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"We're out here getting slaughtered by these abusive people": Perceptions of the effects of COVID-19 movement restrictions among survivors of intimate partner violence

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Abstract

"We're out here getting slaughtered by these abusive people": Perceptions of the effects of COVID-19 movement restrictions among survivors of intimate partner violence

By Kathryn G. Wyckoff

Introduction: Intimate Partner Violence (IPV) poses a severe public health threat globally and within the United States. Preliminary evidence has underscored surges in IPV during the COVID-19 pandemic. The purpose of this study was to understand the effects of COVID-19, including the impacts of movement restrictions (i.e., shelter in place orders, quarantine, isolation orders) on experiences of IPV from the perspective of survivors.

Methods: In-depth interviews were conducted with nine survivors who presented at a large, Atlanta-based public hospital or sought IPV community resources (i.e., domestic violence shelter, therapy services) between March 2020 and December 2020. Thematic analysis was carried out to describe the impact of COVID-19 movement restrictions on IPV and help-seeking behaviors among survivors, in addition to identifying resources to improve IPV response during pandemics.

Results: Survivors cited relationship challenges that were amplified by either movement restrictions or consequences of COVID-19, including substance use, reinforced control tactics in relationships, and increased financial or life stressors resulting from the pandemic. COVID-19 movement restrictions catalyzed new relationships quickly and sparked new or intensified violence in existing relationships, and unveiled holes in IPV support services.

Conclusions: Taken as a whole, these findings suggest COVID-19 movement restrictions and social distancing measures amplify IPV, experiences of trauma, and survivors' subsequent help-seeking experiences. Findings along with recommendations can be used for IPV response during pandemics and inform future pandemic preparedness.

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Demonstrated Competencies

MPH/MSPH Foundational Competencies

2. Select quantitative and qualitative data collection methods appropriate for a given public health context.

3. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software as appropriate.

4. Interpret results of data analysis for public health research, policy or practice.

BSHES Competencies

3. Select study designs to plan health promotion research.

8. Apply qualitative or quantitative methods in public health research or practice.

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Chapter 1: Introduction

Problem Statement

Intimate Partner Violence (IPV) poses a severe public health threat globally and within the United States (U.S.). According to the U.S. Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC), IPV constitutes any physical violence, sexual violence, stalking, psychological aggression, or coercive control tactics enacted by current or previous intimate partners (Breiding et al., 2015). The term 'intimate partner' encompasses any spouses, boyfriends, girlfriends, dating partners, or ongoing sexual partners (Breiding et al., 2015). The National Intimate Partner and Sexual Violence Survey (NISVS), an ongoing, nationally representative survey conducted by the CDC, estimates one in three women and one and three men have experienced IPV in their lifetime (Smith et al., 2018). Adverse consequences stemming from experiences of IPV include fear, safety concerns, injury, medical care needs, the need for law enforcement intervention, missed days of work or school, housing needs, post-traumatic stress disorder (PTSD), sexually transmitted infections, and unstable housing (Smith et al., 2018). Moreover, economic costs associated with IPV are consistently documented in empirical literature, further reinforcing the economic toll of IPV on society. A 2018 study examining the economic burden of IPV among U.S. adults revealed over $3.6 trillion in costs for all IPV survivors, $2.1 trillion of which accounted for medical costs, $1.3 trillion in lost productivity among perpetrators and survivors, $73 billion in criminal justice activities, and $62 billion in other costs (Peterson et al., 2018). While IPV is pervasive across the U.S., the prevalence of IPV in the state of Georgia was reported as 35.1% for women and 39.9% for men in 2010 (Black et al., 2011). The high prevalence of IPV in Georgia predates the Coronavirus Disease 2019 (COVID-19) pandemic.

COVID-19, a disease caused by the SARS-CoV-2 virus, was first discovered in Wuhan, China in December 2019 (Centers for Disease Control and Prevention, 2021a). The virus is highly contagious and has since quickly spread across the world (Centers for Disease Control and Prevention, 2021a). As of December 2021, there were over 53,795,407 cases of COVID-19 in the U.S. resulting in over 800,000 deaths (Centers for Disease Control and Prevention, 2021b). The first case of COVID-19 in Georgia was documented on March 2, 2020 (Georgia Department of Public Health, 2021). Of the five Georgia counties with the highest prevalence of COVID-19 cases, hospitalizations, and total deaths, two include counties within the Metropolitan Atlanta area: Fulton County and Dekalb County (Georgia Department of Public Health, 2021).

On March 14, 2020, Georgia Governor Brian Kemp issued Executive Order No. 03.14.20.01 (2020), which declared a Public Health State of Emergency in Georgia and called for the enactment of social distancing measures. On behalf of the City of Atlanta, Mayor Keisha Lance Bottoms issued Executive Order No. 2020-21 (2020) on March 23, 2020, thereby enacting a citywide shelter in place order. The following week, Governor Kemp issued Executive Order 04.02.20.01 (2020) on April 2, 2020, enacting a statewide shelter in place order. In compliance with these orders, residents were instructed to stay in their homes, leaving only to carry out essential business, during which they were advised to practice social distancing measures. Although these movement restrictions and other infection control methods (i.e., isolation, quarantine orders) have proven successful in reducing the spread of COVID-19, their impacts on IPV had not at the time been thoroughly investigated (D. P. Evans, 2020).

Since the beginning of the pandemic, cross-sectional and anecdotal evidence have documented surges in IPV and IPV help-seeking among survivors worldwide (Davis et al., 2020; D. P. Evans et al., 2020; Leslie & Wilson, 2020; McCrary & Sanga, 2021; McLay, 2021; Mohler et al., 2020;

Piquero et al., 2020). A broad range of research examining COVID-19 and IPV has emerged in the past two years with several systematic reviews pointing to increases in IPV and domestic violence (DV), especially during lockdown and social distancing periods (Bazyar et al., 2021; Kourti et al., 2021; Lausi et al., 2021). Mass media channels have also highlighted several commentaries and reports on IPV and DV as they pertain to COVID-19 and movement restrictions (Kelley, 2020; Kelly, 2021; Mak, 2020; Taub, 2020). Despite the intention to mitigate the negative effects of COVID-19, movement restrictions (i.e., shelter-in-place orders, school closures, curfews) effectively trap survivors with their abusers by creating isolating environments and exacerbating coercive control tactics (M. L. Evans et al., 2020; Rieger et al., 2021; Sower & Alexander, 2021). Research bolstering surges of IPV prevalence in Atlanta, Georgia compared 2018 to 2020 crime data from the Atlanta Police Department, indicating cumulative increases in 2020 DV crimes compared to the previous two years (D. P. Evans et al., 2020). These findings are particularly pertinent, as the current study takes place in Atlanta, Georgia. Significantly, the broader impacts of the pandemic, movement restrictions, and IPV remain largely uninvestigated. Up until now, no study has examined IPV survivors' perceptions of COVID-19 movement restrictions (i.e., shelter-in-place, quarantine, isolation orders) and their effects on traumatic injury and help-seeking behaviors. A recent study assessing survivor safety and safety planning from the perspectives of victim service agency staff found IPV and sexual violence experiences were more severe or escalated, perpetrators used public health guidance to increase control or isolate survivors, and victim services needed to adapt safety planning and resource provision due to pandemic disruptions (Schrag et al., 2021). Additionally, IPV research conducted prior to the pandemic suggests barriers to IPV help-seeking stem from financial challenges, lack of insurance, time constraints, lack of knowledge about IPV resources, lack of

childcare or transportation, perpetrator prevention of help-seeking, isolation from social or family networks, as well as perceived stigma associated with IPV (Fugate et al., 2005). Collectively, these findings reinforce the need to conduct a study focusing on the perspectives and experiences of IPV survivors regarding COVID-19 movement restrictions and their impacts on traumatic injury and help-seeking behaviors.

Prior research underscores the high prevalence of IPV in Georgia (Black et al., 2011), in addition to its rankings as one of the states with higher rates at which women are killed by men (Georgia Coalition Against Domestic Violence, 2020). Moreover, cumulative increases in 2020 DV crimes in Atlanta compared to the previous two years highlight surges of IPV during the pandemic (D. P. Evans et al., 2020). As two counties within the Atlanta area contain the highest prevalence of COVID-19 cases, hospitalizations, and total deaths for the state (Georgia Department of Public Health, 2021), Atlanta, Georgia provides an ideal context in which to examine the effects of the COVID-19 pandemic on IPV from the perspective of survivors.

Purpose Statement

The purpose of this study was to understand the impacts of COVID-19, including the impacts of movement restrictions (i.e., shelter in place orders, quarantine, isolation orders), on experiences of IPV from the perspective of survivors. Exploring this unique perspective provides necessary context to existing evidence.

Research Objective and Aims

The objective of this study was to understand the impacts of COVID-19 and movement restrictions on IPV experiences from the perspective of survivors in Atlanta, Georgia.

The aims of this study were to:

Aim 1: Explain survivors' perceptions of IPV during the COVID-19 pandemic;

Aim 2: Identify risk factors for experiencing IPV during the COVID-19 pandemic;

Aim 3: Identify facilitators and barriers to seeking IPV resources during COVID-19;

Aim 4: Understand changes in IPV experiences during the COVID-19 pandemic compared to before the pandemic; and

Aim 5: Identify resources and supports to help and/or better respond to IPV during pandemics.

Significance Statement

As movement restrictions and social distancing practices lift, the long-term effects of IPV during COVID-19 are still unidentified. Although preliminary anecdotal and empirical data indicate increases in the prevalence of IPV during the pandemic, gaps remain in understanding the overarching impacts of quarantining and movement restrictions on IPV. More research is warranted to assist pandemic response through examination of health, economic, and other invisible impacts of IPV. As most available data come from social media, the internet, anecdotal evidence, helpline reports, and interviews with healthcare providers (HCPs) (Viero et al., 2021), the current study aims to address the gap of qualitative in-depth interviews with survivors of IPV during the COVID-19 pandemic. Up until now, no study has examined IPV survivors' perceptions of COVID-19 movement restrictions (i.e., shelter-in-place, quarantine, isolation orders) and their effects on traumatic injury and help-seeking behaviors. As the pandemic continues to threaten public health and safety, findings from this study can be leveraged to inform IPV response during this and other public health emergencies. Moreover, findings can also be used to inform future pandemic preparedness and response among IPV and public health

resources in Atlanta and the state of Georgia. The methods carried out in this study can be adapted for future research carried out in other areas of Georgia or the broader U.S. pertaining to IPV experiences during COVID-19 and perceptions of IPV survivors.

It is crucial to investigate survivors' experiences of IPV during the COVID-19 pandemic, as movement restrictions and other infection control techniques may exacerbate experiences and impacts of IPV compared to IPV experiences prior to the pandemic. Documenting and comprehending survivors' experiences and perceptions offers a means to explore the connection between COVID-19 and IPV. Such an understanding may result in improved IPV prevention and response tactics implemented during this pandemic, as well as future health emergencies.

Chapter 2: Literature Review

In order to explore IPV survivors' perceptions and experiences of COVID-19 and movement restrictions, a thorough review of IPV experiences during humanitarian emergencies, natural disasters, and other pandemics is essential. Additionally, examination of the social determinants contributing to experiences of IPV outside of and during health emergencies is crucial.

Intimate Partner Violence

Intimate Partner Violence (IPV), referring to the emotional, physical, and/or sexual violence tactics by current or previous intimate partners, impacts a diverse array of individuals worldwide (Breiding et al., 2015). While IPV affects all types of individuals, global IPV estimates suggest a higher prevalence of women experience IPV in their lifetimes, with up to 753 million ever-married women over the age of 15 experiencing IPV (Garcia-Moreno et al., 2021). According to the 2015 National Intimate Partner and Sexual Violence Survey (S. Smith et al., 2018), 43.6 million women and 37.3 million men in the United States reported experiences of rape, violence or stalking by an intimate partner in their lifetime. Moreover, data suggest higher rates of non-Hispanic Black, American Indian or Alaska Native, and multi-racial non-Hispanic women and men experience IPV in their lifetime, suggesting disproportionate rates of IPV among Black, Indigenous, People of Color (BIPOC) (Black et al., 2011). Although North American data suggest associations between racial or minority group membership and IPV, underlying differences in education and income support these associations (Dearwater et al., 1998; Jewkes, 2002; Snow Jones et al., 1999). Of the 80,921,000 men and women estimated nationally to have experienced IPV in their lifetime (S. Smith et al., 2018), 14.5 million estimated lifetime survivors reside in the state of Georgia where this study takes place (Black et al., 2011). It is pertinent to note uniform and comparable national and state-level data for IPV are lacking (Black

et al., 2011). Additionally, due to the stigma and sensitivity surrounding data collection involving IPV survivors, data are likely underestimates of actual IPV prevalence and often do not capture sexual orientation or perpetrator gender identities (Alfaro Quezada et al., 2020; Black et al., 2011; Breiding et al., 2014; Khurana & Loder, 2021). While IPV manifests in overt forms of physical, sexual, and emotional violence, it is important to note most IPV often starts with less visible forms of violence on behalf of perpetrators, such as surveillance and controlling behaviors through limiting time with social connections, public humiliation and shaming, blocking electronic communication streams, and spreading rumors (Park & Jeon, 2021). These "invisible" IPV tactics and their impacts are equally as crucial to investigate, as they contribute to negative short-, mid-, and long-term outcomes. The stigma and sensitivity of IPV often plays a role in help-seeking behaviors of survivors. Despite more than 35% of women and 28% men in the U.S. experiencing IPV in their lifetime (Black et al., 2011), a majority of cases go unreported (Gracia, 2004). The COVID-19 pandemic offers a unique context, with many states and countries enacting movement-restrictions (i.e., shelter-in-place orders) that may exacerbate reported and unreported instances of IPV. Specifically, public health measures restricting movement reinforce and socially legitimize isolation and coercive control tactics enacted by perpetrators of abuse. Therefore, the perspectives of IPV survivors who sought healthcare or resources pertaining to their relationship during COVID-19 are necessary to provide insight into the pandemic's impact on IPV and help-seeking behaviors.

Risk Factors for IPV Victimization

A variety of characteristics have been identified as placing individuals at a higher risk for IPV victimization, including community and financial stress, minority group membership, adolescence and young adulthood, unemployment, low income, exposure to IPV or family

violence as a child, and child abuse (Capaldi et al., 2012; Lipsky et al., 2005; Schafer et al., 2004; World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Other established risk factors for IPV victimization include partner alcohol or use (Lipsky et al., 2005; Schafer et al., 2004; World Health Organization & London School of Hygiene and Tropical Medicine, 2010), separated or divorced marital status (World Health Organization & London School of Hygiene and Tropical Medicine, 2010), lower educational attainment (Breiding et al., 2008; World Health Organization & London School of Hygiene and Tropical Medicine, 2010), poverty (World Health Organization & London School of Hygiene and Tropical Medicine, 2010), mental disorders (i.e., depression) (World Health Organization & London School of Hygiene and Tropical Medicine, 2010), as well as adherence to traditional gender and social norms that reinforce violence (World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Understanding such risk factors allows researchers and practitioners to identify and tailor prevention strategies.

IPV Injury, Morbidity and Mortality

Data from the 2010 National Intimate Partner and Sexual Violence Survey indicate the most predominant form of IPV is physical violence, with 14.8% of women and 4% of men reporting sustained injuries due to IPV (Black et al., 2011). Additionally, several data sources suggest survivors of IPV have higher rates of unmet health needs despite accessing health care services more frequently and accumulating higher medical expenses (Bergman & Brismar, 1991; Plichta, 2007; Wisner et al., 1999). The Nationwide Emergency Department Database revealed 132,806 IPV-related ED visits across the United States between 2010 and 2014, resulting in combined medical costs of $395 million (Alfaro Quezada et al., 2020). Multiple studies on injury patterns and demographics of individuals presenting to EDs across the country indicate a higher

prevalence of presenting female survivors (Alfaro Quezada et al., 2020; Davidov et al., 2015; Khurana & Loder, 2021; Loder & Momper, 2020). Patient profiles indicate a majority of IPV survivors presenting to EDs relied on Medicaid and self-pay methods (Alfaro Quezada et al., 2020; Davidov et al., 2015). While higher numbers of individuals report experiencing IPV for the first time prior to age 25 (Black et al., 2011; S. Smith et al., 2018), IPV is also significant among older patients presenting to EDs, with older, male patients sustaining more and higher severity injuries requiring hospitalization on average compared to female survivors presenting to EDs (Alfaro Quezada et al., 2020; Khurana & Loder, 2021). Documented injury profiles of IPV survivors presenting the EDs also suggest patients commonly present with contusions or abrasions, lacerations, strains or sprains, internal organ injuries, and fractures (Alfaro Quezada et al., 2020; Davidov et al., 2015; Khurana & Loder, 2021; Loder & Momper, 2020).

In conjunction with physical injuries sustained, IPV has been associated with a plethora of negative health outcomes, including depression (Beydoun et al., 2016; Devries et al., 2013; Golding, 1999; Mazza et al., 2021), anxiety (Beydoun et al., 2016; Black et al., 2011), post-traumatic stress disorder (PTSD) (Black et al., 2011; Dutton et al., 2006; Golding, 1999; Mazza et al., 2021), suicidal behaviors (Beydoun et al., 2016; Black et al., 2011; Devries et al., 2013; Golding, 1999; Mazza et al., 2021), alcohol and drug misuse (Beydoun et al., 2016; Golding, 1999; Mazza et al., 2021), sexual problems (Mazza et al., 2021), concentration issues (Mazza et al., 2021), somatization (Mazza et al., 2021), social issues (Mazza et al., 2021), educational challenges (Mazza et al., 2021), feelings of guilt or blame (Mazza et al., 2021; Reich et al., 2014; Ross & Foster, 2012), chronic pain (Black et al., 2011; Mazza et al., 2021), gastrointestinal issues (Black et al., 2011; Mazza et al., 2021), traumatic brain injuries (TBIs) (Mazza et al., 2021; st. Ivany & Schminkey, 2016), as well as cardiovascular disease (Mazza et al., 2021; Stene

et al., 2013; E. N. Wright et al., 2018). Additionally, “invisible” forms of violence stemming from IPV negatively influence help-seeking behaviors and decrease opportunities for survivors to seek social support (Park & Jeon, 2021). In addition to the negative mental health outcomes associated with IPV, prior cross-sectional and case-control studies document the risk of IPV victimization among individuals with pre-existing mental health disorders (i.e., depression, anxiety, PTSD) (Khalifeh et al., 2015; Trevillion et al., 2012).

IPV can also precede mortality outcomes, such as homicide, suicide, among other violent fatalities. The phenomenon of intimate partner homicide (IPH) refers to fatal violent attacks committed by intimate partners (S. G. Smith et al., 2014). More than half of female victims of homicide in the U.S. are killed by IPH, with the top three mechanisms of injury being firearms, sharp instruments, and hanging, strangulation or suffocation (Petrosky et al., 2020). According to the National Violent Death Reporting System (NVDRS), young women belonging to racial or ethnic minority groups experience the highest rates of IPH (Petrosky et al., 2017). Another IPV homicide phenomenon occurs when family members, friends or new intimate partners, known as corollary victims, are killed by perpetrators (S. G. Smith et al., 2014). Significantly, one in every four IPH victims result in additional corollary victims, of which 76.4% are male family members or new intimate partners (S. G. Smith et al., 2014). Perpetrators of IPH may also die by suicide following the homicide event, with males making up 95-97% of perpetrators (Zeppegno et al., 2019). Additionally, IPV victimization may also precede suicide, with recent data from the U.S. establishing associations between heterosexual women experiencing physical IPV and self-reported suicidal ideation (Afifi et al., 2008). Lastly, NVDRS data suggest approximately one in seven legal intervention fatalities are linked to IPV, referring to deaths by active-duty law enforcement officers during IPV incidents (DeGue et al., 2016).

IPV and Natural Disasters

Research conducted over the last 20 years has consistently documented the impacts of natural disasters on experiences of IPV and domestic violence (DV) (Bell & Folkerth, 2016; Clemens et al., 1999; Lauve-Moon & Ferreira, 2017; Weitzman & Behrman, 2016). A scoping review of natural disaster and IPV-related studies conducted between 2000 and 2015 demonstrated increases in PTSD and poor mental health symptoms consistently follow natural disasters (Bell & Folkerth, 2016). Case-control and cross-sectional research on the Deep Horizon oil spill, the 2010 Haiti earthquake, Hurricane Katrina, and the 1997 Grand Forks flood found increased prevalence of IPV and DV following exposure to devastation from natural disasters (Clemens et al., 1999; Harville et al., 2010; Lauve-Moon & Ferreira, 2017; Schumacher et al., n.d.; Weitzman & Behrman, 2016). In addition, factors such as decreased social support, finances, and displacement accompanied increases in IPV and DV (Clemens et al., 1999; Schumacher et al., n.d.; Weitzman & Behrman, 2016). Due to the reduced or limited availability of IPV resources during and following natural disasters, help-seeking behaviors of IPV survivors may be compromised due to decreased social support, displacement, and financial stress.

IPV and Humanitarian Emergencies

In humanitarian emergency settings, higher rates of interpersonal violence occurring inside the home compared to outside the home have been observed (Falb et al., 2013; Khawaja & Barazi, 2005; Stark & Ager, 2011; Wako et al., 2015). Specifically, cross-sectional research conducted across different refugee camps found associations between conflict victimization and increased odds of experiencing IPV (Falb et al., 2013; Wako et al., 2015). In the context of humanitarian emergency planning, higher rates of IPV compared to violence occurring outside the home underscore the importance of incorporating strategies for more uniform, consistent reporting of

IPV in addition to resources targeted toward individuals experiencing violence in the home (Stark & Ager, 2011).

Of notable comparison to the COVID-19 pandemic is the 2013-2015 epidemic of Ebola Virus Disease (EVD) across Guinea, Liberia, and Sierra Leone. An Ebola assessment examining the impact of EVD on men and women, found 22.9% of 1,562 respondents reported cases of gender-based violence occurring during the peak of the epidemic (Korkoyah & Wreh, 2015). Through a mixture of desk reviews, in-depth interviews, and focus group discussions, the United Nations Development Program found disparities between official reports of sexual and gender-based violence (SGBV) and qualitative accounts of experiences of IPV in Eastern Sierra Leone (United Nations Development Programme, 2015). Specifically, while official reporting channels (i.e., medical providers, community service organizations, criminal justice entities) saw decreases in recorded SGBV cases, in-depth interviews and focus group discussions indicated increases in DV during the epidemic (United Nations Development Programme, 2015). Existing literature on EVD also indicate movement restrictions (i.e., school closures, curfews), negative economic impacts (i.e., unemployment), and decreased access to social services due to redirection of resources to EVD mitigation further exacerbated pre-existing SGBV disparities (Korkoyah & Wreh, 2015; United Nations Development Programme, 2015).

IPV and COVID-19

While a broad range of research examining COVID-19 and IPV has emerged in the past year, several systematic reviews point to increases in IPV and DV, especially during lockdown and social distancing periods (Bazyar et al., 2021; Kourti et al., 2021; Lausi et al., 2021). Despite the intention to mitigate the negative effects of COVID-19, movement restrictions (i.e., shelter-in-place orders, school closures, curfews) effectively trap survivors with their abusers by creating

isolating environments and exacerbating coercive control tactics (M. L. Evans et al., 2020; Rieger et al., 2021; Sower & Alexander, 2021). Notably, a majority of emerging literature is cross-sectional or anecdotal in nature, underscoring the need for more incidence data and research on IPV risk factors during COVID-19 (D. P. Evans, 2020).

Mass Media Reports

Since the beginning of the pandemic, mass media has released several commentaries and reports on IPV and DV as they pertain to COVID-19 and movement restrictions. *BBC News* reported on the average of 13,162 calls and messages received per day by Refuge's National Domestic Abuse helpline between April 2020 and February 2021, citing a 7% increase in DV reports to England and Wales police (Kelly, 2021). Similarly, *The Diplomat* noted an increase from 47 reported DV cases in Hubei, China to 162 reported DV cases in 2020 (Mak, 2020). *The New York Times* also highlighted the 18% increase in calls Spain's DV hotline experienced during the first two weeks of lockdown compared to the month prior, in addition to the 30% increase in DV according to the French police (Taub, 2020). Although media reported increases in DV or calls to DV helplines at the beginning of the pandemic, *The New York Times* provided commentary on the drop off of calls to helplines as lockdown continued into the summer of 2020, shedding light on the difficulties concerning help-seeking that DV survivors faced during lockdown (Kelley, 2020).

The Current State of COVID-19 Research

According to a systematic review of cross-sectional and cohort studies conducted on DV during the COVID-19 pandemic, a majority of violence trends were examined in North America (i.e., United States, Canada), followed by Europe (i.e., United Kingdom, Germany, Switzerland, Spain), Australia and New Zealand, and Africa (i.e., South Africa, Ghana) (Kourti et al., 2021).

Across the United States, cross-sectional research suggests increases in DV reports during perpetrator working hours (McCrary & Sanga, 2021), increases in calls to DV service organizations during the 12-week lockdown period beginning in March 2020 (Leslie & Wilson, 2020), increases in DV reports through the Dallas, Texas Police Department during the first two weeks of lockdown (Piquero et al., 2020), an absence of increases in reported DV assaults despite increases in calls to DV service organizations (Mohler et al., 2020), decreases in reported DV cases across Chicago, IL in March 2020 compared to 2019 (McLay, 2021), in addition to increased odds of experiencing IPV among those with COVID-19 symptoms or diagnosis (Davis et al., 2020). Of note, crime data analyzed from the Atlanta Police Department revealed increases in domestic crimes during 2020 compared to the previous two years, suggesting increases in domestic violence (D. P. Evans et al., 2020). These findings are particularly pertinent, as the current study takes place in Atlanta, Georgia.

In conjunction with research on IPV and DV prevalence during COVID-19, much cross-sectional research has been dedicated to exploring risk factors and adverse outcomes associated with experiencing IPV or DV during the pandemic. Results of cross-sectional research examining U.S. ED visits for mental health, overdose, and violence outcomes between 2018 and 2020 noted increases in visits pertaining to IPV during the lockdown period compared to previous years, indicating the severity of violence warranted breaking movement restrictions and navigating health risks of COVID-19 (Holland et al., 2021). Researchers in Spain also found lockdown and economic stress factors significantly contributed to increases in IPV, suggesting lifted movement restrictions will not decrease IPV and DV due to continued economic stress fueled by the pandemic (Bazyar et al., 2021). In the same vein, several cross-sectional studies indicate unemployment, economic stress, poor mental health and decreased social support

increase the likelihood of experiencing violence in the home (Arenas-Arroyo et al., 2021; Jetelina et al., 2021; Lausi et al., 2021; Ravi et al., 2021).

Recent studies have also explored adverse mental health outcomes related to movement restrictions. A large cross-sectional study in the United Kingdom (U.K.) found higher levels of anxiety and depression during the initial COVID-19 lockdown period (L. Wright et al., 2020). Moreover, another large cross-sectional U.K. study found significant relationships between experiences of previous physical and/or psychological abuse, pre-existing mental health issues, decreased social support, and low socioeconomic status and the onset of depressive symptoms during the COVID-19 lockdown period between March and April 2020 (Frank et al., 2020). Qualitative studies using semi-structured in-depth interviews were conducted with female IPV survivors accessing shelter or IPV service agency resources in the Southwestern United States (Ravi et al., 2021), female immigrant IPV survivors in the United States (Sabri et al., 2020), female IPV survivors residing in domestic violence shelters in South Africa (Dekel & Abrahams, 2021), as well as female IPV survivors residing in Mumbai, India (Huq et al., 2021). Evidence from this preliminary qualitative research suggest COVID-19 increased individual stressors, such as financial stress or unemployment (Dekel & Abrahams, 2021; Huq et al., 2021; Ravi et al., 2021; Sabri et al., 2020), mental health complications (Huq et al., 2021; Ravi et al., 2021; Sabri et al., 2020), household work and caregiving burdens (Dekel & Abrahams, 2021; Huq et al., 2021; Sabri et al., 2020), as well as increased severity and incidences of IPV associated with increased alcohol consumption (Huq et al., 2021), control tactics (i.e., partner isolation, control of movements, monitoring) (Dekel & Abrahams, 2021; Huq et al., 2021; Sabri et al., 2020), and confinement within the home (Dekel & Abrahams, 2021; Huq et al., 2021; Ravi et al., 2021; Sabri et al., 2020). Additionally, data from survivors engaged with shelters and IPV service

agencies suggest a lack of support from shelters during COVID-19, in addition to exacerbated feelings of isolation stemming from a combination of strict shelter rules and stay-at-home orders that mirror control or isolation tactics enacted by abusive partners (Ravi et al., 2021).

Anecdotal evidence and commentaries have also emerged amidst COVID-19 and preliminary findings concerning IPV. Notably, they highlight pre-existing disparities exacerbated by the pandemic, such as economic instability, unsafe housing, neighborhood violence, and low social support (M. L. Evans et al., 2020; Ravi et al., 2021; Rieger et al., 2021; Sower & Alexander, 2021). They also explore potential explanations for decreases in help-seeking behaviors or calls to crisis lines due to lack of safety in connecting with resources due to sheltering in place with perpetrators of IPV (M. L. Evans et al., 2020; Sower & Alexander, 2021; Zero & Geary, 2020). Diminished IPV resources and shelters with reduced capacity, overburdened hospitals and HCPs, reduced social support (i.e., family, friends), as well as limited or reduced capacity law enforcement means (i.e., protective orders) leave survivors of IPV at a particularly vulnerable place (M. L. Evans et al., 2020; Sower & Alexander, 2021; Zero & Geary, 2020). Thus, more research into the relationship between movement restrictions, help-seeking behaviors, and IPV during COVID-19 is necessary to inform future pandemic response and address what has been referred to as a "shadow pandemic" (UN Women, n.d.).

Conclusion and Significance

As movement restrictions and social distancing practices lift, the long-term effects of IPV during COVID-19 are still unidentified. Although preliminary anecdotal and empirical data indicate increases in the prevalence of IPV during the pandemic, gaps remain in understanding the overarching impacts of quarantining and movement restrictions on IPV. Moreover, research conducted prior to the pandemic suggest barriers to IPV help-seeking stem from financial

challenges, lack of insurance, time constraints, lack of knowledge about IPV resources, lack of childcare or transportation, perpetrator prevention of help-seeking, isolation from social or family networks, as well as perceived stigma associated with IPV (Fugate et al., 2005). As such, pre-COVID barriers to IPV help-seeking appear to have been exacerbated by the pandemic (Schrag et al., 2021). More research is warranted to assist pandemic response through examination of health, economic, and other invisible impacts of IPV. As most available data come from social media, the internet, anecdotal evidence, helpline reports, interviews with HCPs (Viero et al., 2021), and interviews with victim service agency staff (Schrag et al., 2021), the current study aims to address the gap of qualitative in-depth interviews with survivors of IPV during the COVID-19 pandemic. Up until now, no study has examined IPV survivors' perceptions of COVID-19 movement restrictions (i.e., shelter-in-place, quarantine, isolation orders) and their effects on traumatic injury and help-seeking behaviors. The current study aims to address this specific gap.

Chapter 3: Student Contribution

This thematic analysis was conceptualized in tandem with Dr. Dabney P. Evans. In Fall 2020, my first academic semester at the Rollins School of Public Health, I joined Dr. Evans' multidisciplinary research team conducting research on the impacts of COVID-19 on intimate partner violence (IPV) in Atlanta, Georgia. The aims of the parent study were to: (1) Determine the incidence of traumatic injury, specifically IPV during the COVID-19 pandemic (March-June 2020) as compared to the incidence in the prior calendar year (March-June 2019), using natural language processing analysis, (2) Identify contextual factors related to the occurrence of traumatic injury and IPV during the COVID-19 pandemic through a detailed chart review, and (3) Describe the effects of COVID-19 related movement restrictions on experiences of trauma as a result of IPV including health seeking behaviors through in-depth interviews with IPV survivors and health care providers. My role and thesis work from this project was related to Aim 3.

As a member of the research team, I helped develop in-depth interview guides for survivors, recruit and schedule interviews for healthcare providers and survivors, take field notes and facilitate survivor interviews, quality check survivor interview transcriptions, as well as carry out the analysis with survivor data. For the purposes of this thesis, secondary analysis was conducted with survivor data collected for the study, while Aim 3 of the parent study will combine analysis results from healthcare providers and survivors.

Survivor data collection occurred from April 2021 through November 2021. Despite data collection occurring at a single time point, the study examined IPV survivors' perceptions and experiences prior to and during the COVID-19 pandemic due to inclusion criteria of participants.

Potential issues of recall biases were mitigated by incorporating time frames into the interview guide for participants to focus their responses.

Following pilot testing, I, along with another team member, conducted nine in-depth interviews with IPV survivors, five with survivors recruited from the Grady Memorial Hospital Trauma Registry and four with community survivors who sought resources for IPV. A member of the research team was also present for each interview to take field notes. Interviews were conducted and recorded remotely via Zoom and lasted between 60 and 120 minutes. Following each interview, verbatim transcripts were produced using Happy Scribe (Happy Scribe, n.d.), which were quality checked and deidentified by myself and another member of the research team. Data management and analysis were carried out using MAXQDA Analytics Pro 2022 (VERBI Software, 2021).

Thematic analysis was selected as the analysis framework. Thematic analysis refers to "the method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006). For this project, the phases of thematic analysis identified by Braun and Clarke (2006) were employed. These phases include data familiarization, creating initial codes, searching for themes, reviewing themes, defining themes, and creating a final report (Braun & Clarke, 2006).

In order advance data familiarization, thorough review of all transcripts was completed. Throughout the course data orientation and subsequent analysis, the process of memoing, writing annotations or comments, was employed to keep an audit trail of analytical decisions, notes, methods employed, and develop final themes.

Prior to the identification of codes, I reoriented myself to the original research goals: Describe the impact of COVID-19-related movement restrictions on the experiences of trauma resulting

from IPV, including health or help-seeking behaviors. During the code identification process, I developed codes inductively based off questions from the IDI guides, IPV literature, data familiarization and preliminary memoing. Several initial codes came from breaking the research question down into smaller pieces and some of the examples brainstormed during initial codebook discussions with the larger research team. Examples of deductive codes include "COVID-19 insights," "COVID relationship challenges," "IPV classification," and "Negative help-seeking experiences." This method aligns with Bazeley's (2021) approach to organizing code structures based on conceptual similarities, while also ensuring that each concept only appeared in the code structure one time. I also developed inductive codes based off recurring topics from interviews. Examples of inductive codes include "Financial control," "First-time relationship violence," and "Substance use."

Following coding of the first transcript, additional inductive codes were added, and the final codebook underwent review by the larger research team. I then used the finalized codebook to recode the first transcript and subsequent eight transcripts. After coding was completed, I employed a variety of methods throughout primary data analysis and theme development. These methods include memoing, case summaries, reflections, matrices, as well as comparisons across data. Finally, I ran descriptive statistics on quantitative data using Qualtrics and Excel.

In November 2020, the larger research team was given the opportunity to present preliminary study findings at the Georgia Commission on Family Violence annual conference. This opportunity allowed us to disseminate findings and helped me adhere to thesis submission timelines.

Following thesis defense, I plan to submit the manuscript to a special issue of BMC Public Health focused on IPV and COVID (BioMed Central, n.d.-b). This decision was made when my

thesis committee shared an opportunity to submit the manuscript for the journal's upcoming special collection on the COVID-19 pandemic and intimate partner violence. As such, the manuscript formatting adheres to the manuscript submission guidelines outlined by BMC Public Health (BioMed Central, n.d.-a).

Chapter 4: Manuscript

"We're out here getting slaughtered by these abusive people": Perceptions of the effects of COVID-19 movement restrictions among survivors of intimate partner violence

By Kathryn G. Wyckoff

Abstract: Intimate Partner Violence (IPV) poses a severe public health threat globally and within the United States. Preliminary evidence underscores surges in IPV during the COVID-19 pandemic. The purpose of this study was to understand the impacts of COVID-19, including the impacts of movement restrictions (i.e., shelter in place orders, quarantine, isolation orders) on experiences of IPV from the perspective of survivors. In-depth interviews were conducted with nine survivors who presented at a large, Atlanta-based public hospital or sought IPV community resources (i.e., domestic violence shelter, therapy services) between March 2020 and December 2020. Thematic analysis was carried out to describe the impact of COVID-19 movement restrictions on IPV and help-seeking behaviors among survivors, in addition to identifying resources to improve IPV response during pandemics. Survivors cited relationship challenges that were amplified by either movement restrictions or consequences of COVID-19, including substance use, reinforced control tactics, and increased financial or life stressors resulting from the pandemic. COVID-19 movement restrictions catalyzed new relationships quickly and sparked new or intensified violence in existing relationships, and unveiled holes in IPV support services. Taken as a whole, these findings suggest COVID-19 movement restrictions and social distancing measures amplify IPV, experiences of trauma, and survivors' subsequent help-seeking experiences.

Introduction

Intimate Partner Violence (IPV) poses a severe public health threat globally and within the United States (U.S.). According to the National Center for Injury Prevention and Control, IPV constitutes any physical violence, sexual violence, stalking, psychological aggression, or coercive control tactics enacted by current or previous intimate partners (Breiding et al., 2015). The term 'intimate partner' encompasses any spouses, boyfriends, girlfriends, dating partners, or ongoing sexual partners (Breiding et al., 2015). According to the 2015 National Intimate Partner and Sexual Violence Survey, 43.6 million women and 37.3 million men in the United States reported experiences of rape, violence or stalking by an intimate partner in their lifetime (S. Smith et al., 2018). There are several facets to consider with IPV, including the types of IPV, associated stigma, risk factors for IPV victimization, injury, morbidity and mortality, IPV during public health emergencies, IPV during the COVID-19 pandemic, and IPV in the state of Georgia.

Types of IPV

While IPV manifests in overt forms of physical, sexual, and emotional violence, it is important to note most IPV often starts with less visible forms of violence on behalf of perpetrators, such as surveillance and controlling behaviors through limiting time with social connections, public humiliation and shaming, blocking electronic communication streams, and spreading rumors (Park & Jeon, 2021). These "invisible" IPV tactics and their impacts are equally as crucial to investigate, as they contribute to negative short-, mid-, and long-term outcomes. Of the more overt forms, physical violence encompasses a variety of behaviors, including slapping, pushing, shoving, beating, burning, or choking (Black et al., 2011). Sexual violence refers to rape, forced penetration of someone else, sexual coercion, unwanted sexual contact, and non-contact sexual encounters (Black et al., 2011). Stalking, another type of IPV, consists of repeated harassment or

threatening strategies to instill fear or concern for safety (Black et al., 2011). Of the more "invisible" IPV tactics, psychological or emotional IPV include name calling, insulting, humiliation, or other aggression directed at survivors (Black et al., 2011). Other forms of psychological IPV include coercive control, which refer to perpetrator behaviors aimed at monitoring, controlling or threatening survivors (Black et al., 2011).

IPV and Stigma

Stigma plays a large role in IPV disclosure and related help-seeking behaviors. Due to the stigma and sensitivity surrounding data collection involving IPV survivors, most data are likely underestimates of actual IPV prevalence (Alfaro Quezada et al., 2020; Black et al., 2011; Breiding et al., 2014; Khurana & Loder, 2021). The stigma and sensitivity of IPV often plays a role in help-seeking behaviors of survivors. Despite more than 35% of women and 28% men in the U.S. experiencing IPV in their lifetime (Black et al., 2011), a majority of cases go unreported (Gracia, 2004) .

Risk Factors for IPV Victimization

A variety of characteristics have been identified as placing individuals at a higher risk for IPV victimization, including community and financial stress, minority group membership, adolescence and young adulthood, unemployment, low income, exposure to IPV or family violence as a child, and child abuse (Capaldi et al., 2012; Lipsky et al., 2005; Schafer et al., 2004; World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Other established risk factors for IPV victimization include partner alcohol or substance use (Lipsky et al., 2005; Schafer et al., 2004; World Health Organization & London School of Hygiene and Tropical Medicine, 2010), separated or divorced marital status (World Health Organization & London School of Hygiene and Tropical Medicine, 2010), lower educational

attainment (Breiding et al., 2008; World Health Organization & London School of Hygiene and Tropical Medicine, 2010), poverty (World Health Organization & London School of Hygiene and Tropical Medicine, 2010), mental disorders (i.e., depression) (World Health Organization & London School of Hygiene and Tropical Medicine, 2010), as well as beliefs in traditional gender and social norms that reinforce violence (World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Understanding such risk factors allows researchers and practitioners to identify and tailor prevention strategies.

Moreover, non-Hispanic Black, American Indian or Alaska Native, and multi-racial non-Hispanic women and men are more likely to experience IPV in their lifetime relative to White counterparts, suggesting disproportionate rates of IPV among Black, Indigenous, People of Color (BIPOC) (Black et al., 2011). While associations exist between racial or minority group membership and IPV, differences in education and income and structural racism underlie these associations (Dearwater et al., 1998; Jewkes, 2002; Snow Jones et al., 1999).

IPV Injury, Morbidity and Mortality

Data from the 2010 National Intimate Partner and Sexual Violence Survey indicate the most predominant form of IPV is physical violence, with 14.8% of women and 4% of men reporting sustained injuries due to IPV (Black et al., 2011). Additionally, several data sources suggest survivors of IPV have higher rates of unmet health needs despite accessing health care services more frequently and accumulating higher medical expenses (Bergman & Brismar, 1991; Plichta, 2007; Wisner et al., 1999). The Nationwide Emergency Department Database revealed 132,806 IPV-related ED visits across the United States between 2010 and 2014, resulting in combined medical costs of $395 million (Alfaro Quezada et al., 2020). Multiple studies on injury patterns and demographics of individuals presenting to EDs across the country indicate a higher

prevalence of presenting female survivors (Alfaro Quezada et al., 2020; Davidov et al., 2015; Khurana & Loder, 2021; Loder & Momper, 2020). Patient profiles indicate a majority of IPV survivors presenting to EDs relied on Medicaid and self-pay methods (Alfaro Quezada et al., 2020; Davidov et al., 2015). While higher numbers of individuals report experiencing IPV for the first time prior to age 25 (Black et al., 2011; S. Smith et al., 2018), IPV is also significant among older patients presenting to EDs, with older, male patients sustaining more and higher severity injuries requiring hospitalization on average compared to female survivors presenting to EDs (Alfaro Quezada et al., 2020; Davidov et al., 2015; Khurana & Loder, 2021). Documented injury profiles of IPV survivors presenting the EDs also suggest patients commonly present with contusions or abrasions, lacerations, strains or sprains, internal organ injuries, and fractures (Alfaro Quezada et al., 2020; Davidov et al., 2015; Khurana & Loder, 2021; Loder & Momper, 2020).

In conjunction with physical injuries sustained, IPV has been associated with a plethora of negative health outcomes, including depression (Beydoun et al., 2016; Devries et al., 2013; Golding, 1999; Mazza et al., 2021), anxiety (Beydoun et al., 2016; Black et al., 2011), post-traumatic stress disorder (PTSD) (Black et al., 2011; Dutton et al., 2006; Golding, 1999; Mazza et al., 2021), suicidal behaviors (Beydoun et al., 2016; Black et al., 2011; Devries et al., 2013; Golding, 1999; Mazza et al., 2021), alcohol and drug misuse (Beydoun et al., 2016; Golding, 1999; Mazza et al., 2021), sexual problems (Mazza et al., 2021), concentration issues (Mazza et al., 2021), somatization (Mazza et al., 2021), social issues (Mazza et al., 2021), educational challenges (Mazza et al., 2021), feelings of guilt or blame (Mazza et al., 2021; Reich et al., 2014; Ross & Foster, 2012), chronic pain (Black et al., 2011; Mazza et al., 2021), gastrointestinal issues (Black et al., 2011; Mazza et al., 2021), traumatic brain injuries (TBIs) (Mazza et al.,

2021; st. Ivany & Schminkey, 2016), as well as cardiovascular disease (Mazza et al., 2021; Stene et al., 2013; E. N. Wright et al., 2018). Additionally, “invisible” forms of violence stemming from IPV negatively influence help-seeking behaviors and decrease opportunities for survivors of IPV to seek social support (Park & Jeon, 2021). In addition to the negative mental health outcomes associated with IPV, prior cross-sectional and case-control studies document the risk of IPV victimization among individuals with pre-existing mental health disorders (i.e., depression, anxiety, PTSD) (Khalifeh et al., 2015; Trevillion et al., 2012).

IPV can also precede mortality outcomes, such as homicide, suicide, among other violent fatalities. The phenomenon of intimate partner homicide (IPH) refers to fatal violent attacks committed by intimate partners (S. G. Smith et al., 2014). More than half of female victims of homicide in the U.S. are killed by IPH, with the top three mechanisms of injury being firearms, sharp instruments, and hanging, strangulation or suffocation (Petrosky et al., 2020). According to the National Violent Death Reporting System (NVDRS), young women belonging to racial or ethnic minority groups experience the highest rates of IPH (Petrosky et al., 2017). Another IPV homicide phenomenon occurs when family members, friends or new intimate partners, known as corollary victims, are killed by perpetrators (S. G. Smith et al., 2014). Significantly, one in every four IPH victims result in additional corollary victims, of which 76.4% are male family members or new intimate partners (S. G. Smith et al., 2014). Perpetrators of IPH may also die by suicide following the homicide event, with males making up 95-97% of perpetrators (Zeppegno et al., 2019). Additionally, IPV victimization may also precede suicide, with recent data from the U.S. establishing associations between heterosexual women experiencing physical IPV and self-reported suicidal ideation (Afifi et al., 2008). Lastly, NVDRS data suggest approximately one in

seven legal intervention fatalities are linked to IPV, referring to deaths by active-duty law enforcement officers during IPV incidents (DeGue et al., 2016).

IPV and Public Health Emergencies

Of notable comparison to the COVID-19 pandemic is the 2013-2015 epidemic of Ebola Virus Disease (EVD) across Guinea, Liberia, and Sierra Leone. An assessment examining the impact of EVD on men and women, found 22.9% of 1,562 respondents reported cases of gender-based violence occurring during the peak of the epidemic (Korkoyah & Wreh, 2015). Through a mixture of desk reviews, in-depth interviews, and focus group discussions, the United Nations Development Program found disparities between official reports of sexual and gender-based violence (SGBV) and qualitative accounts of experiences of IPV in Eastern Sierra Leone (United Nations Development Programme, 2015). Specifically, while official reporting channels (i.e., medical providers, community service organizations, criminal justice entities) saw decreases in recorded SGBV cases, in-depth interviews and focus group discussions indicated increases in DV during the epidemic (United Nations Development Programme, 2015). Existing literature on EVD also indicate movement restrictions (i.e., school closures, curfews), negative economic impacts (i.e., unemployment), and decreased access to social services due to redirection of resources to EVD mitigation further exacerbated pre-existing SGBV disparities (Korkoyah & Wreh, 2015; United Nations Development Programme, 2015).

IPV and COVID-19

While a broad range of research examining COVID-19 and IPV has emerged in the past two years, several systematic reviews point to increases in IPV and DV, especially during lockdown and social distancing periods (Bazyar et al., 2021; Kourti et al., 2021; Lausi et al., 2021). Despite the intention to mitigate the negative effects of COVID-19, movement restrictions (i.e., shelter-in-place orders, school closures, curfews) effectively trap survivors with their abusers by

creating isolating environments and exacerbating coercive control tactics (M. L. Evans et al., 2020; Rieger et al., 2021; Sower & Alexander, 2021). Notably, a majority of emerging literature is cross-sectional or anecdotal in nature, underscoring the need for more incidence data and research on IPV risk factors during COVID-19 (D. P. Evans, 2020).

According to a systematic review of cross-sectional and cohort studies conducted on DV during the COVID-19 pandemic, a majority of violence trends were examined in North America (i.e., United States, Canada), followed by Europe (i.e., United Kingdom, Germany, Switzerland, Spain), Australia and New Zealand, and Africa (i.e., South Africa, Ghana) (Kourti et al., 2021). Across the United States, cross-sectional research suggests increases in DV reports during perpetrator working hours (McCrary & Sanga, 2021), increases in calls to DV service organizations during the 12-week lockdown period beginning in March 2020 (Leslie & Wilson, 2020), increases in DV reports through the Dallas, Texas Police Department during the first two weeks of lockdown (Piquero et al., 2020), an absence of increases in reported DV assaults despite increases in calls to DV service organizations (Mohler et al., 2020), decreases in reported DV cases across Chicago, IL in March 2020 compared to 2019 (McLay, 2021), in addition to increased odds of experiencing IPV among those with COVID-19 symptoms or diagnosis (Davis et al., 2020). Of note, crime data analyzed from the Atlanta Police Department revealed increases in domestic crimes during 2020 compared to the previous two years, suggesting increases in domestic violence (D. P. Evans et al., 2020). These findings are particularly pertinent, as the current study takes place in Atlanta, Georgia.

In conjunction with research on IPV and DV prevalence during COVID-19, much cross-sectional research has been dedicated to exploring risk factors and adverse outcomes associated with experiencing IPV or DV during the pandemic. Results of cross-sectional research

examining U.S. ED visits for mental health, overdose, and violence outcomes between 2018 and 2020 noted increases in visits pertaining to IPV during the lockdown period compared to previous years, indicating the severity of violence warranted breaking movement restrictions and navigating health risks of COVID-19 (Holland et al., 2021). Researchers in Spain also found lockdown and economic stress factors significantly contributed to increases in IPV, suggesting lifted movement restrictions will not decrease IPV and DV due to continued economic stress fueled by the pandemic (Bazyar et al., 2021). In the same vein, several cross-sectional studies indicate unemployment, economic stress, poor mental health and decreased social support increase the likelihood of experiencing violence in the home (Arenas-Arroyo et al., 2021; Jetelina et al., 2021; Lausi et al., 2021; Ravi et al., 2021).

Recent studies have also explored adverse mental health outcomes related to movement restrictions. A large cross-sectional study in the United Kingdom (U.K.) found higher levels of anxiety and depression during the initial COVID-19 lockdown period (L. Wright et al., 2020). Moreover, another large cross-sectional U.K. study found significant relationships between experiences of previous physical and/or psychological abuse, pre-existing mental health issues, decreased social support, and low socioeconomic status and the onset of depressive symptoms during the COVID-19 lockdown period between March and April 2020 (Frank et al., 2020). Qualitative studies using semi-structured in-depth interviews were conducted with female IPV survivors accessing shelter or IPV service agency resources in the Southwestern United States (Ravi et al., 2021), female immigrant IPV survivors in the United States (Sabri et al., 2020), female IPV survivors residing in domestic violence shelters in South Africa (Dekel & Abrahams, 2021), as well as female IPV survivors residing in Mumbai, India (Huq et al., 2021). Evidence from this preliminary qualitative research suggest COVID-19 increased individual stressors, such

as financial stress or unemployment (Dekel & Abrahams, 2021; Huq et al., 2021; Ravi et al., 2021; Sabri et al., 2020), mental health complications (Huq et al., 2021; Ravi et al., 2021; Sabri et al., 2020), household work and caregiving burdens (Dekel & Abrahams, 2021; Huq et al., 2021; Sabri et al., 2020), as well as increased severity and incidences of IPV associated with increased alcohol consumption (Huq et al., 2021), control tactics (i.e., partner isolation, control of movements, monitoring) (Dekel & Abrahams, 2021; Huq et al., 2021; Sabri et al., 2020), and confinement within the home (Dekel & Abrahams, 2021; Huq et al., 2021; Ravi et al., 2021; Sabri et al., 2020). Additionally, data from survivors engaged with shelters and IPV service agencies suggest a lack of support from shelters during COVID-19, in addition to exacerbated feelings of isolation stemming from a combination of strict shelter rules and stay-at-home orders that mirror control or isolation tactics enacted by abusive partners (Ravi et al., 2021).

Anecdotal evidence and commentaries have also emerged amidst COVID-19 and preliminary findings concerning IPV. Notably, they highlight pre-existing disparities exacerbated by the pandemic, such as economic instability, unsafe housing, neighborhood violence, low social support (M. L. Evans et al., 2020; Ravi et al., 2021; Rieger et al., 2021; Sower & Alexander, 2021). They also explore potential explanations for decreases in help-seeking behaviors or calls to crisis lines due to lack of safety in connecting with resources due to sheltering in place with perpetrators of IPV (M. L. Evans et al., 2020; Sower & Alexander, 2021; Zero & Geary, 2020). Diminished IPV resources and shelters with reduced capacity, overburdened hospitals and HCPs, reduced social support (i.e., family, friends), as well as limited or reduced capacity law enforcement means (i.e., protective orders) leave survivors of IPV at a particularly vulnerable place (M. L. Evans et al., 2020; Sower & Alexander, 2021; Zero & Geary, 2020). Thus, more research into the relationship between movement restrictions, help-seeking behaviors, and IPV

during COVID-19 is necessary to inform future pandemic response and address what has been referred to as a "shadow pandemic" (UN Women, n.d.).

As movement restrictions and social distancing practices lift, the long-term effects of IPV during COVID-19 are still unidentified. Although preliminary anecdotal and empirical data indicate increases in the prevalence of IPV during the pandemic, gaps remain in understanding the overarching impacts of quarantining and movement restrictions on IPV. More research is warranted to assist pandemic response through examination of health, economic, and other invisible impacts of IPV. As most available data come from social media, the internet, anecdotal evidence, helpline reports, and interviews with HCPs (Hendrix et al., 2021; Viero et al., 2021), the current study aims to address the gap of qualitative in-depth interviews with survivors of IPV during the COVID-19 pandemic. Up until now, no study has examined IPV survivors' perceptions of COVID-19 movement restrictions (i.e., shelter-in-place, quarantine, isolation orders) and their effects on traumatic injury and help-seeking behaviors. The purpose of this study was to understand the impacts of COVID-19, including the impacts of movement restrictions (i.e., shelter in place orders, quarantine, isolation orders), on experiences of IPV from the perspective of survivors. Exploring this unique perspective provides necessary context to existing evidence.

The COVID-19 pandemic offers a unique context, with many states and countries enacting movement-restrictions (i.e., shelter-in-place orders) that may exacerbate IPV. Specifically, public health measures restricting movement reinforce and socially legitimize isolation and coercive control tactics enacted by perpetrators of abuse. Therefore, the perspectives of IPV survivors who sought healthcare or resources pertaining to their relationship during COVID-19 are necessary to provide insight into the pandemic's impact on IPV and help-seeking behaviors.

IPV in Georgia

Of the 80,921,000 men and women estimated nationally to have experienced IPV in their lifetime (S. Smith et al., 2018), 14.5 million estimated lifetime survivors reside in the state of Georgia where this study takes place (Black et al., 2011). It is pertinent to note uniform and comparable national and state-level data for IPV are lacking (Black et al., 2011). Prior research underscores the high prevalence of IPV in Georgia (Black et al., 2011), in addition to its rankings as one of the states with higher rates at which women are killed by men (Georgia Coalition Against Domestic Violence, 2020). Moreover, cumulative increases in 2020 DV crimes in the city of Atlanta compared to the previous two years highlight surges of IPV during the pandemic (D. P. Evans et al., 2020). As two counties within the Atlanta area contain the highest prevalence of COVID-19 cases, hospitalizations, and total deaths for the state (Georgia Department of Public Health, 2021), Atlanta, Georgia provides an ideal context in which to examine the effects of the COVID-19 pandemic on IPV from the perspective of survivors.

Methods

Design

The research team employed a cross-sectional mixed-methods study design to carry out the study. As a relatively novel area of research, the study design maximized the investigation of the impacts of COVID-19 related movement restrictions on IPV and experiences of trauma, health-seeking, and community resource-seeking behaviors from survivors of IPV. As IPV is a sensitive topic, in-depth qualitative interviews were selected, as they prove useful in building rapport and eliciting perceptions and experiences from survivors.

Instrument

Two original in-depth interview (IDI) guides were created, one for IPV survivors recruited using data from a large, Atlanta-based public hospital's trauma registry, and one for IPV survivors recruited from community IPV resources in the metro-Atlanta area. Both guides included questions designed to explore the following topics: (1) knowledge and perceptions of COVID-19 and movement restrictions, (2) perceptions and experiences of IPV during COVID-19, (3) perceived effects of COVID-19 movement restrictions on experiences of IPV, (4) perceived changes in IPV experiences from before compared to during the COVID-19 pandemic, (5) facilitators for experiencing IPV during COVID-19, (6) perceptions of facilitators and barriers to seeking IPV resources during COVID-19, and (7) and perceptions of resources or supports that could improve IPV response during pandemics. Each guide was divided into seven sections. Section one included quantitative questions to collect survivor demographic information. Next, section two included a mixture of quantitative and qualitative questions concerning knowledge and perceptions of COVID-19 and movement restrictions across Atlanta and the state of Georgia, as a whole. Section three consisted of qualitative questions about survivors' lives and challenges prior to and during the COVID-19 pandemic. Section four contained qualitative questions concerning survivors' current or most recent relationships, their relationship challenges prior to and during the pandemic, as well as experiences of IPV before and during the pandemic. Section five differed slightly for survivors recruited from the trauma registry and community survivors, in that survivors recruited from the trauma registry were asked questions concerning their visit to the hospital following IPV; survivors recruited from the community were asked questions about the social services (i.e., DV shelter, therapy services) they sought for IPV during the pandemic. Section six included quantitative and qualitative questions about survivors' current and previous experiences with IPV, knowledge of available resources, and remaining resource needs. Lastly,

section seven included wrap-up questions to debrief survivors, share IPV resources, and close the interview.

The primary interviewer pilot tested both IDIs with members of the research team and feedback from practice interviews were incorporated into the final guides, which also included probing techniques to extract additional information from participants. Once pilot testing was complete and the first set of patient and community survivor interviews were conducted, the research team made iterative changes to the IDIs, including the addition of more probes and inclusion of language stressing the importance of taking the interview in a private space away from family members or intimate partners.

Participants

To be eligible for study participation, survivors had to have presented at a large, Atlanta-based public hospital between March 2020 and December 2020 or have sought IPV community resources (i.e., domestic violence shelter, therapy services) between March 2020 and December 2020. For patient survivors, the research team pulled electronic medical records from the large public hospital using ICD-9 and ICD-10 codes pertaining to IPV. Then the team pulled a subset of those electronic medical records containing social worker notes to capture IPV cases more accurately when querying medical records (Tabaie et al., n.d.; Zeidan et al., n.d.). Once this was accomplished, the team cross-referenced with the hospital's trauma registry to confirm IPV. Purposive sampling of IPV survivors using the hospital's trauma registry was employed to determine the initial sample (n=5). To diversify the sample, the research team used social media study advertisements and reached out to community providers of IPV resources to distribute study fliers among groups and listservs to recruit interested community members with IPV experiences during the COVID-19 pandemic (n=4). Due to the sensitive and challenging nature

of recruiting people actively experiencing relationship violence, all interested and eligible participants who met the inclusion criteria were included in the final sample (n=9).

Survivors from the large, Atlanta-based public hospital were recruited for the study via a variety of methods, the first of which included texts sent to patient phone numbers obtained through the patient's electronic medical record. If there was no reply, the research team followed up three times every three days. Following a reply expressing interest, a short phone call was scheduled to confirm patient identity and eligibility, explain the study's purpose, schedule a date and time for a Zoom interview, and set up an identity passphrase for use during the interview to ensure safety. Participants received confirmation texts or emails with the study's informed consent and Zoom invite, in addition to an interviewer reminder 24 hours in advance.

Survivors from the community were recruited for the study via a distribution of a study flier containing eligibility requirements, study information, and contact information for members of the study team with whom interested individuals could reach out to. Study fliers were posted on social media advertisements, listservs from Atlanta-based IPV organizations, and public spaces (i.e., public transit stations, grocery stores, shopping malls, parks). Once contacted, members of the study team set up a 5-minute phone call to confirm eligibility, explain the study's purpose, schedule a date and time for a Zoom interview, and set up an identity passphrase for use during the interview to ensure safety. Participants received confirmation texts or emails with the study's informed consent and Zoom invite, in addition to an interviewer reminder 24 hours in advance.

All participants received comprehensive IPV resource lists and were compensated with a $25 gift card following interview completion.

Data Collection

Data collection occurred from April 2021 through November 2021. Despite data collection occurring at a single time point, the study examined IPV survivors' perceptions and experiences prior to and during the COVID-19 pandemic due to inclusion criteria of participants. Potential issues of recall bias were mitigated by incorporating time frames into the interview guide for participants to focus their responses.

Following pilot testing, two interviewers conducted nine in-depth interviews with IPV survivors, five with survivors recruited from the trauma registry and four with community survivors who sought resources for IPV. An additional member of the research team was also present for each interview to take field notes. Interviews were conducted and recorded remotely via Zoom and lasted between 60 and 120 minutes. Some interviews were interrupted and rescheduled due to the presence of the perpetrator or a third party that compromised the privacy of survivors. To ensure privacy and safety were maintained, we established a safe phrase with survivors prior to each interview that they could use to end the interview at any time. Following each interview, verbatim transcripts were produced using Happy Scribe (Happy Scribe, n.d.), with quality checks conducted by a graduate research assistant. At the end of each interview, survivors were provided with links to a secure safety planning app and a password protected IPV resource guide containing local resources. Approvals for data collection were obtained by Emory University's Institutional Review Board.

Data Analysis

The current analysis includes nine in-depth interviews with survivors of IPV living in Atlanta, Georgia. Data management and analysis were carried out using MAXQDA Analytics Pro 2022 (VERBI Software, 2021).

Thematic analysis was selected as the analysis framework. Thematic analysis refers to "the method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006). For this project, the phases of thematic analysis identified by Braun and Clarke were employed (Braun & Clarke, 2006). These phases include data familiarization, creating initial codes, searching for themes, reviewing themes, defining themes, and creating a final report (Braun & Clarke, 2006).

In order advance data familiarization, thorough review of all transcripts was completed. Throughout the course data orientation and subsequent analysis, the process of memoing, writing annotations or comments, was employed to keep an audit trail of analytical decisions, notes, methods employed, and develop final themes.

Prior to the identification of codes, the graduate research assistant reoriented themselves to the original research goals: Describe the impact of COVID-19-related movement restrictions on the experiences of trauma resulting from IPV, including health or help-seeking behaviors. During the code identification process, codes were developed inductively based off questions from the IDI guides, IPV literature, data familiarization and preliminary memoing. Several initial codes came from breaking the research question down into smaller pieces and some of the examples brainstormed during initial codebook discussions with the larger research team. Examples of deductive codes include "COVID-19 insights," "COVID relationship challenges," "IPV classification," and "Negative help-seeking experiences." This method aligns with Bazeley's approach to organizing code structures based on conceptual similarities, while also ensuring that each concept only appeared in the code structure one time (Bazeley, 2021). Inductive codes were also developed between the two interviewers based off recurring topics from interviews.

Examples of inductive codes include “Financial control,” “First-time relationship violence,” and “Substance use.”

Following coding of the first transcript, additional inductive codes were added, and the final codebook underwent review by the larger research team. The finalized codebook was then used to recode the first transcript and subsequent eight transcripts. After coding was completed, a variety of methods were employed throughout primary data analysis and theme development. These methods include memoing, case summaries, reflections, matrices, as well as comparisons across data. Finally, descriptive statistics were run on quantitative data using Qualtrics and Excel.

Ethical Considerations

Informed consent forms were emailed or texted to participants in advance of interviews and read aloud to participants prior to the start of each interview. Verbal consent was obtained and documented by the research team for each participant prior to data collection. This research was approved by Emory University’s Institutional Review Board (Study ID 00000432).
Survivors were also provided with access to a secure safety planning app and a password protected IPV resource guide containing local resources (e.g., hotlines, DV shelters, general DV resources, temporary housing, health care, legal assistance) to minimize study harms, potential retraumatization, and ongoing IPV.

Results

Survivors interviewed included 7 female-identifying survivors, 1 male-identifying survivor, and 1 non-binary survivor. The majority of survivors interviewed identified as Black or African American (n=7). The mean age of survivors was 39. Roughly half of survivors interviewed were self-reported as single, not in a relationship, at the time of their interview (n=5). Roughly half of

survivors interviewed had a private insurance plan during 2020 (n=4). When asked about services sought, five survivors reported obtaining services at the large, Atlanta-based public hospital, two sought services at DV shelters, and two sought therapy services following IPV during the pandemic. Six of the survivors interviewed indicated awareness of Atlanta- or Georgia-specific movement restrictions (Table 1).

The results of this study are presented within three thematic categories describing the impact of COVID-19 movement restrictions and social distancing measures described by survivors on their experiences of trauma resulting from IPV and help-seeking behaviors: *COVID-19 impacts paved the way for relationship challenges catalyzing violence*, *COVID-19 movement restrictions catalyzed new relationships quickly and sparked new or intensified violence in existing relationships*, and *IPV help-seeking during COVID unveiled holes in support services*.

The first two themes are comprised of subthemes with elaboration and explanation. All themes include initial summarization and elaboration of findings using paraphrased and verbatim quotes from survivors to contextualize results.

Theme 1: COVID-19 impacts paved the way for relationship challenges catalyzing violence

Each of the survivors cited relationship challenges that were amplified by either movement restrictions or consequences of COVID-19. Dimensions of these recurring relationship challenges include increased substance use, reinforced tactics of control or abuse, as well as increased financial or life stressors resulting from the pandemic. Notably, survivors attributed these COVID-related relationship challenges to higher recurrences of arguments or fights, which often preceded episodes of IPV.

Subtheme 1.1: COVID-19 Substance use as a catalyst for relationship violence

Survivor and/or perpetrator substance use (i.e., alcohol use, drug use) throughout early parts of the pandemic featured in four of the nine cases analyzed. Specifically, survivors discussed substance use preceding relationship violence during COVID-19. Of note, each case featuring substance use as a facilitator of relationship violence came up with survivors recruited for the study from Atlanta's large public hospital who previously presented with IPV injuries between March and December of 2020. Facilitators of increased substance use during the pandemic among survivors and perpetrators include isolation in the home due to movement restrictions, increased employment stress and/or financial stress, working remote, as well as pre-existing substance misuse issues. Some survivors noted their own and their partner's increased alcohol or drug use stemmed from isolating in their homes due to shelter in place orders or other movement restrictions:

> *"It's just, you know, you have nothing else better to do and confined to the home. So, you just drink and I'm drinking to have fun, have a good time." (36-year-old Black/African American female survivor)*

Conversely, other survivors attributed their own and their partner's increased alcohol or drug use to stress or isolation resulting from personal or institutional challenges, such as job instability:

> *"I was, uh, drinking more, of course, but, no, I just lost, I just lost my purpose because I'm not working and I'm just losing ambition. I'm not even goal driven like I used to be* [before the pandemic]*, I'm just really, just waking up to go back to sleep." (31-year-old Black/African American female survivor)*

Regarding perpetrator substance use, two survivors indicated their intimate partners had pre-existing drug or alcohol misuse issues that factored heavily into their relationship challenges during COVID-19. For example, a 65-year-old male Black/African American survivor indicated

weekly fight frequencies increased from two prior to the pandemic to seven or more during the pandemic due to disagreements concerning his partner leaving the house to consume alcohol or use his money to purchase more alcohol.

Notably, perpetrator and/or survivor substance use preceded episodes of IPV during the pandemic in each of the four cases identified from the sample. For example, a 54-year-old female Black/African American survivor relayed an episode of physical IPV during the pandemic, which began with her partner consuming a large amount of alcohol, leaving to use "crack cocaine", and returning to her house, which led to an argument and physical attack in which he strangled her. Other instances in which substance use, primarily alcohol consumption, preceded IPV episodes during the pandemic featured arguments centered around the perpetrator's alcohol consumption, the perpetrator leaving the house to consume alcohol with individuals despite movement restrictions, or the perpetrator initiating arguments or physical attacks following substance use. Thus, this pattern of IPV underscores increased substance use during COVID-19 as a catalyst for relationship violence.

Subtheme 1.2: COVID-19 movement restrictions and social distancing measures reinforced control and abuse tactics contributing to relationship challenges and IPV

Across several cases, COVID-19 movement restrictions and social distancing measures bolstered perpetrator methods of control over survivors. Ensuing episodes of IPV stemmed from the challenges and arguments resulting from these reinforced control or abuse tactics. Among relevant cases, COVID-19 movement restrictions and social distancing measures either overtly or covertly augmented survivor experiences of IPV.

Regarding instances in which perpetrators overtly mechanized COVID-19 movement restrictions to reinforce control tactics, one survivor noted her partner was extremely paranoid about COVID

and claimed he did not want anyone coming to the house or the survivor leaving the house. Moreover, he called her from work every hour to make sure she was home and used COVID to justify installing a tracker on her smart phone to ensure she was not leaving the house. When questioned about if the survivor thought these coercive control tactics were used more so out of fear of COVID or desire to control her, she indicated:

> *"Control. COVID gave him an opportunity to tighten the reins, if you will, around my throat." (39-year-old Indigenous/White female survivor)*

As a result, the intensified control measures reinforced by COVID-19 restrictions contributed to increased arguments when the survivor left the home against the perpetrator's wishes, which were followed by episodes of physical IPV.

Conversely, instances in which COVID-19 movement restrictions and social distancing measures covertly augmented survivor experiences of IPV were present across several cases. For example, one male survivor indicated his long-term partner had issues with jealousy. His partner had cheated on him previously and her feelings of jealousy were amplified during the COVID period:

> *"She would do crazy stuff like all my contacts from my job…church female members and stuff like that. She would erase their phone numbers out my cell phone. My…daughter's number, her mother's number, my sister's number…any female phone number that she found on my phone, she would delete it." (65-year-old Black/African American male survivor)*

Other survivors discussed how, through a combination of COVID-19 movement restrictions and their partner's doing, they were isolated from their social networks (i.e., friends, family, peers).

Notably, one female survivor commented on her partner's deliberate use of COVID movement restrictions to cut her off from her social network:

> *I think he tried to push people away, you know, like* [friend's name] *said... My best friend, she came over to the house, and she was like, "I could stand on one side of the fence, man, you could stand on the other side of the fence in your yard, and we could chop it up. I'll eat on my car, and you could eat on your car." And he wasn't going for it, even though we were six feet apart. So, I don't think it was COVID related. I strongly feel that it was an opportunity to, like I said, tighten those reigns. (39-year-old Indigenous/White female survivor)*

Across interviews survivors indicated this isolation resulted in larger amounts of time spent with their partners, prompting more opportunities for abuse.

Subtheme 1.3: COVID-19 restrictions and impacts pertaining to financial and life stressors bolstered IPV

Other facets of the pandemic contributing to survivors' experiences of IPV pertained to financial and life stressors stemming from COVID movement restrictions and subsequent impacts. Examples of such stressors include, economic instability, housing instability, job instability, stress resulting from remote employment, virtual schooling for children, potential COVID-19 exposure, and relationship strain created by government stimulus payments. Across all cases, survivors discussed high frequencies and intensified arguments in their relationships during the pandemic. Specifically, among the six relationships that occurred prior to and during COVID-19, all survivors indicated the frequency and intensity of arguments increased following the onset of COVID. The high frequency of arguments and subsequent relationship strain contributed to

episodes of IPV. One survivor noted that following the onset of COVID, her relationship became more violent*:*

> *"We argue more after COVID-19 than we did before COVID-19. But to be honest, if I really had to compare the two, we argued the same, things just got worse, like he started really, putting his hands on me after that" (23-year-old Black/African American female survivor).*

Several survivors cited financial stress or economic instability during the pandemic as a key feature of their relationship challenges. For example, one survivor who lost his job during the pandemic felt that he shouldered all financial responsibilities for both himself and his partner during COVID:

> *"She really was* [putting] *more pressure on me because I had two people to look after then, before was just me and myself and I managed very well before COVID hit. And then when I started seeing her it was rough and then COVID hit, that made it super rough." (65-year-old Black/African American male survivor)*

In this example, financial challenges during COVID gave way to more arguments and episodes of IPV because of the perpetrator's high spending on alcohol.

Additionally, job or housing instability resulting from the impacts of COVID-19 contributed to relationship challenges. A number of survivors described how they and/or their partners lost employment or were furloughed during the pandemic, were evicted, or had to move in with their families. Such instability, in turn, contributed to the financial strain within relationships discussed previously. For instance, one survivor discussed how she and her partner lost their restaurant jobs during COVID, which contributed to relationship strain, higher argument

frequency, and subsequent physical IPV due to disagreements concerning finding new employment and personal finances. Additionally, she and her partner had to move in with her mother following an eviction, which she also noted contributed to relationship strain from being confined in the same environment together.

Moreover, COVID-19 movement restrictions and social distancing measures resulting in remote work status and/or virtual schooling for children also fueled more arguments and relationship challenges for survivors. Some survivors indicated they had to work remote while their children also began virtual schooling and their partners worked outside the home as essential workers. Subsequently, working from home coupled with increased caregiving responsibilities or disputes over child discipline, resulted in more relationship strain. For instance,

> *"Um, but COVID…I think made it more, um, of a bigger issue for me, especially 'cause I'm like, okay, you're coming in here asking about cleaning or whatever. Meanwhile, I'm managing kids that are acting crazy and my job...You know, I already told you that it was stressful. So, I'm like, you already know my work situation. So, I don't have time to like... It, it's a lot trying to keep the kids together and do my work. So, why are you...being a jerk about, why isn't the house clean ...So, I think for me, that um, became another layer of resentment." (45-year-old Black/African American female survivor)*

From this relationship strain and higher argument frequencies, survivors noted novel or increased episodes of IPV during the pandemic. In a similar vein, several survivors noted increased disagreements with partners regarding breaking movement restrictions or potential COVID-19 exposure. Regarding perpetrators who worked outside the home as essential workers during

COVID, survivors noted increased arguments and relationship strain attributed to fear and anxiety concerning their partners' potential exposures to COVID while working. For example:

> *"So, she had to travel for work. She has the, what do they call them…Yeah, the essential worker…And so she had to go out of town a lot. She had to go to work and come back home. And. And I was scared because, you know, high risk is on my children." (36-year-old Black/African American female survivor)*

Other types of relationship strain or violence stemming from breaking movement restrictions pertained to one partner, usually the survivor, disagreeing with the other partner's lack of adherence to COVID precautions. In several cases, disagreements over leaving the house during the pandemic resulted in episodes of physical IPV. To illustrate, one survivor indicated:

> *"It got worse after COVID because I tried to keep her isolated, out the street, but…She couldn't stay away from that old neighborhood… A lot of people was dying in that area from COVID. You know, and I don't want her to running over there and running back into my isolation zone." (65-year-old Black/African American male survivor)*

Furthermore, some survivors noted increased relationship challenges or strain resulting from government stimulus payments, also known as stimulus checks. These relationship challenges pertained to disagreements concerning how to use the money. For example, one survivor noted her partner feared she would take his stimulus money and use it for herself and end the relationship while he spent the money: *"It seems like every time a check would roll around, there was, there was a breakup" (37-year-old White female survivor).*

Collectively, novel or preexisting relationship challenges amplified by the impacts of the pandemic contributed to episodes of IPV due to higher rates of escalated arguments. Although some survivors indicated they did not believe COVID directly contributed to their relationship issues or IPV, subsequent challenges described as being invoked or inflated by the pandemic reveal the true magnitude of its impacts.

Theme 2: COVID-19 movement restrictions catalyzed new relationships quickly and sparked new or intensified violence in existing relationships

In addition to pandemic impacts that bolstered relationship challenges and IPV, COVID-19 movement restrictions appeared to impact the trajectory of both new and existing relationships. Dimensions of this theme include new instances of IPV occurring in relationships started during the pandemic, new instances of IPV in existing relationships, and intensified instances of IPV in existing relationships. As such, movement restrictions, social distancing measures, and the negative repercussions of the pandemic influenced the amount of time couples spent together, their relationship challenges, as well as the occurrences of new, more frequent and/or severe IPV episodes.

Subtheme 2.1: COVID-19 movement restrictions catalyzed new relationships and triggered violence

Three survivors discussed how their relationships began and ended during the pandemic, reinforcing this idea of the "COVID relationship." Notably, two survivors indicated their relationships began during March 2020, when movement restrictions and social distancing measures were enacted, and ended in July of 2020 when restrictions were relaxed in Georgia. Common descriptions of this type of relationship included spending large amounts of time with

each other daily, moving in together after dating for a few weeks due to movement restrictions, fear of COVID-19 exposure, financial strain, or job instability.

In terms of spending increased amounts of time together, one survivor in a "COVID relationship" noted: *"I did see them like gradually…we'll spend like a whole day or two together, like, like at much 48 hours or four or 24 hours" (22-year-old Black/African American non-binary survivor).* Moreover, two survivors in "COVID relationships" discussed moving in with their partners after briefly dating due to fear of COVID exposure or instability created by the pandemic. One survivor was particularly fearful of exposure to COVID, stating:

> *"But during the pandemic, um, I started seeing stuff, and he would leave out the house, you know, and he asked me cause we was in a situation, he asked me, well let me just come stay with you, cause you tell me, you know, every time I come over, I gotta be tested, so if I stay here wit you, you know, you'll feel better. And I'm like yeah, get tested [inaudible], I did that, I let him stay…Well, after we started datin', um, I moved him in because I was like, you know, I like you, you get along with my dog." (54-year-old Black/African American female survivor)*

From spending increased amounts of time together and/or moving in with each other, survivors indicated increased frequencies of arguments or disagreements as their short relationships progressed. Moreover, survivors in "COVID relationships" also discussed experiencing IPV, either physical or psychological, for the first time ever, resulting from arguments and relationship strain. When asked if she had experienced fights or arguments with her partner or previous partners prior to an episode of physical IPV requiring hospitalization, one survivor said:

> *"Nooo. No. We didn't have fights or arguments before that. Nooo. First time a man has physically attacked me. That was supposed to be my man, who's supposed to love me. He was supposed to be the man, he was supposed to be my confidant. He was supposed to be my king. What if anything happened to me? He would be there to take care of me. He flipped the script." (54-year-old Black/African American Female survivor)*

Subtheme 2.2: COVID-19 movement restrictions sparked new or intensified violence in existing relationships

In a similar vein, survivors in relationships prior to COVID, frequently discussed new or exacerbated relationship challenges, arguments, or IPV following the onset of the pandemic. Regarding her long-term relationship, one survivor noted:

> *"It was abusive. COVID didn't make it any, um... I mean, CO-...COVID didn't produce the abuse, the abuse was already pre-existing. It just got worse during COVID." (39-year-old Indigenous/White female survivor)*

Other survivors noted the frequency of arguments with their partners increased from a couple per week prior to COVID, to every single day during the pandemic. Following the increased relationship strain, several survivors indicated experiencing episodes of IPV for the first time, physical IPV requiring hospitalization for the first time, or higher, more intense IPV episodes following the onset of COVID. When asked if this was the first time she experienced relationship violence requiring hospitalization, a survivor indicated: *"Yes, in my life, never once experienced something like this in my life" (23-year-old Black/African American female survivor).* As a whole, existing IPV experiences throughout the pandemic can be summed up in the words of one

survivor who declared: *"We're out here getting slaughtered by these abusive people, and it's not just us, it's children, too" (36-year-old Black/African American female survivor).*

Experiences described by survivors in "COVID relationships" drew on accelerated relationship timelines stemming from increased free time and fear of COVID exposure resulting from movement restrictions and pandemic repercussions. Conversely, survivors in existing relationships described new or exacerbated relationship challenges or arguments stemming from the pandemic's movement restrictions and life impacts. Collectively, the impacts of COVID laid the foundation for new or intensified violence within "COVID relationships" and existing relationships by exposing relationship challenges linked to movement restrictions and pandemic impacts (i.e., financial instability, housing instability, job instability, isolation, fear of COVID exposure), thus predisposing survivors to IPV.

Theme 3: IPV help-seeking during COVID unveiled holes in support services

Across all interviews, survivors discussed negative help-seeking or gaps in experiences with healthcare, law enforcement, and social services (i.e., DV shelters, therapy services). When talking about healthcare experiences, survivors frequently commented on not being allowed to have anyone accompany them to the hospital. When discussing their hospital experience following a physical IPV episode, one survivor noted:

> *"So, they couldn't go into the hospital with me. So basically, my mom's best friend, my aunt, the one who she [partner] used to stay with before she moved in with us. I said basically, hey, I had to tuck and roll out of the car and going to the hospital by myself." (36-year-old Black/African American female survivor)*

Other healthcare challenges noted by survivors included longer wait times due to decreased hospital capacity from COVID, with one survivor indicating:

> *"They will put you in the emergency room and you sit there for hours upon hours. I was sitting there three hours bleeding…you know, all the medical facilities were overflowed, understaffed and they was going through hell, so many people with covid so the regular emergency you know their priority was covid related kinda put on the backburner" (65-year-old Black/African American male survivor)*

Several survivors also noted social workers or other healthcare providers spent limited to no time with them during their visits, only offered a list of phone numbers for DV shelters, and repeatedly asked them to describe their IPV episode, which they indicated as contributing to negative help-seeking experiences.

Concerning help-seeking experiences with law enforcement, survivors discussed an array of negative experiences. Some noted they were almost arrested, were arrested with their perpetrator, advised to go back to their home where IPV was occurring, could not receive a protective order because courts were closed, or were simply provided a list of DV shelters to contact. For example, when discussing her experience contacting the police following an episode of physical IPV, one survivor said:

> *"I told them, I talked to 911, and I said I'm goin' right here to the, uh, to the, uh, police station at the [store name], on [street name]...I'm at there knockin' the door, ringin' the doorbell. And the man comes…., we don't come outside and answer, and take reports. I go, look, I'm runnin' for my life right now… The man [police officer] said, ma'am, if you need help, you gonna take yourself down to where you just came. You do the math. If*

> *you need help, you're going to take yourself better than what you just came from." (54-year-old Black/African American female survivor)*

Lastly, several survivors discussed negative help-seeking experiences with social services, such as DV shelters or therapy. A survivor who stayed at a DV shelter for a few weeks during April 2020, indicated communal living combined with social distancing created a plethora of challenges. She said she constantly felt like she had to clean *"in order to be safe,"* and *"wearing a mask 24/7"* felt like being at work. Regarding strict DV shelter rules during COVID-19, the same survivor said:

> *"I mean, the rules related to the house, like clean up after yourself, have chores, all of this, none of that was the problem. It was the rules related to COVID, like you had to, um, get a pass to leave, even if you wanted to go buy a pack of cigarettes…and you're only allowed to leave for 30 minutes and then you have to come back…One day, I had a mandatory meeting at work, and….it was almost like, picking between my job or my place to sleep at night, because they didn't want me to leave because it was more than 30 minutes. That's not helpful to me because if I lose my job, then how do I get out of the situation that I'm already in?" (39-year-old Indigenous/White female survivor)*

Other gaps discussed by two survivors who sought DV shelter and support services included long waiting lists for DV classes, cancelled DV classes during shelter in place orders, a lack of virtual options for DV classes, a lack of accessible support groups, and long waiting lists for transitional housing.

Several survivors who also sought therapy services following their IPV experiences discussed attrition among service providers, in that multiple therapists quit or terminated communication

with them after multiple sessions. Regarding therapist attrition, one survivor said: *"I guess maybe that was their internship or I don't know what, but every time I would get close enough to speak with somebody about the situation, they'll be like, well, it was nice knowing you" (36-year-old Black/African American female survivor).* Finally, some survivors also indicated they had to terminate therapy services due to insurance and cost barriers, or they felt like there were not any accessible support groups for people with their experiences.

Collectively, negative help-seeking experiences and gaps in services highlighted by survivors stemmed from capacity issues, personnel shortages, lack of virtual formats, cost barriers, and IPV resource shortages amplified by COVID-19 movement restrictions and negative repercussions of the pandemic.

Discussion

The purpose of this study was to understand the impacts of COVID-19, including the impacts of movement restrictions (i.e., shelter in place orders, quarantine, isolation orders), on experiences of IPV from the perspective of survivors. Since the beginning of the pandemic, cross-sectional and anecdotal evidence have documented surges in IPV and IPV help-seeking behaviors among survivors (Davis et al., 2020; D. P. Evans et al., 2020; Leslie & Wilson, 2020; McCrary & Sanga, 2021; McLay, 2021; Mohler et al., 2020; Piquero et al., 2020). Consequently, understanding the impact of COVID movement restrictions on survivors' experiences of IPV and their help-seeking behaviors is imperative for providing appropriate support and resources. Negative help-seeking experiences and gaps in IPV services identified by these survivors can be incorporated into current and future practice, recommendations, resources, and services as the COVID-19 pandemic evolves and future public health emergencies emerge.

Survivors discussed a variety of trauma experiences resulting from IPV and how COVID-19 movement restrictions impacted their experiences and help-seeking behaviors. All survivors discussed relationship challenges that were amplified by either movement restrictions or consequences of COVID-19. Some survivors attributed COVID relationship challenges and subsequent IPV to increased substance use, bolstering findings from other qualitative research conducted during the pandemic, which linked increased severity and incidences of IPV with increased alcohol consumption (Huq et al., 2021). Other survivors drew connections between COVID-19 movement restrictions and their partner's control or abuse tactics. For those survivors, movement restrictions (i.e., shelter-in-place orders, school closures, curfews) trapped them with their abusers by creating isolating environments, which may have exacerbated coercive control and other abuse tactics (M. L. Evans et al., 2020; Rieger et al., 2021; Sower & Alexander, 2021). Survivors also indicated increased financial or life stressors resulting from COVID featured as prominent components in their IPV experiences. This may be explained by other COVID-19 research connecting lockdown and economic stress factors to increases in IPV, suggesting lifted movement restrictions will not decrease IPV and DV due to continued economic stress fueled by the pandemic (Arenas-Arroyo et al., 2021; Bazyar et al., 2021; Jetelina et al., 2021; Lausi et al., 2021; Ravi et al., 2021). Notably, survivors attributed these COVID-related relationship challenges to higher recurrences of arguments or fights, which often preceded episodes of IPV, reinforcing preliminary evidence pointing to increases in IPV and DV, especially during lockdown and social distancing periods (Bazyar et al., 2021; Kourti et al., 2021; Lausi et al., 2021).

COVID-19 created an alternative reality discussed by survivors as stemming from unemployment, remote work environments, movement restrictions, and social distancing

measures, allowing intimate partners to spend more time with each other than they might have pre-pandemic. The unique situation and environment created by the pandemic were described by survivors as impacting the trajectory of their relationships, both new and existing. Through discussion of their experiences, survivors indicated movement restrictions, social distancing measures, and the negative repercussions of the pandemic influenced their relationship challenges, as well as the occurrences of new or a higher frequency and/or severity of IPV episodes. Their experiences further bolster prior research suggesting the pandemic increases the likelihood of experiencing IPV and DV, especially during shelter in place orders (Arenas-Arroyo et al., 2021; Bazyar et al., 2021; Jetelina et al., 2021; Kourti et al., 2021; Lausi et al., 2021; Ravi et al., 2021).

Regarding help-seeking behaviors following IPV experienced during COVID, survivors discussed a plethora of gaps in services or negative experiences when seeking healthcare, law enforcement, and social services (i.e., DV shelters, therapy services). Specifically, survivors cited long wait times, lack of follow-up, lack of provider engagement, and limited IPV resources offered by hospitals as contributing to negative help-seeking experiences. Such negative help-seeking experiences may be explained by overburdened hospitals and resources being redirected to COVID-19 patients, much like happened during the EVD epidemic (Korkoyah & Wreh, 2015; United Nations Development Programme, 2015).

Among survivors who sought help from law enforcement, negative experiences cited included being told to leave the relationship, they were almost arrested, they were arrested with their perpetrator, advised to go back to their home where IPV was occurring, could not receive a protective order because courts were closed, or were simply provided a list of DV shelters to contact. Prior research has linked limited or reduced law enforcement services stemming from

COVID restrictions (i.e., closed courts) to higher susceptibility of experiencing IPV (John et al., 2020; Sower & Alexander, 2021). Moreover, survivors who were told to leave their relationship, return home, were almost arrested, or were arrested with their perpetrator align with pre-COVID and COVID research documenting these issues as barriers to IPV help-seeking from police (Voth Schrag et al., 2021; Wolf et al., 2003).

Of the survivors who discussed gaps and barriers pertaining to DV shelter services during the pandemic, challenges pertaining to shelter living during the lockdown period echo results from other qualitative research suggesting a lack of support from shelters during COVID-19 exacerbated feelings of isolation stemming from a combination of strict shelter rules and stay-at-home orders that mirror control or isolation tactics enacted by abusive partners (Ravi et al., 2021). Other identified DV shelter service gaps concerning long wait lists for DV classes, cancelled DV classes during shelter in place orders, a lack of virtual options for DV classes, a lack of accessible support groups, and long waiting lists for transitional housing reinforce the increased vulnerability of IPV survivors during COVID-19 due to shelter closures and reduced capacity (M. L. Evans et al., 2020; Sower & Alexander, 2021).

Survivors' access of therapy services underscores the negative mental health repercussions of IPV, as well as mental health challenges identified throughout the pandemic (Huq et al., 2021; Ravi et al., 2021; Sabri et al., 2020). Additional therapy barriers identified, including termination of services due to insurance and cost barriers or lack of access to support groups, also reiterate findings demonstrating barriers to care prevent a large portion of Americans from accessing mental health services (Cohens Veterans Network & National Council for Behavioral Health, 2018).

Regarding identified barriers to IPV help-seeking during the pandemic, we recommend the following resources and supports to help survivors and improve IPV response during pandemics. First, service providers (i.e., law enforcement, health care, DV shelters) should have access to comprehensive, regularly updated IPV resource lists available to share with survivors. As some survivors noted lists they received only contained contact information for DV shelters, future lists should also contain information and contacts for crisis hotlines, general IPV resource providers (i.e., Georgia Coalition Against Domestic Violence), legal assistance, support groups, free or subsidized counseling, and child and family advocacy resources. Comprehensive resource lists serve as a highly feasible strategy to increase access to support services and facilities for survivors of IPV. Similarly, findings from this study suggest the importance of increasing awareness of IPV resources and support services. Therefore, governments, public health authorities and community advocates should allocate resources to disseminating IPV resources during COVID-19 and future public health emergencies. In conjunction with higher visibility of resources, we also recommend service providers incorporate virtual resources (i.e., support groups, DV classes, counseling) to supplement challenges associated with long wait lists for resources or cancellations of in-person services due to movement restrictions.

Since institutional level changes are less feasible in the immediate future, governments and public health authorities should allocate more resources and advocate for increasing the amount of temporary and transitional housing resources to address capacity gaps previously identified, as well as increase funding for free or subsidized mental health resources for survivors. Furthermore, law enforcement and healthcare entities should expand the use of advocate services to mediate survivor interactions and ensure proper trauma-informed care and resource provision.

Taken as a whole, these findings suggest COVID-19 movement restrictions and social distancing measures amplify IPV, experiences of trauma, and resulting help-seeking experiences. Exacerbated IPV rates and resource challenges documented by this study, COVID-19 research, as well as IPV research conducted during previous health emergencies (i.e., EVD epidemic) suggest that the interaction between IPV, movement restrictions, and help-seeking behaviors is not unique to COVID-19. Thus, this phenomenon and its impacts must receive serious consideration when enacting movement restrictions during future pandemic response.

As the pandemic continues to threaten public health and safety, findings from this study can be leveraged to inform IPV response during this and other public health emergencies. Moreover, findings can also be used to inform future pandemic preparedness and response among IPV and public health resources in Atlanta and the state of Georgia. The methods carried out in this study can be adapted for future research carried out in other areas of Georgia or the broader U.S. pertaining to IPV experiences during COVID-19 and perceptions of IPV survivors.

Limitations

There are several limitations to note for this study. Initially, the study aimed to recruit 30 survivors using the 2020 trauma registry from a large public hospital in Atlanta, Georgia. However, due to recruitment challenges, the research team expanded recruitment to IPV survivors from the metropolitan Atlanta community, resulting in a final sample of nine survivors. Recruitment challenges may be attributed to the hidden nature of IPV survivors and the sensitive topic of the study. Moreover, as with the nature of qualitative research, results cannot be generalized to the entire population of IPV survivors. Additionally, a majority of survivors identified as cisgendered, heterosexual, and Black or African American. Therefore, we are missing perspectives from other racial, gender, and sexual identities. Although the codebook was

created collaboratively with the entire research team, there was only one coder for data analysis. Additionally, there is potential sample bias, as we only interviewed survivors who sought IPV services during the early months of the pandemic. Therefore, we are missing perspectives of IPV survivors who did not seek support services or resources during this time period or those who did not seek services at all. As such, findings from this study should be complemented by expanding data collection to incorporate more voices from IPV survivors in Georgia and other regions of the U.S.

Conclusions

Since the beginning of the pandemic, cross-sectional and anecdotal evidence have documented surges in IPV and IPV help-seeking among survivors worldwide (Davis et al., 2020; D. P. Evans et al., 2020; Leslie & Wilson, 2020; McCrary & Sanga, 2021; McLay, 2021; Mohler et al., 2020; Piquero et al., 2020). While a broad range of research examining COVID-19 and IPV has emerged in the past year, several systematic reviews point to increases in IPV and DV, especially during lockdown and social distancing periods (Bazyar et al., 2021; Kourti et al., 2021; Lausi et al., 2021). As movement restrictions and social distancing practices lift, the long-term effects of IPV during COVID-19 are still unknown. This study addresses the gap in knowledge about IPV survivors' perceptions of COVID-19 movement restrictions (i.e., shelter-in-place, quarantine, isolation orders) and their effects on traumatic injury and help-seeking behaviors. Findings from this study contextualize survivors' experiences of IPV during the COVID-19 pandemic, facilitators of IPV experiences during COVID-19, facilitators and barriers to seeking IPV resources during the pandemic, changes in experiences of IPV from before and during the pandemic, as well as resources needed to improve IPV response during public health emergencies. Documenting and comprehending survivors' experiences and perceptions offers a

means to explore the connection between COVID-19 and IPV. Such an understanding may result in improved IPV prevention and response tactics implemented during this pandemic, as well as future health emergencies.

Table 1. Survivor Demographic Information

Characteristics	**Overall N=9**
Age in years, mean (SD)	39.1 (13.96)
Gender, n (%)	
Female	7 (77.7)
Male	1 (11.1)
Non-binary	1 (11.1)
Race, n (%)	
Black or African American	7 (77.7)
White	1 (11.1)
Mixed (Indigenous/White)	1 (11.1)
Children, n (%)	
Yes	5 (55.5)
No	4 (44.4)
Relationship Status at time of Interview, n (%)	
Single	5 (55.5)
Married	2 (22.2)
In a Relationship	1 (11.1)
Separated	1 (11.1)
2020 Insurance Status, n (%)	
Private Plan	4 (44.4)
Medicaid	3 (33.3)
Uninsured	2 (22.2)
Employment Status at time of interview, n (%)	
Full-time	5 (55.5)
Part-time	2 (22.2)
Unemployed	2 (22.2)
Primary services sought following IPV, n (%)	
Hospital	5 (55.5)
DV Shelter	2 (22.2)
Therapy	2 (22.2)
Knowledge of Atlanta- or Georgia-specific movement restrictions, n (%)	
Yes	6 (66.6)
No	3 (33.3)

Chapter 5: Public Health Implications

Implications

The purpose of this study was to understand the impacts of COVID-19, including the impacts of movement restrictions (i.e., shelter in place orders, quarantine, isolation orders), on experiences of IPV from the perspective of survivors. Since the beginning of the pandemic, cross-sectional and anecdotal evidence have documented surges in IPV and IPV help-seeking behaviors among survivors (Davis et al., 2020; D. P. Evans et al., 2020; Leslie & Wilson, 2020; McCrary & Sanga, 2021; McLay, 2021; Mohler et al., 2020; Piquero et al., 2020). Consequently, understanding the impact of COVID movement restrictions on survivors' experiences of IPV and their help-seeking behaviors is imperative for providing appropriate support and resources. Negative help-seeking experiences and gaps in IPV services identified by these survivors can be incorporated into current and future practice, recommendations, resources, and services as the COVID-19 pandemic evolves and future public health emergencies emerge.

Survivors discussed a variety of trauma experiences resulting from IPV and how COVID-19 movement restrictions impacted their experiences and help-seeking behaviors. All survivors discussed relationship challenges that were amplified by either movement restrictions or consequences of COVID-19. Some survivors attributed COVID relationship challenges and subsequent IPV to increased substance use, bolstering findings from other qualitative research conducted during the pandemic, which linked increased severity and incidences of IPV with increased alcohol consumption (Huq et al., 2021). Other survivors drew connections between COVID-19 movement restrictions and their partner's control or abuse tactics. For those survivors, movement restrictions (i.e., shelter-in-place orders, school closures, curfews) trapped them with their abusers by creating isolating environments, which may have exacerbated

coercive control and other abuse tactics (M. L. Evans et al., 2020; Rieger et al., 2021; Sower & Alexander, 2021). Survivors also indicated increased financial or life stressors resulting from COVID featured as prominent components in their IPV experiences. This may be explained by other COVID-19 research connecting lockdown and economic stress factors to increases in IPV, suggesting lifted movement restrictions will not decrease IPV and DV due to continued economic stress fueled by the pandemic (Arenas-Arroyo et al., 2021; Bazyar et al., 2021; Jetelina et al., 2021; Lausi et al., 2021; Ravi et al., 2021). Notably, survivors attributed these COVID-related relationship challenges to higher recurrences of arguments or fights, which often preceded episodes of IPV, reinforcing preliminary evidence pointing to increases in IPV and DV, especially during lockdown and social distancing periods (Bazyar et al., 2021; Kourti et al., 2021; Lausi et al., 2021).

COVID-19 created an alternative reality discussed by survivors as stemming from unemployment, remote work environments, movement restrictions, and social distancing measures, allowing intimate partners to spend more time with each other than they might have pre-pandemic. The unique situation and environment created by the pandemic were described by survivors as impacting the trajectory of their relationships, both new and existing. Through discussion of their experiences, survivors indicated movement restrictions, social distancing measures, and the negative repercussions of the pandemic influenced their relationship challenges, as well as the occurrences of new or a higher frequency and/or severity of IPV episodes. Their experiences further bolster prior research suggesting the pandemic increases the likelihood of experiencing IPV and DV, especially during shelter in place orders (Arenas-Arroyo et al., 2021; Bazyar et al., 2021; Jetelina et al., 2021; Kourti et al., 2021; Lausi et al., 2021; Ravi et al., 2021).

Regarding help-seeking behaviors following IPV experienced during COVID, survivors discussed a plethora of gaps in services or negative experiences when seeking healthcare, law enforcement, and social services (i.e., DV shelters, therapy services). Specifically, survivors cited long wait times, lack of follow-up, lack of provider engagement, and limited IPV resources offered by hospitals as contributing to negative help-seeking experiences. Such negative help-seeking experiences may be explained by overburdened hospitals and resources being redirected to COVID-19 patients, much like happened during the EVD epidemic (Korkoyah & Wreh, 2015; United Nations Development Programme, 2015).

Among survivors who sought help from law enforcement, negative experiences cited included being told to leave the relationship, they were almost arrested, they were arrested with their perpetrator, advised to go back to their home where IPV was occurring, could not receive a protective order because courts were closed, or were simply provided a list of DV shelters to contact. Prior research links limited or reduced law enforcement services stemming from COVID restrictions (i.e., closed courts) to increased susceptibility of experiencing IPV (John et al., 2020; Sower & Alexander, 2021). Moreover, survivors who were told to leave their relationship, return home, were almost arrested, or were arrested with their perpetrator align with pre-COVID and COVID research documenting these issues as barriers to IPV help-seeking from police (Voth Schrag et al., 2021; Wolf et al., 2003).

Of the survivors who discussed gaps and barriers pertaining to DV shelter services during the pandemic, challenges pertaining to shelter living during the lockdown period echo results from other qualitative research suggesting a lack of support from shelters during COVID-19 exacerbated feelings of isolation stemming from a combination of strict shelter rules and stay-at-home orders that mirror control or isolation tactics enacted by abusive partners (Ravi et al.,

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As the pandemic continues to threaten public health and safety, findings from this study can be leveraged to inform IPV response during this and other public health emergencies. Additionally, findings can also be used to inform future pandemic preparedness and response among IPV and public health resources in Atlanta and the state of Georgia. Results from this study also bolster the exacerbating impacts of COVID-19 and movement restrictions on experiences of IPV posited by prior research. Moreover, results confirm the need for programs, resources, and strategies to mitigate identified barriers to IPV help-seeking during public health emergencies or pandemics.

Recommendations

The methods carried out in this study can be adapted for future research carried out in other areas of Georgia, or the broader U.S., pertaining to IPV experiences during COVID-19 and perceptions of IPV survivors. We also recommend conducting similar studies targeting a diverse

array of survivor perspectives, including racial, immigrant, refugee, sexual and gender minority identities. In tandem with survivor perspectives, future work should synthesize COVID-19 experiences of health care providers, law enforcement personnel, and IPV community organization personnel. From this work, interventions can be designed to identify IPV survivors presenting to health care or law enforcement entities in real-time and pair them with advocates or care coordinators to facilitate proper follow-up and on-going resource provision (i.e., legal assistance, therapy services, temporary housing). This is bolstered by the U.S. Preventive Services Task Force guidelines recommending health care providers screen women of reproductive age for IPV and refer those who screen positive to support services (Force, 2018).

Regarding identified barriers to IPV help-seeking during the pandemic, we recommend the following resources and supports to help survivors and improve IPV response during pandemics. First, service providers (i.e., law enforcement, health care, DV shelters) should have access to comprehensive, regularly updated IPV resource lists available to share with survivors. As some survivors noted lists they received only contained contact information for DV shelters, future lists should also contain information and contacts for crisis hotlines, general IPV resource providers (i.e., Georgia Coalition Against Domestic Violence), legal assistance, support groups, free or subsidized counseling, and child and family advocacy resources. Comprehensive resource lists serve as a highly feasible strategy to increase access to support services and facilities for survivors of IPV. Similarly, findings from this study suggest the importance of increasing awareness of IPV resources and support services. Therefore, governments, public health authorities and community advocates should allocate resources to disseminating IPV resources during COVID-19 and future public health emergencies. In conjunction with higher visibility of resources, we also recommend service providers incorporate virtual resources (i.e., support

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Since institutional level changes are less feasible in the immediate future, governments and public health authorities should allocate more resources and advocate for increasing the amount of temporary and transitional housing resources to address capacity gaps previously identified, as well as increase funding for free or subsidized mental health resources for survivors. Furthermore, law enforcement and health care entities should expand the use of advocate services to mediate survivor interactions and ensure proper trauma-informed care and resource provision.

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