Environment and Social Psychology (2025) Volume 10 Issue 11 ISSN: 2424-8975 (O)
doi: 10.59429/esp.v10i11.4265 2424-7979 (P)

RESEARCH ARTICLE

Women's mental health under domestic violence: Social support structures and group counseling outcomes

Hongyan Li[1,*], Norazlina Zakaria[2], Azlizamani Zubir[2]

[1] *Universiti Utara Malaysia, PHD, Collage of Arts and Sciences, Sintok, Kedah Daryl Aman, 06010, Malaysia*

[2] *Universiti Utara Malaysia, Dr, College of Arts and Science, Sintok, Kedah Daryl Aman, 06010, Malaysia*

*** Corresponding author:** Hongyan Li, lihongyanhope@gmail.com

ABSTRACT

This qualitative study examines how domestic violence affects women's mental health and social support systems in Malaysia, and evaluates the effectiveness of group counseling as a recovery intervention. Based on 20 in-depth interviews and three NGO-led counseling groups, the findings show that survivors experience multidimensional psychological distress—including anxiety, depression, PTSD, and self-blame—exacerbated by cultural pressure and limited institutional accessibility. Family support was often absent, with survivors relying instead on friends, neighbors, religious groups, and NGOs, although access to support varied across urban–rural and ethnic contexts. Group counseling demonstrated significant positive effects by enabling emotional release, shared experiences, mutual support, and empowerment, thereby helping women rebuild confidence and social functioning. The study highlights the need to strengthen cross-sector collaboration between government agencies and NGOs, improve multilingual and culturally sensitive services, and institutionalize group counseling as part of national social-support mechanisms. These findings contribute to localized intervention research by revealing how culture, religion, and social networks shape women's recovery trajectories in Malaysia.

Keywords: domestic violence; women's mental health; social support networks; group counseling; trauma recovery; empowerment; Malaysia; qualitative research

1. Introduction

Domestic violence remains a critical yet understudied social-psychological issue in Malaysia, where multicultural, multilingual, and religious dynamics strongly shape women's help-seeking behaviors and access to institutional protection. Although existing studies have examined domestic violence from legal or general psychological perspectives, limited attention has been paid to how cultural norms, urban–rural disparities, and multi-layered social-support structures jointly influence survivors' mental-health trajectories. Moreover, empirical evidence on the effectiveness of group counseling in Southeast Asian contexts is scarce, leaving a significant knowledge gap regarding how collective, empowerment-oriented interventions function in culturally diverse environments[1]. These gaps highlight the need for a localized, context-sensitive analysis that incorporates Malaysia's social structure, value systems, and community dynamics into discussions of

ARTICLE INFO
Received: 31 October 2025 | Accepted: 07 November 2025 | Available online: 28 November 2025

CITATION
Li HY, Zakaria N, Zubir A. Women's mental health under domestic violence: social support structures and group counseling outcomes. *Environment and Social Psychology* 2025; 10(11): 4265 doi:10.59429/esp.v10i11.4265

mental-health recovery for women experiencing domestic violence[2].In the Malaysian context, domestic violence is embedded within broader structural inequalities and gendered expectations, which interact with socio-religious norms to shape women's lived experiences. While the government has introduced legal frameworks such as the Domestic Violence Act and established institutional services including the One Stop Crisis Centre (OSCC) and the Talian Kasih hotline, survivors' narratives reveal persistent challenges in accessing these services. Cultural stigma, family pressure, language barriers, and geographical disparities frequently hinder formal help-seeking, particularly among rural and minority groups. In these circumstances, the availability and quality of social support—whether from family, friends, community networks, or non-governmental organizations—play a central role in determining psychological outcomes. Understanding these dynamics is therefore essential for developing more effective intervention strategies[3].Within this sociocultural context, social support networks function not merely as coping resources but as critical determinants of whether survivors can break cycles of silence, access professional assistance, and begin psychological reconstruction. Yet research on how these networks operate across different regions, ethnic groups, and religious communities remains insufficient. Similarly, although group counseling has been recognized internationally as a powerful tool for fostering emotional catharsis, mutual aid, and empowerment among survivors of intimate partner violence, its applicability and effectiveness within Malaysia's multicultural setting require further empirical investigation. This study responds to these gaps by integrating women's narratives, group observations, and insights from service providers to present a grounded, contextually nuanced understanding of recovery processes[4].This study contributes to the literature by (1) constructing a localized analytical framework that links domestic violence, mental-health outcomes, and multi-level social support systems; (2) comparing urban and rural experiences to reveal culturally embedded differences in help-seeking behaviors and access to resources; and (3) empirically evaluating the psychosocial mechanisms of group counseling, including emotional release, shared storytelling, mutual support, and empowerment. These contributions offer theoretical insights into the relational and cultural dimensions of domestic violence in Malaysia and generate practical implications for strengthening the national intervention system. The findings also inform policymaking by highlighting the importance of cross-sectoral collaboration, culturally sensitive service design, and the institutionalization of group counseling within formal support structures[5]. Findings from Malaysia's multicultural setting offer transferable insights for other Southeast Asian countries facing similar cultural and institutional challenges[5].

2. Literature review

2.1. Domestic violence and women's mental health

Domestic violence has profound and long-lasting impacts on women's mental health. Qualitative studies reveal that survivors often describe their psychological experiences as "constant anxiety," "suppressed silence," and "uncontrollable fear." Such distress arises not only from direct acts of violence but also from the persistent uncertainty and power imbalance within abusive relationships. Even after the violence ceases, many women continue to experience symptoms such as rapid heartbeat, insomnia, and hypersensitivity to sounds—typical indicators of PTSD. Depression is another recurrent theme. Many women express a "loss of meaning in life" or "a sense of hopelessness," emotions often accompanied by isolation and diminished self-worth. Qualitative findings suggest that depression among survivors is not merely a low mood but a psychological numbness resulting from prolonged control and humiliation[6]. Women's narratives frequently reveal an internalized belief that they are "not worthy of respect," a perception that induces shame and hesitation when seeking help. Anxiety permeates survivors' everyday lives. Interviewees frequently mention "fear of the future" and "constant vigilance." Some described that even after leaving their abusers, they still

experience intense emotional reactions triggered by noises or arguments reminiscent of their past trauma. This phenomenon of "traumatic re-experiencing" further limits their social functioning, making it difficult to manage parenting, employment, or interpersonal relationships. From a phenomenological perspective, women's memories of violence often appear "fragmented," and they struggle to articulate their experiences coherently. Such discontinuity reflects not only the psychological mechanisms of trauma but also the cognitive disruptions it causes. Observations revealed that crying, silence, or sudden emotional outbursts during interviews served as nonverbal indicators of deep-seated distress[7].In summary, domestic violence affects women's mental health at multiple levels: PTSD manifests as emotional and physiological hyperarousal; depression reflects the erosion of self-worth and emotional numbness; and anxiety emerges as persistent fear and constrained daily functioning. Qualitative analysis thus enables a deeper understanding of these mental states within women's lived social contexts, laying the groundwork for examining how social support and group counseling facilitate recovery[8].International research similarly demonstrates that intimate partner violence produces long-term psychological consequences, including depression, anxiety, and trauma-related impairments, underscoring the global relevance of these findings (Howard et al., 2017; Patel et al., 2023).

2.2. The role of social support networks

Within the context of domestic violence, social support networks are often decisive in determining whether survivors can escape isolation and rebuild psychological stability. Qualitative research identifies three major types of support—emotional, informational, and instrumental—arising from various sources including family, friends, community, and NGOs. Recent evidence shows that strong social support networks substantially reduce loneliness, psychological vulnerability, and emotional distress across diverse populations, reinforcing their protective role in trauma recovery (Wang et al., 2022). However, the family, as the most immediate support system, is not always a safe haven. Some participants reported that relatives discouraged them from seeking help, citing cultural norms such as "do not air family shame." Such conflicting or absent support often reinforced isolation, deepened depression, and perpetuated self-blame. Under these conditions, friends, neighbors, and religious groups became essential alternative support sources[9]. One participant stated, "I can only cry freely in front of my friends," underscoring how informal emotional support provided an initial sense of safety. NGOs and community institutions also play critical roles in offering counseling, legal aid, and shelter. For instance, WAO not only provides temporary refuge but also facilitates self-reconstruction through hotlines and group counseling. Many survivors identified NGO-based interventions as "turning points" that marked their shift from passive endurance to active help-seeking. As illustrated in **Figure 1**, Malaysia's social support system for women survivors is multilayered, encompassing intimate relationships, community-based structures, and institutional resources[10].

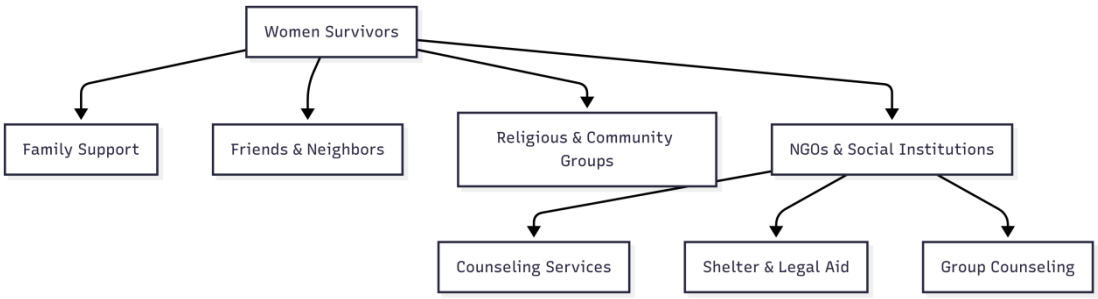

Figure 1. Multilevel social support network for women survivors of domestic violence in Malaysia.

As shown in **Figure 1**, when family support fails, friends and NGOs serve as compensatory networks that provide both emotional and practical support. Group counseling often acts as a "bridge" between personal experiences and institutional resources, facilitating emotional release and introducing survivors to formal systems of assistance. These network dynamics significantly shape women's recovery trajectories[11].

2.3. Malaysia-specific studies and legal-policy context

Since the enactment of the Domestic Violence Act (1994), Malaysia's legal and policy framework for addressing domestic violence has gradually expanded. The 2017 amendment strengthened the mechanisms for interim and emergency protection orders, allowing victims to obtain immediate safety before legal proceedings conclude. However, qualitative findings reveal that survivors continue to face barriers such as lengthy legal procedures, inconsistent enforcement, and social stigma. In rural areas, limited access to courts, shelters, and legal aid further restricts the effectiveness of protection measures[12].Beyond the legal texts, Malaysia has established complementary institutional services. The One Stop Crisis Centres (OSCC) within public hospitals integrate medical, psychological, and legal responses, serving as key entry points for survivors. The Talian Kasih 15999 hotline provides 24-hour crisis support, while NGOs such as WAO continue to offer shelters, counseling, and advocacy. Nevertheless, survivors' lived experiences reveal that these mechanisms intersect rather than function linearly[13]. Some perceive legal protection orders as empowering, while others find them inaccessible due to bureaucratic delays. NGOs are generally viewed as more empathetic and approachable but often constrained by limited resources and weak coordination with government institutions. These insights highlight the gap between "law on paper" and "law in practice" and underline the need for cross-sectoral collaboration and culturally sensitive implementation[14].

2.4. Theoretical and practical foundations of group counseling

In the field of domestic violence intervention, group counseling has been recognized as a low-threshold yet highly effective form of psychosocial support. Unlike individual counseling, group sessions create a shared and interactive environment in which women can break silence, gain validation, and reconstruct self-worth through peer witnessing. Qualitative research indicates that many survivors experience, for the first time, being "listened to without blame," marking the beginning of their psychological recovery[15].The theoretical foundations of group counseling draw from group dynamics, mutual aid theory, and empowerment theory. Group dynamics emphasize how interpersonal interactions within the group influence emotional and behavioral change. Mutual aid manifests in the exchange of experiences and reciprocal support, reducing isolation and enhancing self-efficacy. Empowerment theory further suggests that group processes enable survivors to transition from "victims" to "agents," facilitating access to legal, psychological, and social resources while restoring a sense of control. In Malaysia's multicultural setting, group counseling must also address language diversity, religious sensitivity, and gender role expectations. The choice of language (Malay, English, Mandarin, or Tamil) can affect women's comfort in expressing themselves, while religious and cultural values may function as both constraints and sources of resilience. Thus, group counseling in Malaysia is not only a psychological intervention but also a process of cultural adaptation[16].

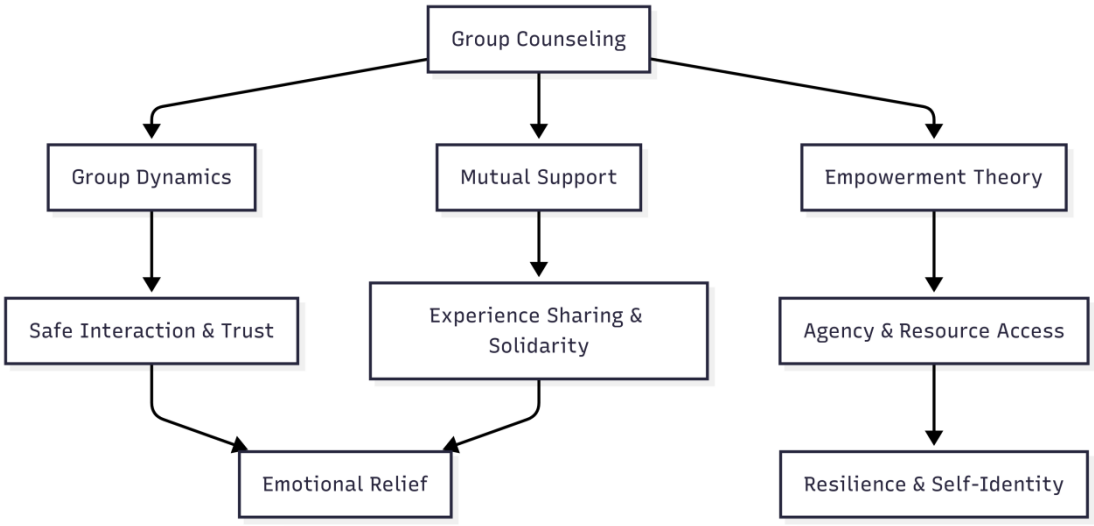

Figure 2. Theoretical foundations and practical outcomes of group counseling.

As illustrated in **Figure 2**, group counseling builds safe interactions through group dynamics, fosters shared experience and solidarity through mutual aid, and enhances resource access and self-agency through empowerment. Ultimately, it supports emotional release, psychological recovery, and the reconstruction of self-identity. These findings suggest that group counseling serves not only as a therapeutic method but also as a vital bridge within broader social support networks. Here is a polished academic English translation of your Chapter 3: Methodology, with consistent terminology and journal-ready grammar and formatting[17].

Although existing studies have provided substantial insights into the psychological consequences of domestic violence and the buffering role of social support, several important gaps remain. First, current research rarely examines how these mechanisms function within Malaysia's uniquely multicultural, multilingual, and religiously diverse context, where cultural norms and community expectations strongly influence women's help-seeking behaviors. Second, comparative analyses across urban and rural settings are limited, leaving unclear how geographical disparities shape access to institutional resources, informal support, and coping strategies. Third, despite global recognition of group counseling as an effective intervention, empirical evidence on its applicability, mechanisms, and outcomes in Southeast Asian settings remains scarce. Therefore, the present study addresses these gaps by investigating how cultural norms, resource distribution, and community structures jointly shape survivors' mental-health trajectories, while offering localized empirical evidence on the therapeutic value and psychosocial processes of group counseling in Malaysia.

3. Theoretical background

This study is anchored in four interrelated theoretical perspectives—trauma theory, social support theory, mutual aid theory, and empowerment theory—which together offer a comprehensive lens for understanding the psychological consequences of domestic violence, the functioning of support networks, and the mechanisms through which group counseling promotes recovery. Trauma theory provides a foundational explanation for the psychological disturbances commonly experienced by survivors of domestic violence. Prolonged exposure to interpersonal violence produces hyperarousal, intrusive memories, avoidance behaviors, and emotional numbing, all of which manifest as anxiety, depression, and post-traumatic stress disorder (PTSD). These symptoms often persist even after physical violence ceases, shaping survivors' cognitive processing, interpersonal trust, and help-seeking behaviors. Trauma theory therefore

underscores the need to examine women's lived experiences and the sociocultural environments that influence the severity and expression of trauma responses. Social support theory posits that emotional, informational, and instrumental support can buffer the negative psychological effects of stressful or traumatic events. In the context of domestic violence, emotional support (e.g., empathy, validation), informational support (e.g., guidance on legal or social services), and instrumental support (e.g., shelter, financial assistance) play critical roles in determining whether survivors seek help, disclose abuse, or begin recovery. Given Malaysia's multicultural and multilingual environment, the availability, accessibility, and cultural appropriateness of social support vary across regions and communities, making the theoretical framework essential for analyzing differences in women's support experiences.Mutual aid theory highlights the therapeutic power of shared experiences within group settings. According to this theory, survivors benefit from reciprocal support, collective storytelling, and peer validation, which together reduce isolation and foster solidarity. In group counseling contexts, mutual aid mechanisms—such as resonance, shared insight, role modeling, and emotional mirroring—enable participants to articulate experiences that might otherwise remain suppressed due to shame, cultural taboos, or social stigma. This theory helps explain how group dynamics function as both emotional and cognitive resources for survivors. Empowerment theory provides a framework for understanding how survivors transform from passive recipients of harm to active agents in their own recovery. Empowerment involves rebuilding self-worth, restoring a sense of control, challenging internalized stigma, and acquiring the knowledge and confidence needed to make autonomous decisions. In group counseling, empowerment emerges through supportive dialogue, role modeling, collective problem-solving, and expanded awareness of rights and resources. This perspective is particularly relevant in Malaysia, where cultural norms surrounding family harmony and gender roles often shape women's perceptions of agency and acceptable behavior. Together, these four theoretical perspectives form the analytical foundation of the present study. Trauma theory explains the psychological impact of domestic violence; social support theory clarifies the multi-level networks influencing survivors' coping options; mutual aid theory illuminates the interpersonal mechanisms of group counseling; and empowerment theory accounts for the transformative outcomes observed as survivors regain confidence and agency. Integrating these frameworks enables a culturally sensitive and contextually grounded examination of women's recovery pathways within Malaysia's diverse social landscape.

4. Methodology

4.1. Research design

This study adopts a qualitative research orientation grounded primarily in phenomenology and grounded theory. Phenomenology focuses on how individuals experience and ascribe meaning within their lifeworlds; it therefore enables in-depth exploration of abused women's post-violence psychological distress and shifts in self-understanding. Grounded theory provides a systematic path for coding and category construction, allowing the researcher to inductively derive a conceptual framework—covering mental health, social support, and the effectiveness of group counseling—from women's narrated experiences, thereby laying a solid foundation for theory building. Operationally, two data-collection strategies were employed to capture both individual experience and the psychosocial dynamics of group interaction: in-depth interviews and group observations[18]. The interviews were semi-structured and covered themes such as psychological impact, social support networks, experiences of group counseling, cultural influences, and empowerment. To ensure both structure and openness, a detailed interview guide was developed based on **Table 1**.**Table 1** summarizes the core themes and guiding questions. During fieldwork, the table served as a flexible framework: the sequence and depth of questions were adjusted to participants' circumstances so that women

were prompted to speak to the research foci without constraining emotional expression or narrative freedom[19].

Table 1. Interview guidelines.

Themes	Guiding Questions
Psychological Impact of Domestic Violence	• Can you describe how your experiences of domestic violence have affected your emotional well-being? • What emotions do you most often feel when recalling these experiences? • Have you experienced anxiety, depression, or sleep disturbances since the incidents? • How do you usually cope when you feel stressed or frightened? • In what ways do you think the violence has influenced your sense of self-worth and confidence?
Social Support Networks	• Who were the first people you turned to for help or comfort after experiencing violence? • How did your family respond when you sought help or shared your situation? • What kind of support have you received from friends, neighbors, or religious groups? • Are you aware of any NGOs, hotlines, or crisis centres that provide assistance to victims? • How easy or difficult was it for you to access these services? • What role did the community or local organizations play in your recovery process?
Group Counseling Experience	• How did you come to join the group counseling program? • What were your first impressions when participating in the group sessions? • Did you find it helpful to listen to other women's stories? • How comfortable did you feel expressing your own experiences in the group? • What changes, if any, have you noticed in your mood or outlook since joining the sessions? • In what ways did the group help you rebuild confidence or a sense of belonging?
Empowerment and Recovery	• What does "recovery" mean to you personally? • How have you changed emotionally or socially since you began receiving support? • After leaving the abusive relationship, have you taken any steps toward independence (e.g., employment or education)? • Do you now feel more capable of making decisions for yourself and your family? • How do you envision your future, and what support would help you move forward?
Cultural and Contextual Influences	• In your community, how is domestic violence usually perceived or discussed? • Have cultural or religious beliefs influenced your decision to seek help or remain silent? • Do you feel that religious or community leaders have been supportive in your recovery? • What barriers do women in your culture face when reporting or leaving abusive relationships? • How could counseling or community programs be adapted to better fit your cultural or linguistic background?
Suggestions for Improvement	• From your experience, what improvements would you like to see in counseling services or community support? • How could the government or NGOs better assist women in situations like yours? • What advice would you give to other women who are currently facing domestic violence? • What message would you want policymakers or social workers to understand about survivors' real needs?

Source: *Author-developed interview guide based on fieldwork design, 2024.*

Table 1. Interview Guidelines for Qualitative Study on Psychological Health, Social Support, and Group Counseling among Women Survivors of Domestic Violence in Malaysia. In practice, the interviewer used the themes in **Table 1** to guide participants in revisiting their experiences, paying particular attention to emotional changes, the construction of social support networks, and processes of psychological recovery within group counseling. Each interview lasted approximately 60–90 minutes, was audio-recorded with informed consent, and was transcribed verbatim for subsequent NVivo coding and analysis. Using **Table 1**

as the core framework ensured systematic and comprehensive inquiry while preserving the flexibility and empathy integral to qualitative research, allowing women's narratives to serve as the basis for theory generation and social understanding[20].

4.2. Participants

Participants were women in Malaysia affected by domestic violence. Sampling covered both urban and rural areas and was intentionally diverse in region, ethnicity, religion, language, and socioeconomic background, reflecting Malaysia's plural society and enabling a fuller picture of the intersections among domestic violence, mental health, and social support systems. Recruitment was conducted through NGOs (e.g., the Women's Aid Organisation, WAO), the government hotline (Talian Kasih 15999), One Stop Crisis Centres (OSCC) in hospitals, and referrals from community religious groups. To protect privacy, pseudonyms were used. The sample size was maintained at approximately 20–25 participants until theoretical saturation was reached. In addition, a small number of professionals involved in domestic-violence intervention (social workers, counselors, and NGO volunteers) were interviewed to triangulate women's narratives from a service-provider perspective. This multi-role sampling deepened explanatory power and strengthened triangulation[21].

Table 2. Characteristics of participants in the qualitative study.

Category	Description
Total Sample	~25 participants (20 women survivors; 5 service providers)
Regional Distribution	Urban (Kuala Lumpur, Penang, Johor); Rural (Kelantan, Sarawak, Terengganu)
Ethnic Composition	Malay (50%), Chinese (30%), Indian (15%), Indigenous/Other (5%)
Age Range	Primarily 25–50, including young mothers and mid-life women
Marital Status	Married (40%), Separated (25%), Divorced (25%), Cohabiting/Single parent (10%)
Education	Primary to tertiary; ≤ upper-secondary: 60%
Employment	Homemakers (45%), part-time/low-wage (35%), formally employed (20%)
Religions	Islam (55%), Buddhism (20%), Hinduism (15%), Christianity/Other (10%)
Recruitment Channels	NGOs, hotline, OSCCs, community and religious referrals
Inclusion Criteria	History of domestic violence; willingness to share; psychologically able to participate
Exclusion Criteria	Acute mental crisis; inability to complete interviews; refusal to provide informed consent

Source: *Author's interview recruitment records and participant demographic information, 2024.*

During fieldwork, the **Table 2** themes were tailored to participant type. For rural women, interviews emphasized cultural taboos, religious influences, and help-seeking barriers; for urban participants, they focused on use of formal services and acceptance of counseling. For NGO workers, questions centered on observations and challenges in counseling and referrals.This pairing of sample design and interview strategy enabled analysis at both individual narrative and systemic structural levels. NVivo coding and thematic synthesis then supported cross-group comparisons, producing a theoretically robust interpretation with both depth and breadth[22].

4.3. Data collection

Guided by the depth and flexibility of qualitative inquiry, data collection combined semi-structured in-depth interviews and group-counseling observations to capture women's psychological experiences, social support networks, and recovery trajectories. All materials were systematically organized and coded to ensure completeness, authenticity, and ethical security[23].

1) Semi-structured in-depth interviews.

Interview questions were designed from **Table 4**: Interview Guidelines to preserve both structure and narrative openness. The guide comprised six domains: psychological impact, social support networks, group counseling experience, empowerment, cultural/religious factors, and suggestions for improvement. Each domain contained prompts encouraging participants to narrate experiences of violence, mental states, and help-seeking in their own words.Practically, contact was made through NGOs or OSCCs. Once safety and willingness were confirmed, interviews were scheduled in safe locations (NGO offices, shelters, or participant-chosen sites)[24]. Each session lasted 60–90 minutes, was recorded with written or oral consent, and included notes on nonverbal behaviors (tone shifts, affective reactions, pauses, silence). Such observations were later coded in NVivo as "emotion nodes" to contextualize the transcripts.Recordings were transcribed verbatim immediately after each session and underwent preliminary open coding. If intense distress or re-traumatization arose, interviews were paused and emotional support provided; where needed, referral pathways were activated (see §3.5 Ethics)[25].

2) Group-counseling observations.

Beyond individual interviews, three NGO-run group counseling programs were observed. Each group comprised 6–8 participants and met 4–6 times for 1.5 hours per session. An observer-as-participant role was assumed during group sessions, and emotional flows, topical shifts, forms of support, and empowerment-related language were systematically recorded throughout the group processes.Two types of notes were maintained: process notes providing objective descriptions of settings and interactions, and reflexive notes documenting immediate impressions for bias monitoring. All notes were subsequently coded in NVivo as "Group Observation Nodes" and cross-checked against interview data for triangulation[26].

3) Document collection and integration.

To validate interview and observation findings, relevant policy texts, legal documents (e.g., Domestic Violence Act 1994/2017, Child Act 2001), NGO reports, and community outreach materials were collected. These sources provided institutional context and enriched narrative interpretation. Using NVivo case nodes, documents were linked to interview excerpts to identify gaps between institutional discourse and lived experience[27].

4) Trust-building and ethical safeguards.

From the first point of contact, a nonjudgmental stance was adopted, and it was emphasized that the interviews did not constitute clinical treatment but rather provided a space for expression and acknowledgment. Participants were informed that they retained full autonomy to skip any question or withdraw from the study at any time. All materials were anonymized and stored in encrypted devices accessible only to the research team[28].

5) Data saturation and verification.

Data collection followed the principle of theoretical saturation—stopping when no new concepts emerged. Using the constant comparison method, new materials were continually compared with prior data to ensure integrity and consistency. Member checking and data triangulation further enhanced credibility and confirmability[29].

In sum, through interviews, group observations, and document analysis, this study systematically captured survivors' subjective experiences and social contexts. **Table 4** provided the structured guide for data capture, while the diversified sample in **Table 5** ensured both depth and breadth—together laying a strong foundation for NVivo coding and thematic analysis[30].

4.4. Data analysis

The primary analytic strategy was thematic analysis, supported by NVivo 12 Plus for systematic coding and data management. This approach is well suited to complex phenomena such as survivors' post-violence psychological experiences, disparities in social support, and the effectiveness of group counseling, allowing latent patterns and meanings to be distilled without sacrificing narrative integrity[31].

1) NVivo coding procedure.

Analysis proceeded through three stages: open coding, axial coding, and selective coding.

Open coding. All interview and observation transcripts were imported into NVivo for initial line-by-line analysis. Line-by-line coding was conducted to capture participants' words and affective cues. Statements such as "I am scared of loud sounds," "my friend found me a place to stay," and "counseling made me brave enough to speak" were coded into initial nodes including trauma avoidance, social support experience, and emotional release. During axial coding, related nodes were subsequently grouped into higher-order categories. For example, "anxiety," "insomnia," and "fear" formed the theme psychological trauma; "help from friends," "NGO support," and "religious consolation" formed social support network; and "emotional catharsis," "experience sharing," and "empowerment" formed group counseling effectiveness. Iterative comparison and refinement ensured that categories reflected participants' lived meanings while maintaining theoretical clarity[32].Selective coding. A core category model was constructed around the research questions, integrating all categories into three central themes:

• the mental-health impacts of domestic violence;

• the stratification and differences of social support systems;

• the recovery mechanisms and empowerment effects of group counseling.

These themes align closely with the logic of **Table 4**, ensuring coherence from data collection to theory generation.

The selection of variables and thematic categories was informed by trauma theory, social-support theory, mutual-aid mechanisms, and empowerment-based group-intervention frameworks, ensuring that all analytical dimensions were grounded in well-established theoretical foundations. To ensure the reliability and consistency of the qualitative coding process, an inter-coder reliability test was conducted. Two trained research assistants independently coded 30% of the transcripts using the preliminary coding framework. Cohen's kappa coefficients were then calculated to evaluate the degree of coding agreement. The resulting kappa value of 0.85 indicated a high level of inter-coder reliability, reflecting strong consistency in the application of thematic categories. Any discrepancies identified during the comparison process were discussed and resolved through consensus, leading to refinement of the final coding framework prior to full-scale analysis.

2) Thematic synthesis and model building.

Guided by a phenomenological orientation, the analysis prioritized meaning-making processes over frequency-based comparisons. With NVivo's Matrix Coding Query, distributions of themes across groups (urban/rural, ethnicities, service providers) were compared to identify commonalities and differences in recovery pathways. The final framework comprised three core themes and twelve subthemes—for example, under psychological trauma: anxiety, depression, PTSD, shame; under social support: family support deficits, compensatory support from friends, community/religious support, NGO collaboration; under group counseling effectiveness: emotional release, mutual support, experience sharing, empowerment. These

themes were interlinked in the NVivo node network and repeatedly validated in narrative analysis, yielding a recovery model with both affective depth and social-structural meaning[33].

3) Member checking and triangulation.

To enhance trustworthiness and validity, member checking and triangulation were implemented.

– Member checking: analytic summaries were returned to selected participants and NGO counselors to confirm congruence with lived experience; discrepancies prompted revisions to theme descriptions or coding scope[34].

– Triangulation: undertaken at three levels—data (interviews, observations, documents), researchers (cross-coding by two research assistants; Cohen's kappa maintained ≥ 0.85), and theory (comparison with Malaysian legal frameworks, NGO reports, and international intervention models).

4) Reflexivity and constant comparison.

Recognizing the iterative nature of qualitative analysis, ongoing constant comparison was maintained to refine thematic coherence, with new materials being confronted with existing themes to ensure that the analysis remained both open and coherent. Personal values, cultural positioning, and emotional reactions were documented in reflexive notes to minimize potential researcher bias[35].

Through these procedures, the study achieved a systematic translation from text to theory within NVivo. The coding and thematic analysis illuminate survivors' trauma, support systems, and recovery pathways in the Malaysian context and provide a robust empirical basis for subsequent chapters.

4.5. Ethical considerations

Given the sensitivity of domestic-violence research and participants' potential vulnerability, strict ethical safeguards were applied to protect safety, dignity, and mental well-being. The protocol received approval from the relevant Institutional Review Board (IRB) and complied with the Declaration of Helsinki and Malaysian social-science ethics guidelines[36].

1) Confidentiality and anonymization.

All data from interviews and group sessions (audio, transcripts, observation notes) were stored using coded identifiers without personally identifiable information (names, addresses, workplaces). Each participant received a unique ID (e.g., A01, B02, C03) to distinguish urban and rural samples. Data were accessible only to the research team and stored on encrypted drives and folders. Any quoted material in publications or presentations was paraphrased or stripped of identifiers to ensure anonymity[37].

2) Informed consent and voluntary participation.

Before data collection, participants were fully briefed on the study purpose, interview content, recording procedure, data use, and withdrawal rights. Written informed consent was obtained; for those unable to sign, oral consent was recorded after verbal explanation. Participation was entirely voluntary. Individuals could withdraw at any time without penalty; withdrawn data were deleted and not used further.

3) Psychological safety and risk management.

Recognizing the risk of re-traumatization, several measures were taken: Safe venues: interviews were conducted only in participant-confirmed safe spaces (NGO offices, shelters, or private locations), never in homes accessible to perpetrators; Affective monitoring and immediate response: interviewers trained in trauma-informed practice paused or redirected discussions when signs of distress arose; Referral pathways: with consent, distressed participants were referred to partner services, including Talian Kasih 15999

(national crisis hotline), WAO (counseling and shelter), and OSCC (medical/trauma services). Referral entries were logged without personal identifiers[38].

4) Cultural sensitivity and respect.

In Malaysia's multiethnic, multireligious, and multilingual context, culturally respectful language and indirect/open questions (see **Table 4**) were used to avoid shame or offense. Where necessary, same-gender interpreters (Malay, Mandarin, Tamil, or local dialects) assisted to prevent misunderstandings and enable full emotional expression.

5) Data security and retention.

All research data will be retained for five years for audit and scholarly verification. After five years, audio files, transcripts, and digital records will be securely destroyed (drive wiping and cloud deletion). Any secondary analysis will require renewed ethical approval and participant authorization.

6) Researcher reflexivity and ethical self-awareness.

A research diary documented the researcher's values, cultural stance, and emotional responses that could shape interpretation. This reflexive practice—both methodological and ethical—helped sustain empathy and accountability when working with a vulnerable population.

In sum, the ethical design not only safeguarded participants' safety and privacy but also enhanced the credibility, authenticity, and cultural sensitivity of the qualitative data. With rigorous confidentiality, informed consent, and psychological-support protocols, the study was able to explore Malaysian women's mental-health and social-support experiences within a foundation of respect and trust.[39]

5. Findings and analysis

5.1. Psychological impacts of domestic violence

Drawing on in-depth interviews and group counseling observations involving more than twenty survivors of domestic violence, the impact of abuse on mental health was found to be distinctly multidimensional.Anxiety, depression, and post-traumatic stress disorder (PTSD) emerged as the most prominent themes. Most participants described persistent feelings of fear, insomnia, helplessness, and self-blame, intertwined with experiences of family dysfunction, social stigma, and barriers to help-seeking. From a phenomenological perspective, survivors' psychological trauma is not the result of a single violent incident but a long-term, cumulative "lived experiential trauma." Even after leaving abusive relationships, many described themselves as "sensitive to sounds," "unable to trust others," or "reliving the night through recurring nightmares." Such re-experiencing reflects both the persistence and depth of trauma's impact[40].

Table 3. Summarizes the primary psychological themes identified in the study, their manifestations, and representative participant quotations.

Theme	Main Psychological Manifestations	Typical Quotations	Researcher's Analysis
Anxiety	Constant tension, hypervigilance, sleep disturbance, extreme sensitivity to conflict sounds	"Every time a door slams, my heart races—I feel like I'm about to be hit again." (Urban sample, A03)	Characterized by conditioned hyperarousal and physiological stress responses to prolonged fear exposure.
Depression	Emotional numbness, self-denial, loss of meaning, social withdrawal	"Sometimes I look at my child and wonder if there's any point in living." (Rural sample, B07)	Long-term devaluation erodes self-worth, fostering hopelessness and emotional desensitization.
PTSD	Flashbacks, nightmares,	"I can't go near that old	Recurrent traumatic memories

Theme	Main Psychological Manifestations	Typical Quotations	Researcher's Analysis
	avoidance, emotional breakdown	street—just seeing the building makes me cry." (Urban sample, C05)	trigger intense emotional reactions that disrupt daily functioning.
Shame & Self-Blame	Believing the violence occurred because they "did something wrong"	"I think I talk too much and make him angry." (Rural sample, B04)	Internalization of gender norms traps survivors in cognitive trauma loops.
Isolation & Fear	Avoidance of social contact, reluctance to speak out, fear of stigma	"I don't tell anyone because I'm afraid they'll look down on me." (Urban sample, A06)	Cultural taboos and social stigma exacerbate psychological isolation and anxiety.

Table 3. (*Continued*)

Source: *NVivo 12 Plus thematic coding of interview transcripts, 2024.*

As shown in **Table 3**, anxiety, depression, and trauma responses frequently recurred in participants' narratives, often interwoven and reinforced by social and cultural structures. Nonverbal expressions—crying, long pauses, trembling voices—indicated that trauma remained active and unresolved. Group observations revealed that when one member shared similar experiences, others exhibited heightened emotional responses, illustrating a phenomenon of "resonant reactivation" of trauma. Overall, the mental-health consequences of domestic violence extend beyond symptoms to fundamentally alter self-identity and interpersonal trust. Psychological trauma becomes an obstacle to rebuilding relationships with the external world and represents a key entry point for social support and group-counseling interventions[41].

5.2. Differences in social support: Absence of family support and compensatory roles of friends and community

Using NVivo's Matrix Coding Query, the study revealed pronounced differences in social-support structures among women survivors. The results show that the absence of family support is a universal theme, while compensatory support from friends, community, and NGOs plays a pivotal role in psychological recovery. Different groups—survivors, service providers, community leaders, and policymakers—demonstrated distinct understandings and experiences of "support," reflecting both disparities in resource accessibility and deeper cultural and institutional dynamics.As illustrated in **Figure 3**, the Matrix Coding Query identified variations in coding density across five participant categories: women survivors, child witnesses, service providers, community leaders, and government officials. Survivors exhibited the highest frequency of "social support" references—highlighting feelings of "misunderstanding," "blame," and "isolation." NGO staff and service providers emphasized "resource constraints" and "coordination gaps," while policymakers' and community leaders' codes were markedly fewer, exposing a perceptual distance between macro-level discourse and individual experience.

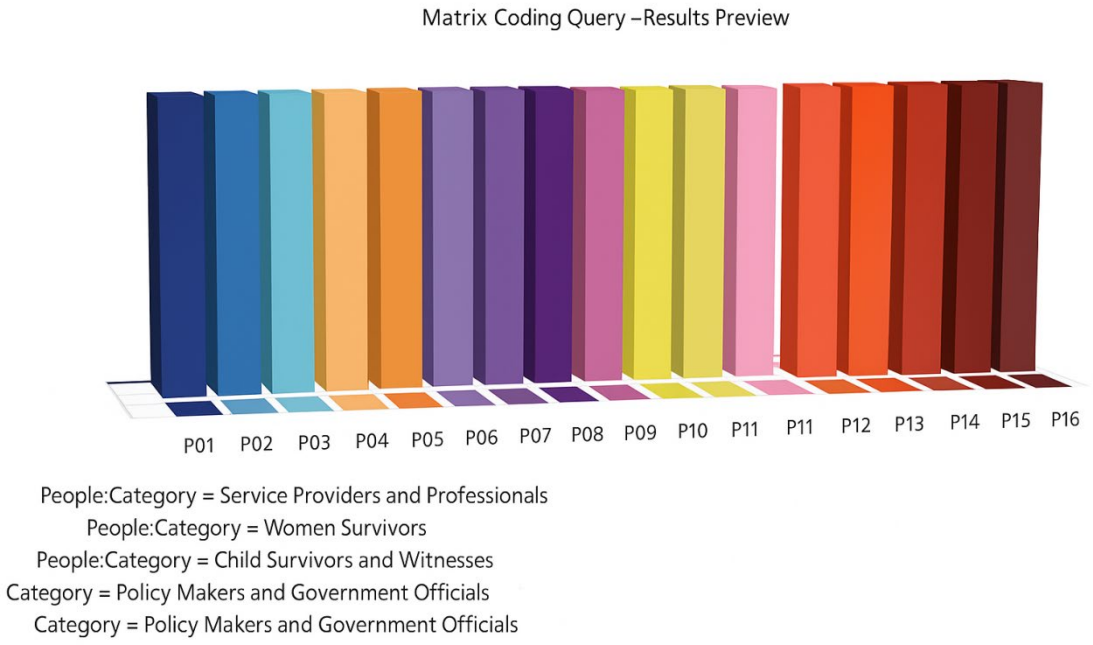

Figure 3. Matrix coding query results: social support theme distribution among participant groups.

1) Lack of Family Support

Most participants reported that family members—especially spouses and elders—were sources of emotional harm rather than support. Some described their natal families refusing to intervene due to traditional beliefs encouraging endurance. A respondent from Kelantan (B06) recalled, "I told my mother he hit me again, and she said, 'There's no marriage without fights.' I felt invisible." Such intra-family silence and denial deepened survivors' shame and delayed help-seeking. Qualitative analysis identified this "secondary violence"—victim-blaming and moral disciplining within families—as a key mechanism perpetuating trauma.

2) Emotional Compensation from Friends and Neighbors

In contrast, friends and neighbors emerged as critical emotional anchors. Many urban participants described "a friend's willingness to listen" as the first step toward recovery. One woman (A04) said, "If my friend hadn't let me stay with her, I would never have dared to call the police." Although such informal support lacks professional intervention, it proved vital for emotional stabilization and restoring safety. Group observations showed that shared experiences often triggered catharsis and connection—demonstrating the "peer resonance" effect in collective healing.

3) Dual Roles of Community and Religious Organizations

Community and religious groups played ambivalent roles. Religious spaces—mosques, churches, temples—offered solace and belonging but sometimes reinforced gendered norms of "harmony" and "obedience." One respondent (B11) shared that a cleric advised her to "pray more and resist less," a culturally gentle but psychologically disempowering message. Conversely, some female religious educators (ustazah) and volunteers exhibited strong sensitivity, acting as vital bridges between formal institutions and survivors.

4) Professional Support from NGOs

Organizations such as the Women's Aid Organisation (WAO) provided essential psychological counseling, shelter, and legal guidance. Participants consistently praised NGO staff for "listening without judgment" and offering "a sense of safety." NVivo coding clustered around nodes like trust, safety, and understanding in NGO-related narratives. An urban participant (A09) reflected, "The counselor didn't tell me what to do—she just reminded me I still had choices." NGOs thus represent a crucial link between empowerment and psychological recovery, though staff noted that limited funding and uneven regional coverage leave rural areas underserved.

5) Gaps between Institutional Design and Lived Experience

Although the government has established One Stop Crisis Centres (OSCC) and the Talian Kasih 15999 hotline, many survivors reported feeling "ignored or redirected" when seeking assistance. This disconnect between institutional accessibility and emotional validation means "formal support" often fails to translate into "felt safety." Service providers cited weak inter-agency coordination and information silos among police, hospitals, and NGOs as major breakdown points. Thematic analysis identified "institutional failure" as a key reason survivors discontinue help-seeking or re-enter abusive cycles.

Table 4. Summarizes the functions, limitations, and emotional meanings of different types of social support.

Source of Support	Primary Function	Common Issues or Limitations	Typical Participant Sentiment	Researcher's Analysis
Family	Emotional and financial support (expected)	Moral judgment, victim-blaming, refusal to intervene	"My family told me to endure—it made me feel more alone."	Absence of family support reproduces trauma and intensifies shame and helplessness.
Friends / Neighbors	Emotional comfort, temporary shelter	Short-term, lack of professional resources	"My friend's home was my only refuge."	Friendship creates a primary psychological safety net and fosters courage to act.
Community / Religion	Spiritual comfort, social belonging	Cultural taboos, gender stereotypes	"The religious leader told me to pray, not what to do."	Dual role—religious discourse can both empower and suppress depending on framing.
NGOs	Counseling, legal aid, shelter	Resource limitations, uneven coverage	"They listened and didn't make me feel at fault."	NGOs provide the most empowering support, bridging emotion and institution.
Government Services (OSCC / Hotline)	Crisis intervention, medical care, referral	Bureaucratic, inconsistent implementation	"They kept transferring me—I didn't know who to ask."	Institutional support lacks warmth and continuity; requires cultural sensitivity.

Source: *Author-developed thematic framework informed by literature review and expert consultation, 2024.*

As the **Table 4** shown, disparities in social support reflect not only unequal resource distribution but also women's subjective experiences of safety and trust. Family failure forces survivors to rely on external networks—friends, communities, and NGOs—yet these are shaped by cultural, institutional, and geographic constraints. As **Figure 3** illustrates, different social actors conceptualize "support" differently: policymakers emphasize institutions, professionals focus on service mechanisms, while survivors prioritize emotional understanding and validation. From a qualitative perspective, effective social support is less about service quantity and more about building accessible, trustworthy, and sustainable emotional connections within a

cultural context. True recovery requires an inclusive support ecosystem where law, institutions, and community coalesce to rebuild safety and empowerment.

5.3. Effectiveness of group counseling: Emotional release, experience sharing, mutual support, and empowerment

Systematic observation and NVivo matrix analysis revealed four major themes demonstrating the effectiveness of group counseling in fostering psychological recovery and social reintegration: emotional release, experience sharing, mutual support, and self-empowerment. These themes are interdependent, forming a psychosocial transformation chain from "emotional unloading" to "action reconstruction."As shown in **Figure 4**, coding frequencies for "emotional release" and "mutual support" peaked in the early stages of group participation, while "self-empowerment" and "social action" increased in later stages—reflecting the inner logic of group counseling: beginning with psychological safety and culminating in empowerment and agency.

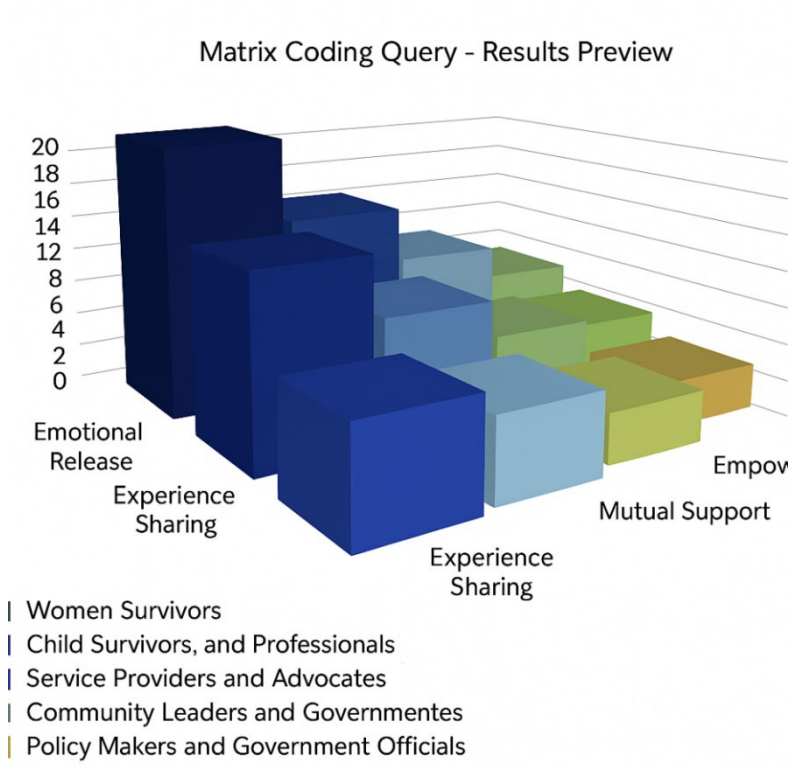

Figure 4. Matrix coding query results: Themes of group counseling effectiveness.

1) Emotional Release: Establishing Safety and Expression

Many participants described the group as "the first place I was allowed to cry." Emotional release was not mere catharsis but the starting point of healing. One survivor (A08) recalled, "I couldn't cry at home—my kids would be scared. In the group, I finally told what happened that night." Nonverbal empathy—nods, tissues passed, silent presence—created a safe emotional atmosphere. Such release marked the transition from repression to expression, breaking long-enforced silence.

2) Experience Sharing: From Individual Narratives to Collective Meaning

Experience sharing was the core interactive pattern. Telling one's story allowed narrative reconstruction, while hearing others' stories generated empathy. "Listening to others felt like looking in a mirror—I realized

I wasn't alone," said participant B05. NVivo coding showed frequent co-occurrence of nodes such as being understood, similar experience, and empathy, demonstrating how collective narrative fosters connection and redefines identity from "victim" to "survivor."

3) Mutual Support: Rebuilding Relationships and Trust

Mutual support combined emotional reassurance with informational exchange. Participants reminded each other about legal steps, hotlines, or shelters, and offered encouragement beyond group sessions. "We text each other every week to check in," said A02. Such ongoing contact extended support beyond meetings, establishing a sustainable social network that restored interpersonal trust—a key marker of recovery.

4) Self-Empowerment: Awakening Agency and Action

Self-empowerment marked the final stage. Some women began exploring new life directions—learning about legal rights, applying for protection orders, or re-entering employment. "Now I accompany new sisters to the police station and show them what papers to bring," said B09. This shift from passivity to action illustrated empowerment as both a psychological and social process.

Table 5. Main themes and illustrative narratives of group counseling effectiveness.

Theme	Key Manifestations	Representative Quote	Researcher's Interpretation
Emotional Release	Crying, expressing anger or fear, first-time disclosure	"I finally said it out loud—I don't have to pretend anymore." (A08)	The group provides a safe space for suppressed emotions—foundation of psychological recovery.
Experience Sharing	Listening to peers, recognizing commonality, gaining understanding	"Her story was just like my life." (B05)	Shared storytelling fosters empathy and meaning reconstruction, dissolving isolation and shame.
Mutual Support	Practical advice, emotional reassurance, resource exchange	"We check on each other every week." (A02)	Groups form continuing support networks, rebuilding trust and security.
Self-Empowerment	Taking action, rebuilding confidence, helping others	"I took the new members to see a lawyer." (B09)	Marks transition from healing to agency—psychological and social rebirth.

Source: *NVivo 12 Plus coding of group counseling observation notes and interview transcripts, 2024.*

As shown in **Table 5**, Qualitative analysis suggests that these four dimensions evolve progressively: emotional release establishes safety, experience sharing builds empathy, mutual support consolidates connection, and empowerment signifies transformation. Moreover, **Figure 5** indicates thematic divergence among participant categories—survivors showed highest emotional expression density, service providers focused on "support services," and policymakers emphasized "education programs" and "systemic challenges." This suggests that group counseling not only supports individual recovery but also inspires social reflection and institutional learning.

In summary, group counseling plays a crucial role in Malaysia's domestic-violence interventions. Beyond individual psychotherapy, it mobilizes collective dynamics and social reciprocity to enable transformation from emotional repair to social empowerment. True recovery, as survivors' narratives show, does not mean forgetting—it means reclaiming suppressed selves and re-entering society with renewed agency.

5.4. Urban – Rural and Cultural Differences

Interviews and group observations revealed that urban–rural disparities and cultural factors are key determinants of support-system effectiveness. Urban and rural women differed significantly in help-seeking channels, resource accessibility, cultural taboos, and linguistic communication—factors that shaped not only their access to support but also the pace and depth of recovery.

1) Differences in Help-Seeking Channels

Urban women had higher information access and were more likely to use formal mechanisms such as OSCCs, WAO, and the Talian Kasih hotline. One respondent from Penang (A11) shared, "I found the WAO hotline online. I was breaking down—I called it right away." The internet and social media served as gateways to formal institutions. In contrast, rural women relied heavily on informal networks—neighbors, religious leaders, or relatives. "I didn't call the police—everyone in the village knows each other. I'd be shamed," said B02. In tightly knit communities, disclosure risks exposure and secondary stigma. Some viewed help-seeking as "disrupting family harmony," limiting institutional reach.

2) Cultural Taboos and Religious Beliefs

Cultural and religious beliefs deeply influenced help-seeking. In Muslim-majority regions, women often felt bound by norms like "the family is sacred" and "wives must obey." Many blamed themselves for not being "dutiful" enough. Even in group sessions, some lowered their voices or avoided the word "violence," signaling linguistic self-censorship. Yet, faith also provided resilience—"When I pray, I feel I'm not abandoned," said B08. Religion thus functions both as a constraint and as a coping resource; culturally sensitive counseling should transform faith into a force of healing rather than submission.

3) Language and Communication Barriers

Language differences—often overlooked—proved significant in Malaysia's multiethnic context. Urban services primarily use Malay or English, while some Chinese or Indigenous women struggled to communicate. "At the police station, they couldn't understand my dialect and told me to come back later," recalled B12 from Sabah. Such experiences undermine trust in institutions and reinforce isolation. NVivo cross-analysis showed that "communication barriers" appeared far more frequently in rural samples, constraining both help-seeking and group interaction.

4) Accessibility of Resources and Trust Structures

Resource disparities were most visible in geography: urban regions had dense NGO networks and medical services, while rural areas faced limited shelters, long travel distances, and financial barriers. Even where services existed, distrust of government institutions discouraged engagement. The theme of "trust" emerged as a key mediator between available resources and survivor action. Urban women trusted NGOs' professionalism; rural women trusted familiar figures like village heads or religious leaders. This trust configuration shaped divergent support pathways—formal versus relational.

5) Comparative Overview of Urban–Rural Support Systems

Table 6. Comparative analysis of urban – Rural differences in social support systems.

Dimension	Urban Women	Rural Women	Qualitative Conclusion
Help-Seeking Channels	Prefer formal institutions (OSCC, NGO, hotline)	Rely on informal networks (family, religious leaders)	Urban support institutionalized; rural support relational.
Cultural Taboos	Emphasize independence, less	Stress family harmony and	Cultural pressure hinders

Dimension	Urban Women	Rural Women	Qualitative Conclusion
	social judgment	endurance; high stigma	rural help-seeking.
Language & Communication	Use Malay/English effectively	Dialect diversity limits expression	Language barriers deepen distrust.
Primary Trust Object	Trust in professional institutions	Trust in familiar or religious figures	Trust orientation shapes support behavior.
Recovery Pathway	Professional counseling and empowerment	Faith-based coping and community belonging	Recovery models diverge across cultural contexts.

Table 6. (*Continued*)

Source: *Comparative NVivo analysis of urban and rural participant transcripts, 2024.*

As shown in **Figure 5**, four main support pathways emerged: formal institutional, informal social, religious/community-based, and non-seeking. Urban participants primarily used formal channels, while rural participants relied on relational and faith-based supports, with a small subset remaining silent or avoidant.

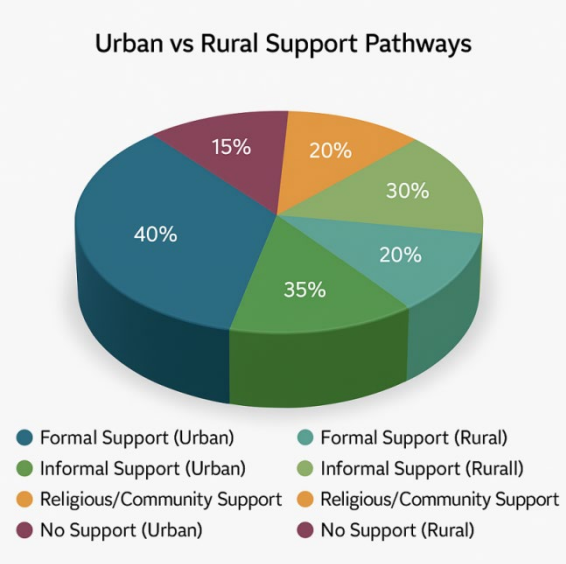

Figure 5. Urban vs. rural support pathways among women survivors of domestic violence in Malaysia.

Collectively, as shown in **Table 6**, urban–rural disparities and cultural dynamics form a "social topography" of Malaysia's domestic-violence intervention system. Urban women possess better access to information and professional services but still face bureaucratic detachment and emotional mistrust; rural women draw comfort from interpersonal and religious ties but lack adequate institutional protection. Effective intervention, therefore, must bridge system and culture—humanizing urban services and embedding culturally sensitive education and community collaboration in rural areas. Only when women both trust and use the support system can psychological recovery and social empowerment become sustainable realities.

6. Discussion

6.1. Localized characteristics of domestic-violence interventions in Malaysia

Based on qualitative analysis of interview and group-observation data, this study finds a pronounced tension in Malaysia's domestic-violence intervention system between legal/institutional design and cultural practice, alongside a distinctive path of local adaptation. Compared with the "legal–psychological–social" triadic model emphasized in international literature, intervention practice in Malaysia is more deeply shaped

by multicultural and religious contexts. At the institutional level, the Domestic Violence Act (1994; amended 2017) and the Child Act (2001) provide the legal framework; however, geographical disparities in implementation and cultural barriers generate a persistent "institutional distance" for help-seeking, particularly in rural areas where women tend to rely on religious or acquaintance networks rather than formal agencies. Unlike the Western pattern of "high institutional trust, lower cultural mediation," Malaysia exhibits "strong cultural scaffolding, weaker institutional trust."The dual role of religion and culture requires a careful balance between sensitivity and effectiveness. Qualitative data show that religious beliefs can act both as constraints on women's actions and as spiritual resources for recovery. Practice experience among NGOs suggests that reframing religious language into empowering discourse (e.g., emphasizing "respect for life" and "care for family" rather than "endurance and obedience") can significantly increase acceptability—an example of cultural translation in localized intervention. Structurally, Malaysia's multilingual environment, ethnic diversity, and urban–rural divides lead to marked differences in the accessibility of support systems. These patterns are consistent with broader findings that socio-economic development and resource distribution strongly shape access to mental-health services and protective mechanisms, particularly in unequal or geographically dispersed societies (Karimi et al., 2023).

Urban women more readily obtain professional services and hotline assistance, whereas rural women rely on informal networks. In line with existing research, universalized models that overlook local culture and social realities are difficult to operationalize. Thus, this study argues that localization is less about copying international frameworks than redefining support, trust, and empowerment within local contexts. **Table 7** summarizes the main localized features of Malaysia's intervention system in comparison with typical Western models.

Table 7. Comparative features of localized domestic-violence interventions in Malaysia.

Dimension	Mainstream Western Model	Localized Features in Malaysia	Qualitative Insight
Legal/Institutional Enforcement	High institutionalization; stable police–social service collaboration	Complete laws but uneven enforcement; local implementation depends on resource distribution	Effectiveness of the legal framework is shaped by geography and administration
Sociocultural Context	Individualism; emphasis on personal rights	Collectivism; emphasis on family harmony and religious ethics	"Family" functions as both support resource and help-seeking barrier
Religious Influence	Separation of religion and social services	Religious bodies play important roles in intervention	Religious language needs translational reframing toward empowerment
Language/Ethnicity	Largely monolingual communication	Multilingual, multiethnic, multicultural	Language barriers hinder trust and communication with institutions
Support System	Close NGO–government collaboration; broad coverage	NGOs lead informal support; government services concentrated in cities	NGOs act as cultural bridges
Recovery Pathway	Predominantly professional psychotherapy	Group counseling combined with religious support	Localized counseling integrates affect and faith

As shown in **Table 6**, Malaysia's intervention path is deeply culturally embedded. Women's help-seeking often oscillates among religious constraints, family pressure, and institutional support. Religion, language, and social networks can be both enabling and obstructive. To illustrate the multidimensional structure of localization, the researcher constructed **Figure 6** (based on NVivo clustering) comparing six

dimensions of the intervention system: legal enforcement, cultural sensitivity, religious integration, institutional trust, social-support coverage, and recovery orientation.

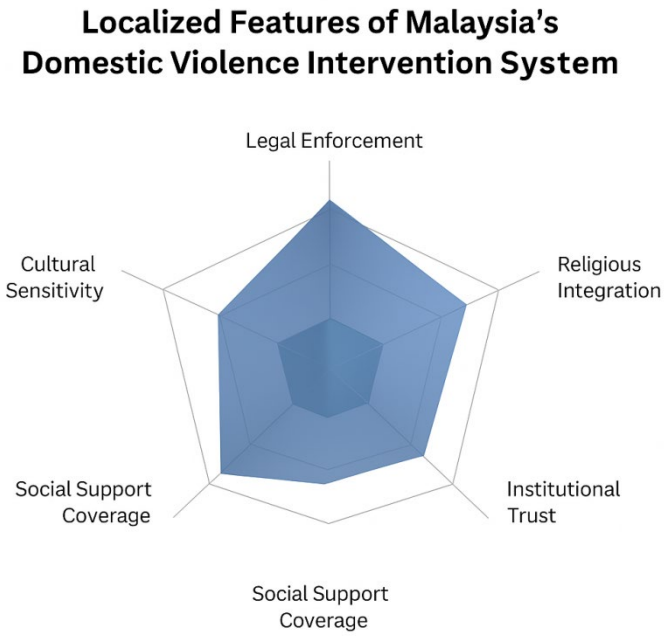

Figure 6. Localized features of Malaysia's domestic violence intervention system (3D Radar Model).

As **Figure 6** indicates, Malaysia scores highly on cultural sensitivity and religious integration but shows clear weaknesses in institutional trust and resource coverage. This structural imbalance reflects a dual tension in localized intervention: cultural embeddedness provides emotional and identity foundations, whereas limited institutional enforcement compromises sustainability. Synthesizing **Table 6** and **Figure 7**, the study contends that Malaysia must locate a new equilibrium between institutionalization and cultural adaptation. Future policy and practice should prioritize cross-cultural communication, empowerment-oriented religious discourse, and more equitable distribution of grassroots resources—advancing a model that balances system design with humanistic care.

6.2. Recovery mechanisms of group counseling and policy implications

Another key finding is the unique effectiveness of group counseling in promoting psychological recovery and social reintegration. Qualitative analysis shows a transformational arc within groups—from emotional release, to mutual aid, to self-empowerment—which helps build a sustained network of social support.

Mechanistically, group counseling achieves a threefold transformation via group dynamics and mutual-aid effects: Psychological level: emotional release and experience sharing break cycles of silence and relieve suppressed affects; Social level: mutual support and peer resonance strengthen connections and restore interpersonal trust;Action level: empowerment processes enable women to regain control of their lives and engage in community mutual aid, moving from "help recipients" to helpers. While consistent with group-therapy theories of trauma recovery, these mechanisms in Malaysia display distinctive cross-religious and cross-ethnic inclusivity.

Policy and practice implications (three recommendations):Strengthen government–NGO coordination, building a cross-sectoral intervention network to ensure seamless linkage from medical and legal services to

psychological counseling. Expand community education and public awareness to dismantle norms such as "family shame should not be aired," enabling women to speak and seek help—leveraging community talks, religious gatherings, and local-language media. Institutionalize group counseling within national social services: train local facilitators and establish multilingual groups to achieve both scale and cultural fit. This will enhance resilience and reshape public understanding and responses to domestic violence. Overall, group counseling is not only a tool for psychological rehabilitation but also a process of social empowerment. Through emotional connection and shared experience, women regain agency by "being seen" and "being understood," offering a practical pathway for a more inclusive and sensitive intervention system in Malaysia.

7. Conclusion

Using a qualitative design with in-depth interviews and group observations, this study examined Malaysian women survivors' mental health, social support systems, and the role of group counseling in recovery. The findings highlight the complexity of domestic-violence intervention within Malaysia's sociocultural context, revealing interactions among institutions, culture, and religion, and tracing survivors' pathways of reconstruction under adversity. These insights align with global mental-health literature emphasizing that women's recovery from violence requires comprehensive psychological support integrated with community-level and institutional systems (Patel et al., 2023).

First, from a mental-health perspective, domestic violence produces multidimensional and long-term trauma. Anxiety, depression, and PTSD were common among participants; social isolation, shame, and self-blame further intensified distress. Trauma is not a single-event outcome but the product of prolonged abuse, cultural pressure, and institutional neglect. Second, regarding social support, the system exhibits stratified and culturally differentiated features. The absence of family support is a major driver of psychological hardship, while compensatory support from friends, communities, and NGOs provides crucial emotional and practical resources. Women tended to trust informal relations and religious groups more than government agencies, consistent with the structural pattern of strong cultural scaffolding and weaker institutional trust. Urban–rural disparities and language barriers widened accessibility gaps. Third, a core finding is the significant impact of group counseling on psychological recovery and social reintegration. Emotional release, experience sharing, mutual support, and empowerment formed four core stages of recovery. Women moved from "victims" to "actors," building new social ties through mutual aid—restoring psychological resilience and facilitating collective empowerment. Fourth, in terms of localized intervention, Malaysia's system is highly culturally embedded. Although legal frameworks exist, enforcement is constrained by geography and culture; religion can both support recovery and regulate behavior; multilingual, multiethnic realities complicate communication and trust. NVivo coding and radar-model analysis show strengths in cultural sensitivity and religious integration, but weaknesses in institutional trust and resource coverage, pointing to the need for balance between institutionalization and cultural adaptation.

Practical implications: Promote cross-sector collaboration between government and NGOs to build multi-level networks linking counseling, legal aid, and community education. Enhance culturally sensitive education and multilingual services in rural and minority communities to improve accessibility. Incorporate group counseling into public services as a routine intervention; train community facilitators to broaden mental-health coverage. Introduce empowerment-oriented narratives within religious and cultural contexts—through faith translation, language adaptation, and social advocacy—to foster recovery and social acceptance. In sum, the study illuminates the localized characteristics of Malaysia's intervention system and the multifaceted mechanisms of women's recovery. Qualitative analysis suggests that effective intervention depends not only on institutional design and resource provision but also on cultural understanding and the

rebuilding of social trust. Future research could integrate quantitative methods and longitudinal designs across cultural groups to construct a more systematic and inclusive model for domestic-violence prevention and response—offering transferable insights for gender-violence interventions across Southeast Asia.

Conflicts of interest

The authors declare no conflicts of interest.

References

1. Vicary, Emily, et al. "The impact of social support on university students living with mental illness: a systematic review and narrative synthesis." Journal of Mental Health 34.4 (2025): 463-475.
2. Xie, Yue, et al. "The impact of stigma on mental health and quality of life of infertile women: A systematic review." Frontiers in psychology 13 (2023): 1093459.
3. Barrett, Simon, et al. "Interventions to reduce parental substance use, domestic violence and mental health problems, and their impacts upon children's well-being: A systematic review of reviews and evidence mapping." Trauma, Violence, & Abuse 25.1 (2024): 393-412.
4. Acoba, Evelyn F. "Social support and mental health: the mediating role of perceived stress." Frontiers in psychology 15 (2024): 1330720.
5. Wild, Jessica. "Gendered discourses of responsibility and domestic abuse victim-blame in the English children's social care system." Journal of family violence 38.7 (2023): 1391-1403.
6. Dissanayake, Lasith, et al. "The aftermath of war; mental health, substance use and their correlates with social support and resilience among adolescents in a post-conflict region of Sri Lanka." Child and adolescent psychiatry and mental health 17.1 (2023): 101.
7. Rippon, Daniel, et al. "The role of self-efficacy and self-esteem in mediating positive associations between functional social support and psychological wellbeing in people with a mental health diagnosis." Journal of Mental Health 33.6 (2024): 721-730.
8. White, Sarah J., et al. "Global prevalence and mental health outcomes of intimate partner violence among women: a systematic review and meta-analysis." Trauma, Violence, & Abuse 25.1 (2024): 494-511.
9. Chu, Yi-Chin, et al. "Outcomes of trauma-informed care on the psychological health of women experiencing intimate partner violence: a systematic review and meta-analysis." Journal of psychiatric and mental health nursing 31.2 (2024): 203-214.
10. Whittingham, Martyn, et al. "Mental health care equity and access: A group therapy solution." American Psychologist 78.2 (2023): 119.
11. Li, Yue, Jun Peng, and Yanqiang Tao. "Relationship between social support, coping strategy against COVID-19, and anxiety among home-quarantined Chinese university students: A path analysis modeling approach." Current Psychology 42.13 (2023): 10629-10644.
12. Zhang, Yushu, et al. "The impact of anxiety, depression, and social support on the relationship between HIV-related stigma and mental health-related quality of life among Chinese patients: A cross-sectional, moderate-mediation study." BMC psychiatry 23.1 (2023): 818.
13. Wall, Stephanie, and Maria Dempsey. "The effect of COVID-19 lockdowns on women's perinatal mental health: a systematic review." Women and Birth 36.1 (2023): 47-55.
14. Lewis, Natalia V., et al. "Trauma-Informed Approaches in Primary Healthcare and Community Mental Healthcare: A Mixed Methods Systematic Review of Organisational Change Interventions." Health & Social Care in the Community 2023.1 (2023): 4475114.
15. Micklitz, Hannah M., et al. "Efficacy of psychosocial interventions for survivors of intimate partner violence: A systematic review and meta-analysis." Trauma, Violence, & Abuse 25.2 (2024): 1000-1017.
16. Cirici Amell, Roser, et al. "Psychological consequences and daily life adjustment for victims of intimate partner violence." The International Journal of Psychiatry in Medicine 58.1 (2023): 6-19.
17. Olsavsky, Anna L., et al. "Associations among gender-affirming hormonal interventions, social support, and transgender adolescents' mental health." Journal of adolescent health 72.6 (2023): 860-868.
18. Chi, Xinli, et al. "Relationship between adverse childhood experiences and anxiety symptoms among Chinese adolescents: The role of self-compassion and social support." Current Psychology 42.15 (2023): 12822-12834.
19. Chavda, Kersi, and Vinyas Nisarga. "Single parenting: Impact on child's development." Journal of Indian Association for Child and Adolescent Mental Health 19.1 (2023): 14-20.
20. Ates, Nazli, et al. "The effect of perceived social support on quality of life in Turkish men with alcohol, opiate and cannabis use disorder." Journal of Ethnicity in Substance Abuse 22.2 (2023): 316-336.

21. Yonemoto, Naohiro, and Yoshitaka Kawashima. "Help-seeking behaviors for mental health problems during the COVID-19 pandemic: A systematic review." Journal of Affective Disorders 323 (2023): 85-100.
22. Bedrov, Alisa, and Shelly L. Gable. "Thriving together: the benefits of women's social ties for physical, psychological and relationship health." Philosophical Transactions of the Royal Society B 378.1868 (2023): 20210441.
23. Tambling, Rachel R., et al. "Predictors of mental health help-seeking during COVID-19: Social support, emotion regulation, and mental health symptoms." The journal of behavioral health services & research 50.1 (2023): 68-79.
24. Amini, Shabnam, Amir Jalali, and Rostam Jalali. "Perceived social support and family members of patients with mental disorders: A mixed method study." Frontiers in public health 11 (2023): 1093282.
25. Alves, Sónia Patricia, et al. "Perinatal mental health counselling programme: A scoping review." Patient education and counseling 106 (2023): 170-179.
26. Kay, Tatjana L., et al. "The role of social support in perinatal mental health and psychosocial stimulation." The Yale journal of biology and medicine 97.1 (2024): 3.
27. Albright, Jamie N., and Noelle M. Hurd. "Activism, social support, and trump-related distress: Exploring associations with mental health." Journal of Diversity in Higher Education 16.1 (2023): 1.
28. Simons, Eadie E., and Matthew D. Bird. "Coach-athlete relationship, social support, and sport-related psychological well-being in National Collegiate Athletic Association Division I student-athletes." Journal for the Study of Sports and Athletes in Education 17.3 (2023): 191-210.
29. Ostadtaghizadeh, Abbas, et al. "Gender-based violence against women during the COVID-19 pandemic: recommendations for future." BMC women's health 23.1 (2023): 219.
30. Theodoratou, Maria, et al. "Emotion-focused coping, social support and active coping among university students: Gender differences." Journal of Psychology & Clinical Psychiatry 14.1 (2023): 5-9.
31. Johnstone, Samantha, et al. "A systematic review of gender-responsive and integrated substance use disorder treatment programs for women with co-occurring disorders." The American Journal of Drug and Alcohol Abuse 49.1 (2023): 21-42.
32. Rea, Jessica. "Social relationships, stigma, and wellbeing through experiences of homelessness in the United Kingdom." Journal of Social Issues 79.1 (2023): 465-493.
33. Mukhtar, Sonia. "COVID-19 feminist framework and biopsychosocial-spiritual perspective for social workers and mental health practitioners to manage violence, abuse, and trauma against children, women, BIPOC, and LGBTQIA+ during and post-COVID-19." International social work 66.1 (2023): 93-106.
34. Stanley, Selwyn, and Anand Jerard Sebastine. "Work-life balance, social support, and burnout: A quantitative study of social workers." Journal of Social Work 23.6 (2023): 1135-1155.
35. Kjellstrand, Jean M., et al. "Social support during incarceration: Predictors of external social support for incarcerated individuals." American journal of criminal justice 48.5 (2023): 1183-1203.
36. Malik, Abid, et al. "Perceived social support and women's empowerment and their associations with pregnancy experiences in anxious women: a study from urban Pakistan." Maternal and child health journal 27.5 (2023): 916-925.
37. Prina, Eleonora, et al. "Task-sharing psychosocial interventions for the prevention of common mental disorders in the perinatal period in low-and middle-income countries: A systematic review and meta-analysis." International Journal of Social Psychiatry 69.7 (2023): 1578-1591.
38. King, N., et al. "Mental health and academic outcomes over the first year at university in international compared to domestic Canadian students." Journal of American college health 71.9 (2023): 2663-2672.
39. Nesset, Merete Berg, et al. "Development of nurse-led videoconference-delivered cognitive behavioural therapy for domestic violence: Feasibility and acceptability." Journal of advanced nursing 79.4 (2023): 1503-1512.
40. Sian,Oram,Hind,et al.Violence against women and mental health[J].Lancet Psychiatry, 2017.DOI:10.1016/S2215-0366(16)30261-9.
41. Xing Z ,Shenghong D .The relationships between social support and loneliness: A meta-analysis and review.[J].Acta psychologica,2022,227103616-103616.DOI:10.1016/J.ACTPSY.2022.103616.