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

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ABSTRACT

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

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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

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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 (Craigen, 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