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Intimate Partner Violence

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BACKGROUND

DEFINITION

Intimate Partner Violence (IPV) is defined as any behaviour within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship by the World Health Organization (WHO).[1] Domestic violence, on the other hand, is a general term that is frequently used interchangeably with IPV although the term domestic violence refers to any type of abuse done onto any member of the household regardless of age or gender.[1]

TYPES OF ABUSE

Specific to IPV, the type of abuse inflicted to the victims can be described as physical, sexual, and emotional abuse. In Malaysia, the Domestic Violence Act (Amended) 2017 also protects against social and financial abuse.[2] The act defines domestic violence as the commission of one or more of the following acts:

1. Wilfully or knowingly placing, or attempting to place, the victim in fear of physical injury;
2. Causing physical injury to the victim by such act which is known or ought to have been known would result in physical injury;
3. Compelling the victim by force or threat to engage in any conduct or act, sexual or otherwise, from which the victim has a right to abstain;
4. Confining or detaining the victim against the victim's will;
5. Causing mischief or destruction or damage to a property with intent to cause or knowing that it is likely to cause distress or annoyance to the victim;
6. Causing psychological abuse which includes emotional injury to the victim;
7. Causing the victim to suffer delusions by using any intoxicating substance or any other substance without the victim's consent or if the consent is given, the consent was unlawfully obtained.

PREVALENCE OF IPV

WHO in 2017 reported that 1 in 3 women have experienced some form of violence, either physical and/or sexual by an intimate partner.[3] The prevalence was highest in the South East Asia region, with 37.7% of women in this region reported to have experienced IPV in their lifetime.[3] This was followed by women in the Eastern Mediterranean region at a prevalence of 37%.[3,4] In the United States of America, the number was similar; 1 in 4 women and 1 in 10 men have experienced some form of IPV during their lifetime.[5]

In Malaysia, a nationwide household survey done in 2013 by Shuib R. et.al. reported that 8% of women in Peninsular Malaysia had experienced some form of violence in their lifetime.[6,7] Othman S. et.al. in 2019 reported that 22% of the 882 surveyed in six public primary healthcare clinics in Kuala Lumpur had experienced IPV in the past 12 months prior to the study. The study reported that the numbers are four times higher than a similar study done in 2008.[8] These findings concurred with the statistics reported by Women's Aid Organisation (WAO) in which the trend of domestic violence has increased steadily from 2010 to 2016.[9]

There is paucity of data amongst the LGBTQI+ community especially in the Malaysian setting. The prevalence is reported to be equal, if not higher amongst the community. More than 60% of bisexual women, and 50% of lesbian women have experienced IPV. It was also reported that

35% of bisexual men, and 26% of homosexual men have experienced IPV throughout their lifetime.[10] Therefore, IPV affects people across various gender and sexuality.

Cycle of Abuse

With the high prevalence of IPV, there are a variety of factors that contribute to this situation in which some are the lack of alternative means of financial support, fear of retaliation by the perpetrator, lack of family support, embarrassment, and the victim's fear of stigma from those around them.[1] First described by Lenore Edna Walker, the cycle of abuse has four phases — the tension building phase, the incident, the reconciliation and the calm phase or the honeymoon phase.[7, 11]

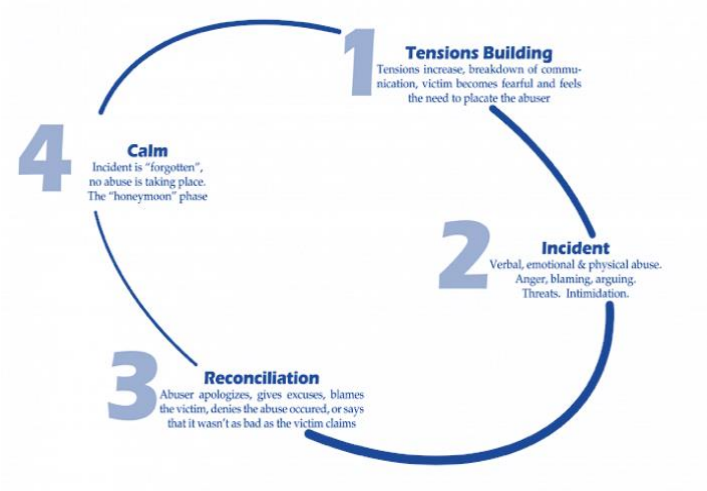

Figure 1. Cycle of Abuse faced by IPV victim. [7]

In the tension building phase, the victims are constantly on edge as the tension builds in their relationship with the perpetrator. The behaviour of the abuser may intensify during this phase and would result in an explosion as a means of releasing the tension.

After a period of time, this would bring the cycle into the incident phase. In this phase, the victim will be at the peak of the abuse following the abuser's outburst.[12] There may be intimidation and arguments between the two leading to injuries and harm being inflicted to the victim during the violence.[11,12]

Following the outburst, the abuser would enter the reconciliation phase in an effort to obtain forgiveness from the victim through their portrayal of affection.[12] The abuser might also deny the incident, guilt-tripping, or manipulate the victim to think that the incident was in fact justifiable and over-exagerrated.[11] They often promise the victim that the incident will never happen again. Some will go the extra length of lavishing the victim with gifts to convince them that the promise made was taken seriously.[12]

Eventually, the victim and the abuser would be in the calm of "honeymoon" phase in which both in the relationship would deny the severity of the situation and may not acknowledge the possibility of the violence recurring as they both feel happy in this phase.[11,12] The cycle of abuse will repeat again when the abuser is triggered.

Consequences of IPV

There are many short- and long-lasting consequences of IPV. Physical violence causes bodily injuries such as bruises, lacerations, fractures and visceral damage.[1] In addition, the psychological well-being and mental health of IPV victims are also affected. They are more likely to experience depression, anxiety, have suicidal ideation, and attempt at suicide.[12] In a small scale study done with over 100 victims of IPV, it was found that more than half of these women were suffering from depression or post-traumatic stress disorder following their experience, with 45% of these women suffering from both the disorders.[13] There is however a paucity of data on the effect of IPV on the

victim's mental health in the Malaysian setting, thus indicating an area that would require further research.

An increased risk of substance abuse among those who had been physically abused by their partners had also been reported.[1, 14] In a study done in 2012, it was found that 6% of IPV victims had abused substances and another 6% of these victims are dependent on a substance. Among these victims, all of them had abused cannabis, 50% of them abused opioids, followed by hallucinogens amongst 33% of them, and some on sedatives.[13]

Rape in marriage is also an issue with IPV, resulting in an increased number of unwanted pregnancy, unsafe abortions and other reproductive health consequences. In addition, practicing safe sex with the use of condoms and contraceptives would be difficult for these victims, especially with promiscuous abusers. Inevitably, the victim is at risk of contracting sexually transmitted infections such as the human immunodeficiency virus (HIV), syphilis, herpes and gonorrhoea.[1]

This has also extended to the socio-economic cost burden on the victim and the society. These victims may potentially lose their job due to the lack of productivity such as absenteeism, and tardiness to work as a result of IPV. In turn, this increases the employers burden secondary to increased administrative cost, doubling the workload of victim's colleagues to compensate for the lack of productivity.[14] Consequentially, IPV victims often neglect the care for themselves due to the effects of IPV on the victim's mental and physical health.[3,14]

ROLE OF HEALTHCARE PROFESSIONALS

Healthcare professionals are one of the primary contacts for victims. They play the most important role in addressing the issues of IPV with patients.[15,16]

General practitioners, obstetricians, gynaecologists, psychiatrists, psychologists, nurses and midwives are at the frontline to identify and manage IPV.[15] During consultations, patients with clinical signs that are suspicious of IPV should be further probed. Healthcare professionals in the private setting should provide ample time for the victim to discuss their experiences.[15,16]

A good rapport is essential to facilitate dialogue for healthcare professionals to risk assess and provide appropriate help. Qualities sought after by patients include a sensitive and attentive practitioner who is mindful of feelings of shame and guilt, and would be careful not to evoke a sense of intrusion in their private affairs.[15-17] Patients also prefer the discussion to be non-judgmental, supportive, encouraging and validating.[15]

The role of healthcare professionals is inevitably the first line of support to patients.[16] This can be achieved through guidance and awareness by helping patients to access important information and resources, which could be in the form of social welfare support or legal help. Practitioners should assist in increasing the safety for the patient and their children. Psychological interventions should also be arranged for those in need. If there is evidence of sexual abuse, emergency contraception or pre-exposure prophylaxis for STIs and HIV must be provided whenever necessary.[16,17]

Presently, unfortunately the role of doctors are only limited to the One Stop Crisis Centre in

every Malaysian hospitals. No current guidelines cease to exists in helping doctors or any healthcare professionals in private sector to aid IPV victims.

IPV In Medical Education

Training of healthcare professionals is a vital part of capacity building to ensure the sustainability of the healthcare system's response towards IPV. However, conventional IPV training programmes done are expensive and difficult to distribute across the country in addition to a need for a continued training to sustain and reinforce the knowledge.[17] As part of healthcare professionals' continuing professional development, training guarantees consistency and competency in managing victims of IPV.[17]

With the COVID-19 pandemic ushering us into the age of virtual education, IPV training can be delivered online with the intent of widespread distribution. Short et al. 2006 suggest that online IPV programmes are effective in improving physicians' knowledge, attitude, beliefs and behaviour when participants are motivated to complete it. The effects were also found to persist beyond 12 months.[18]

Researchers and most of the victims agree that IPV should be integrated into the curricula of health science and other relevant courses.[17,19] The educational strategy most helpful to victims is yet to be clear, but it is suggested that an interprofessional approach involving law enforcement agents, social workers, NGOs will best help expose students to the epidemiology of IPV and the healthcare response.[19]

Currently, issues regarding confidentiality is the most cited reason for excluding healthcare students from IPV training.[19] Training can be offered to senior medical students that are more experienced with sensitive information. Different health science courses should receive specialized training based on their professional responsibilities.[17]

Culture of Acceptance and Toxic Relationship

There are two broad theoretical approaches which may be able to explain the occurrences of IPV: feminist and social learning theories.[20] The feminist theory argues that IPV is directly connected to the patriarchal organisation of the society.[20-22] In many societies, cultures, and religions, traditional roles and socialization patterns implicitly or explicitly dictate gender roles in patrilineal systems of descent and inheritance that allowed male dominance and economical power in a household.[21,23] In some of these families and societies, it is deemed acceptable for a husband to demand sex and to discipline or beat his wife, if she challenges his manhood or insults him.[21,22,24,25] This is further enforced by the societal belief, and even at times, the couple themselves, that these violent acts towards women is a result of the women's behaviour.[24]

Furthermore, men are seen as breadwinners according to traditional gender roles.[21] In poverty where there is a lack of resources, some men would often feel that their masculinity is challenged, and thereby increases the chances of expressing their frustration towards women, especially in a family setting, including their children.[23] Additionally, this is augmented as we transgress from conservative gender roles, where women are gaining more power in the society. Dominance and violence towards women are deemed acceptable, or the social 'norm', as a form of resistance.[21-23]

Men are also vulnerable victims of IPV.[21,26] They are, according to traditional models, trained to suppress their fear and emotions, resulting in them being less likely to seek help. Even if they were to seek help, they would leave the services dissatisfied, feeling unsupported or dismissed.[21]

Experts believed that IPV is a learned social behaviour, hence the theory of Intergenerational Transmission of Violence.[20,21,23] A child who grows up in a family with violence is more likely to accept aggression during adulthood due to emotional dysregulation, of which are risk factors of IPV.[20,23,27] Concurrently, early experiences with violence is linked to Cluster B personality disorders such as antisocial, borderline, and narcissistic personality disorders. These personality disorders tend to have a higher threshold of violence acceptance, further increasing the risk of violence and of IPV.[20]

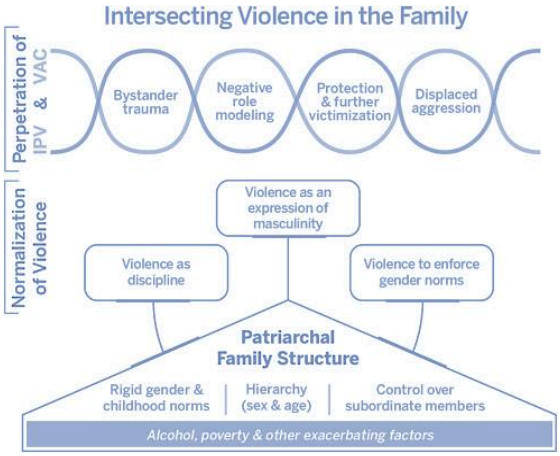

Figure 2. Causes of IPV. [22]

As these theories and researches explain IPV in heterosexual relationships, they are highly relevant in homosexual and pansexual relationships. In addition to traditional societal structures, homosexual or pansexual individuals often experienced additional stress factors, termed minority stress, resulting from stigma, prejudice, and discrimination towards them.[26,28] These factors inevitably create a hostile and stressful environment, which create potentially mental health problems, sometimes resulting in IPV victimisation or perpetration.[26,27] An example of these unique factors is outness stress, when a couple attempts to introduce themselves in the public eye. The lack of external support could potentially lead to IPV and the absence of role models could result in perpetuation of the relationship.[28] Another important factor is internalised homophobia, which has strong evidence of IPV victimisation and perpetration in LGBTQI+ community.[26,28,29] This could be explained with the exosystem factor theory and the psychoanalytic theories. Both theories explain the emotional depletion of resources culturally and during formative years, increasing the risk of IPV victimisation and perpetration.[29]

An important protective factor against IPV is female empowerment, which can be derived from a bountiful of sources such as education, income, and community roles.[23] Additionally, less adherence to traditional roles also acts as a protective factor.[21]

BARRIERS TO REPORTING

Despite the painful consequences, many persist in abusive relationships. Some of the stated reasons include their sympathy towards their children, lack of family and societal support, as well as financial dependence on the other partner.[25,30] In some traditional families, married daughters belong fully in their husbands' custody, and hence intervention from their immediate family members is not encouraged and it is often frowned upon. Additionally, these families often view divorce as a taboo. Hence, these daughters eventually learn to 'live with it' as they realised they would not be able to change the situation that they are in.[25]

Furthermore, the patriarchal organisation of the society also contributes to these long-lasting abusive relationships. Some women explained that they could not leave their husbands because of their financial dependency on them.[21,25,30] This is lastly worsen by the societal belief that violence towards an intimate partner is the norm.[3]

CURRENT AVAILABLE PROTOCOLS, SERVICES, AND SUPPORT SYSTEMS

Since the enactment of the Domestic Violence Act in 1996, OSCC was set up across all state hospitals in the country.[32,33] There were no national policies or guidelines addressing the framework and the implementation of the OSCC before 2015.[33] It was entirely hospital-dependent and they were dependent on multiple NGOs for counselling and support services.

In 2015, the Ministry of Health Malaysia established a policy and guideline for hospital management with regards to the functioning of the OSCC. In this guideline, the Ministry provides a framework on the roles and responsibilities of the hospital and the relevant personnel including the social welfare department and the medical social worker department. OSCC is utilized for documentation, examination and management of evidence which includes the collection, labelling and sealing of specimens from the survivor. The role of OSCC is holistic in that it is responsible to help survivors transition from crisis to rehabilitation.[34]

The responsibilities of the Medical Social Worker Department or Social Welfare Department are:

1. To arrange temporary safe shelter home and social support for the survivor
2. To arrange for an Interim Protection Order and Protection Order for the survivor if required.

Responsibilities of the hospital staffs:

1. Providing medical and psychological services.
2. Assist the survivor in referring to the relevant departments including the Medical Social Worker Department or Social Welfare Department, relevant clinical specialties.
3. Assist in lodging a police report.

Box 1. Responsibilities of the social welfare department and the hospital staff.[34]

OSCC is an integrated health sector model that provides comprehensive care not just to women, but also children and all adults who have been abused, neglected, raped or assaulted.[34] Its success is demonstrated by the replication of this model in several other countries in the South East Asia region.[35-37] In spite of this effort, a study in 2012 showed that IPV is ranked the least in priority and therefore OSCC services and IPV programmes have received very little attention and fewer resources compared to other medical issues. The neglect in dealing with IPV and OSCC in our healthcare system may in part be due to:[38]

1. Lack of leadership and commitment to monitor IPV which then translates to a lack of data and research;
2. Lack of clarity in the standard operational procedures for domestic violence cases in the OSCC;
3. Issue with understaffing and the lack of trained OSCC staff; and
4. Difficulty in reaching out to relevant support services (e.g NGOs) at district level facilities or secondary hospitals.

A report published by WAO has shown that the visibility of our support system including the aid that can be provided by the social welfare department and our OSCC remains low. WAO reports that 83% of women did not approach the social welfare department for assistance due to the lack of awareness of the roles they play.[39] The majority of services that are readily available for IPV are still nevertheless provided by NGOs, such as telephone hotlines, social worker, legal information and assistance, financial assistance, skills training and job placement. Major pitfalls to these services are the limited number of NGOs available and the low awareness of these support services amongst the public. WAO highlights that shelters are especially limited, primarily due to the lack of space, human resources and funding.[39, 40]

LEGISLATIONS AND ENFORCEMENT

In Malaysia, the Domestic Violence (Amendment) Act 2017 provides protection for spouses, ex-spouses, children, and family members (who in the opinion of the court is a family member). The act is also extended to protect de facto spouses, in which a couple is married through religious or customary ceremony but is yet to register the marriage with the government. For couples who have yet to progress to marriage, the act provides no such protection. Under this amended act, there are three orders which can be issued by the relevant authority to protect a victim of domestic violence.[2,41]

First is the Emergency Protection Order (EPO) which can be issued within two hours of the domestic violence by a Social Welfare Officer (SWO) upon receiving the report. It lasts for up to seven days thereafter which allows for the victim to lodge a police report. Contravention to this order in repetition will result in imprisonment of no less than 72 hours, and no more than two year, and/or fine of up to RM 5000.00. [41]

Second is the Interim Protection Order (IPO) which can be issued by the police when an action report I done by the victim. This prevents the perpetrator from continuing the domestic violence and inciting another party to do it. The IPO provides protection for the survivor to retrieve their own personal belongings while being accompanied by a police officer or a SWO. It only comes to an end when the victim is informed by the police that no further action will be taken for the report, or if criminal proceedings are instituted against the person of whom the order is made.[41]

Third is the Protection Order (PO) which can be issued by the Magistrate Court when the victim, or the victim's counsel has put in a request for its protection. This prevents the perpetrator from inciting another party to commit domestic violence against the victim. In addition, the court may grant an exclusive right for occupation of a shared property (between the perpetrator and survivor) to the survivor; continued usage of a vehicle which has previously been ordinarily used by the survivor; restraining order for the perpetrator; any personal contact with the survivor only with the presence of a designated person by the court. The PO is valid for up to a year and may be renewed for another year as long as the case is in court.[2,4]

POSITION STATEMENT

MMI BELIEVES THAT

1. Intimate Partner Violence (IPV) is a serious and pervasive health issue in Malaysia that is often overlooked.
2. Domestic Violence Act (Amended) 2017 is inadequate in its protection for victims of IPV which at present only recognises legally married couples.
3. There is paucity of quality training provided to medical students and young junior doctors to recognise and manage IPV victims.
4. The existing healthcare system is not optimally structured and funded to manage IPV victims with high dependency on non-governmental organisations (NGOs) for subsequent management.
5. The management of IPV requires a nationwide framework that constitutes a comprehensive multilateral collaboration between the law enforcers, healthcare providers, social welfare department, legal aid services, NGOs and other relevant stakeholders.

POLICY

MMI CALLS UPON THE PARLIAMENT OF MALAYSIA

1. To amend the Domestic Violence Act (Amended) 2017 to protect couples regardless of marital status across the spectrum of gender, sexuality, religion, and culture under the act.
2. To acknowledge and support the efforts of NGOs in aiding governmental agencies for the management, rehabilitation, and ongoing support of IPV victims and survivors.

MMI CALLS UPON THE CABINET OF MALAYSIA

1. To establish a joint effort between the Ministry of Health and Ministry of Women, Family and Community Development to set up a proper IPV support system and reduce their dependency on NGOs.

MMI CALLS UPON THE MINISTRY OF HEALTH

1. To improve the accessibility, reliability, and sustainability of services that manage IPV victims.
2. To strengthen their public health campaigns on raising awareness regarding available services for IPV victims to seek help.
3. To produce and distribute a clear guide for victims to seek help discreetly during crises.
4. To prioritise and divert more funds to the One Stop Crisis Centre (OSCC) for capacity-building, improving infrastructure, and training of staffs.
5. To introduce a standardised national training on IPV for healthcare workers, especially those working in OSCC.

6. To improve the transparency of OSCC and to conduct audits on the standards of practice on OSCC.
7. To establish a check-and-balance mechanism between the police, legal bodies, and support services to ensure the IPV victims are properly and carefully handled from the time of victim reporting to subsequent management.
8. To develop a guideline for community healthcare providers, such as general practitioners and pharmacists, to recognise and assist victims of IPV.
9. To facilitate and incentivize research on IPV subject matter at their healthcare facilities.
10. To facilitate the participation of medical students and junior doctors in OSCC sessions with the consent of the patient to train competent practitioners.
11. To provide medical students and junior doctors with sufficient support in dealing with IPV patients.

MMI CALLS UPON THE MALAYSIAN MEDICAL COUNCIL

1. To develop, mandate, and ensure implementation of a standardised national training for IPV across all medical schools in Malaysia.
2. To facilitate learning experience of students and junior doctors by collaborating with the Ministry of Health to allow for their participation in an OSCC session for the purpose of learning.

MMI CALLS UPON THE MINISTRY OF WOMEN, FAMILY AND COMMUNITY DEVELOPMENT

1. To strengthen their public health campaigns for IPV education in the community, especially to areas of higher poverty rates and areas with lower accessibility to education.
2. To expand the 'Hentikan Keganasan Terhadap Wanita' campaign to include males and all other members of the household as potential victims.
3. To urge the employment and training of grievance officers in workplaces in the management of IPV.

MMI CALLS UPON THE MINISTRY OF EDUCATION AND THE MINISTRY OF HIGHER EDUCATION

1. To implement a national curriculum in primary, secondary, and tertiary education to increase awareness of relationship violence and available services.
2. To provide training to all teachers and educational staff in all educational institutions to recognise the red flags of IPV and provide appropriate support.

MMI CALLS UPON ALL INSTITUTIONS, INCLUDING NGOS, CORPORATES, AND ALL GOVERNMENTAL BODIES

1. To implement policies that protect IPV victims (e.g. entitled leave, grievance help).
2. To provide education on IPV to all trainees and employees.

MMI CALLS UPON ALL MEDICAL STUDENTS AND JUNIOR DOCTORS

1. To be proactive in ongoing personal education on issues pertaining to IPV and violence in general.
2. To familiarise themselves with local hospital protocols on critical services and management of IPV patients.
3. To appreciate the available ongoing support for IPV victims (e.g. counselling, mental health services, legal and financial aids, and local shelter services).
4. To recognise that men, LGBTQI+, persons with disabilities, and the elderly are potential victims of IPV.

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POLICY GOVERNANCE

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