

# Practice in a Time of Uncertainty: Practitioner Reflections on Working With Families Experiencing Intimate Partner Violence During the COVID-19 Global Pandemic

Susan Heward-Belle<sup>1</sup> , Renee C. Lovell<sup>2</sup> ,  
Jennifer Jones<sup>2</sup>, Hayden Tucker<sup>1</sup>,  
and Nina Melander<sup>1</sup>

Affilia: Feminist Inquiry in Social Work  
2022, Vol. 37(4) 605-623  
© The Author(s) 2021



Article reuse guidelines:  
[sagepub.com/journals-permissions](https://sagepub.com/journals-permissions)  
DOI: 10.1177/08861099211055519  
[journals.sagepub.com/home/aff](https://journals.sagepub.com/home/aff)



## Abstract

This paper reports findings of a qualitative study examining the perceptions of 21 Australian women professionals who conduct home visiting with families experiencing intimate partner violence. There is scant evidence documenting how home visiting professionals adapted practice to address the safety concerns of women and their children within the context of the pandemic. Practitioners noted an increase in the risk level and complexity of intimate partner violence (IPV), including the ways that perpetrators weaponized the pandemic to exert power and control over women and children. Practitioners reported on their rapid adaptation of practices, to ensure the continuation of services which included moving to online delivery methods, wearing PPE, and negotiating practice from a distance. While responses to these changes were mixed, most reported their desire to continue to use online platforms post-pandemic, reporting increased safety, flexibility, and accessibility for the majority of clients. This research addresses a gap in respect of professionals' perceptions of the issues facing survivors of IPV and of their professional practice during the COVID-19 pandemic. As policies, practices, and protocols continue to adapt to the challenging environment posed by the pandemic the experiences of professionals and service users are critical to inform these changes.

## Keywords

children, COVID-19 pandemic, intimate partner violence, practitioners, research categories, social work/social welfare history and philosophy, women

---

<sup>1</sup> University of Sydney, Sydney, Australia

<sup>2</sup> NSW Health, New South Wales, Australia

## Corresponding Author:

Susan Heward-Belle, Social Work and Policy Studies, University of Sydney, Room 736, Level 7, Education and Social Work Building (A35), Sydney 2006, Australia.

Email: [susan.hewardbelle@sydney.edu.au](mailto:susan.hewardbelle@sydney.edu.au)

## Background

On January 25, 2020, the first case of novel coronavirus 2019 (COVID-19) was reported in Australia. The World Health Organization (WHO) declared COVID-19 a global pandemic on March 11, 2020, and 1 week later, a human biosecurity emergency was declared. Globally, as of September 28, 2021, there have been 232,075,351 confirmed cases of COVID-19, including 4,752,988 deaths reported to WHO (WHO, 2021). Since the first case was detected in Australia, Commonwealth, state, and territory governments have adopted numerous public health strategies to reduce disease transmission.

While strategies including social distancing, isolation, quarantine, and shelter in place orders were successful in “flattening the curve” (Evans, 2020) during the first wave, they have also illuminated pre-existing inequalities, shining a light on gender-based inequality, and, in particular, violence against women. It is acknowledged that not all intimate partner violence (IPV) involves male perpetrators and women victims/survivors, however, based on the fact that such a pattern accounts for most IPV, that is the focus of this research paper. Sánchez et al. (2020) argue that women have borne the brunt of the pandemic through the multiplicity of roles assigned to them, which heightens their exposure to situations that adversely impact their physical and mental health. For example, in the public arena, women comprise 70% of global frontline health professionals (Miyamoto, 2020). In the private arena, women disproportionately perform the bulk of caregiving and child-rearing work within families, with many also being the sole economic providers for their families. Through these multiple roles, many women are enduring human rights violations and high levels of stress in both the public and private arenas.

The multiple roles women have in the private and public arenas are of particular relevance for this article which examines the human rights violations which have been inflicted against women and children survivors of IPV in the private arena during the pandemic. It also examines the experience of women social workers and health professionals in the public arena who attended to the needs of survivors within a context of significant stress and uncertainty. This article reviews the emerging literature about IPV during the pandemic, as well as drawing upon the pre-pandemic knowledge base about violence against women. The paper then turns to report the findings of a qualitative study informed by an intersectional feminist analysis that explored the perceptions of 21 Australian women social workers and health professionals working with women and children experiencing IPV during Australia's first government ordered “lockdown” in April–May 2020, during the “first wave” of COVID-19.

Three years before the declaration of a biosecurity emergency, violence against women in the private domain had already been declared a national pandemic in Australia with approximately one in four Australian women (or 22 million) having experienced at least one incident of violence perpetrated by an intimate partner (Australian Bureau of Statistics, 2018). In the public domain, feminists declared another national problem, namely the chronic under-resourcing of legal, health, and social services to prevent and address violence against women generally and violence against women from underserved communities in particular (Summers, 2021).

## *Prevalence of Violence Against Women During the COVID-19 Pandemic*

UN Women (2020) used the phrase “the shadow pandemic” to refer to the high rates of violence against women during the pandemic. Countries with high numbers of reported COVID-19 cases such as the United States, Argentina, France, Italy, Cyprus, and Singapore reported increased rates of IPV since the outbreak (UN Women, 2020). Evidence for increased rates has come from administrative data including police reports, requests for assistance made to emergency services, women's refuges, and hotlines/helplines.

An online survey of 15,000 Australian women found that 8.8% had suffered physical or sexualized violence perpetrated by current or former cohabitating partners since the pandemic began and

22.4% experienced emotionally abusive, harassing, and controlling behaviors (Australian Institute of Criminology, 2020). Many of these women indicated that this was the first time that their (ex)partners had used violence against them. Women who had experienced IPV prior to the onset of the pandemic indicated that the severity and frequency of physical, sexualized violence, and coercive control had increased since the pandemic.

Men who use violence and coercive control have adapted and/or adopted new tactics to exert power and control over (ex)partners and children. Exploiting fear about the contagion—including transmission and effects has been identified as an additional tactic deployed by perpetrators to isolate women at home and to separate them from social supports (Kofman & Garfin, 2020). Similarly, perpetrators have exploited survivors' anxiety about increased police surveillance in the community and other public health measures deployed by the state to reduce the spread of the virus (Neil, 2020). Women survivors from marginalized communities are at increased risk of being oppressed by such tactics, particularly if they are migrants who have fled countries with oppressive regimes and fear the police and government officials (Cleaveland & Waslin, 2021). The same authors also found that survivors who are not fluent in English may not be provided with up-to-date health advice in their language, particularly when the health directions are continuously changing in accordance with the changing nature of the pandemic. In Australia, where the vaccine roll out has been slow and the public has received contradictory information about the safety of the main vaccine commissioned for use from prominent government officials and medical experts, perpetrators may exploit survivors' vaccine hesitancy to limit their and children's access to vaccines. Threatening to lock survivors out of the house so that they are vulnerable to catching the disease and/or blaming survivors for infecting family members are new tactics commonly reported by callers to the U.S. National Domestic Violence Hotline (Godin, 2020). Perpetrators may also limit (ex)partners' financial, health, legal, and social supports. Many survivors from migrant backgrounds are unable to leave and return to Australia due to the toughest government restrictions on travel and border control seen within OECD nations.

### *Increased Complexity: The Intersection of IPV, Mental Distress, and Substance Misuse*

Domestically violent men were reported to have increased their misuse of substances such as alcohol during the first year of the pandemic (Finlay & Gilmore, 2020). Similarly, increased reports of people experiencing mental distress within the context of the global pandemic have been received from many countries across the globe (Goh et al., 2020). The authors argue that serious psychological repercussions such as fear, frustration, and boredom are associated with post-traumatic symptoms, anxiety, and depression during social isolation periods, which are “closely associated with domestic violence, and add to the catastrophic milieu” (Goh et al., p. 612). However, it should be noted that men who use violence and control are well known to deny, minimize, and justify their behavior—often implicating substance misuse and/or mental health issues to excuse abusive behaviors (Heward-Belle, 2016).

### *Consequences of IPV in the Context of the Pandemic*

An emerging body of evidence indicates that the impact of men's violence and coercive control on women during the pandemic has resulted in more severe physical and mental health outcomes for victims/survivors. In the United Kingdom, deaths resulting from domestic abuse reportedly doubled when compared with the average rate over the last decade (Grierson, 2020). Studies conducted in U.K. hospital settings found an increase in the proportion of serious injuries—including head injuries—resulting from both IPV and child abuse during “lockdown” periods (Sidpra et al., 2020).

During the pandemic, higher rates of mental distress and ill-health have been reported, which when coupled with the challenges of accessing safety and support services has resulted in serious consequences for many women (Pierce et al., 2020). Pre-COVID-19 there was a substantial body of evidence demonstrating that women who were abused by current or former partners experienced higher levels of mental distress, mental ill-health, suicidal ideation, and suicide than women who were not abused (Singh-Chandan et al., 2020). Before the pandemic, survivors' efforts to achieve safety in many countries were already hampered by inadequate legislation, poor public policies, and inadequate resourcing of services to prevent and address IPV. COVID-19 has shone a light on the implications of austerity measures and patriarchal structures which devalue women and their labor, particularly in respect of the consequences of under-resourcing of services to prevent and address IPV (Krishnadas & Taha, 2020).

### *A Double-Edged Sword: Public Health Measures to Reduce the Spread of COVID-19*

Emerging research examining the potential impact of public health measures designed to reduce the spread of the disease has raised serious concerns about the impact of locking down women and children who experience IPV—effectively confining them with men who use violence and control. Feminists have long argued that the home is an unsafe place for many women and children (Scutt, 1983)—an argument recently confirmed in a United Nations Report (UNODC 2018) that concluded that home is one of the most dangerous places for women. Being unable to leave the home to access supports and services has magnified pre-existing safety and wellbeing concerns of women subjected to IPV. Google searches about domestic violence rose 75% in the first weeks of lockdown in Australia (Hegarty & Tarzia, 2020). The largest domestic abuse charity in the United Kingdom reported an 800% increase in calls for assistance during lockdown when compared to pre-lockdown statistics (REFUGE, 2020). The UN Population Fund (UNFPA, 2020) estimated that 6 months of lockdowns could result in an additional 31 million cases of gender-based violence.

### *Rapid Legislative, Policy, and Practice Responses and Experiences of Front-Line Professionals*

Australian Commonwealth, state, and territory governments swiftly enacted a raft of policy and legislative decisions in relation to preventing the spread of the disease, some of which aim to address IPV during the pandemic. The Australian Government announced \$150 million in extra funding to support Australians experiencing domestic, family, and sexual violence. In New South Wales, where this research took place, the liberal government enacted the COVID-19 Legislation Amendment (Emergency Measures) Bill in March 2020 that contained broad amendments that changed the way that professionals in health, justice, community services, corrections, and other areas of public service responded to individuals—including those experiencing IPV.

Changes included a greater reliance on technology, including the use of audio-visual links in health care and counseling settings, courtrooms, correctional facilities, and child protection services. Provisions were made to extend protection orders from 28 days to 6 months. Additional supports were made available for people experiencing homelessness—many of whom are survivors of IPV. Health strategies were put in place to protect Aboriginal and Torres Strait Islander peoples—who experience higher rates of ill-health and health inequality because of racism and oppression. The use of masks and other Personal Protective Equipment (PPE) were used in a variety of settings—including but not limited to hospitals and other health facilities.

Telehealth-type strategies were swiftly deployed to enable people to engage with health professionals over computers, tablets, phones, and other electronic devices. Sanchez and colleagues

(2020) summarized challenges faced by professionals who work with people experiencing IPV, which included developing strategies to assess safety, verify privacy, and facilitate online security. Practitioners around the world developed creative ways to assess danger with survivors including using symbols, hand gestures, and particular words to denote danger. Practitioners also grappled with the ethical issues raised by the rapid introduction of online counseling and therapeutic (OCT) services including how to effectively obtain and ensure consent, assent, and safety (McVeigh, and Heward-Belle 2020). Numerous national and international guidelines have been produced in an effort to provide guidance to health professionals working at the front lines with families experiencing domestic and family violence (UN Women, 2020; WHO, 2020).

Concerns for the wellbeing of professionals caring for victims/survivors during the pandemic have also been the focus of attention in the literature and constitute a feminist issue. Social workers and other practitioners responding to families experiencing IPV are predominantly women (AIHW, 2020), many of whom were directed to work from their homes during lockdown periods, raising particular concerns about their safety and wellbeing. During lockdown periods when children were participating in online schooling, women were overwhelmingly responsible for the care of children, many of whom needed time and attention in order to engage in online learning opportunities. Women professionals juggled multiple roles, conducting sensitive and often traumatic online counseling or support sessions with victims of IPV without the benefit of a work/home divide to provide space between multiple roles. Unsurprisingly, working women experienced higher levels of psychological distress than working men (Xue & McMunn, 2021).

Internationally, 90% of respondents to a global survey of health service providers reported increased stress levels (Semaan et al., 2020). Professionals deemed to provide essential services who were required to continue providing a face-to-face service to patients and/or clients reported experiencing additional levels of stress associated with concerns for their own health and safety. A survey conducted by the U.K. Royal College of Midwives (Royal College of Nursing 2020) found that 35% of midwives disclosed feeling unsafe on the job, mostly due to the lack of sufficient supplies of PPE; 54% indicated that they felt unsafe entering patients' homes. Surveys with midwives from other parts of the world including Bangladesh, Ethiopia, and Iran reported similar concerns (Green et al., 2020).

Emerging research into the impacts of the COVID-19 pandemic on survivors of IPV indicates that intersecting factors including mental health, substance use, as well as swift policy and legislative change have intensified perpetrators' means of coercive control (Kofman & Garfin, 2020). Further, pre-existing gender inequalities in both the public and private arenas have been compounded by changes to work and school arrangements, impacting both survivors of IPV and the women social workers and health professionals who provide care and support to survivors. Johnson et al. (2020) argue that it is imperative that research investigates the perceptions of service users and professionals about their experiences during the pandemic in order to apply insights about current responses to future outbreaks. Thus, this article reports on the findings of a qualitative study that aimed to explore women professionals' perceptions of survivors' experiences of IPV and their experiences of practicing during the first wave of the pandemic.

## Method

This paper draws on qualitative data collected from a larger action research study designed to simultaneously investigate and build the capacity of professionals who work with survivors of IPV in a local health district in Sydney, New South Wales, Australia. In-depth, semi-structured interviews were conducted with 21 women health professionals. Informed by feminist research principles that aimed to create a collaborative, shared discussion minimizing power differentials (Reinhartz,

1992), the following anchor points were used to guide the discussion between researcher and participant:

- Have the key issues facing survivors of IPV who access your service changed since the COVID-19 pandemic began and public health orders were introduced? If so, how have they changed?
- What are the barriers and facilitating factors to effective practice with survivors of IPV within the context of the COVID-19 pandemic and public health orders?
- How have you experienced your work with survivors since the first wave of the pandemic and the introduction of public health orders?

The goals of this research align with the goals of feminist social work research more broadly in the sense that both are concerned with “producing useful knowledge that will make a difference to women’s lives through social and individual change” (Letherby, 2003, p. 317). Theoretically, the research was informed by intersectional feminist perspectives (Crenshaw, 1991). This approach was selected because it attends to the diversity of women’s lived experiences and complex identities, particularly as they are constituted within and between various social divisions, frequently but not exclusively including, race, class, ethnicity, and sexual orientation with gender. This approach was important as the research aimed to understand the diverse and complex experiences of women both as survivors experiencing IPV and as professionals providing care and support.

### *Participants*

Participants were recruited from health and human services agencies across New South Wales, Australia. To be eligible to participate in the study, practitioners had to be employed at an agency that provided home visiting services to women and their children who had experienced or were at risk of experiencing IPV. Participants working within home visiting services in the local health district were sent a flyer describing the study. Interested professionals contacted the researchers to indicate their willingness to participate in the study. Interested participants were sent a Participant Information Statement, and those who chose to participate signed a consent form. Practitioners from a variety of fields of practice participated in the study: five were employed by non-government family support services; two by statutory child protection services; 13 by the state-based health services; and one by a private hospital. Eight participants were social workers, three were nurses, two were specialist Aboriginal workers, and one was a specialist multi-cultural worker. Seven participants did not identify their educational degree. All professionals were women. Participants consented to participating in the study, which was approved by and complied with all requirements of the (ANONYMOUS Research and Ethics Committee).

### *Data Collection and Analysis*

Data was collected via qualitative in-depth, semi-structured interviews conducted between April and May 2020 occurring at the time when New South Wales experienced its first “lockdown” during Australia’s “first wave” of the COVID-19 pandemic. Participants were given a choice about whether to participate in a face-to-face interview over Zoom technology or a phone interview. Interviews were conducted over Zoom with 21 participants. Interviews were audio-recorded using Zoom technology with participants’ permission and audio files were transcribed. A doctoral-level qualified social worker reviewed all interview transcripts.

Qualitative data was organized into themes, following thematic analysis techniques described by Braun and Clarke (2006). Coding was used as a way to link data to ideas and ideas back to supporting data and involved reading and rereading each interview and categorizing the text into emergent

categories and subcategories. NVivo12 was used as a data management tool that assisted the analysis of qualitative data collected.

Initially, three broad themes were identified which included (1) accounts of key issues faced by survivors, (2) barriers and facilitating factors to effective practice, and (3) accounts of working with survivors. Subcategories within each code were also developed and are listed in Box 1.

**BOX 1. Themes and subthemes are identified through thematic data analysis.**

1. Accounts of key issues faced by survivors  
Subcategories include increased violence, exploiting the contagion as a tactic of coercive control, increased complexity of issues experienced by survivors and their families, experiences of Aboriginal and/or Torres Strait Islander women and their families, experiences of culturally and linguistically diverse families
2. Barriers and facilitating factors to effective practice  
Subcategories include working within a fragile system, providing a rapid and innovative response in the face of increased complexity, relying on technology, staying physically safe, confidence, comfortability, and democratizing practice.
3. Accounts of working with survivors  
Subcategories include fear, anxiety and concerns, work–home life imbalance, avoiding vicarious traumatization, optimism, and future practices.

## Findings

This section details the three broad themes and subthemes, beginning with the first broad theme: professionals' accounts of the key issues facing survivors in the context of the pandemic.

### *Professionals' Accounts of the Key Issues Facing Survivors*

*Increased Violence.* Most participants indicated that they perceived the majority of the women they worked with experienced increased rates of violence, with particular groups of women being at higher risk. Participants who worked with Aboriginal and/or Torres Strait Islander people perceived that the rate of IPV had increased dramatically in their communities. An Aboriginal Health Worker indicated that in the clinic in which she worked, there had been a “definite spike” in the number of women disclosing IPV. She hypothesized that this was largely due to pre-existing IPV, stress, and overcrowding whereby “everyone (is) on top of each other and it just ends up exploding when they're together all the time let alone if they've got, you know, DV problems to start.”

Some participants perceived that perpetrators of IPV were using sexualized violence against their (ex)partners more frequently than they had in pre-pandemic times. Two social workers who worked in adult sexual assault services indicated that there had been an increase in women presenting to their services due to sexualized violence that had occurred in the context of IPV. At the same time, they indicated that there had been a decrease in the number of women accessing their services due to sexualized violence that occurred in other contexts commonly seen pre-pandemic such as “tinder dates and parties.” They hypothesized that this may reflect a reduction in people engaging in social activities due to public health orders.

*Exploiting the Contagion as a Tactic of Coercive Control.* Most participants reported that they had observed changes in the coercively controlling tactics deployed by perpetrators which exploited the fear and uncertainty caused by the outbreak and public health measures. Women reported to participants that their partners were disallowing them from leaving their house even to go out for exercise and were spreading misinformation about the virus and public health orders to family members.

Survivors disclosed feeling that they were under increased control through perpetrators' questioning of their movements and surveilling of their technology. The increased use of children as a tactic of power and control was noted, whereby some men were disallowing them to return to their mother's home after contact, claiming that children were more likely to be infected with the virus in their mother's "negligent" care.

In some instances, women's distress and substance misuse related to IPV increased due to the uncertainty and fear surrounding COVID-19. This created a perfect storm for perpetrators to cast aspersions on women's mothering as the following comments from an allied health worker illustrate:

She's been the primary carer for his first 12 months of life and more recently – she's got some mental health issues but the child's been spending more time with his father. There has been in the past reported DV and he's got some mental health, drug and alcohol issues as well. He's taken the child and refused to give the child back, and mum has started drinking more and is coming in a more hopeless state or place. I could see as it was being discussed in our case review yesterday that there was a risk for this father to be set up as the protective parent because he's taken care of the little boy, because the mum is drinking too much and he's stepped in and he's doing the right things whereas, actually this mum has been the primary carer.

Some participants noted that perpetrators were increasing their use of gaslighting as a tactic to destabilize women who had a history of anxiety, which was compounded by the pandemic. The following comments from a health worker illustrate how this tactic was directed at discrediting women's mothering to professionals:

Part of his threats or part of the way gaslights her was to say that she was, that people would say she's an unfit mother, she would be hospitalised ... there was all this focus on how she was going to parent when she was crippled with anxiety, yeah. I think it became part of the manipulation and part of the control.

*Increased Complexity of Issues Experienced by Survivors and Their Families.* Participants perceived that the issues faced by survivors were more complex than in pre-pandemic times. They described working with survivors who were dealing with the challenges of living with IPV, which were compounded by increased rates of emotional distress and/or substance misuse at a time when they had decreased access to supports and services. This situation was further complicated by the fact that many families were dealing with job losses, economic uncertainty, and decreased access to safe and stable housing. This complexity was described by a family support worker working with women from culturally and linguistically diverse backgrounds:

They basically tell me that they've been crying literally non-stop, a lot are suffering with insomnia ... there is a lot of anxiety even those who manage to escape their partner ... their partner or their former partner, is finding other ways to get to them. I have one client whose son has massive fear towards COVID ... as soon as the breakout, he refused to step out of the house, he gets really scared at night he can't sleep himself either.

Many participants believed that the complexity of issues experienced by survivors was related to the fact that perpetrators were at home more often and for longer periods of time, were experiencing increased levels of anxiety and depression, and were misusing substances. Job losses, financial stress, and the closure of men's services like men's behavior change programs were perceived to be contributing to increased levels of emotional distress and substance misuse by men in many families. Many participants opined that these factors combined created a fertile breeding ground for male violence against women and children.



*Experiences of Aboriginal and/or Torres Strait Islander Women Survivors.* Many participants who worked with Aboriginal families described how First Nations women experienced additional responsibilities due to cultural protocols requiring them to provide and care for family members who requested help or came to stay, as described below by a child protection counselor for Government Health:

One of the mum's said "I've got a whole lot of people in my house," that sense of responsibility to your family still—well it's a higher priority than the concerns around COVID. So if your family turned up, it was you had to take them in rather than say, "oh no, I can't because of COVID."

Participants commented that many Aboriginal and/or Torres Strait Islander survivors were worried about the potential early release of prisoners, including (ex)partners who had received custodial sentences due to IPV. Concerns about the impact of changes to contact arrangements were expressed as the following quote by a health service manager illustrates:

Caseworkers weren't providing the service that they would typically do in terms of supervision in person. We were seeing very odd decisions being made around family members all of a sudden being asked to supervise child contact, if not in person, over FaceTime. One particular family where they would have typically been in-person contact supervised by an agency, it went to FaceTime supervised by a grandparent. That then brought the perpetrator into the home via the screen for the mum.

Participants who worked with incarcerated Aboriginal women indicated that their clients experienced increased levels of distress, loneliness, and isolation due to measures taken by Corrective Services who "went down to skeleton staff." A senior NGO manager indicated that this exacerbated women's isolation because "inmates had longer periods ... where they have to stay in their cells. So, there were limits on being able to get out even into the exercise areas, very limited programs and activities, as well as no visits."

Moreover, participants who worked with First Nations families in rural and remote areas indicated that pre-pandemic social problems such as overcrowded and inadequate housing, lack of access to affordable and nutritious food, and lack of technology and connectivity exacerbated the stress and trauma experienced by First Nations people. For example, a senior manager with an NGO said:

Just a standard item like bananas are probably around triple the price ... prices went up ... there were massive shortages of food ... what happened out here in Western NSW, as it went crazy in Sydney, these buses with trailers came out and raided our supermarkets.

Other participants indicated that a number of First Nations children, many of whom who were already educationally disadvantaged, fell further behind due to online, home-based learning with many not having access to required technology nor stable internet connections.

*Experiences of Culturally and Linguistically Diverse Families.* Participants working with culturally and linguistically diverse families indicated that they faced additional issues at this time. Participants indicated that the pandemic illuminated pre-existing cracks in the system that made it difficult for survivors to access appropriate support services. Some practitioners indicated that their clients, particularly those from Asian countries, had experienced higher than normal levels of racism and were blamed for the pandemic.

Many participants worked with CALD families living in one of Sydney's most culturally diverse areas. Demographically, people in this area experience low socio-economic status, and many works in essential services like construction, food distribution, cleaning, and transport. As a result, many did not have the luxury that White-collar workers had to work from home. Adding to this complexity was the fact that many lived in multi-generational families where English is not the first language. The

distribution of health messaging in multiple languages via appropriate cultural communication channels was slow, whereas the spread of the virus was swift in these communities.

### *Barriers and Facilitating Factors to Effective Practice*

Participants identified barriers to effective practice with survivors within the context of the pandemic, which included working within a fragile system, being expected to provide a rapid and innovative response, and providing technology-facilitated services. They also identified some facilitating factors.

*A Fragile System Laid Bare.* Most participants described how the pandemic illuminated the fragility of the fragmented, neglected, and under-resourced legal, health, and social service system which was already failing IPV survivors. This sentiment was best described by a domestic violence counselor:

There aren't enough beds for women. There isn't enough housing for women. They've got to wait too long to get a house or a bed. Just not enough access to money ... structurally, there were real concerns around the police and that people would no longer be held in bail. They would just be released into the community, so that was a real fear. And often, women weren't told when they were being released ... the delay in all the court proceedings which is so anxiety provoking ... The Family Law Court set up a special COVID court ... but there were real delays.

Given the macro-level problems with the legal, health, and social service system that existed in the pre-pandemic environment, participants found it particularly challenging to rapidly pivot towards innovation in a context of resource scarcity. Many social workers who participated in this research also reported feeling unable to voice concerns about the fragility of the system and its often poor response to survivors of IPV. Interestingly, many perceived their participation in this research study as an act of resistance which enabled them to have a voice and to speak openly about the problems within the system.

*Expectations to Provide a Rapid and Innovative Response.* Public health orders to stop the spread of COVID-19 required them to rapidly adapt existing practices and/or create new practices in order to respond to survivors in the face of increased complexity. Participants who were skilled and confident at engaging survivors through face-to-face communication had to rapidly learn new skills with limited training or preparation in order to provide COVID-19 safe services—including providing online counseling and therapeutic services and engaging with service users while wearing PPE.

*Relying on Technology.* Many practitioners found technology-facilitated work to be a significant barrier to effective engagement with survivors. Reasons for this included problems with technology, difficulties sending and receiving non-verbal communication, challenges associated with assessing risks in the environment and providing a buffer between counseling and domestic spaces. Sexual assault counselors indicated that they found Zoom to be “highly problematic” because it precluded them from being able to feel as “present” and to attend to the non-verbal communication cues such as “reading people’s body language.” A senior social worker in a hospital domestic violence service described a client’s concerns about OCT:

It would have been dreadful though, the videoing ... that's how I would have met you when she'd walked into the hospital, she said “your presence, knowing I was safe, that things were contained, I would have never got that over a video, over a Zoom.”

Many participants indicated that they had concerns for survivors' safety when communicating about IPV through technology-facilitated means. Specific concerns related to participants' uncertainty around who might be listening to private conversations. A common concern was the potential for survivors to be at risk if perpetrators listened in on confidential conversations particularly in relation to developing safety or exit plans. Participants were also concerned about the impact on children if they overheard adult conversations about IPV and trauma.

*A Difficult Balance: Staying Physically Safe and Being Emotionally Available.* Practitioners who worked within a hospital or health setting were required to wear PPE, which many believed posed challenges to engagement with people who had experienced trauma. Many expressed the view that while PPE created an effective viral barrier, it also created a barrier for women-centered, trauma-informed engagement with survivors of violence and abuse. Despite the barrier PPE created, a sexual assault social worker described her process of trying to "humanize" this experience for her clients despite her concerns:

When I go and there's a victim at ED usually I'll show them my face first and show them the mask and then explain that I have to ... but I do think you can't see someone's facial expression ... we've been told if a patient is presenting after a sexual assault but they also have flu symptoms then we're supposed to be completely in PPE and I just can't see how that would be reassuring to anyone to be counselled from 1.5 metres distance, completely suited up.

Similarly, a social worker working in a multi-disciplinary team indicated that despite the challenges she was grateful for the opportunity to go into survivors' homes. She recalled how she "didn't really feel human" when she went into homes "all masked up" but felt it "was still so much better than just calling everyone up on the phone." However, some workers indicated that they did not have access to suitable PPE which left them feeling highly vulnerable.

*Facilitating Factors.* Despite the challenges and facilitating factors, many participants stressed that the purpose of their work had not fundamentally changed, which enabled them to confidently work with survivors. Many believed that technology enabled them to effectively continue their work with survivors in these difficult times.

Participants indicated that it was "time consuming and hard work" to reorient their practice towards delivering online counseling and therapeutic services but was worth it, as many believed that the provision of such services had increased some survivors' sense of confidence enabling them to provide honest feedback to workers. For example, a social worker described how she believed that the "protection of the screen" had enabled a family to be "really direct in their criticism of their child protection worker." The social worker was of the view that the family would not have done this in a face-to-face setting.

Another domestic violence social work manager indicated that survivors had told her that they felt safer disclosing and discussing their experiences of IPV in the safety and comfort of their own home. Another senior social worker in a government hospital indicated that she felt that online counseling and therapeutic services had democratized practice by creating a "middle ground or area for negotiation and recognition of the challenges and barriers that our clients face." She believed that practitioners were now demonstrating more creativity and flexibility about how to "meet the needs of the clients and promote engagement rather than expecting the client to come to us"—something that she considered to be a "silver lining" of the pandemic.

Participants who worked closely with culturally and linguistically diverse communities noted particular facilitating factors that helped survivors access supports and services. A domestic violence worker at a family support service noted that her service had relaxed previously stringent gatekeeping

measures which allowed her to respond “more humanely.” Previously, the service’s funding body had only allowed service provision to permanent residents; however, these rules were relaxed to allow refugee and migrant families who had been living in Australia for less than 5 years to access services. A nurse from a government health service confirmed that she had seen other services relax stringent eligibility criteria which she felt was appropriate given that many people “had lost jobs, lost income” and were in living in dire circumstances.

### *Professionals’ Accounts of Working With Survivors*

Participants described their experiences of working with survivors and their families during the first wave of the pandemic. The main themes identified were: experiencing increased levels of fear, anxiety, and concern, striving for a work–home life balance and avoiding vicarious traumatization, and optimism and future practices.

*Increased Levels of Fear, Anxiety, and Concern.* Many participants shared that they experienced a heightened sense of generalized anxiety due to the spread of COVID-19 and its potential impact on themselves, their families, clients, and communities. For some, like a family support worker in a non-government service, these feelings were “overwhelming” to a point whereby she felt “unable to breathe,” let alone innovate her professional practices. Many carried substantial worries for their clients, who already lived in highly complex environments. A domestic violence counselor said that COVID-19 “just fueled what was already an anxiety provoking situation with every client.”

Participants who worked with Aboriginal and/or Torres Strait Islander women and children indicated that they were experiencing increased anxiety because they were unable to physically see their clients, many of whom experienced significant health and social inequalities. As many clients did not have access to technology, they were unable to continue working alongside First Nations women and children.

*Striving for a Work–Home Life Balance and Avoiding Vicarious Traumatization.* Participants who were directed to work from home had to set up home office spaces which made it difficult to maintain a work–home life balance, particularly when they were often required to “bring clients’ trauma into their homes.” A government-allied health worker described her struggle:

As clinicians, the vicarious trauma is pretty intense. And as a person who has young children at home ... I’m more affected by the vicarious trauma that I’m hearing, which obviously then has an impact not only on your work life but your home life as well.

Many participants were mothers who were also struggling to meet the educational, physical, emotional, and social needs of children. They indicated that they were finding it hard to home–school children and juggle work commitments. For many, work became something done before children woke up and after they went to bed, leaving many women feeling physically and emotionally fatigued.

*Optimism and Future Practice.* While the majority of reflections on this period in human history raised distressing and concerning issues, there was a parallel narrative of optimism and hope for a better system in the future. A senior manager of an NGO and others indicated that they had observed that some “high-risk families” that they worked with were coping better in the absence of services, which they associated with reduced familial stress due to reduced surveillance. She felt hopeful about the future prospects of working in a less forensic way that compounded stress for Aboriginal people:

An Aboriginal family ... they've actually really enjoyed having the pressure off from schools and from child protection agencies around that. There is less intrusion in terms of other services being involved and the family are actually just enjoying that space, being together again which is a really kind of different response.

Others identified that their practice had become much more community-minded. For example, they indicated that they were taking the time to get to know the communities that their clients lived in and called on clients' supports—rather than professionals—to provide help and “check in” on clients they were worried about. Others mentioned how government initiatives to enable people to claim a Medicare rebate for online telehealth services, including counseling, had positively impacted rural and remote families who had previously had to travel great distances to receive support. Many participants expressed positivity about the benefits of working from home, which provided more flexibility and family-friendly working conditions. This was a practice that many wanted to maintain beyond the pandemic.

## Discussion

This study documents the perceptions of 21 women social workers and health professionals who worked with women and children experiencing IPV in the context of Australia's first wave of COVID-19. The research addresses a gap in the literature, as few qualitative studies have simultaneously explored women professionals' perceptions of survivors' experiences of IPV and their own experiences of practicing during the first wave of the pandemic. This information is important for feminist social workers for a number of reasons. Firstly, social workers have been criticized for lacking a feminist perspective on IPV that pivots on understanding how perpetrators target and exploit women survivors through tactics of power and control (Black et al., 2010). Understanding the lived experience of survivors during the pandemic is a critical first step in feminist social work. Secondly, it is equally important to hear the voices of professionals reflecting on their experience of practice, particularly in areas where the practice is underdeveloped, as is the case in the pandemic environment. Cook and Wagenaar (2012) argue that professionals play a critical role in generating new knowledge-based upon their practice within the context in which they work.

The findings confirm emerging evidence about how perpetrators targeted and exploited the contagion to exert power and control over (ex)partners and their children (Godin, 2020; Kofman & Garfin, 2020; Neil, 2020). We propose a term for this name, “COVID-19 coercion” and presented new evidence about a particularly pernicious manifestation of this type of coercion, whereby perpetrators exploit women's responses to unprecedented levels of stress and anxiety in order to discredit them as mothers. Although Heward-Belle's (2017) study provided evidence of the myriad ways that domestically violent men instrumentally targeted women's mothering in the pre-COVID environment as a tactic to oppress women, this study contributes to understandings of this phenomenon by providing examples of how women's responses to concerns about COVID-19 were exploited and enabled some men to increase their contact with children and/or gain outright parental responsibility.

The findings also illuminate how COVID-19 and associated public health measures to curb its spread exacerbated pre-pandemic problems and intersectional disadvantage. Through an intersectional lens, social workers can illuminate the interlocking forms of oppression that survivors may experience and understand how women generally, and women from underserved communities, in particular, are disproportionately oppressed by pre-existing inequalities. The inequitable treatment of women survivors from underserved communities in the health, legal, and social service system is well documented (Australian Law Reform Commission & NSW Law Reform Commission, 2010; State of Victoria, 2016). Moreover, practitioners who work with Indigenous families and families from culturally and linguistically diverse backgrounds perceived that stress levels in these communities were compounded

due to pre-existing structural inequalities that produced economic stress, inadequate and overcrowded housing, ill-health, and lack of access to affordable and healthy food and other essentials. An intersectional approach offers a frame through which to consider how these overlapping structural inequalities are further exacerbated within the context of a global pandemic.

The findings align with other research that found that women are bearing the brunt of the pandemic in both the public and private domains (Sanchez et al., 2020). In the public domain, women professionals discussed feeling concerned that they did not have access to adequate PPE yet were expected to work in areas that potentially expose them to significant health risks. These results are consistent with Green et al. (2020) study that examines health professionals' concerns about being placed in dangerous situations with patients due to inadequate PPE. In order to ensure a steady income through continued employment, many participants had to convert spaces in their homes to work areas—severing any semblance of a work/home divide. Most participants described having to conduct interviews, counseling sessions, and risk assessments in their own homes using online facilities, which was experienced as stressful by many—particularly given the traumatic content of many exchanges. In the private domain, participants discussed disproportionately shouldering additional demands in the private sphere which are connected with gendered inequality, including unpaid domestic labor, home schooling, and childcare. These findings corroborate Xue and McMunn's (2021) research that found that women spent more time than men on unpaid domestic labor and childcare during lockdowns and experienced higher levels of psychological distress.

## **Relevance to Social Work**

The findings contribute knowledge for practice that social workers and other professionals may find helpful as they work towards redressing social injustices caused by the intersection of gender-based inequality with other forms of oppression, including but not limited to racism and classism. Stay-at-home orders and pandemic-related stress can further compound already present intersecting forms of oppression. The findings also contribute to the growing body of evidence highlighting how intersecting disadvantage compounds the trauma experienced by survivors of IPV and highlights the need for social workers to be creative, reflective, and connected to the community when attending to survivors' safety and wellbeing needs (Cross & Gonzalez Benson, 2021). These authors also argue that reflective social work responses must attend to the individual while paying attention to differences and overlapping domains of power (Cross & Gonzalez Benson, 2021).

Social workers and other professionals who participated in this study provided first-hand accounts of how the pandemic and associated public health measures have compounded individual trauma for women survivors of IPV generally. They also provided first-hand accounts of the additional challenges faced by survivors who are Aboriginal/Torres Strait Islanders, from culturally and linguistically diverse backgrounds, and who reside in rural and remote areas of Australia. Social work is a profession that is concerned with social justice and as such it is recommended that social workers advocate to ensure that the safety and well-being needs of women survivors, particularly those from underserved communities, are adequately addressed. It was particularly concerning to learn that many social workers who participated in this research expressed the view that their ability to advocate within their agencies and wider systems was limited. Interestingly, many perceived their research participation as an act of resistance because they worked within systems that frequently silenced criticism or dissent. They felt that participating in research provided a vehicle to effect social change by illuminating gender-based violence and intersecting social disadvantage.

Social workers can also advocate for policy and practice change to ensure that domestically violent men are held accountable. Heward-Belle et al. (2019) study of 232 frontline workers across Australia found that some progress was being made pre-pandemic towards redressing sexist practices, by applying a holistic practice approach that involves working with the whole

family where safe to do so. This approach has the potential to hold domestically violent men more accountable. It is notable that study participants described few examples of working with male perpetrators during the pandemic. This is particularly concerning given that many men's behavior change programs and other perpetrator intervention programs were canceled or postponed during this time. In moving forward, it is critical that social workers and other professionals continue to develop policies and practices that are aligned with feminist and social justice goals of eliminating sexist institutional responses, particularly with families experiencing IPV. Sexist institutional practices place the responsibility for ending and ameliorating the impact of IPV on women survivors rather than on male perpetrators and reinforce patriarchal views of family roles and responsibilities. As lockdowns are becoming a regular public health measure used to curb the spread of the virus, social workers must contribute to the ethical and safe development of online counseling and therapeutic interventions that are beneficial for some domestically violent men. Further social work research is also needed to assess the safety and effectiveness of such interventions for domestically violent men and to ascertain when such interventions may be inappropriate.

Some social work participants stressed that they were actively engaged in developing new policies that would influence the way that social work can be practiced during and after the pandemic. For example, social policy rapidly changed to allow professionals to use technology to attend to women's safety and well-being needs. The use of online counseling and therapeutic services, in particular, has the potential to make services more accessible to many, but not all, service users. For those who can afford to access technology, online services provided a space to potentially democratize practice. However, many people who access social work services cannot afford to purchase technology and pay the ongoing costs associated with connectivity. It is recommended that social workers advocate to ensure that technological disadvantage is addressed in policy and practice. Moreover, McVeigh (2020) argues that social workers can contribute to policy recommendations to ensure the safe and ethical use of online counseling and therapeutic services in the future.

## Strengths and Limitations

Interviews were conducted with social workers and other health practitioners at a relatively early stage of the pandemic in Australia. As such, the findings document practitioners' initial perceptions in relation to: (1) survivors' experiences of IPV at the beginning of the pandemic and (2) practitioners' personal and professional experiences of providing services at this time. Due to the unprecedented levels of stress and uncertainty experienced by everyone and particularly survivors of IPV at the beginning of the first wave of the pandemic, a decision was made to rely on professionals' perceptions of survivors' experiences rather than to directly engage survivors in interviews. While some may consider this a limitation of the study, the researchers did not wish to add additional demands nor to increase the risks to survivors at a time when perpetrators were known to be increasing their surveillance of (ex)partners (Godin, 2020). This decision has aligned the principle of non-maleficence in the conduct of ethical social work research (AASW, 2020).

This study was exploratory in nature and hence relied upon a relatively small sample size, and thus cannot be reliably generalized across the population. It would be beneficial to conduct further research with a larger sample of participants to explore emerging trends that came out of the initial study at a later stage of the pandemic.

## Conclusion

The purpose of the present study was to gain a better understanding of how the COVID-19 pandemic influenced the lives of survivors of IPV and the experiences of women professionals who attended to survivors during this time. This research was conducted by feminist researchers and practitioners

who were interested in simultaneously shining a light on the challenges experienced by women survivors of IPV and the challenges experienced by women professionals responding during the pandemic. The present study contributes to the small body of evidence reporting on the nature of IPV during the pandemic, particularly illuminating the way that perpetrators of IPV exploited the contagion as a novel tactic of power and control. These findings provide a snapshot of women professionals' perceptions of service users' experiences and of professional practice at an early stage of the pandemic in Australia. As COVID-19 continues to mutate and spread across the globe, these findings can contribute to the development of practice-led policies and protocols that attend to both the specific needs of survivors of IPV and the women professionals who are working creatively to support survivors within a context of great uncertainty.

It is recommended that feminist social workers engage in micro, mezzo, and macro-level social work interventions. At the micro-level, working alongside survivors to comprehensively assess the perpetrators' pattern of abuse including COVID-19 coercion can facilitate more effective safety planning with women and children. Creative practices at the micro-level evidenced in this study included social workers working with survivors with the aid of technology and/or forming stronger working relationships with neighbors or extended family members nominated by survivors. These significant people played a role in supporting and monitoring the safety and wellbeing of survivors, especially during lockdown periods when professionals were unable to meet survivors face-to-face.

Feminist social workers can work within communities to build on existing strengths to develop violence-resistant communities. When working with communities, social workers can creatively apply concepts from the bystander intervention field to raise awareness of IPV and increase people's confidence in relation to responding effectively if they had concerns for a community member. Strengthening the capacity of communities is critical particularly during lockdown periods when survivors may be unable to leave their residence to seek help. In such circumstances, having an IPV-informed neighbor could be the difference between life and death.

At a macro level, feminist social workers must ensure that the patriarchal attitudes that embed IPV continue to be challenged and exposed. This may include actively resisting hegemonic tropes that frame perpetrators' abusive behaviors as being a direct consequence of pandemic-related stress. Feminist social workers can also advocate and contribute to the development of online perpetrator services that hold men who use violence accountable and promote their growth as ethical, non-violent men. Moreover, it is essential that social workers contribute to the development of feminist policies that promote the human rights of women and children to live violence-free lives and to ensure that survivors have access to a living wage, affordable housing, health care, legal services, and recovery opportunities.

Lastly, it is imperative that policy makers and managers listen to frontline professionals who have a unique perspective regarding the issues facing survivors of IPV during the pandemic. Drawing upon their practice-led knowledge is critical in developing policy and practice at this time of great uncertainty. It is also imperative that the wellbeing needs of professionals are prioritized. As the bulk of the caring workforce are women, ensuring that the organizational environment promotes an atmosphere that cares for professionals and enables them to engage in practices that prevent and address IPV is a critical feminist issue.

### **Declaration of Conflicting Interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### **Funding**


The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This collaborative action research project is primarily funded through a seeding grant from the



Sydney Local Health District and the Sydney Institute of Women, Children and their Families. Additional financial contributions have come from Leichhardt Women's Community Health Centre, the Inner West Council, and the Department of Communities and Justice.

## ORCID iDs

Susan Heward-Belle  <https://orcid.org/0000-0002-0833-414X>

Renee C. Lovell  <https://orcid.org/0000-0003-4921-7393>

## References

- Australian Association of Social Workers (2020). Code of Ethics. Melbourne, VIC. <https://www.aasw.asn.au/document/item/13400>
- Australian Bureau of Statistics (2018). *Personal safety survey, 2016, TableBuilder. ABS cat. no. 4906.0. Findings based on use of ABS TableBuilder data.* ABS.
- Australian Institute of Criminology (2020). *The prevalence of domestic violence among women during the COVID-19 pandemic. Statistical bulletin 28.* AIC.
- Australian Institute of Health and Welfare (2020). Health Workforce.
- Australian Law Reform Commission, & NSW Law Reform Commission (2010). Family Violence – A National Legal Response, Final Report. ALRC Report 114.
- Black, M., Weisz, A., & Bennett, L. (2010). Graduating social work students' perspectives on domestic violence. *Affilia, 25*(2), 173–184. <https://doi.org/10.1177/0886109910364824>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. <https://doi.org/10.1080/17439760.2016.1262613>
- Cleaveland, C., & Waslin, M. (2021). COVID-19: Threat and vulnerability among Latina immigrants. *Affilia, 36*(3), 272–281. <https://doi.org/10.1177/0886109920985232>
- Cook, N., & Wagenaar, H. (2012). Navigating the eternally unfolding present: Toward an epistemology of practice. *The American Review of Public Administration, 42*(1), 3–38. <https://doi.org/10.1177/0275074011407404>
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299.
- Cross, F. L., & Gonzalez Benson, O. (2021). The coronavirus pandemic and immigrant communities: A crisis that demands more of the social work profession. *Affilia, 36*(1), 113–119. <https://doi.org/10.1177/0886109920960832>
- Evans, D. P. (2020). COVID-19 and violence: A research call to action. *BMC Women's Health, 20*(1), 249. <https://doi.org/10.1186/s12905-020-01115-1>
- Finlay, I., & Gilmore, I. (2020). COVID-19 and alcohol—A dangerous cocktail. *British Medical Journal, 369*, m1987. <https://doi.org/10.1136/bmj.m1987>
- Godin, M. (2020). As cities around the world go on lockdown, victims of domestic violence look for a way out. *Time, March 18.* <https://time.com/5803887/coronavirus-domestic-violence-victims>
- Goh, K. K., Lu, M. L., & Jou, S. (2020). Impact of COVID-19 pandemic: Social distancing and the vulnerability to domestic violence. *Psychiatry and Clinical Neurosciences, 74*(11), 612–613. <https://doi.org/10.1111/pcn.13130>
- Green, L., Fateen, D., Gupta, D., McHale, T., Nelson, T., & Mishori, R. (2020). Providing women's health care during COVID-19: Personal and professional challenges faced by health workers. *International Journal of Gynecology & Obstetrics, 151*, 3–6. <https://doi.org/10.1002/ijgo.13313>
- Grierson, J. (2020 Apr 15). Domestic abuse killings 'more than double' amid COVID-19 lockdown. *Guardian.* <https://www.theguardian.com/society/2020/apr/15/domestic-abuse-killings-more-than-double-amid-covid-19-lockdown>
- Hegarty, K., & Tarzia, L. (2020). Domestic violence, isolation and COVID-19. Retrieved from: <https://pursuit.unimelb.edu.au/articles/domestic-violence-isolation-and-covid-19>

- Heward-Belle, S. (2016). The diverse fathering practices of men who perpetrate domestic violence. *Australian Social Work, 69*(3), 323–337. <https://doi.org/10.1080/0312407X.2015.1057748>
- Heward-Belle, S. (2017). Exploiting the ‘good mother’ as a tactic of coercive control: Domestically violent men’s assaults on women as mothers. *Affilia-Journal of Women and Social Work, 32*(3), 374–389. <https://doi.org/10.1177/0886109917706935>
- Heward-Belle, S., Humphreys, C., Tsantefski, M., Laing, L., Healey, L., & Toivenen, C. (2019). Invisible practices: Interventions with men who use violence and control. *Affilia: Journal of Women and Social Work, 34*(3), 369–382. <https://doi.org/10.1177/0886109919848750>
- Johnson, K., Green, L., Volpellier, M., Kidenda, S., McHale, T., Naimer, K., & Mishori, R. (2020). The impact of COVID-19 on services for people affected by sexual and gender-based violence. *International Journal of Gynecology and Obstetrics, 150*(3), 285–287. <https://doi.org/10.1002/ijgo.13285>
- Kofman, Y., & Garfin, D. (2020). Home is not always a haven: The domestic violence crisis amid the COVID-19 pandemic. *Psychological Trauma, 12*(S1), S199–s201. <https://doi.org/10.1037/tra0000866>
- Krishnadas, J., & Taha, S. H. (2020). Domestic violence through the window of the COVID-19 lockdown: A public crisis embodied/exposed in the private/domestic sphere. *Journal of Global Faultlines, 7*(1), 46–58. <https://doi.org/10.13169/jglobfaul.7.1.0046>
- Letherby. (2003). *Feminist research in theory and practice*. Open University Press.
- McVeigh, M., & Heward-Belle, S. (2020). Necessary and good: A literature review exploring ethical issues for online counselling with children and young people who have experienced maltreatment. *Children Australia, 45*(4), 266–278. <https://doi.org/10.1017/cha.2020.59>
- Miyamoto, I. (2020). (Rep.). Daniel K. Inouye Asia-Pacific Center for Security Studies. Retrieved April 8, 2021, from <http://www.jstor.org/stable/resrep24863>
- Neil, J. (2020). Domestic violence and COVID-19: Our hidden epidemic. *Australian Journal of General Practice, 49*(suppl 25). <https://doi.org/10.31128/AJGP-COVID-25>
- Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., Kontopantelis, E., Webb, R., Wessely, S., McManus, S., & Abel, K. (2020). Mental health before and during the COVID-19 pandemic: A longitudinal probability sample survey of the UK population. *The Lancet Psychiatry, 7*(10), 883–892. [https://doi.org/10.1016/S2215-0366\(20\)30308-4](https://doi.org/10.1016/S2215-0366(20)30308-4)
- Refuge (2020). Taking Lives. <https://www.refuge.org.uk/ourwork/campaigns/more-refuge-campaigns/taking-lives/>
- Reinhartz, S. (1992). *Feminist methods in social research*. New York: Oxford University Press.
- Royal College of Nursing (2020). *Personal protective equipment: Use and availability during the COVID-19 pandemic*. London: Royal College of Nursing.
- Sánchez, O., Vale, D., Rodrigues, L., & Surita, F. G. (2020). Violence against women during the COVID-19 pandemic: An integrative review. *International Journal of Gynecology and Obstetrics, 151*(2), 180–187. <https://doi.org/10.1002/ijgo.13365>
- Scutt, J. (1983). *Even in the best of homes: Violence in the family*. Penguin.
- Semaan, A., Audet, C., Huysmans, E., et al. (2020). Voices from the frontline: Findings from a thematic analysis of a rapid online global survey of maternal and newborn health professionals facing the COVID-19 pandemic. *BMJ Global Health, 5*(6), e002967. <https://doi.org/10.1136/bmjgh-2020-002967>
- Sidpra, J., Abomeli, D., Hameed, B., et al. (2020). Rise in the incidence of abusive head trauma during the COVID-19 pandemic. *Archives of Disease in Childhood, 2021*(106), e14. <https://doi.org/10.1136/archdischild-2020-319872>
- Singh-Chandan, J., Thomas, T., Bradbury-Jones, C., Russell, R., Bandyopadhyay, S., Nirantharakumar, K., & Taylor, J. (2020). Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness. *The British Journal of Psychiatry, 217*(4), 562–567. <https://doi.org/10.1192/bjpp.2019.124>
- State of Victoria (2016). Royal Commission into Family Violence: Summary and Recommendations, Parliamentary Paper No 132 (2014-16), Melbourne, Victoria.
- Summers, A. (2021). International Women’s Day 2021: Keynote Speech. University of Technology Sydney Centre for Social Justice.

- The Royal College of Midwives. New RCM Survey reveals more than half of midwives do not feel safe carrying out home visits [RCM website]. 2020. <https://www.rcm.org.uk/media-releases/2020/april/new-rcm-survey-reveals-more-than-half-of-midwives-do-not-feel-safe-carrying-out-home-visits/>: Accessed June 15, 2020
- UNFPA (2020). COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage, Interim Technical Note.
- UNODC (2018). *Global Study on Homicide*. Vienna.
- UN Women (2020). Inter-Agency statement on violence against women and girls in the context of COVID-19. <https://www.unwomen.org/en/news/stories/2020/6/statement-inter-agency-statement-on-violence-against-women-and-girls-in-the-context-of-covid-19>
- WHO (2020). Violence against women and COVID19: What the health sector/system can do. <https://www.who.int/reproductivehealth/publications/emergencies/COVID-19-VAW-full-text.pdf>
- World Health Organisation (2021). WHO Coronavirus (COVID-19) Dashboard, World Health Organisation. <https://COVID-19.who.int/>
- Xue, B., & McMunn, A. (2021). Gender differences in unpaid care work and psychological distress in the UK COVID-19 lockdown. *PLoS ONE*, *16*(3), e0247959. <https://doi.org/10.1371/journal.pone.0247959>

### Author Biographies

**Susan Heward-Belle** is an assistant professor in Social Work and Policy Studies at the University of Sydney. Her research focuses on socially just and gender equitable policies and practices to address violence against women and children.

**Renee C. Lovell** is the Domestic Violence Strategy Coordinator with the Sydney Local Health District.

**Jennifer Jones** is a Clinical Nurse Consultant in Child and Family Health with the Sydney Local Health District.

**Hayden Tucker** is a Research Assistant within Social Work and Policy Studies at the University of Sydney.

**Nina Melander** is a PhD candidate and Research Assistant in Social Work and Policy Studies at the University of Sydney.