Implications of the COVID-19 Pandemic on Interpersonal Violence Within Marginalized Communities: Toward a New Prevention Paradigm

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During the COVID-19 pandemic, reports of domestic violence across the United States increased from 21% to 35%. Stay-at-home orders, designed to protect the public against the spread of COVID-19, along with heightened societal stressors as a result of the global pandemic, inadvertently increased rates of illicit drug and alcohol use, job loss, and isolation, resulting in increased stress and nonphysical (e.g., psychological, emotional, economic, technological) abuse that often escalated to physical violence.

These processes were exacerbated in marginalized communities. These risks were heightened among Black women and Latinas, who experience high rates of domestic violence, long-standing distrust in law enforcement, and compromised self-reporting or anonymous reporting of abuse.

We make recommendations for training key stakeholders (e.g., law enforcement, mental health clinicians, and public health care professionals) to facilitate the safety and well-being of domestic violence survivors and to better manage prevention or intervention efforts targeted at domestic violence. We make public health policy suggestions for individuals, communities, and governing structures. (*Am J Public Health*. 2023;113(S2):S149–S156. https://doi.org/10.2105/AJPH.2023.307289)

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The COVID-19 pandemic stands as a catastrophic worldwide event that has included historically high unemployment rates, reduced social services, long quarantines, and severe social disconnection.[1,2] Similar to what occurs during natural disasters such as earthquakes and catastrophic hurricanes, interpersonal violence (IPV) increased when stay-at-home mandates were implemented in spring 2020.[1,3] For instance, during the period of 2019 to 2020, there was a 21% to 35% increase in reports of domestic violence across the United States.[4] Of note, marginalized communities (e.g., underresourced, socially isolated, discriminated against, underprivileged) experience the highest rates of domestic violence, with Black women and Latinas disproportionately affected.[5–7] For example, in the latest published National Intimate Partner and Sexual Violence Survey from the Centers for Disease Control and Prevention (CDC), 12.3% of Black women and 12.1% of Black men reported experiencing IPV within the last year.[8]

We examine the prevalence of domestic violence overall, with careful consideration of its prevalence in marginalized communities. We outline nonphysical abuse and how it contributed to the increased rates of physical violence during the COVID-19 pandemic, in addition to the barriers to reporting abuse during this time. We make recommendations for training key stakeholders such as law enforcement, mental health clinicians, and public health care professionals to facilitate the safety and well-being of domestic violence survivors and to better manage prevention or intervention efforts targeted at domestic violence. We conclude with public health policy suggestions for individuals, perpetrators, communities, and governing structures to enhance advocacy for survivors of violence.

DOMESTIC VIOLENCE PREVALENCE

The total annual US medical costs associated with domestic violence exceeds $5.8 billion, consequently increasing the health care costs for the entire population.[9] Survivors of domestic violence are more vulnerable to chronic illnesses, including heart disease, diabetes, and traumatic disorders.[9,10] These public health issues are of substantial financial and social significance to survivors, families, and society at large.[11] Domestic violence often occurs when there are power imbalances in relationships, whereby one partner seeks to control, manipulate, or overpower a member or members of the household.[12]

Although women may be perpetrators of IPV, domestic violence more often occurs when toxic masculinity or male privilege pervades the household, as perpetrators with this mindset believe that men control the decisions and that the survivor's purpose is to serve them.[13] Failure to obey or comply is often met with some form of punishment, such as nonphysical abuse (e.g., psychological, verbal, economic, or technological abuse or threatening to report them to be deported) as a way to maintain control.[12–14] Domestic violence increases when perpetrators suffer from substance or alcohol abuse, stress, or mental illness.[3,15] Over time and without proper intervention, nonphysical violence can transition to physical violence; 25% of women in the United States have experienced physical violence.[7,14,16]

Marginalized communities are disproportionately represented in lower socioeconomic areas[7] and often consist of groups who are systematically treated unfairly, discriminated against, or socially excluded.[17] Domestic violence occurs in all communities regardless of race/ethnicity, education, socioeconomic or employment status, neighborhood, religious affiliation, or sexual orientation. However, underresourced communities have higher documented rates of domestic violence,[4–7] perhaps because of the involvement of law enforcement, social service agencies, public schools, hospital emergency departments, and other public facilities with fewer economic resources and privacy protections compared with more affluent communities.[14]

Despite victims' rights, survivors of any socioeconomic stratum may deny incidents of abuse or refuse care out of fear that reporting their perpetrator to authorities may result in additional adverse consequences (e.g., stigma or shame from family, friends, or the larger community).[18] Domestic violence affects Black women at disproportionately higher rates and often has lethal outcomes: they are killed in domestic violence incidents at more than double the rate of other racial/ethnic groups.[5] In addition, 1 in 6 Latinas will experience domestic violence in their lifetime, representing another high-risk group.[17] Women of color, those with low socioeconomic status, and dependent individuals are most affected by abuse[14,18] and have been disproportionately affected by the adverse effects of the COVID-19 pandemic through job loss, increased family demands, and contracting COVID-19.[15] Additional risks for violence victimization among marginalized groups may include the perceived inability to seek protection from social services or law enforcement because of historic mistrust of these systems.[15,18]

NONPHYSICAL AND PHYSICAL ABUSE

It is critical to understand the precursors that lead to physical violence, as it often begins with nonphysical violence and escalates over time.[16,18] When stress increases in a family because of lack or loss of resources, nonphysical violence such as emotional abuse, aggression, and neglect are more likely to occur, leading to an overall increase in both domestic violence and child abuse.[1,7] The risk factors present in US society during the COVID-19 pandemic contributed to increased violence in the home possibly owing to systemic factors that led to the normalization of control and violence in relationships, even when restrictions eased and public access increased.[13,19] For instance, if a perpetrator loses their job or experiences a reduction in family income and the survivor becomes the sole income provider, the perpetrator is more likely to abuse them in an effort to regain control and power.[20]

Abuse in the COVID-19 Context

Homicides and physical violence have been key focuses for research, but other forms of abuse also require research and clinical attention, particularly those that increased during the COVID-19 pandemic. It is important to understand and recognize the signs of nonphysical abuse, as well as its escalation linked to poverty, isolation, and eventual physical violence,[14] all of which were heightened during the COVID-19 pandemic.[1,15] Most of the research on IPV during the COVID-19 pandemic focuses on the physical violence enacted on survivors (e.g., hitting, choking, pushing, biting, throwing items at).

The complexities of the abusive tactics leading to physical abuse are underresearched,[16,18] such as psychological abuse (e.g., manipulation, gaslighting, control, shaming family and friends); verbal abuse (e.g., name calling, attacking personality traits or physical appearances); economic abuse (e.g., limiting spending, destroying credit score); technological abuse (e.g., GPS [Global Positioning System] tracking, ghostwriting, social media stalking); sexual abuse (e.g., forced penetration or pregnancies, coercion, harassment, revoked access to birth control); and abuse related to the survivor's immigration status (e.g., threatening to do something that leads to their deportation).[10,12–14,16–18] Because of the unprecedented conditions created by the COVID-19 pandemic, public health professionals, frontline clinicians, and abuse hotline workers may benefit from learning about understudied forms of physical and psychological abuse.

Box 1 identifies common types of IPV that may occur with explanations of how they may manifest during or after the COVID-19 pandemic. In accordance with the literature referenced in Box 1, 3 main themes emerged: (1) weaponizing COVID-19 using technological abuse; (2) using being sick with COVID-19 to cause isolation, psychological and emotional abuse, and coercion and threats; and (3) neglect or nonphysical sexual abuse from a lack of access to crucial medical care or medication. We explore these themes.

Weaponizing COVID-19 and Technological Abuse

Because COVID-19 is highly contagious, fear of contracting the disease has been used to manipulate and control family members: the lack of freedom owing to this fear can be weaponized.[3] Many community mental health clinics and crisis centers transformed to a hybrid environment using Zoom or HIPAA (Health Insurance Portability and Accountability Act)–compliant video conference platforms.[24] This new reliance on technology will likely persist because use of telemedicine by social services, mental health, and medical practices has brought unprecedented convenience to the providers; however,

BOX 1— Common Types of Interpersonal Violence in the Context of the COVID-19 Pandemic

Types of Interpersonal Violence	How It Has Heightened During the COVID-19 Pandemic
Isolation	This form of psychological mistreatment involves minimizing or restricting access to other people[13] (e.g., prohibiting family and friend visits). The abusive person may control who may visit (or be socialized with) as a means of control and manipulation. They might not curtail their own social or employment activities and hold the rest of the household to a more stringent standard.[16]
Psychological and emotional abuse	The perpetrator may fake being sick with COVID-19 and threaten to infect the survivor, leading to their extended isolation. Or the perpetrator could fake having contracted COVID-19 and pretend to spread it to the survivor.[13]
Coercion, threats, and intimidation	The perpetrator can use COVID-19 mandates, news and media stories, and research to increase the survivor's fear of leaving the house and becoming sick or infecting others, thus keeping survivors isolated at home.[3,4] A perpetrator may prohibit family members' access to COVID-19 vaccines or boosters (by, e.g., citing false medical or religious justifications), thus potentially limiting independence, employment, education, travel, and entertainment access for survivors.
Economic abuse	Perpetrators may threaten to cut funding or medical support to survivors. Job losses could prevent survivors from amassing savings or resources to leave home, perpetrators could make survivors borrow money for them from family or friends or keep them from working by consistently exposing them to COVID-19.[12] Women have been disproportionately affected by pandemic-related unemployment.[15]
Child neglect and abuse	Children are at a higher risk for maltreatment, as families may not have the funds or resources to buy food or essential medications.[3] Adults may take out their frustration and anger on their children in violent ways. Children lack typical protective or escape outlets, such as attending in-person school or worship services.[1,15]
Immigration status–based abuse by coercion and threats	Partners may threaten survivors who are immigrants with being deported or destroy critical documents if they become sick, need medical care or hospitalization,[17] or seek public health resources.
Sexual abuse	Reduced or lack of access to contraceptives or birth control is a sexual violence–related risk factor that could result in forced unwanted pregnancies stemming from coercion or rape,[16,19] especially if the woman feared seeking medical help during the COVID-19 pandemic and governmental distribution of contraceptives has limited women's access.[21,22]
Technological abuse	Those who have traditionally accessed in-person services may not have had access to technological devices or may have lacked privacy in the home while online.[15] Abusive parties may have weaponized this lack of privacy with strategies such as surveillance and ghostwriting, thus resulting in technological abuse.[12,16,23]
Physical abuse	Physical abuse during the COVID-19 pandemic increased, as it normally does following natural disasters.[1] The stay-at-home mandates and closed businesses correspond with an increase in substance use and untreated mental health symptoms, leading to more physical abuse. Pharmacies, marijuana dispensaries, illicit drug dealers, and liquor stores remained opened during the stay-at-home mandates.[15]

telemedicine has also heightened concerns and risks for survivors of domestic violence.[19] Health professionals need to be aware that clients who have traditionally accessed in-person services may not have confidential access to technological devices or they may lack privacy in the home to fully access services online.[15]

Health care trainees should be trained on how to provide telehealth to IPV survivors. This can be demonstrated through mock telehealth sessions in medical and psychology graduate courses supported by the American Medical Association and the American Psychological Association, in which the focus is on telepsychology-related knowledge, technical support, and safety plans for harm reduction.[25,26]

Abuse Related to Contracting COVID-19

COVID-19–related manipulation may extend beyond threats and be compounded in restrictive living situations, at times increasing transmission of the virus. The perpetrator may use COVID-19 as an additional reason to keep survivors in isolation by instilling fear or threatening to leave them if they become ill.[3,4]

The line between physical and nonphysical violence may become blurred when the result is contracting or exacerbating a potentially deadly disease. There may be insufficient physical and emotional barriers when a cohabitant falls ill; this is particularly true in homes with a partner who is overly controlling and demanding. Ways that nonphysical violence can be perpetrated during a pandemic should be incorporated into trainings and definitions of abuse. This form or violence can be as simple as sneezing, touching, or refusing to isolate to a separate area of the home when contagious.[13] Conversely, the abused partner may be the one with COVID-19 but be expected to fulfill household duties despite being sick. This may prolong or intensify the severity of the illness.

Preventing Access to Crucial Medication

When individuals are placed under quarantine, access to essential needs may become problematic, particularly for individuals who identify as immunocompromised, disabled, or dependent (e.g., children, elders) or lack resources. Violence may result from new forms of neglect owing to contracting COVID-19. Even if the neglect is focused on an adult who is immunocompromised or disabled, there can still be traumatic, long-lasting effects for children who witness such abuse.[10]

Sexual Abuse

Restricting access to medications can be used as a form of violence, either through neglect of dependents or through direct intent to produce an unwanted pregnancy. Reduced or lack of access to contraceptives during a pandemic is a sexual violence–related risk factor that can result in forced, unwanted pregnancies, also referred to as "reproductive coercion."[12,16]

On June 24, 2022, the US Supreme Court repealed *Roe v. Wade*, reversing the nearly 50-year-old constitutional right to abortion access. In numerous states, the effect of *Dobbs v. Jackson Women's Health Organization* has restricted or eliminated access to abortions, contraceptives, birth control, and other forms of reproductive health services, which may further burden women in households with violent partners,[21,22] particularly those in which economic resources are limited (e.g., cannot travel to states without abortion bans, cannot stockpile abortion, or "morning after," pills). Health care trainees, such as medical students, physicians, and nursing students, who work with female populations should be made aware of how to remain informed of local and state sexual and reproductive health regulations. For example, the *New York Times* tracks abortion laws in each state and provides online updates, including whether abortion is legal, banned partially or fully, or is permitted in some cases (e.g., rape, incest, gestational age).[27]

BARRIERS TO REPORTING

Survivors of domestic violence often do not seek help from police for various reasons, including that the police have historically intervened in domestic disturbances with indifference, disrespect, and hostility.[7,18,28] Survivors may fear that treatment by law enforcement will be disproportionately worse for their perpetrators than their abusive behavior merits[29] or that their children may be placed in their perpetrator's custody[30] or social services. Long-standing distrust of law enforcement serves to compromise self-reports and anonymous reports of abuse;[18] distrust has been exacerbated by public sociopolitical unrest associated with police killings of unarmed Black men and women.

Some youths involved in incidents of abuse feel that they are unacknowledged and overlooked when law enforcement gathers information and conducts interviews for their reports.[31] For women of color, distrust of law enforcement and language barriers founded on generations of discriminatory practices serves as a significant

barrier when seeking refuge from violence.[14,15] Police violence has been disproportionately high in Black communities, and tensions elevate when law enforcement treats racial/ethnic minority citizens with increased surveillance and excessive or unwarranted violence.[6,7]

ENVISIONING A SOLUTION AFTER THE PANDEMIC

Taken together, these processes support the need for systemic interventions to better support individuals experiencing, or at risk for, IPV. Perpetrators should be required to attend domestic violence courses, also referred to as "battered intervention programs," and parenting classes (if a parent) whenever a police report is filed on domestic violence. One example of a successful intervention focused on perpetrators is called the Duluth model, which is designed to change behavior by teaching perpetrators to recognize past and present abuse patterns related to control and power as well as by having them claim responsibility for their actions.[32]

The CDC discusses programmatic efforts that may change societal norms and thereby reduce violence, such as public education campaigns and bystander programs.[33,34] The US Department of Justice's Office of Community Oriented Policing Services is an example of a successful intervention that focuses on victims and perpetrators. The office promotes community policing development programs by providing federal grants to support training law enforcement in crisis intervention, de-escalation, tolerance, diversity, and antibias.[35]

As US society collectively grapples with the "new normal" of a world of uncertain future COVID-19 strains or alternate threats to global health,[11] it is essential for researchers and practitioners to consider how to best support those living with violence. In preparing future health care providers, training in best practices is essential. The following are recommendations for individual, community, and governmental policies and training.

Telehealth and Individualized Care

The increase in services provided via telehealth makes it especially important to assess whether the client is in a safe and private environment before initiating a therapeutic or medical session, including inquiring about any form of abuse. Questions regarding the extent of the client's privacy should be incorporated into existing screening and intake assessments.[19] If clients lack privacy, health care professionals should come up with potential solutions and advocate alternative arrangements that maximize safety during therapeutic encounters.

Nonphysical violence may also result in altered coping mechanisms, such as increased substance abuse, depression, anxiety, and loss of self-confidence.[1,15] If a survivor indicates they are suffering from nonphysical abuse, mental health professionals can help to marshal a support network and generate ideas about how to safely receive support.[24] Traditional health service professional training programs must incorporate coursework and supervised clinical experience in the provision of resources and safety protocols as well as in their coverage of ethical, legal, and clinical issues of telehealth service provision.[25,26]

Individualized care must be conceptualized broadly and flexibly, integrating various levels of support. For example, survivors may liaison with crisis advocates (e.g., people trained in safety planning to support those fleeing and those who are unable to flee violent situations) and access crisis hotlines and text lines and virtual support groups.[12] Clinicians must be trained to offer support through safety planning, providing essential support, and advocating medical, educational, or social services. Through the Clinic to End Tech Abuse, funding is available to increase survivors' access to private technological devices and help them regain or achieve technology freedom.[36]

Even if domestic abuse survivors are able to leave their abusers, they may remain at heightened risk for violence. Most murders of IPV victims occur when the survivor makes the choice to leave or shortly after leaving their abusive home.[28,30] During the stay-at-home period, the majority of states made provisions for firearms retailers to remain open in some capacity, contributing to an all-time national record in firearm background checks—an indicator that firearm sales substantially increased during the COVID-19 pandemic.[3,20] Although stay-at-home mandates have come to an end, there will likely be future pandemics and disasters, and health care clinicians and trainees need to be prepared for when that time comes.[11]

Acknowledging the reality that people experiencing abuse might not or cannot leave the abusive conditions, proactive strategies include intricate safety planning that accounts for real-time updates of shelter availability, court closures, police practices (e.g., nonbookings or no bail required for certain offenses), and travel restrictions related to future disasters and pandemics.[31] Health care trainees should be knowledgeable about

these conditions or help their clients increase awareness of and access to these resources. Furthermore, care for those who are unable to flee abuse should be tailored to the individual's circumstances, for example, an appropriate crisis hotline, identifying trusted friends or family on whom they can rely during an emergency (accounting for COVID-19 mandates, children, and pets), and finding areas of the home that can be private and safe retreats. Oftentimes, COVID-19 policies caused many people to be at home simultaneously working or being in online school, so considerations for privacy during virtual sessions should be made for all who are at risk for exposure to violence.

Community Care

As communities reacclimate to how its citizens connect with one another because of COVID-19, teaching health care workers and the public how to identify abuse is essential. There is a need to be a good neighbor, one who can recognize when someone is in harm's way and take necessary action (e.g., reporting to authorities, passing along a phone number for crisis services, acting in an active bystander intervention).[18] Bystander intervention is valuable, as neighbors have the opportunity to intervene.

Some communities have Neighborhood Watch, a program that enables neighbors to become trained and empowered to take action in their neighborhood. Although the program is not IPV specific, with appropriate training, neighbors can intervene and support each other's safety. However, such intervention needs to be culturally and contextually appropriate and take into consideration issues related to mistrust of law enforcement and social services (as discussed earlier). In some communities, enlisting the support of relatives, friends, or clergy may be possible.

Training for active bystander intervention can be seamlessly embedded in community programming.[37] Increasing community awareness regarding IPV would remove the invisible nature of the abuse and prepare the community for how to help when future pandemics or disasters occur. Social service centers can provide free virtual training on bystander intervention, including de-escalation tactics, the process of reporting suspected abuse, hotlines for those who display signs of abuse, and available local supportive services for those experiencing abuse. These are all practical skills for health care clinicians.

Policy Recommendations

Communities need to assess how resources are distributed locally, statewide, and nationally to devote more services to domestic crises that occur with pandemics.

At the local level, there is a team of specially trained police officers and a survivor advocate called the Domestic Abuse Response Team in Los Angeles, California. They continued to respond to calls regarding domestic violence during the pandemic. The police assessed whether arrests were to be made, and the survivor advocate provided additional resources to the survivor, if needed.[23] However, police officers are not medically trained clinicians, and the survivor may not use the resources provided or consent to further services recommended by the survivor advocate. In response to this reality, it could prove useful to expand the Domestic Abuse Response Team model to be nationally adopted and to include a team of trained professionals that accompany police when a domestic violence call comes in. This multidisciplinary team could include a conflict resolution specialist, crisis interventionist, survivor advocator, clinician, and medical doctor.

At the state level, a successful example is Right Care, a program developed in 2017 that connected police officers with trained social workers and paramedics to work together in responding to 911 calls. The program was created to combat overcrowding in jails in South Dallas, Texas; as a result, arrests in the city dropped.[38] Trained mental health clinicians and medical professionals must assess survivors and perpetrators properly to ensure their safety and recovery, especially when the perpetrators are not incarcerated for offenses or have not physically abused the survivor yet. Health care professionals who work with victims and perpetrators of domestic violence should be made aware of this collaborative model as a potential career option.

Mandatory training on survivor and perpetrator interventions and the indicators of IPV, including nonphysical violence, should be incorporated into curricula at medical schools for physicians, physician assistants, and nurse practitioners and at public health schools for emergency department professionals, social workers, and teachers. Such training offers the opportunity for mental health and medical providers to spot early abuse signs and to help survivors and perpetrators try to live safely together, as moving out of the home may not be a viable option. These interventions should be culturally congruent, incorporate the US history of structural racism, and include psychoeducation on the cycle of trauma and abuse.[15]

As mentioned previously, many types of nonphysical abuse increased because of COVID-19 (Box 1), and many new episodes appeared because of the hardships initiated or escalated as a result of the pandemic.

However, early interventions focused on behavioral change and psychoeducation could prevent abuse. For example, battered intervention programs are evidence-based interventions built on cognitive behavioral therapy, acceptance commitment therapy, and motivational interviewing and can be offered to perpetrators voluntarily or court ordered. Battered intervention programs differ across states, but all prioritize victim safety and are based on reversing male toxicity and control, psychoeducation, and behavioral modification. The program can be offered as individual, group, or marital therapy.[32]

At the national level, the Coronavirus Aid, Relief, and Economic Security Act (2020) provided significant economic relief and sanctions for preserving housing access; it also made services available through the Family Violence Prevention and Services Act (1984). These funds provided a host of prevention and intervention resources related to domestic violence, including housing and emergency shelter, outreach, education, and case management. These services have been invaluable in providing much needed support and assistance for survivors.[39]

The US Department of Health and Human Services reported that IPV occurs on college campuses and that about 20% of women experience some form of undesired sexual activity. Title IX of the Education Amendments of 1972 legislation enacted federal law that has been extended to prohibit sexual violence and harassment at federally funded colleges. Title IX offices provide services to complainants and victims and respondents and perpetrators but also mandated education to help prevent sexual violence and harassment on college campuses.[40] Being trained in the prevention of sexual violence as young adults may carry forward throughout the lifetime.

CONCLUSIONS

The COVID-19 pandemic increased the likelihood that survivors of domestic violence remain in isolation with their perpetrators. The devastating impact was even greater for marginalized communities, especially for people of color. Clinicians and trainees must understand that violence in the home is a complex issue, one that may begin without physical abuse yet still qualifies as IPV. It may escalate to deadly proportions. Consequently, change must be enacted at individual, community, and national levels to accommodate the additional burden of the COVID-19 pandemic and to prepare for future disasters and pandemics. Furthermore, training in working with survivors of IPV must be prioritized for future and current public health professionals. AJPH

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The authors have no competing interests to declare that are relevant to the content of this essay.

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