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Title: **COVID-19 and domestic violence: impact on mental health**

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Authors:
Parveen Ali[1], Michaela Rogers[2], Susan Heward-Belle[3]
1) Division of Nursing and Midwifery, Health Sciences School, University of Sheffield, UK.
2) Department of Sociological Studies, University of Sheffield
3) The University of Sydney

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COVID-19 and domestic violence: impact on mental health

Abstract

The COVID-19 pandemic has had a devastating affect across the world by interrupting all sorts of social and economic activities. It has resulted in an increased rate of domestic violence and abuse (DVA) as well as mental health problems. This paper aims to explore the mental health impact of DVA within the context of the global pandemic. We will explore factors contributing to rising rates of DVA and mental health problems exacerbated by stressors related to the global pandemic, including public health measures implemented to prevent the spread of COVID-19. It will also explore what can be learnt from the current pandemic situation to prevent DVA in future emergency situations and pandemics and will provide suggestions for policy, practice, and future research.

Introduction

COVID-19 is an illness caused by a coronavirus that has affected millions of people in nearly every country in the world. As of 2nd December 2020, 191 countries across the globe have confirmed a total of 64.2 million cases of COVID-19, with approximately 1.5 million deaths around the world (Center for Systems Science and Engineering (CSSE) at Johns Hopkins University, 2020). The COVID-19 pandemic has not only caused illness and death, but has brought serious public health, social, economic, and psychological problems in the world for everyone without a distinction of gender, social class, religion, and ethnicity. At the same time, it has highlighted already existing inequalities with people from underserved populations disproportionately impacted due to the social determinants of health (Wilkinson & Marmot, 2003; Lundberg, 2020). COVID-19 spreads through respiratory droplets when someone with the disease sneezes, coughs, or talks. Infectious droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. The only effective strategy to control COVID-19 is stopping its person-to-person transmission. A physical distance of at least 1 meter (3 ft) between persons is suggested by the World Health Organization (2020b) to avoid infection, though some countries recommend maintaining greater distances whenever possible (WHO, 2020c). Nearly all countries in the world enacted procedures, including quarantine, social distancing and lockdown, to stem the spread of the virus. This has meant that people have been forced to stay within their household for an extended period. These measures,

consequently, resulted in an increased concern about mental health issues affecting individuals and communities globally (Rogers and Ali, 2020).

Available evidence suggests that any type of natural and human emergency (including the global pandemic but also other phenomena such as tsunamis or earthquakes) results in severe consequence for vulnerable individuals; especially women and children. Numerous reports have highlighted a marked increase in all forms of domestic violence and abuse (DVA), especially intimate partner violence and domestic homicide (Bradbury-Jones & Isham, 2020). The situation is alarming and raises significant concern, especially when the pandemic does not seem to have slowed down as future pandemic waves are imminent despite the recent news of an effective vaccine. Until the widespread immunisation of nations, various regions and cities around the world will continue to be subjected to national, regional, or localised lockdowns and other measures previously reported to have affected the rates of both DVA as well as mental health. This paper aims to explore the interrelationship between DVA and mental ill health and the impact of COVID-19. It will provide an overview of DVA and its prevalence in pre-COVID-19 and during COVID-19 scenarios to provide an overview of the problem and its significance. It will also explore factors contributing to DVA and consider what can be learnt from the current pandemic to develop preventive strategies to curb DVA in future times of emergency situations or natural disasters. We will end by providing suggestions for policy, practice and future research.

What is DVA?

Before exploring the impacts of COVID-19, it is useful to clarify what is meant by the term, domestic violence and abuse (DVA) given the lack of an agreed universal definition. The term refers to various forms of violence and maltreatment that take place within a domestic context. As such, DVA is an umbrella term which includes child abuse, older adult abuse, and intimate partner violence to name a few. In the United Kingdom (UK), DVA is defined as "any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial or emotional" (UK Home Office, 2018, Para 1). This definition also includes acts of so-called 'honour'-based violence, female genital mutilation (FGM) and forced marriage.

In addition to physical, sexual, psychological, emotional, and financial abuse (WHO, 2002), the UK definition also includes coercive control which is now recognised as a pernicious type of abuse with significant impacts on the victim and survivor (See Table 1). The UK Government has made coercive and controlling behaviour a criminal offence and defines it as "a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another" (UK Home Office, 2015, p. 3). It is common for victims/survivors to be exposed to two or more types of abuse, a phenomenon known as poly-victimisation (Devries et al., 2013; World Health Organization, 2013). Finally, the most extreme type of DVA, domestic homicide, is not uncommon with an average of two women killed each week by a current or ex-partner in the UK (Office for National Statistics, 2019). The types of abuse recognised here, present a summary only and this list is by no means exhaustive.

Perpetrators as well as victims of DVA come from diverse backgrounds and are not limited by socioeconomic, age, culture, religion, ethnicity, or relationship status. Whilst gender is not a barrier to experiencing abuse, it should be acknowledged that women, men, trans and non-binary people in straight, gay, or lesbian relationships can all perpetrate *and* experience DVA. Statistics do, however, consistently show that women are the primary victims/survivors of DVA which is perpetrated predominantly by men. For example, globally, one in three women experience physical or sexual violence perpetrated by an intimate partner during their lifetime (Devries et al., 2013; World Health Organization, 2013). Furthermore, the abuse experienced by women is recurring, systematic, more severe, and more likely to result in injury or death. Thirty eight percent (38%) of murders of women globally are reported as being committed by a current or former male intimate partner (WHO, 2017).

The statistics presented here serve only as an illustration as knowing the exact prevalence of the DVA is challenging. This is due to widespread underreporting, lack of recognition of experiences of abuse and inaccurate or missed recording of incidents as DVA by professionals. Comparison across countries is problematised by issues such as the inconsistent definitions, absence of monitoring as well as by the adoption of different methodologies for data collection, analysis, and synthesis (Ali, Naylor, Croot, & O'Cathain, 2015). The World Health Organization, recognising this issue, sponsored a multi-country study that involved ten countries: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand and Tanzania (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Based on

standardised population-based household survey interviews with women aged 15-49 years (n = 24,097), the findings revealed a lifetime prevalence of physical and sexual DVA ranging from 15-71%. The proportion of women who had ever experienced physical violence ranged from 13% in Japan to 61% in Peru province. Lifetime prevalence of sexual violence experienced by women ranged from 6% in Japan to 59% in Peru. Researchers set out to identify the prevalence of physical violence, according to severity: acts such as slapping, pushing and shoving classified as moderate; and acts such as kicking, dragging, threatening with a weapon, or using a weapon against women were classified as severe. The proportion of women who experienced severe physical violence ranged from 4% in Japan to 49% in Peru (García-Moreno, et al., 2005).

In the UK, according to the Crime Survey for England and Wales (2020), an estimated 2.4 million adults aged 16 to 74 years experienced DVA in the year ending March 2019. Women were approximately twice as likely to have experienced DVA than men. (Office of National Statistics, 2020). Similarly, the number of female homicide (by a current or former partner) surged by nearly a third (27%) in the year to March 2019. A total of 80 women were killed by a current or ex-partner (Office of National Statistics, 2020). A study carried out in 2014 by the European Union Agency for Fundamental Rights (2014) used a wider lens capturing evidence from 28 member states by interviewing 42,000 women. The findings of the survey suggested a lifetime prevalence of physical and/or sexual abuse of 33%.

Impacts of DVA

Impacts of DVA are varied and can be physical, sexual, psychological, social and material in nature. Approximately 42% of women who experience physical or sexual abuse from a partner sustain physical injuries as a result (World Health Organisation, 2013). The examples of minor physical consequences may include cuts, punctures, bruises and bites. Severe injuries may result in permanent disability (e.g. loss of limb, hearing loss, damage to teeth). Victims of DVA report higher rates of poor health, compromised ability to walk, pain, vaginal discharge, loss of memory and dizziness and self-harm compared to those who do not (Reuter, Newcomb, Whitton & Mustanski, 2017). Other examples of the impact of sexual abuse include unwanted pregnancy, miscarriage, sexually transmitted infections (STI) and other gynaecological problems

In addition to the physical and sexual injuries resulting from DVA, it is commonly associated with serious psychological and emotional consequences not only for the victim, but others in the family such as children. Psychological effects of DVA may include:

- negative emotions such as fear, shame, guilt and low self-esteem;
- stress-related medical conditions such as headaches;
- mental health conditions and disorders such as depression, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, disassociation, sleep disorders and eating disorders;
- harmful behaviours such as self-harm, substance, and alcohol abuse.

Psychological consequences may also manifest through psychosomatic symptoms, sexual dysfunction and eating problems. In addition, DVA can have fatal consequences for victims resulting from homicide or suicide (Black, 2011). Similar psychological effects are reported by victims of female perpetrated violence or those in a same sex relationship (Reuter, et al., 2017). Internationally, evidence shows that violence during pregnancy is widespread. It commonly begins or increases in severity and frequency during pregnancy and in the early childhood period (García-Moreno, et al., 2005; James, Brody & Hamilton, 2013). DVA is a leading contributor to illness, disability, and premature death in women of childbearing age (Ayre et al, 2016). For example, in Australia, 68% (or 188, 000) of women who experienced DVA reported that they were pregnant during the relationship and 34, 500 were abused during their pregnancy. More women (326 000) reported being abused during pregnancy by a previous rather than the current partner (ABS, 2017).

DVA has adverse impacts on women and their unborn children that include complications in pregnancy and birth, sexually transmitted infections, maternal substance abuse and smoking, and maternal mental health problems, such as perinatal depression and anxiety estimated to impact 1 in 5 mothers of young children (Coker et al., 2012; Allen, 2013). The strongest risk factors for developing antenatal mental illness have constantly been found to include the existence of DVA as well as other factors, including a history of psychiatric illness, low socioeconomic status and insufficient social support (Howard et al., 2014; Howard et al., 2013; Moncrieff, 2018). Of concern, pregnancy significantly increases a woman's risk of becoming a victim of the DVA and domestic homicide and men who abuse their pregnant partners are

very dangerous and more likely to kill them (Campbell, Garcia-Moreno, & Sharps 2004; Spencer, & Stith, 2020).

COVID-19, DVA and mental health impacts

The incidence and prevalence of violence against women tends to increase in any stressful event or emergency, whether it is a natural disaster or a man-made one (Gearhart et al., 2018; Nguyen, 2019; Sklavou, 2019; Yoshihama, Yunomae, Tsuge, Ikeda, & Masai, 2019). During the COVID-19 pandemic, many countries reported increased rates of DVA. The surge in DVA has been associated with the outcomes of restrictions on movement and social distancing as well as economic and social stressors resulting from the pandemic. For instance, the growth in unemployment, uncertainty around furloughing and job security as well as the effects of social isolation have been widely reported during the lockdown period. These results in higher levels of stress, economic difficulties, disruption in social networks and to normal life (Talevi, et al., 2020). The ways in which responses to COVID-19 have isolated people, and affected their ability to move freely and access support, in turn, have exacerbated levels of risk for those experiencing DVA (Rose et al., 2020; Sharma & Borah, 2020).

Available evidence and media reporting suggest an increase in the rate of DVA cases resulting from such measures in the context of COVID-19 (Townsend, 2020). Early data from the UK, the United States, France, Australia, Cyprus, Singapore, Argentina, Canada, Germany, and Spain indicated an increase in DVA and increased demands to women's refuges, and other support services (UN Women, 2020). In the UK, the number of DVA related offences increased each month from April to June 2020, with the largest month-on-month increase (9%) between April and May 2020 (Figure 1). In April, May, and June roughly one-fifth (21%, 20% and 19%) of all offences recorded by the police were DVA related suggesting a five percent increase compared with the same period in previous years.

In the Hubei province of China, a police department reported stark increases in the DVA cases in February 2020 (Allen-Ebrahimian, 2020) and 90% of these cases were related to the COVID-19 pandemic. The UK's largest domestic abuse charity Refuge reported a huge 700% ((from 26,320 to 210,620) increase in calls during a singular day in April (Townsend, 2020; Office of National Statistics, 2020) and by June calls had risen by 800% compared with pre-lockdown figures (Davies, 2020). The charity also reported a 300% increase in visits to its National Domestic Abuse Helpline website and a 950% rise in visits to their website compared to pre-Covid-19 measures. Another report suggests that the deaths from DVA between 23 March and

12 April more than doubled (to 16) compared with the average rate in the previous 10 years (Grierson, 2020).

Concerningly, women from Black and Minority Ethnic (BME) backgrounds have reported to be disproportionately impacted by the pandemic (Asunramu, 2020; Fawcett Society, 2020). There are reports too that people with disabilities (UN Human Rights, 2020; World Health Organization, 2020a) and those from LGBTQ communities (Galea, Merchant, & Lurie, 2020; Green, Dorison, & Price-Feeny, 2020) have been impacted more than the general population. This suggests that situations can be worse for people with additional vulnerabilities or from underserved communities such as those with disabilities, older women, girls and women living in institutional settings, displaced women and women living in conflict affected areas as they face further barriers in accessing appropriate support services. It is likely that these statistics reflect a glimpse of the overall picture given the known difficulties of reporting, which are now intensified for households where the perpetrator is more frequent or consistently at home due to COVID-19.

The results of COVID-19 measures on mental ill health have also been widely broadcast with concerns that further mental health 'devastation' is imminent as we find ourselves in the second wave of the pandemic (Simon et al., 2020). Pandemic-related government measures to stem the spread of the virus such as quarantine, lockdown, and social distancing can contribute to anxiety, fear and sleep disturbance for general populations and aggravate existing symptoms for people living with mental health conditions (Patil et al., 2020). Research shows women experiencing DVA from their partner are three times more likely to suffer depression, anxiety, or severe conditions such as schizophrenia or bipolar disorder (Singh Chandan et al., 2020). Whether new or pre-existing, this impact on mental health is likely to be severe and long-lasting resulting in more demands placed on already overburdened health care systems in any country.

Whilst DVA can precipitate or perpetuate mental distress, perpetrators of DVA frequently deploy mental health coercion as a tactic of abuse. This often involves the use of force, threats, or manipulation and can include deliberate attempts to undermine a survivor's sanity, preventing them from accessing treatment, controlling their medication, and a raft of other tactics to discredit a survivor's mental health. The conditions associated with the pandemic have often mirrored the tactics used by perpetrators. The conditions associated with the pandemic have also heightened risks and barriers to help-seeking: for example, means and opportunity to contact services may be restricted, access to support networks might be limited

or wholly untenable. People with existing mental health conditions might have limited access or difficulties in accessing medication or therapy which, in turn, exacerbates mental ill health. This can trigger behaviours such as self-harming, substance use or even lead to suicidal ideation. Everyday almost 30 women attempt suicide and every week three women take their own lives to escape domestic abuse (Refuge, 2020).

Case study: Learning from natural disasters – Hurrican Harvey 2017

In 2017 Hurricane Harvey hit the US and during the storm 19 trillions gallons of rainwater fell on the state of Texas triggering the largest natural disaster in Texan history (FEMA, 2017). A study was undertaken by Serrata and Hurtado (2019) to explore the impact of Hurricane Harvey on domestic violence services in Texas. They found that Hurricane Harvey affected families that had already experienced DVA, with higher rates of stress associated with the disaster leading to increased DVA during and after the hurricane. In an article published by the American Psychological Association, Serrata compared risk factors with the circumstances resulting from the COVID-19 pandemic:

> "We found social factors that put people more at risk for violence are reduced access to resources, increased stress due to job loss or strained finances, and disconnection from social support systems […] With this pandemic, we're seeing similar things happen, which unfortunately leads to circumstances that can foster violence." (Abramson, 2020, online)

In addition to these increased risk factors, Serrata and Hurtado's study found victims/survivors had increased vulnerability and more risk factors as the combination of stress and social isolation led to higher DVA rates. They also noted that people employed in domestic violence services were exposed to similar levels of trauma to that of victims/survivors not only because of the demands of the service but because they too had been impacted by the effects of Hurricane Harvey. The implications for service providers are detailed in the next section.

The role of service providers

Service providers including healthcare professionals, social workers, police and many others have a very important role to play in responding to DVA. The appropriate training and education of the healthcare professionals (including doctors, nurses, midwives), social workers, police and other frontline practitioners is critical. Professionals need to be trained to assess risk in face-to-face as well as virtual consultations to ensure the provision of appropriate and compassionate service to their client. They also need to be able to refer people to appropriate

services in the local and regional areas to secure the safety of victims/survivors whilst ensuring that services can be accessed virtually if necessary. In addition, disaster responders (emergency services and other public sector keyworkers) should be trained to recognise the signs of DVA and equipped with the knowledge of how to refer to appropriate support (Serrata and Hurtado, 2019).

There is a need to develop and implement appropriate referral pathways of available services including information about support services, helplines, children's services, social services, psychological support, and counselling services for all potential referrers. At the same time, organisations that support people in conflict affected areas should be sensitive to the needs of women subjected to violence and its impact on their children in their COVID-19 response plans. In addition, we need to have reliable information collected about the issues so that we understand the scope of the issue to enable the development of appropriate preventive strategies. COVID-19 will not be the last pandemic or emergency as history suggests such emergency situation arise over time. Learning from the situation in COVID-19 should be used to prepare ourselves better to respond to the crises better, but to also understand the impact of such emergencies on those experiencing DVA and how its impacts can be mitigated. This requires a national and regional coordinated strategy and action plan, and preparedness to keep vicrtims/survivors safety in future emergencies or pandemics (Serrata and Hurtado, 2019).

Many innovative examples of service provisions have emerged during COVID-19 period. For example, internationally, frontline practitioners who work with survivors of DVA adapted their practice to incorporate the use of technology as the primary vehicle to engage with survivors during lockdown periods. Many have provided online counselling and therapeutic services over myriad online applications and videoconferencing. Health services in many counties, for example, provided 'telehealth services' which enabled survivors of DVA to virtually communicate with social workers and other professionals. Whilst such measures offered innovative ways of identifying and managing risk and safety issues with DVA survivors, the implementation of online counselling and therapeutic services is comparatively new and there is limited data available reporting, evidence-based practice with people who have experienced DVA (McVeigh & Heward-Belle, 2020). Preliminary findings from an Australian study with 25 frontline health practitioners (Heward-Belle, 2020) found varying levels of satisfaction with online counselling and therapeutic interventions. Many social workers indicated that they found online counselling and therapeutic services made it difficult to engage with survivors and they held safety concerns for women related to the fact that perpetrators may have been

able to overhear conversations. However, other practitioners found that online counselling and therapeutic services offered survivors a veil of anonymity that is not possible with face to face communication.

Conclusion

As we are now experiencing subsequent waves of the pandemic, there is the likelihood of another surge in DVA prevalence and negative impacts on mental health. Obstacles to accessing support will continue and multiply during further lockdowns and, at the same time, services will remain frustrated by the persisting under-funding and deficient resources in the face of greater demands. The already overburdened systems (e.g. DVA support; mental health services) may become even more frayed at the edges during further lockdowns. To respond to the combined long-lasting and severe impacts of the DVA and mental ill health following COVID-19, there needs to be a long-term investment in research and mainstream interventions centring on the connections between DVA and mental ill health.

Actions which can help during the further waves includes screening for both DVA and mental health, online interventions, and online safety planning. Government should encourage a joined-up approach through more substantial and adequate resourcing and a policy response which recognises and responds to these overlapping issues. Conscious efforts are also needed to ensure that professional regulatory bodies develop ethical standards and practice guidance for health and social care professionals to provide online counselling and therapeutic services in situations where face to face contact is not possible. COVID-19 will not be the last pandemic or emergency, and learning from the current situation should be used to prepare ourselves to better respond to such crises.

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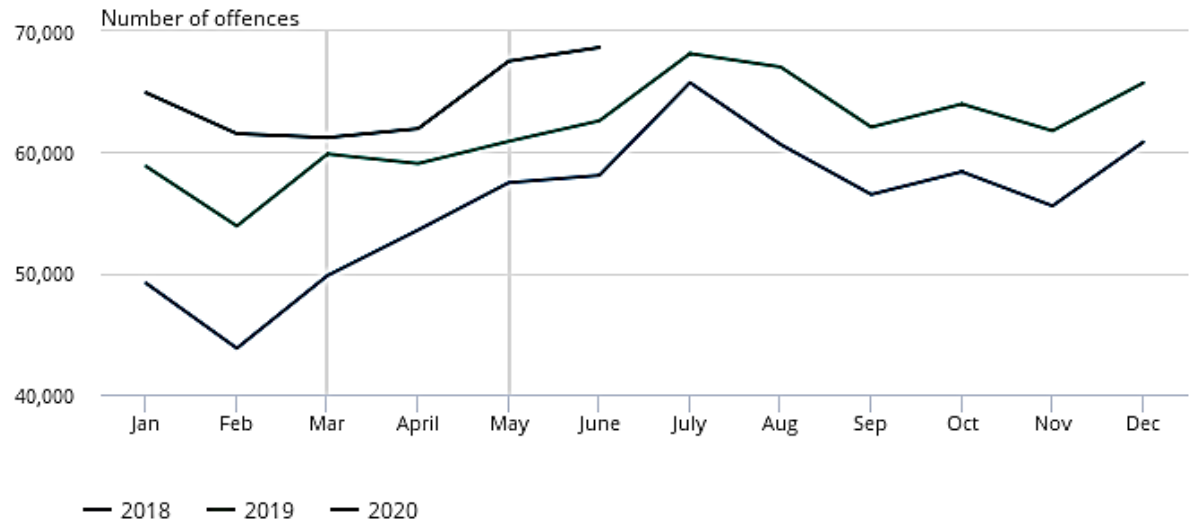
Table 1: Foms of Domestic violence and Abuse

Form	**Definition**	**Acts**
Physical violence or abuse	Use of physical force to inflict pain, injury or physical suffering to the victim	Slapping, beating, kicking, pinching, biting, pushing, shoving, dragging, stabbing, spanking, scratching, hitting with a fist or something else that could hurt, burning, choking, threatening or using a gun, knife or any other weapon
***Sexual* violence**	any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person, regardless of their relationship to the victim, in any setting, including but not limited to home and work	• Physically forcing a partner to have sexual intercourse • Forcing a partner to do something that they found degrading or humiliating • Harming them during sex • Forcing partner to have sex without protection
Psychological violence	use of various behaviours intended to humiliate and control another individual in public or private	• verbal abuse • name calling • Blackmailing • Constantly criticizing • Embarrassing the victim by saying something or doing something • Threats to beat women or children • Monitoring and restricting movements • Restricting access to friends and family • Restricting economic independence and access to information • Assistance or other resources and services such as education or health services
Financial or Economical Abuse	Controlling a person's ability to acquire, use and maintain their own money and resources.	• Not letting victims work; • Sabotaging job interviews • Taking the welfare benefits the victim is entitled to • Using their money without consent

		• Building up debts in their name • Damaging their property and possessions • Withholding maintenance payments
Coercive control	any act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim	•

Figure 1: Total number of offences flagged as domestic abuse-related has increased compared with the corresponding month in the previous year



Source: Home Office – Police recorded crime

For the past three years the total number of offences flagged as domestic abuse-related has increased compared with the corresponding month in the previous year

Notes:

Police recorded crime data are not designated as National Statistics.

April 2020 to June 2020 data are provisional and have not been fully reconciled with police forces.

Data for Greater Manchester Police (GMP) on domestic abuse-related offences are not included in this publication because of issues with their data supply following the implementation of new IT systems.