ORIGINAL ARTICLE

Self-reported Exposure to Domestic Violence and Family Dynamics During the Pandemic of Covid-19 in Malaysia

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ABSTRACT

Introduction: Following the spread of the Covid-19 pandemic, domestic violence (DV) victims had to be together with the perpetrator when lockdowns were implemented. The lockdown disrupted family dynamics and gave space for perpetrators to commit DV. This study aims to assess the prevalence of domestic violence in Malaysia during Covid-19 and its relationship with family dynamics, health, and sociodemographic factors. **Materials and methods:** This is a secondary analysis of the COMET-G study. By utilizing social media, the survey was distributed to the Malaysian communities using Google Forms. Associations between DV, family dynamics, health status and sociodemographic characteristics were measured using the Chi-Square test and correlation analysis. **Results:** Only 637 out of 936 participants who responded to the self-administered questionnaires answered questions related to DV. The overall prevalence of DV was 12.2% and the specific prevalence for both males and females was 13%. The highest prevalence of DV was among those aged below 20 years (16.7%), lived together without special relationship (28.6%), living in rural areas (17.1%), had primary education (21.2%), retirees (16%), lived together with three people (15.1%) and had two children (16.8%). DV was significantly associated with having chronic disease (p=0.024) and mental illness (p=0.009). Additionally, the need to communicate (p=0.028), general quality of relationships (p=0.001), and economic situation in comparison to before the Covid-19 lockdown (p=0.03) were significantly different between those who were exposed to DV and those who were not. **Conclusion:** Focusing on improving family dynamics can help prevent DV, especially among those with chronic illnesses and mental illnesses.
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INTRODUCTION

Domestic violence (DV) is a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner. DV is a hidden, complex phenomenon, often stigmatized, minimized, and underreported, making effective detection and intervention impossible. It is important to note that often DV occurs in conjunction with other forms of violence, including child maltreatment, filicide, and infanticide (1).

Formerly, according to the Domestic Violence Act 1994, Act 521 (DVA 94), DV can be defined as the Act, mainly covering physical injury such as threatening to injure, causing physical injury, engaging in sexual conduct forcefully, confining or detaining the victim and causing property damage. However, in response to the realities and ongoing constraints faced by victims of domestic violence and to provide them with better protection, the definition of DV in the DVA 94, has been amended twice, in 2012 and 2017. Based on the Domestic Violence (Amendment) Act 2012, Act A1414) and the Domestic Violence (Amendment) Act 2017 (Act A1538), the definition of DV has included psychological, emotional abuse and financial loss (2).

The intricate nature of DV can be summarised according to a socioecological framework that divides contributing factors into distal, proximal and individual factors (3). Distal factors include structural abuse in the form of lack of support from authorities and lack of accessible and appropriate services for early detection and effective management of DV, sociocultural disparity, economic inequality, gender-based discrimination, secondary victimisation and victim blaming (3). Proximal factors include the assertion of power and control by the perpetrator; most often the spouse or someone known to the victims (4). Those distal and proximal factors

contribute to the lack of empowerment and self-agency of the survivor in escaping the cycle of violence (1). All the theories related to DV such as Battered Woman Syndrome and the Cycle of Violence (5) and the Wheel of Power and Control (4), describe the continuous pathological and violent attachment between the victim and the perpetrator are accentuated further within the confined environment with limited freedom of movement.

Home is not always the safest place for DV victims since most DV either physical, psychological, or even sexual violence mostly occurs at home (6). The Covid-19 pandemic is disastrous for DV victims when they are locked in the house with the perpetrator (7). During the Covid-19 pandemic, the victims of DV had no other choice but to be together with the perpetrator almost all the time, when the government in most of the countries in the world, including Malaysia had to implement a lockdown (8). Locally known as the Movement Control Order (MCO), the lockdown limits freedom of movement, making going out to seek help very difficult for the victim of DV. Isolation at home during the lockdown has opened up space for perpetrators to dominate and exert more power to control their victims through various tactics (as described by the Wheel of Power and Control theory) and commit aggressive acts, resulting in an increase in DV (9,10). Furthermore, the very limited operation of the public transport system and the closure of various offices have also indirectly prevented victims of DV from getting any help (11). As evidence, there is an increment of 57% in calls (or 1,893 calls) made to Talian Kasih hotline numbers looking for psychological help and support provided by the Ministry of Women, Family and Community Development, during the lockdown in Malaysia (12).

The prevalence of DV was already high before the pandemic (13) and increased further during the pandemic. According to a systematic review of 32 studies from North America, Europe, the Asia-Pacific Area, Africa, and worldwide research the pandemic Covid-19 has caused an increase in DV cases, especially during the first week of the Covid-19 lockdown in each country (14). In Malaysia, before the pandemic, according to the Women's Aid Organisation (WAO), every year the number of reported cases fluctuated between 3500 to 5500 cases. However, the number of DV cases increased to 7500 cases during the pandemic (15).

In addition to affecting DV, the Covid-19 pandemic that swept the world in 2019 is also negatively affecting well-being or family dynamics. Family dynamics refers to the pattern of interaction among family members including their roles and relationships, and all other factors that affect their interactions (16) which can be categorised into five determinants: family relationship, family conflict, social support, financial stress, and family stress (17). In their study (17), they conclude that

family relationships and social support positively affect well-being while financial stress, family conflict and stress negatively affect well-being. Another study that aimed to set the indicators for measuring and reporting the state of family well-being in Malaysia identified five domains of family well-being: family relationships, economic situation, health and safety, community relationships and religion/spirituality (18). During the pandemic, the quality of relationships between families deteriorated further as more families experienced drastic changes in their family dynamics. The pandemic results in increased demand which exceeds the capabilities and the available resources, especially those families who are already at risk (19).

DV causes various negative implications for the victims, most often women and their children and the family. It is a well-known fact that DV results in a variety of physical trauma and injuries due to aggression and physical abuse, chronic diseases (such as lower back pain, headaches, memory loss, difficulty sleeping, diabetes, asthma, and digestive disease) and death (20). DV has also been shown to cause depression, post-traumatic stress disorders, alcohol and substance abuse, child maltreatment and many other psychological disturbances (21) for the victims (19). In most cases, chronic medical illness resulting from DV has had a detrimental effect on the psychological well-being of family members. These psychological impacts may surpass the direct effects experienced by the victims (22) which in turn affects the family dynamics. In some cases, chronic medical conditions resulting from DV can strengthen family relationships because each member pulls together to help the other (23). However, the impact of chronic illness resulting from DV on this type of family dynamics is often overlooked and underestimated (23).

The Covid-19 pandemic has indeed highlighted the damaging effects of DV. Despite the negative consequences of DV, in Malaysia, there is a lack of studies and information on DV during the pandemic. There are gaps of knowledge on the actual prevalence of self-reported DV, the association between sociodemographic characteristics, health status and the role of family dynamics among those who experienced DV. It is crucial to investigate further the factors associated with and the impact of DV to inform appropriate interventions. Thus, this study aimed to measure the prevalence of self-reported exposure to DV in Malaysia during the pandemic Covid-19 and to determine the associations between self-reported exposure to DV and sociodemographic characteristics, health status and family dynamics.

MATERIALS AND METHODS

Data Sources
This research represents a secondary analysis of a cross-sectional survey conducted as part of the Covid-19

Mental Health International for the General Population (COMET-G) study. This global initiative involves over 40 countries and was launched by the Aristotle University of Thessaloniki in collaboration with the Mental Health Sector of the Scientific Research Institute of the Pan-Hellenic Medical Association in Greece. In Malaysia, the survey was shared via social media platforms, including Facebook and Twitter. Participants were required to be at least 18 years old, proficient in either Malay or English, and have internet access to complete the online questionnaire. An introductory page of the survey provided potential participants with information about the study's risks and benefits. Those who consented to participate were then prompted to complete the questionnaires, with implied consent obtained when they advanced to the next page where the actual survey commenced.

Local data on sociodemographic characteristics, health status, family dynamics and self-reported DV are of interest in this study. Sociodemographic characteristics include age, marital status, educational status, employment, residential area, and the number of people and children living together. The health status of the participants and family includes the presence of vulnerable people living together, the status of having chronic medical disease, and the status of having mental illness.

Family dynamics during the pandemic lockdown were measured using a comparative scale range from '-2=much less', '-1=less', '0=same', '1=more' and '2=much more'. The study assessed various aspects of family dynamics, including the need for communication among family members, the level of emotional support received from one another, any conflicts that arose during the pandemic lockdown, and the overall quality of relationships compared to the period before quarantine. Additionally, participants' financial situations were taken into account. The research also evaluated participants' ability to maintain a basic daily routine—such as waking up, having regular meals, sleeping patterns, and engaging in routine activities—using a scoring system that ranged from '0 = not at all' to '3 = always.' Furthermore, the study examined the challenges faced in managing their children's daily lives and behaviors, with scores ranging from '-2 = much more difficult than before' to '2 = much easier than before.

Information on self-reported domestic violence was measured by a dichotomous question (Yes or No) on exposure to any violence at home. Participants were also provided with relevant information about domestic violence in the questionnaire for them to understand what it is. The information provided includes: a) mental or emotional abuse, such as using language to demean or devalue an individual, either directly or through online platforms and social media; b) physical abuse or aggression, which encompasses actions like hitting, pushing, punching, slapping, kicking, throwing objects, or strangling; c) sexual abuse or aggression, involving the use of sexual acts to control or humiliate the victim, including coercing them into unsafe sexual practices against their will; d) economic or financial abuse, characterized by restricting an individual's financial independence or security, such as withholding adequate funds for household needs or seizing a person's earnings; and e) other forms of abuse or aggression. The full protocol of COMET-G can be found elsewhere (24).

Method for Data Analysis
To obtain the prevalence of self-reported exposure to DV, descriptive statistics on self-report DV were calculated for each sociodemographic characteristic and presented as frequency and percentages. The Chi-squared test (χ^2) was then applied to determine whether the differences in the self-reported exposure to DV were associated with their sociodemographic characteristics and health statuses. For the differences in the pattern of family dynamics related to self-reported exposure to DV, the independent t-test (t) was used. IBM SPSS version 26 were used in performing Statistical analyses.

RESULTS

Background of the participant
The results of the descriptive analysis of 963 participants are illustrated in Table I. Out of 963 participants who responded to the survey, only 637(66.1%) answered the section for DV. Of these 637 participants, the majority were female, accounting for 351 participants (55.3%). A total of 242(38%) aged between 31 – 40 years old, 411(64.5%) were married, 233(36.6%) resided in the capital city, 298(46.8%) held a master's degree, 139(21.8%) were salaried employees in the private sector, 218(34.25%) lived with three people in their household and 191(30%) had two children.

Table I: Sociodemographic of the Participants

Sociodemographic data		Self-Report Domestic Violence, n (%)			Statistical Analysis	
		No (n=559)	Yes (n=78)	Total	χ²	*p*-value
Gender	Female	305(86.9%)	46(13.1%)	351	3.124	0.210
	Male	188(87.0%)	28(13.0%)	216		
	Others	66(94.3%)	4(5.7%)	70		
	Total	559(87.7%)	78(12.2%)	637		
Age class	<20	5(83.3%)	1 (16.7%)	6	2.840	0.585
	21-30	102(89.5%)	12 (10.5%)	114		
	31-40	207(85.5%)	35 (14.5%)	242		
	41-50	121(91.0%)	12 (9.0%)	133		
	>50	124(87.3%)	18 (12.7%)	142		
Marital status	Single	112(86.8%)	17(13.2%)	129	3.198	0.670
	Married (or civil partnership)	362(88.1%)	49(11.0)	411		
	Divorced or estranged	42(89.4%)	5(10.6%)	47		
	Live with someone without an official relationship	5(71.4%)	2(28.6%)	7		
	Widower	31(91.2%)	3(8.8%)	34		
	Others	7(77.8%)	2(22.2%)	9		
Residence	Capital city	208(89.3%)	25(10.7%)	233	6.660	0.247
	City<1 million	61(93.8%)	4(6.2%)	65		
	City (100k-1million)	36(90.0%)	4(10.0%)	40		
	Town (20k-1000k inhabitants)	44(89.8%)	5(10.2%)	49		
	Town (>20000 inhabitants)	108(85.0%)	19(15.0%)	127		
	Rural area/ village	102(82.9%)	21(17.1%)	123		
Education	Elementary /primary /no more than 9 years of education	26 (78.8%)	7(21.2%)	33	3.596	0.463
	High school/secondary /no more than 12 years of education	127(86.4%)	20(13.6%)	147		
	Bachelor /diploma/degree	257(89.5%)	30(10.5%)	287		
	Master's degree	119(87.5%)	179(12.5%)	298		
	Doctorate PhD	30(88.2%)	4(11.8%)	34		
Workplace	Working at public sector	32(91.4%)	3(8.6%)	35	3.469	0.748
	Salaried employees at private sector	120(86.3%)	19(13.7%)	139		
	Self-employee/freelancer	4(100.0%)	0(0.0%)	4		
	Retired	42(84.0%)	8(16.0%)	50		
	Unemployed	2(100.0%)	0(0.0%)	2		
	Not working by choice	6(85.7%)	1(14.3%)	7		
	University or college student	77(91.7%)	7(8.3%)	84		
People living in the house	1 live alone	23(85.2%)	4(14.8%)	27	3.835	0.429
	2 people	95(91.3%)	9(8.7%)	104		
	3 people	185(84.9%)	33(15.1%)	218		
	4 people	159(89.8%)	18(10.2%)	177		
	5 or more	97(87.4%)	14(12.6%)	111		
Person children	0(Do not have any children)	151(89.9%)	17(10.1%)	168	5.722	0.221
	1 child	74(89.2%)	9(10.8%)			
	2 children	159(83.2%)	32(16.8%)	83		
	3 children	95(91.3%)	9(8.7%)	191		
	4 or more children	80(87.9%)	11(12.1%)	104		

Notes:χ² =Chi-Squared test; *test is significant with p-value <0.05

Prevalence Of Self-Reported Exposure To DV
Based on those who self-reported exposure to any form of DV, the overall prevalence of DV was 12.2%. Further analysis showed that both male and female participants had almost the same prevalence of DV which was (13%) while for other gender categories, it was only 5.7%. The prevalence of DV was high among those aged below 20 years old (16.7%) followed by those aged between 31-40 years old (14.5%) and the least was among those aged 41 – 50 (9.0%). In terms of marital status, the highest prevalence of DV was among those who lived with someone without a special relationship (28.6%), followed by other types of marital status (22.2%) and the least was from the widowed category (8.8%). Looking at the prevalence of DV based on residence, those who lived in rural areas and towns (>20000 inhabitants) were those with the highest prevalence (17.1% and 15.0% respectively). The prevalence of DV was also found to be very high among those who had only elementary / primary or no more than nine years of education (21.2%) followed by those who had high school/secondary or no more than 12 years of education (13.6%). In terms of the workplace, the prevalence of DV among retirees was the highest (16%), followed by those who are not working by choice (14.3%) and 0% prevalence among the unemployed and self-employed/freelancers. Participants who were living together with three people (15.1%) and those who were living alone (14.8%) are the two groups with the highest prevalence of DV. Finally, based on the number of children, those who had two children had the highest prevalence of DV with 16.8%, followed by those with four or more children (12.1%).

Associations Between DV, Family Dynamics, Health Status and Sociodemographic Characteristics
Even though there are differences in the prevalence of DV according to the sociodemographic characteristics, the chi-square analysis proves no significant association (p>0.05) between DV and all categories of the sociodemographic characteristics of the participants.

Table II describes the differences in family health status between participants who self-reported exposure to any form of DV and those who did not. Of the total 637 participants, 148(23.2%) had chronic medical disease and 93(14.6%) had mental illness. A total of 153(24.0%) of the participants were living with someone vulnerable. Further analysis based on the Chi-square independent test proved that there are significant associations (p<0.05) between self-reported DV and having a chronic disease (p=0.024) and having a mental illness (p=0.009). On the other hand, the Chi-square independent test also proves that there is no significant association between self-reported DV and having a vulnerable family member.

Table II: Self-reported Exposure to Domestic Violence and Health Status

Family Heath Status		Self-report to DV, n(%)		Statistical Analysis	
		No (n=559)	Yes (n=78)	χ^2 test	p-value
Having chronic medical disease	No	437 (7.8%)	52(66.7%)	5.083	0.024*
	Yes	122 (21.8%)	26(33.3%)		
Having mental Illness	No	485(86.8%)	59(75.6%)	6.790	0.009*
	Yes	74(13.2%)	19(24.4%)		
Having a vulnerable family member	No	424(75.8%)	60(76.9%)	0.043	0.835
	Yes	135(24.2%)	18(23.1%)		

Notes:χ^2 =Chi-Squared test; *test is significant with p-value <0.05

Table III describes the differences in the mean of elements of family environment between participants who self-reported exposure to any form of DV and those who did not. The significant differences between the two groups of self-reported DV were reported in three out of seven elements of family dynamics, that is the need to communicate with other family members (p=0.028), the general quality of relationships within the family in comparison to before Covid-19 lockdown (p=0.001), and the economic situation as a result of the pandemic (p=0.03). Based on the mean values, individuals who self-reported exposure to any form of domestic violence had lower needs to communicate with other family members. The general quality of family relationships within the family in comparison to before the Covid-19 lockdown, was also worse for this group. Additionally, they faced a more challenging economic situation as a result of the pandemic compared to those who did not report exposure to domestic violence. This proved that family dynamics among participants who experienced DV are worse than those participants who did not during the pandemic Covid-19.

Table III: Self-reported Exposure to Domestic Violence and Family Dynamic

Family Dynamic	Self-report DV, Mean (SD)		Statistical Analysis	
	No (n=559)	Yes (n=78)	t-test	p-value
Need to communicate with other family members	-0.97(1.08)	-1.26(0.97)	2.21	0.028*
Need more emotional support from other family members	-0.15(1.02)	-0.40(0.94)	1.96	0.050
Conflicts with the other family members	-0.42(0.96)	-0.32(0.86)	-0.80	0.422
General quality of relationships within the family in comparison to before the Covid-19 lockdown	0.20(1.20)	-0.27(1.07)	3.30	0.001*
Keeping a basic daily routine	1.18(0.82)	1.17(0.71)	0.13	0.901
Difficulty to manage children's everyday life and behaviour	-0.63(0.10)	-0.71(0.87)	0.59	0.553
Economic situation as a result of the pandemic	-0.43(1.02)	-0.71(0.88)	2.24	0.030*

Notes:*p-value with* * - test is significant at significant level of 0.05

DISCUSSION

The World Health Organization recently estimated that one-third of women (33%) worldwide experience DV or abuse in their lifetime (WHO, 2021). However, this study showed that only 13% of female participants, and 13% of male participants reported DV while only 5.7% of other gender participants reported DV. This finding is not surprising, because DV is known to be under-reported and taboo in Malaysia (25). Although this statistic is much smaller than that reported by the WHO, it should not be taken lightly for the sake of society's well-being.

The associations between DV and having chronic medical disease and mental illness have been proven to be significant in this study. The relationship between experiencing DV and mental illness has been reported to be bi-directional. Khalifeh, et al. for example, suggested that people with mental illness were at higher risk of experiencing DV (26) as they might be less aggressive and more likely to accept DV and have difficulty forming a healthy relationship which brings them to an abusive relationship. Apart from that, another researcher suggests that experiencing DV would increase the risk of having a mental illness (27). Stress caused by DV can trigger or worsen mental health conditions. Not only causing mental health problems, but DV can also precipitate new mental health problems. Depression, anxiety, post-traumatic stress disorder (PTSD), and substance misuse are the mental health issues that are most frequently linked to DV (27).

The relationship between DV and chronic medical disease exists for a variety of reasons. First, a chronic medical disease might increase a person's vulnerability to abuse (28). People who suffer from chronic medical diseases may find it challenging to leave abusive partners because they may be reliant on them for emotional or financial support (29) which will make their chronic medical disease worse. On the other hand, physical injuries may also result from DV, which can lead to chronic pain and other health conditions (30). Many more studies have reported this bi-directional relationship between DV and chronic medical disease,

that is chronic medical disease increases the likelihood of experiencing DV, as well as how DV increase the likelihood of having chronic medical disease (31). However, the direction of the relationship between mental illness, chronic medical disease, and DV was not examined in this study.

Furthermore, the relationships between DV and the need to communicate with other family members, the general quality of relationships within the family, the economic situation due to the pandemic and the economic burden during the pandemic have been indicated in this study. Good communication among family members has become a great influence in dealing with domestic conflicts and violence (32). The need to communicate, express and receive love among family members reflects family dynamics (16). In terms of economic situation and burden, the results of this study are in line with the findings obtained by one Malaysian study (11). Based on their study, the pandemic, accompanied by industry-wide lockdowns, had led to the economic situation and depression among those affected, resulting in DV.

CONCLUSION

This study highlights the associations between the health status of having medical disease and mental illness and DV. Even though, the direction of the relationship between mental illness, chronic medical disease, and DV was not examined in this study, Malaysian healthcare providers need to be aware of such a bidirectional relationship (33) to provide effective support to victims of DV with mental illness and chronic medical disease.

This study also indicated the relationships between DV and family dynamics; the need to communicate with other family members, the general quality of relationships within family, the economic situation due to the pandemic and the economic burden during the pandemic. Family dynamics are not only associated with DV but also play a significant role in a person's health status. Negative family dynamics are associated with poor sleep quality, increased heart rate, and increased blood pressure, leading to an increased risk of hypertension (16). Thus, to prevent DV and help the

victims, it is important to understand how health status and family dynamics contribute to it.

This study has a few limitations. Although collecting data via online survey is safe during the pandemic, it limits the recruitment to only those with internet services which creates a bias in terms of sampling. Given the small number of samples and poor randomisation, the findings may not represent the population. Hence, an epidemiological study that can gather data from victims of DV is recommended.

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