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Addressing Gender-Based Violence Using Evidence-Based Practices During COVID-19: The Case of Puerto Rico

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Abstract

As gender-based violence (GBV) surged during the COVID-19 pandemic, the 65th session of the Commission on the Status of Women (CSW65) called for member states, civil, and other stakeholders to consider the specific needs of women and girls in COVID-19 response and recovery efforts. Psychology provides scientific knowledge to help answer this call. Despite existing global guidance and psychological research to mitigate GBV, COVID-19 presents new challenges for consideration. This article summarizes existing GBV guidance/research and COVID-19 considerations, uses an illustrative case study to describe Puerto Rico's application of GBV guidance/research during COVID-19, and provides preliminary policy and practice recommendations.

Keywords

gender-based violence, cultural adaptation, trauma-informed care, United Nations, Commission on the Status of Women

Introduction

COVID-19 has exacerbated gender-based violence (GBV) and gender inequality resulting in dual pandemics (UN Women, n.d.; Mittal & Singh, 2020; United

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Nations High Commissioner for Refugees, 2020). One in three women worldwide will be abused during her lifetime (World Health Organization, 2021) and approximately 137 women and girls are killed by GBV per day (United Nations Office on Drugs and Crime, 2018). GBV disproportionately impacts women and girls from marginalized groups (e.g., those living with disabilities, living in poverty, trans women, ethnic/racial minorities) (Crooks et al., 2019). GBV also contributes to short- and long-term physical, mental, sexual, developmental, and reproductive health problems for women and girls and leads to high societal and economic costs (WHO, 2021).

COVID-19 has presented unique considerations and challenges for global efforts to mitigate GBV and existing evidence-based approaches to GBV intervention. Most recently, the 65th session of the Commission on the Status of Women (CSW65), the principal global intergovernmental body exclusively dedicated to the promotion of gender equality and the empowerment of women, called on Member States, civil society, and other stakeholders to take account of the specific needs of women and girls in COVID-19 response and recovery efforts. The call specifically spotlighted the surge in GBV and its disproportionate impact on existing obstacles to girls' and women's full and effective participation and decision-making in society (Commission on the Status of Women Sixty-Fifth Session, 2021). Due to a long-established role in GBV research, practice, and advocacy, psychology is well-positioned to respond to this call.

Despite much available GBV-related global guidance and psychological research, integrated approaches are needed to inform rapid adaptation to GBV mitigation during COVID-19. To address this gap, this article (a) presents global guidance and psychological approaches informing GBV supports for survivors during COVID-19; (b) utilizes a case study to illustrate the local application of these integrated perspectives and program adaptation during COVID-19; (c) provides preliminary lessons learned and recommendations to support the empowerment of women and girl survivors during COVID-19 and beyond; and (d) responds to CSW65's call to address the disproportionate impact of COVID-19 on women and girls.

Global Context and Guidance

In April 2020, the UN Secretary-General, António Guterres, released a policy brief outlining the effects of COVID-19 on the lives of women and girls. The findings demonstrated that in every area of life, women and girls had been disproportionately affected by the pandemic (United Nations Entity for Gender Equality and the Empowerment of Women & United Nations Secretariat, 2020). Women and girls suffered economically through loss of wages and jobs, propelling many into poverty; lost access to health care services; and decreased paid labor while unpaid labor increased. Due to the stress of lost income and employment, cramped living quarters, social isolation, and the restriction of movement and education of children at home, many women and girls became the targets of increased GBV (United Nations Entity for Gender Equality and the Empowerment of Women & United Nations Secretariat, 2020). The Secretary-General called on nations to prioritize their responses to women

experiencing GBV using evidence-based approaches. He encouraged States to include prevention efforts and services for violence against women as part of the COVID-19 response plan, including expanding access to domestic violence shelters and designating them as essential services, making online domestic violence services available, and providing safe spaces where people can report abuse and violence (United Nations Entity for Gender Equality and the Empowerment of Women & United Nations Secretariat, 2020).

In response to the Secretary-General's call to address the needs of women and girls, the United Nations Development Programme (UNDP) and UN Women developed the COVID-19 Global Gender Response Tracker to monitor how governments are addressing the COVID-19 crisis and to collect data through a gender-sensitive lens (UNDP, n.d.). In March 2021, UNDP published a fact sheet highlighting the progress made to date by governments with respect to developing policies through a gender-sensitive lens. According to the UNDP, many countries have made efforts to strengthen and expand the services provided to GBV survivors, such as expanding access to shelters and helplines; ensuring access to justice using technology (e.g., videoconferencing of court hearings, remote filing of requests for protection orders); partnering with community organizations to support survivors of violence; raising awareness of VAWG; extending social protections and economic support; and providing additional funding to address the needs of women and girls with disabilities and LGBTQI persons (UNDP, 2021).

Furthermore, UN Women recommends that COVID-19 responses align with the Sustainable Development Goals (SDGs), to ensure that rights of women and girls are promoted and protected. For example, pertaining to SDG5, Target 5.6, which aims to ensure access to sexual and reproductive health care, the UN recommends that "National-level committee decisions on COVID-19 must be made in consultation with groups working on women's rights and sexual reproductive health and rights to ensure consideration of best health practice recommendations" (Azcona et al., 2021, p. 24). Without this alignment, COVID-19 is on track to derail progress across SDGs and will disproportionately impact women and girls (Azcona et al., 2021). In a call to action, the CSW65 urged for members of civil society, member states, and other stakeholders to address the elimination of violence against women and girls as well as provide evidence-based practices (EBPs) that would lead to women's empowerment and sustainable development.

Psychological Approaches

The field of psychology has generated vast knowledge on the causes of GBV and effective approaches to mitigate GBV. For example, clinical psychology made important contributions at the individual level, including the development of effective trauma-informed interventions to treat GBV survivors (Sperlich et al., 2021); cultural adaptations to better serve individuals from diverse cultural backgrounds (O'Brien & Macy, 2016); and training and tools for mental health professionals to deliver effective treatment to survivors and/or perpetrators of GBV (Taft et al., 2016). Developmental

psychology has helped to identify adolescence as the most effective developmental stage for GBV prevention efforts (De Koker et al., 2014; Stöckl et al., 2014) and informed prevention efforts such as interventions to promote attitudes that prevent GBV (Lundgren & Amin, 2015). Social psychology GBV research has focused on the complex interplay between individual, relationship, community, and societal factors that place people at risk or protect them from violence (e.g., Anderson & Anderson, 2008; Hollomotz, 2009). For example, Rieger et al. (2021) recently explored this interplay within the context of intersectionality, defined as the holding of multiple and intersecting identities (e.g., Latina lesbian youth), and GBV. Their work concluded that effective GBV efforts must be tailored to address structural inequalities and include prioritization of resources and opportunities (e.g., economic, educational), especially for those with intersecting identities who are at increased risk.

The case study presented here is grounded in trauma-informed care (TIC). TIC is a psychological approach that *realizes* the direct impact that trauma can have on access to services; *responds* by changing policies, procedures, and practices to minimize potential barriers; fully integrates knowledge about trauma into all aspects of services; trains staff to *recognize* the signs and symptoms of trauma; and avoids any possibility of *re-traumatization* (SAMHSA, 2014). Despite TIC showing efficacy in addressing GBV (Menschner & Maul, 2016), psychology research and practice has identified the need for culturally informed TIC approaches (Ranjbar et al., 2020). Psychologists have made critical cultural modifications to traditional TIC, resulting in Trauma and Culturally Informed Care (TCIC). TCIC expands traditional TIC by specifically integrating a cultural lens. TCIC *realizes* the prevalence of trauma, individually and collectively, and the presence of strength and resilience; *recognizes* how trauma affects, directly and indirectly, all individuals involved with the program, organization, or system, including recognizing inner and collective growth; *responds* by putting this knowledge into practice by learning from the community, promoting safety and cultural wellness; and *resists* re-traumatization by drawing from cultural resiliency, traditional healing tools, and collective wisdom.

COVID-19 presents important considerations in the delivery of TCIC. First, many who experience GBV are part of marginalized communities with devastating and long histories of epidemics/pandemics. COVID-19 exacerbates historical and individual trauma from previous epidemics (Corless et al., 2020), resulting in heightened fear and distrust of systems that have harmed these communities. Second, the expanded use of telehealth, in of itself, can result in trauma and re-traumatization. Application of culturally and trauma-informed principles to telehealth should be considered to alleviate some of the potentially negative impacts and enhance engagement in care during COVID-19 (Gerber et al., 2020). Psychological approaches, especially centered around TCIC, when integrated with UN guidance provide important contextual considerations and strategies to enhance efforts to address GBV during COVID-19. These considerations and strategies will guide the following illustrative case study from Centro de Ayuda a Víctimas de Violación (Rape Victims Support Center, RVSC) in Puerto Rico.

Local Context and Population

In recent years, Puerto Rico has experienced a multitude of complex environmental and community stressors such as poverty, community violence, natural disasters, and public health emergencies, setting the stage for a significant rise in GBV during COVID-19. Pre-pandemic, 43.1% of the total population and 57% of children lived in poverty (Smyrnios, 2020); there was a rising wave of community violence; and ongoing disaster recovery from Hurricanes Irma and Maria in 2017 (Youth Behavioral Risk Factor Surveillance System and earthquakes in January 2020.

Pre-COVID-19, Puerto Rico was already grappling with rising rates of GBV. According to the UN, in 2019, Puerto Rico was among the five areas in Latin America and the Caribbean Region with the highest number of femicides (Economic Commission for Latin America and the Caribbean, 2020). Puerto Rico's Behavioral Risk Factor Surveillance System (BRFSS) data indicated a 100% increase in reports of sexual assaults among adults from 2015 to 2017, suggesting a possible effect of Hurricane Maria and its aftermath on GBV (Behavioral Risk Factor Surveillance System 2020). With respect to youth sexual violence, youth in PR had a higher incidence of being victims of sexual violence at some point in their lives when compared to national rates (9.1% vs. 7.1%) (YBRFSS, 2019). Moreover, a comparative analysis of the YRBSS-PR between 2017 and 2019 showed an increase from 2.8% to 4.7% in date rape among youth during the aftermath of 2017 Hurricane Irma and Hurricane Maria.

During COVID-19, GBV increased in Puerto Rico. There was a 62% increase in women being murdered from 2019 to 2020 (Santoni Ortiz, 2021). Program records from the Puerto Rico Department of Health indicate that women and girls experiencing GBV were not able to reach outside services; called emergency hotline services as the only immediate resource for help; reported increases in GBV due to partner substance use; and feared leaving their homes to seek a protective order or emergency services (Centro de Ayuda a Víctimas de Violación, Department of Health, 2021). Due to the preexisting high rates of GBV and increasing risk factors during COVID, a state of emergency was declared on January 25, 2021. Funds were earmarked to support a multipronged GBV mitigation approach aligned with UN guidance, and targeting (1) public awareness of GBV as a public health crisis; (2) evidence-based and culturally specific programs to end GBV and address risk factors; (3) prevention and intervention efforts at the individual and community levels; and (4) enforcement of legal protections.

Program Description

Centro de Ayuda a Víctimas de Violación (RVSC), a program of the Department of Health, has been a main provider of GBV treatment and prevention services on the island since 1977. RVSC provides free advocacy and psychological services to survivors; develops and implements safety and prevention campaigns; educates the public about GBV; and collects data on the problem of sexual and domestic violence in PR.

To be eligible for RVSC services, individuals must be a survivor of sexual violence, defined as sexual assault, incest, lewd acts, sexual harassment, child pornography, sexual harassment, human trafficking, obscene exposures, and/or spousal sexual assault. Individuals receive individual and group therapy; family members receive psychoeducation and conjoint sessions with the survivor (when appropriate); the survivor and family members are linked to support services and groups; and the survivor receives advocacy support for medical, legal, and social needs.

Survivors receive Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an empirically supported treatment to support children and adolescents (aged 5–18) and their parents or caregivers in the aftermath of traumatic experiences. It integrates trauma-sensitive interventions and cognitive-behavioral principles, and addresses post-traumatic stress disorder (PTSD), depression, and anxiety (Cohen et al., 2016). Research has found that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple, and complex trauma experiences. TF-CBT has been culturally adapted and implemented in many countries and cultures (Cary & McMillen, 2012).

Guided by existing research (National Child Traumatic Stress Network, 2008), RVSC culturally adapted TF-CBT to meet the unique needs of the client population. First, RVSC therapists assess and integrate several cultural constructs throughout treatment such as spirituality, traditional gender roles, and other common values in Latin culture such as familismo (e.g., dedication, commitment, and loyalty to family), and personalismo (e.g., valuing personal relationships over status, material gain, and institutional relationships). RVSC therapists are trained to be respectful of and responsive to cultural beliefs including norms for interpersonal interactions. Therapists are also trained to assess and address potential challenges to the development of strong therapeutic relationships, including previous interactions with mental health treatment providers or "the system" in general, as well as racism or discrimination. Since some research suggests a greater tendency to express somatic symptoms (e.g., aches and pains, lethargy) among Latinos experiencing depression and/or anxiety, therapists also integrate an informal assessment of somatization that is mindful of idioms of distress and culture-bound syndromes. Although not a specific "cultural risk factor," some communities have elevated risk factors for different types of traumas (e.g., community violence). Therefore, these risks are also addressed in treatment and attempts are made to reduce future exposure. In combination, these adaptations enhance the cultural relevance of TF-CBT for the RVSC client population.

Implementation

Due to the restriction on movement during COVID-19, TF-CBT in-person services needed to rapidly transition to telehealth. Therefore, all health-related services were provided via virtual video conferencing and phone. To enhance staff capacities to implement all RVSC services via telehealth, clinical staff completed telehealth training offered by the American Psychological Association (APA). APA offered this usually paid training for free to all providers during the COVID-19 crisis to aid the psychology community in their vigilant efforts to rapidly transition to telehealth. The training series

was an introduction to the ins and outs of real-world telepsychology and detailed the competencies needed for telepractice, including critical ethical, legal, clinical, and technical issues. Clinical staff also accessed free resources provided by the developers of TF-CBT to inform telehealth delivery. This training was complemented with internal staff discussion, review of the existing literature, and consultation with the community to gather guidance on specific local, cultural, and structural considerations to inform the transition to telehealth. The following research-based and community-generated priorities guided implementation during the rapid transition to telehealth: (1) linkage to and provision of remote culturally relevant education, support services, and safety resources (e.g., crisis hotlines and virtual groups); (2) consideration of social determinants of health (e.g., housing stability, food insecurity, discrimination in treatment access and engagement); (3) identification of religious/cultural champions who can inform and support safety planning virtually; (4) staff training in the historical-cultural context of pandemics for the communities they serve, including ways to identify and bolster cultural strengths that have historically supported these communities; (5) regular supervision of and consultation with support staff during the rapid transition; (6) enhanced evaluation efforts to assess the impact of COVID and the transition to telehealth services on needs and outcomes; and (7) a strategic plan to use evaluation findings to advocate for policy change and funding.

TF-CBT was delivered online and/or by phone during 30–65-minute sessions facilitated by RVSC counselors. Prior to starting TF-CBT, survivors and caregivers completed an assessment battery including the Child Behavior Checklist Inventory (CBCL), a widely used caregiver report form identifying problem behavior in children, and the University of California Los Angeles Post-Traumatic Stress Disorder (UCLA PTSD) scale, an instrument that assesses reactions to trauma in children and adolescents. Per the TF-CBT protocol, survivors receive 8–25 sessions of TF-CBT. Children and their caregivers meet individually with the therapist and later in the final phase of treatment, conjoint sessions are offered to work through the trauma narrative. This is an effective psychological technique used to help survivors of trauma make sense of their experiences, while also exposing the survivor to trauma-related memories, feelings, and situations to help reduce fear, anxiety, and avoidant behavior. TF-CBT's core components include psychoeducation, parenting skills, relaxation techniques, and cognitive processing. At the end of treatment, the assessment battery is readministered to assess change over time. This assessment will be part of a larger program evaluation assessing program impact on mental health symptomatology and overall functioning. Program evaluation was a critical component in our implementation plan and will be used to inform services, policy, and advocacy efforts at the community and governmental levels.

Below we include a brief survivor case example to illustrate the implementation and clinical considerations and application of psychological approaches during COVID-19.

Case Example

A 15-year-old female survivor of sexual abuse perpetrated by an adult male family member presented for care with her mother. She lived in a low-income community

and was referred by the police to the RVSC hotline, due to a complaint of sexual violence intra-family. Police filed the complaint, and the perpetrator admitted the crime. The survivor presented with complex trauma. In addition to the sexual abuse, she witnessed domestic violence in her early childhood, lost her house due to flooding during Hurricane Maria, and had been in a serious accident. At intake, she was living with her mother, brother, and stepfather. Her biological father was a positive source of support, often spending time with her on alternating weekends. Her major strengths included her academic performance and engagement in academic activities, her artistic ability and drawings (which she also sold to generate a small income for her family), and her participation on a sports team. Her main concerns at intake were the upcoming legal process, particularly fears about potentially having to confront the perpetrator; being isolated from peers because of remote schooling; suspension of her sports team due to COVID-19; poor communication with her mother; and low self-esteem. Although she suffered isolation from the lockdown and social distancing, this was further compounded by emotional and physical distancing from her mom, who had to continue working during the pandemic, and the loss of emotional support from her grandmother, who previously served as a mother figure but rejected her upon the revelation of the abuse. At intake, her CBCL results supported a diagnosis of depression characterized by anxiety, isolation, and social problems and her UCLA PTSD scale results supported a PTSD diagnosis.

At the start of treatment, COVID-19-related stressors included diminished access to friends and family; difficulties with technology and Internet access; and concerns that she wasn't learning as much in her remote schooling. In addition to the traditional TF-CBT curriculum, initial sessions were dedicated to help orient her and her caregiver to the telehealth platform and discuss and problem solve COVID-19-specific stressors. In the spirit of trauma-informed telehealth delivery, her therapist implemented trauma and culturally informed principles in new ways. For example, to address trauma-informed principles such as safety, the therapist suggested using headphones to enhance confidentiality and established adapted safety planning procedures. For example, if the survivor suddenly appeared frightened or concerned, the clinician was trained to ask yes or no questions such as: "Do I need to call 911? Do we need to disconnect? Do I need to reach out to your emergency contact?" or use a nonverbal gesture to communicate a safety concern. To address transparency, the therapist positioned herself in front of the screen, so the client could clearly see her body language. To address cultural considerations, the therapist worked closely with the client and family members to make telehealth more accessible. In addition, the therapist explored historical trauma related to the hurricane, allowing space to explore and process the event. The therapist also assessed and addressed SDoH needs that increased during COVID, including food insecurity, neighborhood safety concerns, and economic instability.

This survivor successfully completed 22 TF-CBT sessions. At the end of treatment, she had a reduction in depression and PTSD symptomatology (as measured by the CBCL and UCLA PTSD scale), was able to share her trauma narrative with herself and her mother with reduced anxiety and distress, returned to in-person schooling,

and resumed participation with her sports team. A primary treatment accomplishment was the new bond between mother and daughter as a result of parenting interventions and psychoeducation on trauma and sexual abuse, all delivered virtually. Although reduced, she was still experiencing some anxiety related to the pending case in court. It was agreed that she would follow up and complete booster sessions as needed to help support her through the court proceeding. The family reported that TF-CBT delivered virtually reduced worries about transportation as well as interruptions to her mother's work schedule and the associated financial impact, all of which would have been significant barriers to participation in care prior to COVID-19.

Recommendations and Lessons Learned

The following key recommendations and lessons learned came from the RVSC's TF-CBT work with GBV survivors during COVID-19:

- **Telehealth:** Consistent with the literature (Stewart et al., 2017), preliminary program evaluation findings suggest that telehealth can be effective in delivering TF-CBT. COVID-19 presented an opportunity to develop and implement telehealth to reach GBV survivors who previously had no access to metropolitan areas and regional offices due to geographical distance and lack of resources (e.g., transportation and childcare). Telehealth launched in response to COVID-19 addressed some of the preexisting access issues for this historically underserved population. Continued funding for and availability of telehealth and hybrid services post-COVID-19 are strongly recommended.
- **Technology access:** Access to technology is still a significant concern. Although a recent study suggests that most people on the island have mobile phones and Internet coverage, a closer look at the data shows access is not equally distributed around the island. For example, some data show limited coverage within the island's central region, suggesting an access disparity (Daly, 2020; Farjardo, 2020). Addressing the digital divide is crucial, especially as COVID-19 persists and many critical services/supports have quickly transitioned to telehealth. Governmental and public–private partnership efforts are needed to ensure equitable access. Efforts in this direction are well aligned with recent calls for universal Internet access and a growing understanding that almost every aspect of the UN's SDGs depends upon access to broadband connectivity, the Internet, and digital platforms (Bamford et al., 2021).
- **Evaluation:** The preliminary program evaluation suggests that teletherapy could be an effective alternative or addition to in-person service for GBV survivors receiving TF-CBT. More robust research, including control group comparisons, is needed to fully assess the effectiveness of GBV teletherapy services during COVID-19. Due to limited resources island-wide, funding often is not available to support more robust research and evaluation. Community–university research partnerships may be a cost-effective way to further support the development of robust evaluations to inform policy during COVID-19.

- **Adaptation of evidence-based interventions:** Despite psychology's contribution to the cultural adaptation of EBPs, additional modifications may be needed for younger survivors who have differing developmental needs and survivors living with disabilities who have unique considerations impacting participation and engagement in telehealth during COVID-19 and beyond. Significantly more research is needed to inform the adaptation of EBPs to meet the needs of individuals with multiple and intersecting marginalized identities.
- **Vicarious trauma:** During a public health emergency, staff are experiencing extreme stressors as well. They are at risk for a host of psychological challenges themselves, including depression and anxiety. Due to the nature of the work, there is an elevated risk for burnout and compassion fatigue. It is recommended that organizations center trauma-informed workforce wellness during COVID-19 and post-recovery. Suggested strategies include centering workforce equity and inclusion in decisions and communications about any practice and procedural changes; uplifting and supporting workforce resilience and strengths; and creating avenues for staff to confidentially request and access accommodations (e.g., flex time, childcare, basic needs such as food).
- **Policy:** A recent executive order (Gobierno de Puerto Rico, 2021) in Puerto Rico promotes nationwide GBV prevention and intervention policies to enhance resource mapping, capacity building, and public awareness of gender equity principles. There is a critical need for these types of policies in the community. In addition, policies supporting enhanced collaborative networking between agencies and training of first responders on GBV will facilitate much more rapid identification and referral for GBV survivors.
- **Training:** As COVID-19 unfolded, leading training and professional organizations quickly provided training and consultation free of charge (e.g., American Psychological Association). This was extremely helpful, especially for low-resource settings that do not have equitable access to ongoing health professional training. Post-COVID-19, these organizations should continue to provide equitable access to training and consultation for low-resource settings.
- **Infrastructure:** The existing GBV infrastructure is inadequate to meet the projected increases in GBV as the pandemic persists (Blofield et al., 2021). Governments should ensure stable funding to support investments in further infrastructure for emergency services; first-response services; shelters; and gender-sensitive social protection programs including housing, economic supports, counseling, and vocational/educational training.

Conclusion

The COVID-19 pandemic has compounded the preexisting epidemic of GBV. Integration and application of psychological approaches and global guidance can greatly inform GBV mitigation at the local, national, and international levels. Continuing to tackle these issues using evidence-based interventions will help

to empower women and girls, providing them with an agency that will ensure they are not left behind as the global community seeks to build back better. As scientists predict future COVID-19 waves and pandemics, rapid dissemination of case examples, lessons learned, and recommendations can help practitioners, researchers, and policymakers better serve diverse survivors, families, and communities impacted by GBV during COVID-19 and beyond.

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