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[Dabney Evans](#), *Emory University*

[Randi Smith](#), *Emory University*

[Amy Zeidan](#), *Emory University*

[Subasri Narasimhan](#), *Emory University*

[E Hendrix](#), *Emory University*

[CE Ripkey](#), *Emory University*

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# “Boiling Water but There’s No Pop-Off Valve”: Health Care Provider Perceptions of the Effects of COVID-19 on Intimate Partner Violence

Ellen Hendrix<sup>1</sup> , Subasri Narasimhan<sup>1,2</sup>,  
Carrie E. Ripkey<sup>1</sup>, Amy Zeidan<sup>3</sup>,  
Randi N. Smith<sup>4,5</sup>, and Dabney P. Evans<sup>1,2,4</sup>

## Abstract

This study sought to understand the effects of COVID-19, including movement-related restrictions such as shelter-in-place, quarantine, and isolation orders, on intimate partner violence (IPV) from the perspective of health care providers (HCPs) working at a public hospital in Atlanta, Georgia. From November 2020 to May 2021, we conducted 12 interviews. Three themes emerged: (1) HCPs perceived that COVID-19 movement-related restrictions likely exacerbated IPV; (2) HCPs encountered many practice-oriented and community barriers in IPV care provision during COVID-19; and (3) HCPs suggested process and partnership improvements for IPV response. These findings can inform future pandemic preparedness including improved communication, improved IPV screening and follow-up, and strengthened hospital-community partnerships.

## Keywords

violence prevention, COVID-19, emergency medicine, intimate partner violence, movement restrictions

<sup>1</sup>Hubert Department of Global Health, Emory University, Atlanta, Georgia, USA

<sup>2</sup>The Center for Reproductive Health Research in the Southeast (RISE), Emory University, Atlanta, Georgia, USA

<sup>3</sup>Department of Emergency Medicine, Emory University School of Medicine, Atlanta, Georgia, USA

<sup>4</sup>Department of Behavioral, Social, and Health Education Sciences, Emory University, Atlanta, Georgia, USA

<sup>5</sup>Department of Surgery, Emory University School of Medicine, Atlanta, Georgia, USA

## Corresponding Author:

Ellen Hendrix, 301-443-3938, 5600 Fishers Lane, Rockville, MD 20852, USA.

Email: ehendrix14@gmail.com

Intimate partner violence (IPV), defined as physical violence, sexual violence, stalking, and psychological aggression, including coercive tactics, by a current or former intimate partner, is a significant public health threat in the United States (U.S.) (National Center for Injury Prevention and Control, 2020). During their lifetime, one in four women and one in 10 men in the U.S. experience sexual violence, physical violence, and/or stalking by an intimate partner and report a related impact such as an injury or missing days of work or school (Smith et al., 2018). In Georgia, before the emergence of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the related COVID-19 pandemic, around 35% of women experienced physical violence, sexual violence, and/or stalking from an intimate partner, underscoring the substantial public health burden of IPV experience in the state (CDC, 2014).

On March 2, 2020, the Georgia Department of Public Health (GDPH; 2020) confirmed the first case of COVID-19 in the state. Several weeks later, shelter-in-place orders were enacted, first in Atlanta and shortly after across the state, directing residents to stay in their homes unless conducting essential business and encouraging them to practice social distancing (“Atl. Exec. Order No. 2020-21,” 2020; “Ga. Exec. Order No. 04.02.20.01,” 2020). While these and other movement-related restrictions such as isolation and quarantine orders were successful in slowing the community spread of COVID-19, their ramifications on IPV were largely unmeasured (Evans, 2020; Evans et al., 2021).

At the start of the pandemic, concerns that COVID-19 mitigation measures were contributing to new and existing violence in relationships were mostly drawn from mounting anecdotal evidence (Evans, 2020; Evans et al., 2021; Godin, 2020; Taub, 2020). The pandemic exacerbated issues that underlie IPV including low socioeconomic status, unemployment, low educational attainment, and previous history or exposure to violence (Moreira & Pinto da Costa, 2020). Quarantine, shelter-in-place orders, and other movement restrictions constrained people in households with abusive partners by mirroring isolation tactics frequently used by violent perpetrators and curtailing victims’ access to health care (Piquero et al., 2020). Moreover, early in the pandemic, utilization of IPV support resources skyrocketed, including increases in calls to domestic violence (DV) helplines in China, Spain, and Peru, a 30% surge in DV police reports in France, increases in IPV-related homicides in Brazil, Argentina, and the United Kingdom, and increases in DV calls to police departments across six North American cities in the first months of COVID-19 (Aguero, 2021; Allen-Ebrahimian, 2020; Azcona et al., 2020; Barbara et al., 2020; Bastos et al., 2020; Daya & Azpirir, 2020; Evans, 2020; Evans et al., 2021; Lopez, 2020; Matoori et al., 2020; Taub, 2020).

As the pandemic progressed, more systematically collected evidence emerged in support of these concerns. In a systematic review of 18 studies reporting police, DV hotline, and health record data, Piquero et al. (2021) found a 7.86% average increase in DV reports following the implementation of COVID-19 movement-related restrictions. One study included in this systematic review comparing DV calls in 14 U.S. cities before and after social distancing orders relative to similar periods in 2019 found that COVID-19 led to a 7.5% increase in calls for DV service during March,

April, and May 2020 with the largest increase occurring during the first 5 weeks after widespread social distancing began (Leslie & Wilson, 2020). Using police department data, researchers at our study site in Atlanta, Georgia discovered a rise in cumulative counts of domestic crimes during 2020 compared with the previous 2 years, suggesting an increase in DV occurrence (Evans et al., 2021). Despite this emerging evidence, the full effects of COVID-19 and movement-related restrictions on IPV—including contextual factors and personal experiences—are still largely unknown. While a recent qualitative study of health care providers (HCPs) working in Boston revealed that the pandemic restricted access to IPV support services, knowledge of HCP perspectives of the pandemic's effects on IPV from other locales—especially where COVID-19 mitigation tactics may have varied—is lacking (Williams et al., 2021).

This perspective is important to capture as frontline workers in hospital settings provide crucial medical and supportive care to survivors of IPV, including referral for social services and support in safety planning, during the pandemic (Evans et al., 2020). Despite the critical support offered by these providers, barriers such as limited time and resources, insufficient training, and inconsistent IPV screening may have limited their ability to provide these referrals or even identify cases of IPV (Sprague et al., 2012; Tower, 2006; Zero & Geary, 2020). Due to the strains COVID-19 has placed on health care system resources and their corresponding potential impacts on service delivery, it is crucial to learn about HCPs' experiences in caring for IPV patients during the COVID-19 pandemic. As such, the purpose of this study was to understand the effects of COVID-19, including movement-related restrictions such as shelter-in-place, quarantine, and isolation orders, on IPV from the perspective of HCPs working in Atlanta, Georgia.

## Methods

### *Design and Instrument*

We conducted a cross-sectional mixed-methods study using in-depth interviews (IDIs). IPV is a sensitive issue which lends itself well to the use of qualitative methods where researchers build rapport with participants during data collection. IDIs were chosen as the method of data collection as they are conducive to identifying personal experiences and gaining rich information on HCPs' perceptions and experiences.

An original IDI guide was created beginning with a short quantitative survey on participant demographics. We placed demographic questions at the beginning of the interview to ensure this information was captured in the event that participants were unable or unwilling to complete the entire IDI. The remainder of the IDI guide included three domains: (1) the health effects of COVID-19 including questions on differences in presentation or health observed among IPV patients and changes related to patient injury; (2) COVID-19 movement-related restrictions and violence including questions on how shelter-in-place, quarantine, and isolation orders affected patients; and (3) health-seeking behaviors during the pandemic including questions on social issues experienced by IPV patients and IPV patients' decisions and concerns on healthcare

seeking during the pandemic. So as not to bias the interviews, additional quantitative questions were included before the second and third qualitative domains to gauge participants' knowledge of movement-related restrictions and their experiences working directly with IPV patients before entering the interview phase on these topics.

The primary interviewer conducted three practice interviews with members of the study team. Feedback from these practice interviews informed changes to the IDI guide including the addition of probing follow-up questions to gain a deeper understanding of responses. Following practice interviews, the primary interviewer pilot-tested the guide with two HCPs purposively selected based on their extensive experience working with IPV patients prior to and during the pandemic. Iterative changes to the IDI guide were also made during pilot testing including adjusting questions for clarity to gain better insight into participant experiences. One such adjustment was the replacement of a generalized question about changes in provider practice with additional probing questions about potential challenges experienced during the COVID-19 pandemic to allow more time for discussion of specific issues related to our research purpose.

### *Study Site*

Georgia was one of the first states to “re-open,” lifting its statewide shelter-in-place order on April 30, 2020 (Elassar, 2020). Moreover, as of August 17, 2022, the Georgia Department of Public Health has reported over 2.1 million cases, nearly 33,000 deaths, and over 122,000 hospitalizations (Georgia Department of Public Health, 2022). Due to the significant burden on Georgia's health care system during COVID-19, a large public hospital in Metropolitan Atlanta, Georgia provided an ideal context in which to study the effects of this pandemic on IPV from the perspective of HCPs. The study period of March–December 2020 allowed us to examine HCP experiences during the early days of the pandemic as well as into the beginning of the protracted period.

### *Participants*

To be eligible to participate in this study, HCPs had to work at the study site, a large public hospital in Metropolitan Atlanta, Georgia, during both the pre-COVID period (January–June 2019) and the COVID-19 period defined as January–June 2020. Participants were recruited from pre-selected fields (social work, nursing, and medicine) from the Departments of Emergency Medicine (EM) and Trauma Surgery based on these Departments' engagement with and responsibility for IPV case management. A list of employees from these fields was obtained from the fourth and fifth authors who work at the study site ( $N = 113$ ). To ensure a diverse sample across disciplines and a diversity in experiences and perspectives, the sample list was divided into the following four categories of providers: (1) advanced practice providers, (2) full-time social workers, (3) EM physicians, and (4) trauma surgeons. Study Co-Investigators were excluded from these subframes. Microsoft generated a random number for each individual in the sample and the random selection function

in Excel was used to identify three providers from each subframe to be recruited in the study. Two participants selected from the surgeon subframe were ineligible, so two other participants from this subframe were randomly selected to replace them.

Participants were recruited for the study via a series of emails, the first of which introduced the study's purpose. If there was no reply, follow-up emails were sent up to 3 times every 3 days. After a reply expressing interest, we sent three subsequent emails confirming eligibility and scheduling a date and time for an interview via Calendly, confirming the date and time of the interview, and reminding participants of their interview 24 hours in advance. Our response rate was 10.6% calculated by dividing the number of participants ( $N = 12$ ) by our total sample of 113.

### *Data Collection*

Data collection occurred from November 2020–May 2021. Although data from each participant was only collected at one time point, we were able to examine HCPs' perceptions and experiences before and during the COVID-19 pandemic due to the study's inclusion criteria. Recall bias was mitigated in the IDI guide by offering time frames for participants to focus their reflection and responses, namely January–June of 2019 relative to the same time frame in 2020. Following the two pilot interviews, the first author conducted 10 IDIs with HCPs. Interviews lasted between 45 min and 75 min and were conducted and recorded remotely via Zoom. Each interview was transcribed verbatim using Happy Scribe, and transcripts were fidelity checked for accuracy by a research team member who compared the written transcript to the original Zoom audio recording.

### *Data Analysis*

A thematic analysis of the qualitative data was conducted using MAXQDA 20 to identify core concepts, patterns, and themes across participants. To begin, the research team collectively created a codebook of deductive codes using the IDI guide. Next, the primary interviewer conducted several close reads of the data and developed memos. Using the preliminary deductive codebook, the primary interviewer coded one transcript. From this transcript, deductive codes and definitions were revised, and inductive codes were added to the codebook. This updated codebook was used to recode the first transcript and the subsequent 11 transcripts. Descriptive statistics were calculated for the quantitative data using Qualtrics and Excel. For quantitative questions where participants provided a range (e.g., number of IPV patients encountered during a typical shift), we used the lower value of the range when calculating the mean and standard deviation. Therefore, the data presented for these questions are a conservative estimate of the true value.

### *Ethical Considerations*

This study was approved by Emory University's Institutional Review Board (Study ID 00000432). Informed consent forms were emailed to participants twice in advance of the

interview and read aloud to participants before the interview. Verbal consent was given by each participant before data collection began and documented by the research team.

## Results

Three themes emerged from interviews with HCPs on the impact of COVID-19 movement-related restrictions on IPV. These themes included that: (1) HCPs perceived that movement-related restrictions for COVID-19 likely exacerbated IPV and its associated contextual factors; (2) HCPs encountered many practice-oriented and community barriers in IPV care provision during COVID-19; and (3) HCPs suggested process and partnership improvements for IPV response.

### *Participant Demographics*

Participants included EM physicians ( $n = 8$ ), trauma surgeons ( $n = 3$ ), and a social worker ( $n = 1$ ). All ( $n = 12$ ) were aware of city-wide, Atlanta-specific, COVID-19 movement-related restrictions; however, only half ( $n = 6$ ) of participants could recall statewide movement restrictions. Most participants ( $n = 10$ ) did not have any training on responding to IPV or relationship violence; only two participants reported having specialized training in this area. Participants reported encountering an average of 1.9 patients experiencing relationship violence during a “typical shift”; across HCPs, shift times ranged from 8 to 12 hours (Table 1).

### *COVID-19 Movement-Related Restrictions Likely Exacerbated IPV and Its Associated Contextual Factors*

When asked about the effects of movement-related restrictions on patients experiencing IPV, most HCPs ( $n = 10$ ) felt these restrictions could exacerbate relationship violence. One surgeon expressed that “every single day, you’d hear another story” about IPV from a patient. One EM physician likened the impact of shelter-in-place orders on violent relationships to a “powder keg” and a trauma surgeon likened the impact to a tank of “boiling water but there’s no popoff valve,” meaning a volatile circumstance on the precipice of exploding in more violence. HCPs also noted that movement-related restrictions might contribute to increased stress and mental trauma, and/or magnifying feelings of loneliness and isolation. They saw these situations as reducing the ability of IPV perpetrators to “modulate their emotional state or [use their] coping mechanisms.” Participants believed such stress alongside sheltering in place with an abuser was a potential risk factor for increased violence. The combination of these factors was described by an EM physician as having a “compounding effect”:

I feel like people at baseline were just more stressed out, everybody, just because we didn’t know, it [the virus/pandemic circumstances] was new, we didn’t know what to be worried about, we didn’t know how deadly it was or how to avoid it .... So, I think there was a lot of, like external pressures and then kind of you compound that with the

**Table 1.** Demographic Information for Health Care Providers Serving Intimate Partner Violence (IPV) Patients in a Large Public Hospital.

Characteristics	Overall, N = 12
Age in years, <i>mean (SD)</i>	40.9 (8.8)
<b>Gender, n (%)</b>	
Female	5 (41.7)
Male	7 (58.3)
<b>Race, n (%)</b>	
White	7 (58.3)
Black or African American	4 (33.3)
Asian/Pacific Islander	1 (8.3)
<b>Marital status, n (%)</b>	
Never married	2 (16.7)
Married	8 (66.7)
Divorced	1 (8.3)
Separated	1 (8.3)
<b>Highest education, n (%)</b>	
Master's degree	1 (8.3)
Professional degree	11 (91.7)
<b>Profession, n (%)</b>	
Emergency medicine physician	8 (66.7)
Trauma surgeon	3 (25.0)
Social worker	1 (8.3)
Length in years in current position, <i>mean (SD)</i>	5.0 (6.9)
Length in years in health care field, <i>mean (SD)</i>	13.6 (7.3)
<b>Knowledge of Atlanta movement-related restrictions, n (%)</b>	
Yes	12 (100.0)
No	0 (0.0)
<b>Knowledge of Georgia movement-related restrictions, n (%)</b>	
Yes	6 (50.0)
No	6 (50.0)
<b>Special IPV training, n (%)</b>	
Yes	2 (16.7)
No	10 (83.3)
# Patients experiencing violence in relationships per shift, <i>mean (SD)</i>	1.9 (1.7)

fact that no one can leave and then your social circle shrunk significantly .... And, you know, some people have good coping mechanisms, and some don't ... so I feel, kind of all those factors played into, would have potentially played into an increase in intimate partner violence.

HCPs often speculated on potential explanations for partner violence as a phenomenon including the inability of survivors to distance themselves from abusive partners. One EM physician recounted hearing about an increase in the number of calls made to the Georgia Coalition Against Domestic Violence, noting that "there was an uptick in intimate partner violence for people who had to shelter-in-place with their abuser."



Participants also speculated that movement-related restrictions reduced the number of “outlets” people experiencing IPV had for support, noting that the reduced ability to connect to support systems such as family and friends, likely contributed to feelings of isolation. Nearly a third of participants shared fears that movement-related restrictions may limit a person’s ability to escape a violent situation. One EM physician explained these and other challenges that survivors of IPV may have faced under movement-related restrictions:

We know that perpetrators want to isolate you. And so now we’ve given them a gift of isolation .... Victims or survivors are now compelled to and have to be isolated with their abuser. I can’t imagine the trauma that might incur. And even if you want to call out to somebody or try to go visit, if the phone is all you have, but you’re in imminent danger, you know, what does that mean in terms of thinking about taking your children, if you have them, along with you in an environment where you might be exposed, or not exposed? Do you have masks to be able to go where you need to go? Are people going to accept you in without perhaps a COVID negative test? I mean, it is just unbelievable the number of what ifs, if you will, that people are thinking about.

Most participants ( $n = 9$ ) were unable to comment on how movement-related restrictions impacted violence perpetrators and the control they exerted over their partners; however, three described how movement-related restrictions have “increased the amount of dominance the partner has over” their victim. Two HCPs believed that movement-related restrictions may have contributed to an increased risk of abuse; abusers may have a “heightened awareness of power” with the knowledge that their partner may not have the option to leave the relationship under shelter-in-place or quarantine orders.

Participants also discussed how the COVID-19 pandemic exacerbated social issues among their patients, which put them at greater risk for both COVID-19 infection and IPV. These issues included chronic homelessness, substance use, food insecurity, unstable transportation, unstable employment, and health insurance insecurity. However, one trauma surgeon commented that he was not aware of any changes in social issues among his patients experiencing IPV as trauma providers do not spend a lot of time “delving deeply into specific social issues.” An EM physician commented that shelter-in-place orders may have contributed to job loss. One social worker commented that when the public transportation system in Atlanta severely limited its routes at the beginning of the pandemic, patients experiencing IPV had transportation issues. When discussing IPV patients with multiple social issues during the pandemic, a physician shared the following:

Maybe there’s more [social issues] or maybe because the resources in the city are so limited, we become more aware of them because [patients are] having to stay a couple of days. And sometimes the psychological issues are unmasked as they stay for a day or two, that all of a sudden, the story of what happened starts to devolve a little bit.

While HCPs perceived an increase in IPV during the COVID-19 pandemic, they did not describe any observed changes to IPV patient demographic profiles in terms of race, age, or gender. While some men presented with IPV-related injuries, most patients presenting with injuries from IPV were young women, which mirrored pre-pandemic demographic profiles. Two participants noted that during the pandemic, there were more instances of mutual violence rather than single-perpetrator situations with “one person clearly being the victim.” A trauma surgeon shared the following examples:

The husband beat up the wife, and so the wife threw a knife into his back as he was walking out the door. Or the wife ran over the husband but when you look further into it, it’s because the husband was beating up the wife with a hammer.

In these altercations, it seemed to one EM physician as if both partners, “came to their senses at some point in the thing and decided not to kill each other.” However, other participants ( $n = 10$ ) did not comment on instances of mutual violence during the pandemic. Another change related to the types of weapons used in IPV cases, with a shift towards more household objects. An EM physician discussed the change in this way:

There’s a lot less guns and more like fist [or] found objects like frying pans, stuff like that. And it felt like there were people who weren’t initially violent or didn’t have access to weapons like lost it. So, like that was my going into the summer [2020] takeaway. It wasn’t as much guns and knives as much as it was frying pans, video game controllers, stuff like that.

The physician went on to describe a case where a woman was beaten severely with a frying pan by her partner who “didn’t have anything else to use as a weapon.” The physician could not recall the last time they had that type of weapon used in an IPV case during their many years of medical practice.

### ***HCPs Encountered Many Practice-Oriented and Community Barriers in IPV Care Provision During COVID-19***

Significant discussion of barriers to providing care and support for IPV patients emerged. These barriers included practice-oriented barriers faced within the hospital and community barriers experienced upon patient discharge.

HCPs described the necessary adaptations to patient contact, including the use of personal protective equipment (PPE) and telemedicine as a practice-oriented barrier for IPV patients. A few ( $n = 3$ ) discussed the difficulty of making connections to patients through COVID-19 PPE. One EM physician commented that while using PPE—including multiple masks, goggles, and gowns—“you look more like an object than a person.” Another EM physician shared a struggle in figuring out how to connect patients to counseling resources as support became virtual through telehealth,

saying that “a lot of telemedicine assumes that people have a certain level of privilege to have a TV or phone.” Lack of this privilege presented its own barriers to care.

Half of participants ( $n=6$ ) saw the pace and heavy workload in the hospital as a barrier to tailored care for IPV survivors. Under the burden of the heavy workload, provider–patient interactions were expedited—asking the necessary questions before quickly moving on to the next patient. The lack of time and resources to provide emotional support to patients experiencing IPV, an existing problem before the pandemic, was described by an EM physician in this way:

We are busy all the time, and these patients require time, whether it’s a sexual assault or violent assault or both. I mean, the other day, the patient that I had, it took the SANE [Sexual Assault Nurse Examiners] nurse over two and a half hours to do her forensic exam. So, if I’m seeing like three to four patients an hour, that’s like 10 patients that don’t get seen and we just really don’t have the luxury of doing that, especially as our volumes go back up. Now, that’s an extreme case. So, in most cases, that’s not there. But I would say to really, truly have this conversation, you need at least like a good 20 minutes of uninterrupted time, which sounds crazy that that doesn’t happen. But I get interrupted, like, every 10 seconds. So, it’s a hard thing to get to happen.

This problem was further exacerbated during COVID-19 as the hospital ran “lean” to “minimize the number of people in-house” in an effort to prevent infection. For one EM physician, the pace challenge overlapped with a lack of community resources:

How can you keep pace with the response and how can you keep pace with the services that might be needed for survivors/victims, right? Because if you are trying to move somebody into a place of safety, where are you moving them to? If there are struggles and challenges with access, right? So, it is tough.

Further in-hospital barriers included general staffing and bed capacity issues at the study site. This hospital was “chronically full” due to structural damage that occurred to patient care areas pre-pandemic making rooms unusable, long-lasting nursing and bed shortages, and patients being boarded longer during the pandemic. Finally, there was low compliance with the hospital’s current violence screening tool which one surgeon attributed to high nursing turnover and high trauma volumes. Further, the tool is not specific to IPV, but rather screens for multiple forms of interpersonal and community violence. An EM physician also aware of low IPV screening compliance shared this possible explanation: “People are afraid to ask [about IPV], and I suspect because then what do you do with it? You know, if resources are scarce.”

Respondents described additional barriers that were faced upon patient discharge. Most participants ( $n=10$ ) discussed a lack of community resources, including shelters, in Atlanta which predated the pandemic. A social worker felt that this lack of resources was due to “not enough time and attention put into the need.” Compounding this issue, many facilities required a negative COVID-19 test before admission or repeatedly changed their intake protocols, which further delayed the safe discharge of patients experiencing IPV as explained by one EM physician:

We've now ... had to get COVID rapid tests on patients who are going to communal living. And we've had a lot of shortages of rapid COVID [tests]. So that's required patients to stay in the emergency department a lot longer .... We also had drug and reagent shortages due to supply chain issues.

Navigating the safe discharge for patients was further complicated by the closing of shelters. One EM physician described this challenge—including the extreme difficulty in placing male IPV patients into communal living—in this way:

We did experience difficulty in our resources for placement. So, there were a bunch of women's and children's shelters that shut down because they couldn't safely isolate people within their shelter. So, we took an already fairly scarce resource with kind of a lack of ability to provide safe places for patients to go. And it's honestly, it's even worse for male patients if they come in with intimate partner violence ... like I don't have any options for them. They basically have to go to like a regular old men's shelter, which is not always ideal for somebody who's experienced violence.

While a social worker was not aware of the use of hotels to support patients experiencing IPV, an EM physician described a "COVID hotel" that was accessible to patients experiencing homelessness. This participant described the precarious nature of discharging patients to hotels during the pandemic:

We have had cases where I think patients were appropriately placed in hotels, but then their, you know, perpetrator tracked them down there and they returned reinjured and stuff like that. So, I mean, this safe discharge is a real thing.

The lack of community resources in Atlanta was particularly challenging on the weekends. With shelters largely unavailable in Atlanta, HCPs had to "cast [their] net wider and find shelters in other cities. Some as far away as Stockbridge or Valdosta." Given the distance to these alternate sites (>200 miles in some cases), transportation remained an important issue. One EM physician shared a case encapsulating this challenge.

We had one lady who presented on a Friday night, and it was clear that we were not going to be able to get her any transportation until Monday. So, she wound up staying in the emergency department all weekend .... We even looked through our social services and our social worker was trying to get approval from his manager to spend money on a Lyft, which would have been, I think, over \$400 .... Which is funny because I think, you know, the hospital probably spent more than \$400 keeping this person there for three days. You know, but it's just differential budgets. And nobody puts those two things together. And it's hard, because then you get the next person. It's like, well, what do you do with that?

## *HCPs Suggested Process and Partnership Improvements for IPV Response*

Looking forward, HCPs offered suggestions to better respond to IPV during pandemics. Suggestions included improving communication about IPV support resources, stronger hospital-community partnerships to improve the availability of IPV support resources, and improving IPV screening and follow-up for IPV patients.

Several participants suggested the need for early and widespread communication of support available to people experiencing IPV during a pandemic. They suggested that such communications could be shared on social media platforms at the state or even national level along with COVID-19 information. An EM physician explained:

I wonder if, like a PR [public relations] campaign could be useful, like, hey, you're going to be stressed out. This is stressful. If you need help, call this national hotline and talk it out like so people feel like they have an outlet other than just the person that they're cooped up in the house with. Umm, so I wonder if it can have a more of a national approach to like, you know, mental health and like, call this hotline if you feel like you need someone to talk to.

Another EM physician emphasized that if movement-related restrictions are enacted in the future, messaging should be disseminated that encourages those whose homes are not safe to seek alternate shelter at safe places.

HCPs also suggested stronger hospital-community partnerships. Several participants discussed the success of a hospital liaison from the Women's Resource Center to End Domestic Violence as facilitating improved IPV care. This "fixer," established in the spring of 2020, helped HCPs marshal resources for social support in the hospital. This person had the ability to authorize transportation, clothing distribution, and hotel stays. One EM physician shared the following success story from this new collaboration:

We did have a case a couple of weeks ago where we successfully got somebody a plane ticket to New Orleans. So, we kind of repatriated them back in New Orleans where they had a place where they could go. So, I'm not sure how we came about the funds for the plane ticket, but we were able to do that.

Participants also cited screening and follow-up care as important areas of improvement in IPV-related care during pandemics. One trauma surgeon discussed the need to put in place a "very stringent way to screen for" IPV where everybody who engages health care in any setting is screened. According to one surgeon, this suggestion is being acted upon. The trauma center at the study site is working to enact IPV screening in a more standardized way based on best practice guidelines from the American College of Surgeons. The goal is to develop a nursing-driven protocol where a four-question validated tool is used to assess potential IPV. The trauma center started this process before the pandemic, but it was sidetracked for about 6 months. Multiple providers discussed the possibility of cases of IPV that went unrecognized in the health

system during COVID-19, highlighting the need for improved follow-up. One surgeon shared “a case where somebody came in after being beaten up by their significant other and then came back two weeks later and they got missed completely.” A similar case during the COVID-19 pandemic was shared by another surgeon.

We had a guy who got beat up by his partner because he didn’t want to have sex with them. He got a brain bleed from it. He was in the hospital. We sent him home. And then like a week later, he came back, because his partner beat him up again and killed him.

When asked whether this person was referred to social services, this surgeon explained “I think he declined ... but no one ever did the follow up for him.” Two participants proposed a robust and active follow-up system for IPV patients including home visits to ensure patients know how to isolate and have an environment where they can properly isolate. This would “probably deter more violence.” However, these participants also stressed that if these home visits were employed during a pandemic response, they would need to be conducted according to any necessary social distancing protocols.

## Limitations

The study aimed to recruit 12 providers, three from each of four professions (social workers, EM physicians, trauma surgeons, and advanced practice providers). Through this strategy, our team aimed to build diversity in characteristics such as age, educational attainment, and clinical experience into our sample. However, we were only able to recruit one social worker, two surgeons, and no advanced practice providers following the pilot interviews. Therefore, we are missing perspectives from advanced care providers and social workers, who may have a more nuanced understanding of patients’ social situations, experiences, and health care-seeking behaviors. We are also missing perspectives from other health professionals who provide care to IPV patients including radiologists, obstetricians, and gynecologists among others. To address this issue, we encourage more qualitative studies on the perspectives of HCPs across provider types—where little research currently exists—to allow the body of evidence to reflect the diversity of experiences serving IPV patients across HCPs.

Another limitation of this study is the potential for a clinical sample bias; we only interviewed HCPs who interact with survivors of IPV who seek emergency health services. Therefore, the experiences of survivors of IPV who did not seek emergency medical care during the COVID-19 pandemic following a violent incident were not known to participants nor were the perspectives of providers who provide preventive or primary care both inside and outside of hospital settings. While the deductive codebook was created collaboratively across the research team, only one researcher coded the data for analysis. Finally, due to the methods used, the results presented are not generalizable and may not reflect the situation in other cities in Georgia or in other U.S. states.

## **Discussion**

These findings provide an understanding of HCPs' perceptions of the effects of COVID-19 on IPV, including movement-related restrictions and the barriers HCPs faced in providing care to their IPV patients during the pandemic. HCPs perceived increases in IPV during the pandemic supporting the evidence that IPV intensified during the COVID-19 pandemic, a phenomenon described by UN Women as a "shadow pandemic" (Azcona et al., 2020; Bastos et al., 2020; Daya & Azpirir, 2020; Piquero et al., 2021; UN Women, 2020). This also supports the numerous studies which point to increased violence against women during times of emergency (Buttell & Carney, 2009; Clemens et al., 1999; Enarson et al., 2018; Lauve-Moon & Ferreira, 2017; Parkinson, 2019). The stress related to sheltering in place and other movement-related restrictions was highlighted as a risk factor in the uptick of IPV observed by HCPs in this study. These findings support reports of negative psychological impacts of quarantine and shelter-in-place orders (Brooks et al., 2020; Raj et al., 2020) and the findings of Peterman et al. (2020) who identified movement-related restrictions as a core contributor to IPV during pandemics.

To respond to the "shadow pandemic" and the practice-oriented and community barriers faced by HCPs during the pandemic, quality improvement measures can be taken by hospitals and public health departments. One such measure is the integration of messaging about IPV into existing communications strategies. Improved public health communications have implications and transferability for statewide or even national implementation since IPV is a global issue which threatens public health and safety both during and beyond emergencies. Therefore, statewide, or even nationwide messaging to improve awareness of the stressors and social issues that accompany a pandemic or other health emergencies along with information on support services available to people experiencing IPV could improve the response to IPV during pandemics. Further messaging that identifies safe locations for people experiencing IPV, even if public health and government officials are encouraging people to stay at home, could help prevent incidents of violence in relationships.

While improved communications may increase the public's awareness of IPV support services, hospital emergency preparedness plans would benefit from provisions ensuring the continuation of IPV screening throughout emergencies and improving current screening protocols, issues transcending the pandemic period. During the COVID-19 pandemic, IPV screening processes were stopped due to strain on the health system. Although the intensification of IPV during pandemics may be known by HCPs, it is difficult to respond effectively to problems that are not measured. Thus, it is critical that IPV screening, as a standard of care, continues during times of emergency. The suggestion to implement a more stringent IPV screening process at the study site is highly feasible given that proponents have already begun work on this task. If enacted, this change could reduce the number of patients experiencing relationship violence who go undetected in the health system. It could also have implications in overcoming low compliance with the current IPV screening tool, one of the barriers to care shared by HCPs. Upon further discussion of low IPV screening

compliance, participants shared contributors like high nursing turnover, high trauma volumes, and lack of time to spend with patients, which align with results from Sprague et al.'s (2012) non-pandemic focused systematic review describing time and resource constraints and lack of knowledge as the most commonly reported barriers to IPV screening among HCPs. Structural changes related to increased staffing and time per patient would support greater attention to IPV-related screening and care. Addressing these issues is crucial since—as noted by study participants—screening is of little use without accompanying support resources.

HCPs identified a lack of community resources in Atlanta including shelters and other communal living spaces during the COVID-19 pandemic which complicated the safe discharge of IPV patients. This lack was largely linked to the closing of multiple shelters, although the perspectives of community-based organizations were not considered as a part of this work. To respond to this need for alternative safe environments, governments and public health agencies can build resources for these support services into their preparedness and response plans for future pandemics. Needs assessments to assess the current availability of IPV support services would provide evidence for the expansion of services to meet current and future needs including the allocation of resources. Increasing the number of communal living spaces for patients experiencing IPV is likely a time-consuming process. Thus, advocacy in favor of increasing support services and facilities for people experiencing IPV in Atlanta is a potential strategy to help improve HCPs' ability to connect patients to support services. Such actions may include the assessment of community-based organizations' perspectives during the pandemic, companion navigation for IPV survivors seeking hospital-based care and warm handoffs from hospitals to community-based organizations to ensure the safe discharge of IPV patients. Immediate action and allocation of resources by governments and public health agencies may be necessary to meet the current demand that exists for support services.

Although HCPs provide an important clinical perspective, they lack a personal perspective on the experiences of IPV during the pandemic. Additionally, HCP discourse on the impacts of COVID-19 movement-related restrictions on experiences of IPV is subject to provider biases (Sprague et al., 2013). These include implicit biases which perpetuate health inequities. While one EM physician emphasized their patient-centered approach in practicing medicine, this lens may not be centered by others in our sample which could limit their ability to describe the experiences and realities of their patients. For instance, a full understanding of the challenges patients experiencing IPV faced during COVID-19 may be unknown to HCPs, as the discourse on the impacts of movement-related restrictions on patient experiences was largely speculative, although based on clinical observation. The lack of time expressed by one trauma surgeon to dive deeply into their patients' social issues may also result in a limited understanding of patient experiences. Despite these possible biases and limitations, our participants may be more attuned to their patients' social environments than HCPs outside our sample, as our study site was a large, public safety-net hospital that serves many low-income, uninsured, and vulnerable populations. In addition, we were able to include a sample which represented several HCP provider types and whose



perspectives included depth, breadth, context, and nuance suggesting heterogeneity even within our small sample (Hennink et al., 2020).

The findings from this study prompt recommendations for future research to address the key results in other contexts. Expanding data collection methods to include more quantitative measures will enhance our understanding of the impacts of COVID-19 on IPV. For example, while HCPs perceived no marked changes in IPV patient profiles, a quantitative examination of hospital records into the circumstances and types of IPV injuries during the COVID-19 pandemic is necessary to validate this finding. In recognition of the inability to rely solely on HCPs as a data source, expanding data collection to survivors of IPV is needed to add context to the impacts of COVID-19 and movement-related restrictions on experiences of IPV during the pandemic. For instance, our understanding of HCP perceptions on the exacerbation of IPV by the pandemic and related movement restrictions and on instances of mutual violence will be enhanced through conversations with IPV survivors on these topics. The capacity of each state to provide support services to those experiencing IPV during the pandemic likely differs. Thus, additional data collection on IPV during COVID-19 is needed to help understand the availability of support services including among community-based organizations serving IPV survivors. Together these efforts can bolster the response to IPV during the current pandemic and beyond.

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### **ORCID iD**

Ellen Hendrix  <https://orcid.org/0000-0003-3998-7183>

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### Author Biographies

**Ellen Hendrix**, MPH, is a Public Health Analyst with the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Women's Health. Her research focuses on sexual and reproductive health, global health, and violence prevention. At the time of writing, she worked as a Graduate Research Assistant and Assistant Program Coordinator at the Rollins School of Public Health.

**Subasri Narasimhan**, PhD, MPH, is an Assistant Professor in the Hubert Department of Global Health and an affiliated faculty member with the Center for Reproductive Health Research in the Southeast at Emory University. She uses mixed methodologies to research reproductive and maternal health within vulnerable populations.

**Carrie E. Ripkey**, MPH, worked as an Assistant Program Coordinator at the Rollins School of Public Health coordinating the research efforts of the Evans Research Group. This group focuses its research endeavors on public health and human rights violence prevention and response. She currently works as a Field Coordinator with the CDC Foundation.

**Amy Zeidan**, MD, is an Assistant Professor of Emergency Medicine at Emory University School of Medicine. Her research focuses on barriers to health and health rights of displaced and detained populations.

**Randi N. Smith**, MD, MPH, is an Assistant Professor of Surgery at Emory University School of Medicine and an Assistant Professor in the Behavioral, Social, and Health Education Sciences Department at the Emory University School of Public Health. Her research explores how social determinants of health affect violent and nonviolent injuries. She is also active in implementing and studying ways to improve the effectiveness of hospital-based violence prevention strategies.

**Dabney P. Evans**, PhD, MPH, is an Associate Professor in the Hubert Department of Global Health at Emory University. Her research focuses on gender-based violence and sexual and reproductive health and rights. Dr. Evans is the author of over 60 peer-reviewed manuscripts. Her public scholarship has appeared in *The Pacific Standard*, *Ms. Magazine*, and *The Hill*.