

A Pandemic within a Pandemic — Intimate Partner Violence during Covid-19

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As Covid-19 cases surged in the United States in March 2020, stay-at-home orders were put in place. Schools closed, and many workers were furloughed, laid off, or told to work from home. With personal movement limited and people confined to their homes, advocates expressed concern about a potential increase in intimate partner violence (IPV). Stay-at-home orders, intended to protect the public and prevent widespread infection, left many IPV victims trapped with their abusers. Domestic-violence hotlines prepared for an increase in demand for services as states enforced these mandates, but many organizations experienced the opposite. In some regions, the number of calls dropped by more than 50%.¹ Experts in the field knew that rates of IPV had not decreased, but rather that victims were unable to safely connect with services. Though restrictions on movement have been lifted in most regions, the pandemic and its effects rage on, and there is widespread agreement that areas that have seen a drop in caseloads are likely to experience a second surge. This pandemic has reinforced important truths: inequities related to social determinants of health are magnified during a crisis, and sheltering in place does not inflict equivalent hardship on all people.

One in 4 women and one in 10 men experience IPV, and violence can take various forms: it can be physical, emotional, sexual, or psychological.² People of all

racess, cultures, genders, sexual orientations, socioeconomic classes, and religions experience IPV. However, such violence has a disproportionate effect on communities of color and other marginalized groups. Economic instability, unsafe housing, neighborhood violence, and lack of safe and stable child care and social support can worsen already tenuous situations. IPV cannot be addressed without also addressing social factors, especially in the context of a pandemic that is causing substantial isolation.

Economic independence is a critical factor in violence prevention. For many people who experience IPV, the financial entanglement with an abusive partner is too convoluted to sever without an alternative source of economic support. The pandemic has exacerbated financial entanglement by causing increased job loss and unemployment, particularly among women of color, immigrants, and workers without a college education.³ The public health restrictions put in place to combat the spread of the virus have also reduced access to alternative sources of housing: shelters and hotels have reduced their capacity or shut down, and travel restrictions have limited people's access to safe havens. Shelters have made valiant efforts to ease crowding and to help residents move into hotels, extended-stay apartments, or the homes of family members and friends. Though some restrictions have been lifted, many shelters remain

closed or are operating at reduced capacity, which creates challenges for people who need alternative housing arrangements.

Closures of schools and child care facilities have added to the stress at home. Virtual learning often requires the involvement and supervision of parents and guardians. Some families don't have access to a reliable Internet connection, and child care obligations may fall to friends, neighbors, or family members while parents work or attempt to find work. Some parents are considered essential workers and cannot work from home, and others are required to work virtually. The added stress of balancing work, child care, and children's education has led to a rise in child abuse.⁴ Mandated reporters, such as teachers, child care providers, and clinicians, also have fewer interactions with children and families and fewer opportunities to assess, recognize, and report signs of abuse than they did before the pandemic.

There may also be barriers to reporting IPV during the pandemic. The way in which police reports can be filed varies among precincts, with some offering online options and others requiring in-person visits. Similarly, individual trial courts have discretion to determine filing procedures for restraining orders. The lack of a coherent and consistent process for reporting abuse can be discouraging for people seeking help through the legal system. Black and Brown people, who have long

IPV Resources for Patients.

Crisis Text Line (text HOME to 741741)
National Parent Hotline (call 1-855-427-2736)
Childhelp National Child Abuse Hotline (visit <https://www.childhelp.org/childhelp-hotline/> or call 1-800-422-4453)
National Domestic Violence Hotline (visit <http://thehotline.org>, text LOVEIS to 22522, or call 1-800-799-7233)
Futures Without Violence (visit <https://www.futureswithoutviolence.org/resources-events/get-help/>)

faced oppression and brutality by police, may also be less likely than White people to involve the police when IPV escalates.

Most people who experience IPV don't seek help. Medical professionals have an opportunity to identify these patients in health care settings and to provide counseling and connect people with social services. Medical offices can be safe places for patients to disclose abuse. Physical examination findings; a patient's behavior during or while discussing physically intimate components of a breast, pelvic, or rectal examination; or an aggressive partner can be warnings signs of possible IPV. In settings such as emergency departments and labor and delivery suites, policies mandate screening for IPV when patients are alone. Evaluation in a clinic or hospital setting permits immediate intervention, including involvement of social workers, safety planning, and a review of services available to victims and their dependents. Even this opportunity has often been absent in the Covid-19 era. As offices canceled and rescheduled nonurgent clinic visits and moved to telemedicine platforms, safely screening patients for IPV became more difficult. Not only might patients live in areas with unreliable Internet or cellular service, but abusers might be listening in on conversations, leaving

patients unable to disclose escalating abuse at home.

Certain steps could promote more equitable access to services as a second wave of Covid-19 infections looms. First, communities could ensure equal access to broadband Internet service in people's homes. Access could be expanded by means of a subsidy program mirroring the Federal Communications Commission Lifeline program or the installation of wireless access points in public spaces.⁵ Such approaches would not only enable wider access to telehealth, but would also permit people who have experienced IPV to search for resources and maintain their critical social connections.

Providers can continue to screen for IPV and discuss safety planning with their patients during telemedicine appointments. Clinicians can normalize screening using standardized questions and can offer information to all patients, regardless of whether they disclose IPV. Available resources are shown in the box. Clinicians can also educate themselves about available community resources. If abuse is disclosed, the clinician and patient can establish signals to identify the presence of an abusive partner during telemedicine appointments. Such signals could include a raised fist on a video call or set phrases during an audio call.

When it is safe to have a discussion about IPV, clinicians can review safety practices, such as deleting Internet browsing history or text messages; saving hotline information under other listings, such as a grocery store or pharmacy listing; and creating a new, confidential email account for receiving information about resources or communicating with clinicians.

Finally, governing bodies should consider social determinants of health when developing crisis standards of care. Privilege, finances, and access to resources all affect the impact of IPV on patients.

The Covid-19 pandemic has put a spotlight on numerous ongoing public health crises, including violence within the home. As state mandates relax and people begin to live a new version of normal, clinicians, public health officials, and policymakers cannot stop addressing the layers of social inequities in our communities and the ways in which they affect people's access to care. The pandemic has highlighted how much work needs to be done to ensure that people who experience abuse can continue to obtain access to support, refuge, and medical care when another public health disaster hits.

Disclosure forms provided by the authors are available at [NEJM.org](https://www.nejm.org).

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This article was published on September 16, 2020, at [NEJM.org](https://www.nejm.org).

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Telephone

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As a child, you probably played the game “Telephone”: you whispered a message into the ear of the person next to you, who whispered it to the next person, and so forth down the line. When revealed at the end of the chain, the message was inevitably garbled, illustrating how fragile human communication can be. For children, these mistranslations were hilarious. But for doctors, such a breakdown in communication can be heart-rending, and we do everything we can to ensure that they never happen.

A version of Telephone played out when I was a medical student. A young, deaf Peruvian woman was in the oncology clinic, and her scans showed progression of her cancer. To communicate with her, we coordinated a high-stakes game of Telephone using an American Sign Language (ASL) interpreter to translate spoken English to ASL, and then a Peruvian Sign Language (PRL) interpreter to translate ASL into PRL. My attending physician slowly delivered the news, ensuring understanding at each step of the way. The patient was tearful, yet somehow resolute in the face of the news. She thanked us as we said good-bye. Despite our barriers

of language and understanding, her emotion was something we could all recognize. I walked away knowing that sharing our voices with our patients — no matter how we do it — is a critical part of patient care. But I couldn't have imagined the communication challenges that Covid-19 would bring.

To prepare for a surge in critically ill patients, our oncology ward was converted into a fully functioning intensive care unit (ICU) in 48 hours. Our floor had originally been designed to meet the needs of patients with leukemia and those receiving bone marrow transplants, who often have extended inpatient stays. Rooms are secluded and lack the central alarm infrastructure for ventilators and medication pumps, so the unit can be eerily quiet as compared with a standard ICU. After research labs had been locked down, a student, who would otherwise have been in a lab, was drafted into a new role of “listener” to substitute for hard-wired sirens. He paced the corridors of the nascent ICU, notifying the nurses when pump and ventilator alarms sounded. This procedure proved vital. A transport ventilator, intended for only

short-term use, spontaneously failed. The listener shouted for the nurse, who rallied the rest of the team while manually ventilating the patient until the machine could be rebooted.

Even something as simple as talking to a patient's loved ones, who could no longer sit at the bedside, required entirely new procedures. After rounds on my first day on the team, an intern swiftly doffed her respirator, face shield, and gown and began phoning families. She confessed that in a unit containing largely sedated patients, this human interaction was the best part of her day — despite the fact that she often had bad news to share.

Oncologists like me, tragically, must be adept at delivering bad news. This skill is so essential that in my first year of fellowship we had a seminar with simulated patients to practice the nuances of these encounters. “Take the time to find chairs so you can sit down face to face,” we were taught. “Build rapport by touching the arm, making eye contact, or holding hands.”¹ In the Covid-19 era, when families are often not in the same city, let alone the same room, how could we build a connection? While our