

The Shadow Pandemic: A Qualitative Exploration of the Impacts of COVID-19 on Service Providers and Women Survivors of Intimate Partner Violence and Brain Injury

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Background: Intimate partner violence (IPV) affects up to 1 in 3 women over their lifetime and has intensified during the COVID-19 pandemic. Although most injuries are to the head, face, and neck, the intersection of IPV and brain injury (BI) remains largely unrecognized. This article reports on unexplored COVID-19–related impacts on service providers and women survivors of IPV/BI. **Objectives:** To explore the impact of the COVID-19 pandemic on survivors and service providers. **Participants:** Purposeful sampling through the team’s national Knowledge-to-Practice (K2P) network and snowball sampling were used to recruit 24 participants across 4 categories: survivors, executive directors/managers of organizations serving survivors, direct service providers, and employer/union representatives. **Design:** This project used a qualitative, participatory approach using semistructured individual or group interviews. Interviews were conducted via videoconferencing, audio-recorded, and transcribed. Transcripts were thematically analyzed by the research team to identify themes. **Findings:** COVID-19 has increased rates and severity of IPV and barriers to services in terms of both provision and uptake. Three main themes emerged: (1) implications for women survivors of IPV/BI; (2) implications for service delivery and service providers supporting women survivors of IPV/BI; and (3) key priorities. Increased risk, complex challenges to mental health, and the impact on employment were discussed. Adaptability and flexibility of service delivery were identified as significant issues, and increased outreach and adaptation of technology-based services were noted as key priorities. **Conclusions:** The COVID-19 pandemic has intensified IPV/BI, increased challenges for women survivors and service providers, and accentuated the continued lack of IPV/BI awareness. Recommendations for service delivery and uptake are discussed. **Key words:** brain injury, COVID-19, intimate partner violence

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INTIMATE PARTNER VIOLENCE (IPV) was prevalent before the COVID-19 pandemic, with up to 1 in 3 women experiencing it over their lifetime.^{1,2} As public health restrictions remain, violence rates rise, creating a “shadow pandemic”^{3–7} leaving women vulnerable to an overlooked consequence of IPV—brain injury (BI). With more than 90% of physical IPV altercations focusing on hits to the head, face, and neck and/or strangulation,⁸ BI is startlingly common among survivors. Emerging evidence reports that up to 75% have a BI^{9–12}; yet, research examining the intersection of IPV and BI (IPV/BI) is limited.¹⁰

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Intimate partner violence refers to actions committed by a spouse or intimate partner, which can be physical, sexual, or psychological in nature, and can result in significant emotional and bodily harm.² Although IPV is experienced by individuals across gender identities, including men, the majority of survivors are cisgender and transgender women,^{13–15} an increased vulnerability that directed us to focus on women survivors. Brain injury is defined as an injury producing an alteration in brain function, or other evidence of brain pathology, caused by an external force or an acceleration-deceleration-rotational force.¹⁶ During an episode of physical IPV, blunt force trauma to the head or face or violent shaking can cause neurological deficits, loss of consciousness, traumatic brain injury (TBI), and death.^{17,18} Strangulation is often experienced during IPV and can result in hypoxic ischemic brain injury due to oxygen and nutrient deprivation in the brain.¹⁰ Individually, BI and IPV are associated with elevated rates of unemployment, poverty, homelessness, and increased challenges with mental health.^{9,19} Despite the many social and economic repercussions of BI and IPV individually^{9,19} and heightened challenges brought about by COVID-19, there remains a gap in IPV/BI research, policy, and practice and its impact on women survivors.^{5,20} While emerging literature is exploring the impact of COVID-19 on women exposed to IPV,^{3,4,21–25} very little has considered the implications for those dealing with IPV/BI.^{5,20,26} The highly complex nature of IPV/BI demands research-informed supports sensitive to both conditions. The emergence of COVID-19, and subsequent need for extraordinary containment measures, has increased challenges faced by survivors and service providers. Research has noted a critical need for further information^{4,20} and consideration of post-pandemic approaches to programming, education, and training.^{4,20,22,23,25} Directly addressing these gaps, this study explored the impact of COVID-19 on survivors of IPV/BI and service providers.

METHODS

Ethics

Approval was granted by the Research Ethics Boards at the University of Toronto (protocol #39175) and Wilfrid Laurier University (protocol #6611).

Recruitment and data cocreation

This qualitative, participatory project was conducted in combination with a study exploring the employment and mental health experiences of women survivors of IPV/BI. In response to the emergence of COVID-19, the research team saw the need to additionally explore the impact of the pandemic and amplify the voices of

survivors and service providers during this critical time. The research team included 5 women with varying levels of research experience. Four were White, all hold at least a master's level degree representing a variety of disciplines, and one woman openly identified as having a BI. Interview guides were designed to identify (a) employment and mental health-related barriers and facilitators, service needs, and priorities for women survivors of IPV/BI; (b) needs, priorities, facilitators, and barriers to IPV/BI support service delivery; and (c) impacts of the COVID-19 pandemic. In keeping with qualitative methodology^{27–29} and to encourage an unstructured discussion, we asked one broad, open-ended interview question that specifically asked participants to identify COVID-19-related impacts on health, employment, support, and/or resources as relevant to their experience. Participants were recruited from the following groups:

1. Service providers employed in a management or direct service position in an organization mandated to support women survivors of IPV and/or BI and/or employment services;
2. Frontline workers employed in direct service provision for women survivors of IPV, such as intake, counseling, outreach, or other emotional, physical, or health-related support services;
3. Women survivors of IPV who self-identify as a woman (cisgender and/or transgender); and
4. Employers or representatives of employers or labor unions with a capacity to speak to organizational policies and practices intended to support women employees who have been exposed to IPV or BI.

Participants were purposively recruited from the research team's Knowledge-to-Practice (K2P) network or through snowball sampling. The K2P network is an informal network of professionals and individuals with a vested interest in IPV/BI developed since 2015.³⁰ Women survivors were also recruited with the assistance of frontline workers, an approach recommended by community-based partners as they have direct contact with survivors and experience judging safety and privacy. Participants needed to speak, read, and write in English, be older than 18 years, and be able to provide legal consent to participate.

In-depth, semistructured individual or group interviews lasting 60 to 90 minutes were conducted by 2 research team members (H.H. and D.T.) via videoconferencing. All interviews were audio-recorded and transcribed by an off-site professional transcription service. The sample size was consistent with what is recommended for homogeneous subgroups in qualitative research,²⁸ and recruitment and interviews continued until saturation was obtained. A thematic analysis approach was taken as it has been established as a method for "identifying, analysing and reporting patterns (themes) within data."^{29(p79)} It allows for a flexible

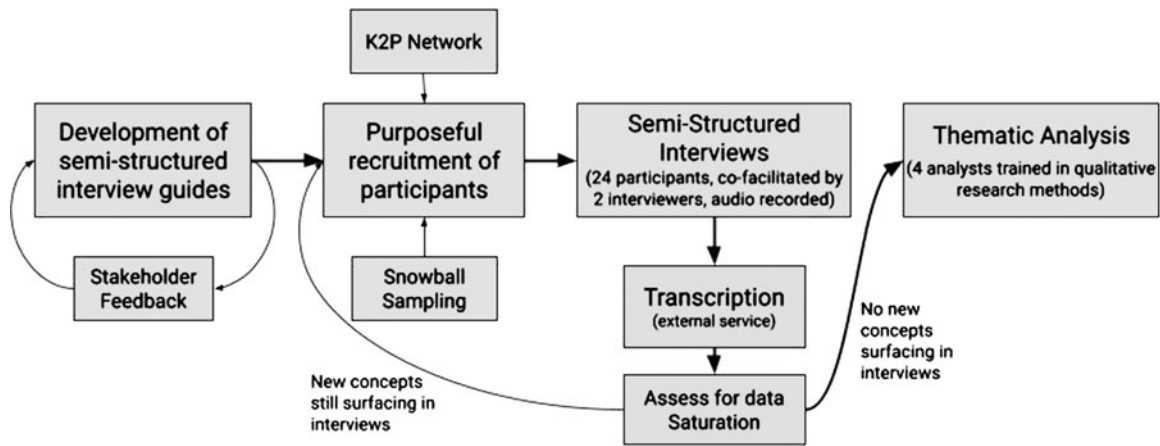


Figure 1. Data collection and process schematic. K2P indicates Knowledge-to-Practice.

approach to the analytic process in order to provide a broad understanding of an underexamined area, remaining close to the data without being confined by a single theoretical position.^{27–29} This was particularly important due to the novelty of the topic. Transcripts were manually coded independently (H.H., D.T., J.E., A.M.), beginning with descriptive coding, followed by grouping of codes into broader, topic-oriented categories. Postinterview and while coding, researchers engaged in reflexive note taking and met to discuss reactions and responses to the data. Multiple meetings were held to examine and interpret findings, negotiate interpretation differences, and refine and finalize themes. At the final stage of analysis, a list of emerging COVID-19-related themes with supporting data was created and reviewed by the research team. If 4 analysts did not agree, the fifth was to be consulted; however, this was not needed. Trustworthiness was established through peer debriefing; triangulation of analysts; regular meetings to compare, contrast, and ensure consistency in the interpretation of codes and categories; and development of an audit trail. A schematic depicting the data collection and processing phases has been included to assist clarity (see Figure 1).

Participant and organization characteristics

Twenty-four individuals participated: 6 women survivors, 6 executive director/program managers, 7 direct service providers, and 5 employer/union representatives. The majority participated in individual interviews; however, 2 group interviews were held, one with direct service providers and one with employer/union representatives. While we made efforts to attract participants from diverse groups, all but one participant identified as a woman and most identified as White or of European origin. Participants were an average age of 48.5 years, and almost all had at least some postsecondary education. For complete participant demographics, see Table 1.

Because of a high prevalence and difficulty identifying BI among survivors of IPV, formal diagnosis of a BI was not an inclusion criterion; however, questions about experiences indicative of BI were asked. All survivors interviewed had experienced hits or injury to the head, face, or neck, and all but one endorsed a resulting loss or alteration of consciousness, suggestive of BI. It is worth noting that the survivor who did not endorse a loss or alteration of consciousness did report several ongoing BI-related challenges. As many survivors are unaware of the possibility of BI resulting from IPV and/or may have

TABLE 1 Participant demographics (N = 24)

	n (%)		n (%)
Education level		Ethnicity	
Some high school	3 (13)	Indigenous	2 (8)
High school diploma	1 (4)	African origin	1 (4)
Some postsecondary education	4 (17)	South Asian	1 (4)
College degree	3 (13)	Black	1 (4)
University degree	14 (58)	Middle Eastern	1 (4)
Age, mean (SD), y	48.54 (12.73)	European origin	18 (75)
Sex at birth (female)	23 (96)	Multiple visible minorities	1 (4)
Gender identity (woman)	23 (96)		

TABLE 2 *COVID-19 Implications for Women Survivors of IPV and TBI***Increased experiences of violence and risk for violence**

Those who were at minimum risk, have risen to moderate risk. Those who were moderate risk have risen to high risk. And so, we have found this pandemic to be a really dangerous amplifier . . . of violence in women's lives. And I talk about how COVID is an abuser's dream, it is, because she has nowhere to go. Family can't come around, people can't call, she can't leave the house, the kids, just like the mother for whom work was a reprieve, school was a reprieve. But now you're doing online learning and he is behind you, so the tensions for everybody have been amplified. **P6**

The level of intensity has been escalated by COVID because of not only just the climate around it but also that this is a very powerful way to make that woman feel more disconnected than she already did feel. And, you know, the idea that if she goes and seeks help that she's putting everyone's life in danger and she's being irresponsible by going and meeting a support worker, getting that help, that she's somehow putting her children at danger. These are things that women can very easily get messages around. So it's a very powerful tool of coercive control basically. **P8**

Impact on survivors' mental health

I think that the key thing, and I know that this affects everybody regardless of whether or not they've dealt with this in the past, but being isolated, like being alone and working with other survivors and things like that I know that that is the key thing for them. So many women have been isolated from their families, from their friends . . . when they were dealing with their abuser. So, this really can throw them back into that set of trauma. **P2**

Impact on survivors' employment

For a lot of survivors and their children, pre-COVID they could go to work, she could [go]to work and there was reprieve, there was escape for eight hours. She left the house and she could do something, but now you're home, he's there, you're here, there's nowhere to go, so it's a 24 hour constant belittling, constant harassing and there is no reprieve. **P6**

Well, one way COVID has helped, in that employers seem to be much more willing to have a four-day work-week, to do some work at a distance. And I can see that being so helpful for someone with children, or someone who needs to go slow throughout the day, or just have a break. In my home right now, there's less stimuli, I'm not interrupted by people, I don't have to worry about an hour commuting. That is so helpful to me, and so I imagine that structure would be very helpful for somebody with kids, with a brain injury, leaving an abusive situation. **P7**

difficulty with recollection of events, it may be wise to assume BI based on other factors such as exposure to hits to the head, face, and neck and reporting of typical symptoms. Survivors were asked about 16 potential ongoing challenges commonly associated with BI and reported an average of 13, with the most commonly reported being headaches, memory problems, fatigue or tiredness, trouble concentrating, difficulty multitasking, and problems organizing tasks.

FINDINGS

Considerable discussion of the implications of COVID-19 occurred alongside the broader exploration of employment and mental health experiences, and many themes and subthemes emerged. The COVID-19 findings focused on 3 key areas: (1) implications for women survivors of IPV/BI; (2) implications for service delivery and service providers supporting women survivors of IPV/BI; and (3) key priorities in addressing these implications moving forward. Quotes that elucidate the concepts discussed are included in Supplemental Digital Content Tables 2 (available at: <http://links.lww.com/JHTR/A499>), Supplemental Digital Content Table 3 (available at: <http://links.lww.com/JHTR/A500>), and Supplemental Digital Con-

tent Table 4 (available at: <http://links.lww.com/JHTR/A501>).

COVID-19 Implications for women survivors of IPV/BI (Supporting quotes in Table 2)**Increased experiences of violence and risk for violence**

Participants referred to COVID-19 as an "amplifier" of violence. Service providers reported a quiet period in the first months of lockdown, followed by a surge in calls, housing applications, and requests for peer support and counseling once communities began reopening. They observed not only an increase in the number of survivors contacting organizations but also more severe levels of violence for those coming into shelter. They attributed this to diminished avenues for self-care and help-seeking and increased capacity for surveillance and control. Survivors and perpetrators are confined at home without work, recreational, and social supports, leading to heightened tensions and an increased risk for violence. Participants described COVID-19 as an "abuser's dream," as public health restrictions and fear of contracting the virus offer more opportunity for perpetrator manipulation and control (eg, perpetrators guilt-tripping survivors into thinking they are endangering

their children or others by seeking help). They expressed concern for the safety and health of women survivors with disabilities and those infected with COVID-19 who are dependent on the perpetrator for support, as well as pandemic-related release of perpetrators from prison.

Impact on survivors' mental health

Many survivors are experiencing increased isolation and loneliness due to lack of social activity and fear of contracting the virus, worsening mental health challenges such as depression and anxiety. Participants shared varying experiences and challenges related to mental health. Some were able to be proactive, immediately seeking medical care and increasing their medications. Others spoke of fear of leaving their homes, with increasing cases in hospitals. Some service providers noted more women requesting small group activities. Daily living challenges such as shopping for groceries when living alone and affording basic needs on a limited income were reported. These were often discussed as existing challenges that were exacerbated by pandemic-related restrictions. Some expressed concern for older women living alone as well as women postviolence, whose present experiences of isolation could trigger memories of past abuse. With more things to consider and fewer resources to support them, comments emphasized the increasing complexities brought about by the pandemic and the negative feelings they bring to women survivors.

Impact on survivors' employment

Participants discussed the effect of the pandemic on women survivors' employment, highlighting the loss of jobs among women who work precariously. They spoke about increased challenges among mothers who are forced to navigate caring for themselves and their children without family and friends for support. They reported that COVID-19 has introduced modified work schedules and remote work, both of which may be helpful for survivors, noting women survivors may benefit from an environment with less stimuli, a slower pace of working, or multiple breaks throughout the day.

COVID-19 Implications for service delivery and service providers supporting women survivors of IPV/Bi (Supporting quotes in Table 3)

Reduced capacity, prolonged processes, and tension between control and safety

Reduced capacity and prolonged processes for support have made women's lives more complicated, with participants citing challenges in legal services and housing. Women may be living in situations of uncertainty

and feeling unsafe with delayed or halted services in court. Outreach initiatives have shown a perception that shelters are closed; however, most are operating, albeit at a reduced capacity and with difficult accessibility. Shelters previously housing 6 families now only house 3, women are required to test negative for COVID-19, and those who could not be accommodated were asked to quarantine in hotels. Service providers reported challenges ensuring safety in communal living settings and providing transition support for women living in hotels. They discussed the need for better public health guidance as many are concerned that in controlling movement and enforcing safety precautions, communal settings are inadvertently mimicking IPV dynamics, causing disempowerment and retraumatization among survivors.

Impact on service providers

Service providers reported increased stress and mental health challenges. They identified difficulties coping with abrupt changes and COVID-19-related anxiety while dealing with personal circumstances. Participants added that despite adequate supports, there remains an anxiety in not having a template for best practice and having to respond to situations as they happen. They described work environments as "incredibly reactive," highlighting challenges in taking on new roles, becoming more flexible in how they offer support, and collaborating and managing relationships with colleagues and managerial staff. The separation between teams is more apparent, and service providers are left feeling they need to fill the gap where human resources and teamwork are lacking. Some noted tensions regarding policies and decision making, particularly when leaders and staff are not bound by the same professional code of ethics. They described these stressors as taxing and reported feeling siloed and less engaged when providing care. Although no concrete solutions were suggested, participants felt that colleague validation is valuable.

Adaptability and flexibility of services

The need to adapt services as pandemic restrictions were enforced, such as moving programs online, being more encouraging and flexible, and continuously running groups and activities to offer hope and combat isolation, was discussed. Identified barriers to virtual care included limited access to technology, difficulty adapting to online restrictions particularly when assessment and treatment in an individual's home are required, and challenges in offering consistent support. Service providers reported having to reschedule appointments with symptomatic clients, potentially affecting rapport, trust, and dependability. Participants noted the impact

TABLE 3 *COVID-19 Implications on services and service providers supporting women survivors of IPV and TBI*

Reduced capacity, prolonged processes, and tension between control and safety

We, certainly, were not prepared to operate during a pandemic and had no knowledge of how to best operate during a pandemic, so immediately opened and went into scramble mode. We've implemented all sorts of very restrictive policies and like restricted movement policies, and "where are you going?" And "where are you going to be around?" And "when are you going to be back?" And "you have to submit a form to leave the shelter," and it is re-traumatizing. So, I feel like there's been large-scale disempowerment of the women that we serve. **P9**
 But our shelters are still, although they say they're open, they're very hard to access, right? You have to have a negative COVID test. You have to, while you wait for that test, be confined in either a hotel room or room at the shelter with your children for up to two weeks, right, depending on how long the testing takes to come back. And so, our shelters who used to be full beyond capacity right now have maybe three families in them, you know, like less than half full. Women just don't want to do that. Or that doesn't feel safe for them. They feel safer with their abuser. **P3**

Impact on service providers

And I know that the trauma counsellors are in frequent arguments with management because of the policies. Management has the responsibility of keeping the overall organisation, staff, and women safe and free of exposure to the best of their ability, and we are the advocates for the women and feel that the policies put forth by the organisation are unethical. And there's just a lot of infighting, and residents are like "well the staff are fighting with each other, and this feels like a very uncomfortable environment." **P9**
 I've had lots of conversations with my partner about the fact that he and I work from two very different worlds, so when the world shut down, he got to stay home for three months. And I was like I'm knees deep in this every single day. I don't get to hideaway in my house. I don't get to not go to the store. I don't get to not go to offices. And I definitely know that within that first three months or so after the big lockdown it was extremely mentally taxing and really having to learn how to put aside my own anxieties and my own stress about COVID so that I could be present for those people that I'm working with. **PG1**

Adaptability and flexibility of services

COVID [has] impacted ability for people to have support or accompaniment that often need it. So, when I think about brain injury, we can't even go to the hospital with her to help communicate or explain symptoms or what's going on, right? Because you can't have visitors or that support person. And that's both the hospital rules, but also as an [executive director], I'm considering how best to keep my staff safe, but also how to keep victims safe. **P3**
 I think one of the big challenges that I'm noticing that is more COVID related, is that the consistency of support is crucial. That relationship that gets built between a support worker and a client is crucial. What happens now though is that the health protocols are really stringent and so now a sniffle or a couple of things and all of a sudden, you need a COVID test or we're doing virtual – you're sick, so I have to stay away for a day or two, I'm sick, I can't come and see you. It's hard to keep a consistent schedule with the Health and Safety protocols around that now. Client . . . structure and trust and dependability, is super important. So, that's been hard. **P10**

of virtual care on survivors, highlighting online fatigue, limited engagement in virtual programs, delay in recovery, and dismissal of other health concerns when virtual diagnosis is not possible. They shared situations of low attendance at weekly online groups, clients having difficulty managing pain conditions without rehabilitation, and limited access to support workers for such things as help communicating with a health provider.

Key priorities: Outreach and technology (Supporting quotes in Table 4)

Participants identified need for widespread outreach and technological support during the pandemic. Media campaigns to disseminate signs or calls for help, encourage help seeking, emphasize available shelters and services, and publicize messages of safety are crucial. Funding to develop a COVID-19–specific safety plan, with direct input from survivors, that covers help seeking

and other supports was deemed urgently needed and beneficial. Other suggested strategies include using every interaction with women to increase awareness about IPV and BI resources and checking in on both survivors and perpetrators to provide support and lessen the risk for violence.

Understanding and addressing barriers to technology-based care were identified as a key priority. Participants noted lack of technological devices, data plans, and existing knowledge and comfort levels as common barriers to virtual care. They indicated need for funding to obtain technological devices, software, and internet access and support training for women survivors. Some noted that although virtual care is a necessity, most survivors still prefer in-person appointments; hence, providing both online and in-person services would be beneficial. Finally, providers should keep in mind other aspects of care valued by survivors, such as reassuring and nonjudgmental supports, consistency, and dependability.

TABLE 4 *Key Priorities: Outreach and Technology***Outreach**

We're telling everybody to check in on everyone that you know. Place a call [to say] "hi, how [are] you doing?" and what that does is it tells the aggressor that she is not alone, contrary to what you might think that she's not going out, people still remember her, still check in on her. And then the real transformational shift is telling people who know the aggressor to check in on him, check in on him, because again they need supports, these men need supports. That's the only way we're going to end violence is when they stop and the only way they're going to stop is that they are cushioned, they are cushioned with supports. **P6**

It goes back to that relationship piece for a lot of people, their frontline worker is their lifeline. And so, ensuring that those workers are essential and that there are, there are ways that we can continue to connect with them that aren't only tech related [is important]. Cause a lot of our clients were so willing to jump on it – "OK, I'll talk on the phone – if that's all I can get I'll talk on the phone." Or, "If that's all I can get, we'll do a FaceTime." Or, whatever and we were trying to be as adaptable as we could. And many of them did but their preference is always face-to-face, always. **P10**

Technology

Well, I would say one thing that I feel that has come up is that this idea that access to the internet is kind of like a human right I feel at this point in time. [...] if we could learn from this and [...] allow people of certain income access to free Wi-Fi and even devices. [...] we need to be thinking a lot more about the barriers that are in place when we all of a sudden go oh, everything's online, your kid's school, that's online, your work that's online, your addictions program, that's online. And go OK, what does that actually look like for a woman who maybe all she has is her cell phone and [...] most of our women are doing like a month-to-month thing where they're paying 50 bucks at a time or whatever. **P8**

As far as getting counselling, as soon as COVID hit, any of the counselling and connections that I was getting ended, there wasn't even phone contact. Everybody went their separate ways and self-isolated and that was it. And there was no physical access to the elder that I was spending time with, he was from way up north. There was no funding to bring him down, and so, I guess they ended the funding and they didn't think the phone was sufficient. **P13**

DISCUSSION

Three key areas of COVID-19–related concern emerged: (1) implications for women survivors, including an increased risk of violence and challenges experienced with mental health and employment; (2) implications for service providers and delivery, including reduced capacity, complex processes, tensions between control and safety, and the personal and professional impacts on workers; and (3) key priorities moving forward to focus on community outreach and solutions to technological challenges. COVID-19 has increased IPV globally, a crisis referred to as the shadow pandemic.^{6,7} Risk of IPV,^{3,22,24} reported incidence rates,^{3,4,21,24,25} higher levels of severity,^{4,31} and demand for emergency shelter^{4,32} have all increased. Our findings verified these early observations as discussions highlighted the increased risk of exposure and severity for women. Particularly concerning is the ongoing exposure to repetitive head injury, a known concern for athletes in high-impact sports and an emerging concern for women survivors of IPV/BI.^{10,33–35}

Equally concerning is the accompanying decline in contact and service use during the first lockdowns and shelter-in-place orders. Similar to early commentaries attributing this period of quiet to women being trapped and unable to report their victimization and fear of COVID-19 exposure,^{3–5,21,23,24,32,36} participants noted an eerie calm during this time for the same rea-

sons. Interestingly, they also discussed increased risks to COVID-19–positive survivors forced to rely on their abuser for medical care. Pandemic home-based quarantine and care protocols effectively put women under heightened levels of legally and socially sanctioned control from abusive partners. As noted by earlier commentaries,^{3,21–23} and supported by our findings, pandemic-related protocols are an abuser's dream, providing legitimacy and mechanisms for control under the guise of public health.

Similar to our findings, increases in risk and health-related challenges have been discussed in relationship to employment and mental health,^{4,21} in particular discussion around scarce resources due to disruption of livelihoods,^{4,6} lack of adaptive coping strategies,²¹ and increased challenges with mental health.⁴ Shutdown-driven layoffs and nonessential work closures have increased financial instability and accompanying stress and anxiety. In addition, our findings noted the lack of respite often provided through a workplace environment. Increased isolation, loneliness, and fear were reported widely here, as women were no longer able to access critical informal support networks. Complicating this increased need for supports are challenges accompanying unstable service provision and virtual care that surfaced quickly within IPV and BI care communities.

Reduced service delivery capacity and the impact on women survivors have been noted in the early

IPV-related^{4,23} and BI-related literature.²⁰ Notably, Kolakowsky-Hayner and Goldin²⁰ identify an increased risk of IPV-related BI for women, suggesting specific attention is needed. One study discussed challenges around increased childcare responsibilities and a lack of respite through informal and formal care supports,⁴ findings also supported here. Authors note difficulties with safety and privacy inherent in online service models.^{3,4,22,23,25} In particular, challenges to safety planning were highlighted by previous authors^{4,22} and verified here. Additional comment here noted that survivors should be involved in the development of COVID-19-specific safety plans. Some IPV-related literature has discussed challenges regarding access to technology in terms of hardware and internet access, as well as difficulty in adapting to new ways of using it. Interestingly, Kolakowsky-Hayner and Goldin²⁰ also noted heightened challenges with technology usage often accompany BI, a complication that continues to be overlooked in the IPV support community as an overwhelming majority of service providers are not yet BI literate.³⁰ Access and ability difficulties were often discussed here, highlighting the need for IPV/BI-sensitive services. While a few authors have provided suggestions addressing these concerns,^{4,23,24} there continues to be a gap in support strategies for navigating technological services for survivors who are also living with a BI.²⁰

While the strain on support services has been acknowledged in the emerging literature as noted earlier, to our knowledge, this is the first study to explore the impact on service providers themselves, a gap specifically noted by Sabri and colleagues.⁴ Participants here noted a tension between the need for safe, trauma-informed care and COVID-19 containment protocols. They discussed the impact of this tension, feeling unable to provide ethical client care as new protocols mimicked abusive behaviors and risked retraumatizing women survivors. Some noted the physical and mental impacts of these tensions, particularly in light of their personal COVID-19 fears and pandemic-related challenges, discussing difficulty with mental health, stress, and their own professional and interpersonal relationships. The impact on frontline service providers has been significant and should not be overlooked moving forward. Solutions to care that consider service users and providers should be sought.

Findings here focused on 2 key priorities with post-pandemic support approaches moving forward. The first discussed the critical role of community engagement and outreach and the need to be creative and collaborative among new partnerships. Participants discussed the importance of being proactive in safety checking and developing innovative, subtle ways to communicate with survivors prevented from using traditional methods or spaces. They highlighted the importance for women

to feel safe to seek shelter and basic healthcare for non-COVID-19-related issues. This reflects early solutions put forward by some authors who discuss the potential for unexpected contacts through postal workers, repair professionals, and food delivery services.^{21,22} Some authors discuss the need to consider new spaces to post support-related information such as grocery stores, pharmacies, and workplaces.^{4,22,23} Similar to our findings, the value of signals and code words was highlighted,^{4,22} along with a proactive approach to safety checking.²⁴ One study noted the need for online supports for abusers as a means of providing respite for women, as well as education, support, and de-escalation.⁴ Interestingly, one participant in our study also discussed the need to support abusers saying that without it, an end to violence would not be achieved. Importantly, participants noted a preference for in-person care models, supporting existing focus on community engagement and personal contact as critical to effective IPV/BI support.^{4,20,21,25}

The second priority focused on the need for effective technology-based solutions moving forward. The notions of universal internet access and the requirement for women to have affordable, reliable access to both hardware and online service were highlighted as critical concerns. Participants commented that a lack of comfort or knowledge was as much a barrier to service as the equipment itself, noting the need to assist women in adapting to new support models. Interestingly, while technology issues have been raised in the literature, previous discussion has focused on issues of safety rather than access. This may be indicative of Canadian infrastructure challenges or intersections of racial or economic marginalizations that are not as prevalent in the limited studies available. One previous study noted challenges with technology access and comfort for immigrant women,⁴ highlighting existing service gaps and the need for future solutions to consider this.

LIMITATIONS

These findings are a subset of a larger project focused on mental health and employment and as such, we recruited participants with knowledge and input on those topics. It is possible that had we recruited participants to share their COVID-19-related experiences specifically, we would have obtained broader discussions. Participants were recruited through our existing K2P network and via snowball sampling, meaning most were at least aware of the intersection of IPV/BI. Participants without knowledge of the intersection may identify different concerns than those raised by this group. Only 25% of the participants identified as either Indigenous or People of Color, groups that have been particularly disadvantaged by COVID-19.

It is unclear why recruitment efforts aimed at a more diverse sample were unsuccessful; however, it is possible that COVID-19–related challenges, which are known to be more predominant among People of Color, may have prevented participation. We would suggest future efforts be made to include a broader range of ethnicity and social circumstance among participants as they might raise more awareness regarding the multiple intersections of challenge. While the research team included a woman with lived experience of BI and representatives from a variety of disciplines, they were all women and predominantly White, which may have limited their ability to see diverse experiences within the data. Future research conducted by a broader representation of identities might provide more nuanced analysis. Finally, although a phone-in option was made available,

all our interviews were conducted online and required internet access, which may have excluded a broader range of participants.

CONCLUSION

Despite the World Health Organization's call to include measures addressing IPV as a component of pandemic preparedness and response plans,³⁷ BI as a consequence of IPV continues to be overlooked.⁵ We highlighted challenges faced by women experiencing IPV/BI and frontline workers, including difficulties with service delivery models, consumer access and uptake, and ethical tensions between safety and retraumatization. Key priorities were identified for safe, accessible postpandemic services.

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