should not make any decisions for survivors, which was in accordance with the standards of respect that are emphasized in the helping profession (Battaglia et al., 2003; Peled, Eisikovitz, Enosh, & Winstok, 2000; WHO, 2013). However, this finding was in contradiction to the learned helplessness theory, as Walker (2009) believed that IPV survivors often become ‘paralyzed’ and vulnerable to the situation, and they believe they have no control over it. Thus, participants were highly concerned with the empowerment approach which is common in the Western feminist model of intervention, but was seen as an outlier from the women’s virtue continuum (Liu & Regehr, 2009). It was a double oppression especially for women survivors since they were victims of IPV, as well as part of a minority group in society. Additionally, the participants’ reports of a lack of competence and knowledge in treating IPV survivors caught the research team’s attention regarding the risk of assisting survivors in leaving the abusive relationship without a safety plan or a discussion of the complexity of women’s decisions about leaving or staying. Providers may misguide or respond judgmentally to survivors’ expression of ambivalence about leaving (Morse, Lafleur, Forgarty, Mittal, & Cerulli, 2012). Other studies found the

empowerment approach was effective for IPV survivors and helped them to build their own self-efficacy and strengths (Song, 2013; Cattaneo & Goodman, 2015).

As a result, health providers' personal factors, training, and professional responsibilities, as well as institutional factors, sociocultural factors, and IPV survivors' resistance all affected providers' performance in working with IPV. Providers' unhelpful responses could inhibit IPV survivors' future likelihood of disclosure and help-seeking (Bosch & Bergen, 2006).

### **Research Question 3: What Factors Do Health Providers Perceive Toward Influencing Malaysian IPV Survivors' Help-Seeking Behaviors?**

Numerous studies investigate barriers that prevent IPV survivors' help-seeking behaviors from the experiences of women survivors (Bauer et al., 2000; Malcoe et al., 2004; Ramos et al., 2011; Yoshioka & Choi, 2005). There is scant research exploring the survivors' help-seeking behaviors from the lens of health providers. According to Smith, Braunack-Mayer, and Wittert (2006), providers' understanding of survivors' help-seeking behaviors could help them to provide a more useful approach in addressing survivors' needs and acknowledge the complex barriers that impede survivors in seeking help. In particular, it can help them to reframe survivors' perceptions about their barriers and re-educate them in the appropriate ways to seek help from mental health systems. Thus, this research question purposed to learn about factors that health providers perceived toward influencing IPV survivors' help-seeking behaviors. Two factors highlighted by participants were IPV survivors' resistance and sociocultural factors. Other additional factors that have been discussed previously, such as institutional factors and providers' personal factors, also contributed in inhibiting survivors' help-seeking behaviors.

**IPV survivors' resistance.** IPV survivors' fear of being judged and their desires to repair the relationship were the internal factors discussed by the participants. All participants agreed that feelings of embarrassment, fear of telling others, resistance to disclosing, and delay in seeking help were related to their fear of being judged, particularly when participants lived in a community with a strong culture sense. This result was echoed the studies of Plichta (2007) and Bauer et al. (2000), who stated that many survivors were overwhelmed with emotions such as shame, guilt, or fear, and that these feelings of shame and the cultural stigma of divorce prevented survivors from seeking help. This study found families could be a leading factor for survivors to have feelings of shame; this is consistent with Morrison, Luchok, Richter, and Parra-Medina. (2006), who indicated that families being judgmental with various forms of criticism and verbal belittlement of victims caused the victims to be embarrassed and subsequently reluctant to ask for help.

Furthermore, nine participants perceived the survivors' desires to repair their relationship as a preventive factor for them in seeking help from others. One participant stated, "Survivors believe their husbands will change if they stay in the relationship, and they believe it is the best for their children." This false belief was described by Walker (2009) in learned helplessness theory as symptoms of being 'paralyzed' and feeling helpless about the situation. This may trap them in the cycle of violence, which involves a process of staying, leaving, and returning (Dobash & Dobash, 1992). Several participants concerned about survivors' easiness to forgive their partners also contributed to the cycle of violence as the perpetrators may remind the survivors about the initial loving relationship (Walker, 2009). In order to create a respectful provider-client

relationship, participants admitted they will do their best to assist IPV survivors to build or repair their relationship. This is another concern for the research team, as the danger of rekindling the relationship, the risk for survivors, and other coping strategies were not mentioned by participants during the interview.

IPV survivors' resistance also comes from external factors, including lack of trust and lack of protection and support from providers and authority. Eight participants recognized that the survivors' lack of trust toward providers impeded them from disclosing or seeking help. They highlighted confidentiality issues as the cause of survivors' lack of trust. This finding did not coincide with the literature, as most of the studies related IPV survivors' lack of trust to providers' lack of competence (Plichta, 2007; Klap et al., 2007), training issues (Jafee et al., 2005), discrimination (Latta et al., 2008), and lack of interest (Rodriguez et al., 2009) in treating IPV survivors.

Additionally, lack of support and protection from the police department and a distrust of the health system can deter women from seeking help (Rodriguez et al., 2009). Ten participants expressed that many survivors experienced re-victimization through the court, the police department, or the media. One participant described how the media published a survivor's family photo and caused secondary harm to her and her family. However, media harm to survivors is rarely discussed in the literature. Most of the studies focused on the influence of the media on public perceptions toward IPV and the way it creates a negative imagery of survivors implying that they deserve to be abused (Morrison et al., 2006). Thus, media ethics in reporting survivors' stories need to be taken into consideration in Malaysia.

**Sociocultural factors.** This study found that sociocultural factors were related to cultural values and of survivors' lack of legal awareness. All participants acknowledged cultural values as a barrier for survivors as well as for providers who work within the cultural context. One participant explained, "People grow up in this cultural environment, and they get used to the system. It is a normal system for them, and there is no way for them to change it unless the culture changes." This finding revealed that cultural values are embedded within the health care system and Malaysians' daily lives. Both health providers and survivors have high potential responses to IPV based on their preconceptions or assumptions about their cultural norms (FVPPF, 2009; Rodriguez et al., 2009). This finding served to fill the gap in the IPV literature, particularly in the context of Malaysia, as the influences of sociocultural factors on providers is still a novel question in the literature.

Several sociocultural factors, including traditional gender roles, religious values, acceptance of IPV as normal, collectivism, educational background, and socioeconomic status were listed by participants of the study. Since Malaysia is ruled by the monarchy system, the patriarchal concept is integrated at the societal level as well as within family systems. All participants kept in mind the concept of male privilege and female subordination, and they believed gender equality would never happen in Malaysia. One participant accepted traditional gender roles as a standard for maintaining the peacefulness of the society. These results were in line with Yusoff (2010), who noted that a patriarchal relationship between husband and wife is part of the wider inequality between men and women in Malaysia. Consistently, feminist theory believes that the way society supports patriarchal structure in gender roles, thereby preventing the participation

of women and allowing the continued male domination of the system, could be the contributing factor in maintaining IPV (O'Leary & Woodin, 2009). As society views traditional gender roles as normal and acceptable, this may cause survivors to feel they deserve the abuse and prevent them from seeking help (Dobash & Dobash, 1992).

Furthermore, few research studies have included religious values as barriers for survivors in reaching out for help (Alexander & Welzel, 2011; Chelliah & John, 2003; El-Khoury et al., 2004; Fortune et al., 2010; Ross, 2013). In this study, 12 participants noted that religious values were grounded in the legal system, and customs for marriage, and influenced individuals' daily conduct, especially among Muslims. Participants perceived women as bound to serve and obey to their husbands. For Malay survivors, they believed that husbands are their gatekeepers to the heaven. These religious values could prevent survivors from disclosing their abusive experiences to others. These findings are also consistent with the survivors' perspectives that their religious communities reinforced the notions of keeping IPV issues secret and of not leaving violent relationships (Peterson, Moracco, Goldstein, & Clark, 2004). In African-Americans communities, women believed that using prayer or spirituality to cope with IPV was more culturally accepted (El-Khoury et al., 2004). This belief was also reflected in this study as one participant insisted on using religious teaching as part of the counseling process to assist survivors in repairing their relationships with their partners. However, he admitted that religion was a barrier for him to provide further help for the survivors.

All participants agreed that the societal and cultural norms that have accepted IPV as normal could impede survivors in seeking help. The society believes that IPV is not a

crime and they downgrade abuse to a marital issue, which has created a high level of tolerance toward IPV. The survivors may feel ashamed to tell others as people perceived IPV as a family issue, especially two participants who mentioned that survivors' family members advised them to stay in the relationship. These results were supported by the study in Garcia and Herrero (2006) which found the acceptance of IPV and victim blaming attitudes highly contributed to a climate of social acceptability. In particular, Asian females attempted to persevere or cope with IPV through endurance and tolerance to avoid feelings of shame (CRVAW, 2010). As discussed in the cultural violence theory, subcultures that perceive violence as acceptable can help explain the occurrence of IPV in our society (Wolfgang & Ferracuti, 1967).

In alignment with feminist theory, the pervasiveness of IPV in society and the silent acceptance of female victimization by a male-dominated society influence the health care system and affect providers' responses in regard to IPV (Holtzworth-Munroe et al., 2002). According to Colombini et al. (2013), many clinicians may feel that violence is normal and they may hold negative views about providing services for IPV or develop victim blaming attitudes. This phenomenon was addressed in this study through participants' statements, as seven of them have demonstrated victim blaming attitudes by blaming survivors for having a lack of awareness regarding IPV symptoms. This could be explained due to providers often sharing the same cultural norms and practices of their clients, and sharing similar gender values on IPV as the community (Morrison et al., 2006).

A strong sense of collectivism is part of the quality of most Asian countries, as well as in Eastern European countries (Haj-Yahia & Sadan, 2008). However, in an IPV

context, collectivism value is perceived as a negative connotation for survivors. For example, all participants associated collectivism value with saving face, protecting family reputation, an intention to maintain the wholeness of the family, and perceiving divorce as shameful. Two participants believed family members were the barrier to survivors seeking help as the family misled survivors in believing that it was their responsibility to keep the family intact at all costs (Shoultz et al., 2010). This concept of maintaining family reputation and avoiding shame in both public and private is vital in Malaysian culture (Kim & Nam, 1998). These findings echoed the findings that membership in a group can contribute to perpetrators' tendency to be violent (Felson et al., 1994), as well as survivors' sense of belonging to the subculture (Wolfgang & Ferracuti, 1967) by not reporting IPV. Additionally, a strong attachment of survivors to their families and culture values could lead to their being afraid to report IPV and an intention to maintain a secure attachment with their family (Bowlby, 1973).

Eight participants perceived educational background as an influence factor for survivors in seeking help. Most of the survivors did not have a high level of education and they were afraid to leave the relationship. They also did not know that resources or information are available for them. These results were in accordance with the study in Dalal et al. (2009) showing that lower levels of education have a 2-to-5 fold increased risk of being involved in IPV as compared to more highly educated women. This can be explained by showing that women with low education levels have poor communication skills and a lack of conflict resolution skills in handling an abusive relationship. Two participants also emphasized that highly educated victims felt embarrassed to seek help. Though the number of highly educated women being abused was underestimated in

Malaysia, the literature has indicated that women with higher levels of education are likely to be physically and psychologically abuse (Costa et al., 2013).

Another critical factor was the socioeconomic status of survivors, where financial reasons were the common element that prevented survivors from leaving an abusive relationship (Browne et al., 1999; DeMaris et al., 2003; Gelles, 1997; Jewkes, 2002). All participants pointed out the reality that many women are in poverty, especially women survivors who were dependent on their husbands financially. This factor also posed a challenge for providers due to their lack of available resources to accommodate survivors. A similar result was also found in Jewkes (2002) stating that IPV occurs more frequently and severely in lower SES groups across the United States, Nicaragua, and India. Other studies that related IPV with lower SES background, including Browne et al. (1999), studied American women who lived on a household income of less than \$10,000; Alim et al. (2006) investigated African American women; Malcoe et al. (2004) studied Native American women; and Wong and Othman (2008) interviewed 710 female adult patients. This study's findings were inconsistent with Bamiwuye and Odimegwu (2014), stating that IPV was higher among women from rich households. This could be explained by the fact that not many highly educated women or high SES level women reported their abusive experiences due to concerns about family reputation and feelings of shame (Kim & Nam, 1998).

**Lack of legal awareness.** Lack of legal awareness among IPV survivors could lead to their hesitation in reporting IPV. Specifically, 12 participants reported that many survivors were unaware of women's acts and women's rights. Some of them tended to ignore their rights as women and did not know who could protect them. These findings

are an addition to the literature, as previous studies focused on survivors' lack of awareness in general, instead of specifically emphasizing their lack of legal awareness. A similar situation occurs with providers as several of them reported a lack of legal knowledge when assisting IPV survivors. Moreover, IPV survivors may encounter various complex legal and personal issues when reporting their cases, particularly in child custody issues (Dufort, Gumpert, & Stenbacka, 2013). Fourteen participants perceived children as a barrier for the survivors in seeking help from others. For example, PA05 said, "If they were to leave their husbands, then they might not be able to support themselves and children financially. They might also lose custody of their children if they lose in court." This study was aligned with Bent-Goodley and Brade (2006), who reported that many African American women choose not to report IPV cases because they know they would be at greater risk of losing their children. Similar results were found in Fugate et al. (2005) and Logan and Walker (2004), specifically that the fear of losing custody was a primary concern for survivors when they seek help from formal support. Thus, increased awareness and knowledge of IPV law enforcement is crucial for facilitating the decisions of survivors with dependent children (Meyer, 2010).

Overall, IPV survivors' resistance and sociocultural factors were the highlighted factors that perceived by participants as influencing IPV survivors in seeking help from others. Other related factors such as health providers' personal factors, training, and institutional factors that also contributed as barriers for survivors' help seeking behaviors have been identified in this study as well as in the literature (Colombini et al., 2013; Giocolea et al., 2013; Othman & Adenan, 2008; Tjaden & Thoennes, 2002).

#### **Research Question 4: What Recommendations Do Health Providers Have to Improve Training for Working with IPV Survivors in Malaysia?**

Several studies have reviewed the evidence for the effects of training health providers in IPV and have found some improvement in the knowledge of providers (Coonrod et al., 2000; WHO, 2013), but there is little support for the interventions for providers which involve multicomponent aspects of IPV such as identification, clinical skills, documentation, and provision of referral (Campbell et al., 2001). There is a lack of evidence showing the elements of training courses that improve skills and ability of providers to respond adequately to IPV survivors. Rastam (2002) found that the sustainability of IPV training in the long term was a challenge for maintaining the operations of the OSCC. Thus, this research question was critical to explore providers' perspectives of the needs to improve training to enhance their ability to respond adequately to IPV survivors. Participants suggested three superordinate themes, representing levels of changes at the provider level, the institutional level, and the societal level, that should be included as part of IPV training.

**Personal changes.** All participants noted personal changes as a critical element in training. They suggested four components of personal changes: communication skills, awareness of professionalism, continuing education, and self-awareness of providers. Nine participants recommended communication skills associated with screening, verbally communicate IPV resources, questioning skills, and creating a climate of openness for survivors. This element contains basic counseling skills that were most common for counselors or social workers, but may not be as common for nurses, medical doctors, or providers who did not receive formal training. The communication issue among health

providers was also noted by Roberts and Bucksey (2007), who asserted that lack of effective communication is a common complaint in health facilities. Even though integral of interpersonal or communication skills have been implemented in medical or related education programs (Rider & Keefer, 2006), the issue of poor communication skills among health providers is still reported at a high rate in the literature (Johnston, Fidelie, Robinson, Killion, & Behrens, 2012; Taran, 2011). In this fashion, participants hoped the training could assist them in improving their communication skills and questioning skills, particularly during screening for IPV.

Eight participants emphasized the need to instill an awareness of professionalism in providers during IPV training. They believed providers' awareness of professionalism could not only impact their attitudes of serving IPV survivors, but also affect survivors' help-seeking behaviors. These findings were an addition to the literature, as most studies were focused on enhancing providers' awareness of IPV or domestic violence, instead of their awareness of professionalism when working with IPV survivors. For example, PA15 stated, "Most of the providers are in these positions, but they have no intention or even lack of interest in assisting survivors." Thus, there is a need to enhance awareness about being professional when working with IPV survivors.

Furthermore, providers' self-awareness about their own strengths, weaknesses, thoughts, beliefs, motivation, and emotional provocations are important to note and to avoid projecting them onto their clients. This recommendation was consistent with the study in Sabin-Farrell and Turpin (2003) showing that it was critical to appraise the potential for vicarious traumatization on providers, as survivors' experiences with abuse may indirectly impact health providers. To maintain self-awareness, eight participants

would like the training to include providers' self-care and well-being, particularly focusing on emotional management when working with survivors. This could be a challenge as ethical dilemmas may emerge if providers' reactions to being traumatized enter into the therapeutic relationship, possibly exposing clients to psychological harm or re-victimization (Hesse, 2002). Thus, continuing education was recommended in this study by participants as a way to improve their self-awareness.

In the United States, some states such as Florida require providers to seek out continuing education on IPV on a periodic basis, but no universal support exists for such mandates (Cohn, Salmon, & Stobo, 2002). This can be evidenced when most of the participants reported they received training only at the beginning of their job entry. Thus, they believed continuing education could be helpful for them by focusing on providing IPV-related skills and interventions, basic IPV knowledge, assessment training, and practical training. There is no empirical study indicating the effectiveness of continuing training, but CDC (2010) encouraged providers to engage in on-going training and to integrate training into their ongoing work. Through this continuing education, the researchers expected providers would be able to get adequate consultation and supervision from IPV experts.

**Institutional changes.** The second level of changes involve institutional changes that consist of practical protocol or guidelines for treating IPV survivors, better referral sources, support teams, inter-agency collaboration, and supervision. Twelve participants recommended the need to teach about a practical protocol or guidelines for treating IPV survivors, particularly in helping agencies or institutions in order to develop a practical IPV response protocol. These findings were echoed in the study by WHO (2013), which

emphasized, “training should go beyond the providers and include system-level strategies such as patient flows, reception, area, and support mechanism to enhance the quality of care and sustainability” (p. 36). Additionally, Campbell et al. (2001) found that system-change training was effective in improving providers’ attitudes and knowledge about IPV. One participant described how low charts about the work processes, the referral system, the available law, and counseling skills need to be included in training to prepare competent providers. In particular, better referral resources were needed not only for providers, but also for IPV survivors trying to seek help from experts. This aspect was also noted in the study of Colombini et al. (2013) regarding the way limited referral resources could influence providers’ ability to respond immediately.

Moreover, eight participants wanted the support team that was formed in the OSCC to be improved and well-trained. Seven of them found that a teamwork-based protocol was the key factor in delaying the helping process, and only one reported a positive influence on her ability to respond. However, all of them believed that training can serve as a platform to provide support to the team and enhance providers’ ability to respond to IPV. These results support the study in Chamberlain (2004), showing that the health care setting and NGOs or the department of social welfare are inextricably interwoven, but providers can learn from one another and work together through teamwork. However, the risks of delay caused by a teamwork-based approach have not been discussed in the literature, as IPV requires an immediate response from providers.

In additional, Espinoza (2005) found that inter-agency collaboration was a more practical model to maximize resources, reduce women’s suffering, and avoid duplication of efforts, especially in data collection. This result was also reflected in this study as five

participants suggested a collaboration between agencies or departments to provide better service for survivors. However, the implementation of this model needs the agencies involved to define procedures and standards of treatment, as well as develop treatment protocols based on the level of care that a facility provides (Espinoza, 2005). Thus, the challenges of inter-agency collaboration are obvious and can only happen if all agencies involved take responsibility for their parts. However, it could be a good initiation to introduce during the training in order to assist providers in building a strong professional network with other agencies.

The last institutional change that needs to be included in training was supervision. This is a new component that is missing in the literature, as no attention has been paid to continue monitoring of providers' skills and interventions in working with IPV survivors. Four participants acknowledged that supervision should be provided to beginning providers who are involved in working with IPV survivors. This could help to maintain the quality of service and ensure the effectiveness of training. The most important element is to ensure the client's welfare. Thus, the inclusion of institutional changes are needed as part of the IPV training process, as providers must work closely with the system when responding to IPV survivors.

**Societal changes.** Health providers are playing multiple roles when they are working with IPV survivors, so it will be necessary to include psychoeducation for survivors, legal knowledge, and increased public awareness about IPV as part of the IPV training. Eleven participants discussed how many survivors had a lack of awareness about IPV and available resources, thus, psychoeducation is necessary for these survivors. These findings were in line with the study in Babcock et al. (2004), which that included a

psychoeducational model as part of the clinical intervention for survivors. However, this study revealed that psychoeducation needs to be given carefully, as providers' insensitivity may tend to assign responsibility to survivors or subject the survivors to victim blaming for not knowing the symptoms of IPV or being unable to seek help immediately. Furthermore, nine participants noted that imparting legal knowledge to survivors as well as the public is necessary in order to enhance their awareness about the legal perspectives on IPV and who can protect survivors. Particularly, for those providers who work with immigrant and refugee IPV survivors, legal knowledge is indeed important for survivors as well as for providers (Runner, Yoshihama, & Novick, 2009). The effort to enhance public awareness of IPV was also discussed by six participants. They believed that IPV training should not only focus on health providers, but also needs to be given to the public in order to educate them that IPV is a crime and appropriate procedures should be taken to handle IPV cases. This suggestion has been included in the previous research for many decades as a way to combat IPV (Campbell et al., 2002; CDC, 2013; WHO, 2013). However, there is a need for collaboration providers at the individual, institutional, and societal levels in order to promote awareness of IPV and improve the quality of services for IPV survivors.

Overall, health providers' perceptions of IPV could directly influence their attitudes to work with IPV survivors. In addition to the various aspects such as training, institutional factors, providers' personal factors, IPV survivors' resistance, professional responsibilities, and sociocultural factors could also influence health providers' knowledge, skills, and responses to IPV, as well as affect the IPV survivors' help-seeking

behaviors. Three levels of changes, which involving providers, the institutional level, and the societal level, are necessary to improve training in working with survivors.

### **Implications for Health Providers**

Health providers have a unique opportunity to identify and support IPV survivors due to many survivors preferring to seek help through hospital emergency room, clinics, social departments, or NGOs for injuries they have experienced from an abusive relationship (Colombini et al., 2013; Robinson & Spilsbury, 2008). However, some of the themes and subthemes identified in the current study specifically reflected current practices and services of health providers toward IPV survivors in Malaysia. The common identifying factors for the current study included inadequate training, lack of competence, victim blaming, lack of self-efficacy, resistance to professional roles, lack of resources, the need to refer survivors to other departments, delayed responses to survivors, and differences in self-values and beliefs. Health providers' personal factors and institutional factors are matters to be identified and resolved in order to assist IPV survivors in receiving better service. In particular, the scarcity of research conducted on this subject in Malaysia suggests an urgent need for more empirical research. Thus, the research findings of this study could benefit health providers who work with IPV survivors in various settings, as well as U.S. counselors who might be interested in international counseling and advocacy work.

Health providers who work in the emergency rooms of hospital serve as frontline responders to IPV survivors. The research findings indicate that there is a need for health providers to equip themselves with IPV knowledge, skills, interventions, and positive attitudes in responding to the survivors. They should be trained with effective

communication skills, particularly during screening and when imparting information to survivors. This should begin with a professional awareness of their job responsibilities in working with IPV, so that IPV training can confront and resolved any possible resistance of professional roles, fear of offending clients, and any discomforts about IPV screening prior to encountering their first IPV client in clinical practice. Additionally, the OSCC was founded in the emergency room in 1994 (Colombini et al., 2013) and is a great platform to train providers to work with IPV survivors. Providers should be familiar and comfortable with the protocol or procedure used to treat survivors, especially when integrating IPV screening as part of initial treatment for all patients. In addition, the emergency response team should involve a health care team (medical treatment), social care team (social support and psychological treatment), and legal experts including police officers and legal advocate. This comprehensive team with a high level of commitment is required to ensure the functioning of the OSCC, as well as to better serve survivors who may need multiple types of assistance from providers. Thus, this study provides an overall guideline regarding factors that influence providers' abilities to respond to IPV and aspects that they might need to improve in order to better serve the survivors.

Furthermore, health providers who serve with IPV survivors in the departments of social welfare or religious bodies are recommended to take full responsibility for referral clients who need additional assistance, such as shelter facilities, religious counseling, and legal advice. Health providers are recommended to strategically distribute available resources to survivors and incorporate multicultural and social justice competencies into their services. For example, this study shows that a majority of IPV survivors have lower educational backgrounds and low SES. This information is useful for social workers and

counselors to be aware of when considering survivors' immediate needs and being sensitive about factors that may lead to their resistance. Collaborating with other professionals will be essential in providing sufficient services and care across settings. Health providers should also familiarize themselves with IPV laws and legal procedures as the research findings reveals that it is sometimes necessary for providers to accompany IPV survivors in going through the legal process. However, it is recommended that health providers empower survivors in the decision-making process and give them guidance to achieve the best decision for their situation. Multiple counseling-based services, including crisis counseling, career counseling, religious and spiritual counseling, and additional interventions such as art therapy, play therapy, and sand tray therapy might be useful for treating survivors as discussed by the participants in this study.

Additionally, health providers who work in NGOs or women crisis centers may encounter different challenges in working with IPV survivors. Due to a lack of staff and resources, it might be good for them to establish an effective network with other departments or agencies and develop a coordinated system that allows them to refer clients in a confidential manner. Inter-agency collaboration as recommended by participants may be helpful for providers as well. Moreover, providers need to take the initiative to get consultation and reach out for training in order to enhance their knowledge and skills in working with survivors.

These research findings are not only beneficial for Malaysian health providers, but also provide a window of opportunity for U.S. counselors or providers who might be interested in international counseling and advocacy work in IPV. Specifically, detailed description of factors that impede IPV survivors' help-seeking behaviors and

sociocultural factors that deeply rooted in Malaysians daily lives could prepare U.S. counselors both mentally and physically before they work with Malaysians, or survivors from other similar culture-norm Asian countries. Indeed, a culturally responsive IPV model, as introduced by Vargas and Dickson (2006), could be adapted to the Malaysian health care system, but it may require providers to be sensitive about local culture norms before making the appropriate adaptations. This study also serves as a basis for international collaboration between researchers and U.S. scholars who are interested in becoming involved in international work, especially in advocating for IPV survivors.

### **Implications for Counselor Training**

The results highlight the continued need to emphasize IPV training that consists of three levels of changes: the provider, institutional, and societal levels. Health providers' interpersonal skills, awareness of professionalism, self-awareness, and continuing education are the critical elements that should be emphasized when training counselors or individuals who are interested in working with IPV survivors. This information can be useful for counselor educators in Malaysia as well as in the United States. Several studies have indicated that health providers have poor communication skills (Johnston et al., 2012; Taran, 2011). Thus, counselor training is strongly encouraged to ensure the integration of basic counseling skills when teaching IPV issues. This basic counseling skills course should also be covered in the curricula of other programs such as medical, nursing, and social work programs, when they prepare providers to work with IPV cases.

Furthermore, counselor training should also include counselor values, boundaries, sexual orientation, gender discrimination, sociocultural issues, religious values and spirituality, and appropriate referral within the curricula. A thorough discussion on these

issues should be conducted during the courses as a preparation for counselors to work with clients from diverse backgrounds both in the United States and internationally. As stated in the ACA Code of Ethics (ACA, 2014), professional counselors may not make referrals based purely on their own values or beliefs. Therefore, the research findings provide a great sense to U.S. counselors in training regarding the wide between the U.S. culture and Malaysian culture particularly between individualism versus collectivism values and how survivors handle their issues. Additionally, methods or interventions that are needed for survivors may be slightly different as most of the Malaysian survivors will only seek help when their situation becomes worse. But this might not be the case in the U.S., as there is a more comprehensive prevention and intervention system available to assist survivors compared to Malaysia, which encounters issues like the lack of well-trained providers and resources.

On the other hand, Malaysia is making efforts to produce more competent providers to work with IPV survivors, including sending potential counselor educators or health care practitioners to attend courses or programs in the U.S. This has also occurred in other Asian countries when they need experts in a particular field. This can be evidenced by the fact that the number of international counseling students has increased from year to year (Ng, 2006). There is a need for American counselor educators to be aware of language barriers, cultural differences and racial discrimination, social interaction, and personal adjustment difficulties that might be encountered by these students (Abe, Talbot, & Geelhoed, 1998). Additionally, counselor educators should include step by step-by-step training on treatment for IPV survivors and the integration of any other related methods or interventions that could be helpful in preparing these

students. Counselor educators are encouraged to embrace cultural differences and openly discuss cultural issues in the classroom. As identified in the research findings, participants prefer in-vivo training on IPV. Counselor educators could include various real clients cases in class and do demonstrations on how to handle each situation. Additionally, the infusion of professionalism and leadership skills are important to help lead changes in the country and advocate for IPV survivors when they return to serve in their home countries.

The content of counselor training should be inclusive by focusing on the symptoms of IPV, risk factors, IPV outcomes, legal knowledge and IPV act, women's rights, specific interventions and treatments, referral resources, the involvement of male survivors, and same-sex partners, and a standard protocol can be used by health providers when responding to IPV cases. Infusing supervision into counselor training is useful, particularly as the findings show that there is no supervision for providers after training. Thus, counselor educators are encouraged to implement supervision for counseling training programs and engage masters and doctoral students in learning supervision skills. This could be a great preparation for international students to become competent in IPV knowledge, skills, and interventions, as well as being able to supervise other providers who are just getting involved in the field.

### **Limitations**

There were several limitations of this research that related to (a) researcher bias, (b) data collection, (c) participant bias, and (d) technology. The primary researcher had both personal and professional experiences regarding IPV and would have also qualified as a potential participant in this study, as she has had direct experience working with IPV

survivors within the state required for this study. She was raised in the same cultural background as the research participants and may have a high potential to interpret the data from her cultural perspectives. Thus, prior to the study, the primary researcher bracketed her preconceptions and assumptions about IPV in Malaysia. She also kept her reflexive journal and memo throughout the research process, and she also did member checking with research participants after each interview to ensure the data reflected their voices. Additionally, the primary researcher employed a diverse research team with one Caucasian, one European American, and one African American, and an independent auditor with an Asian background to address any researcher bias that arose, and validated the quality of the data and the study process.

No data sources came from other states of Malaysia and all participants were recruited from well developed health systems and the study did not include providers from less organized systems and rural areas. The participants were only interviewed once in this study, which the primary researcher may not capture all their thoughts, feelings, and experiences in working with IPV survivors. The nature of the interview questions were semi-structured, it took longer than the expected time to complete an interview. This might affect the participants' motivation to further describe their answer for each question. The interview questions were specific for health providers, thus, no data were collected from IPV survivors regarding their abusive relationship.

Another limitation for this study was participant bias. As the data were collected through interviews, social desirability factors could affect participants' responses to the interview questions. The primary researcher knew four of the participants and had connections with them prior to this study. This may have led them to be either more open

or more hesitant to tell the truth about their experiences in working with IPV survivors. Thus, these relationships may have impacted the interviews. Thus, it was important to do member checking after completing the transcriptions in order to get further clarification from the participants. Technology used for this study also is a limitation for this study. This method could create anxiety and discomfort within participants. The primary researcher took more time to build the relationship with participants due to the distance and technology.

### **Future Research Directions**

The purpose of this grounded theory study was to examine factors that influence health providers' knowledge, attitudes, and responses to IPV survivors. Specifically, it attempted to explore health providers' perceptions of IPV, the factors that influence the ways they work with IPV survivors, the factors they perceived as influencing IPV survivors' help-seeking behaviors, and their recommendations for improving training for working with IPV survivors. A continued expansion of literature on this topic is needed and both qualitative and quantitative research would be beneficial.

Qualitatively, future research would benefit from exploring health providers' knowledge, attitudes, and responses to IPV survivors with greater racial/ethnic, religious/spirituality, and geographical diversity, along with various settings and positions. For example, participants who work in the emergency room have reported utilizing a medical model to work with IPV survivors. In contrast, participants who work at departments of social welfare and NGOs focused more on the psychological model. All of them agreed that differences in religious values/spirituality required specific interventions. Additionally, participants from East Malaysia perceived that more

resources were available for survivors in West Malaysia. Including more individuals from various settings (religious bodies, government organizations, international organizations, and related agencies who work with IPV survivors), as well as individuals from different work positions (psychologist, psychiatrist, volunteer worker, clinical psychologist) may produce different results. Also, participants noted there was a need for providers to move into suburban and rural areas to serve IPV survivors. Thus, additional target qualitative research with providers who work in suburban or rural areas, particularly in Sabah and Sarawak may add to the literature. This information is critical and needs to be included in IPV training in order to prepare competent health providers to work with geographically diverse survivors.

Participants in this study have mentioned specific interventions such as sand tray therapy, play therapy, or art therapy, which are helpful for IPV survivors. This is a gap in IPV research in Malaysia, as no specific intervention type has been introduced to Malaysian health providers in working with survivors. Thus, future research can focus on exploring techniques or interventions that providers have found were helpful for them and seeing how those work for IPV survivors. The findings are expected to be useful when preparing health providers to respond to IPV survivors.

Furthermore, a qualitative research can be conducted on IPV survivors regarding their lived experiences of seeking help from the health care system and/or other related agencies. In particular, male survivors and same-sex partners' voices need to be heard as scant attention has been paid to these groups in regard to IPV. Additionally, barriers or problems that the survivors have encountered in the process of seeking help need to be explored. To this end, a more authentic and comprehensive IPV protocol or procedure

could be developed based on recommendations from health providers and IPV survivors. Moreover, this information may add to the literature as the majority of available protocols are more favorable to women survivors (Kubiak, Sullivan, Fries, Nnauwulezi, & Fedock, 2011). Future research may also explore different interview methods (i.e., focus groups), other research traditions (e.g., phenomenological, consensual qualitative research), or other research paradigms (e.g., feminist, critical theory), or investigate health providers who have more than five years of experience working with IPV survivors.

Quantitatively, future research could focus on constructing an instrument that measures the factors that influence health providers' knowledge, attitudes, and responses to IPV survivors, as all the available instruments were in English (Gutmanis et al., 2007; Nicholaidis, 2005) and were tested with Western populations. The only screening tool adapted into the Malay language and for the Malaysian culture was the Women Abuse Screening Tool (WAST), which is used to assess IPV survivors' experiences with abuse (Othman & Wong, 2008). Thus, developing an instrument or translating and adapting an established English language measure could help future researchers recruit a larger sample pool across states or regions.

Finally, based on the emergent theory that was constructed in this study, future research should construct a culturally-based IPV training program guided by this theoretical model. As reported by most of the participants, the training they were offered were a short-term and non-specific IPV training. This research particularly will benefit all parties including health providers, as well as the institutional and societal levels in providing quality services for IPV survivors. Moreover, an experimental research can be

conducted to test the effectiveness of this training program in assisting providers to respond to IPV in Malaysia.

### **Conclusion**

This study has thoroughly discussed health providers' perceptions of IPV, factors that influenced health providers' responses to IPV survivors, and factors they perceived as influencing IPV survivors' help-seeking behaviors. Their recommendations for improving IPV training, which consisted of changes at the provider, institutional, and societal levels were new additions to the literature. The findings also demonstrate the continued need for an expansion of health providers' and IPV survivors' voices within IPV research, both qualitatively and quantitatively, in order to fully understand the IPV phenomenon and adequately develop inclusive tools, treatment, and training for health providers and IPV survivors. The results of this study and its implications for future research serve as a platform for the next stages of scholarship toward adequate and quality responses of health providers toward IPV survivors.

**CHAPTER VI****MANUSCRIPT**

**A Grounded Theory of Health Providers' Responses to Intimate Partner Violence (IPV)**

**Survivors in Malaysia**

**Kee Pau**

**Sultan Idris University of Education**

**Danica G. Hays**

**University of Nevada-Las Vegas**

*Author Note*

Kee Pau is an Assistant Professor of the Psychology and Counseling Department, Faculty of Education and Human Development, at the Sultan Idris University of Education, Malaysia; Danica G. Hays is Professor and Executive Associate Dean of the College of Education at the University of Nevada, Las Vegas.

Correspondence for this article should be addressed to Kee Pau, pau\_kee@upsi.edu.my, Psychology and Counseling Department, Faculty of Education and Human Development, Sultan Idris University of Education, Malaysia, 35900, Tanjong Malim, Perak, Malaysia.

To be submitted to

*International Journal of Public Health*

### Abstract

This qualitative grounded theory examined factors that influence Malaysian health providers' (N=17) attitudes, knowledge, and responses to IPV survivors. Results indicated five primary factors that influence health providers: training, institutional factors, health providers' personal factors, IPV survivors' resistance, and sociocultural factors. Findings provide insights into how health providers can better serve IPV survivors to health providers regarding aspects of improvement they need to better serve IPV survivors.

*Keywords:* intimate partner violence, health provider, grounded theory, Malaysia

## A Grounded Theory of Health Providers' Responses to Intimate Partner Violence (IPV) Survivors in Malaysia

Intimate partner violence (IPV) is a pervasive, yet underrecognized human rights violation in all societies worldwide (Browne–Miller, 2012; Heise, Ellsberg, & Gottmoeller, 2002). Globally, approximately 1.8 million women are victimized each year by their intimate male partners (Fife, Ebersole, Bigatti, Lane, & Brunner Huber, 2008). Specifically, in Malaysia, Subramaniam and Abdullah (2003) reported that the state of Selangor records each year the highest rate of IPV at 30%, followed by Kuala Lumpur (20%) and Penang (13%). However, these statistics only represent a small portion of IPV due to the privacy of the family and the intimacy of the marital relationship (Colombini, Ali, Watts, & Mayhew, 2011; Lees, Phiminister, Broughan, Dignon, & Brown, 2013).

Given the prevalence of IPV, it is inevitable that health providers will encounter IPV cases in their work, and they will be the first professional contact for IPV survivors. Unfortunately, Rhodes et al. (2011) reported of nearly 80 out of 993 female victims visiting emergency rooms, 72% were never identified as victims of IPV, even though women visited on average the emergency rooms seven times. Barriers of health providers in providing services to IPV survivors, such as the discomfort in asking IPV-related questions, fear of offending patients, failure to identify IPV survivors' history of abuse, victim blaming (Colombini et al., 2013; Humphreys & Thiara, 2003), time constraints, and lack of familiarity with written protocols (Othman & Adenan, 2010). Despite research that has outlined factors impeding health providers' responses to IPV survivors, research is scarce on the topic of cultural factors embedded in health providers' delivery of services, as well as on the notion of IPV held by policymakers directly involved in

managing IPV through legal manners. At the same time, studies that explore possible barriers to and facilitators of providing health services remains rare in Malaysia. In fact, previous research on the topic has focused primarily on quantitative design.

The roles of health providers in detecting and responding to IPV have become increasingly important in the United States (Family Violence Prevention Fund, 2010) and globally (World Health Organization, 2013). This attention has turned to how health providers could best assist IPV survivors who come to seek help and provide quality services to them by offering routine assessment, documentation, intervention, referral, and advocacy. The existing studies investigated health providers' readiness in screening IPV mostly conducted in the United States (Borowsky & Ireland, 2002; Kramer, Lorenzon, & Mueller, 2004; Rhodes et al., 2011; Tjaden & Thoennes, 2002); two studies were found in Malaysia that focused on health providers' responses to IPV. However, the study conducted by Othman and Adenan (2008) was a quantitative study and no further description of health providers' experience of working with IPV survivors. Another qualitative study conducted by Colombini et al. (2013) was focused on two Northern States in Malaysia, which did not include states with high IPV rates and/or limited IPV research. Thus, this study served to fill these gaps and provide insight for health providers to better serve IPV survivors.

The purpose of this grounded theory is to examine factors that influence health providers' knowledge, attitudes, and responses to IPV survivors. The primary research question was as follows: What factors influence the ways health providers' work with IPV survivors? Constructivist grounded methodology was used to help the primary researcher (first author) develop a deeper understanding of IPV through interaction with

participants and explore the complexity of social life within the participants' context (Charmaz, 2008). Data were systematically collected and analyzed, and constant comparison technique was utilized throughout the research process to ensure the theory constructed was grounded in data (Corbin & Strauss, 2008).

## **Method**

### **Participants and Data Collection**

Participants who met the following criteria were recruited using theoretical and snowball sampling: (a) have formerly worked or were currently working in the emergency or trauma departments at general hospitals, NGOs, or the Department of Social Welfare; (b) have had direct experience working with IPV survivors or have provided assistance to IPV survivors; and (c) have formerly worked or were currently working within the states of Selangor, Penang, Sabah, Sarawak, and the federal territory of Kuala Lumpur – areas with high recorded high IPV rates and/or limited IPV research (Subramaniam & Abdullah, 2003).

Of the 17 participants (11 females, 6 males), 7 identified as Chinese, 2 Kadazan, 4 Malay, 3 Indian, and 2 Iban. Participant ages ranged from 23 to 59 ( $M = 33$ ;  $SD = 9.64$ ). Their religious or spiritual affiliations was Buddhist ( $n = 4$ ), Christian ( $n = 7$ ), Islam ( $n = 4$ ), and Hindu ( $n = 2$ ). Participants listed highest degree completed as diploma ( $n = 3$ ), bachelors ( $n = 13$ ), or master's ( $n = 1$ ). Further, six identified as social workers, 2 medical doctors, 2 medical assistant officers, 3 nurses, 2 counselors, 1 para-counselor, and 1 as a social worker and a counselor. Participants were from five states (4 participants each from Selangor, Sabah, and Sarawak respectively; 3 participants from

Kuala Lumpur; and 2 participants from Penang). The participants' current work experiences ranged from 1 to 39 years ( $Md = 3$  years;  $M = 6.44$ ;  $SD = 7.56$ ).

### **Research Team and Researcher Bias**

The research team included three researchers who identified themselves as Caucasian, African American, and European American; one of them was doctoral graduate and two current doctoral students at a Mid-Atlantic urban research university in the United States. The primary researcher conducted and transcribed all interviews and the research team member assisted in the data analysis process. Further, an independent auditor who identified as an Asian female and a faculty member in a Psychology and Counseling department at a Southeastern university. Her roles were to review the audit trail and provided both written and oral feedback on themes and subthemes that need to remove or add on. She also suggested the placement of themes into higher order domains and categories.

The primary researcher provided a brief training to the research team regarding study topic, data analysis procedure, and discussion on research team members' biases prior to the study. The primary researcher also bracketed her personal and professional experiences of IPV. She believed cultural norms allowed violence to prevail in society and people accepted IPV as a normal phenomenon in Malaysia. She also believed health providers had received minimal training in working with IPV survivors.

### **Data Collection Methods**

**Demographic sheet.** Participant completed a demographic sheet that assessed participant's cultural demographics (e.g., age, gender, ethnicity, religion, relationship status, highest degree completed, and geographical location) and work characteristics

(e.g., work setting, number of years in current position). This demographic sheet was prepared in English and Malay versions based on participants' language preferences.

**Individual interviews.** Upon IRB approval, semi-structured individual interviews with approximately 17 questions were conducted; duration ranged from 30 to 65 minutes ( $M = 45.70$ ,  $SD = 11.12$ ). Sample questions were as follows: (1) Could you please describe what training, if any, you have had for working with IPV survivors?; (2) How would you determine the presence and history of IPV for a man or a woman who seeks treatment?; (3) What, if any, factors influence your ability to respond adequately to the needs of IPV survivors?; (4) What personal factors, if any, influence the way you identify and or treat IPV survivors? A copy of Malay language interview protocol was translated and used upon the request of participants.

In order to ensure the accuracy of the translation from Malay language to English, a reviewer from Malaysia, who spoke both Malay and English, to check all the accuracy of the translation of the demographic data questionnaire, interview protocol, and interview transcripts for participants who requested to speak in their native language. The reviewer had a basic knowledge about IPV and cultural norms in Malaysia and was obtained her Master's degree in English. Two participants were requested to use their native language and translation and review were done before distributed the research team for coding.

### **Data Analysis**

Data analysis in grounded theory occurred in four phases: (a) qualitative coding, (b) memo-writing, (c) theoretical sampling, and (d) theory reconstruction (Charmaz, 2008). Qualitative coding involved three phases of coding process: (a) open coding, (b)

axial coding, and (c) selective coding. Each research team member were given copies of first two interview transcripts and performed line-by-line coding independently. The primary researcher and research team then met for consensus codes with a priori codebook that was developed during a pilot study. Constant comparison technique was used to compare codes found in each subsequent set of the interviews in the first set. Data collection and data analysis were occurred concurrently in this study. Thus, every two or three copies of interview transcripts collected were coded independently by research team and it followed by consensus coding meeting to determine and discuss the existing categories, and compare them with the new emerging themes. Memos developed by the research team were used throughout data analysis to minimize researcher bias and assist with theory development. In order to engage in theoretical sampling, the research team coded data and compared these codes with each other, initial codes, and the identified categories. The primary researcher continued data collection process to gather new insights and refine the concepts until the data were saturated.

### **Measures to Ensure Participant Confidentiality and Safety**

The Darden College of Education's Human Subjects Committee at Old Dominion University approved this study prior to its initiation. Each participant reviewed and signed an informed consent form prior to his or her interview, and the primary researcher removed all participant-specific information from the study documents.

### **Strategies to Ensure Trustworthiness**

To ensure the trustworthiness of the study, the research team utilized multiple strategies to satisfy several criteria of trustworthiness (credibility, dependability, confirmability, and transferability; Hays & Singh, 2012; Lincoln & Guba, 1985). Several

strategies were employed including: (a) memo-writing, (b) audit trail, (c) prolonged engagement with research team and participants through interaction to keep the primary researcher closer to the data and understand the context and culture of the study, (d) thick description, (e) triangulation of researchers and auditor to review that the themes or categories constructed were grounded in data, and (f) member checking with participants after completing each interview through email checking. All participants responded member checking requests and only two participants provided additional feedback regarding misheard phrases and further clarified their statements.

### Findings

The research team identified five superordinate themes with 10 themes and 29 subthemes to describe the factors that influence the ways health providers conceptualize IPV and provide services. Table 1 provides illustrative quotes for the subthemes.

### Training

This superordinate theme, *training*, includes two themes to describe education received by health providers to work with IPV survivors in various settings: *short-term training* and *inadequate training*.

**Short-term training.** Short-term training refers to a training activity that can be completed within a period of no more than 3 months. It includes seminars, workshops, continuing education classes, or non-credit courses. All participants reported having received some short-term training, either specifically focused on IPV training or learned only general counseling skills and interventions. Training ranged from several hours to a week ( $n = 16$ ) and only one participant (PA12) received 3 months of para-counselor

training. Three subthemes were identified: *experiencing in vivo training scenario*, *general counseling skills and interventions*, and *comprehensive training program*.

***Experiencing in vivo training scenario.*** In vivo training is a practical and work experience training that involved practice while watching a video, or live demonstration from an expert. Five participants (35.39%) noted their training content included learning from victims' experience, observing a live counseling session, sensitizing exercises learned, and watching a video about IPV. They agreed that in-vivo training provided them a broad sense of how to work with IPV survivors.

***General counseling skills and interventions.*** General counseling skills included basic helping skills such as listening, empathizing, paraphrasing, reflecting, and questioning. Interventions could be varying, such as play therapy, art therapy, cognitive behavioral therapy, and other IPV specific interventions (e.g., trauma-informed treatment, group counseling and brief motivational intervention). Fifteen participants (88.24%) indicated that they at least received basic helping skills training that mostly focused on listening and being empathy to the survivors. Two participants (PA07 and PA14) from a medical background did not mention any counseling skills.

***Comprehensive training program.*** Comprehensive training program involves imparting knowledge of IPV, protocol for handling IPV survivors, resources, organizations or departmental collaboration, and legal perspectives. Seven participants (41.18%) described the specific IPV training they had attended. Content of the training program included communication skills, protocol or guidelines to work with survivors, and agency policy and procedures for responding to IPV, and other specific approaches.

However, so many of those participants also expressed that they have difficulty to work with IPV survivors (i.e., PA03, PA10, PA12, PA13, PA14).

**Inadequate training.** Inadequate training refers to insufficient or lack of requisite qualities to prepare health providers to work effectively with IPV survivors. Fifteen participants (88.24%) claimed they received inadequate training to work with IPV survivors. Two subthemes were identified: *non-specific IPV training* and *centered on female survivors*.

***Non-specific IPV training.*** Ten participants (58.82%) reported that they received a non-specific IPV training. Two participants (PA01, PA03) described their experience as ‘having no formal training in IPV or domestic violence issues.’ They learned the theories on handle the situation, but no skills have been taught. Because of that, one participant reported having difficulty in gathering information from survivors (PA04). Thus, PA09 emphasized that referral clients were part of the protocol for providers due to the inadequate training and lack of competence.

***Centered on female survivors.*** Fourteen participants (82.35%) revealed they only provided services to female survivors. They noted they were not well prepared to work with male survivors, and were referred male survivors to other agencies or departments. Particularly, 10 of 14 participants excluded male IPV survivors from their services.

### **Institutional Factors**

This superordinate theme of *institutional factors* involved those within a setting that influenced health providers’ ability to respond to IPV survivors. Institutional factors were divided into two main themes: *internal factors* and *external factors*.

**Internal factors.** Internal factors related to the institutional characteristics, such as the objectives of the institutions, capabilities, relationships, rules, protocol, resources, and environment. All participants emphasized that internal institutional factors were the primary factor that influenced their ability to respond to the survivors. They highlighted seven factors: *need to collaborate with other departments, protocol in treating IPV survivors, delaying responses to survivors, professional supports, lack of resources, busy working environment, and lack of supervision.*

***Need to collaborate with other departments.*** This subtheme refers to the needs of health providers to work collaboratively with other departments in serving IPV survivors. All participants noted collaboration with other departments as a challenge due to time constraints, lack of commitment from other departments, and low rate of response from other departments. On the other hand, participants were aware there is a need for them to work collaboratively with other departments in order to provide better services for the survivors.

***Protocol in treating IPV survivors.*** Protocol in treating IPV survivors refers to the guideline or procedure that use by health providers when working with IPV survivors. Fifteen participants (88.24%) reported a protocol was needed to work with survivors. However, several of the participants complained that the protocol they used was overly complicated and not client friendly (i.e., PA04, PA07, PA12, PA13, PA14). Two participants admitted they don't have any specific guideline for working IPV (PA09, PA10). Additionally, all 15 participants believed the same methods or protocols should be used for all types of clients, regardless of gender or age.

***Delaying responses to survivors.*** Health providers' delay in responding to IPV survivors means no immediate responses is given to survivors when they come to seek help. Eleven participants (64.71%) acknowledged that the delay occurred during the helping process due to several conditions: complicated protocol needs to follow (PA03), lack of shelter facilities (PA15), referral difficulty (PA15), and providers' intention to delay the process (PA13, PA14). The delay of response reflected health providers' incompetent, as well as prevent IPV survivors' help-seeking behaviors.

***Professional supports.*** Professional supports refer to emotional or physical support from colleagues in the department. Seven participants (41.18%) reported professional supports could impact them negatively or positively. Six of the seven participants believed the attitudes of providers and administrators had negatively impacted them. For example, lack supportive (PA13), insufficient well-trained workers (PA10), and lack of sub-teams for rural area (PA11). Only one participant admitted she received positive support from colleagues (PA01). However, those participants believed professional support could help to maintain the quality work of providers.

***Lack of resources.*** Lack of resources refers to deficiency of shelter facilities and funding of an organization to maintain service to IPV survivors. Eleven participants reported that they encountered lack of resources in their centers or organizations, did not have enough space or any at all or adequate funding to accommodate IPV survivors. These participants also noted a lack of resources might limit survivors' abilities to seek help from others as most of them were not financially independent.

***Busy working environment.*** Seven participants (41.18%) claimed that busy working environment was one of the internal factors that influenced the ways they work

with IPV. Busy working environments occurred in hospital settings and NGOs reduce providers' attention to further inquire about IPV symptoms or history of abuse. They might see these cases as a hassle to handle because the social part is never as straightforward (PA11). Another two social workers indicated their busyness due to the lack of the number staff working in the center.

***Lack of supervision.*** Five participants (29.41%) noticed that a lack of supervision had impacted their ability to respond to IPV survivors. Lack of supervision includes failure to provide adequate supervision to individuals. PA 13 and PA15 described that lack of supervision was critical in health care system as they were not sure whether the training they received was helpful for clients.

***External factors.*** There were nine participants (52.94%) who reported that external factors of the institution, such as *the police department's response* and *abide to religious principles* (subthemes) influenced their ability to respond to IPV survivors.

***Police department responses.*** Police department responses include survivors seeking help from a police department, filing a police report, the investigation process, and bringing the case to court. Seven participants (41.18%) expressed their feelings of dissatisfaction toward police officers' attitudes and their insensitivity when working with survivors. For example, police officers asked for physical evidence of abuse, blamed the victim, delayed assisting the survivors, and refused to go to the scene (PA05, PA06, PA11, PA16). This could affect health providers' ability to respond, as they did not get a full commitment from police officers.

***Abide to religious principles.*** Abide to religious principles refers to health providers' obligations to follow the religious principles that are implemented in the

country, in particular when treating Malay IPV survivors. Five participants (29.41%) acknowledged abiding by religious principles limited their ability to assist the survivors. Two participants believed religious principles focused more on wanting to rekindle a loving relationship without considering the consequences or that the safety issues of the survivors could bring harm to the survivors (PA05, PA12).

### **Providers' Personal Factors**

This superordinate theme refers to *providers' personal factors* that influence their ability to work with IPV survivors. There were two themes identified: *work performance* and *self-experience and assumptions*.

**Work performance.** Work performance refers to a health providers' ability to perform when working with IPV survivors. Fifteen participants (88.24%) spoke about their work performance as one of the biggest factors that determined their service quality. There were four subthemes connected to work performance: *lack of competence*, *lack of self-efficacy*, *resistance-professional roles*, and *victim blaming*.

**Lack of competence.** Lack of competence includes lack of knowledge, skills, and awareness of serving IPV survivors. This study found 88.24% of the participants ( $n = 15$ ) reported lack of competence to provide service to IPV survivors. Lack of competence was related to lack of training (PA01, PA04, PA13, PA15), lack of IPV knowledge (PA12), and lack of awareness (PA05, PA16). Consequently, participants reported misunderstanding of survivors' stories (PA03), forced survivors to report abuse alone (PA09, PA10, PA11), coerced the survivors to disclosing IPV (PA02, PA04), and minimized survivors' experiences (PA13).

***Lack of self-efficacy.*** Lack of self-efficacy refers to health providers' belief in their capacity or ability to handle IPV cases. Nine participants (52.94%) reported lack of self-efficacy when working with IPV survivors. Feelings that reported by participants included feeling unprepared and untrained to address IPV issues, feeling dependent on other providers, feeling ineffective in helping the survivors, feeling of lack of experience, feeling lack of confident, and feeling limited in ability to help IPV survivors (PA02, PA04, PA09, PA13, PA16).

***Resistance-professional roles.*** Resistance of professional roles refers to unwillingness of providers to screen or serve IPV survivors. Seven participants (47.06%) indicated resistance of their professional roles in helping IPV survivors. The reasons they used included lack of interest, lack of motivation, perceived IPV as social worker's job, refused to work beyond the job responsibility (i.e., PA09, PA10, PA12, PA15).

***Victim blaming.*** Victim blaming is identified as a common obstacle for health providers to work with the survivors. Seven participants (41.18%) revealed victim blaming attitudes when they shared their experience in handling IPV cases. Their victim blaming attitudes included asserting that victims put themselves at risk to get injured, assigning client the responsibility to prevent abuse and identify warning sign, feeling disappointment in client, and removing blame from perpetrators (PA04, PA08, PA09, PA10, PA13, PA15).

***Self-experience and assumptions.*** Self-experience and assumptions refer to health providers' personal experiences with IPV that includes self-beliefs, self-values, and emotional reactions toward IPV. Thirteen participants (76.47%) mentioned some personal experience and assumptions toward IPV during the interviews. Three subthemes

were identified: *personal experience of being abused, differences of self-values and beliefs, and Emotional reactions.*

***Personal experience of being abused.*** Health providers' personal experience of being abused was reported by three participants (17.65%). It could bring positive or negative impacts on health providers when working with IPV survivors. PA01 denied her personal experience impacted her professional work. However, PA03 and PA13 expressed that they have been re-traumatized by the survivors' experiences and easily attached stereotype to survivors' stories.

***Differences of self-values and beliefs.*** Eight participants (47.06%) acknowledged they held certain values and beliefs that might be contradictory to IPV survivors, such as divorce as a reasonable solution, prayer and religion could prevent IPV or divorce is bad. PA05 struggled to keep balance between his values and the survivors' desires to divorce. Several participants acknowledged clients perceived marriage is everything for them, which contradicted to their intention to help survivors to get away from the situations (i.e., PA03, PA08, PA09, PA13).

***Emotional reactions.*** Emotional reactions refer to any feelings or emotions that are evoked when working with IPV survivors. Seven participants (41.18%) noticed that their emotional reactions could influence their ability to provide quality service to survivors. PA02 felt challenged by the survivors who didn't disclose personal information. Similarly, two participants expressed feelings of discomfort because of survivors' age and gender (PA01, PA11).

## Sociocultural Factors

This superordinate theme refers to traditional values and social norms that are rooted in Malaysians daily lives. One theme was identified: *cultural values*.

**Cultural values.** Cultural values relate to values, beliefs, norms, or core principles that are shared by the members of a group. All participants agreed that cultural values are an important factor that influence IPV survivors' help seeking behaviors, as well as health providers' responses. Four subthemes were identified that are associated to this theme: *traditional gender roles*, *religious values*, *accept IPV as normal*, and *socioeconomic status*.

**Traditional gender roles.** Traditional gender roles refer to a set of societal norms determining how males and females should behave as being considered as acceptable or appropriate. All participants mentioned gender roles issues occur within the family system, the political structure, and at the societal level. PA06 expressed that the concept of male privilege and female subordination is still practiced in society, and that lead to IPV and gender inequality. PA09 believed men and women should act in their roles to maintain harmony in the society. The concept of gender roles has shaped the patriarchal system in the family, where men have more power than women.

**Religious values.** Religious values was mentioned by 70.59% of the participants ( $n = 12$ ) and refer to ethical principles grounded in religious traditions, texts, and beliefs. Participants noted that marriage is legally binding by Islamic law for Muslim and women need to obey and respect their husbands (i.e., PA01, PA02, PA05, PA16). Thus, religious values by obeying the husbands could be a barrier and even the process to get out from

the abusive relationship is difficult (i.e., PA05). This caused providers difficulty when assisting the survivors since they need to abide to religious values as well.

***Accept IPV as normal.*** All participants agreed that society and cultural norms have accepted IPV as a normal phenomenon in Malaysia. Several participants said that Malaysians in general believe that a good woman will not be abused or IPV is not a crime (i.e., PA06, PA11, PA13). Due to the high tolerance of society towards IPV, survivors believed their abusive experience to be normal and common in marital relationships (i.e., PA10, PA12, PA15). This also reflected in providers' attitudes when they noticed no internal injury on survivors' bodies, they tended to delay response to survivors.

***Socioeconomic status.*** Socioeconomic status refers to social class and economic background of an individual or family. All participants mentioned that socioeconomic status of the survivors was an important factor in preventing them from seeking help. Many women survivors were in poverty depend on their husband, and being full time housewives with no income (i.e., PA02, PA06, PA07, PA08). This factor also given a big challenge to health providers when they received clients who need financial help and they might not be able to provide long-term financial support to survivors (i.e., PA08).

### **IPV Survivors' Resistance**

This superordinate theme refers to a type of emotional or behavioral reaction toward something that could recall an anxiety-producing experience. It also recognizes a defense mechanism for the survivors to protect themselves. This superordinate theme was connected to two themes: *internal factors* and *external factors*.

**Internal factors.** Internal factors refer to the survivors' internal reactions toward their experience of being abused. All participants recognized that a survivor's self-

resistance was an important barrier for them to seek further treatment. Two subthemes were identified: *fear of being judged* and *wanting to repair the relationship*.

***Fear of being judged.*** Fear of being judged refers to the survivors' feelings of fear about other people's opinions toward him or her. All participants noted that fear of being judged was a strong factor that contributed to IPV survivors' resistance to seek help or to disclose their stories during the initial session. Fear of being judged was related to embarrassment, fearful of telling others, delay to seek help from others, resist to disclose, and provide minimal information to providers (i.e., PA02, PA05, PA07, PA13, PA14, PA15, PA16).

***Wanting to repair the relationship.*** Nine participants (52.94%) talked about survivors' desires to repair their relationship that prevented them from filing a police report or seeking help from others. Some participants noted that many survivors believed that their partner will change if they stay in the relationship and it is the best choice for their children (i.e., PA17, PA10). Thus, they easily forgiven and continue the cycle of violence according to one participant (i.e., PA10). Several participants expressed they will do their best to assist clients to build a good relationship with their partners (i.e., PA05, PA08, PA09).

**External factors.** External factors associated to external supports and protection by providers, police officers, court, and media. It also included health providers' ability to maintain confidentiality and build trust with the survivors who want help. Fourteen participants (82.35%) discussed external factors that caused resistance in survivors. They mentioned two external factors during the interview: *lack of trust* and *lack of protection and support* (subthemes).

***Lack of trust.*** Eight participants (47.06%) expressed a lack of trust towards others by the survivors as one of the factors that made them feel insecure to seek help or disclose their stories. Several participants also highlighted confidentiality as a critical element when treating IPV survivors (i.e., PA06, PA09, PA13, PA16, PA17). PA06 also expressed feelings about survivors' concerns, as there was no guarantee they would win the cases if they reported the cases and the cases were brought to court. Thus, health providers' competencies in maintaining confidentiality and services had affected IPV survivors' decisions and trust toward health care and legal systems.

***Lack of protection and support.*** Lack of protection and support associated with health providers, police department, court, and media as well as survivors' family members' attitudes when assisting IPV survivors. Ten participants (58.82%) acknowledged that lack of protection and support from providers could prevent survivors come to seek help from them. Due to lack of legal support, the re-victimization through court proceedings, time demands of the divorcing process, and the media could affect survivors' help-seeking behaviors. Many of them would like to seek a compassionate listening and support sources (i.e., PA06, PA07).

### **Discussions**

Findings included five superordinate themes (i.e., training, institutional factors, health providers' personal factors, IPV survivors' resistance, and sociocultural factors), 9 themes, and 29 subthemes help to identify factors that influence the ways health providers work with IPV survivors. Most of the participants admitted they did not receive adequate training, which led to their difficulty in identifying IPV. Literature indicated that lack of training has impacted health providers' ability to work with IPV survivors

(Colombini et al., 2012; Borowsky & Ireland, 2002). Poor communication skills has been noted among health providers, which affects IPV screening (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007). Time constraints, lack of commitment during referral process, complicated protocol, lack of resource, busy working environment were the institutional factors that affected health providers' ability to perform. Although Malaysia has implemented the OSCC model, Colombini, Mayhew, and Watts (2008) pointed out that this model may result in more limited coverage than interventions implemented at a primary-care level and its dependent upon referring survivors externally to legal or other support services.

Participants reported lack of competent, lack of self-efficacy, resistance of professional roles, and victim blaming had affected their performance and IPV survivors' help-seeking behaviors. This result was in line with the literature that health providers' lack of competent led to their feelings of discomfort when talking to patients about abuse (Sprague et al., 2012), fear of offending patients (Elliot, Nerney, Jones, & Friedmann, 2002; Hamberger et al., 2004), and uncertainty about how to ask, and did not screen clients for IPV (Elliot et al., 2002; Rose et al., 2011; Sundborg, Saleh-Stattn, Wandell, & Tornkvist, 2012). Lack of competent is also linked to lack of self-efficacy, lack of empathy, and lack of training and experience (Yeung, Chowdhury, Maplass, & Feder, 2012).

On the other hand, IPV survivors' resistance was reported to challenge providers to gather further information and delay the response process. In particular, lack of support and protection from health providers and other legal system could impede survivors to seek help. This is supported by the literature that lack of support and protection from

police department and distrust of health system can deter women from seeking help (Rodriguez et al., 2009). For the survivors who lived in a strong cultural sense community and family, they might fear of being judged and wanting to repair the relationship to maintain the family reputation (Morrison, Luchok, Richter, & Parra-Medina, 2006). Thus, providers need to assist clients to repair the relationship, instead of getting out from abusive relationship. This may lead survivors to repeat the cycle of violence (Walker, 2009).

Participants believed there is no way for providers to change the system unless the culture changes, as culture values are embedded within the health care system and Malaysians' daily lives. Both health providers and survivors have high potential responses to IPV based on their preconceptions or assumptions from their cultural norms (FVPPF, 2009; Rodriguez et al., 2009). Sociocultural factors such as traditional gender roles, religious values, perceived IPV as normal, and socioeconomic status were noted throughout the study as well as in the literature (El-Khoury et al., 2004; Costa et al., 2003). Due to Malaysia as a patriarchal society, gender inequality is a prevalent issue (O'Leary & Woodin, 2009; Yusoff, 2010).

In alignment with feminist theory, the pervasiveness of IPV in society and the silent acceptance of female victimization by a male dominated society influence health care system and affect providers' responses in regard to IPV (Holtzworth-Munroe et al., 2002). This phenomenon was addressed in this study through participants' statements as seven of them have demonstrated victim-blaming attitudes and they blamed survivors for having lack of awareness regarding IPV symptoms. This could be explained as providers often share the same cultural norms and practices of their clients, and similar gender

values on IPV of the community (Morrison et al., 2006). Additional to the strong sense of collectivism values in Malaysians cultures, this could lead to the survivors' fear of report and intention to protect family reputation (Shoultz et al., 2010). In addition, there was a discrepancy found in participants' statements regarding their denial to serve male victims and their recognition of same method should be used for all clients, regardless of gender or age. These contradictory statements revealed participants' strong belief of male dominance in intimate partner relationships (Stark & Flitcraft, 1996) and women are vulnerable to their husbands (Dutton, 2006) by ignoring the potential gender difference within-group. These hidden beliefs and values seemed to have an impact on participants' responses as they unable to perform adequately to IPV survivors.

Results of this study could benefit health providers who work with IPV survivors in various setting, as well as U.S. counselors who might be interested in international counseling and advocacy work. The results indicate a greater need for health providers to equip themselves with IPV knowledge, skills, interventions, and positive attitudes of responding to the survivors. This should begin with a professional awareness towards their job responsibilities to work with IPV, so that IPV training confront possible resistance of professional roles, fear of offending clients, and any discomforts about IPV screening prior to encountering their first IPV client in clinical practice. In addition, these results also provide insight to counselor educators to ensure the mastery of counseling skills by students and encouraged the infusion of basic counseling skills course within medical, nursing, and social work programs. A detailed description of factors that impede health providers' ability to respond could prepare U.S. counselors mentally and physically before they work with Malaysians, as well as other Asian countries with

similar culture norms. The infusion of professionalism and leadership skills are important to prepare international students to be the agent of change and advocate for IPV survivors when they return to serve in their home country.

### **Study Limitations**

There were several limitations of this research that related to (a) data collection, (b) participant bias, and (c) technology. No data sources came from other states of Malaysia and all participants were recruited from well-developed health systems. This study did not include providers from less organized systems and rural areas. In addition, the participants were only interviewed once in this study, which the primary researcher may not capture all their thoughts, feelings, and experiences in working with IPV survivors. The interview questions were specific for health providers, thus, no data were collected from IPV survivors regarding their abusive relationship. Another limitation is that as the data was collected through interviews, social desirability factors could affect participants' responses to the interview questions. The relationship between primary researcher-participant may have impacted the interviews as well. Technology used for this study also is a limitation for this study. This method could create anxiety and discomfort within participants. The primary researcher took more time to build the relationship with participants due to the distance and technology used.

### **Future Research Directions**

Qualitatively, future research would benefit from exploring health providers' knowledge, attitudes, and responses to IPV survivors with greater racial/ethnic, religious/spirituality, and geographical diversity, along with various settings and positions. Future research should also focus on exploring techniques or interventions that

providers have found were helpful for them and seeing how those work for IPV survivors. Furthermore, a qualitative research can be conducted on IPV survivors regarding their lived experiences of seeking help from the health care system and/or other related agencies; including male survivors and same-sex partners' voices in the study. Future research may also explore different interview methods (i.e., focus groups), other research traditions (e.g., phenomenological, consensual qualitative research), or other research paradigms (e.g., feminist, critical theory).

Quantitatively, future research could focus on constructing an instrument that measures the factors that influence health providers' knowledge, attitudes, and responses to IPV survivors, as all the available instruments were in English (Gutmanis et al., 2007; Nicholaidis, Curry, & Gerrity, 2005) and were tested with Western populations. Thus, developing an instrument or translating and adapting an established English language measure could help future researchers recruit a larger sample pool across states or regions. Moreover, a culturally-based IPV training program guided by this theoretical model should be developed to train health providers and to enhance services quality for survivors in Malaysia. Finally, an experimental research can be conducted to test the effectiveness of this training program in assisting providers to respond to IPV in Malaysia.

## References

- Borowsky, T. A., & Ireland, M. (2002). Parental screening for intimate partner violence by pediatricians and family physicians. *Pediatrics*, 110, 509-516. doi: 10.1542/peds.110.3.509.
- Browne-Miller, A. (2012). *Violence and abuse in society: Understanding a global crisis*. Santa Barbara, CA: ABC-LLIO/Praeger.
- Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of emergent methods* (pp. 155-170). Thousand Oaks, CA: Sage.
- Colombini, M., Ali, S. H., Watts, C., & Mayhew, S. H. (2011). One top crisis centers: A policy analysis of the Malaysian responses to intimate partner violence. *Health Research Policy and Systems*, 9(25), 1-8. doi: 10.1186/1478-4505-9-25.
- Colombini, M., Mayhew, S., & Watts, C. (2008). Health-sector responses to intimate partner violence in low-and middle-income settings: A review of current models, challenges and opportunities. *Bulletin World Health Organization*, 86(8), 635-642. doi: 10.2471/BLT.07.045906.
- Colombini, M., Mayhew, S. H., Ali, S. H., Shuib, R., & Watts, C. (2012). An integrated health sector response to violence against women in Malaysia. Lessons for supporting scale up. *BMC Public Health*, 12 (548), 1-10. doi: 10.1186/1471-2458-12-548.
- Colombini, M., Mayhew, S., Ali, S. H., Shuib, R., & Watts, C. (2013). "I feel it is not enough..." Health providers' perspectives on services for victims of intimate partner violence in Malaysia. *BMC Health Services Research*, 13(65), 1-11. doi:10.1186/1472-6963-13-65.

- Corbin, J. & Strauss, A., (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.
- Costa, D., Soares, J., Lindert, J., Hatzidimitriadou, E., Sundin, O., Loannidi-Kapolo, E., Degomme, O., Cervilla, J., & Barros, H. (2013). Socioeconomic inequalities in victims of intimate partner violence in Europe. *The European Journal of Public Health*, 23(1). Retrieved from [http://eurpub.oxfordjournals.org/content/eurpub/23/suppl\\_1/ckt126.296.full.pdf](http://eurpub.oxfordjournals.org/content/eurpub/23/suppl_1/ckt126.296.full.pdf).
- Dutton, D. G. (2006). *Rethinking domestic violence*. Vancouver, CA: University of British Columbia Press. Retrieved from <http://www.cjsonline.ca/reviews/domesticviol.html>.
- Elliot, L., Nerney, M., Jones, T., & Friedmann, P. D. (2002). Barriers to screening for domestic violence. *Journal of General International Medicine*, 17(2), 112-116.
- El-Khoury, M. Y., Dutton, M. A., Goodman, L. A., Engel, L., Belamaric, R. J., & Murphy, M. (2004). Ethnic differences in battered women's formal help-seeking strategies: A focus on health, mental health, and spirituality. *Cultural Diversity and Minority Psychology*, 10(4), 383.
- Family Violence Prevention Fund (2009). *Intimate partner violence in immigrant and refugee communities: Challenges, promising practices and recommendations*. Retrieved from [https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/IPV\\_Report\\_March\\_2009.pdf](https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/IPV_Report_March_2009.pdf).
- Family Violence Prevention Fund (2010). *Reproductive health and partner violence guidelines: An integrated response to intimate partner violence and reproductive*

- coercion*. San Francisco, CA: FVPF. Retrieved from [http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro\\_Guide.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf)
- Fife, R. S., Ebersole, C., Bigatti, S., Lane, K. A., & Brunner Huber, L. R. (2008). Assessment of the relationship of demographic and social factors with intimate partner violence (IPV) among Latinas in Indianapolis. *Journal of Women's Health, 17*(5), 769-775. doi: 10.1089/jwh.2007.0759.
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7*(1), 12.
- Hamberger, L.K., Guse, C., Boerger, J., Minsky, D., Pape, D. & Folsom, C. (2004). Evaluation of a health care provider training program to identify and help partner violence victims. *Journal of Family Violence, 19*, 1-11.
- Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: The Guilford Press.
- Heise, L. L., Ellberg, M., & Gottmoeller, M. (2002). Violence against women: A global public health crisis. *Journal of Public Health, 34*, 1-4. doi:10.1016/0277-9536(94)90349-2.
- Holtzworth-Munroe, A., Meehan, J. C., Rehman, U., & Marshall, A. D. (2002). Intimate partner violence: An introduction for couple therapists. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (vol. 3, pp. 431–465). New York: Guilford Press.
- Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: 'I'll call it symptoms of abuse.' *British Journal of Social Work, 22*(2), 209-226.

- Kramer, A., Lorenzon, D., & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women Health Issues, 14*(1), 19-29. doi:10.1016/j.whi.2003.12.002.
- Lees, S., Phimister, D., Broughan, C., Dignon, A., & Brown, M. (2013). Domestic violence: The base of the iceberg. *British Journal of Midwifery, 21*(7), 493-498. doi: 10.12968/bjom.2013.21.7.493.
- Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. *Naturalistic inquiry, 1985*, 289-331.
- Morrison, K. E., Luchok, K. J., Richter, D. L., & Parra-Medina, D. (2006). Factors influencing help-seeking from informal networks among African American victims of intimate partner violence. *Journal of Interpersonal Violence, 21*(11), 1493-1511.
- Nicolaidis, C., Curry, M., & Gerrity, M. (2005). Measuring the impact of the voices of survivors program on health care workers' attitudes toward survivors of intimate partner violence. *Journal of Gender Internal Medicine, 20*(8), 731-737.
- O'Leary, K., & Woodin, E. M., (2009). *Psychological and physical aggression in couples*. Washington, D.C.: American Psychological Association.
- Othman, S., & Adenan, M. N. A. (2010). Domestic violence management in Malaysia: A survey on the primary health care providers. *Asia Pacific, 7*(1), 2. doi:10.1186/1447-056X-7-2.
- Rhodes, K. V., Kothari, C. L., Dichter, M., Cerull, C., Wiley, J., & Marcus, S. (2011). Intimate partner violence identification and response: Time for a change in

- strategy. *Journal of General Internal Medicine*, 26(8), 894-899. doi: 10.1007/s11606-011-166-4.
- Rodriguez, M. A., Valentine, J. M., Son, J. B., & Muhammad, M. (2009). Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. *Trauma, Violence & Abuse*, 10(4), 358-374. doi: 10.1177/1524838009339756.
- Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosure of domestic violence by mental health service users: Qualitative study. *The British Journal of Psychiatry*, 198, 189-194. doi: 10.1192/bjp.bp.109.072389.
- Shoultz, J., Magnussen, L., Manzano, H., Arias, C., & Spencer, C. (2010). Listening to Filipina women: Perceptions, responses and needs regarding intimate partner violence. *Issues Mental Health Nursing*, 31(1), 54-61.
- Sprague, S., Madden, K., Simunovic, N., Goden, K., Pham, N.K., Bhandari, M. & Goslings, J.C. (2012). Barriers to screening for intimate partner violence. *Women & Health*, 52(6), 587-605.
- Stark, E., & Flitcraft, A. (1996). *Women at risk: Domestic violence and women's health*. Thousand Oaks, CA: Sage.
- Subramaniam, M., & Abdullah, S. (2003). *Buku panduan keganasan rumah tangga*.
- Sundborg, E. M., Saleh-Stattn, N., Wandell, P., & Tornkvist, L. (2012). Nurses' preparedness to care for women exposed to intimate partner violence" A quantitative study in primary health care. *BMC Nursing*, 11(1). Retrieved from <http://www.biomedcentral.com/1472-6955/11/1>.

- Sundborg, E. M., Saleh-Stattn, N., Wandell, P., & Tornkvist, L. (2012). Nurses' preparedness to care for women exposed to intimate partner violence" A quantitative study in primary health care. *BMC Nursing*, 11(1). Retrieved from <http://www.biomedcentral.com/1472-6955/11/1>.
- Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the national violence against women survey*. Washington, D.C.: Department of Justice.
- Walker, L. E. (2009). *The battered women syndrome*. New York, NY: Springer.
- World Health Organization (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Switzerland: World Health Organization Publications.
- Yeung, H., Chowdhury, N., Maplass, A., & Feder, G. S. (2012). Responding to domestic violence in general practice: A qualitative study on perceptions and experiences. *International Journal of Family Violence*, 1-7. doi: 10.1155/2012/960523.
- Yusoff, R. C. S., (2010). The cultural and legal perspectives on wife battering in Malaysia. *The Law Review*, 613-622.

Table 1

## Factor Influencing Malaysian Health Providers' Responses

Themes and Sub-themes	Sample Quotes
<b>Subordinate Theme 1: Training</b>	
<i>Short-Term Training</i>	
<i>Experiencing in vivo training scenario</i>	PA01 described her training experience: "We had a live session counseling during training. It means they had brought a real victim to the training session. The victim told us her experiences of being abused. Then, a CR – counselor registered [Licensure Professional Counselor] demonstrated to us how to handle the victim."
<i>General counseling skills and interventions</i>	PA10 stated, "The training was general counseling skills training—skills such as listening, empathizing, and exploring clients' stories. There were also taught counseling theories and other models that are relevant to helping different clients."
<i>Comprehensive training program</i>	PA16 explained, "I received several short-term trainings through our center – One Stop Crisis Center. The OSCC training was a full set of trainings that involved many other departments who work as our team members. The initial training that I received focused mostly on basic knowledge of IPV, the role of the provider in assisting clients, domestic violence acts, and some exercises such as role-playing and watching videos. The second training was more intensive and helped me learn the overall function of OSCC and protocol to assist IPV patients."
<i>Inadequate training</i>	
<i>Non-specific IPV training</i>	PA03 stated, "We didn't have any specific training on IPV or domestic violence, and the training was a general training for all types of clients."
<i>Centered on female survivors</i>	PA06 stated, "Since our center focuses only on women survivors, most of our cases are women." PA15 stressed, "Most perpetrators are men and that victims are women and children. So, perpetrators don't need any assistance from us."
<b>Subordinate Theme 2: Institutional Factors</b>	
<i>Internal Factors</i>	
<i>The need to collaborate with other departments</i>	PA06 also imparted, "Lack of commitment or collaboration from police department, the Department of Social Welfare, and the court can affect my ability to assist clients because we might have taken a long time, from nine months to several years, depending on the investigation process by the police department."
<i>Protocol in treating IPV survivors</i>	PA03 asserted, "Sometimes the complicated procedures not only influenced my ability, but also prevented

	survivors from coming to seek help from us. We might need to think about this aspect by providing an easier procedures and guidelines to help them to get better assistance.”
<i>Delaying responses to survivors</i>	PA15 reported the delay in service is due to lack of shelter facilities, “Sometimes, our shelter is full, and clients might have to wait a long time while I contact other shelters. If there isn’t any room there, then I might not be able to accommodate the clients and have to ask them to stay with their friends or relatives.”
<i>Professional supports</i>	PA01 stated, “I think the support of the department is helpful for me. No matter how difficult the cases, all staff will help each other to assist the clients.” PA13 stated, “I think they influence me mostly negatively. The attitudes of providers and administrators of the departments are not supportive or helpful in assisting me with helping survivors.”
<i>Lack of Resources</i>	PA06 also shared her regret of not being able to assist all survivors, “Due to the lack of resources and funding, staff members at the center have to handle many different things including food and daily necessities and gather funding from outside. Thus, lack of funding could be another factor that limits my ability to assist more survivors.”
<i>Busy working environment</i>	PA04 stated, “A lot of times, I don’t have enough time to fulfill all of the needs of the survivors, and I may not get enough information from them.”
<i>Lack of supervision</i>	PA15 mentioned, “We don’t have anyone to monitor or supervise us after training. So, people may or may not use those skills with clients. Nobody knows if the training was effective for providers or helpful for clients. That is a limitation that I noticed a long time back.”
External factors	
<i>Police department response</i>	PA06 stated, “A lot of time when women report cases, they will be blamed by the police officer for not being able to remember what was happening to them or what tools the perpetrator used to hurt them and so forth. For me, this is an insensitive way of handling victim
<i>Abide by religious principles</i>	PA05 stated, “I feel that my intention to provide counseling is to assist clients to repair their relationships or address situations that they have experienced. However, certain cases have not progressed as I expected in terms of the decisions made by survivors. If the survivors do not want to continue the relationship with their husbands, then divorce would be a solution. But if the survivors want to repair their relationships, then it could become better through our counseling sessions.”
<b>Subordinate Theme 3: Providers Personal Factors</b>	
Work Performance	
<i>Lack of competence</i>	PA15 admitted his limitation as a provider: “I am not an expert in handling all of these complicated issues. I haven’t received enough training about IPV, particularly specific interventions that I could use to assist clients.”

<i>Lack of self-efficacy</i>	PA04 also felt he was unprepared and untrained to address IPV issues: "I have no experience in handling this type of client [IPV], but it does occur in the emergency room. I feel uncertain about what kind of questions I need to ask. I worry that my questions might offend them."
<i>Resistance to Professional Roles</i>	PA09 and PA10 stated, "I need to refer them if their needs are beyond my ability to handle. I should not provide services out of my services scopes." PA05 also talked about health provider's resistance to addressing IPV: "A lot of the times, medical doctors might see IPV or domestic violence as the social worker's job and not a part of a medical doctor's job. On the other hand, providers' patience when dealing with IPV patients also influences my ability to identify survivors."
<i>Victim blaming</i>	PA09 also blamed the survivors for putting oneself at risk to get injured: "The survivors will only report to the police if things get worse. If things don't get worse, they will not report it to others. Reporting is their last choice. Because of this mentality, women may get hurt, and they may not be able to resolve the problem."
<i>Self-experience and assumptions</i>	
<i>Personal experience of being abused</i>	PA01 described: "He beat me for a couple times within a six-month period. Um... he punched my face, arms, and legs. I was depressed due to his violent behaviors. However, it did not impact my professional work. I got involved in helping other IPV survivors after I recovered from my own trauma."
<i>Differences in self-values and beliefs</i>	PA05 struggled to keep balance between his values and the survivors' desires to divorce: "Most of the clients want me to help them to get out from the problematic situations. They want to divorce with their partners. This will make me feel disappointed because I cannot fulfill the needs of my clients. I should try my best to persuade the client to find the best solution for the problem."
<i>Emotional reactions</i>	PA06 stated, "Since the cases involve a lot of deep emotions from the victims, indirectly I will also have strong emotions toward the legal system and various parties that are supposed to assist victims but don't. All of these things can influence the way I treat my clients."
<b>Subordinate Theme 4: Sociocultural Factors</b>	
<i>Cultural values</i>	
<i>Traditional Gender Roles</i>	PA09 believed men and women should act in their roles to maintain harmony in the society: "I think men and women should play their own roles. If women becomes too strong and takes over the responsibilities of men, then that is not seen as a good sign either. In contrast, if men give up their male roles, then the dynamics of a whole society are disrupted."
<i>Religious values</i>	PA05 described, "From Islamic perspectives, women and men are the same and need to tolerate each other. Marriage is legally binding by Islamic law. Thus, women need to obey their husbands no matter what they say and also respect elderly family members. Non-Muslims have their principles that they need

	to follow. Most of the time, husbands have more power than their wives in family matters.”
<i>Accept IPV as normal</i>	PA16 regarding the cultural context and Malaysians’ attitudes of downgrading IPV to marital issues. She said, “When survivors tell their families about their abusive experiences, the family members might advise them to be patient and that their husbands might be stressed at work, or give other reasons to convince them to stay in the relationship. They say this is not a crime; that it’s a marital problem.”
<i>Socioeconomic status</i>	PA07 stated, “Most married women who are in these relationships are unemployed; they are full-time housewives. Thus, they rely heavily on their husbands. At the same time, if the husband is unemployed and the wife is working to feed the family, then the unemployed husband can be abusive to his wife.”
<b>Subordinate Theme 5: IPV Survivor’s Resistance</b>	
<b>Internal Factors</b>	
<i>Fear of being judged</i>	PA02 described her experience of encountering IPV survivors’ resistance: “Sometimes the victims will not tell because they are ashamed of the situation. They are afraid.” PA06 shared, “Several of them did not want to see their families because they hated to be asked or judged by others.”
<i>Wanting to repair the relationship</i>	PA03 said, “The reason she came in was to find someone to listen to her and help her find a way to repair her relationship with her husband. She wanted their relationship to go back to normal since their children were young.” PA17 said, “They believe their husbands will change if they stay in the relationship, and they believe it is the best for their children.”
<b>External Factors</b>	
<i>Lack of trust</i>	PA01 articulated the curiosity of survivors toward the confidentiality of the services: “I had clients who came to the center to seek help, but they kept their feelings and [were] scared to tell others about their experiences. They were scared that their problems will be known by others and they questioned about the confidentiality of our services.”
<i>Lack of protection and support</i>	PA06 stated, “The legal system in Malaysia does not protect women since the process of reporting cases and bringing them to court is very complicated, and it takes several months or years to settle the cases. For the victims, it is another traumatic experience and pain that they need to go through. In terms of the media role, sometimes the media also cause survivors from seeking help.”

## References

- Abe, J., Talbot, D. M., & Geelhoed, R. J. (1998). Effects of a peer program on international student adjustment. *Journal of College Student Development*, 39, 539-547.
- Abraham, M. (2000). *Speaking the unspeakable: Marital violence among South Asian immigrants in the United States*. New Brunswick, NJ: Rutgers University Press.
- Abrahams, N., Mathews, S., Martin, L. J., Lombard, C., & Jewkes, R. (2013). Intimate partner violence femicide in South Africa in 1999 and 2009. *PLOS Med*, 10(4), 1-8. doi: 10.1371/journal.pmed.1001412.
- Abramsky, T., Watts, C., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., Jansen, H. A., ... Heise, L. (2011). What factors are associated with recent intimate and domestic violence? *BMC Public Health*, 11(109), 1-17. doi: 10.1186/1471-2458-11-109.
- Ackard, D. M., Eisenberg, M. E., & Neumark-Sztainer, D. (2007). Long-term impact of adolescent dating violence on the behavioral and psychological health of male and female youth. *Journal of Pediatrics*, 151(5), 476-481. doi: <http://dx.doi.org/10.1016/j.jpeds.2007.04.034>.
- Ackerson, L. K., Kawachi, I., Barbeau, E., & Subramanian, S. V. (2008). Effects of individual and proximate educational context on intimate partner violence: A population-based study of women in India. *American Journal of Public Research*, 98(3), 507-514. doi: 10.2105/AJPH.2007.113738.

- Adams, A. E., Sullivan, C. M., Bybeen, D., & Greeson, M. R. (2008). Development of the scale of economic abuse. *Violence against Women, 14*, 563-588. doi: 10.1177/1077801208315529.
- Aghtaie, N., & Gangoli, G. (2014). *Understanding gender based violence: National and international contexts*. London, England: Routledge.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Alexander, A. C., & Welzel, C. (2011). Islam and patriarchy: How robust is Muslim support for patriarchal values? *World Values Research, 4*(2), 40-70. doi: <http://dx.doi.org/10.2139/ssrn.239063>.
- Alexander, R. (1993). Wife battering: An Australian perspective. *Journal of Family Violence, 8*(3), 229-251. doi: 10.1007/BF00988770.
- Alim, T. N., Charney, D. S., & Mellman, T. A. (2006). An overview of posttraumatic stress disorder in African Americans. *Journal of Clinical Psychology, 62*(7), 801-813. doi: 10.1002/jclp.20280.
- Allen, M. (2013). *Social work and intimate partner violence*. New York, NY: Routledge.
- American Counseling Association. (2014). *Code of ethics*. Retrieved from <http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4>
- Amirthalingam, K. (2003). A feminist critique of domestic violence laws in Singapore and Malaysia. *ARI Working Paper Series*, 1-29.
- Anderson, J. E., Abraham, M., Bruessow, M., Coleman, R. D., McCarthy, K. C., Harris-Odimbe, T., & Tong, C. K. (2008). Cross-cultural perspectives on intimate partner violence. *JAAPA, 21*(4), 38-40.

- Anderson, M. A., Gillig, P. M., Sitaker, M., McCloskey, K., Malloy, K., & Grigsby, N. (2003). "Why doesn't she just leave?": A descriptive study of victim reported impediments to her safety. *Journal of Family Violence, 18*(3), 151-155.
- Anderson, M. L., & Kobek-Pezzarossi, C. M. (2011). Is it abuse? Deaf female undergraduates' labeling of partner violence. *Journal of Deaf of Studies and Deaf Education, 17*, 273-286. doi: 10.1093/deafed/enr048.
- Anderson, T. R., & Aviles, A. M. (2006). Diverse faces of domestic violence. *ABNF Journal, 17*(4), 129.
- Ansara, D. K., & Hindin, M. J. (2009). Perpetration of intimate partner aggression by men and women in the Philippines: Prevalence and associated factors. *Journal of Interpersonal Violence, 24*, 1579-1590. doi: 10.1177/0886260508323660.
- Araji, S. K., & Carlson, J. (2001). Family violence including crimes of honor in Jordan: Correlates and perceptions of seriousness. *Violence Against Women, 7*, 586-621. doi: 10.1177/10778010122182613.
- Archer, J. (2006). Cross-cultural difference in physical aggression between partners: A social-role analysis. *Personality and Social Review, 10*, 133-153. doi: 10.1207/s15327957pspr1002\_3.
- Ard, K. L., & Makadon, H. J. (2011). Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. *Journal of General Internal Medicine, 26*(8), 930-933. doi: 10.1007/s11606-011-1697-6.
- Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*, 385-405.

- Awang H., & Hariharan, S. (2011). Determinants of domestic violence: Evidence from Malaysia. *Journal of Family Violence*, 26, 459-464. doi: 10.107/s10896-011-9380-6.
- Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical psychology review*, 23(8), 1023-1053.
- Babcock, J. C., Waltz, J., Jacobson, N. S., & Gottman, J. M. (1993). Power and violence: The relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology*, 61(1), 40-50. doi: <http://dx.doi.org/10.1037/0022-006X.61.1.40>.
- Bacchus, L., Bewley, S., Wong, S. L. F. Alonso, C. F., Helbernd, H., Otasevic, S., ... Savola, T. (2012). Promising health sector interventions for partner violence in Europe. *WAVE*, 7-8. Retrieved from [http://www.wave-network.org/sites/default/files/fempower21\\_engl\\_0.pdf](http://www.wave-network.org/sites/default/files/fempower21_engl_0.pdf).
- Bachman, R. (1998). The factors related to rape reporting behavior and arrest: New evidence from the National Crime Victimization Survey. *Criminal Justice and Behavior*, 25(1), 8-29. doi: 10.1177/0093854898025001002.
- Bagshaw, D., & Porter, E. (2009). *Mediation in the Asia-Pacific: Transforming conflicts and building peace*. New York, NY: Routledge.
- Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice*, 25(2), 127-131. doi: 10.1093/fampra/cmn003.

- Bamiwuye, S. O., & Odimegwu, C. (2014). Spousal violence Sub-Saharan African: Does household poverty-wealth matter? *Reproductive Health, 11*(45), 1-10.  
doi:10.1186/1742-4755-11-45.
- Bandyopadhyay, M., & Khan, M. R. (2003). 'Loss of face: Violence against women in South Asia.' In L. Manderson & L. R. Bennett (Eds.), *Violence Against Women in Asian Societies* (pp. 61-73). London, England: Routledge.
- Banyard, V. L., & Cross, C. (2008). Consequences of teen dating violence: Understanding intervening variables in ecological context. *Violence Against Women, 14*(9), 998-1013. doi: 10.1177/1077801208322058.
- Barber, C. (2008). Domestic violence against men. *Nursing Standard, 22*(51), 35-39.  
doi: 10.7748/ns2008.08.22.51.35.c6644.
- Barner, J. R., & Carney, M. M. (2011). Interventions for intimate partner violence: A historical review. *Journal of Family Violence, 26*, 235-244. doi: 10.1007/s10896-011-9359-3.
- Barnes, G., Hoffman, J. H., Welte, J. W., Farrell, M. P., & Dintcheff, B. A. (2006). Effects of parental monitoring and peer deviance on substance use and delinquency. *Journal of Marriage and Family, 68*(4), 1084-1104.  
doi: 10.1111/j.1741-3737.2006.00315.x.
- Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2010). *Family violence across the life span: An introduction*. Thousand Oaks, CA: Sage.
- Barnish, M. (2004). *Domestic violence: A literature review*. London, England: HM Inspectorate of Probation.

- Bartholomew, K., Henderson, A. L., & Dutton, D. G. (2001). Insecure attachment and abusive intimate relationship. In C. Clulow (Ed.), *Adult attachment and couple psychotherapy: Applying the 'secure base' in practice and research* (pp. 43-61). London: Brunner-Routledge.
- Battaglia, T. A., Finley, E., & Liebschutz, J. M. (2003). Survivors of intimate partner violence speak out: Trust in the patient-provider relationship. *Journal General Internal Medicine*, 18(8), 617-623. doi: 10.1046/j.1525-1497.2003.21013.x.
- Bauer, H. M., Rodriguez, M. A., Quiroga, S. S., & Flores-Ortiz, Y. G. (2000). Barriers to health care for abused Latina and Asian immigrant women. *Journal of Health Care for the Poor & Underserved*, 11, 33-44. doi: 10.1353/hpu.2010.0590.
- Baynyard, V., Potter, S., & Turner, H. (2011). The impact of interpersonal violence in adulthood on women's job satisfaction and productivity: The mediating roles of mental and physical health. *Psychology of Violence*, 1(1), 16-28. doi: 10.1037/a0021691.
- Bazargan-Hejazi, S., Mederios, S., Mohammadi, R., Lin, J., & Dalal, K. (2013). Patterns of intimate partner violence: A study of female victims in Malawi. *Journal of Injury and Violence Research*, 5(1), 38-50. doi: 10.5249/jivr.v5i1.139.
- Belknap, J. (2007). *The invisible women: Gender, crime, and justice* (3<sup>rd</sup> ed.). Belmont, GA: Thompson Wadsworth.
- Bendall, C. (2010). The domestic violence epidemic in South Africa: Legal and practical remedies. *Women's Studies*, 39(2), 100-118. doi: 10.1080/00497870903459275.
- Bent-Goodley, T. B., & Brade, K. (2006). Domestic violence and kinship care: Connecting policy with practice. *Journal of Health & Social Policy*, 22(4), 65-83.

- Berburg, J. G., & Thorlindsson, T. (2005). Violent values, conduct norms and youth aggression: A multilevel study in Iceland. *The Sociological Quarterly*, 46, 457-478. doi: 10.1111/j.1533-8525.2005.00022.x.
- Bernett, L. R., & Manderson, L. (2003). *Violence against women in Asian societies: Gender inequality and technologies of violence (ASAA Women in Asia Series)*. New York, NY: Routledge.
- Bevacqua, M. (2000). *Rape on the public agenda: Feminism and the politics of sexual assault*. Boston: Northeastern University Press.
- Bimbi, D. S., Palmadessa, N. A., & Parsons, J. T. (2008). Substance use and domestic violence among urban gays, lesbians, and bisexuals. *Journal of Lesbian, Gay, Bisexual, and Transgender Health Research*, 3(1), 1-7. doi: 10.1300/J463v03n02\_01.
- Birks, M., & Mills, J. (2011). *Grounded theory: A practical guide*. Thousand Oaks, CA: Sage.
- Birmingham Violence Against Women Board (2012). *Birmingham violence against women strategy 2013-15*. Retrieved from <http://birminghamcsp.org.uk/wp-content/uploads/2013/06/BIRMINGHAM-VAW-STRATEGY-2013-15-FINAL-DRAFT.pdf>.
- Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness*, 23(1), 75-91. Retrieved from: <http://purl.umh.edu/59612>.

- Black, M. C. (2011). Intimate partner violence and adverse health consequences: Implications for clinicians. *American Journal of Lifestyle Medicine*, 5(5), 428-439. doi: 10.1177/1559827611410265.
- Black, M. C., Basile, K. C., Breiding, M. J., ... & Stevens, M. R. (2011). *The national intimate partner and sexual violence survey (NISVS): 2010 summary report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease for Disease Control and Prevention.
- Blanchfield, L. (2011). United Nations systems efforts to address violence against women. *Congressional Research Service*. Retrieved from <http://www.refworld.org/docid/4e3901632.html>.
- Bloom, S. L. (2009). Domestic violence. In O'Brien, J. (Ed.), *Encyclopedia of gender and violence* (pp. 1-18). Thousand Oaks, CA: Sage.
- Bograd, M. (1988). How battered women and abusive men account for domestic violence: Excuses, justifications, or explanations? In G. T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, & M. A. Strus (Eds.), *Coping with family violence: Research and policy perspectives* (pp.60-70). Newbury Park, CA: Sage.
- Bonomi, A. E., Anderson, M. L., Cannon, E. A., Slesnick, N., & Rodriguez, M. A. (2008). Intimate partner violence in Latina and non-Latina women. *American Journal of Prevention Medicine*. 36(1), 43-48. doi:10.1016/j.amepre.2008.09.027.
- Borowsky, T. A., & Ireland, M. (2002). Parental screening for intimate partner violence by pediatricians and family physicians. *Pediatrics*, 110, 509-516. doi: 10.1542/peds.110.3.509.

- Bosch, K., & Bergen, M. B. (2006). The influence of supportive and nonsupportive persons in helping rural women in abusive partner relationships become free from abuse. *Journal of Family Violence, 21*(5), 311-320.
- Botuck, B., Berrety, P., Cho, S., Tax, C. A., Archer, M., & Cattaneo, L. B. (2009). *Understanding intimate partner stalking: Implications for offering victim services*. Washington, D.C.: United States Department of Justice, Bureau of Justice Statistics.
- Bowlby, J. (1973). *Attachment and loss*. New York, NY: Basic Books.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.
- Bowman, C. G. (2003). Domestic violence: Does the African context demand a different approach? *International Journal of Law and Psychiatry, 26*, 473-491.
- Boyle, A., & Jones, P. B. (2006). The acceptability of routine inquiry about domestic violence towards women: A survey in three healthcare settings. *British Journal of General Practice, 56*(525), 258-261. Retrieved from: <http://bjgp.org/content/bjgp/56/525/258.full.pdf>.
- Boyle, M. H., Georgiades, J. C., Cullen, J., & Racine, Y. (2009). Community influences on intimate partner violence in India: Women's education, attitudes towards mistreatment and standards of living. *Social Science and Medicine, 69*(5), 691-697. doi:10.1016/j.socscimed.2009.06.039.
- Breiding, M. J., Black, M. C., & Ryan, G. W. (2008). Chronic disease and health risk behaviors associated with intimate partner violence—18 U.S. states/territories,

2005. *Annals Journal of Epidemiology*, 18(7), 538-544.

doi:10.1016/j.annepidem.2008.02.005.

Breiding, M. J., Chen, J., & Black, M. C. (2014). *Intimate partner violence in the United States – 2010*. Atlanta, GA: National Center for Injury Center and Control, Centers for Disease Control and Prevention.

Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization – National intimate partner violence and sexual violence survey, United States, 2011. *Morbidity and Mortality Weekly Report*, 63(8), 1-24.

Breiding, M. J., Ziembroski, J. S., & Black, M. C. (2009). Prevalence of rural intimate partner violence in 16 US states, 2005. *The Journal of Rural Health*, 25(3), 240-246. doi: 10.1111/j.1748-0361.2009.00225.x.

Brickell, K. (2008). 'Fire in the house': Gendered experiences of drunkenness and violence in Siem Reap, Cambodia. *Geoforum*, 39, 1667-1675. doi:10.1016/j.geoforum.2008.04.002.

Browne-Miller, A. (2012). *Violence and abuse in society: Understanding a global crisis*. Santa Barbara, CA: ABC-LLIO/Praeger.

Browne, A., Salomon, A., & Bassuk, E. (1999). The impact of recent partner violence on poor women's capacity to maintain work. *Violence Against Women*, 5(4), 393-426. doi: 10.1177/10778019922181284.

Burguiere, A., Klapisch-Zuber, C., Segalen, M., & Zonabend, F. (1996). *A history of the family*. Cambridge, MA: Harvard University Press.

- Bui, H. N., & Morash, M. (1999). Domestic violence in the Vietnamese immigrant community. *Violence Against Women*, 5(7), 769-795. doi: 10.1177/10778019922181473.
- Burke, J. G., Mahoney, P., Gielen, A., McDonnell, K. A., & Campo, P. O. (2009). Defining appropriate stages of change for intimate partner violence survivors. *Violence and Victims*, 24(1), 36-51. doi: <http://dx.doi.org/10.1891/0886-6708.24.1.36>.
- Burnette, L. B., & Adeler, J. (2006). *Domestic violence*. Retrieved from <http://www.emedicine.com/emerg/topic153.htm>.
- Burrill, E., Roberts, R., & Thornberry, E. (2010). *Domestic violence and the law in Africa*. Athens, OH: Ohio University Press.
- Caetano, R., Nelson, S., & Cunradi, C. (2001). Intimate partner violence, dependence symptoms and social consequences from drinking White, Black, and Hispanic couples in the United States. *American Journal on Addictions*, 10, 60-69. doi: 10.1080/10550490150504146.
- Caetano, R., Vaeth, P. A. C., & Ramisetty-Mikler, S. (2008). Intimate partner victim and perpetrator characteristics among couples in the United States. *Journal of Family Violence*, 23(6), 507-518. doi: 10.1007/s10896-008-9178-3.
- Caldwell, J. E., Swan, S. C., & Woodbrown, V. D. (2012). Gender differences in intimate partner violence outcomes. *Psychology of Violence*, 2(1), 42.
- Campbell, J., Garcia-Moreno, C., & Sharps, P. (2004). Abuse during pregnancy in industrialized and developing countries. *Violence Against Women*, 10, 770-789. doi: 10.1177/1077801204265551.

- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, 359(9314), 1331-1336. doi:10.1016/S0140-6736(02)08336-8.
- Campbell, J. C., Coben, J. H., McLoughlin, E., Dearwater, S., Nah, G., Glass, N., Lee, D., & Durborow, N. (2001). An evaluation of a system-change training model to improve emergency department response to battered women. *Academic Emergency Medicine*, 8(2), 131-138. doi: 10.1111/j.1553-2712.2001.tb01277.x
- Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., ... Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health*, 93(7), 1089-1097. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447915/?report=reader>
- Campbell, R. (2008). The psychological impact of rape victims' experiences with the legal, medical, and mental health systems. *Psychology of Women Quarterly*, 31, 357-370.
- Cao, L., Adams, A., & Jensen, V. J. (1997). A test of the black subculture of violence thesis: A research note. *Criminology*, 35, 367-379. doi: 10.1111/j.1745-9125.1997.tb00880.x.
- Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*, 3(2), 231-280. doi: 10.1891/1946-6560.3.2.231.
- CARE International Report (2013). *Challenging gender-based violence worldwide: CARE's program evidence*. Retrieved from

[http://www.care.org/sites/default/files/documents/Challenging-GBV-Worldwide-CARE\\_s-program-evidence.pdf](http://www.care.org/sites/default/files/documents/Challenging-GBV-Worldwide-CARE_s-program-evidence.pdf).

Carillo, R., Connor, M., Fried, S., Sandler, J., & Waldorf, L. (2000). *Not a minute more: Ending violence against women*. New York, NY: United Nations Development Fund for Women [UNIFEM]. Retrieved from

[http://iknowpolitics.org/sites/default/files/notminutemore\\_completebook.pdf](http://iknowpolitics.org/sites/default/files/notminutemore_completebook.pdf)

Catalano, S. (2007). *Intimate partner violence in the United States*. Washington, D.C.: United States Department of Justice, Bureau of Justice Statistics.

Catalano, S. (2012). *Stalking victimization in the United States-Revised*. U.S. Department of Justice. Retrieved from [http://www.bjs.gov/content/pub/pdf/svus\\_rev.pdf](http://www.bjs.gov/content/pub/pdf/svus_rev.pdf).

Catalano, S. (2013). *Intimate partner violence: Attributes of victimization, 1993-2011*. U.S Department of Justice, Bureau of Justice Statistics. Retrieved from <http://www.bjs.gov/content/pub/pdf/ipvav9311.pdf>.

Cattaneo, L. B., & Goodman, L. A. (2015). What is empowerment anyway? A model for domestic violence practice, research, and evaluation. *Psychology of Violence*, 5(1), 84-94.

Center for Disease Control and Prevention [CDC] (2010). *National intimate partner and sexual violence survey*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Center for Disease Control and Prevention (2012). *Intimate partner violence*. Retrieved from <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>.

Centers for Disease Control and Prevention (2013). *Intimate partner violence*.

Retrieved from

<http://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>.

Center for Gun Policy and Research [CGPR] (2011). *Intimate partner violence and firearms: Fact sheet*. Baltimore, MD: Johns Hopkins Bloomberg, School of Public Health.

Chakwana, C. D. (2004). "Domestic violence." In National Statistical Office Malawi (NSO) and ORC Macro (Eds.), *Malawi demographic and health survey 2004* (pp. 265-279). Calverton: NSO and ORC Macro.

Chamberlain, L. (2004). The missing link: A coordinated public health response to domestic violence. *Health Alert. Family Violence Prevention Fund*, 9, 1-5.

Chan, K. L. (2009). Sexual violence against women and children in Chinese societies. *Trauma Violence Abuse*, 10, 60-85. doi: 10.1177/1524838008327260.

Chang, J. C., Decker, M. R., Moracco, K. E., Martin, S. L., Petersen, R., & Fraiser, P. Y. (2005). Asking about intimate partner violence: Advice from female survivors to health care providers. *Patient Education and Counseling*, 59(2), 141-147.

Chavis, A. Z., & Hill, M. S. (2009). Integrating multiple intersecting identities: A multicultural conceptualization of the power and control wheel. *Women & Therapy*, 32(1), 121-149. doi: 10-1080/02703140802384552.

Chazmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks: CA: Sage.

Chelliah, A., & John, C. (2003). *A handbook on understanding domestic violence*. Malaysia: Education and Research Association for Consumers.

- Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of emergent methods* (pp. 155-170). Thousand Oaks, CA: Sage.
- Charmaz, K. (2011). Grounded theory methods in social justice research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4<sup>th</sup> ed., pp.203-241). Thousand Oaks, CA: Sage.
- Chepuka, L., Taegtmeier, M., Chorwe-Sungani, G., Mambulasa, J., Chirwa, E., & Tolhurst, R. (2014). Perceptions of the mental health impact of intimate partner violence and health services responses in Malawi. *Global Health Action*, 7, 24816. Retrieved from <http://dx.doi.org/10.3402/gha.v7.24816>.
- Chuemchitt, M., & Perngparn, U. (2014). Intimate partner violence: Thailand situation and intervention program. *International Journal of Social Science and Humanity*, 4(4). Retrieved from <http://dx.doi.org/10.7763/ijssh.2014.v4.362>.
- Clarke, J. (1998). *The lineaments of wrath: Race, violent crime, and American culture*. New Brunswick, NJ: Transaction Publishers.
- Cohn, F., Salmon, M. E., & Stobo, J. D. (2002). Confronting chronic neglect: The education and training of health professionals on family violence. *Institute of Medicine Report*. Washington, DC: National Academy Press.
- Coker, A. L., Derrick, C., Lumpkin, J., Aldrich, T. E., & Oldendick, R. (2000). Help-seeking for intimate partner violence and forced sex in South Carolina. *American Journal of Preventive Medicine*, 19(4), 316-320. doi:10.1016/S0749-3797(00)00239-7.

- Colombini, M., Ali, S. H., Watts, C., & Mayhew, S. H. (2011). One top crisis centers: A policy analysis of the Malaysian responses to intimate partner violence. *Health Research Policy and Systems*, 9(25), 1-8. doi: 10.1186/1478-4505-9-25.
- Colombini, M., Mayhew, S. H., Ali, S. H., Shuib, R., & Watts, C. (2012). An integrated health sector response to violence against women in Malaysia. Lessons for supporting scale up. *BMC Public Health*, 12 (548), 1-10. doi: 10.1186/1471-2458-12-548.
- Colombini, M., Mayhew, S., Ali, S. H., Shuib, R., & Watts, C. (2013). "I feel it is not enough..." Health providers' perspectives on services for victims of intimate partner violence in Malaysia. *BMC Health Services Research*, 13(65), 1-11. doi:10.1186/1472-6963-13-65.
- Colombini, M., Mayhew, S., & Watts, C. (2008). Health-sector responses to intimate partner violence in low-and middle-income settings: A review of current models, challenges and opportunities. *Bulletin World Health Organization*, 86(8), 635-642. doi: 10.2471/BLT.07.045906.
- Conroy, A. A. (2014). Gender, power, and intimate partner violence: A study on couples from rural Malawi. *Journal of Interpersonal Violence*, 29(5), 866-888. doi: 10.1177/088620513505907.
- Conyers, J. (2007). The 2005 reauthorization of the violence against women act why congress acted to expand protections to immigrant victims. *Violence against women*, 13(5), 457-468. doi: 10.1177/1077801207300650.

- Coonrod, D. V., Bay, C., Rowley, B. D., Del Mar, N. B., Gabriele, L., Tessman, T. D., & Chambliss, L. R. (2000). A randomized controlled study of brief interventions to teach residents about domestic violence. *Academic Medicine*, 75, 55-57.
- Coulter, M. L. & Mercado-Crespo, M. C., (2015). Co-occurrence of intimate partner violence and children maltreatment: Service providers' perceptions. *Journal of Family Violence*, 30, 255-262. doi: 10.1007/s10896-014-9667-5.
- Costa, D., Soares, J., Lindert, J., Hatzidimitriadou, E., Sundin, O., Loannidi-Kapolo, E., Degomme, O., Cervilla, J., & Barros, H. (2013). Socioeconomic inequalities in victims of intimate partner violence in Europe. *The European Journal of Public Health*, 23(1). Retrieved from [http://eurpub.oxfordjournals.org/content/eurpub/23/suppl\\_1/ckt126.296.full.pdf](http://eurpub.oxfordjournals.org/content/eurpub/23/suppl_1/ckt126.296.full.pdf).
- Craigien, L. M., Sikes, A., Healey, A., & Hays, D. G. (2009). School counselors' role in dating violence intervention. *Journal of School Counseling*, 7(18). Retrieved from <http://jsc.montana.edu/articles/v7n18.pdf>.
- Creswell, J. W. (2009). *Research design: Qualitative and mixed methods approaches* (3<sup>rd</sup> Ed.). Los Angeles, CA: Sage.
- Cruz, M., & Bair-Merritt, M. H. (2013). Screening and intervention for intimate partner violence a practical approach. *Contemporary Pediatrics*, 12-25.
- Cunradi, C. B. (2009). Intimate partner violence among Hispanic men and women: The role of drinking, neighborhood disorder, and acculturation-related factors. *Violence and Victims*, 24(1), 83-97.
- Cunradi, C., Caetano, R., & Schafer, J. (2002). Alcohol-related problems, drug use, and male intimate partner violence severity among US couple. *Alcoholism: Clinical*

- and Experimental Research*, 26(4), 493-500. doi: 10.1111/j.1530-0277.2002.tb02566.x.
- Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing*, 31(6), 1476-1484. doi: 10.1046/j.1365-2648.2000.01430.x.
- Dalal, K., Rahman, F., & Johnson, B. (2009). Wife abuse in rural Bangladesh. *Journal of Biosocial Science*, 41(5), 561-573. doi: <http://dx.doi.org/10.1017/S0021932009990046>.
- Daniel, M. A., & Milligan, G. (2013). Intimate partner violence: How clinicians can be an asset to their patients. *Journal of Psychosocial Nursing and Mental Health Services*, 51(6), 20-27. doi: 10.3928/02793695-20130404-01.
- Dasgupta, S. D. (2000). Charting the course: An overview of domestic violence in the South Asian community in the United States. *Journal of Social Stress and the Homeless*, 9(3), 173-185. doi: 10.1023/A:1009403917198.
- Davidson, T. (1978). *Conjugal crime: Understanding and changing the wife-beating problem*. New York, NY: Hawthorne Books.
- DeMaris, A., Benson, M. L., Fox, G. L., Hill, T., & Wyk, J. V. (2003). Distal and proximal factors in domestic violence: A test of an integrated model. *Journal of Marriage and Family*, 65(3), 652-571. doi:10.1111/j.1741-3737.2003.00652.x
- Denzin, N., & Lincoln, Y. (2003). *Strategies of qualitative inquiry* (2<sup>nd</sup> Ed.). Thousand Oaks, CA: Sage.
- Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., Astbury, J., ... & Watts, C. H. (2013). Intimate partner violence and incident depressive

- symptoms and suicide attempts: A systematic review of longitudinal studies. *PLOS Medicine*, 10(5). doi: 10.1371/journal.pmed.1001439.
- DiLillo, D., Giuffre, D., Tremblay, G. C., & Peterson, L. (2001). A closer look at the nature of intimate partner violence reported by women with a history of child sexual abuse. *Journal of Interpersonal Violence*, 16(2), 116-132. doi: 10.1177/088626001016002002.
- Dobash, R. E., & Dobash, R. E. (1979). *Violence against wives: A case against the patriarchy*. New York, NY: Free Press.
- Dobash, R. P., & Dobash, R. P. (1992). *Women, violence, and social change*. London and New York: Routledge.
- Doe, S. S. (2000). Cultural factors in child maltreatment and domestic violence in Korea. *Children and Youth Services Review*, 22(3), 231-236. doi:10.1016/S0190-7409(00)00077-3.
- Domestic Violence Collection of Laws (2003). *Domestic violence act 1994 (Act 521) & Akta keganasan rumah tangga 1994 (Akta 521)*. Retrieved from [https://www.wcwonline.org/pdf/lawcompilation/malaysia\\_DVact1994.pdf](https://www.wcwonline.org/pdf/lawcompilation/malaysia_DVact1994.pdf).
- Dora, M. T., & Abd Halim, N. B. A. (2011). Issues and factors of problematic families in Malaysia. *International Journal of Humanities and Social Science*, 1(4), 155-159.
- Doumas, D. M., Pearson, C. L., Elgin, J. E., & McKinley, L. L. (2008). Adult attachment as a risk factor for intimate partner violence: The “mispairing” of partners’ attachment styles. *Journal of Interpersonal Violence*, 23, 616-634. doi: 10.1177/0886260507313526.

- Downs, W. R., Rindels, B., & Atkinson, C. (2007). Women's use of physical and nonphysical self-defense strategies during incidents of partner violence. *Violence Against Women, 13*(1), 28-45.
- Dufort, M., Gumpert, C. H., & Stenbacka, M. (2013). Intimate partner violence and help-seeking – a cross-sectional study of women in Sweden. *BMC Public Health, 13*, 866. doi: 10.1186/1471-2458-13-866.
- Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology, 14*(2), 111-124. doi: 10.1080/13645579.2010.494930.
- Durant, N., Kephart, R., & McGowan, C. (2014). *Domestic violence awareness guide*. Oklahoma, OK: Oklahoma Department of Human Services. Retrieved from [http://www.okdhs.org/NR/rdonlyres/2EEB223C-9881-4D99-9F00-87AB5E511C89/0/0105\\_DomesticViolenceAwarenessGuide\\_afs\\_05012014.pdf](http://www.okdhs.org/NR/rdonlyres/2EEB223C-9881-4D99-9F00-87AB5E511C89/0/0105_DomesticViolenceAwarenessGuide_afs_05012014.pdf)
- Dutton, D. G. (2006). *Rethinking domestic violence*. Vancouver, CA: University of British Columbia Press. Retrieved from <http://www.cjonline.ca/reviews/domesticviol.html>.
- Dutton, D. G. (2011). *The domestic assault of women: Psychological and criminal justice perspectives*. UBC press.
- Dutton, D. G., & Nicholls, T. L. (2005). The gender paradigm in domestic violence research and theory: Part I – The conflict of theory and data. *Aggression and Violent Behavior, 10*, 680-714. doi:10.1016/j.avb.2005.02.001.

- Eastman, B. J., & Bunch, S. G. (2007). Providing services to survivors of domestic violence: A comparison of rural and urban service provider perceptions. *Journal of Interpersonal Violence, 22*(4), 465-473.
- El-Khoury, M. Y., Dutton, M. A., Goodman, L. A., Engel, L., Belamaric, R. J., & Murphy, M. (2004). Ethnic differences in battered women's formal help-seeking strategies: A focus on health, mental health, and spirituality. *Cultural Diversity and Minority Psychology, 10*(4), 383.
- Elliott, L., Nermey, M., Jones, T., & Friedmann, P. D. (2002). Barriers to screening for domestic violence. *Journal of General Internal Medicine, 17*(2), 112-116.
- Ellsberg, M., & Heise, L. (2005). *Researching violence against women: A practical guide for researchers and activists*. Washington, D.C.: World Health Organization.
- Retrieved from [www.path.org/files/GBV\\_rvaw\\_front.pdf](http://www.path.org/files/GBV_rvaw_front.pdf).
- Engward, H. (2013). Understanding grounded theory. *Nursing Standard, 18*(7), 37-41.
- <http://dx.doi.org/10.7748/ns2013.10.28.7.37.e7806>.
- Erez, E. (2002). Domestic violence and the criminal justice system: An overview. *The Online Journal of Issues in Nursing, 7*(1). Retrieved from
- [www.nursingworld.org/ojin/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume72002/No1Jan2002/DomesticViolenceandCriminalJustice.aspx](http://www.nursingworld.org/ojin/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume72002/No1Jan2002/DomesticViolenceandCriminalJustice.aspx).
- Erez, E., & Ammar, N. (2003). *Violence against immigrant women and systemic responses: An exploratory study*. National Institute of Justice Report Grant #98-WT-VX-0030. Retrieved from
- <https://www.ncjrs.gov/pdffiles1/nij/grants/202561.pdf>.

- Eschelman, L., & Levendosky, A. A. (2012). Dating violence: Mental health consequences based on type of abuse. *Violence Victims*, 27(2), 215-228. doi: <http://dx.doi.org/10.1891/0886-6708.27.2.215>.
- Espinoza, H. (2005). A paradigm for developing a comprehensive treatment protocol for survivors of domestic violence. *Public Health*, 17(2), 116-118.
- Estrich, S. (1987). *Real rape*. Cambridge, MA: Harvard University Press.
- European Commission (2010). *Domestic violence against women report*. Retrieved from [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_344\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_344_en.pdf)
- European Union (2010). *The issue of violence against women in the European union*. Retrieved from [http://www.europarl.europa.eu/RegData/etudes/note/join/2010/419623/IPOL-FEMM\\_NT\(2010\)419623\\_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/note/join/2010/419623/IPOL-FEMM_NT(2010)419623_EN.pdf)
- European Union Agency for Fundamental Rights (2014). *Violence against women: An EU-wide survey*. Belgium: Office of the European Union.
- Exner-Cortens, D., Eckenrode, J., & Rothman, E. (2013). Longitudinal associations between teen dating violence victimization and adverse health outcomes. *Pediatrics*, 131(1), 71-78. doi: 10.1542/peds.2012-2029.
- Eze-Anaba, I. (2010). Domestic violence and legal reforms in Nigeria: Prospects and challenges. *Cardozo Journal of Law & Gender*, 14(21), 21-59. Retrieved from <http://law.bepress.com/cgi/viewcontent.cgi?article=6857&context=expresso>.
- Fals-Stewart, W. (2003). The occurrence of partner physical aggression on days of alcohol consumption: A longitudinal diary study. *Journal of Consulting and*

*Clinical Psychology*, 71(1), 41-52. doi: <http://dx.doi.org/10.1037/0022-006X.71.1.41>.

Family Violence Prevention Fund (2004). *National consensus guidelines: On identifying and responding to domestic violence victimization in health care settings*. San Francisco, CA: National Health Resource Center. Retrieved from <http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf>.

Family Violence Prevention Fund (2009). *Intimate partner violence in immigrant and refugee communities: Challenges, promising practices and recommendations*. Retrieved from [https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/IPV\\_Report\\_March\\_2009.pdf](https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/IPV_Report_March_2009.pdf).

Family Violence Prevention Fund (2010). *Reproductive health and partner violence guidelines: An integrated response to intimate partner violence and reproductive coercion*. San Francisco, CA: FVPF. Retrieved from [http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro\\_Guide.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf).

Felson, R., Liska, A. E., South, S. J., & McNulty, T. L. (1994). The subcultural of violence and delinquency: Individual vs. school context effects. *Social Forces*, 73(1), 155-173. doi: 10.1093/sf/73.1.155.

Fernandes-Alcantara, A. (2014). Family violence prevention and services act (FVPSA): Background and funding. *Congressional Research Service*. Retrieved from <https://www.hsdl.org/?view&did=751765>.

Fife, R. S., Ebersole, C., Bigatti, S., Lane, K. A., & Brunner Huber, L. R. (2008). Assessment of the relationship of demographic and social factors with intimate

- partner violence (IPV) among Latinas in Indianapolis. *Journal of Women's Health*, 17(5), 769-775. doi: 10.1089/jwh.2007.0759.
- Fife, R. S., & Schrager, S. S. (2012). *Family violence: What health care providers need to know*. London, England: Jones and Bartlett Learning, LCC.
- Fisher, B. S., Cullen, F. T., & Tunner, M. (2002). Being pursued: Stalking victimization in a national study of college women. *Criminology and Public Policy*, 1, 257-308. doi: 10.1111/j.1745-9133.2002.tb00091.x.
- Fee, E., Brown, T. M., Lazarus, J., & Theerman, P. (2002). Domestic violence – Mediaval and modern. *Images of Heath*, 92(12), 1908. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447351/>
- Flicker, S. M., Cerulli, C., Zhao, X., Tang, W., Watts, A., Xia, Y., & Talbot, N. L. (2011). Concomitant forms of abuse and help-seeking behavior among White, African American, and Latina women who experience intimate partner violence. *Violence Against Women*, 17(8), 1067-1085. doi: 10.1177/1077801211414846.
- Foley, R. (2003). Violence against women: The challenge for Malaysian women. In L. Manderson, & L. R. Bennett (Eds.), *Violence against women in Asian Societies* (pp.130-149). London: Routledge.
- Foran, H. M., & O' Leary (2008). Alcohol and intimate partner violence: A meta-analytic review. *Clinical Psychology Review*, 28(7), 1222-1234. doi:10.1016/j.cpr.2008.05.001.
- Fortune, M. M., Abugideri, S., & Dratch, R. M. (2010). *A commentary on religion and domestic violence*. Retrieved from <http://www.faithtrustinstitute.org/resources/articles/Commentary.pdf>.

- Foshee, V. A., Benefield, T., Ennett, S. T., Bauman, K. E., & Suchindran, C. (2005). Assessing the effects of the dating violence prevention program “safe dates” using random coefficient regression modeling. *Prevention Science*, 6, 245-258. doi: 10.1007/s11121-005-0007-0.
- Fox, V. C. (2002). Historical perspectives on violence against women. *Journal of International Women's Studies*, 4(1), 14-34. Retrieved from <http://vc.bridgew.edu/jiws/vol4/iss1/2> .
- Fox, J. A., & Zawitz, M. W. (2006). *Homicide trends in the United States*. U. S. Department of Justice, Bureau of Justice Statistics. Retrieved from <http://www.ojp.gov/bjs/homicide/homtrnd.htm>.
- Fraley, R. C., & Shaver, P. R. (2000). Adult romantic attachment: Theoretical developments, emerging controversies, and unanswered questions. *Review of General Psychology*, 4, 132-154. doi: 10.1037//1089-2680.4.2.132.
- Frias, S. M., & Angel, R. J. (2005). The risk of partner violence among low-income Hispanic subgroups. *Journal of Marriage and Family*, 67(3), 552-564.
- Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking implications for intervention. *Violence against women*, 11(3), 290-310.
- Fulu, E. (2014). *Domestic violence in Asia: Globalization, gender, and Islam in the Maldives*. New York, NY: Routledge.
- Fundamental Rights Agency (2014). *Violence against women: An EU-wide survey*. Vienna, Austria: European Union Agency for Fundamental Rights.
- Furlow, B. (2010). Domestic violence. *Radiologic Technology*, 82(2), 133-153.

- Gage, A. J. (2005). Women's experience of intimate partner violence in Haiti. *Social Science Medicine*, 61(2), 343-364. doi:10.1016/j.socscimed.2004.11.078
- Ganapathy, N. (2008). *Policing marital violence in Singapore*. Singapore: Brill.
- Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *Lancet*, 368(9543), 1260-1269.
- Gay, L. R., & Airasian, P. (2008). *Educational research: Competencies for analysis and applications* (10<sup>th</sup> ed.). Upper Saddle River, NJ: Pearson.
- García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., ... & Watts, C. (2015). Addressing violence against women: A call to action. *The Lancet*, 385(9978), 1685-1695.
- Garimella, R., Plichta, S. B., Hoseman, C., & Garzon, L. (2000). Physician beliefs about victims of spouse abuse and about the physician role. *Journal of Women's Health & Gender-Based Medicine*, 9(4), 405-411.
- Gebeye, B. A. (2013). Women's rights and legal pluralism: A case study of the Ethiopian Somali regional state. *Women in Society*, 6, 5-42.
- Gelsthorpe, L., & Larrauri, E. (2013). Gender and crime in Europe. In S. Body-Gendrot, M. Hough, K. Kerezsi, R. Levy, & S. Snacken (Eds.), *The Routledge handbook of European criminology* (pp.188-203). London: Routledge.
- Gelles, R. J. (1997). *Intimate violence in families*. Thousand Oaks, CA: Sage.
- Gerbert, B., Johnston, K., Caspers, N., Bleecker, T., Woods, A., & Rosenbaum, A. (1996). Experiences of battered women in health care settings: A qualitative study. *Women Health*, 24(3), 1-17. doi: 10.1300/J013v24n03\_01.

- Ghani, M. A. (2014). *Exploring domestic violence experiences from the perspective of abused women in Malaysia*. Retrieved from <https://dspace.lboro.ac.uk/2134/14620>.
- Gil-Gonzalez, D., Vives-Cases, C., Ruiz, M. T., Carrasco-Portino, M., & Alvarez-Dardet, C. (2007). Childhood experiences of violence in perpetrators as a risk factor of intimate partner violence: A systematic review. *Journal of Public Health, 30*(1), 14-22. doi: 10.1093/pubmed/fdm071.
- Giller, B., & Goldsmith, E. (1980). All in the family: A study of intra-familial violence in the Los Angeles Jewish community. *Unpublished master's thesis*. Los Angeles, CA: Hebrew Union College and University of Southern California.
- Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociological Press.
- Goff, B. G., & Goddard, H. W. (1999). Terminal core values associated with adolescent problem behaviors. *Adolescence, 34*(133), 47-60.
- Goicolea, I., Briones-Vozmediano, E., Ohman, Ann., Edin, K., Minvielle, F., & Vives-Cases, C. (2013). Mapping and exploring health systems' response to intimate partner violence in Spain. *Public Health, 13*(1162). doi: 10.1186/1471-2458-13-1162.
- Golberg, J. M., Matte, N., MacMillan, M., & Hudspith, M. (2003). *Community survey: Transition/cross-dressing services in BC-Final Report*. Vancouver, BC: Vancouver Coastal Health and Transcend Transgender Support & Education Society.

- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132. doi: 10.1023/A:1022079418229.
- Goodman, L., Dutton, M. A., Weinfurt, K., & Cook, S. (2003). The intimate partner violence strategies index. *Violence Against Women, 9*(2), 163-186. doi: 10.1177/1077801202239004.
- Govender, V., & Penn-Kekana, L. (2008). Gender biases and discrimination: A review of health care interpersonal interactions. *Global Public Health, 3*(S1), 90-103. doi: 10.1080/17441690801892208.
- Gover, A. R., Paul, D. P., & Dodge, M. (2011). Law enforcement officers' attitudes about domestic violence. *Violence Against Women, 17*(5), 619-636. doi: 10.1177/1077801211407477.
- Gracia, E. (2014). Intimate partner violence against women and victim blaming attitudes among Europeans. *Bulletin World Health Organization, 92*, 380-381. doi: 10.2471/BLT.13.131391.
- Gracia, E., & Herrero, J. (2006). Acceptability of domestic violence against women in the European Union: A multilevel analysis. *Journal of Epidemiology Community Health, 60*(2), 123-129. doi: 10.1136/jech.2005.036533.
- Graham-Kevan, N., & Archer, J. (2003). Physical aggression and control in heterosexual relationships: The effect of sampling. *Violence and Victims, 18*, 181-196.
- Green, D. O., Creswell, J. W., Shope, R. J., & Plano-Clark, V. L. (2007). Grounded theory and racial/ethnic diversity. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 472-492). Thousand Oaks, CA: Sage.

- Gremillion, D. H., & Evins, G. (1994). Why don't doctors identify and refer victims of domestic violence? *NCMJ*, 55, 428-432.
- Griffin, C. (2007). Being dead and being there: Research interviews, sharing hand cream and the preference for analyzing 'naturally occurring data.' *Discourse Studies*, 9(2), 246-269. doi: 10.1177/1461445607075340.
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology*, 29(2), 75-91. Retrieved from <http://www.jstor.org/stable/30219811>.
- Gullum, T. L. (2009). *The intersection of spirituality, religion, & intimate partner violence in the African American community*. Institute on Domestic Violence The African American community [IDVAAC]: University of Minnesota. Retrieved from <http://www.idvaac.org/media/pubs/TheIntersectionofSpirituality.pdf>
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health*, 7(1), 12.
- Haj-Yahia, M. M., & Sadan, E. (2008). Issues in intervention with battered women in collectivist societies. *Journal of Marital and Family Therapy*, 34, 1-13. doi: 10.1111/j.1752-0606.2008.00049.x.
- Hamberger, L. K. (2005). Men's and women's use of intimate partner violence in clinical samples: Toward a gender-sensitive analysis. *Violence and Victims*, 20, 131-151. doi: 10.1177/0886260507313945.

Hamberger, L.K., Guse, C., Boerger, J., Minsky, D., Pape, D. & Folsom, C. (2004).

Evaluation of a health care provider training program to identify and help partner violence victims. *Journal of Family Violence*, 19, 1-11.

Hankin, A., Smith, L. S., Daugherty, J., & Houry, D. (2010). Correlation between intimate partner violence victimization and risk of substance abuse and depression among African-American Women in an urban emergency department. *Western Journal of Emergency Medicine*, xi(3), 252-256.

Hart, B. J., & Klein, A. R. (2013). *Practical implications of current intimate partner violence research for victim advocates and service providers*. United States, US: Department of Justice. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/244348.pdf>.

Harway, M., & Hansen, M. (1993). Therapist perceptions of family violence. In Hansen, M. *Battering and family therapy: A feminist perspective* (p.42-53). Newbury Park, CA: Sage.

Hass, G. A., Dutton, M. A., & Orloff, L. E. (2000). Lifetime prevalence of violence against Latina immigrant: Legal and policy implications. *Domestic Violence: Global Response*, 93-113. doi: 10.1177/026975800000700306.

Hassan, S., & Malik, A. A. (2011). Factors for intimate partner violence (IPV) in urban Pakistani families. *Pakistan Journal of Clinical Psychology*, 10(1), 3-20.

Hausmann, R., Tyson, L. D., & Zahidi, S. (2011). *The global gender gap report 2011*. Geneva, Switzerland: World Economic Forum. Retrieved from [http://www3.weforum.org/docs/WEF\\_GenderGap\\_Report\\_2011.pdf](http://www3.weforum.org/docs/WEF_GenderGap_Report_2011.pdf)

- Hayden, S. R., Barton, E. D., & Hayden, M. (1997). Domestic violence in the emergency department: How do women prefer to disclose and discuss the issues? *Journal of Emergency Medicine*, 15(4), 447-451.
- Hayes, T. C., & Matthew, R. L. (2005). The Southern culture of honor and violent attitudes. *Sociological Spectrum*, 25, 593-617. doi:10.1080/02732170500174877.
- Hays, D. G. & Emelianchik, K. (2009). A content analysis of intimate partner violence assessments: Implications for mental health counselors. *Measurement and Evaluation in Counseling and Development*, 42, 139-153. doi: 10.1177/0748175609344090.
- Hays, D. G., Michel, R. E., Cole, R. F., Emelianchik, K., Forman, J., Lorelle, S., McBride, R., & Sikes, A. (2011). A phenomenological investigation of adolescent dating relationships and dating violence counseling interventions. *The Professional Counselor: Research and Practice DIGEST*, 1(3), 222-233. doi:10.15241/dgh.1.3.222.
- Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: The Guilford Press.
- Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52(3), 511-524. doi: <http://dx.doi.org/10.1037/0022-3514.52.3.511>.
- Heise, L. L., Ellberg, M., & Gottmoeller, M. (1999). *Ending violence against women*. Baltimore, MD: Johns Hopkin University School of Public Health, Population Information Program.

- Heise, L. L., Ellberg, M., & Gottmoeller, M. (2002). Violence against women: A global public health crisis. *Journal of Public Health, 34*, 1-4. doi:10.1016/0277-9536(94)90349-2.
- Heise, L. L., Pitanguy, J., & Germaine, A. (1994). *Violence against women: The hidden health burden*. Washington, D.C.: World Bank. Retrieved from [http://apps.who.int/iris/bitstream/10665/48688/1/WHISQ\\_1993\\_46\\_No.1\\_p78-85\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/48688/1/WHISQ_1993_46_No.1_p78-85_eng.pdf?ua=1).
- Helfrich, C. A., Fujiura, G. T., & Rutkowski-Kmitta, V. (2008). Mental health disorders and functioning of women in domestic violence shelters. *Journal of Interpersonal Violence, 23*(4), 437-453. doi: 10.1177/0886260507312942.
- Henderson, A. J. Z., Bartholomew, K., & Dutton, D. G. (1997). He loves me, he loves me not: Attachment and separation resolution of abused women. *Journal of Family Violence, 12*(2), 169-191. doi: 10.1023/A:1022836711637.
- Hemerway, D., & Richardson, E. G. (2011). Homicide, suicide, and unintentional firearm fatality: Comparing the united states with other high-income countries. *Journal of Trauma, 70*, 238-242. doi:10.1097/TA.0b013e3181dbaddf.
- Henderson, A. J. Z., Bartholomew, K., & Dutton, D. G. (1997). He loves me; he love me not: Attachment and separation resolution of abused women. *Journal of Family Violence, 12*(2), 169-191.
- Hesse, A. R. (2002). Secondary trauma: How working with trauma survivors affects therapists. *Clinical Socioal Work Journal, 30*(3), 293-309.
- Hester, M. (2012). Portrayal of women as intimate partner domestic violence perpetrators. *Violence Against Women, 18*(9), 1067-1082. doi: 10.1177/1077801212461428.

- Hines, D. A., Brown, J., & Dunning, E. (2007). Characteristics of callers to the domestic abuse helpline for men. *Journal of Family Violence*, 22(2), 63-72.
- Hendricks-Matthews, M. K. (1997). A survey of family violence curricula in Virginia medical schools and residencies at university medical centers. *Academy Medicine*, 72(1), 54-56.
- Hensengerth, O. (2011). Violence research in Northeast and Southeast Asia: Main themes and directions. *International Journal of Conflict and Violence*, 5(1), 55-86.
- Hindin, M. J., & Adair, L. S. (2002). Who's at risk? Factors associated with intimate partner violence in the Philippines. *Social Science & Medicine*, 55(8), 1385-1399.
- Hines, D. A., Brown, J., & Dunning, E. (2007). Characteristics of callers to the domestic abuse helpline for men. *Journal of Family Violence*, 22(2), 63-72. doi: 10.1007/s10896-006-9052-0.
- Hines, D. A. & Douglas, E. M. (2011). Alcohol and drug abuse in men who sustain intimate partner violence. *Aggressive Behavior*, 38, 31-46. doi: 10.1002/ab.20418.
- Ho, D. Y. (1976). On the concept of face. *American Journal of Sociology*, 81(4), 867-884.
- Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Holtzworth-Munroe, A., Meehan, J. C., Rehman, U., & Marshall, A. D. (2002). Intimate partner violence: An introduction for couple therapists. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (vol. 3, pp. 431-465). New York: Guilford Press.

- Howard, L. M., Trevillion, K., Agnew-Davies, R. (2010). Domestic violence and mental health. *International Review of Psychiatry*, 22(5), 525-534.  
doi:10.3109/09540261.2010.512283.
- Hui, C. H., & Triandis, H. C. (1986). Individualism – collectivism: A study of cross-cultural researchers. *Journal of Cross-Cultural Psychology*, 17, 225-248. doi: 10.1177/0022002186017002006.
- Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: ‘I’ll call it symptoms of abuse.’ *British Journal of Social Work*, 22(2), 209-226.
- Hunnicut, G. (2009). Varieties of patriarchy and violence against women: Resurrecting “Patriarchy” as a theoretical tool. *Violence Against Women*, 15, 553-573. doi: 10.1177/1077801208331246.
- Iliffe, G., & Steed, L. G. (2000). Exploring the counselor’s experience of working with perpetrators and survivors of domestic violence. *Journal of interpersonal violence*, 15(4), 393-412.
- Ingram, E. M. (2007). A comparison of help seeking between Latino and non-Latino victims of intimate partner violence. *Violence Against Women*, 13(2), 159-171. doi: 10.1177/1077801206296981.
- International Classification of Health Workers (2008). *Classifying health workers: Mapping occupations to the international standard classification*. Geneva, Switzerland: World Health Organization.
- Jaffee, K. D., Epling, J. W., Grant, W., Ghandour, R. M., & Callendar, E. (2005). Physician-identified barriers to intimate partner violence screening. *Journal of Women’s Health*, 14(8), 713-720.

- Jamal, M. (2006). Type-A behavior in a multinational organization: A study of two countries. *Stress and Health*, 23, 101-109. doi: 10.1002/smi.112.
- Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *The Lancet*, 359, 1423-1429. Retrieved from <http://ethicsinhealth.org/wp-content/uploads/2012/01/intimate-partner-violence-jewkes.pdf>.
- Jewkes, R., Sen, P., & Garcia-Moreno, C. (2002). Sexual violence. In: E. G. Krug, L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp.149-181). Geneva: World Health Organization.
- Johnston, J., Fidelia, L., Robinson, K. W., Killion, J. B., Behrens, P. (2012). An instrument for assessing communication skills of healthcare and human services students. *The Internet Journal of Allied Health Sciences and Practice*, 10(4). Retrieved from <http://ijahsp.nova.edu/articles/Vol10Num4/pdf/Johnston.pdf>.
- Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violence resistance, and situational couple violence*. Boston: Northeastern University Press.
- Johnson, M. P., & Ferraro, K. J. (2000). Research on domestic violence in the 1990s: Making distinctions. *Journal of Marriage and Family*, 62(4), 948-963.
- Jones, M., & Alony, I. (2011). Guiding the use of grounded theory in doctoral studies – An example from the Australian film industry. *International Journal of Doctoral Studies*, 6, 95-114. Retrieved from <http://ijds.org/Volume6/IJDSv6p095-114Jones322.pdf>.
- Jones, M., Davidson, W. S., Bogat, G. A., Levendosky, A., & Von, E. A. (2005). Validation of the subtle and overt psychological abuse scale: An examination of

construct validity. *Violence and Victims*, 20(4), 407-416. doi:

<http://dx.doi.org/10.1891/0886-6708.20.4.407>.

Jordan, C. E., Campbell, R., & Follingstad, D. (2010). Violence and women's mental health: The impact of physical, sexual and psychological aggression. *Annual Review of Clinical Psychology*, 6, 607-628.

Kamimura, A., Ganta, V., Myers, K., & Thomas, T. (2014). Intimate partner violence and physical and mental health among women utilizing community health services in Gujarat, India. *BMC Women's Health*, 14, 127-138. doi:10.1186/1472-6874-14-127.

Kane, J. (2008). *Family violence*. European Commission, Daphne Program. Retrieved from [http://ec.europa.eu/justice\\_home/daphnetoolkit/files/others/booklets/05\\_daphne\\_booklet\\_5\\_en.pdf](http://ec.europa.eu/justice_home/daphnetoolkit/files/others/booklets/05_daphne_booklet_5_en.pdf).

Kass-Bartelmes, B. L. (2004). Women and domestic violence: Programs and tools that improve care for victims. *Agency for Healthcare Research and Quality*, 15, 1-12.

Keddie, A. (2009). Giving muslim girls 'a voice': The possibilities and limits to challenging patriarchal interpretations of Islam in one English community. *Pedagogy, Culture & Society*, 17(3), 265-278. doi: 10.1080/14681360903194301.

Keeling, J., & Birch, L. (2004). Asking pregnant women about domestic violence. *British Journal of Midwifery*. Retrieved from <http://dx.doi.org/10.12968/bjom.2004.12.12.17172>.

Kelly, L. (2008). *Combating violence against women: Minimum standards for support services*. London: Council of Europe.

- Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review, 46*, 3, 476-499.
- Kernbach-Wighton, G. (2014). Intimate partner and domestic violence. In B. Madea (Ed.), *Handbook of Forensic Medicine*. Oxford, United Kingdom: John Wiley & Sons. doi: 10.1002/9781118570654.
- Kendall-Tackett, K. A. (2009). Psychological trauma and physical health: A psychoneuroimmunology approach to etiology of negative health effects and possible interventions. *Psychological Trauma, 1*, 35-48. doi: 10.1037/a0015128
- Khan, M. (2000). Domestic violence against women and girls. *Innocenti Digest, 6*, 1-22. Retrieved from <http://www.unicef-irc.org/publications/pdf/digest6e.pdf>.
- Kim, J. Y., & Nam, S. H. (1998). The concept and dynamics of face: Implications for organizational behavior in Asia. *Organization Science, 9*(4), 522-534.
- Klap, R., Tang, L., Wells, K., Starks, S. L., & Rodriguez, M. (2007). Screening for domestic violence among adult women in the United States. *Journal of General Internal Medicine, 22*(5), 579-584.
- Klein, M. A. (1998). *Slavery and colonial rule in French West Africa*. Cambridge University Press.
- Kramer, A., Lorenzon, D., & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women Health Issues, 14*(1), 19-29. doi:10.1016/j.whi.2003.12.002.

- Krebs, C., Breiding, M. J., Browne, A., & Warner, T. (2011). The association between different types of intimate partner violence experienced by women. *Journal of Family Violence*, 26, 487-500. doi: 10.1007/s10896-011-9383-3.
- Kubiak, S., Sullivan, C. M., Fries, L., Nnawulezi, N., & Fedock, G. (2011). *Best practice toolkit for working with domestic violence survivors with criminal histories*. Michigan Coalition Against Domestic and Sexual Violence. Retrieved from [http://www.mcadsv.org/projects/Toolkit/Files/Best\\_Practice\\_Toolkit\\_Entire\\_Document.pdf](http://www.mcadsv.org/projects/Toolkit/Files/Best_Practice_Toolkit_Entire_Document.pdf).
- Kwagala, B., Wandera, S. O., Ndugga, P., & Kabagenyi, A. (2013). Empowerment, partner's behaviors and intimate partner physical violence among married women in Uganda, *Public Health*, 13(1112), 1-10. doi. 10.1186/1471-2458-13-1112.
- Landers, G. & Gilsanz, P. (2011). *The health of lesbian, gay, bisexual, and transgender (LGBT) persons in Massachusetts: A survey of health issues comparing LGBT persons with their heterosexual and nontransgender counterparts*. Boston, MA: Massachusetts Department of Public Health.
- Langenderfer-Magruder, L., Whitfield, D. L., Walls, N. E., Kattari, S. K., & Ramos, D. (2012). Experiences of intimate partner violence and subsequent police reporting among lesbian, gay, bisexual, transgender, and queer adults in Colorado: Comparing rates of cisgender and transgender victimization. *Journal of Interpersonal Violence*, 1-17. doi: 10.1177/0886260514556767.
- Langhinrichsen-Rohling, J. (2010). Controversies involving gender and intimate partner violence in the United States. *Sex Roles*, 62(3-4), 179-193. doi: 10.1007/s11199-009-9628-2.

- Latta, R. R., & Goodman, L. A. (2005). Considering the interplay of cultural context and service provision in intimate partner violence: The case of Haitian immigrant women. *Violence Against Women, 11*(11), 1441-1464.
- Lawoko, S., Sanz, S., Helstrom, L., & Castren, M. (2011). Screening for intimate partner violence against women in healthcare Sweden: Prevalence and Determinants. *ISRN Nursing*. doi: 10.5402/2011/510692.
- Lawson, J. (2012). Sociological theories of intimate partner violence. *Journal of Human Behavior in the Social Environment, 22*(5), 572-590.  
doi:10.1080/10911359.2011.598748.
- Lee, Y. S., & Hadeed, L. (2009). Intimate partner violence among Asian immigrant communities Health/mental health consequences, help-seeking behaviors, and service utilization. *Trauma, Violence, & Abuse, 10*(2), 143-170. doi: 10.1177/1524838009334130.
- Lee, M. Y., & Lawy, P. F. M. (2001). Perceptions of sexual violence against women in Asian American communities. *Journal of Ethnic and Cultural Diversity in Social Work, 10*(2), 3-25. doi: 10.1300/J051v10n02\_02.
- Lees, S., Phimister, D., Broughan, C., Dignon, A., & Brown, M. (2013). Domestic violence: The base of the iceberg. *British Journal of Midwifery, 21*(7), 493-498.  
doi: 10.12968/bjom.2013.21.7.493.
- Leisenring, A. (2012). Victims' perceptions of police response to intimate partner violence. *Journal of Police Crisis Negotiation, 12*, 146-164. doi: 10.1080/15332586.

- Leonard, R. L., & Senchak, M. (1996). Prospective prediction of husband marital aggression within newlywed couples. *Journal of Abnormal Psychology, 105*, 369-380. doi: <http://dx.doi.org/10.1037/0021-843X.105.3.369>.
- Leung, P. & Cheung, M. (2008). A prevalence study on partner abuse in six Asian American ethnic groups in the USA. *International Social Work, 51*(5), 635-649. doi: 10.1177/0020872808093342.
- Levesque, R. J. (2001). *Culture and family violence: Fostering change through human rights law*. Washington, D.C.: American Psychological Association.
- Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. *Naturalistic inquiry, 1985*, 289-331.
- Littleton, H. L., Berenson, A. B., & Breitkopf, C. R. (2007). An evaluation of health care providers' sexual violence screening practices. *American Journal of Obstetrics & Gynecology, 196*, 564e1-564e7. doi: 10.1016/j.ajog.2007.01.035.
- Liu, C. J., & Regehr, C. (2009). Power and control as a framework for practice – The case of intimate partner violence work in Taiwan. *Brief Treatment and Crisis Intervention, 8*(4), 381-389.
- Logan, T. K., & Walker, R. (2004). Separation as a risk factor for victims of intimate partner violence: Beyond lethality and injury. A response to Campbell. *Journal of Interpersonal Violence, 19*(12), 1478-1486.
- Love, C., Gerber, B., Caspers, N., Bronstone, A., Perry, D., & Bird, W. (2001). Dentists' attitudes and behaviors regarding domestic violence. The need for an effective response. *The Journal of the American Dental Association, 132*, 85-93.

- Lowe, P., Humphreys, C., & Williams, S. J. (2007). Night terrors women's experiences of (not) sleeping where there is domestic violence. *Violence Against Women, 13*(6), 549-561. doi: 10.1177/1077801207301556.
- Lussier, P., Farrington, D. P., & Moffitt T. E. (2009). Is the antisocial child father of the abusive man? A 40-year prospective longitudinal study on the developmental antecedents of intimate partner violence. *Criminology, 47*(3), 741-780. doi: 10.1111/j.1745-9125.2009.00160.x.
- Main, M., Kaplan, K. & Cassidy, J. (1985). Security in infancy childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development, 50*(1-2, Serial No. 209), 66-104.
- Malcoe, L. H., Duran, B. M., & Montgomery, J. M. (2004). Socioeconomic disparities in intimate partner violence against Native American women: A cross-sectional study. *BMC Medicine, 2*(1), 20.
- Matsui, Y. (2001). Women's international war crimes tribunal on japan's military sexual slavery: Memory, identity, and society. *East Asia, 19*(4), 119-142.
- Matthews, D. D. (2004). *Domestic violence sourcebook* (2<sup>nd</sup> ed.). Detroit, MI: Omnigraphics.
- Mayhew, S. H., Lush, L., Cleland, J., & Walt, G. (2000). Implementing the integration of component services for reproductive health. *Stud Fam Plann, 31*, 151-62. doi: 10.1111/j.1728-4465.2000.00151.x pmid:10907280.
- McCauley, J., Jenckes, M. W., McNutt, L. A. (2003). The effectiveness of a continuing medical education video on knowledge and attitudes about interpersonal violence. *Academy Medicine, 78*, 518-24.

- McCloskey, L. A., Williams, C., & Larsen, U. (2005). Gender inequality and intimate partner violence among women in Moshi, Tanzania. *International Family Planning Perspectives, 31*(3), 124-130.
- McDonald, C. (2012). The social context of woman-to-woman intimate partner abuse (WWPIA). *Journal of Family Violence, 27*(5).
- McLeod, A. L., Muldoon, J., & Hays, D. G. (2014). Intimate partner violence. In B. T. Erford, & Jackson-Cherry (Eds.), *Crisis Intervention*. Upper Saddle River, NJ: Pearson Merrill Prentice Hall.
- Menard, K.S., Anderson, A. L., & Godbolt, S. M. (2009). Gender differences in intimate partner recidivism: A 5-year follow up. *Criminal Justice and Behavior, 36*(1), 61-76. doi: 10.1177/0093854808325905.
- Mendlinger, S., & Cwiker, J. (2008). Spiraling between qualitative and quantitative data on women's health behaviors: A double helix model for mixed methods. *Qualitative Health Research, 18*(2), 280-293. doi: 10.1177/1049732307312392.
- Merali, N. (2009). Experiences of south Asian brides entering Canada after recent changes to family sponsorship policies. *Journal of Family Violence, 13*(3), 310-339. doi: 10.1177/1077801208330435.
- Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: John Wiley & Sons.
- Meyer, S. (2010). Reponding to intimate partner violence victimization: Effective options for help-seeking. *Trends & Issues in Crime and Criminal Justice, 389*. Retrieved from [http://aic.gov.au/media\\_library/pulications/tandi\\_pdf/tandi389.pdf/](http://aic.gov.au/media_library/pulications/tandi_pdf/tandi389.pdf/)

- Midlarsky, E., Venkataramani-Kothari, A. N. I. T. H. A., and Plante, M. (2006). Domestic violence in the Chinese and South Asian immigrant communities. *Annals of the New York Academy of Sciences*, 1087(1), 279-300.
- Miller, E., McCauley, H. L., Tancredi, D. J., Decker, M. R., Anderson, H. A., & Silverman, J. G. (2013). One-year follow-up of a coach-delivered dating violence prevention program: A cluster randomized controlled trial. *American Journal of Preventive Medicine*, 45(1), 108-112.
- Milwertz, C., & Bu, W. (2007). Non-governmental organizing for gender equality in China-Joining a global emancipatory epistemic community. *International Journal of Human Rights*, 11(1-2), 131-149.
- Miller, W. R., & Seligman, M. E. (1975). Depression and learned helplessness in man. *Journal of abnormal psychology*, 84(3), 228.
- Moffitt, T. E., & Caspi, A. (1999). *Findings about partner violence from the Dunedin Multidisciplinary Health and Development Study*. US Department of Justice, Office of Justice Programs, National Institute of Justice.
- Mohan, S. B. V. R., & Sorooshian, S. (2012). Counseling in the context of Malaysian living style. *Australian Journal of Basic and Applied Sciences*, 6(10), 292-329.
- Mohajan, H. K. (2012). Human trafficking in Asia: A heinous crime against humanities. *International Journal of Cross-Cultural Studies*, 2(1), 29-41.
- Mohamad, M., & Wieringa, S. (2014). Family ambiguity and domestic violence in Asia: Reconceptualizing law and process. *IIAS Newsletter*, 67, 21-23.

- Montoya, C. (2009). International initiative and domestic reforms: European Union efforts to combat violence against women. *Politic & Gender, 5*, 325-348. doi:10.1017/S1743923X0999016X.
- Montalvo-Liendo, N. (2009). Cross-cultural factors in disclosure of intimate partner violence: An integrated review. *Journal of Advancing Nursing, 65*(1), 20-34. doi: 10.1111/1365-2648-2008.04850.x.
- Moore, A. M., Frohwirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science & Medicine, 70*(11), 1737-1744.
- Moore, T. M., & Stuart, G. L. (2004). Illicit substance use and intimate partner violence among men in batterers' intervention. *Psychology of Addictive Behaviors, 18*(4), 385.
- Morrison, K. E., Luchok, K. J., Richter, D. L., & Parra-Medina, D. (2006). Factors influencing help-seeking from informal networks among African American victims of intimate partner violence. *Journal of Interpersonal Violence, 21*(11), 1493-1511.
- Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist, 35*(2), 209-235. doi: 10.1177/0011000006286990.
- Morse, D. S., Lafleur, R., Fogarty, C. T., Mittal, M., & Cerulli, C. (2012). "They told me to leave": How health care providers address intimate partner violence. *The Journal of the American Board of Family Medicine, 25*(3), 333-342.
- Morse, J. M. (2000). Determining sample size. *Qualitative Health Research, 10*, 3-5.

- Mulford, C., & Giordano, P. (2008). Teen dating violence: A closer look at adolescent romantic relationships. *National Institute of Justice Journal*, 251, 34-40.  
Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/224089.pdf>.
- Murray, C. E., & Mobley, A. K. (2009). Empirical research about same-sex intimate partner violence: A methodological review. *Journal of Homosexuality*, 56(3), 361-386. doi: 10.1080/00918360902728848.
- Nagassar, R. P., Rawlins, J. M., Sampson, N. R., Zackerali, J., Chankadyal, K., Ramasir, C., & Boodram, R. (2010). The prevalence of domestic violence within different socio-economic classes in Central Trinidad. *West Indian Medical Journal*, 59(1), 20.
- Nathanson, A. M., Shorey, R. C., Tirone, S., & Rhatigan, D. L. (2012). The prevalence of mental health disorders in a community sample of female victims of intimate partner violence. *Partner Abuse*, 3(1), 59-75. doi: 10.1891/1946-6560.3.1.59.
- National Coalition of Anti-Violence Programs (2014). *Lesbian, gay, bisexual, transgender, queer, and HIV-affected: Intimate partner violence in 2013*. New York, NY: New York City Gay and Lesbian Anti-Violence Project, Inc.
- National Network of End Domestic Violence (2013). *Domestic violence counts 2013*. Retrieved on November 25, 2014 from [http://nnedv.org/downloads/Census/DVCounts2013/Census13\\_FullReport\\_forweb\\_smallestFileSizeWhiteMargins.pdf](http://nnedv.org/downloads/Census/DVCounts2013/Census13_FullReport_forweb_smallestFileSizeWhiteMargins.pdf).
- National Resource Center on Domestic Violence (2007). *LGBT communities and domestic violence: Information & Resources*. Retrieved from [http://www.vawnet.org/Assoc\\_Files\\_VAWnet/NRC\\_LGBTDV-Full.pdf](http://www.vawnet.org/Assoc_Files_VAWnet/NRC_LGBTDV-Full.pdf).

- National Asian Women's Health Organization (2002). *Silent epidemic: A survey of violence among young Asian American Women*. Retrieved from <http://www.nawho.org/pubs/NAWHOSilentEpidemic.pdf>.
- National Center for Injury Prevention and Control (2012). *Understanding intimate partner violence*. Retrieved from <http://fortbendwomenscenter.org/wp-content/uploads/2014/09/National-Center-for-Injury-Prevention-and-Control-Understanding-Intimate-Partner-Violence-Fact-Sheet-2012.pdf>
- National Coalition of Anti-Violence Programs (2012). *Lesbian, gay, bisexual, transgender, queer, and HIV-Affected: Intimate partner violence*. New York, NY: Arcus Foundation.
- Ng, K. (2006). International students in CACREP-accredited counseling programs. *Journal of Professional Counseling: Practice, Theory, and Research*, 34, 20-32.
- Niaz, U. (2003). Violence against women in South Asian countries. *Archives of Women's Mental Health*, 6, 173-184. doi: 10.1007/s00737-003-0171-9.
- Nicolaidis, C., Curry, M., & Gerrity, M. (2005). Measuring the impact of the voices of survivors program on health care workers' attitudes toward survivors of intimate partner violence. *Journal of Gender Internal Medicine*, 20(8), 731-737.
- Nisbett, R. E., & Cohen, D. (1996). *Culture of honor: The psychology of violence in the South*. Boulder, CO: Westview Press.
- Noor, N. M., & Mahudin, N. D. M. (2014). Work, family and women's well-being in Malaysia. In M. Connerley, & J. Wu (Eds.), *Handbook on well-being of working women*. New York, NY: Springer.

- O' Brien, J. (2009). *Encyclopedia of gender and violence*. Thousand Oaks, CA: Sage.
- Okin, S. (1999). Is multiculturalism bad for women? In J. Cohen, M. Howard, & M. C. Nussbaum (Eds), *Is multiculturalism bad for women?* (pp.7-26). Princeton: Princeton University Press.
- O'Leary, K., & Woodin, E. M., (2009). *Psychological and physical aggression in couples*. Washington, D.C.: American Psychological Association.
- Othman, S., & Adenan, M. N. A. (2010). Domestic violence management in Malaysia: A survey on the primary health care providers. *Asia Pacific*, 7(1), 2. doi:10.1186/1447-056X-7-2.
- Ousey, G., & Wilcox, P. (2005). Subcultural values and violence delinquency: A multilevel analysis in middle schools. *Youth Violence and Juvenile Justice*, 3, 3-22. doi: 10.1177/1541204004270942.
- Outlaw, M. (2009). No one type of intimate partner abuse: Exploring physical and non-physical abuse among intimate partners. *Journal of Family Violence*, 24(4), 263-272. doi: 10.1007/s10896-009-9228-5.
- Oyediran, K. A., & Isiugo-Abanihe, U. C. (2005). Perceptions of Nigerian women on domestic violence: Evidence from 2003 Nigeria Demographic and Health Survey. *African Journal of Reproductive Health*, 38-53.
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-12. doi: 10.1007/s10488-013-0528-y.

- Panda, K. U. (2011). Role conflict, stress and dual-career couples: An empirical study. *The Journal of Family Welfare*, 57(2), 72-88.
- Park, Y. S. (2008). Revisiting the welfare state system in the Republic of Korea. *International Social Security Review*, 61(2), 3-19. doi: 10.1111/j.1468-246X.2008.00307.x.
- Peled, E., Eisikovits, Z., Enosh, G., & Winstok, Z. (2000). Choice and empowerment for battered women who stay: Toward a constructivist model. *Social Work*, 45(1), 9-25.
- Pence, E. & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. New York, NY: Springer.
- Peterson, C., Maier, S. F., & Seligman, M. E. P. (1993). *Learned helplessness: A theory for the age of personal control*. New York, NY: Oxford University Press.
- Petersen R, Moracco, K. E., Goldstein, K. M., Clark, K. A. (2004). Moving beyond disclosure: Women's perspectives on barriers and motivators to seeking assistance for intimate partner violence. *Women & Health*. 63-76.
- Phillips, K. E., Rosen, G. M., Zoellner, L. A., & Feeny, N. C. (2006). A cross-cultural assessment of posttrauma reactions among Malaysian and US women reporting partner abuse. *Journal of family violence*, 21(4), 259-262. doi: 10.1007/s10896-006-9023-5.
- Pistole, C. M. (1994). Adult attachment styles: Some thoughts on closeness-distance struggle. *Family Process*, 33(2), 147-159. doi: 10.1111/j.1545-5300.1994.00147.x

- Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice implications. *Trauma Violence & Abuse*, 8(2), 226-239. doi: 10.1177/1524838007301220.
- Potera, C. (2014). The VAWA Makes American Indian Women Safer. *AJN The American Journal of Nursing*, 114(5), 20. doi: 10.1097/01.NAJ.0000446768.09825.a0.
- Primeau, L. A. (2003). Reflections on self in qualitative research: Stories of family. *American Journal of Occupational Therapy*, 57(1), 9-16. doi:10.5014/ajot.57.1.9.
- Purcell, R., Pathé, M., & Mullen, P. E. (2002). The prevalence and nature of stalking in the Australian community. *Australasian Psychiatry*, 36(1), 114-120. doi: 10.1192/bjp.187.5.416.
- Raj, A., & Silverman, J. G. (2002). Intimate partner violence against South Asian women in Greater Boston. *Journal of American Medical Women's Association*, 57(2), 111-114. doi: 10.1177/026975800701400108.
- Rakel, R. E., & Rakel, D. P. (2011). *Textbook of family medicine (8<sup>th</sup> ed.)*. Philadelphia, PA: Elsevier Inc.
- Ramos, M. M., Green, D., Booker, J., & Nelson, A. (2011). Immigration status, acculturation, and dating violence risk for Hispanic adolescent girls in New Mexico. *Maternal and Child Health Journal*, 15(7), 1076-1080. doi: 10.1007/s10995-010-0653-0.

- Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L. L., Feder, G. (2002). Should health professionals screen women for domestic violence.? Systematic review. *BMJ*, 325 (314). Retrieved from <http://dx.doi.org/10.1136/bmj.325.7359.314>.
- Rasanathan, J. J. K., & Bhushan, A. (2011). *Gender-based violence in Vietnam: Strengthening the response by measuring and acting on the social determinants of health*. Regional Office for the Western Pacific: World Health Organization.
- Rashidah, A., Rita, R. H., & Schmitt, G. (1995). *Battered women in Malaysia: Prevalence, problems, and public attitudes: A summary report of women's aid organization Malaysia's national research on domestic violence*. Petaling Jaya, Selangor: Women's Aid Organization.
- Rastam, A. (2002). The rape report: An overview of rape in Malaysia. *All Women's Action Society*, 208.
- Rees, A., Agnew-Davies, R., & Barkham, M. (2006, June). *Outcomes for women escaping domestic violence at refuge*. Paper presented at the Society for Psychotherapy Research Annual Conference, Endinburgh, Scotland.
- Regina, A. O. & Patrick, O. (2011). Cultural violence and the Nigerian woman. *An International Multidisciplinary Journal, Ethiopia*, 5(4), 369-381.
- Rennison, C. M., & Welchans, S. (2000). Intimate partner violence. *Violence Against Women*, 1993, 98.
- Renzetti, C. M. (1992). *Violence betrayal: Partner abuse in lesbian relationships*. Newbury Park, CA: Sage.
- Rhode, D. L. (1989). Feminist critical theories. *Stan. L. Rev.*, 42, 617.

- Rhodes, K. V., Frankel, R. M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). "You're not a victim of domestic violence are you?" Provider-patient communication about domestic violence. *Annals of Internal Medicine*, 147(9), 620-627.
- Rhodes, K. V., Kothari, C. L., Dichter, M., Cerull, C., Wiley, J., & Marcus, S. (2011). Intimate partner violence identification and response: Time for a change in strategy. *Journal of General Internal Medicine*, 26(8), 894-899. doi: 10.1007/s11606-011-166-4.
- Rich, P. (2012). Inside the black box: Revealing the process in applying a grounded theory analysis. *The Qualitative Report*, 17(25), 1-23. doi: 10.1007/s10995-010-0653-0.
- Rider, E. A., Hinrichs, M. M., & Lown, B. A. (2006). A model of communication skills assessment across the undergraduate curriculum. *Medical Teacher*, 28(5), e127-e134.
- Rintala, T. M., Paavilainen, E., & Åstedt-Kurki, P. (2014). Challenges in combining different data sets during analysis when using grounded theory. *Nurse researcher*, 21(5), 14-18. doi: 10.7748/nr.21.5.14.e1220.
- Richardson, E. G., & Hemenway, D. (2011). Homicide, suicide, and unintentional firearm fatality: Comparing the United States with other high-income countries, 2013. *Journal of Trauma*, 70(1), 238-243. doi: 10.1097/TA.0b013e3181dbaddf.
- Riviello, R. (2010). *Manual of forensic emergency medicine: A guide for clinicians*. Sudbury, MA: Jones and Bartlett publishers.

- Roberts, L., & Bucksey, S. J. (2007). Communicating with patients: What happens in practice? *Physical Therapy*, 78, 586-594.
- Robinson, L., & Spilsbury, K. (2008). Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health Social Care Community*, 16(1), 16-30. doi: 10.1111/j.1365-2524.2007.00721.x.
- Roche, M., Moracco, K. E., Dixon, K. S., Stern, E. A., & Bowling, J. M. (2007). Correlates of intimate partner violence among female patients at a North Carolina emergency department. *North Carolina Medical Journal*, 68(2), 89-94.
- Rodriguez, M. A., & Battaglia, T. (2003). Asking patients about intimate partner abuse. *AMA Journal of Ethics*, 5(11). Retrieved from <http://journalofethics.ama-assn.org/2003/11/ccas1-0311.html>.
- Roelens, K., Verstraelen, H., Van Egmond, K., & Temmerman, M. (2006). A knowledge, attitudes, and practice survey among obstetrician-gynaecologists on intimate partner violence in Flanders, Belgium. *BMC Public Health*, 6(1), 238.
- Rodriguez, M. A., Valentine, J. M., Son, J. B., & Muhammad, M. (2009). Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. *Trauma, Violence & Abuse*, 10(4), 358-374. doi: 10.1177/1524838009339756.
- Romito, P. (2008). *A deafening silence: Hidden violence against women and children*. Bristol, UK. The Policy Press.
- Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosure of domestic violence by mental health

- service users: Qualitative study. *The British Journal of Psychiatry*, 198, 189-194.  
doi: 10.1192/bjp.bp.109.072389.
- Ross, L. E. (2013). Religion and intimate partner violence: A double-edge sword?  
*Catalyst: A Social Justice Forum*, 2(3), 1. Retrieved from  
<http://trace.tennessee.edu/catalyst/vol2/iss3/1>
- Royal Malaysian Police (2013). *Statistics of abuse in Malaysia from 2000-2012*.  
Retrieved from  
[http://www.wao.org.my/Police+Statistics+on+Violence+Against+Women+2000-2012\\_99\\_6\\_1.htm](http://www.wao.org.my/Police+Statistics+on+Violence+Against+Women+2000-2012_99_6_1.htm).
- Runner, R. M., Novick, S., & Yoshihama, M. (2009). *Intimate partner violence in immigrant and refugee communities: Challenges, promoting practices and recommendations*. Retrieved from <http://hdl.handle.net/10244/788>.
- Saddki, N., Suhaimi, A. A., & Daud, R. (2010). Maxillofacial injuries associated with intimate partner violence in women. *BMC Public Health*, 10(268). Retrieved from <http://www.biomedcentral.com/1471-2458/10/268>.
- Sadler, G. R., Lee, H. C., Lim, R. S. H., & Fullerton, J. (2010). Recruiting hard-to-reach United States population sub-groups via adaptations of snowball sampling strategy. *Nursing Health Science*, 12(3), 369-374. doi: 10.1111/j.1442-2018.2010.00541.x.
- Saltzman, L. E., Fanslow, J. L., McMahon, P. M., & Shelley, G. A. (2002). *Intimate partner violence surveillance uniform definitions and recommended data elements*. Atlanta, GA: National Center for Injury Prevention and Control.
- Sampson, R. (2008). Rethinking crime and immigration. *Contexts*, 7(1), 28-33.

- Sapra, K. J., Jubinski, S. M., Tanaka, M. F., & Gershon, R. R. M. (2014). Family and partner interpersonal violence among American Indians/Alaska Natives. *Injury Epidemiology, 1*(7). Retrieved from <http://www.injepijournal.com/content/1/1/7>.
- Sarah-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23*, 449-480.
- Schelong, K. M. (1994). Domestic violence and the state: Responses to and rationales for spousal battering, marital rape, and stalking. *Marquette Law Review, 78*, 79-120.
- Schafer, J., Caetano, R., & Cunradi, C. B. (2004). A path model of risk factors for intimate partner violence among couples in the United States. *Journal of Interpersonal Violence, 19*(2), 127-142. doi: 10.1177/0886260503260244.
- Schechter, S. (1982). *Women and male violence: The visions and struggles of the battered women's movement*. Cambridge: South End.
- Schornstein, S. L. (1997). *Domestic violence and health care: What every professional needs to know*. Thousand Oaks, CA: Sage.
- Schwandt, T. A. (2001). *Dictionary of qualitative inquiry* (2<sup>nd</sup>). Thousand Oaks, CA: Sage.
- Segala, U. (1999). Family violence: A focus on India. *Aggression and Violence Behavior, 4*, 2. doi:10.1016/S1359-1789(97)00051-7.
- Sekhri, S., & Storeygard, A. (2011). "The impact of climate variability on crimes against women: Dowry deaths in India." Retrieved from [http://people.virginia.edu/~ss5mj/women crimes\\_2013.pdf](http://people.virginia.edu/~ss5mj/women crimes_2013.pdf).
- Shen, Y. F. (2011). China in the post-patriarchal era. *Chinese Sociology and Anthropology, 43*(4), 5-23. doi: 10.2753/CSA0009-4625430401.

- Shim, W., & Nelson-Becker, H. (2009). Korean older intimate partner violence survivors practice recommendations. *Loyola eCommons*. School of Social Work: Faculty Publication & Other Works.
- Shoultz, J., Magnussen, L., Manzano, H., Arias, C., & Spencer, C. (2010). Listening to Filipina women: Perceptions, responses and needs regarding intimate partner violence. *Issues in mental health nursing*, 31(1), 54-61. doi: 10.3109/01612840903200043.
- Shuib, R., Endut, N., Ali, S. H., Osman, I., Abdullah, S., Oon, S. W., Ghani, P. A., Prakaran, G., Husin, N. S., & Sharudin, S. H. (2013). Domestic violence and women's well-being in Malaysia: Issues and challenges conducting a national study using the WHO multi-country questionnaire on women's health and domestic violence against women. *Procedia – Social and Behavioral Sciences*, 91, 475-488. doi:10.1016/j.sbspro.2013.08.445.
- Shuler, C. A. (2010). Male victims of intimate partner violence in the United States: An examination of the review of literature through the critical theoretical perspective. *International Journal of Criminal Justice Sciences*, 5(1), 163-173.
- Simon, T. R., Anderson, M., Thompson, M. P., Crosby, A. E., Shelley, G., & Sacks, J. (2001). Attitudinal acceptance of intimate partner violence among U.S. adults. *Violence and Victims*, 16(2), 115-126.
- Sims, C. L. (2008). Invisible wounds, invisible abuse: The exclusion of emotional abuse in newspaper articles. *Journal of Emotional Abuse*, 8(4), 375-402. doi: 10.1080/10926790802480422.

- Smith, H. A., Braunack-Mayer, A., & Wittert, G. (2006). What do we know about men;s help seeking and health service use? *Medical Journal of Australia*, 184, 81-83.
- Smith, M. (1990). Patriarchal ideology and wife beatings: Test of a feminist hypothesis. *Violence and Victims*, 5(4), 257-273.
- Smith, S. C., Fowler, K., & Niolon, P. H. (2014). Intimate partner homicide and corollary victims in 16 states: National violence death reporting system, 2003-2009. *American Journal of Public Health*, 104(3), 461-466. doi: 10.2105/AJPH.2013.301582.
- Smith, K., Lader, D., Hoare, J., & Lau, I. (2012). *Hate crime, cyber security and the experience of crime among children: Findings from the 2010-2011 British crime survey*. Retrieved from <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb0612/>.
- Smyth., A. & Holian, R. (2008). Credibility issues in research from within organizations. In P. Sikes, & A. Potts (Eds.), *Researching education from the inside* (pp. 33-47). New York, NY: Taylor & Francis.
- Soglin, L. F., Bauchat, J., Soglin, D. F., & Martin, G. J. (2009). Detection of intimate partner violence in a general medicine practice. *Journal of Interpersonal Violence*, 24(2), 338-348. doi: 10.1177/0886260508316481.
- Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women*, 11(38), 38-64. doi: 10.1177/1077801204271476.

- Song, L. (2013). The association between the utilization of empowerment strategies and clients' changes of self in the field of intimate partner abuse: From the perspective of social workers. *British Journal of Social Work*, 1-22. doi: 10.1093/bjsw/bct134.
- Sprague, S., Madden, K., Simunovic, N., Goden, K., Pham, N. K., Bhandari, M. & Goslings, J. C. (2012). Barriers to screening for intimate partner violence. *Women & Health*, 52(6), 587-605.
- Stake, R. (2010). *Qualitative research: Studying how things work*. New York, NY: The Guilford Press.
- Stark, E. (2007). *Coercive control: How men entrap women in personal life*. New York, NY: Oxford University Press.
- Stark, E. (2009). Rethinking custody evaluations in domestic violence cases. *Journal of Child Custody*, 6, 287-321.
- Stark, E., & Flitcraft, A. (1996). *Women at risk: Domestic violence and women's health*. Thousand Oaks, CA: Sage.
- Steward, E., Simons, R. L., Conger, R. D., & Scaramella, L. (2002). Beyond the interactional relationship between delinquency and parenting practices: The contribution of legal sanctions. *Journal of Research in Crime and Delinquency*, 39(1), 36-59. doi: 10.1177/002242780203900102.
- Stewart, D. E., MacMillan, H., & Wathen, N. (2012). Intimate partner violence. *Canadian Journal of Psychiatry*, 58(6), 1-17.
- Straus, M. A. (1979). Measuring intra-family conflict and violence: The conflict tactics (CT) scales. *Journal of Marriage and the Family*, 41, 75-88.

- Straus, M. A. (1983). Corporal punishment, child abuse, and wife-beating: What do they have in common? In D. Finkelhor, R. J. Gelles, G. T., Hotaling, & M. A., Strauss (Eds.), *The Dark Side of Families: Current Family Violence Research* (pp.213-234). Beverly Hills, California: Sage.
- Straus, M. A. (2006). Future research on gender symmetry in physical assaults on partners. *Violence Against Women*, 12, 1086-1097. doi: 10.1177/1077801206293335.
- Straus, M. A., & Gelles, R. J. (1990). *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families*. New Brunswick, NJ: Transaction.
- Strauss, A., & Corbin, J. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press.
- Stuart, G. L., Moore, T. M., Gordon, K. C., Hellmuth, J. C., Ramsey, S. E., & Kahler, C. W. (2006). Reasons for intimate partner violence perpetration among arrested women. *Violence Against Women*, 12(7), 609-621. doi: 10.1177/1077801206290173.
- Subramaniam, M., & Abdullah, S. (2003). *Buku panduan keganasan rumah tangga*. Malaysia: ERA Consumer Malaysia.
- Sundborg, E. M., Saleh-Stattn, N., Wandell, P., & Tornkvist, L. (2012). Nurses' preparedness to care for women exposed to intimate partner violence" A

- quantitative study in primary health care. *BMC Nursing*, 11(1). Retrieved from <http://www.biomedcentral.com/1472-6955/11/1>.
- Tan, M. G. (2006). The Indonesian Commission on violence against women. In C. A. Coppel (Ed.), *Violent conflicts in Indonesia: Analysis, representation, resolution* (pp.229-241). London and New York: Routledge.
- Talib, M. A. (2010). Cultural influences and mandated counseling in Malaysia. *Asian Culture and History*, 2(1), 28-33.
- Taran, S. (2011). An examination of the factors contributing to poor communication outside the physician-patient sphere. *Mcgill Journal of Medicine*, 13(1), 86-91.
- Temple, J. R., & Freeman, D. H. (2011). Dating violence and substance use among ethnically diverse adolescents. *Journal of Interpersonal Violence*, 26, 701-718. doi: 10.1177/0886260510365858.
- Tenkorang, E., Nwabunike, C., & Sedziafa, P. (2014). Domestic and marital violence among three ethnic groups in Nigeria. Retrieved from <http://paa2014.princeton.edu/papers/140023>.
- Thapa, P., Sharma, B., Moktan, S., Subedi, S., & Khakurel, K. (2007). *Violence against women (Root causes and consequences): A research report*. Nepal: Social Inclusion Research Fund (SIRF).
- Thapa-Oli, S., Dulal, H. B., & Baba, Y. (2009). A preliminary study of intimate partner violence among Nepali women in the United States. *Violence Against Women*, 15(2), 206-223. doi: 10.1177/1077801208329389.
- Thomas, S. B. (2011). Sample size and grounded theory. *Journal of Administration and Governance*, 5 (1), 45-52.

- Thornberg, R. & Charmaz, K. (2011). 'Grounded theory.' In S. D. Lapan, M. T. Quartaroli, & F. J. Reimer (Eds.). *Qualitative Research: An Introduction to Methods and Designs* (pp. 41-67). San Francisco: John Wiley/Jossey-Bass.
- Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the national violence against women survey*. Washington, D.C.: Department of Justice.
- Tower, M. (2007). Intimate partner violence and the health care response: A postmodern critique. *Health Care Women International*, 28(5), 438-452.
- Tracy, S. R. (2007). Patriarchy and domestic violence: Challenging common misconceptions. *Journal of the Evangelical Theological Society*, 50(3), 573-594.
- Triandis, H. C. (2013). Toward understanding violence in Islam. *Psychological Research Records*, 3(1), 969-985. doi:10.1016/S2007-4719(13)70946-3
- Truman, J. L., & Morgan, R. E. (2014). *Nonfatal domestic violence 2003-2012*. U.S. Department of Justice, Bureau of Justice Statistics.
- Tyson, S. Y., Herting, J. R., & Randell, B. P. (2007). Beyond violence: Threat reappraisal in women recently separated from intimate-partner violent relationships. *Journal of Social and Personal Relationships*, 24, 693-706. doi: 10.1177/0265407507081455.
- United Nation (1993). *Declaration on the elimination of violence against women*. Retrieved from <http://www.un.org/documents/ga/res/48/a48r104.htm>.
- United Nations (2009). Violence against women. Retrieved from [http://www.un.org/en/events/endviolenceday/pdf/UNiTE\\_TheSituation\\_EN.pdf](http://www.un.org/en/events/endviolenceday/pdf/UNiTE_TheSituation_EN.pdf)

- United Nations Children's Fund (2014). *A statistical snapshot of violence against adolescent girls*. New York, NY: UNICEF.
- United Nations Population Fund (2009). *Intimate partner violence: High costs to households and communities*. Washington, D.C: International Center for Research on Women.
- United Nations Statistics Division (2010). *The world's women 2010: Trends and statistics*, 127. United Nations Publication ST/ESA/STAT/SER.K/19.
- United Nation Women (2014). *Facts and figures: Ending violence against women*. Retrieved from <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>.
- United Nation (UN) Women (2010). *Handbook for legislation on violence against women*. New York, NY: United Nations.
- U. S. Department of Homeland Security (2013). *2012 year of immigration statistics*. Washington, D. C.: U. S. Department of Homeland Security, Office of Immigration Statistics.
- U.S. Department of Justice (2015). *National crime victimization study: 2009-2013*. Retrieved from <https://rainn.org/get-information/statistics/sexual-assault-offenders>
- U. S. Preventive Service Task Force (2004). Screening for family and intimate partner violence: Recommendation statement. *American Family Physician*, 70(4), 747-751. doi: 10.1370/afm.128.
- Unluer, S. (2012). Being an insider researcher while conducting case study research. *The Qualitative Report*, 17(58), 1-14.

- Vargas, L. A., & Dickson, S. A. (2006). The importance of cultural responsiveness when treating domestic violence survivors. *VISTAS Online*. Retrieved from [http://www.counseling.org/resources/library/vistas/vistas06\\_online-only/Vargas.pdf](http://www.counseling.org/resources/library/vistas/vistas06_online-only/Vargas.pdf)
- Vetten, L. (2005). *Addressing domestic violence in South Africa: Reflections on strategy and practice*. Centre for the Study of Violence and Reconciliation, South Africa: UN Division for the Advancement of Women.
- Vung, N. D., Ostergren, P. O., & Krantz, G. (2009). Intimate partner violence against women, health effects and health care seeking in rural Vietnam. *European Journal of Public Health*, 19(2), 178-1782. doi: 10.1093/eurpub/ckn136.
- Walker, L. E. (1984). *The battered women syndrome*. New York, NY: Springer Publishing Company.
- Walker, L. E. (2009). *The battered women syndrome*. New York, NY: Springer.
- Walton-Moss, B. J., Manganello, J., Frye, V., & Campbell, J. C. (2005). Risk factors for intimate partner violence and associated injury among urban women. *Journal of Community Health*, 30(5), 377-389. doi: 10.1007/s10900-005-5518-x.
- Wandita, G. (1998). The tears have not stopped, the violence has not ended: Political upheaval, ethnicity, and violence against women in Indonesia. *Gender and Development*, 6(3), 36-37. Retrieved from <http://www.jstor.org/stable/4030500>
- Warshaw, C. (1998). Identification, assessment, and intervention with victims of domestic violence. *Improving the health care response to domestic violence: A resource manual for health care providers*, 49-86.

- Weaver, T., Sanders, C., Campbell, C., & Schnabel, M. (2009). Development and preliminary psychometric evaluation of the domestic violence-related financial issues scale [DV-FI]. *Journal of Interpersonal Violence, 24*(4), 569-585. doi: 10.1177/0886260508317176.
- Welsh, K. (2008). Current policy on domestic violence: A move in the right direction or a step too far? *Crime Prevention and Community Safety, 10*, 226-248. doi: 10.1057/cpcs/2008.7.
- Whitaker, D. J., Haileyesus, T., Swahn, M., & Saltzman, L. S. (2007). Differences in frequency of violence and reported injury between relationship with reciprocal and nonreciprocal intimate partner violence. *American Journal of Public Health, 97*, 941-947. doi: 10.2105/AJPH.2005.079020.
- Wilcox, P. (2006). *Surviving domestic violence: Gender, poverty and agency*. London: Palgrave Macmillan.
- Wolfgang, M., & Ferracuti, F. (1967). *The subculture of violence*. London: Tavistock.
- Wolak, J., Mitchell, K., & Finkelhor, D. (2006). *Online victimization: 5 years later* (NCMEC 07-06-025). Alexandria, VA: National Center for Missing & Exploited Children.
- Wolf, M. E., Ly, U., Hobart, M. A., Kernie, M. A. (2003). Barriers to seeking police help for intimate partner violence. *Journal of Family Violence, 18*, 2, 121-129.
- Wong, Y. L., & Othman, S. (2008). Early detection and prevention of domestic violence using the women abuse screening tool (WAST) in primary health care clinics in Malaysia. *Asia Pacific Journal Public Health, 20*(2), 102-116. doi: 10.1177/1010539507311899.

- Women's Aid Federation UK (2002). *The key issues facing abused women with insecure immigration due to entering the UK to join their settled partner*. United Kingdom: Women Aid Policy.
- Women's Aid Organization (1992). *Draft report of the national study on domestic violence*. Kuala Lumpur: Women's Aid Organization.
- Women's Aid Organization (2000). *WAO research and advocacy: Single mothers' needs assessment survey: Survivors of domestic violence*. Retrieved from <http://www.wao.org.mybackup.v1.21.7.2011./research/singlemom.htm>.
- Women's Aid Organization (2011). *WAO annual statistics*. Retrieved from <http://wao.org.my/file/file/WAO%20Annual%20Statistic%202011.pdf>
- Woodman, G. R. (1996). Legal pluralism and the search for justice. *Journal of African Law*, 40(2), 152-167. doi: 10.1017/S0021855300007737.
- World Health Organization (1999). *The world health report: Making a difference*. Geneva, Switzerland: World Health Organization.
- World Health Organization (2002). *Stop violence against women*. Geneva: World Alliance of YMCA.
- World Health Organization (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes, and women's responses*. Switzerland: World Health Organization Publications.
- World Health Organization (2006). *National report on violence and health Malaysia*. Kobe, Japan: WHO Kobe Center.
- World Health Organization (2012). *Understanding and addressing violence against women*. Retrieved from [www.paho.org](http://www.paho.org).

- World Health Organization (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Switzerland: World Health Organization Publications.
- Wright, E. M., & Benson, M. L. (2010). Immigration and intimate partner violence: Exploring the immigrant paradox. *Social Problems*, 57(3), 480-503.
- Yeung, H., Chowdhury, N., Maplass, A., & Feder, G. S. (2012). Responding to domestic violence in general practice: A qualitative study on perceptions and experiences. *International Journal of Family Violence*, 1-7. doi: 10.1155/2012/960523.
- Yick, A. G. (2007). Role of culture and context: Ethical issues in research with Asian Americans and immigrants in intimate violence. *Journal of Family Violence*, 22(5), 277-285. doi: 10.1007/s10896-007-9079-x.
- Yoshihama, M. (2002). The definitional process of domestic violence in Japan: Generating official response through action-oriented research and international advocacy. *Violence Against Women*, 7, 339-366. doi: 10.1177/10778010222183099.
- Yoshihama, M., Bybee, D., Dabby, C., & Blazeovski, J. (2010). *Lifecourse experiences of intimate partner violence and help-seeking among Filipina, Indian, and Pakistani women: Implications for justice system response [Report]*. National Institute of Justice.
- Yoshikawa, K., Shakya, T. M., Poudel, K. C., & Jimba, M. (2014). Acceptance of wife beating and its association with physical violence towards women in Nepal: A cross-sectional study using couple's data. *Plos One*, 9(4), 1-10. doi: 10.1371/journal.pone.0095829.

- Yoshioka, M. R., & Choi, D. Y. (2005). Culture and interpersonal violence research paradigm shift to create a full continuum of domestic violence services. *Journal of Interpersonal Violence, 20*(4), 513-519. doi: 10.1177/0886260504267758
- Yoshioka, M. R., DiNoia, J., & Ullah, K. (2002). Immigrants-in-context framework: Understanding the interactive influence of socio-cultural contexts. *Evaluation Program Planning, 24*(3), 307-318. doi:10.1016/S0149-7189(01)00021-0
- Yusoff, R. C. S., (2010). The cultural and legal perspectives on wife battering in Malaysia. *The Law Review, 613-622*.
- Zeitler, M. S., Paine, A. D., Bretbart, V., Rickert, V. I., Olson, C., Stevens, L., Rottenberg, L., & Davidson, L. L. (2006). Attitudes about intimate partner violence screening among an ethnically diverse sample of young women. *Journal of Adolescent Health, 39*(1), 119.e1-8. doi:10.1016/j.jadohealth.2005.09.004.
- Zamorski, M. A., & Wiens-Kinkaid, M. E. (2013). Cross-sectional prevalence survey of intimate partner violence perpetration and victimization in Canadian military personnel. *BMC Public Health, 13*(1019), 1-18. doi: 10.1186/1471-2458-13-1019.
- Zimmerman, C. (1994). *Plates in a basket will rattle: Domestic violence in Cambodia*. Phnom Phenh, Cambodia: Asia Foundation/USAID.

**Appendix A**  
**Descriptive Data Questionnaire (For Research Team)**

Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_

Please list your educational background.

Please list your professional background in the counseling field, including licenses and certifications.

Number of years you have provided services to client in general.

Please briefly elaborate your research interests.

Please share your perspectives on IPV and thoughts about your role (if any) in addressing IPV.

Thank you for your participation!

## Appendix B

### IRB Approved Letter



#### OFFICE OF THE VICE PRESIDENT FOR RESEARCH

**Physical Address**  
 4111 Monarch Way, Suite 200  
 Norfolk, Virginia 23508  
**Mailing Address**  
 Office of Research  
 Old Dominion University  
 Norfolk, Virginia 23529  
 Phone (757) 683-3460  
 Fax (757) 683-5902

**DATE:** March 5, 2015

**TO:** Danica Hays

**FROM:** Old Dominion University Education Human Subjects Review Committee

**PROJECT TITLE:** [722307-1] An exploration of health providers' responses to intimate partner violence (IPV) survivors in Malaysia

**REFERENCE #:**

**SUBMISSION TYPE:** New Project

**ACTION:** DETERMINATION OF EXEMPT STATUS

**DECISION DATE:** March 3, 2015

**REVIEW CATEGORY:** Exemption category # 6.2 & 6.4

Thank you for your submission of New Project materials for this project. The Old Dominion University Education Human Subjects Review Committee has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact Ed Gomez at 757-683-6309 or [egomez@odu.edu](mailto:egomez@odu.edu). Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Old Dominion University Education Human Subjects Review Committee's records.

## **Appendix C**

### **INFORMED CONSENT FORM**

#### **PROJECT TITLE**

An Exploration of health providers' responses to Intimate Partner Violence (IPV) Survivors in Malaysia.

#### **INTRODUCTION**

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participate in this research, and to record the consent of those who say YES. Individual interviews will be conducted via Skype or other video conference software depending on your preference.

#### **RESEARCHERS**

Danica Hays, PhD, LPC, NCC (Research Supervisor)  
Darden College of Education, Department of Counseling and Human Services

Kee Pau, M.Ed., NCC (Primary Researcher)  
Darden College of Education, Department of Counseling and Human Services

Jamie Bower, M. Phil. Ed., M. S. Ed. (Research Team Member)  
Doctoral Student in the Darden College of Education, Department of Counseling and Human Services

Eric Brown, M.Ed., M. Div., Eds. (Research Team Member)  
Doctoral Student in the Darden College of Education, Department of Counseling and Human Services

Katherine Shirley, PhD, NCC (Research Team Member)  
Doctoral Graduate from the Darden College of Education, Department of Counseling and Human Services

Hsin-Ya Tang, PhD, NCC (Independent Auditor)  
Assistant Professor in the Counseling and Psychology Department, Louisiana State University

#### **DESCRIPTION OF RESEARCH STUDY**

Several studies have been conducted looking into the subject of intimate partner violence (IPV), but there is a paucity of research has been done in the area of health providers' responses to IPV survivors in Malaysia. Most of these studies have primarily focused on the One-Stop Crisis Center (OCCS) that has been implemented in emergency departments in Malaysia since 1994. Limited studies have explored health providers' competency in respect of their knowledge, attitudes, and responses to IPV survivors. Furthermore, those studies that do take into account health providers' views and attitudes on IPV make the assumption that health care system and the integration of the OCCS

were the challenges for health providers to provide quality services to IPV survivors. This study does not make this assumption, but integrates the participants' perspectives in researchers' ways of understanding the phenomenon, the participants, and the contexts. Therefore, this study proposes to explore Malaysian health providers' views on IPV, risk factors for Malaysian women, factors that influence the way they work with IPV survivors, factors that they perceive influencing Malaysian IPV survivors' help-seeking behaviors, as well as their recommendations to improve training to work with IPV survivors in Malaysia.

If you decide to participate, then you will join a study involving research of your views on IPV, risk factors for Malaysian women, and reflect back on factors that influence the way you work with IPV survivors and factors that you perceive toward influencing IPV survivors' help-seeking behaviors, and your recommendations to improve training to work with IPV survivors. If you say YES, you will to participate in an individual interview of roughly 30 minutes to 40 minutes in duration that will be recorded. This interview will be conducted via Skype or other video conference software depending on your preference. You may be asked to review your responses later to ensure the researcher understands your perspectives correctly. All videotapes will be destroyed after verification of the transcripts.

### **POTENTIAL RISKS OF DISCOMFORT AND BENEFITS**

Due to the nature of this study, there are no identifiable risks to participants. All aspects of participation are voluntary and you, as a participant, can choose to conclude the interview at any point. The researcher will strive to protect your records so that your identifying information will remain private and we commit to high standards of confidentiality. The possible benefits to you for participating in this study include increasing your awareness regarding IPV and the outcomes of the study may give you a guideline to work with IPV survivors.

### **CONFIDENTIALITY**

The information/data you provide for this research will be treated confidentially, and all raw data will be kept in a secured file by the researcher. Results of the research will be reported as aggregate summary data only, and no individually identifiable information will be presented unless explicit permission is given to do so.

### **VOLUNTARY PARTICIPATION**

Your participation in this study is voluntary. You have the right to withdraw from the study at any time. Throughout the interviews, you have the right to answer or not answer any questions. Even if you decide to participate and withdraw later, any comments you made will not be used in the study and will be destroyed. You also have the right to review the results of the research if you wish to do so. A copy of the results may be obtained by contacting the researcher.

**PARTICIPANT CONSENT**

I, (print full name) \_\_\_\_\_, have read and understand the foregoing information explaining the purpose of this research and my rights and responsibilities as a subject. My signature below designates my consent to participate in this research, according to the terms and conditions listed above.

Signature \_\_\_\_\_

Date \_\_\_\_\_

I, (print full name) \_\_\_\_\_, give the researcher permission to use, publish, and republish, in the context of this research audio reproductions of my voice made for this study.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Thank you for your participation!

Sincerely,  
Kee Pau, M.Ed., NCC  
Ph.D Candidacy and Graduate Teaching Assistant  
Department of Counseling and Human Services  
Old Dominion University  
[kxpau001@odu.edu](mailto:kxpau001@odu.edu)

## Appendix D

### Descriptive Data Questionnaire (For Participant)

Please complete this demographic questionnaire. The information you provide below will be kept strictly confidential and will be used only for interview selection purposes as well as to understand and describe research findings in context. Thank you.

Fill in the blank or circle the appropriate responses.

1. Suggested pseudonym: \_\_\_\_\_
2. Gender:    Female                      Male                      Transgender
3. Age: \_\_\_\_\_
4. Please identify your ethnicity: \_\_\_\_\_
5. Religion/Spiritual Affiliation: \_\_\_\_\_
6. Highest Degree Completed: \_\_\_\_\_
7. Relationship Status:      Married              Divorced              Widowed              Separated  
    Partnered              Never Married  
    Other, please specify \_\_\_\_\_
8. Work setting:      General Hospital  
    Social Welfare Department  
    Non-governmental Organization (NGO)  
    Other, please specify \_\_\_\_\_
9. State/Region: \_\_\_\_\_
10. Number of years of work experience in current position: \_\_\_\_\_
11. Total number of years in health settings in general: \_\_\_\_\_
12. Percentage of your clients who have experienced intimate partner violence:  
       \_\_\_\_\_

## Versi Bahasa Malaysia (Malay Version)

### Soal Selidik Latar Belakang Responden

Sila lengkapkan soal selidik ini. Maklumat yang anda berikan berikut akan dirahsiakan dan hanya digunakan untuk tujuan penyelidikan.

Isikan tempat kosong atau bulatkan jawapan yang sesuai.

1. Nama samaran: \_\_\_\_\_
2. Jantina: Perempuan      Lelaki      Lain-lain (sila nyatakan) \_\_\_\_\_
3. Umur: \_\_\_\_\_
4. Bangsa : \_\_\_\_\_
5. Agama/Kepercayaan: \_\_\_\_\_
6. Kelulusan Ijazah Tertinggi: \_\_\_\_\_
7. Status Hubungan:      Sudah berkahwin      Berceraai      Duda      Berpisah  
                                  Dalam hubungan      Tidak pernah berkahwin  
                                  Lain-lain (sila nyatakan): \_\_\_\_\_
8. Tempat kerja:      Hospital Kerajaan  
                                  Jabatan Kebajikan Sosial  
                                  Pertubuhan Bukan Kerajaan (NGO)  
                                  Lain-lain (sila nyatakan): \_\_\_\_\_
9. Negeri: \_\_\_\_\_
10. Pengalaman kerja dalam jawatan sekarang: \_\_\_\_\_
11. Jumlah pengalaman kerja dalam sektor kesihatan secara umum: \_\_\_\_\_
12. Anggaran peratusan klien yang pernah mengalami keganasan pasangan intim:  
                                  \_\_\_\_\_

Sekian terima kasih atas penyertaan anda!

## **Appendix E**

### **Interview Questions**

1. What are your perceptions of how women and men are treated in Malaysia?  
Probe: Could you please explain more about it?
2. Could you please describe what training, if any, you have had for working with IPV survivors?  
Probe: When did you receive that training? What were the components?
3. How would you define IPV?
4. What, if anything, have been your professional experiences with IPV survivors?  
Probe: Please give an example.
5. What, if at all, do you see your role as a health provider in treating IPV?  
Probe: Role in assessing IPV? Preventing IPV?
6. If a woman comes to your department to seek treatment, what steps or procedures, if any, do you take to determine whether she is currently dealing with IPV and/or she has an IPV history?  
Probe: Please give me a specific example on what you should do and what you should not do.
7. How would you determine the presence and history of IPV for a man who seeks treatment?  
Probe: Please give a specific example on what you should do and what you should not do.
8. What methods or interventions, if any, do you use to treat female IPV survivors?
9. What methods or interventions, if any, do you use to treat male IPV survivors?
10. To what degree are these methods or interventions similar to the way you work with other clients? Or are they different?
11. What, if any, resources do you perceive for IPV survivors who seek help from others?
12. How, if at all, do you communicate resources to IPV survivors?
13. What, if any, barriers do you perceive for IPV survivors who seek help from others?
14. What, if any, factors influence your ability to respond adequately to the needs of IPV survivors?

Probe: Please give a specific example for those [internal/external] factors that you have mentioned [that positively/negatively] influence how you are able to respond.

15. What personal factors, if any, influence the way you identify and/or treat IPV survivors?
16. If I were to create a training program for health providers in Malaysia to work with IPV survivors, what would you recommend be included in the training program?
17. Any additional thoughts regarding working with IPV survivors you would like to share with me?

Thank you! [End session]

## **Versi Bahasa Malaysia (Malay Version)**

### **Soalan Temu Bual**

1. Apakah persepsi anda terhadap bagaimana wanita dan lelaki dilayan di Malaysia?  
Soalan susulan: Sila terangkan secara terperinci pendapat anda.
2. Sila terangkan latihan yang pernah anda terima untuk membantu mangsa-mangsa keganasan pasangan intim?  
Soalan susulan: Bila anda menerima latihan tersebut? Apakah komponen latihan tersebut?
3. Apakah definisi anda bagi keganasan pasangan intim?
4. Apakah pengalaman profesional anda dalam membantu mangsa-mangsa keganasan pasangan intim?  
Soalan susulan: Sila berikan saya satu contoh.
5. Bagaimana anda melihat peranan anda sebagai kakitangan kesihatan dalam menangani keganasan pasangan intim?  
Soalan susulan: Peranan anda dalam mengenalpasti keganasan pasangan intim? Mencegah keganasan pasangan intim?
6. Sekiranya terdapat seorang wanita datang ke unit kecemasan dan trauma atau agensi anda untuk mendapatkan rawatan, bagaimana anda mengenalpasti wanita tersebut, sama ada dia sedang mengalami keganasan pasangan intim dan/atau mempunyai pengalaman lepas berkaitan keganasan pasangan intim?  
Soalan susulan: Sila berikan satu contoh yang khusus tentang apa yang anda lakukan dan apa yang tidak sepatut anda lakukan.
7. Bagaimana anda mengenalpasti pengalaman semasa dan pengalaman lepas keganasan pasangan intim yang dialami oleh seorang lelaki yang mendapatkan rawatan daripada anda?  
Soalan susulan: Sila berikan satu contoh yang khusus tentang apa yang anda lakukan dan apa yang tidak sepatut anda lakukan.
8. Apakah kaedah atau intervensi yang anda gunakan untuk merawat mangsa-mangsa wanita yang mengalami keganasan pasangan intim?
9. Apakah kaedah atau intervensi yang anda gunakan untuk merawat mangsa-mangsa lelaki yang mengalami keganasan pasangan intim?
10. Apakah tahap kesamaan atau perbezaan berkaitan dengan kaedah atau intervensi yang anda gunakan untuk merawat klien lain?

11. Apakah sumber yang anda lihat untuk mangsa-mangsa keganasan pasangan intim mendapatkan bantuan daripada orang lain?
12. Bagaimana anda memberitahu mangsa-mangsa keganasan pasangan intim tentang sumber-sumber bantuan yang boleh mereka rujuk?
13. Apakah halangan yang anda lihat bagi mangsa-mangsa keganasan pasangan intim untuk mendapatkan bantuan daripada orang lain?
14. Apakah faktor yang mempengaruhi kemampuan anda untuk memberi respon kepada keperluan mangsa-mangsa keganasan pasangan intim?  
Soalan susulan: Sila berikan satu contoh yang spesifik bagi faktor-faktor (dalaman/luaran) yang anda kemukakan (telah mempengaruhi anda secara positif/negatif)
15. Apakah faktor peribadi yang mempengaruhi cara anda mengenalpasti dan/atau merawat mangsa-mangsa keganasan pasangan intim?
16. Jika saya ingin mereka satu program latihan untuk kakitangan kesihatan di Malaysia bagi membantu mangsa-mangsa keganasan pasangan intim, apakah cadangan yang anda akan berikan untuk program latihan ini?
17. Apakah pandangan lain yang anda ingin berkongsi dengan saya mengenai perkhidmatan kepada mangsa-mangsa keganasan pasangan intim?

Sekian, terima kasih. [Tamat temubual]

## Appendix F

### Final Codebook

Superordinate Themes	Themes	Sub-themes	Definition & Example
<b>Perceptions of Men and Women in general</b>	IPV Gender Stereotyping	Women as victims	<u>Definition:</u> Identifying women as victims in the abusive relationship. <u>Example:</u> PA05 & PA06 stated, “Women have greater potential to be victims than men.”
		Men as perpetrators	<u>Definition:</u> Refers to the notion that men commit the majority of violence acts against women. <u>Example:</u> PA02, PA08, PA09 & PA10 said, “male partners or husbands are the perpetrators in abusive relationship.”
		Denial of IPV male victims	<u>Definition:</u> Did not believe men could be a victim or IPV or no experience working with male survivors. <u>Example:</u> PA12 said, “I don’t know how it could happen – that is, men being abused.”
		Gender discrimination	<u>Definition:</u> Prejudice or discrimination based on a person’s sex or gender. <u>Example:</u> PA05 stated, “Men have more power than women in most aspects, because people view men can do better, and that men can become leaders.”
<b>Conceptualization of IPV</b>	Types of IPV	Physical abuse	<u>Definition:</u> the intentional use of physical force with potential for causing death, disability, injury or harm. <u>Example:</u> PA06 shared, “Many of the survivors have been beaten, hit, kicked, burnt with cigarettes, punched in the face, or abused with tools or weapons.”
		Sexual abuse	<u>Definition:</u> Includes molestation, forcing undesired sexual behavior by one person upon another. <u>Example:</u> PA03 stressed, “IPV involves sexual abuse, rape, and forced involvement in sex activity with other guys.”
		Emotional abuse	<u>Definition:</u> Involves trauma to the victims caused by acts, threats of acts, words, gestures, weapons, or coercive tactics. <u>Example:</u> PA14 stated, “Coercive tactics included threatens the other partner, hurts family members, or abuses the partner in any way that scares or harms him or her.”
	IPV outcomes	Mental health issues	<u>Definition:</u> Refer to those such as depression, stress, suicide, PTSD, nightmares, insomnia, and emotional instability. <u>Example:</u> PA16 said, “She was emotionally unstable and we thought she might need to see our psychiatrist or counselor.”
		Behavioral	<u>Definition:</u> Include the acts of the survivors

		outcomes	or perpetrators to end IPV situation. <u>Example:</u> PA02 disclosed, "The survivors might run away from home, or the worst is that they might kill their husbands."
	Types of relationships	Marital relationship	<u>Definition:</u> Refers to the relationship between wife and husband. <u>Example:</u> PA06 & PA07 emphasized, "IPV mostly involved husbands and wives."
		Partner relationship	<u>Definition:</u> Refers to any couples relationship, or cohabitation relationship between same-sex or heterosexual partners. <u>Example:</u> Utilized the term 'boyfriend or girlfriend' during the interviews.
		No prior relationship	<u>Definition:</u> No prior relationship with IPV. <u>Example:</u> PA06 said, "IPV also involves individuals who can be unknown to abusers, such as the survivors of being raped by someone unknown to them."
	Risk of IPV	History of abuse	<u>Definition:</u> Individual who had been abused or witnessed of abuse in the past. <u>Example:</u> PA09 stated, "She had past experience of being abused. Those experience might have occurred a long time back."
		Substance abuse	<u>Definition:</u> Refers to the harmful or hazardous use of psychoactive substances, including alcohol and drugs. <u>Example:</u> PA07 described, "The husband will demand his wife to hand over her earnings to him, and he seems to have the right to squander all of the money and waste it all for other women, alcohol, and drugs."
Training	Short-term training	Experiencing in vivo training scenario	<u>Definition:</u> A practical and work experience training that involved practice while watching video or live demonstration. <u>Example:</u> PA01 said, "We had a live session counseling during training. The victim told us her experience of being abused. Then, a counselor demonstrated to us how to handle the victim."
		General counseling skills and interventions	<u>Definition:</u> Included basic helping skills such as listening, empathizing, paraphrasing, reflecting, and questioning. <u>Example:</u> PA10 stressed, "The training was general counseling skills training- such as listening, empathizing, and exploring client's stories."
		Comprehensive training program	<u>Definition:</u> Includes IPV or domestic violence specific program. <u>Example:</u> PA06 stated, "I also attended specific training on IPV or DV that specifically about what IPV is, what it looks like, what survivors' emotional states or reactions aftermath are."
	Inadequate	Non-specific IPV	<u>Definition:</u> Training content was not focused

<b>Institutional Factors</b>	training	training	on discussing IPV. <u>Example:</u> PA01 & PA03 said, "We don't have any specific training on IPV or DV."
		Centered on female survivors	<u>Definition:</u> Only provided services to female survivor. <u>Example:</u> PA11 & PA15 said, "Only provided shelter for women and children."
	Internal factors	The need to collaborate with other departments	<u>Definition:</u> Work collaboratively with other departments. <u>Example:</u> PA05 stated, "Through the department, the clients are referred to the Syariah Court if needed. This process usually takes several months or years to settle."
		Protocol in treating IPV survivors	<u>Definition:</u> a guideline or procedure to work with IPV survivors. <u>Example:</u> Several participants complained the protocol they used was overly complicated and not client friendly (PA04, PA07, PA12, PA13, PA14)
		Delaying responses to survivors	<u>Definition:</u> Did not respond to IPV survivors immediately. <u>Example:</u> PA15 stated, "The referral process is not easy. Sometimes it takes a long time to get permission or approval from both sides before transferring clients. Clients do not get immediate help from providers."
		Professional supports	<u>Definition:</u> Emotional supports or provide assistance to each other. <u>Example:</u> PA13 said, "The attitude of providers and administrators of the departments are not supportive or helpful in assisting me with helping survivors."
		Lack of Resources	<u>Definition:</u> Deficiency of shelter facilities and funding of an organization to maintain service to IPV survivors. <u>Example:</u> PA01, PA06, & PA15 informed, "We have shelter for survivors, but we don't have enough facilities to accommodate all survivors who come to seek help."
		Busy working environment	<u>Definition:</u> Having less time for each clients due to the busy schedule. <u>Example:</u> PA04 said, "A lot of time, I don't have enough time to fulfill all of the needs of the survivors, and I may not get enough information from them."
		Lack of supervision	<u>Definition:</u> Deficiency of monitoring from senior staff or expert. <u>Example:</u> PA15 said, "We don't have anyone to monitor or supervise us after training."
	External factors	Police department response	<u>Definition:</u> Respond from police officers <u>Example:</u> PA06 stated, "A lot of time when women report cases, they will be blamed by the police officer for not being able to remember what was happening to them or what tools the perpetrator used to hurt them."

		Abide by religious principles	<p><b>Definition:</b> Health providers' obligation to follow the religious principles.</p> <p><b>Example:</b> PA01 &amp; PA03 said, "For the Muslim survivors, we need to refer them to the religious bodies because they have different approaches in handling the Muslim survivors compared to non-Muslims."</p>
<b>Providers Personal Factors</b>	Work Performance	Lack of competence	<p><b>Definition:</b> Includes lack of knowledge, skills, and awareness of serving IPV survivors.</p> <p><b>Example:</b> PA16 indicated, "I basically focus more on medical models. Due to the fact I only conduct screening processes and referral processes, I don't need specific interventions to handle the clients."</p>
		Lack of self-efficacy	<p><b>Definition:</b> Health providers' belief in their capacity or ability to handle IPV cases.</p> <p><b>Example:</b> PA13 stated, "I think my feeling unprepared to handle survivors reduced my confidence in serving them."</p>
		Resistance to Professional Roles	<p><b>Definition:</b> Include lack of interest, lack of motivation, perceived IPV as social workers' job, refused to work beyond the job responsibility.</p> <p><b>Example:</b> PA09 &amp; PA10 said, "I need to refer them if their needs are beyond my ability to handle. I should not provide services out of my services scopes."</p>
		Victim blaming	<p><b>Definition:</b> Putting responsibility on victims to avoid or trigger IPV; blaming them for not reporting.</p> <p><b>Example:</b> PA09 said, "The survivors will only report to the police if things get worse. Because of this mentality, women may get hurt, and they may not be able to resolve the problem."</p>
	Self-experience and assumptions	Personal experience of being abused	<p><b>Definition:</b> Having experience of being abused.</p> <p><b>Example:</b> PA01 stated, "He beat me for a couple times within a 6-month period. However, it did not impact my professional work."</p>
		Differences in self-values and beliefs	<p><b>Definition:</b> Having self-values and beliefs that are different from survivors.</p> <p><b>Example:</b> PA05 said, "They want to divorce with their partners, this will make me feel disappointed because I cannot fulfill the needs of my clients. I should try my best to persuade the client to find the best solution for the problem."</p>
		Emotional reactions	<p><b>Definition:</b> Any feelings or emotional evoke when working with IPV survivors.</p> <p><b>Example:</b> PA11 said, "I felt uncomfortable to talk with someone older than me."</p>

<b>Sociocultural Factors</b>	Cultural values	Traditional Gender Roles	<p><b>Definition:</b> A set of societal norms determining how males and females should behave.</p> <p><b>Example:</b> PA15 stated, “We are very particular about men’s and women’s roles in the family. Men should provide food and income to their families.”</p>
		Religious values	<p><b>Definition:</b> Refer to ethical principles grounded in religious traditions, text, and beliefs.</p> <p><b>Example:</b> PA16 stated, “Religious values of obeying husband could be a barrier for the survivors to seek help.”</p>
		Accept IPV as normal	<p><b>Definition:</b> The society and cultural norms have accepted IPV as normal phenomenon.</p> <p><b>Example:</b> PA17 stated, “No relatives or friends may be willing to let them stay in their houses as they perceive IPV as normal family problems and think the women should be settle the family problems and not tell others.”</p>
		Collectivism	<p><b>Definition:</b> Refers to the subjection of the individual to a group, such as focuses on family orientation or community orientation.</p> <p><b>Example:</b> PA03 said, “Many survivors feel embarrassed if other people knew about their family issues, and their family reputation might be affected, especially for women.”</p>
		Education background	<p><b>Definition:</b> Refers to level of education that completed by an individual.</p> <p><b>Example:</b> PA17 said, “Many of them don’t have high education, and they afraid that, after they leave the relationship, they can’t support themselves.”</p>
		Socioeconomic status	<p><b>Definition:</b> Refers to social class and economic background of an individual or family.</p> <p><b>Example:</b> PA02 stated, “They are very poor and have no money. If they go to tell people, their husbands will not give them money.”</p>
	Lack of Legal Awareness	Women Acts and Women Rights	<p><b>Definition:</b> Refers to unmindful of the survivors toward women acts and women.</p> <p><b>Example:</b> PA11 said, “They don’t know their rights or that an IPO can protect them.”</p>
		Child custody	<p><b>Definition:</b> Refers to guardianship or a parent right to have a child live with him or her.</p> <p><b>Example:</b> PA06 stated, “Sometimes the perpetrators threatened the survivors with children and made them feel scared and so that they stay in the relationship.”</p>
<b>IPV Survivor’s Resistance</b>	Internal Factors	Fear of being judged	<p><b>Definition:</b> Refers to the survivors’ feelings of fear about other people’s opinions toward him or her.</p> <p><b>Example:</b> PA02 described, “Sometimes the victims will not tell because they are</p>

			ashamed of the situation, they are afraid.”
		Wanting to repair the relationship	<u>Definition:</u> Survivors’ desires to repair their relationship. <u>Example:</u> PA10 stated, “The survivors’ easily forgive had place them into a cycle of violence.”
	External Factors	Lack of trust	<u>Definition:</u> Related to the confidentiality and safety issues. <u>Example:</u> PA03 said, “Lack of trust with health providers can influence their [survivors] choices to seek help from us.”
		Lack of protection and support	<u>Definition:</u> Associated to health providers, police department, court, and media, as well as family members’ attitudes when assisting survivors. <u>Example:</u> PA06 & PA07: “The complicated reporting process has caused secondary harm to survivors.”
<b>Professional Responsibilities</b>	Acting as a first responder	Focus on external injuries (medical model)	<u>Definition:</u> Focused on external injuries <u>Example:</u> PA14 & PA16 said, “I provide external treatment and medical examinations for survivors.”
		High vigilance	<u>Definition:</u> Carefully noticing problems or signs of IPV. <u>Example:</u> PA14 & PA16: “We will further ask the patient to confirm our suspicious.”
	Protocol of Services	Screening	<u>Definition:</u> An initial step to address current or history of IPV. <u>Example:</u> PA09: “If, during the session, the client shared an abuse experience, I would ask her several questions.”
		Referral of clients to other departments	<u>Definition:</u> Get further assistance or treatment from expertise in other departments. <u>Example:</u> PA12 said, “A lot of time, if I can’t handle clients, I still need to refer them to other departments to get further help.”
		Involvement in legal processes	<u>Definition:</u> Involved in legal processes with IPV survivors. <u>Example:</u> PA11 said, “I assist the survivors by contacting with different agencies or police departments and assist police in the investigation process.”
	Treatment	Counseling Services	<u>Definition:</u> Exploring client’s presenting problems, teaching skills, infusing hope, listening to client’s needs, and guiding clients through steps of recovery. <u>Example:</u> PA06 stated, “I will make sure that she receives counseling services at the center and help her to walk out of the darkness.”
		Crisis Management	<u>Definition:</u> A process to handle critical and urgent cases that bring by the survivors. <u>Example:</u> PA09, PA10, PA11, & PA12 reported, “I also discussed a safety plan with the client to prepare for it if the situation

	Prevention		were to get worse.”
		Provide psychoeducation to public	<u>Definition:</u> Provide IPV information and psycho-education to public. <u>Example:</u> PA17 said, “We provide psychoeducation to public and set up a violence against women counter, banner, and flyers through media to educate people that IPV is a crime.”
		No direct involvement in prevention	<u>Definition:</u> No involvement in prevention. <u>Example:</u> PA16: “I work in the emergency room and at OSCC, and I don’t think we have any prevention programs.”
	Being sensitive	Considering multiculturalism	<u>Definition:</u> Aware about multiculturalism issues. <u>Example:</u> PA07 said, “One thing that we should not do is be judgmental. We should not be too pushy in trying to impose our own views on patients.”
		Empowering clients in decision making	<u>Definition:</u> To give the clients power to make their own decisions. <u>Example:</u> PA12 stated, “We should not make any decisions for survivors. We can provide information to assist them to make their decisions.”
		Respecting patient’s privacy	<u>Definition:</u> Includes keep confidentiality, create a safe environment, establish professional relationship, and being respectful. <u>Example:</u> PA13, PA14, PA16 shared, “We take her to a private room for screening, where a record is made, and she is examined closely, particularly if she has filed a police report.”
<b>Recommendations for Improving IPV Training and Services</b>	Personal Changes	Communication skills	<u>Definition:</u> Include interpersonal skills. <u>Example:</u> PA09 stated, “It would so need to teach health providers how to communicate with survivors about the prevention of IPV, and how clients can protect themselves from being abused again.”
		Awareness of professionalism	<u>Definition:</u> Aware about professional roles and responsibilities. <u>Example:</u> PA06 & PA07 expressed, “All parties involved in helping IPV survivors should know their responsibilities and aware about personal job scopes in serving the survivors.”
		Continuing education	<u>Definition:</u> Consists of short or part-time courses. <u>Example:</u> PA11 said, “The available of the training and the providers’ continuing upgrade themselves through various training programs were be more helpful for the survivors.”
		Self-awareness	<u>Definition:</u> The ability of health providers to recognize oneself strengths, weaknesses,

			<p>thoughts, beliefs, motivations, and the dynamic between provider-client relationship.</p> <p><u>Example:</u> PA06 shared, “We have our own emotional involvement in the client’s case, and we should be aware about it and walk away to take a break before we come back to continue our work.”</p>
	Institutional Changes	Practical protocol or guidelines for treating IPV survivors	<p><u>Definition:</u> A set of protocol or guidelines for treating IPV need to be provided.</p> <p><u>Example:</u> PA01 said, “The basis protocol to handle the clients’ cases is important.”</p>
		Better referral sources	<p><u>Definition:</u> A list of available resources is needed.</p> <p><u>Example:</u> PA03, PA10, &amp; PA12 said, “The training should provide a right referral resources for providers in order to help them to communicate with survivors about what other resources are available for them.”</p>
		Support team	<p><u>Definition:</u> A group providers who work together as a team to serve IPV survivors.</p> <p><u>Example:</u> PA14 stressed, “The training should include each agency or department’s role in serving the survivors, as well as infuse a sense of responsibilities on them.”</p>
		Inter-agency Collaboration	<p><u>Definition:</u> Refers to the collaboration between agencies or departments for the purpose to provide better service for IPV survivors.</p> <p><u>Example:</u> PA15 stated, “All of us need to know what we need to do and who we should contact when we have clients who need to be referred out.”</p>
		Provide supervision	<p><u>Definition:</u> To review or monitor of IPV works by senior staff or expert of the field.</p> <p><u>Example:</u> PA11 stated, “I think that I would recommend that the training program includes supervision training, since we need that to monitor our skills and interventions in treating survivors.”</p>
	Societal Changes	Psychoeducation for the survivors	<p><u>Definition:</u> Psychoeducation for the survivors.</p> <p><u>Example:</u> PA02 suggested, “Educate survivors on the need to tell us and let them know it is violence if their husbands beat them.”</p>
		Legal knowledge	<p><u>Definition:</u> Includes Domestic Violence Act, laws, and women rights in term of IPV.</p> <p><u>Example:</u> PA14 said, “Training program should focus on public by educating society about IPV is crime and the appropriate steps they should take to protect themselves.”</p>
		Increase public awareness on IPV	<p><u>Definition:</u> Enhance public awareness about IPV.</p> <p><u>Example:</u> PA01 recommended, “We can</p>

			offer outreach program and some classes to educate public about IPV, domestic violence, and children abuse. We also can provide them the available resources they can use to seek help."
--	--	--	--

## VITA

Kee Pau, earned her Bachelor of Education degree in Guidance and Counseling from Sultan Idris University of Education in 2007. She began her career in counseling as a secondary school counselor. In 2008, she joined the Department of Psychology and Counseling at Sultan Idris Education University, Malaysia as a faculty member while also working on a Master's degree in Counseling at Universiti Sains Malaysia. She completed her master's degree in 2011. She also worked as a volunteer practitioner in several clinical settings to gain more experiences before pursuing her doctoral degree.

She began her doctoral work at Old Dominion University (ODU) in 2012 with the aim of becoming mental health practitioner and professional counselor educator. During her time at ODU, Ms. Pau awarded with three years graduate assistantship and she worked as a teaching assistant, instructor, research assistant, program evaluation assistant, and doctoral supervisor in the Counseling and Human Services Department. She also gained her clinical skills through practicum and internship.

Ms. Pau is currently a National Certified Counselor in the United States and Licensed Professional Counselor in Malaysia. She is a member of American Counseling Association, American Mental Health Counseling Association, Association of Virginia Counseling Association, Association of Virginia Counselor Education and Supervision, and the Chi Sigma Iota. She has presented at local, state, region, national, and international conferences on topics such as personality traits, perfectionism, self-concept, supervision, international student self-advocacy, and multicultural issues in counseling. Her multi-languages ability helps her have the privilege to interact with different clients from various backgrounds who are both local and international clients.