Victims' Barriers to Discussing Domestic Violence in Clinical Consultations: A Qualitative Enquiry
Sajaratulnisah Othman, Chris Goddard and Leon Piterman

*J Interpers Violence* 2014 29: 1497 originally published online 8 December 2013
DOI: 10.1177/0886260513507136

The online version of this article can be found at:
http://jiv.sagepub.com/content/29/8/1497

Published by:

[SAGE](http://www.sagepublications.com)

On behalf of:

American Professional Society on the Abuse of Children

Additional services and information for *Journal of Interpersonal Violence* can be found at:

Email Alerts: [http://jiv.sagepub.com/cgi/alerts](http://jiv.sagepub.com/cgi/alerts)

Subscriptions: [http://jiv.sagepub.com/subscriptions](http://jiv.sagepub.com/subscriptions)

Reprints: [http://www.sagepub.com/journalsReprints.nav](http://www.sagepub.com/journalsReprints.nav)

Permissions: [http://www.sagepub.com/journalsPermissions.nav](http://www.sagepub.com/journalsPermissions.nav)

Citations: [http://jiv.sagepub.com/content/29/8/1497.refs.html](http://jiv.sagepub.com/content/29/8/1497.refs.html)

>> Version of Record - Mar 25, 2014

OnlineFirst Version of Record - Dec 8, 2013

What is This?
Victims’ Barriers to Discussing Domestic Violence in Clinical Consultations: A Qualitative Enquiry

Sajaratulnisah Othman,¹ Chris Goddard,² and Leon Piterman²

Abstract
Victims of domestic violence frequently attend health care facilities. In many cases, their abusive experience is neither disclosed nor discussed during clinical consultations. This study examined the barriers faced by women when discussing abuse with health care providers, specifically in cases involving Malaysian women with a history of domestic violence. A qualitative study using in-depth interviews was conducted with 10 women with a history of domestic violence residing at a shelter. Purposive sampling was conducted until data saturation. Using the grounded theory approach of analysis, themes that emerged from these interviews were then further analyzed to examine the barriers faced by these women. Women who experienced domestic violence faced multiple barriers while discussing their accounts of abuse with others. Values placed on the privacy of domestic violence; upholding the traditional gender roles; preserving the family unity; minimizing the abuse, the feeling of shame, self-blame; and fearing their abuser generally create internal barriers when discussing their encounters of abuse with health care providers. The perceived unknown role of health care professionals when dealing with patients experiencing domestic violence as well as the previous

¹University of Malaya, Kuala Lumpur, Malaysia
²Monash University, Clayton, Victoria, Australia

Corresponding Author:
Sajaratulnisah Othman, Department of Primary Care Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, 50603, Malaysia.
Email: sajaratul@ummc.edu.my
negative experiences in clinical consultations acted as external barriers for discussing abuse with health care providers. Women with domestic violence experiences faced internal and external barriers to discussing their abuse during clinical consultations. Physicians and health care providers must consider domestic violence in consultations with female patients. A good doctor–patient relationship that encompasses empathy, confidence, trust, support, assurance, confidentiality, and guidance can help patients with abusive backgrounds overcome these barriers, leading to the disclosure and discussion of their abusive encounters. Proper education, guidelines, and support for health care providers are required to help them assist women with histories of domestic violence.

**Keywords**
domestic violence, cultural contexts, disclosure of domestic violence, support seeking, sexual assault

**Introduction**

Domestic violence, also known as intimate partner violence, is a major public health problem (World Health Organization, 1996). Women and children who experience domestic violence frequently visit health care facilities as a result of the medical implications of domestic violence (K. Hegarty, Hindmarsh, & Gilles, 2000; Shipway, 2004). The prevalence of domestic violence among women attending primary care settings ranges between 5.6% and 41%, depending on the definition and the measurement tools used (Coker et al., 2007; K. L. Hegarty, Gunn, Chondros, & Small, 2004; McCauley et al., 1995; Ruiz-Perez, Plazaola-Castano, & Del Rio-Lozano, 2007; Yut-Lin & Othman, 2008). A previous study among women attending government-funded primary care clinics in Malaysia reported that 5.6% of women had experienced some form of domestic violence (Yut-Lin & Othman, 2008).

Every clinical encounter provides opportunity for health care providers to address the needs of those exposed to domestic violence. Unfortunately, women experiencing domestic violence face many obstacles in their efforts to disclose their problems to health care professionals (K. L. Hegarty & Taft, 2001; McCauley, Yurk, Jenckes, & Ford, 1998; Rodriguez, Szkupinski Quiroga, & Bauer, 1996). Among women attending the primary care clinics in Malaysia, 92.4% reported that their attending physicians never questioned them about domestic violence (Yut-Lin & Othman, 2008). Rodriguez et al. (1996) has defined this as a silence or the “unspoken agreement” between battered women and other members of society to not disclose or address their
abuse (Rodriguez et al., 1996). The failure to address these abusive experiences leads to female victims not receiving proper medical care and support. Intervention in domestic violence should aim at breaking this silence in order to stop the escalation of abuse when victims return to their abusive relationships unsupported (Nelson, Bougatsos, & Blazina, 2012).

Studies on help-seeking behaviors among Asian women have reported that certain cultural values acted as barriers to discussing abuse with others (Bent-Goodley, 2005; Bhuyan, Mell, Sullivan, & Shiu-Thornton, 2005; Niaz, 2003; Song, 1996). Most women in Asian countries believed that family matters, including domestic violence, are considered private and should be kept secret (Niaz, 2003). The patriarchal nature of family relationships is upheld with the acceptance of male dominance. However, some men misused this position of said dominance through violent acts in order to maintain their traditionally dominant position in the family (Bhuyan et al., 2005; Kasturirangan, Krishnan, & Riger, 2004; Rydstrom, 2003; Shiu-Thornton & Sullivan, 2005; Yoshihama, 2000). Both men and women uphold certain traditional roles in the relationship. For example, in Vietnam, society assumes that women have a “cool” and enduring character while men have a “hot” and dominating character (Rydstrom, 2003, p. 676). Asian women tend to accept the abusive behavior from their husband despite their suffering, and in doing so, they are viewed as being loyal to their marriage (Rydstrom, 2003; Yoshihama, 2000). This assumption of gender characteristics has been suggested to justify men’s physically abusive behavior and unfairly places the expectation for these women to not retaliate and tolerate this abuse. There is also a great deal of emphasis on “saving face” among Asians. Women are very cautious to discuss matters that might attract any negative perception onto themselves or their family (Abdullah & Pedersen, 2003). The Asian value of family unity creates a dilemma for women to take active intervention as the society places emphasis on efforts to avoid family disintegration (Abdullah & Pedersen, 2003; Malley-Morrison & Hines, 2004, p. 202). Being from a collective society, women appeared to be more concerned about the well-being of their family rather than themselves (Shiu-Thornton & Sullivan, 2005).

To assist victims, health care providers need more than just knowledge of domestic violence issues but must also be sensitive to specific local cultural values and backgrounds of their female patients. To date, there has not been any research to explore the barriers faced by Malaysian women in discussing their encounters of abuse during clinical visits. This study aimed to explore these barriers. Understanding these obstacles is important in improving medical services to support these women.
Methods

Interviews were conducted with 10 women with domestic violence experience residing at a women’s shelter situated in Klang Valley, Malaysia. This shelter is an independent, non-governmental, and non-religious organization that is committed to eliminating violence against women. The social workers at the shelter helped to identify and recruit participants, as they knew who were sheltered for domestic violence or for reasons other than domestic violence. The participants were individually informed of the objectives of this research by the social workers and that participation was voluntary. The social workers were explicitly instructed not to use persuasion or emotional coercion to promote study involvement.

All interviews were conducted in a counseling room at the shelter and audio-recorded with participant permission. The primary author conducted all the interviews. Informed consent was obtained before the interview began. Women were asked questions regarding their experience in help seeking, including their experience with health care providers. Open-ended questions were asked along with other questions, which were added as the interview process progressed. Field notes were taken.

Audio-recorded interviews were transcribed verbatim. The primary author coded all data. A random selection of data was coded and checked by the second author. Any ambiguities were resolved in discussion. Categories were reduced to major themes through ongoing discussion between researchers and the re-reading of transcripts. The data were managed using NVivo software and analyzed using the grounded theory approach (Strauss & Corbin, 1990). Grounded theory approach is used to determine the representativeness of concepts and how those concepts differ, leading to the development of a theory that attempts to explain behavioral patterns in terms of relevance for the population being studied (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). The interviews were stopped when the data reached saturation point (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998).

This study received ethics approval from Monash University Standing Committee on Ethics in Research Involving Humans (reference project number 2003/769) and University of Malaya Ethical Committee (reference project number HU-61/12/1-1).

Results

Socio-Demographic Backgrounds

Participants with domestic violence background in this study consisted of 10 women ranging between 27 and 44 years old. All the women were current
residents of the shelter during the interview period and were married. Three of these women were Malays, six were Indians, and one Chinese. Five of the women had received education up to primary school level, four at secondary level, and one at diploma level. Three of them were employed when they fled to the shelter, while three others were forced by their husbands to quit their job after marriage. Five women had been married for more than 10 years, four women between 5 and 10 years, and only 1 had been married for less than five years. All but two women started to experience domestic violence within the first year of their marriage. Four of the women reported experiencing some form of childhood abuse.

**Women’s Barriers to Discussing Domestic Violence**

Women with domestic violence background expressed various barriers to discussing their experience of abuse with others, including health care providers. In view of this, they tend to manage the abuse in isolation and try to cope with their abusive relationship. Seeking help was delayed until the abuse was out of hand or too severe, often with involvement of children abuse or severe physical injuries. The barriers existed both internally as well as within the environment, where they lived.

**Internal Barriers**

The main barrier preventing the women from seeking help was the perception that domestic violence is a private matter that needs to be solved strictly between the couple involved. Almost all participants mentioned this and reported that disclosure of domestic violence to others including health care professionals and family members was difficult. Domestic violence was perceived as a marital problem and it was thought best not to involve others. This idea was not confined to these women only but was shared by other family members.

> Whether you have any arguments, it should be confined to the room. It should not be disclosed to others. This is what my parents taught me. (AW2)

Most women would not discuss their abuse because of their role as a “good wife” and the need to maintain their husband’s good name. Women in this study believed that discussing their husband’s abusive behaviors would expose their husband’s limitations. They were concerned about humiliating the name of their family should there be any involvement of the police or the court.
In most cases, discussion regarding domestic violence was confined to the family members unless the violence was perceived as beyond control. The perception that their abuse relationship was “not being out of hand and not being too severe” acted as a major barrier that delayed their disclosure.

His abuse was not bad before, not serious until he pointed a knife at me and threatened me with it. He was not like this before. (AW1)

The past 8 years he has been abusing me only but since last month, he started to abuse my children. (AW9)

In addition, discussing their abusive background was described as embarrassing. Some women in this study thought that domestic violence occurred due to their own faults and blame themselves for the occurrence. They believed their husband acted in such as a way to correct their mistakes.

As a Muslim, I cannot humiliate my husband. (AW1)

Others will look down on you if you tell them. (AW2)

Women with domestic violence experiences also perceived that a wife must endure all the hardships within marriage, unless it was severe. Domestic violence was considered as “severe” only if they suffered bleeding injuries. Other kinds of domestic violence should be tolerated.

It’s a small matter (initially), I just leave it, it’s okay after all. I did not think that it will go and cause a big problem then. (AW5)

Two of the women stated that abuse was “normal” as they observed similar happenings with their other family members. It was only after they entered the shelter that they realized that domestic violence was wrong and should not occur in a healthy relationship.

Only when I came here (the shelter), I came to know about this (domestic violence). Earlier I used to think that this hitting is normal. (AW6)

I really didn’t know that it was a domestic violence. I thought it’s just a problem; a common problem between a husband and wife which should resolve by itself. (AW5)

Some women deliberately minimized the impact of their abusive relationships and surrendered to their abusive relationship as they took it as their fate
or karma. A Muslim participant was threatened by her husband and her husband’s family to be *nusyuz* (women who disobey her husband’s order and thus there will be risk of her not having the rights for any maintenance [monetary and/or custody] should divorce occur) when she planned to leave her abusive relationship. Her fear of *nusyuz* stopped her from making any effort to ask for help.

This is fate. There is not much left to say. (AW1)

I just call upon God. It’s very hard but I just thank God. (AW5)

All female victims were initially convinced that their partner’s abusive behavior was temporary and change could occur eventually if given the opportunity and time. Help from others is deemed to be intrusive and unnecessary.

I think he will be back to normal. You see because after the children have grown up, he sees that he is supposed to have more responsibilities. But things become worse. (AW5)

Women expressed an intense fear of their husband and were very cautious of their actions. Most did not have their own source of income or had very little income and were financially dependent on their partners. They feared of not being able to support themselves. Despite persistent abuse, some women felt gratitude toward their partners who have been supporting them all these years.

No, I have not confided my relationship problem because I was living in fear. You see, he said he will know everything about me. Even though I’m educated, I am put in a situation that he will know whatever or where I’m going, what I’m doing outside, whether I’m going to work or not. (AW5)

Women also felt a strong belief in maintaining family unity in all matters. There was concern about breaking the family apart if they started discussing their abusive relationships and being persuaded to leave the relationships. They were afraid of separating the children from their father.

“I want my father. I don’t want to let go of my father even though he has done a lot of mistake. He will be nice later,” my son said. (AW7)

I just keep quiet. I have to think about my children too. (AW1)
External Barriers

Women in this study started approaching others for help when the abuse escalated, the abuse affected their children’s well-being, or when their husband married another woman. They usually approached their family members or close friends first. Even then, it took them years to open up. It took them a far longer time to disclose to formal resources including police and health care providers.

Even my father did not know this until after many years. (AW1)

Women in this study had limited knowledge in terms of what formal resources they had for help. All participants mentioned getting the police to help but very few were aware of the opportunity to discuss their abuse with health care providers. Most women sought help from health facilities only if injuries occurred, or when they were asked to make medical reports upon making police report. This lack of awareness caused a lack of access to the help of health facilities unless medical treatment was needed.

I really didn’t have the idea that I could consult with the doctor. (AW5)

In addition, there seemed to be a lack of confidence about getting help from their doctors for a number of reasons, including a view that domestic violence is a relationship problem and that physicians should only be involved if injuries occur. With poor explanations given to them, most women felt intimidated whenever a referral to a psychiatrist was prescribed during their contact with an emergency department physician. They perceived that it was their abusive husbands who needed the counseling toward changing abusive behavior instead of themselves. Others believed that there should be physicians specializing in domestic violence, as in other medical specialities, and access to these specialized doctors was lacking or non-existent. Some women who have sought help felt that they did not get the support they wanted in terms of empathy and explanation.

If I go to an ordinary clinic to tell my problem, I don’t think the doctor will understand since the doctor only treat ordinary cases only. (AW1)

She (the doctor) didn’t have much time to really be concerned. I mean to have a really nice talk. She just has to finish up that patient and she has to go to the next person you see. (AW5)

One of the women, AW9, spoke of her initial encounter with a general practitioner when she sustained an injury to one of her ears after being hit by...
her husband. She was hoping the physician would initiate a discussion with her about abuse, but that did not occur.

If the doctor would ask, I might tell him because my body had all the bruises from his beating. However the doctor looked at my ear only. (AW9)

AW9 also reported being told by a physician that the abuse she experienced was a family matter, and that there was not much that health services could offer. This gave the impression that domestic violence should not be discussed in a clinical setting. There was also a report that some health care providers put more sympathy toward the perpetrators if conviction occurs. One of the women reported that her physician knew the husband, which created problems discussing the abuse. A few women reported that their husband followed them everywhere, including the consultation room, causing difficulty for them to discuss matters related to domestic violence.

Even if the doctor asked seriously, I would ask myself, “Previously I was told that this is a family problem and nothing can be done” Then I told myself, “I might as well keep my mouth shut. My friend told me that she went to see a doctor in order to make a police report. The doctor said, “Why do you want to make a report? Don’t you pity your husband? You have children” How can a doctor say like that. I thought only the police would say like that but doctors too. (AW9)

While women with experience of abuse wish to get support from their health care providers, some women voiced concern regarding possible mandatory reporting of domestic violence cases. They were concerned that mandatory reporting would lead to them being asked to leave their relationship. Many of them felt that they were not ready to live a separate life from their husband. All what they wanted was for the abuse to stop although they themselves were uncertain of the definitive ways to achieve this.

I just keep quiet. I have to think about my children too. (AW1)

They also feared that their doctor would persuade them to make a police report. Most women have the perception that their husband would end up behind bars once a police report has been made.

When the doctor noticed the bruises on my body (every time I was beaten, whenever I was beaten, there would be very obvious bruises, sometimes my face was swollen and there were bruises on my arms), then the doctor will say, “Okay laa, you have to make a police report.” If I make a police report, my husband will definitely be taken away. (AW9)
Past experience with health care providers when discussing domestic violence influenced their perception toward discussing the matter further. While some women expressed satisfaction with their physician visits, many were unhappy with the responses given at the health facilities. In many encounters, the health care providers failed to ask about abuse even though these women presented with physical signs and were ready to disclose, if questioned. These women victims preferred that their physicians asked them questions rather than their physicians waiting for them to begin retelling their abusive encounters. The long waiting time, absence of special treatment, and poor explanation also contributed to the negative experience when at health facilities. The women described some physicians as not empathetic or not expressing interest in their problems. They claimed that they were not provided with adequate information or explanation about the actions planned for them, leading to uncertainty and confusion. There was no on-site counseling available, and they were asked to return to the health care facilities on a separate day for an appointment with a psychiatrist and a social worker. The women felt that the practical support, such as providing them with a temporary safe place to stay, was inadequate. These women felt they were not given enough opportunity to discuss their problems with the physicians but were merely given orders on what to do next. All of the women claimed that they would be pleased if the health care providers acknowledged their problems, showed genuine interest in helping them, and instilled some hope.

Discussion

The objective of this study was to understand the barriers faced by women with domestic violence experience when discussing their abuse with the health care providers. Two major themes emerged from the analysis: the internal and external barriers faced by women who have experienced domestic violence, which led to difficulty in disclosing or discussing the abuse with others including health care providers. Within the themes, various important concepts emerged. Although the themes are presented separately, they share an interrelationship as certain aspects in the first theme strongly relate to those in the second and vice versa.

The first theme that was identified was the internal barriers. These are barriers that exist within women living with domestic violence, strongly relating to their cultural values and beliefs. These beliefs, which center around the societal ideal of the “good wife”—such as endurance, loyalty, maintaining privacy of family matters, and maintaining the family unity—have affected their decision to hide their abuse from others. In addition, the value of “saving face” and the feelings of shame and self-blame, when combined with
financial dependency on the abuser as well as normalization and minimization of the abuse and lack of information on available resources, contribute to the creation of these internal barriers.

Despite efforts to create public education awareness on the criminal nature of domestic violence in Malaysia, many women still view domestic violence as a private matter. Sharing the experiences with others was considered as inappropriate. This tradition asks women, who have been abused, to accept and adapt to their situation rather than seek early intervention from external help. Therefore, it is not surprising to find that many female victims remained in their abusive relationships for a considerable amount of time before ultimately making the decision to leave. In this study, women who had been abused displayed an exceptionally high level of endurance and tolerance. This behavior coincided with Asian values stated in other research where the victims’ persistence and hardship is seen as a way to prove marital strength and loyalty to their husbands (Malley-Morrison & Hines, 2004, p. 201).

The value of maintaining their husband’s “good name” and family is a huge responsibility to women in this study. Upholding this value acted as a major hindrance for these women to discuss the matter in view of stigmas surrounding the issues of domestic violence. Consistent with other reports (Ariffin, 1999; Rydstrom, 2003; Shiu-Thornton & Sullivan, 2005; Tang, 1997), the tendency to conceal these abusive experiences was more prevalent as the female victims tried to avoid being negatively perceived as someone deserving of the punishment for failing to be a good wife.

Leaving the abusive relationship was difficult for women in this study, considering the stigma surrounding single parents or divorcées in Malaysia. Some members of the society perceived women in this position as a threat to other women (Omar, 2003). The Malaysian society has difficulty accepting any kind of sexual relationship beyond the boundary of matrimony (Raj-Hashim et al., 2003). Women may choose to suffer in silence rather than endure the risk of being discriminated against and be shamed by the disclosure of her intimate relationship, and meeting social disapproval.

These women reported that the most important thing was maintaining family unity harmony. This could be one of the reasons for women with a history of domestic violence seeking initial help from their family members, apart from their effort in keeping the discussion of private matters within the confines of the family unit. However, a strong sense of family can be a disadvantage when the priority of maintaining family unity is at the expense of the woman’s well-being. Similar reports regarding family unity have been reported from other studies among Asians (Bhuyan et al., 2005; Malley-Morrison & Hines, 2004; Rydstrom, 2003; Tang, 1997). Leaving the abusive relationship was often a tough choice to make for women and was often the last resort.
This study found that certain religious understanding of women influenced help-seeking behaviors. Muslim women in this study talked about submission to fate while Buddhists mentioned their karma. These beliefs have led to their acceptance of abuse and prevented them from seeking help (Bhuyan et al., 2005).

The value of maintaining family unity most probably derived from their religious teaching. For instance, in Islam, the family unit is perceived as the most important social institution. A divorce, although allowed, should be avoided (Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003). In view of this, most Muslim participants with domestic violence experiences have difficulty taking action that may lead to divorce. Furthermore, the counseling offered to them at the religious departments mainly focused on reconciliation and maintaining the marriage rather than supporting divorce or separation (Women’s Aid Organization, 2002).

Another religious issue brought up in this study is an alleged accusation of disobedience when women leave their relationship. Unfortunately, with women’s poor understanding of what actions constitute nusyuz, they have been threatened with nusyuz to keep them in the abusive relationship.

The second theme that emerged from this study was external barriers, which contributed to the overall challenges faced by women with domestic violence arising from their surroundings. Patients unclear of the role of health care professionals being able to assist in domestic violence, as well as previous negative experiences with clinics, contributed to the external barriers the women faced, which prevented them from receiving help from health care facilities.

The misconception that health care professionals do not assist patients with domestic violence means that these women are missing valuable opportunities to receive help—ultimately prolonging their suffering. It may be possible that domestic violence has not been accurately portrayed in the health agenda, causing women to lack awareness of what health care providers could offer to those experiencing domestic violence (Peckover, 2003). Nevertheless, women explicitly stated that they wanted their physicians to initiate conversations regarding abuse during their clinical consultations. Women experiencing domestic violence were more inclined to down-play the injuries endured from abuse and self-treat their injuries unless the injury was severe. This finding is similar to that of K. L. Hegarty and Taft (2001): Some women felt their situation was not severe enough to discuss with their physicians.

Clearly, there appears to be a lack of confidence in the support provided by the medical facilities among women experiencing domestic violence. Most of them were unable to see how health care providers could put a stop
to the abuse. Most did report, though, they would appreciate it if they were
given a safe place to stay in the health facilities when needed, and wanted
health care providers to provide them with more information on available
options to help them deal with their problems.

For women with previous clinical consultations, negative experiences
from their past had worsened the existing barriers, further preventing them
from disclosing the abuse. Clearly, a lack of confidence exists in the support
provided by the medical facilities among women experiencing domestic vio-

Apart from facing internal barriers, women in this study reported that
they were not given enough opportunity to discuss their problem with physi-
cians and they were merely given referrals for counseling. They wanted their
physicians to acknowledge their problem, show genuine interest in helping
them, and to instill some hope. Similar to other research, women had a ten-
dency to keep their abuse problem from their physician, facing difficulty
initiating a discussion regarding their experience of domestic violence
unless specifically asked by their general practitioners (Bacchus, Mezey, &
Bewley, 2003; Rodriguez et al., 1996). They preferred their physician to
initiate the discussion about domestic violence issues and not to wait for
them to volunteer the information (Bacchus et al., 2003). This suggests that
health care providers must be prepared to initiate the discussion about
domestic violence and need to have adequate knowledge on this issue. Just
as in other studies (Bacchus et al., 2003; Hamberger, Ambuel, Marbella, &
Donze, 1998; K. L. Hegarty & Taft, 2001; McCauley et al., 1998), the
women in this study wanted their physicians to be approachable and sincere
in asking about potential abuse. They wanted to be asked further about abuse
rather than enquiring superficially during history taking, to be assured of
confidentiality, and to be offered provision of a safe place to stay. At the
same time, they were concerned about being forced into leaving or making
a police report when their problem was made known. It is important for
health care providers to give autonomy to these women. Forcing these
women to make decisions against their will may only expose them to insti-
tutional victimization when they were forced to face another patriarchal
relationship within the institutional environment where ironically they were
supposed to get help (Stark & Flitcraft, 1996; Warshaw, 1989).
The identified theoretical framework outlined that both internal and external barriers exist among women with domestic violence experience. These barriers are fundamental roadblocks to discussing their abuse with others. These barriers emerged from the social and cultural context where they live. In order for clinical services to be effective, there is a need to consider offering relevant and ongoing support that is responsive to the individual needs of each case. This support should be based on the barriers that exist internally and externally to these women, taking into consideration that some of these barriers are strongly tied to their cultural and religious values. As for the health care professionals, there is a need to evaluate how health care facilities execute their services in domestic violence interventions. This would avoid negative or inaccurate perceptions regarding the role of health care providers when supporting victims of domestic violence. Efforts to improve health care professionals’ inquiry procedures and reactions to abuse are necessary in order to ensure they are viewed as a solution instead of an obstacle.

The qualitative data collected in this study provided substantial insights into domestic violence in Malaysia. However, as with other qualitative approaches, these results cannot be generalized to describe universal attitudes, experiences, and reactions to domestic violence. This study was conducted in a single shelter location. The findings might not reflect the experiences of other Malaysian women suffering domestic violence who do not utilize any shelter services. It is possible that those who reside in the shelter may have suffered a more severe form of violence causing them to leave their relationship. Since the recruitment of participants was on a voluntary basis, those participating might be those who were interested in and felt more comfortable about the chosen topic. It is not possible to determine whether differences exist between those who participated and those who did not. Further research is required to evaluate societal and health care professionals’ views regarding domestic violence and the issues surrounding disclosing abuse.

**Conclusion**

Disclosing domestic violence to health professionals is not easy for those who are experiencing the problem. Even if women managed to present themselves to health facilities, they faced internal and external barriers to discussing abuse with health care professionals. Health care professionals must be aware of these barriers to understand the reasons for their action or inaction and provide empathy and culturally sensitive management, in order to provide beneficial support to female victims.
Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by Research Development Unit of University of Malaya, Vot F 03652002B.

References


**Author Biographies**

**Sajaratulnisah Othman** is an associate professor of primary care medicine at University of Malaya, Malaysia. She received a PhD in primary care medicine at Monash University, Australia. Her research focuses on gender based violence intervention from medical and health perspective.

**Chris Goddard** is Adjunct Professor, Monash University. Formerly Head of Social Work, he is currently Director of Child Abuse Prevention Research Australia, a joint initiative between the Monash Injury Research Institute and the Australian Childhood Foundation.

**Leon Piterman** is Professor of General Practice, Pro-Vice Chancellor Berwick and Peninsula Campuses of Monash University. He was formerly the Deputy Dean of Medicine Nursing and Health Sciences and has established the School of Primary Health Care at Monash University. His research interests include mental health, chronic disease and medical education with over 120 refereed publications in these areas and is the co-editor of the text “General Practice Psychiatry”.

---

*Othman et al.* 1513

Downloaded from *jiv.sagepub.com* at Universiti Malaya (S141J/J/2004) on May 25, 2014