Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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The impact of the Covid-19 pandemic in the precipitation of intimate partner violence

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HIGHLIGHTS

- Intimate Partner Violence cases increase during emergencies.
- An increase in IPV cases has been reported during the Covid-19 pandemic.
- IPV has been related to numerous risk factors.
- Risk factors for IPV can be exacerbated during the Covid-19 pandemic.
- Health care professionals face new challenges managing IPV cases during the Covid-19 pandemic.

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ABSTRACT

Intimate Partner Violence (IPV) is a global pandemic and many have been victims of it long before Covid-19. International organizations have documented an increase in IPV reports during the current pandemic, raising awareness of the potential causes for such an increase. Reflecting on risk factors associated with IPV, and the underlying need of the perpetrators to exert control over the victims, it becomes increasingly important to understand how the current policies of social distancing, self-isolation, and lockdown can precipitate episodes of IPV. Furthermore, access to specialized services and health care can be compromised, and health care professionals face new challenges and demands imposed by the pandemic while managing IPV cases. This article begins by examining the main risk factors more commonly associated with IPV in the literature. It proceeds by reflecting on how these risk factors may be exacerbated during the Covid-19 pandemic, which can explain the increased number of reports. Finally, it emphasizes the new challenges faced by health care professionals, while assisting IPV victims during the pandemic and provides possible recommendations on actions to implement during and beyond the Covid-19 pandemic to prevent such cases.

1. Introduction

Intimate Partner Violence (IPV) represents a serious, highly prevalent, and preventable public health problem worldwide. Laws contextualizing intimate partner violence as a crime can differ in some particularities between countries. The definition, however, in the literature usually encompasses any act of physical, sexual, or psychological abuse perpetrated within an intimate relationship (Miller & McCaw, 2019).

Its prevalence can be molded by social, economic, and cultural backgrounds, but it is nonetheless extended to all demographic groups. The same can be said about gender and sexuality, but women in heterosexual relationships appear to represent the overwhelming majority of victims (Miller & McCaw, 2019; Sugg, 2015).

Extensive literature has been debating which factors may predispose someone to be part of a violent relationship, either as a victim or the perpetrator of the abuse, with most agreeing with a combination of individual, relationship, community, and societal factors (Miller & McCaw, 2019). Some of these factors acquire a more significant impact at moments of social distress like the one we are currently facing during

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the Covid-19 pandemic. It is known from previous studies, that intimate partner violence tends to increase during emergencies, including epidemics, and although robust data is still lacking, reports from China, the United States of America, and several European countries, point towards the same tendency concerning the Covid-19 pandemic (Boserup, McKenney, & Elkbuli, 2020; Bradley, DiPasquale, Dillabough, & Schneider, 2020; Gupta, 2020; Mahase, 2020; Newberry & Cruz, 2020; Parveen & Grierson, 2020; World Health Organization, 2020).

IPV can have devastating and long-lasting effects on the victims and their families' health and quality of life. Victims tend to have more health problems and frequently look from assistance from health care services, in the context of acute traumatic injuries, physical, sexual and psychological sequels of abuse, and many acute and chronic pathologies (which are significantly less frequent in the general population) (Bonomi et al., 2009; Bradbury-Jones & Isham, 2020; Ellsberg et al., 2008; Mazza, Marano, Lai, Janiri, & Sani, 2020; McCauley et al., 1996; Telles, Valença, Barros, & da Silva, 2020). Contacts with health care services constitute a significant opportunity and should be used to increase the detection and referral of victims of IPV. However, many barriers can compromise the capacity for screening patients about IPV, including some social actions implemented to control the Covid-19 pandemic.

Many governments have adopted policies to prevent the spread of the virus (self-isolation, social distancing, and lockdown) that may have an impact on the increase and precipitation of episodes of IPV. These policies pose new challenges for health care professionals to manage IPV situations during the pandemic. In this article, we provide an overview of the potential challenges faced by health care professionals and possible recommendations to address and minimize them.

2. Methods

We conducted a narrative review on IPV and its associated risk factors, in the context of the current reality of the Covid-19 pandemic. We searched PubMed database for relevant articles. The following keywords were used: “Intimate Partner Violence” OR “Domestic Violence” AND “Risk Factors.” We selected articles in English that met the following eligibility criteria: (1) the article was published before May 2020 (when the literature search was performed); (2) the article reported Risk Factors for Intimate Partner Violence; (3) the article was a review or experimental study reflecting on diverse populations. Articles were excluded if they addressed other forms of family violence, like Child or Elder Abuse or if they were focused on very restricted populations (i.e. pregnant women, HIV patients or very restricted geographic areas). We did a similar search in the same database using the following keywords: “Intimate Partner Violence” OR “Domestic Violence” AND “Covid-19.” We selected articles in English published or accepted for publication before June 2020 (when the literature search was performed). Given the scarcity of articles we screened all articles that reflect on IPV during the Covid-19 pandemic, except for ones focused on other forms of family violence. We also searched for international public media articles related to Intimate Partner Violence and the Covid-19 pandemic. We selected reports based on interviews with domestic violence advocates or disseminated by specialized organizations.

3. Results

The first search regarding “Risk factors for IPV” yielded 7234 references. Titles and abstracts were screened to exclude citations that were clearly irrelevant based on the selection criteria. Eleven articles were selected. The second search regarding “IPV during the Covid-19 pandemic” yielded 35 articles. Similarly, titles and abstracts were screened, and thirteen articles were selected. The full texts were analyzed and the results were reported narratively. Regarding the public media search, we selected five articles with relevant information concerning the fears and strategies being adopted by domestic violence advocates to contradict the difficulties faced by IPV victims during the Covid-19 pandemic.

3.1. Current knowledge around possible factors influencing IPV

Some factors have been consistently associated with an increased likelihood of experiencing or perpetrating violence in an intimate relationship. Understanding these factors and the dynamics of a violent relationship can lead researchers to extrapolate on how they can be affected by external and uncontrollable forces, such as the global state of emergency associated with the Covid-19 pandemic. Importantly, these risk factors, in conjunction with some clinical signs and symptoms frequently associated with IPV, can function as red flags to health care professionals, helping them identifying and advise victims of IPV.

3.1.1. Individual factors

The bulk of research into IPV has been focused on individual-level risk factors. This encompasses demographic characteristics, prior exposure or experiences of violence, and psychological characteristics of both victims and perpetrators.

While IPV occurs in all demographic groups, the overwhelming global burden of IPV is borne mostly by women. The World Health Organization estimates that worldwide one in every three women experience physical and/or sexual violence during their lifetime (WHO et al., 2013). It is, however, important not to ignore male victims, as pointed out by Warburton et al., since men are less likely to disclose the abuse (Warburton & Raniolo, 2020).

Age and stage of development are crucial factors and play a role in the translation of the different social constructions and degrees of acceptability towards violence. Overall younger age appears to be related to a higher risk of victimization and perpetration of IPV, with age inversely associated with aggression towards a partner (Gerino, Caldarera, Curti, Brustia, & Rollè, 2018; Miller & McCaw, 2019; Rodriguez, Lasch, Chandra, & Lee, 2001; Yakubovich et al., 2018).

Regarding ethnicity, in general, studies have found that belonging to a minority in a specific society appears to play a more significant role than belonging to any specific group in itself (Burman & Chantler, 2005; Gerino et al., 2018; Hayward, Honegger, & Hammock, 2018).

Low socioeconomic status and unemployment have also been linked to an increased risk of abuse. Men of lower socioeconomic status have an increased risk for perpetrating abuse and tend to inflict more severe forms of violence than their higher socioeconomic counterparts (Heise & Garcia, 2002; Riggs, Caulfield, & Street, 2000). A systematic review and meta-analysis for risk and protective factors for IPV reveal that the strongest evidence available for modifiable risk factors for IPV against women was for unplanned pregnancy and parents having less than a high-school education, factors that the authors associated with lower socioeconomic status (Yakubovich et al., 2018). The great majority of research pointed to low levels of education as a risk factor for preparation and victimization (Miller & McCaw, 2019). However, in some societies with a male-dominant culture, high levels of education in women can put them at risk for IPV. This observation has been linked to the tendency of educated women to challenge male authority (Barnawi, 2017).

One of the most robustly supported factors for IPV is the previous history of exposure or experience of violence, especially during the formative years. Witnessing or experiencing violence as a child is a powerful predictor for becoming a perpetrator or the victim of violence in adulthood (Fazel, Smith, Chang, & Geddes, 2018; Hayward et al., 2018; Riggs et al., 2000). This relation between past experiences and violence led researchers to suggest that cognitive factors, such as perceived legitimacy of violence in family relationships, mitigate whether or not aggression is transmitted to the next generation (Gerino et al., 2018).

Multiple studies have tried to evaluate a possible connection between IPV and psychopathology. Regarding victims, IPV has been

linked to high rates of psychological disorders, including depression, anxiety, phobias, personality disorders, post-traumatic stress disorder, eating and sleeping disorders, substance abuse and suicidality (Gulati & Kelly, 2020; Riggs et al., 2000). Generally, these disorders have been regarded as a consequence of the abuse. However, it has also been suggested that some preexisting mental disorders could possibly predispose victims to subsequent abuse (Gulati & Kelly, 2020; Kessler, Molnar, Feurer, & Appelbaum, 2001). Regardless of whether psychopathology predates or follows the abuse, symptoms are still prevalent between victims and may serve as red flags during clinical evaluation. In the case of perpetrators, researchers have linked IPV with depressive symptoms, post-traumatic stress disorder, some personality disorders, including antisocial, aggressive and borderline disorders, and alcohol and substance abuse (Gulati & Kelly, 2020; Heise & Garcia, 2002; Riggs et al., 2000). An umbrella review of meta-analyses revealed that neuropsychiatric disorders were among the strongest risk factors for violence, specifically substance use disorders (Fazel et al., 2018). Usually, however, the vast majority of IPV seems to be more closely related to societal and cultural norms, perceived gender roles and general acceptance of violence than to any preexisting medical condition.

3.1.2. Relationship factors

Violence appears to occur more frequently in relationships permeated by conflict and discord and characterized by negative interactions between the couple. Couples who experience severe distress are at a greater risk for violence than non-distressed couples (Riggs et al., 2000). This distress can arise from within the relationship or be a consequence of external influences on the relationship. For example, low or insufficient income may add to family stress and feelings of frustration and inadequacy, creating an environment where violence can easily be triggered (Barnawi, 2017).

One unifying point between studies is the evidence pointing to a power imbalance in the relationship connected to the perpetrator's need for control over their victims. Control is the basis of a violent relationship. The perpetrators make use of several strategies to exert their control over the victims and even display that to others, including emotional abuse, intimidation, and isolation (Portwood & Heany, 2007).

3.1.3. Community and societal factors

Initially, research on IPV put more emphasis on the determination of individual factors influencing the predisposition to perpetration and victimization. However, recently, more focus has been given to the exploration of possible community factors to explain the phenomenon.

As stated, low socioeconomic status has been generally presented as a risk factor for IPV. Although all socioeconomic groups are affected, poverty appears to be a risk factor for IPV. It is, however, unclear if the problem resides in the lack of income or the social disadvantages that arise from poverty. The inability to provide for their families can lead a man to feel frustrated by being incapable of adhering to the provider's socially established role. Stress and frustration are standard fuel to violence. On the other hand, the victim may be put in a difficult position if planning to leave the relationship by the lack of economic means to sustain themselves and possibly their children (Hayward et al., 2018; Heise & Garcia, 2002).

Violent and disorganized neighborhoods, with a lack of social resources and opportunities for social integration, appear to be associated with more violent conduct inside the household, possibly because of the normalization of the behavior and the absence of defined protective social rules. On the contrary, stronger neighborhood ties, cohesion, trust, and an informal sense of social control are negatively associated with IPV (Thulin, Heinze, Kusunoki, Hsieh, & Zimmerman, 2020).

IPV is more common in societies with higher gender inequality, more rigid gender roles, where violence is regarded as a justifiable means to resolve conflicts (Gerino et al., 2018; Yakubovich et al., 2018). Heavier sanctions can function as a deterrent from IPV, being these formal legal sanctions, or the mere pressure from the community. Integration of the victim in the community and workgroups can also protect them from violence by providing them with social and economic support (Heise & Garcia, 2002). The presence of shelters, support organizations, family, friends, and community support, even if not initially protective, can serve to ameliorate and prevent the continuation of violence.

As mentioned, many factors have been associated with IPV. Nonetheless, there are no rigid cause and effect rules. Even when more than one of these factors is reunited, that does not directly mean violence will occur, and there may be violent relationships where no perceived factor is associated. What appears to be critical in predicting and recognizing the risk for IPV is a constellation of sights and escalation of behavior problems exhibited by the perpetrator, especially those that relate to control, shaming, and isolating the victims.

3.2. How Covid-19 can increase some risk factors associated with IPV

Data suggests that violence, including IPV, increases during humanitarian crises and emergencies (Chandan et al., 2020; Roesch, Amin, Gupta, & García-Moreno, 2020; Stark & Ager, 2011; World Health Organization, 2020). By understanding the dynamics of a violent relationship and the factors associated with IPV, we can also understand how Covid-19 can exacerbate those factors leading to an escalation of violence and even new types of abusive behavior. Adding to violence, the social measures implemented to reduce the transmission of Covid-19 and the reconfiguration of health care services can impact victims' psychological health being (Gulati & Kelly, 2020). Different mental health interventions may be implemented in different timings of the COVID-19 as a recent conceptual framework suggested (Ransing et al., 2020).

The challenges imposed by the Covid-19 pandemic, including managing the fear of the disease, the restructuration of the regular household routine, increase time with the partner and isolation from other people outside the household, and economic crises can significantly contribute to the increase of stress in a previously already strenuous relationship, precipitating IPV episodes. Moreover, the availability and access to specialized services may be compromised or considerably changed (Women's Aid UK, 2020).

Governments across the world implemented measures to stop the rapid spreading of the SARS-CoV-2 virus, including recommendations on self-isolation, lockdown, and closing of non-essential business and other working posts. These measures raised an immediate concern regarding victims of IPV, many that suddenly saw themselves closed at home twenty-four seven with their aggressors (Women's Aid UK, 2020). During quarantine, couples are forced to spend many hours together (many more than in normal circumstances) with limited contact with other people. With the absence of coping mechanisms and the security given by an established daily routine, this stressful situation can fuel the perpetration or escalation of violence (Gupta, 2020).

Self-isolation and social distancing puts victims in constant danger by the imposed proximity with the perpetrator and removes important protective factors such as moments of relative freedom when the perpetrator or victim goes to work, or access to support by additional people in private spaces. Isolation and control are critical tactics applied by violent partners. The upper mentioned measures can function as an excuse to extend that control further, for example, by keeping victims at home and limiting contact with friends or family using the risk of infection as an excuse (Gupta, 2020; Women's Aid UK, 2020).

Access to support can be very limited or non-ideal. Besides having limited opportunities of contact, victims and services had to quickly adapt previously implemented procedures to answer the need to protect victims from their aggressors while also protecting them from the virus. Shelters are generally group living facilities, which implied the restructuring of housing norms adhering to social distancing and execution of plans to isolate potential infected victims. Even with this

restructuring, victims may abstain from using these services for fear of catching the virus. This same fear can be extended to seeking health care in the context of abuse, and victims may feel that they should not put more strain on an already overwhelmed health system. Furthermore, many support organizations are financed by donations, which can diminish during a period of predictable economic recession (North, 2020).

Support organizations now give preference to contacts not in-person like phone calls or email. However, in some impoverished populations, access to the internet or a phone can be limitted (Joska et al., 2020). Even when access is not a problem, when living with the perpetrator of violence, calling for help may not be that easy. Calls to support lines or health care services can be controlled and overheard by the perpetrator, which can, in turn, precipitate violence as retaliation (Women's Aid UK, 2020). Similarly, victims may be forced by the perpetrator to allow them access to their email and other online accounts, compromising their capability to look for help or divulge the abuse either to formal support services or even to friends and family members.

Services like hotlines, crisis centers, legal aid, and protective services may be scaled down by a lack of personnel or funding, further reducing access (World Health Organization, 2020). It may also be difficult for victims to look for support among their preferred informal care providers. Recurring to friends and family for support or shelter may be seen as undesirable by the victims that fear to possibly infect those close to them (Sullivan, 2020).

Low or insufficient income, compromised by the change of employment status during the lockdown, may add to family stress, frustrations, and inadequacy, an environment where violence can be triggered (Barnawi, 2017). The disruption of jobs and family economy, currently seen as a consequence of the lockdown, can limit access to essential needs and services. As resources become scarce, victims may be at a greater risk of experiencing economic abuse (Gupta, 2020). This abuse may impact any plan of leaving the abusive relationship by compromising the victims' economic independence.

In families that adhere to rigid gender rules, the impact on women can be even more significant. The closure of schools implies extra work to provide constant care for the children and arrange means to guarantee their education during the lockdown. Women are more likely to take the burden of caring for their families around the clock and tend to relatives in fragile health, with consequently limited time for work and economic opportunities (Wenham, Smith, & Morgan, 2020). Furthermore, according to the World Health Organization, women account for 70% of workers in the health and social sector, which implies an increased risk of contracting the virus (Boniol et al., 2019). Health care professionals may experience stigmatization, isolation, and social ostracization by those fearing contamination (Miller & McCaw, 2019).

The stress caused by Covid-19 can have a significant impact on already fragile populations, namely social minorities, stigmatized groups, or people with previous health conditions that may be at a greater risk of developing severe illness in case of infection (Joska et al., 2020; Zero & Geary, 2020). This stress, frustration, and lack of control can exacerbate psychopathological problems related to IPV, further precipitating violent episodes (Gulati & Kelly, 2020; Sullivan, 2020; Telles et al., 2020). New threats and psychological abuse may arise linked to the fear of infection. Threatening the victim with “throwing her outside if she coughs one more time,” preventing the victim from seeking medical care in case of infection, proposedly infecting her, or blaming her in the case of infection have been reported (Newberry & Cruz, 2020; North, 2020). Perpetrators may also deny access to necessary items, like soap or hand sanitizer, or limit the transmission of reliable information about the pandemic, spreading misinformation to manipulate the victims even further (World Health Organization, 2020).

3.3. The challenge for health care professionals

The safety and specific needs of IPV victims should be considered during the Covid-19 pandemic, and governmental institutions should include services and measures to protect victims in their contingency plan. Social distancing does not mean social isolation (Pinto da Costa, 2020). Governments and support organizations urge the public to be alert, to reach out to friends and family, to provide care and support, and ascertain if they feel safe at home (Parveen & Grierson, 2020).

In this context, health care providers play a pivotal role by keeping an attentive eye for symptoms of the current pandemic and those that can arouse suspicion to a case of IPV. In normal circumstances, victims of IPV present more acute and chronic health problems and often seek professional attention (Bonomi et al., 2009; Ellsberg et al., 2008). However, victims frequently do not fully disclose the reasons behind their medical problems, and perpetrator interference with health care has been reported (McCloskey et al., 2007). This inability to disclose or to even seek professional attention can be exacerbated by diminished opportunities of contact during the lockdown, the increase of control exerted by the perpetrator, or even the decision of not seeking professional attention because of the fear of infection.

Hospitals and health care centers are giving preference to not in-person contacts with many consultations being performed by phone or email when such is perceived as a possibility (Sanchez et al., 2020). Despite the logical advantage of diminishing the risk of infection, by limiting the contact with an overcrowded clinical setting, this approach also presents important disadvantages. It demands the adaptation of services and professionals, which are now asked to learn new communication and technical skills to manage situations using telemedicine. Even so, studies have proven that this approach can efficiently diagnose and assess clinical problems (Hilty et al., 2013).

In the context of IPV, victims may find it difficult to disclose the abuse in this distant, not in-person setting, partially because of the risk of being overheard by the perpetrator but also by the lack of a more meaningful face to face interaction. Similarly, it can be more challenging for health care professionals to evaluate the situation since some important nonverbal clues are inadvertently lost. Health care professionals must also remember that they are not in direct contact with their patients in a safe, controllable clinical setting. They must make sure that the conversation can be taken privately, and that it is safe for the patient to disclose any abuse. Initiating the conversation with a simple closed “yes or no” question about whether it is safe or not to talk, or if the patient is alone can be a useful strategy (IRISi et al., 2020; Zero & Geary, 2020). If the answer is negative, then another time for a call can be suggested, always taking into account that the situation may change at any moment during the conversation, for example, by the entrance of the perpetrator in the room (IRISi et al., 2020). Asking about IPV is one of the most important steps to increase detection. Studies suggest that victims react favorably when questioned about IPV, especially if they perceived health care professionals' responses to the disclosure as nonjudgmental, nondirective, and tailored to their specific needs (Feder, 2006). The response also necessarily needs to be tailored to the restrictions imposed by the not in-person setting. Health care professionals should be trained to validate their patient's feelings and experiences, inquire about their needs and concerns, assess the risk, and provide guidance and support, including reference to specialized services (IRISi et al., 2020; Miller & McCaw, 2019). In essence, the role of the professional managing these situations has not changed, but further challenges have been introduced (IRISi et al., 2020).

Another challenge relates to the fact that identification of risk factors and detection of the signs and symptoms commonly associated with IPV can be compromised in not in-person settings. Importantly, psychological symptoms can be disregarded as a direct consequence of the emergency state, and health care professionals may fail to explore the actual reasoning behind them. Sentences such as: “We have all been more anxious right now” are frequently heard to bring comfort to a stressed patient. However, if the reason is not the virus but the threat of living with a violent partner, this type of approach may not only fail in having the desired effect, but also detour the patient from providing

more information by perceiving that their complaints are being disregarded. Health care professionals should perform a careful exploration of the patient's clinical history to facilitate the detection of IPV.

Even when more direct contact is not possible, health care professionals and institutions can make use of online services and social media to disseminate essential available services (hotlines, shelters, legal counselors, and other IPV specialized services). This information can be disguised among other Covid-19 information so that patients can access it without raising suspicions about what they are genuinely looking for (IRISi et al., 2020; Miller & McCaw, 2019).

4. Discussion

In this review, we describe the key risk factors associated with IPV, discussing them in light with the current context in the Covid-19 pandemic raising awareness to the safety of victims and the recognition and management of cases by health care professionals. The significance of this discussion can be translated into the adoption of protective measures that guarantee the safety of victims in other potential public health emergencies.

We believe that by understanding the dynamics of violence and risk factors associated with IPV, we can then extrapolate how emergencies, like the Covid-19 pandemic, can influence and further exacerbate those factors precipitating episodes of IPV. Situations that increase stress on the relationship and dynamics based on control, isolation, and manipulation of the victims, restricting their capability to protect themselves and their access to help, appear to be significant factors in the perpetuation of violence. Unfortunately, the generalized fear and uncertainty related to the virus itself and the social policies adopted to control it can be detrimental to victims by further straining an already stressful relationship and allowing for even more restrictive isolation of the victim. This isolation can, in turn, compromise victims' access to critical services, including health care services leading to an unrecognition and underestimation of violence. Specialized organizations worldwide have reported an increase in reports and calls for help from IPV victims, during the Covid-19 pandemic (Gupta, 2020; Newberry & Cruz, 2020; Parveen & Grierson, 2020; World Health Organization, 2020). However, these numbers may still be an underestimation of the true, facilitated by the greater control exerted by the perpetrator, the change and diminished availability of services, and the fear of contagion. Health care professionals must take any opportunity of contact to inquire about violence and patients' current safety, leading to an increase in the diagnose and provision of guidance to the victims.

IPV is a social, medical, and legal problem, requiring a combination of social, medical, and legal responses to address it. For most victims of IPV, informal contacts represent the primary system of detection and support (van Gelder et al., 2020). Community initiatives should be created and public media should be utilized to increase awareness of the increased risk of IPV during the pandemic, encouraging people to “check on their neighbors” (whilst adhering to social distancing regulations) (Telles et al., 2020; van Gelder et al., 2020). Social media can play a significant role by raising awareness and providing an indirect link to friends, family, and institutions during the lockdown, mitigating the psychological effects of isolation, and allowing victims to reach out for help if needed. Similarly, it is necessary to implement policies that increase awareness of health care professionals for their pivotal role in the assessment and support of the victims allowing them to offer information and referral safely (van Gelder et al., 2020). Routine screening for IPV can be opportunely implemented with any contact, including in Covid-19 testing sites (Anurudran, Yared, Comrie, Harrison, & Burke, 2020). “Safe words” and “Signal for Help” campaigns have been applied, facilitating the request for help during clinical contacts when safety conditions are not gathered (Bradley et al., 2020). The “Mascarilla 19” campaign, in Spain and Portugal, has already proven effective with three women requesting for help in pharmacies across Andalucia in the first week of its implementation (Oakley, 2020). Given the known association between IPV and psychopathology disorders, either in victims or in perpetrators, and the impact that the Covid-19 pandemic can have on their mental state, health care professionals should pay careful attention to their patients' mental stability, intervening to reduce the exacerbation of comorbid psychiatric disorders and therefore reducing the potential risk of violence (Telles et al., 2020). Finally, while legislation protecting victims of IPV will probably remain unaltered during the pandemic, it is essential to guarantee that access to legal services and police protection is not compromised. Governments should invest in a multidisciplinary approach and include IPV protective measures in their contingency plans. More robust data is still needed to define the impact of the Covid-19 pandemic, and each independent risk factor, on the prevalence and precipitation of IPV, allowing for the reformulation and development of social policies that minimize the impact.

4.1. Strengths and limitations

Selection bias can significantly permeate narrative reviews, especially in this context, when trying to apply a more generalized concept to a somewhat specific situation. By attempting to establish a connection between the risk factors for IPV and the increase in the reported cases during the Covid-19 pandemic, we may have selected aggregable more divulged reports, ignoring other significant factors. The still minimal research surrounding the consequences of the Covid-19 pandemic to IPV victims limits any definitive conclusion. In addition, the exclusion of more specific populations may risk to lead to an oversimplification of data. The application of general concepts and ideas to a minority population can be not only erroneous but also harmful. More robust and systematic work needs to be done in the future to understand the real impact of the different factors and diminish the possible bias introduced by this narrative approach. However, we hope that this work may serve as an initial reflection on the theme.

5. Conclusions

Understanding the dynamics of violence and risk factors associated with IPV can facilitate the discussion and understanding of how emergencies, like the Covid-19 pandemic, can influence and further exacerbate those factors precipitating episodes of IPV. Furthermore, the social policies adopted to control the virus can also compromise victims' access to critical services, including health care services, which need to be prepared to provide an adequate response. More robust data is still needed in other to clearly define the impact of the Covid-19 pandemic on victims of IPV. However, policies that seek to protect victims must constitute a priority in any contingency plan.

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