The Impact of the COVID-19 Pandemic on Intimate Partner Violence (IPV)

Jessica Head

Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

April 2025

Total word count: 17,378

THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	**Professional Doctorate in Clinical Psychology**
Candidate name	Jessica Head
Registration number	22042131
Initial date of registration	September 2022

Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed: *J M Head* Date: 28/04/2024

Table to show total word counts:

Title	Word Count
Acknowledgements	212
Thesis Abstract	254
Paper One: Literature Review	7563
Paper Two: Empirical Paper	7984
Paper Three: Executive Summary	1365
TOTAL WORD COUNT	17,378

Acknowledgements

I would like to express my deepest gratitude to the brave women who participated in this research. Thank you for sharing your incredibly difficult and personal stories with me. I know it can be challenging to open up about such painful experiences, and I am truly honoured that you entrusted me with yours. I hope this thesis does you proud, and it was a privilege to work with each and every one of you. I wish you nothing but compassion, peace and healing for the future.

Violence against women remains an epidemic and I dedicate this thesis to the survivors, to the women still enduring domestic abuse and to the women who are unfortunately no longer with us. May their stories continue to inspire change, and may we never forget the lives lost.

I would also like to extend my sincere thanks to my supervisors, Dr. Lisa Berry and Dr. Jason Lines, for their unwavering support, guidance, and insightful feedback throughout this journey. Your continued encouragement and expertise have been invaluable.

To my brother, James, my partner, Adil, and my wonderful friends, I am profoundly grateful for your endless support, kindness and reminders to believe in myself. You have all been my rock, and I couldn’t have done this without you.

Table of Contents

Acknowledgements 3
Thesis Abstract 7
Paper 1: Exploring the Experiences of Staff who Work in Specialist Services for Intimate Partner Violence (IPV) during the COVID 19 Pandemic: A Literature Review 8
Abstract 9
Introduction 9
Rationale 10
Aim 11
Method 11
Search Strategy *11*
Search Terms *13*
Screening Procedure *13*
Results 15
Study Characteristics *15*
Critical Appraisal 20
Aims *20*
Methodology and Design *20*
Recruitment *21*
Reflexivity *22*
Ethics *23*
Analysis *23*
Findings and Value *24*
Synthesis of Themes across the Literature 25
Discussion 28
Strengths 30
Limitations 31
Research Recommendations 31
Conclusion 32
References 33
Appendix A – Table Evidencing Qualitative CASP Scores 36
Appendix B – Process of Coding and Literature Theme Generation 38
Appendix C – Qualitative CASP Guidance 39
Appendix D - Journal Submission Guidelines 40
Paper 2: Survivors Experiences of Coping and Help Seeking for Intimate Partner Violence (IPV) during Pregnancy and the COVID-19 Pandemic in the United Kingdom. 42

Abstract 43
Introduction 43
Method 46
Research Design 46
Participants 46
Table 1. 47
Participant Demographics 47
Ethical Considerations 47
Recruitment 48
Table 2: 49
Study Inclusion Criteria 49
Interview Procedure 49
Analysis 50
Reflexivity 50
Triangulation and Service User Involvement 51
Results 51
Diagram 1. 51
Thematic Map 51
Theme 1: Navigating IPV During Pregnancy and Lockdown 52
Sub-theme 1.1: Entrapment Through Pregnancy 52
Sub-theme 1.2: Lockdown Impact on IPV 53
Theme 2: Coping Strategies: Survival and Avoidance 54
Sub-theme 2.1: Psychological Coping 54
Sub-theme 2.2: Accessing Support 55
Theme 3: Missed Opportunities 56
Sub-theme 3.1: Missed Opportunities in Healthcare 56
Sub-theme 3.2: Missed Opportunities in Other Services 57
Theme 4: Barriers to Help-Seeking and Systemic Failures 58
Sub-theme 4.1: Psychological Barriers 58
Sub-theme 4.2: Systemic Issues that Impact Help-Seeking 58
Theme 5: Future Directions Post-Covid 60
Sub-theme 5.1: IPV Knowledge in Healthcare 60
Sub-theme 5.2: Community, Court and Criminal Justice Reforms 61
Discussion 62
Clinical Implications 63
Strengths and Limitations 64
Suggestions for Future Research 65

References 65
Appendix A – Interview Schedule 69
Appendix B – Example of Thematic Analysis Process: Initial Coding Exported from NVivo 70
Appendix C – Example of Thematic Analysis Process: Categorising Codes 72
Appendix D – Consent Form – Questions were uploaded onto Qualtrics for online consent 76
Appendix E – Participant Information Sheet 77
Appendix F – Debrief Form 83
Appendix G – Online Recruitment Poster 85
Appendix H – Ethical Approval Letter 86
Appendix I – Reflective Journal Extract (Documented Virtually) 87
Appendix J – Braun and Clark (2021) 6 step Thematic Analysis Process 88
Paper 3: Executive Summary 89

Thesis Abstract

This thesis presents three interrelated papers, examining different sides of intimate partner violence (IPV) and the impact of the COVID-19 pandemic on survivors and professionals.

Paper 1 is a systematic literature review that explores the experiences of professionals working within specialist domestic abuse services during the pandemic. Thirteen papers were reviewed, and key themes identified include the increase in domestic abuse incidents, challenges in service delivery, psychological impacts on staff, and ethical dilemmas. The review highlights the operational difficulties and emotional strain resulting from the transition to remote support. It also highlights the need for further research into longer-term impacts, diverse global contexts, and innovative approaches to remote support.

Paper 2 presents an empirical study using semi-structured interviews with nine survivors of IPV during pregnancy, focusing on coping strategies and help-seeking during the pandemic in the UK. The study found that survivors predominantly adopted avoidant and appeasement-based coping strategies, with limited access to formal support. Key findings also revealed systemic failures, such as missed opportunities for intervention, lack of IPV knowledge within services and ineffective legal processes. The study emphasises the need for more intersectional research on IPV, particularly in relation to race, culture and socioeconomic status, and highlights the importance of considering help-seeking behaviours over time, once survivors have left their abusive relationships.

Paper 3 is an executive summary intended for dissemination to the participants and the public. It provides a concise overview of the findings from Paper 2, with a focus on practical implications for improving support services for survivors.

Paper 1: Exploring the Experiences of Staff who Work in Specialist Services for Intimate Partner Violence (IPV) during the COVID 19 Pandemic: A Literature Review

Author Note: Papers 1 and 2 have been written with the intent to submit for publication in the *Journal of Social Science and Medicine* (Appendix D). Amendments will be made prior to submission to ensure the papers adhere to all submission guidelines.

Abstract

This literature review examines the experiences of professionals working within specialist domestic abuse services during the COVID-19 pandemic. Electronic literature searches were conducted during May 2024 and papers were selected according to pre-defined inclusion and exclusion criteria. A restriction of papers published from 01/04/2020 onwards was set to capture relevant papers published following the COVID-19 pandemic. In total 13 papers were included which varied in quality.

Key themes identified were the increase in domestic abuse incidents, challenges in service delivery, psychological impacts on staff, and ethical dilemmas of working during the pandemic. The findings evidenced operational difficulties, including the quick transition to remote support, resulting in emotional strain on staff. Methodological limitations, such as the lack of reflexivity in some studies and the prevalence of Western contexts were noted. Future research should explore longer-term impacts, diverse global contexts and innovative approaches to remote support.

Key words: COVID-19, professional, services, staff, domestic abuse, intimate partner violence

Introduction

In 2020, the World Health Organisation (WHO) declared COVID-19 a global pandemic, prompting countries worldwide to implement restrictive measures such as stay-at-home orders, mobility reductions and social distancing (WHO, 2020; Boserup et al., 2020). While effective in reducing virus transmission, these measures triggered far-reaching consequences in public health, economic stability, employment and domestic life (Mari et al., 2020). One critical consequence was the exacerbation of gender-based violence, particularly intimate partner violence (IPV), as many victims were forced to remain in close proximity with abusive partners (Usher et al., 2020).

Multiple overlapping stressors contributed to heightened IPV risk during the pandemic, including reduced income, diminished social support, increased isolation, and shifts in childcare and schooling responsibilities (Campbell, 2020). These conditions intensified existing vulnerabilities, and research suggests they may also have led to first-time IPV incidents. For example, Morgan et al. (2022) identified a link between financial hardship and new instances of IPV, while Lyons & Brewer (2021) argued that economic strain reduces survivors' ability to leave abusive relationships.

The pandemic also disrupted access to support services, leading to rapid innovation in remote service delivery such as hotlines and tele-counselling (Emezue, 2020). However, these digital alternatives posed new challenges, including concerns about user safety, confidentiality, and data privacy; especially when abusers could overhear or monitor communication. Nonetheless, services adapted quickly, maintaining essential operations through flexible, physically distanced models. These adaptations were urgently needed in response to a surge in IPV cases. The United Nations Population Fund (2020) projected 15 million additional gender-based violence cases globally for every three months of lockdown. In the UK, domestic abuse reports rose by 33%, and overall safeguarding concerns increased by 20% (Brink et al., 2021). Similar trends were observed elsewhere: Spain saw a 23% rise in IPV, with psychological abuse most common (Arenas-Arroyo et al., 2021), and the USA reported increased IPV severity, including economic and physical abuse (Murugan et al., 2022). At the pandemic's onset, support services shifted from preventative approaches to crisis-driven responses, as victims were often isolated with perpetrators (Funston et al., 2023). This rapid shift in service models highlights the critical need to understand how frontline professionals navigated such challenges.

This literature review explores professionals' experiences working in specialist IPV services during the COVID-19 pandemic. It aims to synthesise key findings across relevant studies, highlight challenges and service adaptations, and identify practice gaps. By doing so, the review seeks to inform future policy and support mechanisms for professionals delivering specialist services during times of crisis.

Rationale

Prior to the pandemic, several literature reviews have examined the issue of IPV and its characteristics from the perspectives of victims, police and healthcare facilities (Williamson et al., 2020). Following the pandemic, Lausi et al., (2021) conducted a review through a multi-perspective phenomenon analysis of victims, police and healthcare staff. The experiences of professionals working within specialist domestic violence services during the pandemic are less documented, and the research that is available has not yet been synthesised. This review aims to fill this gap by synthesising existing research on their experiences. It will contribute to the field by providing insights into the unique challenges and adaptations during the pandemic, informing future crisis management and support strategies.

At the time of writing, no other paper has reviewed the literature on domestic violence professionals' experience working within specialist services during the COVID-19 pandemic. The findings will benefit policymakers, service providers and researchers by potentially highlighting the need for more robust services with staff who are well supported, which will subsequently benefit service users too.

Aim

This review aimed to systematically identify and collate the evidence of professionals' experiences working within specialist services during the COVID-19 pandemic. Specifically, the review considers what is known about professionals' experiences with a focus on how professionals coped with these changes in service delivery during the pandemic. The review aims to identify gaps in the understanding of specialist domestic violence services and enhance knowledge of the phenomena. Overall, this review aims to address the overarching question: What were the experiences of professionals working in specialist domestic violence services during the COVID-19 pandemic?

Method

Search Strategy

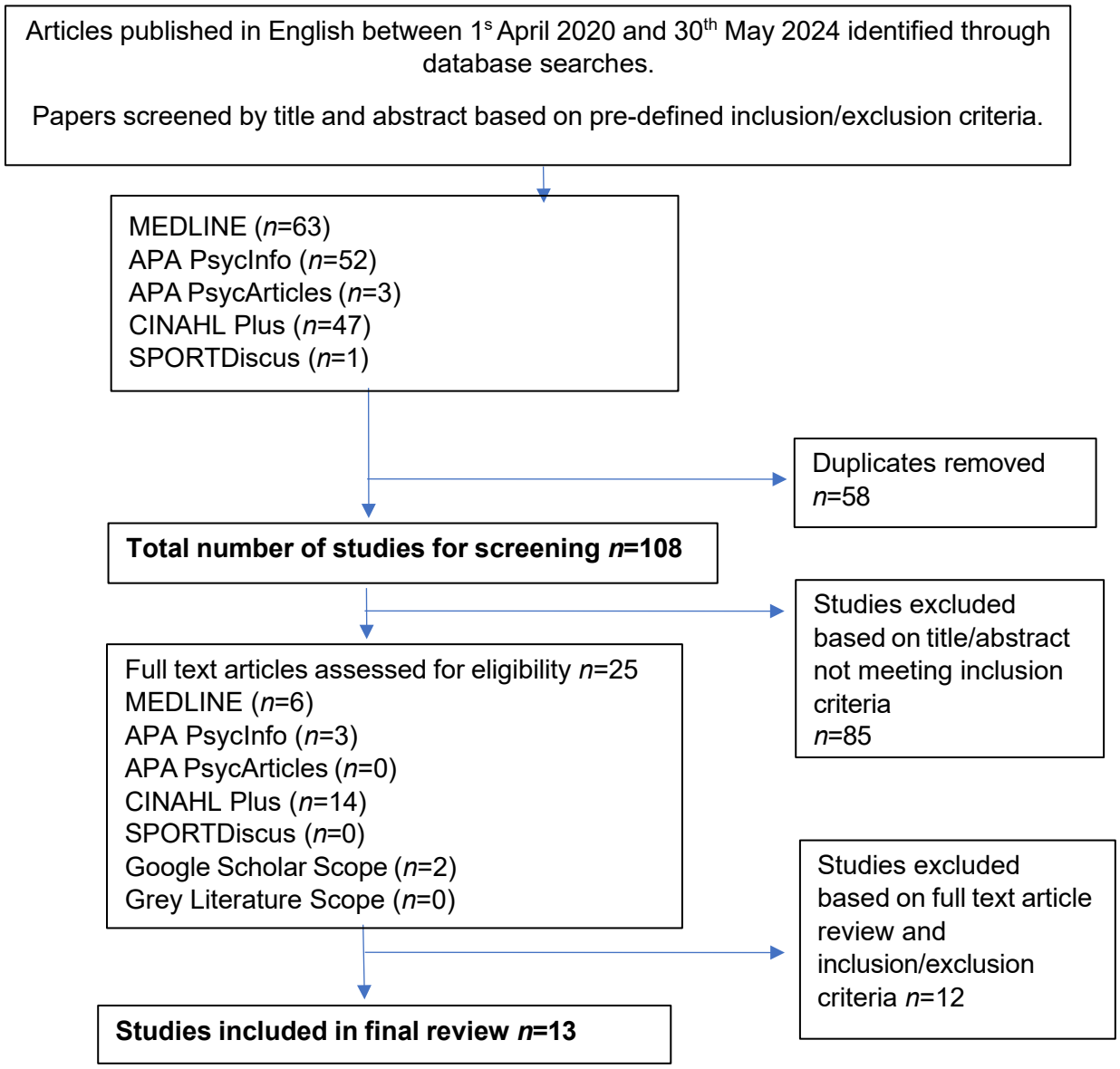
Preliminary scoping searches were conducted in February 2024 to assess whether existing research was sufficient for a systematic review. During this phase, search terms were developed, relevant terms were gathered, and synonyms were identified. The selection of search terms was also shaped by meetings with a research supervisor who had expertise in the field; this collaborative approach helped refine the scope of the review. An electronic search of the following databases was conducted between 1st-31st May 2024: MEDLINE, APA PsycInfo, CINAHL Plus, APA PsycArticles and SPORTDiscus. (Figure 1). Databases were selected based on their relevance and coverage of the subject matter. During the preliminary search conducted through the university library system, these databases were identified as containing studies that matched the search string and research criteria. The focus on peer-reviewed sources from established databases ensures a higher standard of evidence.

In addition to the database searches, a brief scope of Google Scholar retrieved two additional papers that did not emerge from the initial database search. The inclusion of Google Scholar aimed to capture a broader range of academic work, including less traditional or emerging research not yet published in major databases. These papers were screened and

included in the review. Grey literature was also briefly scoped, but no relevant results were found to contribute to this review. The screening process resulted in 13 papers for inclusion in the review. PRISMA flow diagram was used to illustrate the study selection process (Moher et al., 2009).

Figure 1:

Literature search screening process PRISMA flow diagram



Search Terms

The terms used were (‘professionals’ OR ‘staff’ OR ‘practitioner’) AND (‘experiences’ OR ‘perspectives’) AND (‘intimate partner violence’ OR ‘domestic violence’ OR domestic abuse) AND (‘pandemic’ OR ‘COVID-19’ OR ‘coronavirus’).

Screening Procedure

The inclusion and exclusion criteria were developed to ensure that all relevant papers were captured. Although methodology was not a criterion for inclusion, only qualitative and mixed-methods studies emerged during the search. To align with the review’s focus on domestic violence services and staff experiences during the COVID-19 pandemic, studies were included only if both elements were explicitly referenced in the title or abstract.

Papers that included data from generalised services such as the police or healthcare were excluded, as were studies focused on other specialist services like sexual violence. This narrowed scope allows for a more precise understanding of staff experiences within domestic violence services. Studies focusing on victim experiences were also excluded, as this was not the review’s focus. Publication date limit of 01/04/2020 onwards was applied to ensure the relevance to the pandemic period (WHO, 2020).

The initial search yielded 166 papers; after removing 52 duplicates, 108 abstracts and titles were screened using a pre-determined inclusion/exclusion framework (see Table 1). Most exclusions were due to a lack of focus on specialist domestic violence services, a focus on survivors, or inclusion of generalised services. Full texts of 25 relevant papers were reviewed, and 13 met all criteria. Two papers were excluded due to inaccessible full texts despite attempts to obtain them through the university library and individual databases.

Table 1.

Inclusion and Exclusion criteria

Inclusion	Exclusion
Title/abstract referenced staff experiences	Papers focused on survivors' experiences
Focused on domestic violence specialist services	Focused on other professional organisations (i.e. police, healthcare services)
Published from March 2020 (when pandemic restrictive measures were introduced globally)	Published prior to the COVID-19 pandemic (March 2020 or before)
Written in English	Not written in English or not translated
Papers whereby full text could be accessed	Papers that did not have access to full text

Publication Bias

Although the research community has long recognised the issue of publication bias, challenges persist, as research tends to be published only if it produces significant results (Easterbrook et al., 1991). While qualitative research does not rely on significance values, it is still vulnerable to publication bias, with studies lacking striking findings often remaining unpublished (Petticrew et al., 2008).

The 13 papers in this review predominantly appeared in journals focused on public health, social work, and domestic violence, indicating a preference for these outlets. Despite a brief scope for grey literature, no relevant unpublished papers were found, potentially reinforcing publication bias by excluding less prominent insights and may indicate an over-reliance on peer-reviewed sources.

Critical Appraisal

Critical appraisal tools are commonly used to systematically evaluate research for its relevance and value (Brice, 2022). In this review, the papers were assessed using the Critical Appraisal Skills Programme (CASP, 2018; see Appendix C) specifically designed for qualitative papers. While there are various tools available for assessing qualitative research, the CASP was deemed most appropriate because it was specifically designed for use within health research and is endorsed by both Cochrane and the World Health Organisation (Long et al., 2020).

The CASP does not provide a quality score; instead, it guides a thorough evaluation of each paper's strengths and weaknesses through its structured questions and prompts. Reviewers are instructed to mark ‘Yes’, ‘No, or ‘Can’t Tell’ in response to questions when appraising papers. This qualitative approach is particularly well-suited for appraising qualitative research, as it ensures that the nuanced aspects of each study are carefully considered. To assist in this process, the researcher created a colour-coded chart to visually appraise the papers, highlighting patterns and key areas across the studies (see Appendix A). By following the CASP guidelines, this review systematically appraises the included studies, emphasising critical aspects such as the clarity of research aims, appropriateness of methodology, thoroughness of data analysis and ethical considerations.

Results

Study Characteristics

10 qualitative and three mixed-methods papers were included for review. Key characteristics were extracted from each paper (Table 2). All papers included were peer reviewed. Most studies employed qualitative methodologies, for example, Petersson & Hansson (2022) and Riddell & Haighton (2022) used qualitative thematic analysis, while Lipp & Johnson (2023) and Cortis et al. (2021) combined qualitative and quantitative approaches. Lipp & Johnson (2023) tracked service usage quantitatively and explored staff well-being qualitatively, while Cortis et al. (2021) combined quantitative surveys with open-ended questions for qualitative insights from staff members; only the qualitative aspects of these mixed-methods papers were analysed for the review. The quantitative aspects were excluded to align with the review’s focus on the qualitative exploration of lived experience.

Data collection methods varied, with semi-structured interviews and focus groups common in qualitative studies, and surveys with open textboxes and Likert scales prevalent in mixed- methods research. Sample sizes ranged from small groups, such as four staff members in Magill (2023), to larger samples like 368 survey respondents in Pless et al., (2023). The studies were conducted in a range of Western countries, including Sweden (n=2), the UK (n=2), the USA (n=4), Canada (n=1), Australia (n=3), and Finland (n=1), highlighting the global impact of the pandemic on domestic violence services. Participants in all studies were primarily shelter staff and service professionals.

Key findings across studies indicated increased emotional strain and workload for shelter staff, as noted by Petersson & Hansson (2022) and Burd et al. (2023). The adaptation to digital services and related challenges, such as digital exclusion and maintaining client safety, were highlighted in Riddell & Haighton (2022) and Pfitzner et al., (2022). Financial strains and the need for enhanced resources were emphasised in Lipp & Johnson (2023) and Pless et al., (2023). Unique challenges of working with migrant women were noted in Magill (2023).

Table 2.

Study Characteristics

Author, Date, Country	Design & Data Source Methodology	Key strengths (+) or (-) limitations	Main Findings
Burd et al., (2023) **Canada**	Qualitative-Interpretive description; 26 interviews and 5 focus groups	+Data analysis process clearly outlined with table of themes. +Reflexivity and data triangulation mentioned in method section. -Researcher role not critically examined	The COVID-19 pandemic exacerbated stress and moral distress among staff, who faced increased workloads, evolving roles, and job insecurity. Public health guidelines reduced shelter capacities, straining resources and flexibility. Remote work blurred boundaries, causing isolation and tension amongst staff.
Cortis et al., (2021) **Australia**	Mixed methods-qualitative and quantitative feedback from a survey containing open and closed questions; 100 respondents	+Analysis process was outlined and well described. -Reflexivity not considered, although thematic analysis was used in qualitative section. -Research aims were not very clear.	During COVID-19, demand patterns for domestic violence services fluctuated, with most shelters reporting increased demand and complexity of needs. Most adapted to remote delivery methods despite challenges in risk assessment and maintaining client safety.
Pless et al., (2023) **USA**	Mixed methods – feedback from a survey; 368 respondents	+Participants recruited across America from a range of states. +Methodology and analysis well documented. - Surveys limit the depth of insights compared to interviews/focus groups.	Domestic violence shelter staff showed resilience and adaptability, balancing survivor autonomy with safety and expanding non-residential services. Most felt prepared for future crises, recommending increased mental health support and policy transparency.
Skillmark et al., (2023) **Sweden**	Qualitative-thematic analysis with 11 professionals	+Analysis process clearly documented. +Considers clinical implications. -Recruitment strategy not clearly outlined and reflexivity not considered.	Specialist social workers responded to pandemic restrictions by complying, negotiating, and resisting. They adapted to remote work, finding it beneficial under certain conditions, but sometimes broke rules to prioritise client safety.

Pfitzner et al., (2022) **Australia**	Qualitative – thematic analysis from a survey with open-ended questions; 117 respondents	+Data triangulation is mentioned in method section. +Recruitment strategy clearly outlined. -Researchers' own role not critically examined.	Remote domestic violence service delivery faced challenges, impacting risk assessment and practitioner well-being. The study highlights the need for support and supervision for specialists and effective, sustainable remote service delivery models.
Leigh et al., (2022) **USA**	Qualitative – thematic analysis with staff members from various service providers across different cities	+Clear explanations of the data collection and analysis processes. +Participants recruited from a diverse range of services and areas. -Limited reflexivity.	Increased workload and stress among staff were common due to the rise in domestic violence cases. Service delivery challenges included difficulties transitioning to remote support and managing increased demand with limited resources.
Wong & Nowland (2022) **Australia**	Qualitative-grounded theory, 3 focus groups with professionals	+Researcher positioning statement included. +Reflexivity and data triangulation mentioned in method section. +Analysis process clearly documented.	Staff experiences highlighted challenges in tele-practice adaptation, technical skill and equipment shortages, along with increased workload. Blurred boundaries and reduced collegial contact intensified emotional strain, with a need for support mechanisms during crisis response.
Garcia et al., (2021)	Qualitative – thematic analysis, interviews with staff from various service providers across urban areas in the USA	+Clear explanations of the data collection and analysis processes. +Diverse geographic representation of participants.	Domestic violence service staff in urban areas adapted to increased demand, implementing flexible support and improving outreach, but faced difficulties related to safety and remote support during the pandemic.
Petersson & Hansson (2022) **Sweden**	Qualitative – thematic analysis, semi-structured interviews with 14 professionals.	+Detailed consideration of ethics +Data triangulation is mentioned in method section. -Does not appear to consider reflexivity +Detailed results section with themes and interview extracts	Swedish women's shelter professionals faced increased client needs and case severity, leading to significant emotional strain. They adapted by enhancing digital services and infection control measures but encountered barriers like reduced help-seeking due to clients' fears and economic difficulties.
Riddell & Haighton	Qualitative–thematic analysis, semi-structured interviews with 10	-Statement of reflexivity not included. +Data triangulation is mentioned in	Increased domestic abuse during COVID-19 lockdowns, with remote services providing benefits like accessibility but challenges

(2022) **UK**	staff members.	method section.	such as digital exclusion. Technology-based interventions were effective, especially for male victims, but highlighted the need for safety measures and attention to digital divides.
Lipp & Johnson (2023) **USA**	Mixed methods; case study methodology, survey feedback and semi-structured interview with service director	+Data triangulation is mentioned in method section. -One interview only represents a single perspective. -Reflexivity is not considered, although not as crucial for mixed methods designs.	The research revealed shifts in domestic violence service utilisation amid COVID-19, with declines during lockdown and higher usage afterward. Staff experienced role changes and isolation challenges, highlighting the importance of well-being support. Financial strains emphasised the necessity for increased resources and organisational backing.
Magill (2023) **UK**	Qualitative-interpretative phenomenological analysis, semi-structured interviews with 4 staff members	-Analysis process was not documented. -Researchers do not comment on their relationship with research. +Research highlights nuanced difficulties for migrant and racial minoritised women and staff working in these services	Staff experienced heightened demand during the pandemic, adapting services online. However, closures of physical locations left vulnerable women, particularly migrants with no public funds, struggling to access support.
Kaittila et al., (2024) **Finland**	Mixed methods, quantitative and qualitative, survey feedback and inductive content analysis, 29 respondents	-The relationship between the researchers and the research was not documented. +Adherence to ethical guidelines ensuring participant safety. +Analysis process clearly documented.	The study explored the impact of COVID-19 on shelter services in Finland. Findings revealed that government stringency predicted shelter use. Staff faced challenges in adapting to new protocols, ensuring client safety, and managing their well-being amidst uncertainties.

Critical Appraisal

Aims

Twelve of the papers clearly outlined their research aims, enabling the reader to identify the researchers' priorities and better understand the significance of the findings (Petersson & Hansson, 2022; Riddell & Haighton, 2022; Lipp & Johnson, 2023; Burd et al., 2023; Pless et al., 2023, Skillmark et al., 2023; Pfitzner et al., 2022; Wong & Nowland, 2022; Magill, 2023; Kaittila et al., 2024; Garcia et al., 2021 and Leigh et al., 2022). The remaining paper (Cortis et al., 2021) was marked as ‘cannot tell’ as although the paper was explorative, the research aims were not clearly outlined in the text.

Methodology and Design

The CASP tool assesses methodology by evaluating how well the chosen method suits a qualitative design. Papers with clearly stated aims are easier to evaluate, as this is indicative of whether the research intends to examine the experiences of participants. The next step is to consider the appropriateness of the selected design for achieving the research aims.

The thirteen studies reviewed predominantly utilised qualitative methodologies and designs, each tailored to their specific research aims. Two studies (Kaittila et al., 2024 and Cortis et al., 2021) utilised mixed-method approaches, combining quantitative surveys with qualitative interviews for a comprehensive understanding. However, only the qualitative aspects of these studies were appraised for this review. Several studies applied thematic analysis to interpret qualitative data, providing in- depth insights into the experiences of staff and service providers during the pandemic (Skillmark et al., 2023; Pfitzner et al., 2022; Riddell & Haighton, 2022; Pless et al., 2023; Petersson & Hanson, 2022; Leigh et al., 2022 and Garcia et al., 2021). Whereas other qualitative methodologies were applied in different studies such as grounded theory (Wong & Nowland, 2022), interpretative phenomenological analysis (Magill, 2023), interpretive description (Burd et al., 2023) and content analysis (Lipp & Johnson, 2023).

Overall, qualitative methodologies were well-suited for studies aiming to interpret participants' experiences, and the qualitative aspects of mixed methods designs contributed valuable insights. Each study's design and methodology were aligned with its research goals, ensuring appropriateness for addressing the specific research questions.

Recruitment

All studies in this review used purposive sampling, a non-probability method where participants are selected based on specific criteria and the researcher's judgment (Rai & Thapa, 2015). This approach ensures participants have relevant expertise but often results in smaller, targeted samples. Burd et al., (2023) initially used purposive sampling but expanded through snowball sampling, where initial participants referred others.

Riddell and Haighton (2022) recruited frontline staff from a domestic abuse service in north-east England via email and existing professional networks. One researcher's dual role as service commissioner posed potential bias. Wong and Nowland (2023) mitigated bias by including researcher positioning statements when recruiting focus group participants from specialist services. Garcia et al., (2021) purposively sampled providers from diverse urban areas in the U.S. to reflect varied experiences, while Leigh et al., (2022) targeted 32 service providers across 24 U.S. cities. Pfitzner et al. (2022) and Pless et al. (2023) recruited large samples through anonymous surveys of agency staff across metropolitan, rural and remote areas in Australia. Though anonymity encouraged honesty, participant demographics were predominantly white, highly educated women, limiting generalisability.

Magill (2023) purposively sampled four employees from Southall Black Sisters, a specialist UK organisation supporting migrant and racially minoritised women. While broader surveys like Pless et al., (2023) achieved scale, Magill (2023) highlighted the value of focusing on underrepresented voices. All studies in this review employed purposive sampling, clearly explaining how participants were selected and why they were appropriate for the study. Discussions around recruitment challenges were generally limited but were implicit in the purposive sampling methodology, ensuring relevant and knowledgeable participants.

Reflexivity

In qualitative research, reflexivity, the process of researchers describing the contextual and intersecting relationships between themselves and the area of study, is crucial for providing the reader with a deeper understanding of the work (Dodgson, 2019). Additionally, reflexivity enhances the credibility of the findings, as researchers who step back to examine their own roles and interpretations increase the rigor of the study (Guillemin & Gillam, 2004).

Indication of reflexivity is noted in five of the papers: Petersson & Hansson (2022), Riddell & Haighton (2022), Burd et al., (2023), Leigh et al., (2002) and Lipp & Johnson (2023). Leigh et al., (2022), using Thematic Analysis, discussed the role of the researchers in interpreting the data but did not explicitly examine their own relationship to the study area. Additionally, Riddell & Haighton (2022) also utilising Thematic Analysis, highlighted their bias within the study limitations section as one of the authors had an existing working relationship with the participating organisation, however, reflexivity is expected to be integrated throughout the research process for Thematic Analysis (Braun & Clarke, 2006). Burd et al., (2023) outlined the relationship between the researcher and participant in their methodology section, however Interpretive Description requires a more critical examination to fully address reflexivity (Thorne, 2016). This indicates some level of reflexivity, but links to personal views or attitudes are not made.

Only one paper, by Wong & Nowland (2022), critically examined their own relationship to the research. They included researcher positioning statements and engaged in reflexive practices, consistent with Grounded Theory's emphasis on reflexivity linked to the theory development process (Charmaz, 2014). Some papers did not indicate reflexivity at all, for example, Magill (2023) did not explicitly discuss reflexivity, which is vital in Interpretative Phenomenological Analysis given its focus on the double hermeneutic process (Smith et al., 2009). The absence of reflexivity in this context limits the transparency of the findings. In the mixed methods papers, Kaittila et al., (2024) and Cortis et al., (2021) included some reflexive considerations, such as ethical reflections, however neither study explored the researchers' positionality or the influence of their perspectives on the findings. The absence of reflexivity in most of the reviewed papers affects their overall quality, particularly for qualitative papers. The researchers' personal connections to the topic, along with any individual biases or epistemological stances, remain unclear.

Ethics

The studies reviewed varied in their reporting of ethical considerations. Most obtained ethics approval and informed consent, with varying levels of detail on their procedures. For instance, Burd et al., (2023) confirmed informed consent but did not describe the process, while Cortis et al., (2021) and Kaittila et al., (2024) provided comprehensive details, including confidentiality measures. Magill (2023) addressed the ethical handling of sensitive data but lacked specific procedures, and Lipp & Johnson (2023) ensured informed consent but did not discuss potential study impacts. Pless et al., (2023) did not provide details on informed consent or confidentiality. Garcia et al., (2021) and Leigh et al., (2022) both provided detailed accounts of their ethical procedures, including how they ensured participants' confidentiality and informed consent. Skillmark et al., (2023) and Wong & Nowland (2023) included typical ethical considerations for qualitative studies, with the latter also providing positioning statements to address bias. Overall, while most studies followed ethical standards, the depth of reporting varied, which can affect the quality of the papers, as ethical considerations are crucial for ensuring validity, trustworthiness of research and safety of participants.

Analysis

Across the thirteen studies, data analysis methods varied, with over half employing Thematic Analysis (Skillmark et al., 2023; Pfitzner et al., 2022; Pless et al., 2023; Riddell & Haighton, 2022; Garcia et al., 2021; Leigh et al., 2022; Petersson & Hansson, 2022). Most used a traditional approach (Braun & Clarke, 2006), though few clarified whether Reflexive Thematic Analysis (Braun & Clarke, 2019) was used. This version emphasises researcher reflexivity and the subjective nature of theme development, yet these aspects were not explicitly addressed, and tools such as thematic maps were often omitted.

Several studies described coding and theme development processes, though not always clearly. Petersson & Hansson (2022) and Leigh et al., (2022) described iterative coding and theme building, involving multiple researchers to enhance credibility. In contrast, Riddell & Haighton (2022) relied on one researcher, who also held an existing relationship with participants, raising questions around potential bias and validity.

Kaittila et al., (2024) and Cortis et al., (2021) also used Thematic Analysis but did not demonstrate reflective practices such as journaling or mapping. Magill (2023) employed Interpretative Phenomenological Analysis but gave limited detail on the analytic process, relying instead on rich interview excerpts to support findings. Wong & Nowland (2022)

provided a thorough step-by-step outline of their grounded theory analysis, incorporating ongoing researcher reflexivity to enhance credibility. However, they did not specify when data saturation was reached.

The lack of reflexivity within the papers, apart from Wong & Nowland (2022) who critically examined their own roles in relation to the research, impacts on the quality of the analysis as the researcher's stance and bias from subjective experience is unknown. Without understanding researchers' subjective experiences and positions, the analysis may lack transparency and objectivity, potentially compromising the validity of the findings.

Findings and Value

All reviewed papers clearly presented their findings. However, six studies (Magill, 2023; Skillmark et al., 2023; Pless et al., 2023; Petersson & Hansson, 2022; Garcia et al., 2021; Leigh et al., 2022) did not suggest future research directions. While this does not diminish their quality, including recommendations would have enhanced their integration into ongoing discourse, especially regarding the evolution of domestic abuse services.

Most papers reported that the COVID-19 pandemic had a substantial impact on domestic abuse service staff, increasing their workload, stress and emotional burden. Burd et al., (2023) and Magill (2023) observed rising domestic abuse rates, intensifying service demands and pressuring staff to maintain safety protocols. Cortis et al., (2021) and Riddell & Haighton (2022) detailed the challenges of shifting to remote service delivery, requiring staff to rapidly adopt new technologies. Similarly, Kaittila et al., (2024) and Petersson & Hansson (2022) noted burnout and operational strain in shelters due to rising demand and limited resources. Lipp & Johnson (2023) and Skillmark et al., (2023) echoed these operational difficulties and highlighted adjustments in service delivery models.

Garcia et al., (2021) emphasised how the pandemic deepened pre-existing social issues like economic hardship and isolation, further stressing staff. Leigh et al., (2022) reported an initial drop in survivor contact during lockdowns, followed by a sharp increase as restrictions eased, often involving more severe cases. Pfitzner et al., (2022) and Pless et al., (2023) linked increased staff stress to funding cuts and job insecurity. Wong & Nowland (2023) explored the psychological toll on staff, reporting higher anxiety, depression and burnout due to social isolation and vicarious trauma. Collectively, these studies demonstrate the urgent need for improved staff support systems, mental health resources and job security measures.

In terms of clinical value, all papers adhered to qualitative standards and were peer-reviewed, strengthening their credibility (Kelly et al., 2014). The CASP tool enabled critical appraisal based on qualitative criteria rather than numerical metrics, promoting nuanced assessments of research rigor. These studies make a meaningful contribution to the literature by demonstrating the pandemic's complex effects on domestic abuse services and suggesting directions for policy and practice reform. All papers underwent peer review, enhancing their credibility and reliability (Kelly et al., 2014). However, it's important to consider that even peer-reviewed papers can be subject to publication bias influenced by factors like journal interests, funding streams, and researcher affiliations (Petticrew et al., 2008).

Synthesis of Themes across the Literature

Findings relating to staff experiences were collated from the reviewed papers and organised into themes using thematic analysis (Braun & Clarke, 2006). Through a guided process of coding and reviewing the data, key themes were identified that capture the challenges and experiences of staff working in specialist services during the pandemic. Four dominant themes emerged: (1) Increase in domestic abuse incidences, (2) Challenges in service delivery, (3) Psychological impact on staff and (4) Ethical and practical dilemmas.

Increase in Domestic Abuse Incidences

The first theme outlined across the studies reviewed is the significant increase in domestic abuse incidents during the COVID-19 pandemic, which placed additional strain on service providers. Although this was not the primary focus, this theme highlights the context within which staff were working, supporting the increased demand for services and the pressure on staff to manage higher caseloads under pandemic restrictions. Several papers, including Burd et al., (2023), Leigh et al., (2022), and Garcia et al., (2021), consistently reported a significant increase in domestic abuse incidents during the COVID-19 pandemic. This increase, noted in seven of the reviewed papers, placed additional strain on service providers, which in turn, would have also impacted on professionals' experiences during this time too.

Similarly, Pfitzner et al., (2022) highlighted a surge in coercive control and other forms of gender-based violence, particularly during the early stages of the pandemic, stressing how this escalation overwhelmed staff who were already working in challenging conditions and complicating the work of service providers. Wong & Nowland (2022) provided

further context by explaining how social isolation exacerbated the risk factors for domestic abuse. They noted that abusers could exert more control over their victims without external scrutiny, increasing the demand on service providers who had to manage more severe cases under constrained circumstances.

Petersson & Hansson (2022) found that shelters saw an influx of residents seeking refuge from increased violence at home. Staff had to adapt quickly to the growing demand, often working overtime and under significant stress to accommodate new safety protocols and increased occupancy. Lipp & Johnson's (2023) case study of a specialist agency in the United States reported a similar spike in service requests. The study noted that the initial decrease in service utilisation during the early lockdown period was followed by a sharp increase, surpassing pre-lockdown levels. Professionals experienced heightened stress as they balanced physical distancing requirements with the need to support service users, adapting to remote working whilst managing increased caseloads and more severe abuse cases.

Challenges in Service Delivery

The second theme directly addresses the review's aim to explore how service delivery adaptations impacted staff experiences and outlined across the studies reviewed that the pandemic created unique challenges for domestic abuse service providers, requiring rapid adaptations to continue supporting victims. Cortis et al., (2021) discussed how service providers had to quickly transition to remote support models and digital tools to maintain contact with clients. This shift required significant upskilling and adaptability amongst staff, who faced technical difficulties and concerns over confidentiality while trying to provide effective support remotely. Riddell & Haighton (2022) echoed these findings, noting that while virtual support services expanded accessibility, they also highlighted digital literacy gaps amongst both service providers and users, which further complicated service delivery.

Lipp & Johnson (2023) evidenced operational disruptions emphasising the strain on resources and the increased workload on staff due to the pandemic. Staff had to navigate new safety protocols, adjust to remote working, and handle an increased volume of cases, often with limited support. Magill (2023) focused on the intersection of public health measures and domestic abuse service delivery in the UK, highlighting how the implementation of necessary health measures like social distancing and lockdowns led to a significant increase in workload for service providers. Staff were required to innovate quickly, developing new procedures for remote intake and support, whilst managing their

own risk of infection. Kaittila et al., (2024) also highlighted staff difficulties in adapting to new protocols, such as increased sanitisation and social distancing requirements, ensuring client safety and increased workload. Petersson & Hansson (2022) offered insights from Sweden, displaying how women's shelters adapted to increased demand by collaborating with local authorities and community groups. Staff at these shelters had to cope with the logistical challenges of maintaining safe environments for clients whilst dealing with heightened stress and workload.

Psychological Impact on Staff

The third theme that emerged across the reviewed studies highlights the mental health impact on professionals working in domestic abuse services during the pandemic. This theme is central to the literature review's focus on lived experience, which also consisted of personal and professional challenges. Skillmark et al., (2023) explored how social workers had to balance their safety with the need to support their clients, often dealing with increased anxiety and stress due to the pressures of personal risk and professional responsibility. Social workers reported feelings of burnout and emotional exhaustion, as they were continually exposed to traumatic situations without sufficient support. The study highlighted the need for mental health resources and systemic support to help staff manage their well-being. Lipp & Johnson (2023) further highlighted the emotional impact on staff, who had to manage their own mental health while dealing with the increased severity and frequency of domestic abuse cases during the pandemic. Their case study detailed the psychological strain on staff, emphasising the need for mental health support and resources for those providing front-line services.

Cortis et al., (2021) and Riddell & Haighton (2022) both noted that the shift to remote work added a layer of isolation for service providers, who missed the mutual support of working in a shared physical space. The lack of in-person interaction with colleagues made it more challenging to debrief and share the emotional burdens of the work, further contributing to feelings of isolation and stress. Garcia et al., (2021) further noted the emotional toll on staff as they managed more severe cases during the pandemic. Magill (2023) also reported the significant mental health impacts on staff, highlighting the need for thorough support systems to address both the immediate and long-term effects of working under such high-pressure conditions. Overall, professionals in specialist services during the pandemic experienced burnout, emotional exhaustion and isolation due to increased workloads, increased case complexity and limited support.

Ethical and Practical Dilemmas

The fourth theme emerged that staff faced significant ethical and practical dilemmas; this theme captures the conflicts faced by staff in balancing public health measures with client safety. Skillmark et al., (2023) detailed how social workers had to navigate the balance between their safety and the need to support their clients, often in the absence of clear guidelines. This led to diverse responses, including strict adherence to safety protocols and sometimes resistance to restrictive measures perceived as detrimental by staff to client safety. Magill (2023) discussed the broader public health implications, highlighting the tension between implementing health measures and ensuring the safety and support of clients. Public health policies sometimes conflicted with the needs of clients, forcing staff to make difficult decisions about how to best protect their clients while also adhering to health guidelines.

Cortis et al., (2021) and Riddell & Haighton (2022) both described the practical challenges of shifting to remote support, including issues related to confidentiality and effectiveness of communication. These challenges often placed staff in difficult positions where they had to decide between maintaining client privacy and ensuring effective support. Additionally, Petersson & Hansson (2022) highlighted the ethical dilemmas faced by staff in women's shelters, who had to manage the immediate safety needs of residents while navigating the broader implications of pandemic restrictions. Professionals experienced ethical conflicts, struggling to balance client safety with public health measures, whilst navigating logistical challenges such as remote support and maintaining confidentiality.

Discussion

The COVID-19 pandemic presented unprecedented challenges for professionals working within specialist domestic abuse services, leading to increased workloads, stress, and operational difficulties. The review aimed to explore the experiences of these staff members during the pandemic. Through this exploration, key themes such as the rise in domestic abuse incidences, service delivery challenges, psychological impacts on staff, and ethical and practical dilemmas emerged. This evidence suggests that there is a need for specific support and adaptations within these specialist services.

The studies reviewed reported a significant increase in domestic abuse incidences during the pandemic, placing additional strain on service providers. Burd et al., (2023) and Magill (2023) highlighted a rise in cases, contributing this to stressors such as social isolation and financial hardship caused by lockdown measures. Similarly, Pfitzner et al. (2022) and Wong & Nowland (2023) noted that social isolation increased risk factors for domestic abuse, thus increasing the demand on services. Petersson & Hansson (2022) and Lipp & Johnson (2023) documented increased demand in women's shelters and specialised services, highlighting the need for services to adapt to meet the growing needs effectively. This surge aligns with the reviews aim to explore professionals' experiences, highlighting service adaptation as a key challenge for those in specialist services during the pandemic.

The shift towards remote service delivery was highlighted in a number of papers as a significant difficulty. Cortis et al., (2021) and Riddell & Haighton (2022) described how services had to quickly adapt to digital ways of working, which posed new technical difficulties and challenges for professionals and raised concerns about confidentiality. Lipp & Johnson (2023) emphasised the operational difficulties faced by specialist services, noting the strain on resources and increased workloads. Magill (2023) and Kaittila et al., (2024) also reported on the challenges in maintaining service continuity while adhering to public health guidelines. This highlights the need to improve digital systems, extend training programmes and increase access to support systems, directly aligning with the review's goal of exploring professionals' experiences in specialist services during the COVID-19 pandemic.

The psychological impact on professionals working in services was also significant. Skillmark et al., (2023) and Lipp & Johnson (2023) highlighted emotional strain and burnout among social workers and shelter staff. The shift to remote work added layers of isolation, as noted by Cortis et al., (2021) and Riddell & Haighton (2022), who pointed out that the lack of in person interaction with colleagues made it more challenging to debrief and reflect on difficult cases. Magill (2023) also emphasised the need for stronger support systems to address mental health challenges faced by professionals, particularly those working with vulnerable populations such as migrants.

Professionals also faced numerous ethical and practical dilemmas. Skillmark et al., (2023) discussed the balance social workers had to find between their own safety and the need to support clients. This led to varied responses, fluctuating from strict adherence to safety guidelines to resistance against measures seen as harmful to client safety. Magill

(2023) and Petersson & Hansson (2022) highlighted the conflict between public health policies and the need to provide safe, effective support to victims, requiring staff to make difficult decisions.

Clinical Implications

The findings from these studies point to important changes needed in specialist IPV services. One key priority is improving mental health support for staff, who faced high levels of stress, burnout and emotional strain whilst working during the pandemic. Providing access to mental health resources, counselling and peer support can help better manage these stressors. The increase in severe domestic abuse cases during the pandemic also highlights the need for more proactive risk assessments and adapted interventions to better support service users. These services could implement flexible tools to quickly identify high-risk cases, better managing the unpredictable nature of crises and the associated risks. Additionally, the need to strengthen digital systems for remote service delivery was highlighted. Adequately training staff to use digital software effectively whilst maintaining client confidentiality will be crucial, especially with hybrid-working becoming the norm.

Strengths

This literature review demonstrates several strengths, such as capturing the diverse experiences of professionals working in specialist IPV services during the COVID-19 pandemic. Analysing a broad range of studies, key themes emerged such as increased workloads, psychological stress, and ethical dilemmas, providing a rationale for future recommendations, such as service adaptations and policy changes. The review's focus on qualitative research offers rich, in-depth insights into the lived experiences of professionals during this time, highlighting the real-world impact of service delivery changes. Although the papers are all from Western contexts, they stem from a variety of countries, adding a range of perspectives to the review. Whilst quantitative data was excluded from the analysis in mixed-method studies, the qualitative focus throughout anchors the review in the theme of lived experience, which quantitative data cannot always capture effectively. Furthermore, the review highlights the resilience and adaptability of these professionals, offering valuable lessons for potential future crisis management.

Limitations

This literature review has several limitations. The rapid pace of pandemic-related research means recent studies may not be captured. The review focused on Western countries, limiting global relevance, as professionals in non-Western contexts may face different socio-cultural and economic challenges. Only qualitative data were appraised using the CASP tool, excluding quantitative findings from mixed-methods studies. Many papers lacked detailed reflexivity, raising concerns about potential researcher bias. Two relevant studies were excluded due to inaccessible full texts, potentially omitting valuable insights. This was partly due to the review being conducted by a single trainee clinical psychologist without funding to purchase restricted articles. While grey literature was considered, the search was not exhaustive, possibly missing further relevant work. Additionally, the rapid drive for research from healthcare bodies like the NHS may have influenced study quality. Despite these limitations, the review offers valuable insight into the experiences of professionals in domestic abuse services during COVID-19.

Research Recommendations

Future research could explore the long-term impacts of the COVID-19 pandemic on domestic abuse specialist services and professionals, considering how challenges faced and service adaptations evolve over time. As this review highlighted themes such as the psychological impact on staff and ethical and practical dilemmas, future studies could also examine the ethical challenges that arise in crisis situations. This could include investigating the ethical considerations around confidentiality, consent, and duty of care when working within remote service delivery settings. There is also a need for research focusing on mental health support for staff working in these specialist services, which could centre on strategies to mitigate burnout and emotional strain.

Studies could also include different countries that are not Western nations to diversify the literature and capture experiences of domestic abuse services in a wider, global context. Additionally, research could focus on innovative approaches to remote service delivery, assessing their effectiveness and sustainability in the longer term.

Conclusion

This literature review aimed to explore the experiences of professionals working within domestic abuse specialist services during the COVID-19 pandemic. The review found that staff experienced increased workload, stress, and operational difficulties. The rapid shift to remote service delivery and the heightened emotional strain on staff highlighted the need for stronger support systems and adaptive service models. The challenges faced by staff have potential consequences for the clients who rely on these services, possibly impacting on the quality and accessibility of support available to victims of domestic abuse. As staff were expected to manage with increased stress and operational constraints, their ability to provide consistent and effective care may be negatively affected; ultimately impacting client outcomes. Key themes identified include the rise in domestic abuse incidences, the challenges of transitioning to remote service delivery, the psychological impact on staff, and the ethical and practical dilemmas of working during the pandemic. Whilst the studies included provide valuable insights, future research should focus on longer-term impacts, wider global contexts, and providing more robust support for staff.

References

Arenas-Arroyo, E., Fernandez-Kranz, D., & Nollenberger, N. (2021). Intimate partner violence under forced cohabitation and economic stress: Evidence from the COVID-19 pandemic. *Journal of Public Economics*, *194*, 104350.

Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *The American journal of emergency medicine*, *38*(12), 2753.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589-597.

Brice, R. (2022). *What is critical appraisal?* CASP - Critical Appraisal Skills Programme. https://casp-uk.net/what-is-critical-appraisal/

Brink, J., Cullen, P., Beek, K., & Peters, S. A. (2021). Intimate partner violence during the COVID-19 pandemic in Western and Southern European countries. *European journal of public health*, *31*(5), 1058-1063.

Burd, C., MacGregor, J. C., Ford-Gilboe, M., Mantler, T., McLean, I., Veenendaal, J., ... & Violence Against Women Services in a Pandemic Research Team. (2023). The impact of the COVID-19 pandemic on staff in violence against women services. *Violence against women*, *29*(9), 1764-1786.

Campbell, A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. *Forensic science international: reports*, *2*, 100089.

Cortis, N., Smyth, C., Valentine, K., Breckenridge, J., & Cullen, P. (2021). Adapting service delivery during COVID-19: experiences of domestic violence practitioners. *The British Journal of Social Work*, *51*(5), 1779-1798.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). SAGE Publications

Dodgson, J. E. (2019). Reflexivity in Qualitative Research. *Journal of Human Lactation*, *35*(2), 220–222. https://doi.org/10.1177/0890334419830990

Easterbrook, P. J., Gopalan, R., Berlin, J. A., & Matthews, D. R. (1991). Publication bias in clinical research. *The Lancet*, *337*(8746), 867-872.

Emezue, C. (2020). Digital or digitally delivered responses to domestic and intimate partner violence during COVID-19. *JMIR public health and surveillance*, *6*(3), e19831.

Funston, L., Krayem, G., & Shackel, R. (2023). Transformative social responses to domestic, family, and sexualized violence: a qualitative exploration of insight exchange, a victim-survivor-

centered initiative informed by response-based practice. *Violence against women*, *29*(12-13), 2569-2598.

Guillemin, M., & Gillam, L. (2004). Ethics, Reflexivity, and "Ethically Important Moments" in Research. *Qualitative Inquiry*, *10*(2), 261–280. https://doi.org/10.1177/1077800403262360

Kaittila, A., Tuominen, J., Peltonen, J., Äärelä, E., & Husso, M. (2024). The Impact of the COVID-19 Pandemic on Shelter Use Frequency and Experiences of Shelter Professionals in Finland: A Mixed-Method Study. *Partner Abuse*, *15*(1).

Kelly, J., Sadeghieh, T., & Adeli, K. (2014). Peer review in scientific publications: benefits, critiques, & a survival guide. *Ejifcc*, *25*(3), 227.

Lausi, G., Pizzo, A., Cricenti, C., Baldi, M., Desiderio, R., Giannini, A. M., & Mari, E. (2021). Intimate partner violence during the COVID-19 Pandemic: A review of the phenomenon from victims' and help professionals' perspectives. *International journal of environmental research and public health*, *18*(12), 6204.

Lipp, N. S., & Johnson, N. L. (2023). The impact of COVID-19 on domestic violence agency functioning: A case study. *Journal of Social Issues*, *79*(2), 735-746.

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the Value of the Critical Appraisal Skills Programme (CASP) Tool for Quality Appraisal in Qualitative Evidence Synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. Sage Journals. https://doi.org/10.1177/2632084320947559

Magill, S. (2023). The "epidemic within the pandemic": meeting the needs of racially minoritised women experiencing domestic abuse during the Covid-19 pandemic. *Journal of aggression, conflict and peace research*, *15*(3), 187-200.

Mari, E., Fraschetti, A., Lausi, G., Pizzo, A., Baldi, M., Paoli, E., & Avallone, F. (2020). Forced cohabitation during coronavirus lockdown in Italy: a study on coping, stress and emotions among different family patterns. *Journal of Clinical Medicine*, *9*(12), 3906.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine, 6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Morgan, A., Boxall, H., & Payne, J. L. (2022). Reporting to police by intimate partner violence victim-survivors during the COVID-19 pandemic. *Journal of Criminology*, *55*(3), 285-305.

Murugan, V., Weaver, T. L., Schafer, T., & Rich, Q. (2022). Crisis work embedded in a global crisis: The early phase impact of COVID-19 on survivors of intimate partner violence and service provisions. *International journal of environmental research and public health*, *19*(8), 4728.

Petersson, C. C., & Hansson, K. (2022). Social work responses to domestic violence during the COVID-19 pandemic: Experiences and perspectives of professionals at women's shelters in Sweden. *Clinical social work journal*, *50*(2), 135-146.

Petticrew, M., Egan, M., Thomson, H., Hamilton, V., Kunkler, R., & Roberts, H. (2008). Publication bias in qualitative research: what becomes of qualitative research presented at conferences?. *Journal of Epidemiology & Community Health*, *62*(6), 552-554.

Pfitzner, N., Fitz-Gibbon, K., & Meyer, S. (2022). Responding to women experiencing domestic and family violence during the COVID-19 pandemic: exploring experiences and impacts of remote service delivery in Australia. *Child & Family Social Work*, *27*(1), 30-40.

Pless, J., Schroeder, E., Blackburn, J., & Choi, Y. J. (2023). "They Knew They Were Still Safe with Us": Experiences of Domestic Violence Shelter Staff on Survivors' Experiences in Shelter in the Early COVID-19 Pandemic. *Journal of Family Violence*, 1-13.

Rai, N., & Thapa, B. (2015). A study on purposive sampling method in research. *Kathmandu: Kathmandu School of Law*, *5*(1), 8-15.

Riddell, H., & Haighton, C. (2022). Staff perspectives on the impact of COVID 19 on the delivery of specialist domestic abuse services in the UK: A qualitative study. PLOS Glob Public Health 2 (5): e0000310.

Skillmark, M., Denvall, V., Kjellgren, C., Thulin, J., & Agevall-Gross, L. (2023). Balancing in the pandemic: how social workers respond to new risks when supporting clients who experience domestic violence. *European Journal of Social Work*, *26*(5), 935-947.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE Publications

Thorne, S. (2016). *Interpretive Description: Qualitative Research for Applied Practice* (2nd ed.). New York: Routledge.

United Nations Population Fund. (2020, April 28). *New UNFPA projections predict calamitous impact on women's health as COVID-19 pandemic continues*. https://www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues

Wessells, M. G., & Kostelny, K. (2022). The psychosocial impacts of intimate partner violence against women in LMIC contexts: toward a holistic approach. *International journal of environmental research and public health*, *19*(21), 14488.

Wong, S., & Nowland, T. (2022). Practitioner Experiences with Domestic and Family Violence in COVID-19. *Australian and New Zealand journal of family therapy*, *43*(4), 423-441.

Williamson, E., Lombard, N., & Brooks-Hay, O. (2020). Domestic violence and abuse, coronavirus, and the media narrative. *Journal of Gender-Based Violence*, *4*(2), 289-294.

World Health Organization (WHO). Violence against Women during COVID-19. Available online: https://www.who.int/newsroom/q-a-detail/coronavirus-disease-covid-19-violence-against-women (accessed on 5 January 2024).

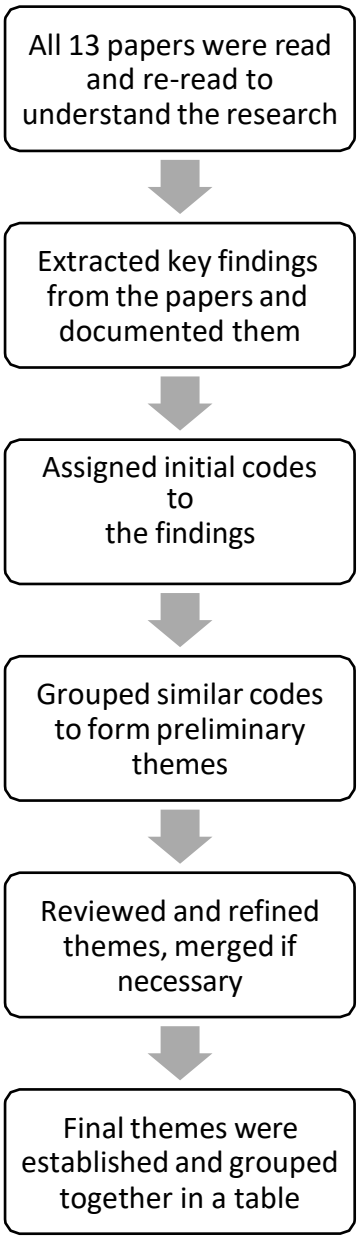
Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International journal of mental health nursing*, *29*(4), 549.

Appendix A – Table Evidencing Qualitative CASP Scores

Study	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Petersson & Hansson (2022)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Valuable
Riddell & Haighton (2022)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Valuable
Lipp & Johnson (2023)	Yes	Yes	Yes	Yes	Yes	Can't tell - discussed limitations but no researcher reflexivity	Yes	Yes	Yes	Valuable
Burd et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes - mentioned reflexivity and data triangulation but did not explicitly discuss	Yes	Yes	Yes	Valuable

Cortis et al. (2021)	Can't tell - aims not very clear	Yes	Yes	Yes	Yes	No	Yes	Can't tell - analysis process briefly outlined	Yes	Valuable
Pless et al. (2023)	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Skillmark et al. (2023)	Yes	Yes	Yes	Can't tell - not clearly outlined	Yes	No	Yes	Yes	Yes	Valuable
Pfitzner et al. (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Wong & Nowland (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Magill (2023)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Kaittila et al. (2024)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Leigh et al. (2022)	Yes	Yes	Yes	Yes	Yes	Can't tell - briefly discussed researcher impact	Yes	Yes	Yes	Valuable
Garcia et al. (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable

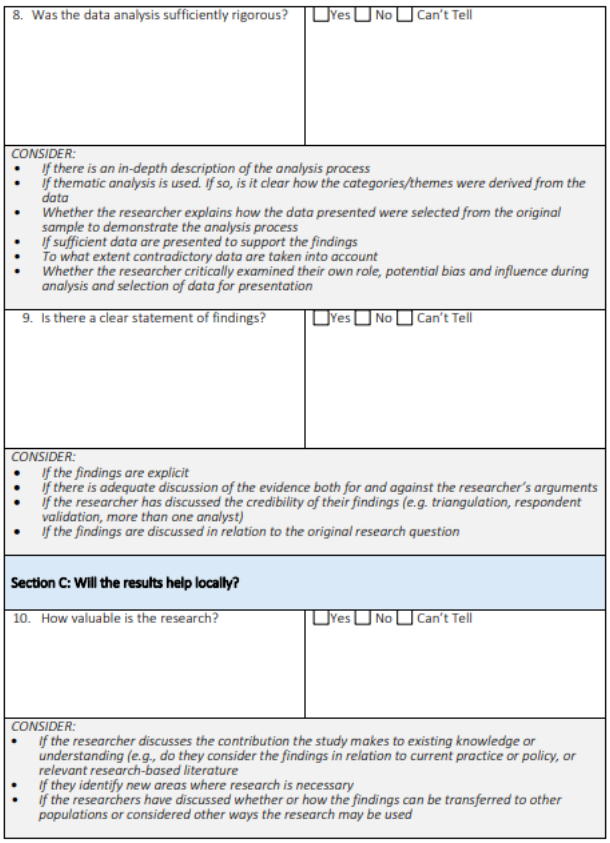
Appendix B – Process of Coding and Literature Theme Generation



Theme	Description
1. Increase in Domestic Abuse Incidences	Significant rise in domestic abuse cases during the COVID-19 pandemic creating a strain on services.
2. Challenges in Service Delivery	Difficulties in adapting to remote service delivery, managing increased workload and communication.
3. Psychological Impact on Staff	Increased stress, anxiety, and burnout amongst staff - heightened by isolation and severe abuse cases.
4. Ethical and Practical Dilemmas	Conflicts in balancing client safety with public health measures, maintaining confidentiality and service operational challenges.

Appendix C – Qualitative CASP Guidance

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
5. Was the data collected in a way that addressed the research issue?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
6. Has the relationship between researcher and participants been adequately considered?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	



8. Was the data analysis sufficiently rigorous?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature* • *If they identify new areas where research is necessary* • *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	

Appendix D - Journal Submission Guidelines

Social Science & Medicine | Journal | ScienceDirect.com by Elsevier

Key Points:

- The journal is an international, peer-reviewed publication focusing on high-quality, original research related to health and social sciences. It includes a wide range of topics in health policy, practice, and social science disciplines (e.g., anthropology, economics, psychology, sociology).
- The Journal of Social Science & Medicine considers manuscripts under the following conditions:
    - The manuscript must be original and not previously published or under review elsewhere.
    - Manuscripts must not contain abusive, defamatory, libelous, obscene, fraudulent, or illegal content.
    - Authors must ensure that the work adheres to ethical standards, including considerations of human subjects or animals where applicable.

- Submission Structure:

1. Title Page (including article title, author names, affiliations, acknowledgments, declaration of interest, corresponding author's address and email)
2. Abstract (a concise, factual summary of the research, max 250 words)
3. Keywords (1-7 keywords for indexing)
4. Main Text (Introduction, Materials and Methods, Results, Discussion)
5. Acknowledgments
6. Declaration of Interest
7. References
8. Appendices (if necessary)
9. Tables and Figures (with captions)

- Word Limits:
    - Original research articles: Up to 9,000 words (including abstract, tables, figures, references, and appendices).
    - Systematic reviews and literature reviews: Up to 15,000 words.
- Format-Free Submission:
    - Authors may submit in any scholarly format without strict formatting requirements. References can be in any style or format.

The guidelines will be fully addressed prior to submission for publication.

Paper 2: Survivors Experiences of Coping and Help Seeking for Intimate Partner Violence (IPV) during Pregnancy and the COVID-19 Pandemic in the United Kingdom.

Abstract

This study explores the experiences of survivors of intimate partner violence (IPV) during pregnancy, focusing on ways of coping and help-seeking during the COVID-19 pandemic. Using reflexive thematic analysis within a critical feminist epistemology, nine participants were recruited online from the UK to take part in semi-structured interviews via Microsoft Teams (MST).

Key themes identified were coping strategies, missed opportunities for intervention, navigating IPV through pregnancy and lockdown, systemic issues and barriers to help-seeking and future directions for service improvement. The findings highlighted avoidant and appeasement-based coping strategies, lack of formal support during the abuse period, and higher use of informal support within the constraints of lockdown restrictions. Systemic failures, including missed opportunities for disclosure and intervention, lack of IPV knowledge in services and ineffective policing and legal processes, were also identified.

Future research should explore intersectionality, particularly around race, culture and socioeconomic status, and explore help-seeking behaviours over time, once a survivor has left their relationship.

Key words: COVID-19, pregnancy, intimate partner violence, coping, help-seeking

Introduction

The rapid and unexpected outbreak of COVID-19 in 2020 led the World Health Organisation (WHO) declaring it a global pandemic in the March of that year (WHO, 2020). In response, countries worldwide implemented a range of restrictive measures to curb the virus's spread, including lockdowns, restrictions on movement, and social distancing policies (Boserup et al., 2020). While evidence suggests these strategies were effective in reducing virus transmission, they also created significant challenges across multiple factors, such as public health, economic stability, employment rates and domestic living conditions (van Barneveld et al., 2020). The implementation of lockdown and contact restrictions within the UK placed pressure on the living conditions for many people. In particular, this paper focuses on the first national lockdown in March 2020, although some participants also described experiences during subsequent lockdowns up to December 2021. There was a 33% increase in domestic violence reports under COVID-19 lockdown and overall safeguarding concerns increased by 20% during the same period (Marie Stopes UK, 2020).

One major consequence of these restrictions was an increased risk of gender-based violence, including intimate partner violence (IPV), particularly for victims forced to cohabit with their abuser during lockdown (Usher et al., 2020). Financial strain, social isolation, lack of external support, and disruptions to childcare and schooling all contributed to heightened stress levels, factors that have been strongly associated with an increased risk of IPV (Campbell, 2020). These compounding social pressures not only

raised the likelihood of IPV occurring but also intensified its severity (Wessells & Kostelny, 2022). Evidence also suggests that the pandemic not only exacerbated existing abuse but also acted as a catalyst for new incidences of IPV in relationships where there had been no prior history (Bhuptani et al., 2023). This highlights how the pandemic acted as both a continuation and an emergence of abuse, requiring further understanding into the intersections between IPV and public health crises.

IPV manifests in various forms, including physical, sexual, emotional, and economic abuse, and is often perpetuated through coercive control (Breiding et al., 2015), acts of assault, threats, humiliation and intimidation that is used to harm, punish, or frighten the victim (Womens Aid, 2024). In Western Europe, an estimated 19.3% of heterosexual women have experienced IPV in their lifetime, while in the UK, approximately one in four women are expected to encounter IPV (Brink et al., 2021; Refuge, 2023). Data from the Crime Survey for England and Wales estimates that approximately 699,000 men experienced domestic abuse in the year ending March 2022, compared to 1.7 million women (ONS, 2022) highlighting that whilst men can be victims of IPV, it disproportionately affects women. On a global scale, the WHO reports that one in three women will experience IPV, with 42% of cases leading to physical injury and 38% of female homicides linked to IPV (WHO, 2013). Previous research indicates that between 20% and 30% of pregnant women will experience physical violence at the hands of a partner or ex-partner during pregnancy (Devries et al., 2010; Johnson et al., 2003). It has been reported that for pregnant women in the USA, around 36% experience verbal abuse, 14% experience severe physical violence and 20% experience sexual violence (Bailey, 2010).

Research has consistently demonstrated that societal and global crises such as pandemics and natural disasters are associated with increased IPV rates. The disruption to social support networks, restricted access to essential services, and intensification of financial and emotional stressors are thought to contribute to this increased rate (Lauve-Moon & Ferreira, 2017; Brink et al., 2021). A literature review and meta-analysis by Ghahramani et al., (2024) reviewed 41 studies and concluded that about one-third of women experienced IPV during the COVID-19 pandemic, with psychological abuse being the most prevalent (33%). The studies included in this literature review came from a diverse range of countries, such as Iran, Turkey, USA and Ethiopia. Furthermore, in the UK, the number of domestic abuse-related killings of women more than doubled in the first three weeks of the COVID-19 lockdown compared to the average for the same period over the previous decade (Grierson, 2020).

In a similar vein, research has also demonstrated that in general pregnancy is correlated with increased incidences of IPV (Devries et al., 2010; Johnson et al., 2003; Bailey, 2010). In many cases, domestic abuse begins in pregnancy, while for others it escalates in terms of frequency of incidences and severity of violence (Women's Aid, 2019). Most notably, in the USA, homicide is ranked as the leading cause of death during pregnancy and the post-partum period, with a 16% higher than homicide prevalence among

nonpregnant and non-postpartum women (Wallace, 2021). Therefore, pregnancy may act as a catalyst in the dynamics of IPV, intensifying abuse in relationships where IPV was previously less evident. The increased incidence of IPV during both pregnancy and societal crises indicates that further investigation into this intersection is warranted, particularly in understanding how they may exacerbate each other and impact the safety of the victims.

Previous literature concerning this intersectionality by Huldani et al., (2022) a review and meta-analysis of six quantitative papers, found a significant rise in IPV among pregnant women during the pandemic, with psychological abuse being the most prevalent. The studies, from countries such as Canada, South Africa and Jordan, highlight the global nature of the issue. However, the review did not include any UK-based studies. Limitations such as significant heterogeneity and publication bias were noted, raising concerns about the generalisability of the findings. Similarly, Maharlouei et al., (2023) conducted a study in Shiraz, Iran, and found a high prevalence of IPV among pregnant women during the COVID-19 pandemic, with 93.1% of participants reporting experiences of abuse. Again, psychological abuse was the most common form of IPV reported, suggesting that emotional and psychological abuse is prevalent in these circumstances. It has been reported previously that the prevalence of violence during pregnancy is slightly lower than the non-pregnant population, between 2% and 13.5% (Devries et al., 2010).

The Survivor Theory

The Survivor Theory (Gondolf & Fisher, 1988) highlights how women actively cope with and survive abuse, whether through accessing formal or informal support or relying on personal coping strategies. Prior research has shown that women use medical, legal, social and community services as a means of coping (Swan & Sullivan, 2008; Fugate et al., 2005). Access to both formal and informal support is often essential for leaving abusive relationships. Rose and Campbell (2000) found that disclosure to family or friends often led to further, more formal help-seeking, reducing isolation and enabling access to services such as shelters or legal aid.

However, the COVID-19 pandemic severely disrupted these pathways to support. Lockdowns limited access to services, with many shifting to remote working (Emezue, 2020), which exacerbated vulnerability, increasing IPV severity (Usher et al., 2020) and contributed to a rise in domestic abuse related killings (Grierson, 2020). The Survivor Theory was chosen for this study due to its recognition of survivor agency, in contrast to earlier models such as learned helplessness (Walker, 1979). Aligned with a critical feminist position, it emphasises how women navigate abuse within structural constraints, that were intensified during lockdown, limiting agency and shaping help-seeking behaviours.

Recent research by McKinlay et al., (2023) applied a reflexive thematic analysis (Braun & Clark, 2022) to explore how IPV was experienced during the pandemic. They identified themes of escalating abuse, limited service access, fear and isolation. Their work highlighted systemic failures but does not consider the

unique vulnerabilities of pregnancy.

The Current Study

This study builds on previous literature and expands the findings of McKinlay et al., (2023) by specifically exploring how women coped with and sought help for IPV during pregnancy within the unique constraints of the UK's COVID-19 lockdown. The intersection of pregnancy, IPV and a public health crisis remains significantly under-researched in the UK, and this study seeks to address that gap by centring survivors' voices.

Through qualitative interviews, the research explores women's experiences of IPV during pregnancy, focusing on their coping strategies, the physical and psychological barriers to help-seeking and the role of systemic responses to abuse during the pandemic.

The research question guiding this study is: *How did women who were pregnant during the UK COVID-19 lockdown(s) experience and navigate IPV, including their coping strategies and help-seeking behaviours?*

The findings aim to inform clinical practice, guide trauma-informed approaches and contribute to policy development across services.

Method

Research Design

This study employed a qualitative research design using semi-structured interviews to explore the experiences of women who were pregnant and living with an abusive partner during the COVID-19 lockdown(s). Semi-structured interviews allowed for in-depth exploration of participants' perspectives while providing flexibility for individual experiences to emerge. The study was underpinned by a critical feminist epistemology, which views knowledge as socially and structurally constructed, particularly through gendered experiences. This perspective shaped the entire research design, including the use of open-ended questions to explore systemic barriers, power dynamics within relationships and patriarchal influences on help-seeking.

Participants

Seventeen women initially agreed to participate in the study. However, only nine completed the full interview process, see Table 1. The reasons for non-participation included discomfort with being recorded and the absence of incentives for participation. Additionally, some participants who initially expressed interest did not respond to the researcher when invited to schedule an interview.

This study focused on heterosexual IPV due to the gendered nature of domestic violence, where women are disproportionately affected (ONS, 2022). Therefore, including LGBTQ+ relationships was outside the scope of this project, as their experiences may differ and require separate contextual analysis (Donovan

& Hester, 2014).

Table 1.

Participant Demographics

Participant	Age (years)	Ethnicity
1	31	White British
2	32	White British
3	28	Mixed African & White
4	42	White British
5	30	White Irish
6	29	White British
7	33	White British
8	39	White British
9	39	White British
Mean Age	**33.00**	**—**

Ethical Considerations

Ethical approval for the study was obtained through the Staffordshire University Ethics Committee. Informed consent was obtained from all participants prior to their participation, ensuring they fully understood the study's aims, their rights and the voluntary nature of their participation. Participants were also informed of their right to withdraw which was 28 days following interview completion. Due to the sensitive nature of the topic and to safeguard their well-being, all participants were required to confirm that they had a source of

support they could access following the interview, see Table 2.

Recruitment

Recruitment was initially attempted through third-sector domestic abuse and maternity services, though responses were limited, with only one local Staffordshire service agreeing to share the recruitment poster. As a result, the researcher also pursued recruitment via social media. An online influencer known as LaLaLaLetMeExplain, who has a background in social work and creates content around sex, dating, and relationships, was approached due to her large platform of 250,000 followers on Instagram and relevance to the research topic. The researcher had followed her for several years and was subscribed to her Patreon service. Following outreach, LaLaLaLetMeExplain agreed to share the recruitment poster via her Instagram story.

The poster directed potential participants to a study website created by the researcher using Wix software. The website included study background, inclusion and exclusion criteria, and a downloadable participant information sheet. Also, a link to a consent form via Qualtrics software was provided on this site. Participants were asked to confirm their name, age, ethnicity, and email address so the researcher could arrange an online interview. The form also captured key ethical considerations, including informed consent, recording for transcription purposes and confirmation that the participant had access to support after the interview.

Table 2:

Study Inclusion Criteria

Criterion	Description	Rationale
Pregnant During Lockdown(s)	Participant was pregnant whilst living with the abusive partner during UK COVID-19 lockdown (March 2020 – December 2021)	To explore the unique intersection of pregnancy and IPV during the societal constraints of the pandemic.
Relationship Status	Must have left the abusive relationship at least 12 months prior to participation	To ensure safety, emotional distance and reduce risk of re-traumatisation.
Age	18 years or older	To ensure participants were legally able to consent and reflect adult experiences.
Gender Identity	Identifies as female	The study focused on gendered experiences of IPV during pregnancy in line with feminist epistemology.
Residency	Lives in the United Kingdom	To maintain consistency in lockdown policies, service access and healthcare systems.
Support Access	Has access to a source of support following participation	To safeguard participants' well-being due to the sensitive nature of the research.

Interview Procedure

The interview questions were shaped by the researcher's lived experience of domestic abuse and critical feminist epistemology, aiming to explore how gendered power and systemic barriers impact survivors. This informed the inclusion of questions about healthcare access, power dynamics in relationships and structural barriers to help-seeking. Questions were reviewed by the project supervisor and ethics committee as part of the approval process (see Appendix A).

Semi-structured interviews were conducted online via Microsoft Teams, lasting approximately one hour. The researcher (JH) facilitated all interviews, which were audio-recorded for transcription with participants providing verbal consent beforehand. Following each interview, JH provided a clinician-led debrief, validating participants' experiences and offering a containing space to ensure emotional safety before ending the call. Additional time was offered if participants became tearful or distressed, and follow-up emails were sent with a summary of the study and links to domestic abuse and maternity-specific resources. All identifying information, such as names and locations, was anonymised. Audio recordings, transcriptions, and consent forms were stored in separate, password-protected folders on Staffordshire University's OneDrive system. Once transcription was completed, all audio files were permanently deleted to maintain

confidentiality and data security.

Analysis

Reflexive Thematic Analysis (RTA), informed by Braun and Clarke (2022), was used due to its compatibility with the study's critical feminist lens, allowing for flexible, nuanced interpretation of lived experiences and acknowledgment of multiple truths. RTA was particularly appropriate as it embraces the active role of the researcher in the analytic process, centres reflexivity in ways that other approaches may not and supports the co-construction of meaning between researcher and participant, aligning with the study's epistemological stance.

After transcription, interviews were uploaded to NVivo v.20 software for coding. The researcher (JH) generated 368 initial codes, grounded in participants' language, and then grouped them into categories such as 'pregnancy IPV' and 'barriers to help-seeking'. These were refined into themes based on relevance to the research question. The study did not aim for thematic saturation, prioritising depth and survivor voice over generalisability. Theme development was iterative and reviewed with project supervisors.

Reflexivity

As a researcher with lived experience of domestic abuse, I approached the study with an awareness of the systemic barriers participants described and the changes they hoped to see post-COVID. I adopted a gradual approach to transcription and coding to avoid emotional burnout, shared reflections in my DClinPsy reflective practice group, received supervision from my field supervisor and kept a reflective journal throughout (see Appendix I).

This reflexive process supported my existing awareness of specific issues raised by participants, such as fear of child removal and inconsistent police responses, as well as their calls for legal reform, community-based services and more curiosity and validation from professionals. It also enhanced my sensitivity to power, service failures and informed how I interpreted participants' narratives. While maintaining professional boundaries, I offered clinician-led debriefs to provide emotional containment and validation after each interview. Reflexivity was embedded throughout the process, supporting transparency and ensuring participants' voices remained central to the analysis.

Triangulation and Service User Involvement

To enhance credibility, informal triangulation was undertaken through consultation with a midwife during the researcher's perinatal clinical placement. This discussion provided valuable insight into systemic challenges within maternity services, such as staff shortages, lack of confidence and limited continuity of care, which contextualised participants' accounts. In addition, all participants were invited to comment on and provide feedback on a summary of the analysis. This collaborative approach aimed to ensure the findings resonated with their experiences and remained grounded in survivor voices.

Results

Diagram 1.

Thematic Map

Dotted lines represent the interconnected nature of the main themes, highlighting how participants' experiences often overlapped across multiple areas rather than existing in isolation.

Theme 1: Navigating IPV During Pregnancy and Lockdown

This theme highlighted how both pregnancy and lockdown escalated the severity and/or frequency of IPV, and how survivors experienced this:

Sub-theme 1.1: Entrapment Through Pregnancy

Participants described pregnancy as a catalyst for escalating control and abuse, leaving them feeling increasingly trapped and unable to leave the relationship:

I think the pregnancy definitely made it harder. The pregnancy made it more difficult, and the pregnancy awoken another sense of shit, how am I going to… you know? – Niamh

I felt like I was too far in, I've fucked up now, haven't I? I'm having a baby, I can't leave – Danielle

Both Niamh and Danielle share how pregnancy intensified their sense of entrapment within the relationship, as pregnancy became both a psychological and physical barrier to leaving the perpetrator. Both quotes, with the hesitant and fragmented language used, indicate emotional overwhelm and uncertainty in how they navigated their pregnancies and parenthood within an abusive dynamic.

Once I was actually pregnant, he went sour and just became really horrible. Almost like, 'I don't have to keep the act up anymore because now she's pregnant - now she's not going to go anywhere' – Emma

This excerpt showed how pregnancy can become a turning point in abusive relationship dynamics, whereby it is implied that the perpetrator felt a stronger sense of control over Emma once she became pregnant. When Emma describes him as not having to *'keep up the act anymore'* highlighted how any previous affection may have been performative, and how his underlying personality or abusive tendencies began to surface. Once Emma was *'not going to go anywhere'*, the perpetrator no longer needed to maintain a façade. Emma's experience demonstrated how abusers may use reproductive events, such as pregnancy, to shift power dynamics further in their favour.

I think that one thing for me when I was pregnant was you couldn't put on any weight, he was like, 'you can't get fat, don't get fat, it's so embarrassing to get fat when you're pregnant. You're looking fat, stop eating Jaffa cakes' – Danielle

Danielle was a PE teacher and described herself as fit prior to pregnancy. This was her first pregnancy and the first time she experienced IPV. Her experience evidenced how pregnancy can serve as a catalyst for psychological and emotional abuse, with perpetrators shaming the survivors during a life event when

physical changes are inevitable. Comments made such as *'you can't get fat'* and referring to this as *'embarrassing'* devalue the natural process of pregnancy. Humiliation is utilised as a form of abuse as the perpetrator attempts to assert control over Danielle with basic behaviours such as eating.

Sub-theme 1.2: Lockdown Impact on IPV

Lockdown restrictions amplified abuse by increasing isolation, worsening perpetrators' behaviours and removing access to vital support during key moments such as labour:

There were nights where I would barricade the door, I'd take the dog in, I'd put push something against the door. I'd have all the children in with me because I didn't know what he was going to do next. I was terrified of him – Joanna

Joanna's experience demonstrated how the lockdown(s) exacerbated already challenging home dynamics. Her description of barricading the door and keeping her children and dog with her reflects the extreme fear she must have experienced during this time. The context of her partner experiencing psychotic episodes and subsequently being sectioned during the lockdown adds further complexity, highlighting how mental health crises can also intersect with IPV. However, Joanna's narrative makes it clear that she was subject to escalating abuse, and the restrictions of lockdown left her with limited options for safety or support.

His addictions got worse because he didn't have an outlet, and it was all contained within our house, and he couldn't keep a lid on it. It was just a complete shit show – Niamh

In this extract, Niamh linked worsening addiction to lockdown, as she positions the pandemic as a catalyst that intensified pre-existing difficulties for her partner. This demonstrated how crises can amplify IPV risk factors, such as substance misuse and addictive behaviours. When Niamh states *"he didn't have an outlet",* this suggests that the lockdown removed structures, such as work or social activities, that may have previously masked his behaviours.

I couldn't have my mum because it was COVID. I had to have one person, and I had to have him. I wanted my mum so bad and I was just on my own – Samantha

It is important to remember that many survivors also had to give birth during lockdown restrictions, and how this limited personal choice and autonomy during critical moments, such as labour. Although Samantha's partner was present during the birth, she refers to being *'on my own'* indicating the distress and loneliness she must have felt during this time. Samantha's experience highlighted how lockdown measures consequently increased control and power for perpetrators, by removing access to informal support networks, such as having her mum present during the birth.

Theme 2: Coping Strategies: Survival and Avoidance

This theme highlighted how survivors coped and the support they received. Participants tended to rely on hopefulness or avoidance as a means of coping with their experience. Informal support (i.e. family) and access to private therapists were the most used:

Sub-theme 2.1: Psychological Coping

This sub-theme explored the psychological coping strategies employed by survivors:

He kept saying he would be a good dad; he would be better. So, I just hoped that he would. I was like, well, how can you not step up? How could you not be there for us two? You know, I just didn't even think that was an option – Charlotte

Keep him happy and then he'll change. He'll change when she's born. Keep him happy, keep him happy – Samantha

In these quotes, Charlotte and Samantha both utilised hopefulness as a psychological coping strategy and held onto the belief that their partners would change following the birth of their babies. However, Charlotte's locus of control was external, placing responsibility on the perpetrator, expressing hope that *he* will improve. Whereas Samantha expressed an internal locus of control, assuming responsibility for managing the perpetrator's behaviour; her repetition of *"keep him happy"* may indicate a belief that her actions can determine his treatment of her.

Relatedly, another common coping strategy among participants was appeasement and avoidance, where some minimised their distress to prevent conflict, while others denied the abuse altogether:

I just pretended that it wasn't happening and carried on, I said sorry for a lot. I tried to do what I could to not piss him off – Danielle

I don't think I had any particular coping strategies which I can think of which stand out to me.
I just remember always trying to keep the peace with him because obviously I wasn't seeing my friends – Leila

Danielle and Leila's experiences both reflected coercive control, where the survivor adapts their behavior to

avoid triggering further abuse. This also highlighted how the lockdown measures reduced access to informal support, as Leila mentioned, she was unable to see her friends, forcing survivors into increased emotional dependence on their abusive partners.

Sub-theme 2.2: Accessing Support

This sub-theme examined the role of informal and formal support in helping survivors cope with IPV:

My in-laws knew and they provided help to an extent, the best they could. I did have a therapist at that time. I wasn't seeing her regularly. I'd just phone her up every so often and book an appointment – Niamh

I did have my own therapist that I was speaking with, and I did have the support of my family, but they were far away – Joanna

Despite lockdown restrictions, some survivors still relied on informal support, particularly family assistance. In the cases of Niamh and Joanna, this support was present but limited. Phrases like "to an extent" (Niamh) and "they were far away" (Joanna) suggest that while support existed for them, it may not have been fully adequate or accessible. Some participants also utilised private therapists as a means of support, however these examples also highlighted how the responsibility often fell on the survivor to seek and maintain support during an already difficult time.

My mum would bring food parcels round just so she knew I was eating because it'd be days on end where I wouldn't eat because I couldn't, as I had the baby – Hannah

My mum and dad came up and they stayed at a campsite for a couple of weeks to be close by and help with stuff – Danielle

Although this support was reportedly not present during their pregnancies, both Hannah and Danielle's families provided practical support following the birth of their babies. In Hannah's case, her mother was aware of the abuse and intentionally brought food parcels to ensure she was eating, a quiet act of care and emotional presence. In contrast, Danielle's parents also provided practical support post-partum but were unaware of the abuse until she had left her relationship. These excerpts highlighted how the meaning of informal support may depend not only on the act itself, but on whether the supporter has knowledge of the abuse.

Theme 3: Missed Opportunities

This theme highlighted failures in professional responses to IPV, where opportunities to intervene, provide support, or offer a safe disclosure space were repeatedly missed:

Sub-theme 3.1: Missed Opportunities in Healthcare

Participants described a pattern of hope followed by disappointment in healthcare settings, where they anticipated opportunities for disclosure or support, only to be met with inadequate responses:

I knew being pregnant that potentially there was a way out for me because I know they look for signs like that and I thought, here's my way out. You know, I can tell someone what's going on at home, but he made sure he was there at every single opportunity. I was never seen on my own, bar my first scan. – Hannah

My midwife said to me 'you're not being abused, are you?' I remember thinking, well, if I was, that's not a very good way to ask me – Samantha

Both quotes highlighted how the language used, and the logistics of healthcare appointments, can impact on IPV disclosure. Hannah's experience reflected how abusers can manipulate healthcare settings to maintain control and ensure that a disclosure was not made. Whereas Samantha's experience demonstrated how the line of questioning and language used during appointments can determine whether a disclosure is made or not.

During the COVID-19 lockdown(s), these challenges were exacerbated by reduced in-person appointments and staff shortages, which meant that survivors like Hannah were less likely to be seen alone. In this context, missed opportunities carried even greater risk (SafeLives, 2021).

During the lockdown(s), Joanna experienced IPV alongside the traumatic loss of her baby, whilst also navigating her partner's mental health difficulties:

I rang up my bereavement midwife to say 'this is what's been going on, this is why he was behaving like that in the hospital when I had the baby'. They referred me to a GP to get some antidepressants. That was it. – Joanna

Joanna's experience highlighted the dominance of the medical model in health services. The response to her disclosure was medicalised, rather than trauma-informed and formulation led as she was offered antidepressants, and the cause of her distress was not addressed. The limitations in care were likely intensified during lockdown, when mental health services were overwhelmed and face-to-face support was harder to access. The content of her excerpt reflected a tone of resignation, suggesting she had hoped for

support and understanding, but was met with an impersonal and blaming response instead.

He [ex-partner] shouted on the ward 'sit down, you dumb bitch, don't ever intervene with me and my son' and I was just like, I want somebody to overhear this. – Leila

Leila's experience evidenced how signs of abuse can be ignored in public and professional settings. Despite her being verbally abused in the labour ward, no intervention was made by healthcare professionals. The restrictions during COVID likely reduced staff presence, limiting opportunities for staff to witness or respond to such abuse. Leila's use of the phrase '*I want somebody to overhear this'* may have indicated some hopefulness of staff overhearing what was said to her and appropriately intervening.

Sub-theme 3.2: Missed Opportunities in Other Services

This sub-theme captured how police and specialist support services failed to provide protection or follow-up, leaving survivors to feel dismissed at moments when they hoped for support the most:

The police were called because it was a domestic and the police left me with him. They didn't take me away, even though I was very heavily pregnant. They interviewed me in the same room as him – Hannah

Hannah described an incident of police officers failing to separate her, the survivor, from the abuser, by interviewing her in the same room as him, likely making it impossible for a safe disclosure to be made and contravening police protocols around safe disclosure during domestic abuse enquiries (HM Government, 2023). The decision to leave her with the perpetrator demonstrated a lack of awareness around IPV and the heightened risk during pregnancy.

I tried calling Refuge so many times and no one ever picked up. I remember the police didn't put me in touch with any kind of support. And then in the end I found a local charity and I spoke to them, but they were like, you've already left – Charlotte

Charlotte's experience illustrated the inaccessibility of support services, where helplines were unresponsive and how survivors can fall through the gaps in service provision, particularly post-separation. Her experience with the police further highlighted a breakdown in signposting and missed opportunity for appropriate intervention; suggesting that women may not have access to the necessary resources after leaving an abusive relationship, which is also the riskiest time for survivors. Staffing shortages and overburdened services during the pandemic may have compounded these access issues too.

Theme 4: Barriers to Help-Seeking and Systemic Failures

This theme explored psychological barriers to help-seeking, such as feelings of shame and fears around social services involvement. It also identified systemic failures that make it more challenging for survivors to access support.

Sub-theme 4.1: Psychological Barriers

Survivors expressed how shame, stigma, and fear of social services prevented them from seeking help:

You're just really, really shamed over here. You're more ashamed than the person actually doing the abuse. It's well, why did you stay with them? Or you could have left at any time. Why would you do that? Why would you get pregnant? With somebody like that? You're not doing good for your kids – and that's horrible - Maeve

Maeve's experience reflected how societal stigma reinforces self-blame among survivors, particularly regarding motherhood and IPV. The social expectation that women should simply leave abusive relationships ignores the controlling nature of these relationships and the complex barriers that they regularly face. Feelings of shame and judgment not only deter help-seeking but also reinforce isolation, trapping women in situations where they feel unable to reach out.

I could have very easily said to the midwife 'look, I've got a problem here, I need help', but I was also very aware I didn't want that stigma attached to my children because I've worked in child protection – Niamh

Social services were definitely the biggest barrier just because I was uneducated, and I thought that social services are going to sweep in and take your baby off you – Leila

In both excerpts, Leila and Niamh both highlighted fears of social services involvement as a deterrent to disclosing their abuse to professionals. Leila referred to herself as being *'uneducated'* about social services, which may suggest that misinformation about services can reinforce avoidance. Whereas Niamh's background in child protection enhanced her fears of being stigmatised and wanting to shield her children from societal judgement. Niamh's phrase of *'I could have very easily said…'* demonstrated an awareness of opportunity, but her fears overrode the ability to act.

Sub-theme 4.2: Systemic Issues that Impact Help-Seeking

Systemic failings, such as lack of housing and financial support, left survivors trapped or returning to abusive partners. The impact systemic issues can also have on survivors' mental health is discussed:

I just felt there was no actual help at all. It got to the point where I contemplated taking my own life and putting my son into care just before I left, that was the only way I saw out and it's horrendous to admit it, but I didn't have any help or support from people that I thought would actually help me – Hannah

Hannah's account highlighted the impact of being unsupported by professional services when attempting to seek help when she had left her abuser, highlighting a systemic failure in meeting survivors' needs. Hannah described experiencing suicidal ideation, showing that she had reached a breaking point due to repeated failings from services that are meant to support survivors. This demonstrated how a lack of accessible and adequate professional intervention can worsen emotional suffering in abusive situations.

I really, really did try. I tried to get emergency housing from the housing executive over here [Northern Ireland]. I tried to get support with Women's Aid, I tried hostels. I tried everything to get housing before I went back home to him, and I couldn't get anything – Maeve

Maeve's attempts to seek housing support reflect the disparities in support across the UK, particularly in Northern Ireland, leaving her no choice but to return to her abuser. The language used by Maeve in this extract, *'I really, really did try'*, is indicative of the effort she made attempting to leave her abusive partner at the beginning of the pandemic. This highlighted the systemic failures that prevent survivors from escaping abusive relationships.

Emma described discovering she was pregnant for a second time after finding out she had been subjected to 'stealthing' by her partner, the non-consensual removal or failure to use a condom during sex without the partner's knowledge (Bates, 2022):

I didn't qualify for maternity leave for the second time, so I had to quit my job. I was on benefits at this point – Emma

Emma's experience evidenced the intersection of financial abuse, reproductive coercion and systemic barriers within IPV, leaving her financially and emotionally vulnerable. Emma was forced to quit her job and rely on benefits when she didn't qualify for maternity leave again. This experience highlighted how survivors of reproductive coercion may be left without economic protection, thus increasing their financial dependency on the abuser.

Theme 5: Future Directions Post-Covid

Survivors shared first-hand suggestions for improving support, highlighting the need for trauma-informed care, safer disclosure opportunities and wider systemic reforms in healthcare, justice and community services based on their lived experiences:

Sub-theme 5.1: IPV Knowledge in Healthcare

Participants reported that healthcare professionals often failed to identify signs of IPV, and overlooked the wider context of abuse:

I think GP's need more training and spotting the signs of domestic abuse. If you looked at my health record from before my son was born, up until about a year ago, I was going to the GP for all kinds of things, like Vertigo and heart palpitations. I don't get any of that now - Leila

Leila's experience focussed on a systemic failing within the medical model of healthcare, whilst also providing a suggestion for future reforms. Leila's physical presentation may have been a manifestation of the stress she was experiencing due to the abuse; however, this was viewed in isolation rather than explored holistically.

After my first was born, I had post-partum depression, simply I think because of the situation we were in – Emma

I felt so sad thinking have I got post-natal depression? I didn't, it's just him – Samantha

They put it in my notes that they were concerned about pre-natal depression. It wasn't even that I had pre-natal depression, it was him, obviously causing me all the distress – Maeve

Emma, Samantha and Maeve all reflected on how their emotional distress during their pregnancies, or when post-partum, were medicalised as a mental health difficulty. However, is it possible that their presentations at the time were indicative of a response to living in an abusive environment. Their experiences suggested that healthcare professionals may not explore the context that those experiencing IPV are living in, and automatically default to diagnosing depression, localising the problem within the survivor.

I think whether it's a health visitor, or a health professional and if the guy's just hanging around and won't leave there's got to be opportunities or they've got to be tuned in to say, well, 'that doesn't look and feel right' – Charlotte

In this excerpt, Charlotte highlighted a need for vigilance amongst healthcare professionals, particularly when a perpetrator could be displaying controlling behaviour, such as refusing to leave appointments. The perpetrator being present during these consultations is framed as a barrier to disclosure, and Charlotte suggested that professionals should be *'tuned in'* on non-verbal indicators of abuse and utilise their professional curiosity to explore this further.

Sub-theme 5.2: Community, Court and Criminal Justice Reforms

Survivors called for systemic and legal reforms, citing poor experiences with courts, police, and safeguarding professionals, while emphasising the value of grassroots and community-led support:

Our laws need change, so there needs to be laws that actually protect women. I've had a lot of dealings with courts and a man that literally attempted to murder me. They couldn't arrest him; they didn't do anything about it because he wouldn't go to the interview – Maeve

He was able to play out this whole situation in court for two years, because non-fatal strangulation is an either way offence, and I never went to the police before, they kind of saw it as trivial in the magistrates – Leila

Maeve's excerpt called for legal reforms that work for survivors and prioritise their testimonies. Often, when there is no physical evidence or the abuse is historical, legal inaction is often a common response, even in life-threatening situations such as Maeve's. Similarly, Leila explained that despite experiencing non-fatal strangulation, the magistrates treated the case as trivial due to it being her first report to the police and the offence being treated as *"either way."* Current laws and policing protocols fail to protect survivors when no immediate proof is available, preventing justice from being served and allowing abusers to evade accountability.

I think when it actually gets to the courts and stuff, I had the social worker, the CAFFCASS officer, I don't think they're educated well enough to understand that stuff [IPV], it's got to be the whole system that has to understand what that is – Charlotte

Charlotte's experience highlighted the lack of professional training in IPV she encountered and that the whole system needs a better understanding to improve their support provided to survivors. Charlotte demonstrated the ongoing struggle that IPV survivors face, even once they have left their relationship and may need to navigate the court process.

Maybe a service that women could go to, or contact, where there's just other women there to chat to, a little social meeting for when you're pregnant – Hannah

My thing is always if you help the mother, you help the children. All that any woman who is going through a hard time needs is just their community. They need people around them to help, to empower them to push on – Joanna

Joanna and Hannah both made suggestions for community reforms in their quotes and highlighted the importance of peer-based support and supporting mothers, to indirectly support their children too. Hannah suggested informal, safe social spaces for pregnant women to make connections and talk, whereas Joanna demonstrated the significance of empowering maternal wellbeing. Both quotes indicated a preference for grassroots support, as opposed to more formal, clinical services – this was also echoed by other participants during interviews.

Discussion

This study explored the experiences of coping and help-seeking among survivors of intimate partner violence (IPV) during pregnancy and the COVID-19 pandemic. Nine women participated in semi-structured interviews, with thematic analysis identifying psychological coping strategies such as avoidance, appeasement and hopefulness. Barriers to accessing formal support were also identified and systemic limitations in professional responses. These findings expand on McKinlay et al., (2023), who reported service barriers during the pandemic, by applying a more intersectional focus on pregnant women.

Throughout the interviews, informal support was more consistently utilised than formal, professional services. Pregnant women may prefer informal support due to fear of child removal, stigma, or mistrust of professional services (Lapierre, 2010). Rose & Campbell (2000) found that disclosing to family or friends often facilitated further formal help-seeking, acting as a bridge to services and reducing survivors' sense of isolation. However, during the COVID-19 lockdown, this support system was disrupted due to social distancing and contact restrictions (Emezue, 2020), contributing to increased isolation and exacerbated IPV severity (Usher et al., 2020; Campbell, 2020).

These findings align with Survivor Theory (Gondolf & Fisher, 1988), which conceptualises survivors' agency in navigating abuse through coping and help-seeking strategies. The use of appeasement, denial and hopefulness reflected efforts to preserve autonomy or maintain safety in abusive environments. This is consistent with earlier research showing that women draw on both personal and social resources to survive

IPV (Fugate et al., 2005). However, in the context of lockdown, external constraints such as forced cohabitation with perpetrators and reduced access to services reduced the effectiveness of these coping strategies.

One key finding was the limited access to formal support after separation. Participants were often deemed ineligible for women's refuges or outreach services due to having already left the relationship. This reflects a significant service gap during the post-separation period, widely acknowledged as the most dangerous time for survivors (Campbell et al., 2003). Delayed help-seeking was met with exclusion from services, pointing to an urgent need for reform in eligibility criteria and funding to provide accessible post-separation support. Participants also described the medicalisation of emotional distress during pregnancy and postpartum. Symptoms were often attributed to depression and treated with antidepressants, without recognising the abusive contexts in which distress emerged. These findings support feminist critiques that pathologising survivors' responses can mask the social and systemic causes of trauma (Johnstone & Boyle, 2018; Ussher, 2011).

Researcher positionality influenced the study's design and conduct. The researcher, informed by lived experience of domestic abuse, prioritised emotional safety and empathetic engagement, which likely contributed to the creation of a safe environment for disclosure. Standard debrief protocols felt impersonal and were accompanied with containing and validating clinical responses, acknowledging participants' mistrust of formal services. Emotional support from supervision and reflective practice groups helped the researcher manage the emotional intensity of the research. Post-analysis consultation with a specialist midwife added context on systemic challenges within maternity care.

Clinical Implications

National guidance from NICE (2014) recommends routine enquiry about domestic abuse in maternity and primary care settings. This study highlights gaps between policy and practice, particularly during COVID-19. Primary care and maternity services emerged as key areas for reform. In primary care, women were often not asked about abuse during postnatal appointments or when presenting with medically unexplained symptoms. Although IRIS (Identification and Referral to Improve Safety) training is available (IRISi, 2023), it remains non-mandatory, leading to variation in responses depending on individual clinicians' confidence and awareness of IPV.

Healthcare responses must move beyond the traditional medical model and adopt trauma-informed approaches that acknowledge the relational and social elements of IPV. Staff training should emphasise trauma-informed communication, safe disclosure protocols and the ability to identify subtle signs of abuse. Trauma-informed care should embed relational safety and emotional containment to ensure that survivors feel secure when disclosing traumatic experiences. Without continuity and trust, opportunities for intervention are likely to be missed. Continuity of care remains a significant challenge in maternity services. Systemic

issues such as staff shortages, burnout and high reliance on temporary staff, disrupt the stability of therapeutic relationships which are essential for safe disclosure. The Royal College of Midwives (2022) reported that current working conditions have led to widespread burnout and long-term sickness. Although NHS England's Better Births review (2020) recommended continuity of care models, a national shortfall of approximately 2,500 full-time midwives (RCM, 2024) poses serious implementation difficulties.

The concept of compassion fatigue (Figley, 1995) offers insight into how repeated exposure to trauma can reduce healthcare professionals' capacity for empathy. Professionals experiencing compassion fatigue may avoid emotionally difficult conversations or revert to standardised responses. This highlights the need for staff well-being initiatives, reflective supervision and team-based care models. Programmes such as POPPY (Slade et al., 2019), which integrated trauma-awareness and peer support, have demonstrated success in reducing burnout and improving service quality. Wider adoption of similar programmes may enhance both staff and service user outcomes.

Another barrier to help-seeking was fear of child removal. Many participants expressed reluctance to disclose abuse due to concerns about social service involvement. Providing psychoeducation about social services, perhaps embedded into antenatal classes, may help reduce stigma and clarify the roles of these agencies. Third-sector partnerships between maternity services, social care and domestic abuse charities could facilitate these efforts. While some women in this study accessed private therapy, this is financially inaccessible for many survivors. There is an urgent need for investment in free and accessible psychological support for IPV survivors.

Criminal justice systems were also found to have significant limitations. Training for police and courts should address the heightened risks associated with IPV during pregnancy and post-separation. The Casey Review (2023) and Shifting the Scales report (HM Government, 2023) both highlighted the prevalence of misogyny and the deep mistrust survivors feel toward police. More than 80% of IPV survivors do not report abuse, often due to fear of disbelief or escalation. These are not isolated failings but symptoms of wider systemic issues, including underfunding and patriarchal institutional norms.

This study is grounded in a critical feminist perspective, demonstrating how survivors' experiences are shaped by intersecting structural inequalities, including gendered power dynamics, medicalisation of trauma and under-resourced public services. Clinical psychologists are well-positioned to influence systemic change, such as designing trauma-informed services, shaping organisational cultures and advocating for survivor-centred care across healthcare, social care and justice systems.

Strengths and Limitations

This study is the first UK-based qualitative research to explore the intersection of pregnancy, intimate partner violence (IPV), and the COVID-19 pandemic. The findings are timely and align with current political and public health priorities, including the 2024 Government Select Committee call for evidence on violence

against women and girls (VAWG). The research offers survivor-led insights into service gaps and has potential clinical and policy implications, such as improvements to maternity screening, trauma-informed training for professionals and legal reforms. Another strength was the researcher's identity as a woman and their critical feminist stance, which informed a sensitive and respectful approach to interviews. These values helped foster emotional safety and empathy, likely enhancing rapport and encouraging open disclosure in a sensitive research area. Qualitative design allowed for rich, in-depth exploration of women's lived experiences, capturing complexities that would be missed in quantitative research. The sample size (n=9) is appropriate for thematic analysis and participants represented diverse socioeconomic backgrounds and geographic regions across the UK.

Limitations to consider are that the sample lacked ethnic diversity, with White British participants forming the majority. While one participant raised issues of racial inequality, the findings may not fully reflect the experiences of racially minoritised women. Research shows that cultural background significantly influences how IPV is experienced and how help is sought (Burman et al., 2004), limiting the transferability of the findings across cultures. Online recruitment may have introduced sampling bias and the requirement for video-recorded interviews could have excluded participants with limited digital access.

Suggestions for Future Research

Future research using complementary quantitative methods and larger samples could help generalise these findings. Broader ethnic diversity should also be prioritised, as racially minoritised women often face additional barriers to support, impacting their safety and ways of help-seeking (Burman et al., 2004; Thiara & Roy, 2022). Many participants only sought formal help after leaving the relationship, suggesting a need for longitudinal research to explore this process over time. Additionally, systemic failings identified in this study highlight the need for further research into institutional responses to IPV, particularly within healthcare, policing, and the family or criminal court systems.

References

Bailey, B. A. (2010). Partner violence during pregnancy: Prevalence, effects, screening, and management. *International Journal of Women's Health, 19*(10), 183–197. https://doi.org/10.2147/IJWH.S8632

Bates, S. (2022). Stealthing: Assessing non-consensual condom removal and its consequences. *Violence Against Women*, 28(1), 105-128. https://doi.org/10.1177/10778012211062943

Bhuptani, P. H., Hunter, J., Goodwin, C., Millman, C., & Orchowski, L. M. (2023). Characterizing intimate partner violence in the United States during the COVID-19 pandemic: A systematic review. *Trauma, Violence, & Abuse,*

24(5), 3220–3235. https://doi.org/10.1177/15248380221126187

Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *The American Journal of Emergency Medicine, 38*(12), 2753–2755. https://doi.org/10.1016/j.ajem.2020.04.077

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. SAGE.

Breiding, M. J., Basile, K. C., Smith, S. G., Black, M. C., & Mahendra, R. R. (2015). Intimate partner violence surveillance: Uniform definitions and recommended data elements, version 2.0. *Centers for Disease Control and Prevention (CDC).* https://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf

Brink, J., Cullen, P., Beek, K., & Peters, S. A. (2021). Intimate partner violence during the COVID-19 pandemic in Western and Southern European countries. *European Journal of Public Health, 31*(5), 1058–1063. https://doi.org/10.1093/eurpub/ckab118

Burman, E., Smailes, S. L., & Chantler, K. (2004). "Culture" as a barrier to service provision and delivery: Domestic violence services for minoritized women. *Critical Social Policy, 24*(3), 332–357. https://doi.org/10.1177/0261018304044363

Campbell, A. M. (2020). An increasing risk of family violence during the COVID-19 pandemic: Strengthening community collaborations to save lives. *Forensic Science International: Reports, 2*, 100089. https://doi.org/10.1016/j.fsir.2020.100089

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., & Ulrich, Y. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health, 93*(7), 1089–1097. https://doi.org/10.2105/AJPH.93.7.1089

Casey, L. (2023). *The Casey Review: A review into the standards of behaviour and internal culture of the Metropolitan Police Service*. UK Government. https://www.gov.uk/government/publications/casey-review-into-standards-of-behaviour-and-culture-in-the-metropolitan-police-service

Devries, K., Mak, J. Y., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., & Watts, C. H. (2010). Intimate partner violence during pregnancy: Analysis of prevalence data from 19 countries. *Reproductive Health Matters, 18*(36), 158–170. https://doi.org/10.1016/S0968-8080(10)36533-5

Donovan, C., & Hester, M. (2014). *Domestic violence and sexuality: What's love got to do with it?* Policy Press.

Emezue, C. (2020). Digital or digitally delivered responses to domestic and intimate partner violence during COVID-19. *JMIR public health and surveillance*, *6*(3), e19831. doi:10.2196/19831

Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner/Mazel.

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to Domestic Violence Help Seeking: Implications for Intervention. *Violence Against Women*, 11(3), 290-310. https://doi.org/10.1177/1077801204271959

Ghahramani, S., Najjari, B., Bayattork, R., & Arab-Zozani, M. (2024). Prevalence and factors influencing intimate partner violence against women during the COVID-19 pandemic: A systematic review and meta-analysis. *Medical Journal of the Islamic Republic of Iran, 38*, 104. https://doi.org/10.47176/mjiri.38.104

Gondolf E.W., Fisher E.R., *Battered women as survivors: An alternative to treating learned helplessness*. Lexington, MA: Lexington Books; 1988.

Grierson, J. (2020, April 15). *Domestic abuse killings more than double amid Covid-19 lockdown*. The Guardian. https://www.theguardian.com/society/2020/apr/15/domestic-abuse-killings-more-than-double-amid-covid-19-lockdown

HM Government. (2023). *Shifting the scales: Transforming the criminal justice response to domestic abuse*. Home Office. https://www.gov.uk/government/publications/transforming-the-criminal-justice-response-to-domestic-abuse/shifting-the-scales-transforming-the-criminal-justice-response-to-domestic-abuse-accessible

Huldani, H., Fitria, N., Hamidah, H., et al. (2022). Intimate partner violence against pregnant women during the COVID-19 pandemic: A systematic review and meta-analysis. *BMC Public Health, 22*(1), 774. https://doi.org/10.1080/03630242.2022.2096755

IRISi. (2023). *IRIS (Identification and Referral to Improve Safety): Domestic abuse and the health sector*. IRISi. https://irisi.org/

Johnson, J., Haider, F., Ellis, K., Hay, D., & Lindow, S. W. (2003). The prevalence of domestic violence in pregnant women. *BJOG: An International Journal of Obstetrics & Gynaecology, 110*(3), 272–275. https://doi.org/10.1046/j.1471-0528.2003.02216.x

Johnstone, L., & Boyle, M. (2018). *The Power Threat Meaning Framework: Overview*. British Psychological Society. https://www.bps.org.uk/power-threat-meaning-framework

Lapierre, S. (2010). Striving to be 'good' mothers: Abused women's experiences of mothering. *Child Abuse Review, 19*(5), 342–357. https://doi.org/10.1002/car.1113

Lauve-Moon, K., & Ferreira, R. J. (2017). An exploratory investigation: Post-disaster predictors of intimate partner violence. *Clinical Social Work Journal, 45*(2), 124–135. https://doi.org/10.1007/s10615-015-0572-z

Maharlouei, N., Roozmeh, S., Zahed Roozegar, M., et al. (2023). Intimate partner violence during pregnancy in COVID-19 pandemic: A cross-sectional study from South-west of Iran. *BMC Public Health, 23*(325). https://doi.org/10.1186/s12889-023-15258-x

Marie Stopes UK. (2020, June 1). *33% rise in domestic violence reports under COVID-19 lockdown*. https://www.msichoices.org/latest/marie-stopes-uk-sees-a-33-rise-in-domestic-violence-reports-under-covid-19-lockdown/

McKinlay, A.R., Simon, Y.R., May, T. *et al.* How did UK social distancing restrictions affect the lives of women experiencing intimate partner violence during the COVID-19 pandemic? A qualitative exploration of survivor views. *BMC Public Health* 23, 123 (2023). https://doi.org/10.1186/s12889-023-14987-3

National Institute for Health and Care Excellence. (2014). *Domestic violence and abuse: Multi-agency working* (Public health guideline [PH50]). https://www.nice.org.uk/guidance/ph50

NHS England. (2020). *Better births four years on: A review of progress*. https://www.england.nhs.uk/publication/better-births-four-years-on-a-review-of-progress/

Office for National Statistics. (2022, November 23). *Domestic abuse in England and Wales overview: November 2022*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022

Refuge. (2023). *Domestic abuse statistics.* Refuge UK. https://www.refuge.org.uk/our-work/domestic-abuse-statistics/

Rose, L. E., & Campbell, J. (2000). The role of social support and family relationships in women's responses to battering. *Health Care for Women International*, *21*(1), 27-39. https://doi.org/10.1080/073993300245384

Royal College of Midwives. (2022, August 16). *RCM calls for investment in maternity services as midwife numbers fall in every English region*. https://rcm.org.uk/media-releases/2022/08/rcm-calls-for-investment-in-maternity-services-as-midwife-numbers-fall-in-every-english-region/

Royal College of Midwives. (2024, June 12). *Midwives give 100,000 hours of free labour to the NHS per week to keep England's maternity services safe, says RCM* [Press release]. https://www.rcm.org.uk/media-releases/2024/june/midwives-give-100000-hours-of-free-labour-to-the-nhs-per-week-to-keep-englands-maternity-services-safe-says-rcm/

SafeLives. (2021). *SafeLives' 2020/21 survey of domestic abuse practitioners in England and Wales* [PDF]. SafeLives. https://www.safelivesresearch.org.uk/Comms/2020_21%20Practitioner%20Survey%20Final%202.pdf

Slade, P., Sheen, K., Collinge, S., Butters, J., & Spiby, H. (2019). A programme for the prevention of post-traumatic stress disorder in midwifery (POPPY): Indications of effectiveness from a feasibility study. *European Journal of Psychotraumatology, 9*(1), 1518069. https://doi.org/10.1080/20008198.2018.1518069

Swan, S. C., & Sullivan, T. P. (2008). The resource utilization of women who use violence in intimate relationships. *Violence Against Women*, *14*(10), 1050–1078. https://doi.org/10.1177/1077801208322361

Thiara, R. K., & Roy, S. (2022). 'The disparity is evident': COVID-19, violence against women and support for Black and minoritised survivors. *Journal of gender-based violence*, *6*(2), 315-330. https://doi.org/10.1332/239868021X16425822144020

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International Journal of Mental Health Nursing, 29*(4), 549–552. https://doi.org/10.1111/inm.12735

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International journal of mental health nursing*, *29*(4), 549. https://doi.org/10.1111/inm.12735

Ussher, J.M. (2011). *The Madness of Women: Myth and Experience (1st ed.).* Routledge. https://doi.org/10.4324/9780203806579

van Barneveld, K., Quinlan, M., Kriesler, P., Junor, A., Baum, F., Chowdhury, A., & Junankar, P. N. (2020). The COVID-19 pandemic: Lessons on building more equal and sustainable societies. *The Economic and Labour Relations Review, 31*(2), 133–157. https://doi.org/10.1177/1035304620927107

Walker, L. E. (1979). *The battered woman*. Harper & Row.

Wallace, M., Gillispie-Bell, V., Cruz, K., Davis, K., & Vilda, D. (2021). *Homicide during pregnancy and the postpartum period in the United States, 2018–2019. Obstetrics & Gynecology, 138*(5), 762–769. https://doi.org/10.1097/AOG.0000000000004567

Wessells, M. G., & Kostelny, K. (2022). The psychosocial impacts of intimate partner violence against women in LMIC contexts: Toward a holistic approach. *International Journal of Environmental Research and Public Health, 19*(21), 14488. https://doi.org/10.3390/ijerph192114488

Women's Aid. (2019). *Supporting women and babies after domestic abuse: A guide for professionals.* Women's Aid Federation of England. https://www.womensaid.org.uk/wp-content/uploads/2019/12/Supporting-women-and-babies-after-domestic-abuse.pdf

Women's Aid. (2024, August 19). *Coercive control - Women's Aid*. https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/#:~:text=What%20is%20coercive%20control%3F,the%20heart%20of%20domestic%20abuse.

World Health Organisation (WHO). (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence.* World Health Organisation. Publication Item

World Health Organisation (WHO). (2020). *Coronavirus disease (COVID-19) pandemic.* World Health Organisation. https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Appendix A – Interview Schedule

Section	Content
Introduction	Brief introduction of the interviewer and purpose of the study.
	Explanation of the consent process and assurance of confidentiality and anonymity.
Interview Questions	1. Can you describe your experiences of intimate partner violence (IPV) during pregnancy and the COVID-19 lockdown?
	2. In what ways did being pregnant during the lockdown influence the frequency and/or severity of IPV incidents?
	3. Did you feel that your pregnancy impacted your ability or decision to seek help or support during the lockdown? If so, what kind of support did you seek?
	4. Were there any barriers or challenges you faced in accessing support services during the lockdown?
	5. What strategies or mechanisms did you use to cope with the IPV during the lockdown?
	6. How did you maintain your well-being and mental health during the lockdown?
	7. What improvements or changes would you recommend for services for IPV survivors during and post-pandemic?
	8. Now that the pandemic is over, how has your experience of IPV during COVID affected how you think about or seek support now?
Debrief	Provide information on available support services and resources for IPV survivors.

Appendix B – Example of Thematic Analysis Process: Initial Coding Exported from NVivo

Name	Description
A&E - Missed Opportunities	<Files\\Transcripts\\Charlotte Interview> - we ended up going to A&E, but again I felt like no one was really like asking or like what's going on.
abandoning victim post-birth	<Files\\Transcripts\\Emma Interview> - he broke up with me after two weeks after the baby was born and he was just like, oh, you just, you're just a *****. Basically, you need to get a grip, like. Then he turned around was like, I didn't even really want a kid.
Abandonment	<Files\\Transcripts\\Charlotte Interview> - he started doing things like he would, he'd have a big argument and then he'd, like, drive off and just leave me there. So he'd have the car and I was just left with our child.
Abuse worsening during pregnancy	Files\\Transcripts\\Hannah Interview> - As the pregnancy got on and I got obviously more and more and more pregnant, the abuse just got worse and worse that, you know it was physical, physically abusive throughout the relationship and sexually abusive as well.
Appeasement Strategy	<Files\\Transcripts\\Charlotte Interview> - being made to apologise, even though I wasn't sorry, just 'cause I wanted, things to be OK.
attending appointment alone	<Files\\Transcripts\\Hannah Interview> - in regards to like appointments and stuff like that, obviously scans and things like that. I had to go on my own, but it was made that that was my fault.
Attending appointments	<Files\\Transcripts\\Danielle Interview> - in terms of like day-to-day, stuff like any appointments I had and stuff, if he had

alone	something better to do, he wouldn't be there
Baby as motivation to leave	<Files\\Transcripts\\Danielle Interview> - I left in the end because I was like, I'm not raising a son to be like this. I don't want to raise someone who's going to be like that man, and that's what in the end, like made me leave.
Baby as motivation to leave (2)	<Files\\Transcripts\\Hannah Interview> - I knew because I'd been with him so long and nothing had changed. I couldn't get out. I was too scared to leave. I thought if I have this baby, I will leave. And I did. Like after five weeks after having my kid, I left and I've never gone back.
Bad Advice from Services Post-Leaving	<Files\\Transcripts\\Danielle Interview> - Citizens Advice told me to let him stay in my house. I was like, don't think so. Honestly, I've actually had some really bad advice from places like that since.

Appendix C – Example of Thematic Analysis Process: Categorising Codes

Coping Strategies	Quotes to Codes
Coping - Appeasement	yeah, he really hated that. So I stopped wearing makeup, which was something I was very passionate about before. I really liked doing my makeup before I got with him when I met him, I had a face full of makeup.
Coping - Appeasement (2)	it started off by just toning it down and not wearing like foundation for example. But still doing my eyes and lipstick and then I'd get rid of the lipstick and then I get rid of the eyeshadow and just had mascara and then eventually it was just nothing.
Coping - Private Therapy	So in the end I paid for counselling.
Coping strategy - appeasement when leaving	I knew I wasn't coming back, but to get out, I had to say to him it's only going to be for a couple of days.
Psychoeducation through media	I just feel in the last couple of years, there's so much more in the media, in the press and stuff to understand and like, see those things for what they are.
Physical Coping - Avoidance Going to Work	I was going to school a lot and I think probably I was going to avoid spending time with him as well.
Psychological Coping - Questioning Partner's Behaviours	His excuse was always like all I just need to have some time for myself, which I get, but then it's always like, does it have to be every single day? Does it have to involve drugs? Can't you just go over to the neighbours and have a beer and be happy?
Psychological Coping	I remember, like, lying in bed at night thinking how can I get away? How do I leave? You know it's lockdown, I've got a newborn, I can't pack up in the middle of the night.
Psychological Coping - Appeasement	I don't know, really. Just pretended it wasn't happening and carried on, said sorry for a lot. Tried to do what I could to like not piss him off.
Psychological Coping - Appeasement (2)	So I called people less and it just ended up being texting. And then obviously texting is really tedious. So it didn't really happen much either then.
Psychological Coping - Hopefulness	I guess he kept saying like he would be a good dad. He would be better. So like, I just hoped that he would. I was like, well, how can

	you not step up? How could you not be there for us two? You know, I just didn't even think that was an o
Psychological Coping - Hopefulness	I was like, maybe things will get better when my son arrived and they didn’t.
Baby as motivation to leave	I left in the end because I was like, I'm not raising a son to be like this. I don't want to raise someone who's going to be like that man, and that's what in the end, like made me leave.
Baby as motivation to leave (2)	I knew because I'd been with him so long and nothing had changed. I couldn't get out. I was too scared to leave. I thought if I have this baby, I will leave. And I did. Like after five weeks after having my kid, I left and I've never gone back.
Appeasement Strategy	being made to apologise, even though I wasn't sorry, just 'cause I wanted, things to be OK.
psychological coping - appeasement	I don't think I had any particular coping strategies which I can think of which stand out to me. I just remember always trying to keep the peace with him because obviously I wasn't seeing my friends and going out and I wasn't going to uni or work or anything, so he was really my only kind of lifeline and social life
Psychological coping - appeasement (3)	Obviously I was at home by myself, so I was like, OK, got to keep a living. I got to keep living it. I was aware that I wanted to keep the peace, I didn't want another row.
Psychological coping - appeasement (4)	I just thought I just won't mention it. I just won't think about it and I won't mention it. I'll think about it in my own head. I'll talk about it with my mum. I won't talk about it with him.
Psychological coping - appeasement (5)	keep him happy. Keep him happy and then he'll change. He'll change when she's born. Keep him happy, keep him happy.
Psychological coping - creating a fake world	I don't know if I created like a fake world that I was learning where it was all OK
psychological coping - denial	I think part looking back, what hindsight, I think half me was like, yeah, this couldn't possibly be real.
Psychological coping - hopefulness	I thought maybe whenever the baby was born, he would maybe wise up a wee bit and maybe it would actually be like the reality check that he needed and stuff. But it wasn't
Psychological coping - hopefulness for therapy	I pinned all my hopes on him getting therapy to fix him. Now, with hindsight, it's never going to happen.
psychological coping -	I just kind of shut myself away. I tried my best to just carry on and

avoidance	pretend that everything is OK. But it wasn't.
Psychological coping - normalising situation	it was a shock, but by that stage I think I've had so many shocks. I was like, oh, OK, this is this week's problem.
coping - avoidance	So I kind of just left him to it. You know, we had quite a big house and so I just let him do his thing, I did my thing and I just carried on and then so
Coping - using previous strategies learnt	if I hadn't had the coping strategies that I've been given at the Priory, I think I probably would have got mad.
Focussing on problem solving to cope	by that stage I was like, oh, today's problem is this. OK.
Clinging onto false hope	It wasn't just me, it was her and he didn't change. I think I had this kind of, like, fake living this, like, this fake world where, like once she's once she's born, he'll change. And I think it was the only sort of hope I'd left to cling on to.
anger as motivator to leave	that's when my anger started to grow. Because, like, you're not going to change. This actually. Isn't that that horrible ******* that I've been living with for nearly a year is just you, isn't it? I was thinking that's it's not stress with having a baby. It's not stress becoming a father. It's not stressful - that's you. You are just a horrible, horrible person
preference for telephone counselling due to childcare issues	Nobody else would take me for counselling because it had to be face to face. And I was like, I can't do face to face
private therapist	I did have my own therapist that I was speaking with.
Thinking about leaving	Think I remember being in the shower and being like, right if I left him, would I be able to raise this baby on my own? So I was having those thoughts
trying to solve partners problems	then he went into a full blown psychosis and had to go back into hospital again. At which point, then there's no time for grieving or anything like that. It's straight into right. What am I going to do? How am I going to fix this?
Wanting to think I had the perfect life	When you're stuck in the middle of it, you don't want to get rid of your perfect life. Even though it wasn't even a perfect life, I don't know what I'm saying. I wanted the world to think I had a perfect life.
media influence -	then there was something on like This Morning of someone who's

comparing experiences	interviewing, who had coercive control, I'd remember my ears just picking up and listening to her, because then she was like a BBC presenter or something. Yes, yes, she was. And her husband controlled, like how much she sleeps and everything. And I was like, I was thinking he's not that bad.
self-help resources	I kind of started to self-help myself by reading books, listening to podcasts and kind of engaging with like social media content that was like pro feminism and, you know, raising awareness about domestic abuse, really.
look at my amazing life - denial	I found myself in an abusive marriage and probably a few months before that, I was patting on myself on the back, saying look at this amazing life I've created for myself
Denial - we have the perfect life	although that was going on in the background to the outside world. I was like, no, me and my husband love each other. We've got the perfect life.
Accessing private therapist remotely	I had a couple of sessions with the therapist. I remember distinctly speaking like I remember distinctly, and I don't know what triggered it, but I booked an appointment with the woman
got to get this done	I'm like, 'can't deal with that right now. Just got to get this done'. Which is awful. It's absolutely awful. It's the wrong thing to do, but it's where I am right now, so I've just kind of got to deal with what's in front of me. So that's what I did during lockdown
Trying to establish boundaries	then one night, he was like, oh, can we just we just try it without a condom. And I was like, no, absolutely not. I'm going to get pregnant instantly.
Resistance	I had made some furniture for the baby and asked him to take it up. And again he was like, do it yourself. And that's when I was literally like, why are you here? I said that to his face. Why are you here if you're not going to help me with anything whatsoever?

Appendix D – Consent Form – Questions were uploaded onto Qualtrics for online consent

CONSENT FORM

Title of Project: **Survivors' Experiences of Coping and Help-Seeking for Intimate Partner Violence (IPV) during Pregnancy and the Covid-19 Pandemic in the United Kingdom.**

- ☐ I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- ☐ I understand that my participation is voluntary and that I am free to withdraw at any time, up until **28 days** from the date of interview without giving any reason, without my medical care or legal rights being affected. After 28 days, the transcription process would have begun, and you will no longer be able to withdraw your data from the research.
- ☐ I confirm that I am eligible to participate in this study based on the Inclusion and Exclusion Criteria presented in the study advert and participant information sheet.
- ☐ I agree to the interview being audio-recorded, visually recorded and understand that once the recording has been written up (transcribed) the recording will be deleted.
- ☐ I understand that the anonymised data collected during this study may be looked at by the researcher and their supervisor. Staffordshire University may also access my anonymised data for auditing purposes. I give permission for these individuals to have access to my data.

☐I would like to be contacted after the research is completed. Please confirm: **YES** or **NO**

I agree to take part in the above study and can confirm I have a source of support I can contact following interview if required. I confirm that I have been out of the abusive relationship for a minimum of 12 months, and I am not currently at risk of harm.

Appendix E – Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Project Reference Number: SU_23_043

Survivors' Experiences of Coping and Help-Seeking for Intimate Partner Violence (IPV) during Pregnancy and the Covid-19 Pandemic in the United Kingdom.

Invitation Paragraph

My name is Jessica, and I am a Trainee Clinical Psychologist on the Staffordshire University Clinical Psychology Doctorate. I would like to invite you to participate in this research project which forms part of my doctoral research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish.

Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

I would like to find out how COVID-19 lockdowns affected women, specifically those who were pregnant, who experienced domestic violence from their partners. Lockdowns made it easier for abusers to be at home with their victims, and usual places to get help might have been closed or not easy to reach. By understanding the experiences of these pregnant women during the pandemic, we hope to learn how to better help them when they seek care. The United Nations predicted that for every 3 months of lockdown, there could be an extra 15 million cases of domestic violence worldwide. In the UK, there were more reports of domestic abuse during the first lockdown, but we don't know much about what this was like for pregnant women involved and how they managed during this difficult time.

Why have I been invited to take part?

You have been invited to take part in this research as you have been identified, according to the inclusion criteria in the study advert and below, as experiencing intimate partner violence (IPV) during the COVID-19 pandemic lockdown period (from March 2020 – December 2021). To participate in this research, and to ensure your safety, you must meet the inclusion criteria below:

- You were **pregnant** while **living with** the abusive partner during COVID-19 lockdown restrictions
- You left the abusive relationship ***at least*** 12 months ago
- You are aged 18 or over and identify as female
- You live in the UK
- You have access to a source of support you can contact following your participation in the study

What will happen if I take part?

If you choose to take part in the research you will be invited to attend an interview which will be conducted at a convenient time for yourself via Microsoft Teams, an online video software. During the interview, you will be asked to talk about your personal experience of intimate partner violence (IPV) during your pregnancy and the COVID-19 lockdown. This will follow the style of a conversation, and the researcher may ask questions such as *'Can you describe your experiences of intimate partner violence during your pregnancy and the COVID-19 lockdown?"* or *"Did you seek help or support during the lockdown? If so, what kind of support did you seek?"* As this is your own personal story there is no right or wrong things to say and it is important that you only share what you feel comfortable sharing during the interview.

The interview will take place online via Microsoft Teams, technical support can be offered if you are not familiar with the system. As the interview will be done online it is important that you are able to find a quiet, private place where you feel comfortable talking and will not be overheard or interrupted. The interview will be recorded and both visual and audio data will be collected and transcribed exactly. It is important that you have your camera on during the interview so the researcher can see that you are okay and stop if they start to see that you are finding it difficult. The recording will only start with your consent and the researcher will make you aware before they begin recording.

You have the choice if you would like to be contacted after the research project is completed, and if you would like to provide feedback on the research project or receive a summary of the research report itself. You can select either opt in or opt out on the Consent Form to indicate your choice.

Do I have to take part?

No. Participation is completely voluntary. You should only take part if you want to and choosing not to

take part will not disadvantage you in any way. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. You may also discuss your participation with your support network should you wish to. If you do decide to take part, we will ask you to sign a consent form, and you will be given a copy of this consent form to keep. Contacting the researcher does not affect the decision to participate in that after receiving more information you can still decide not to take part. It's important that you know that you can stop and withdraw from the research at any time during the interview and you do not need to give an explanation why.

Once transcription of your data set has commenced, which would be after 28 days following the date of interview, withdrawal from the study will no longer be possible.

What are the possible risks of taking part?

Taking part in the interview may bring up some difficult emotions. This may be the first time you have been asked about your personal experiences of domestic abuse/intimate partner violence, and you may have unexpected emotions in relation to this. It is recommended that you can identify someone that you trust that can provide support after the study, should you feel like you need it.

Quotations from the data extracts will be included in the final report; there is the chance that you may be able to identify yourself through the use of quotations. However, it is not expected that anyone else will be able to identify you from the quotations. Steps will be taken to mitigate the chances of this and to ensure your anonymity (e.g. the use of pseudonyms and changing names of significant people/places in data extracts).

The below links are options for support should any be required, and you will be reminded of these at the end of the interview when you receive a debrief form:

- CALM - CALM, the campaign against living miserably is a suicide prevention charity that offers free, anonymous and confidential support via their helpline and webchat for anyone who is in crisis. Phone: **0800 58 58 58** (daily 5pm-midnight) Get Help - Campaign Against Living Miserably (thecalmzone.net)

- National Domestic Abuse Helpline – this free helpline can be used for confidential support, 24-hours a day. Phone: **0808 2000 247.**

- Shout - Shout is a 24/7 text service, free on all major mobile networks, for anyone struggling to cope and in need of immediate help. Text SHOUT to 85258 Get help - free, 24/7, confidential

mental health text support service | Shout 85258 (giveusashout.org)

- The Dash Charity – Provides information, a helpline, advocacy services and legal support for adults who have experienced domestic abuse. Phone: **0175 354 9865.**

- The Samaritans – Provides emotional support to anyone in emotional distress, struggling to cope or at risk of suicide. Phone: **116 123**

- PANDAS Foundation: Support for perinatal mental health (https://www.pandasfoundation.org.uk/)

- Birth Trauma Association: Support for women experiencing trauma related to pregnancy and childbirth (https://www.birthtraumaassociation.org.uk/)

- You can also contact your local GP surgery.

- In the event of a mental health crisis, you can also contact your local crisis team for support.

What are the possible benefits of taking part?

Whilst there are no direct benefits, some people find it therapeutic to share their experiences. If you choose to participate, you may benefit from having the space to discuss your experience and how you felt during this time. Also, knowing that the findings might help further an understanding into survivors' experiences which will benefit clinicians working in the healthcare sector, as it will provide further knowledge that can inform clinical practice.

Data handling and confidentiality

Participant data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR). Your consent form will be stored separately to your interview transcript.

Your anonymised data may be discussed with the project supervisor and direct quotes from the interview will be used in the final research paper; however, your real name will not appear on any documentation. To ensure anonymity during this study you will be assigned a pseudonym or alias for yourself so that your

interview data does not contain any identifiable information. If anything is said that the researcher feels will make you identifiable this will be left out of the final report.

Although it is not anticipated, if you talk about anything that may put yourself or another at risk this information will have to be passed on for yours or another's protection. Your confidentiality will not be broken without it being discussed first.

Data Protection Statement

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

The data controller for this project will be Staffordshire University. The university will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the GDPR is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What will happen to my data?

Your name and demographic information will be held on a secure University MS Cloud database. This information will be stored separately to your interview transcripts but will also be held on a secure University MS Cloud database. Following transcription of your interview the recordings will be destroyed. The transcripts will be stored securely by the University for a period of ten years, in keeping with their policy, and destroyed thereafter. Consent forms will be stored separate to any interview data and destroyed 2 years after study completion. The University stored data may be audited.

What if I change my mind about taking part?

You are free to withdraw at any point during the interview, without having to give a reason. Withdrawing from the research will not affect you in any way. You are able to withdraw your data from the research up until your data has begun being processed for transcription, after this point, withdrawal will no longer be possible due to analysis having started (28 days after interview date).

If you choose to withdraw from the study all information you have provided for the study will be deleted.

What will happen to the results of the study?

The results of the study will be written up for a doctoral thesis and submitted for publication in a journal.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Jessica Head (Researcher)
h042131m@student.staffs.ac.uk

If you prefer to, you can contact my research supervisor:

Dr. Jason Lines

j.lines@staffs.ac.uk

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Professor Sarah Jones

sarahjane.jones@staffs.ac.uk.
Co-Chair of the Staffordshire University Ethics Committee
Staffordshire University
College Road
Stoke-on-Trent ST4
2DE

Thank you for reading this information sheet and for considering taking part in this research.

Appendix F – Debrief Form

Survivors' Experiences of Coping and Help-Seeking for Intimate Partner Violence (IPV) during Pregnancy and the COVID-19 Pandemic in the United Kingdom.

This research was conducted to learn more about survivors' experiences of coping and/or help-seeking for IPV during the COVID-19 lockdown restrictions. Previous research has shown that domestic abuse rates increased during lockdown within the United Kingdom. Here, our interest was in how survivors experienced this unprecedented time and the means in which they coped and sought support.

Thank you for participating in this research, it is greatly appreciated.

Please remember that from today's date, you have up to 28 days to withdraw your contribution to the study. After 28 days, the interview transcription process would have started and therefore I will be unable to withdraw the findings from that point.

If you wish to contact the researcher or research supervisor, please see the contact information below:

Jessica Head (Researcher) h042131m@student.staffs.ac.uk

Dr. Jason Lines (Supervisor) j.lines@staffs.ac.uk

Professor Sarah Jones
sarahjane.jones@staffs.ac.uk.
Co-Chair of the Staffordshire University Ethics Committee
Staffordshire University
College Road
Stoke-on-Trent ST4 2DE

The information below provides options for support should any be required following this interview:

- CALM - CALM, the campaign against living miserably is a suicide prevention charity

that offers free, anonymous and confidential support via their helpline and webchat for anyone who is in crisis. Phone: 0800 58 58 58 (daily 5pm-midnight) Get Help - Campaign Against Living Miserably (thecalmzone.net)

- National Domestic Abuse Helpline – this free helpline can be used for confidential support, 24-hours a day. Phone: 0808 2000 247.
- Shout - Shout is a 24/7 text service, free on all major mobile networks, for anyone struggling to cope and in need of immediate help. Text SHOUT to 85258 Get help - free, 24/7, confidential mental health text support service | Shout 85258 (giveusashout.org)
- The Dash Charity – Provides information, a helpline, advocacy services and legal support for adults who have experienced domestic abuse. Phone: 0175 354 9865.
- PANDAS Foundation: Support for perinatal mental health (https://www.pandasfoundation.org.uk/)
- Birth Trauma Association: Support for women experiencing trauma related to pregnancy and childbirth (https://www.birthtraumaassociation.org.uk/)
- The Samaritans – Provides emotional support to anyone in emotional distress, struggling to cope or at risk of suicide. Phone: 116 123
- You can also contact your local GP surgery.

In the event of a mental health crisis, you can also contact your local crisis team for support.

Appendix G – Online Recruitment Poster

Appendix H – Ethical Approval Letter

University of Staffordshire

School of Health, Education, Policing and Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	**Jessica Head**
Title of Study:	**Female Survivors' Experiences of Coping and Help-Seeking for Intimate Partner Violence during the Covid- 19 pandemic in the United Kingdom**
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of a minor amendment to your ethics application to change the research question/rationale.

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Signed: **Date: 30.10.2024**

Sarah Rose

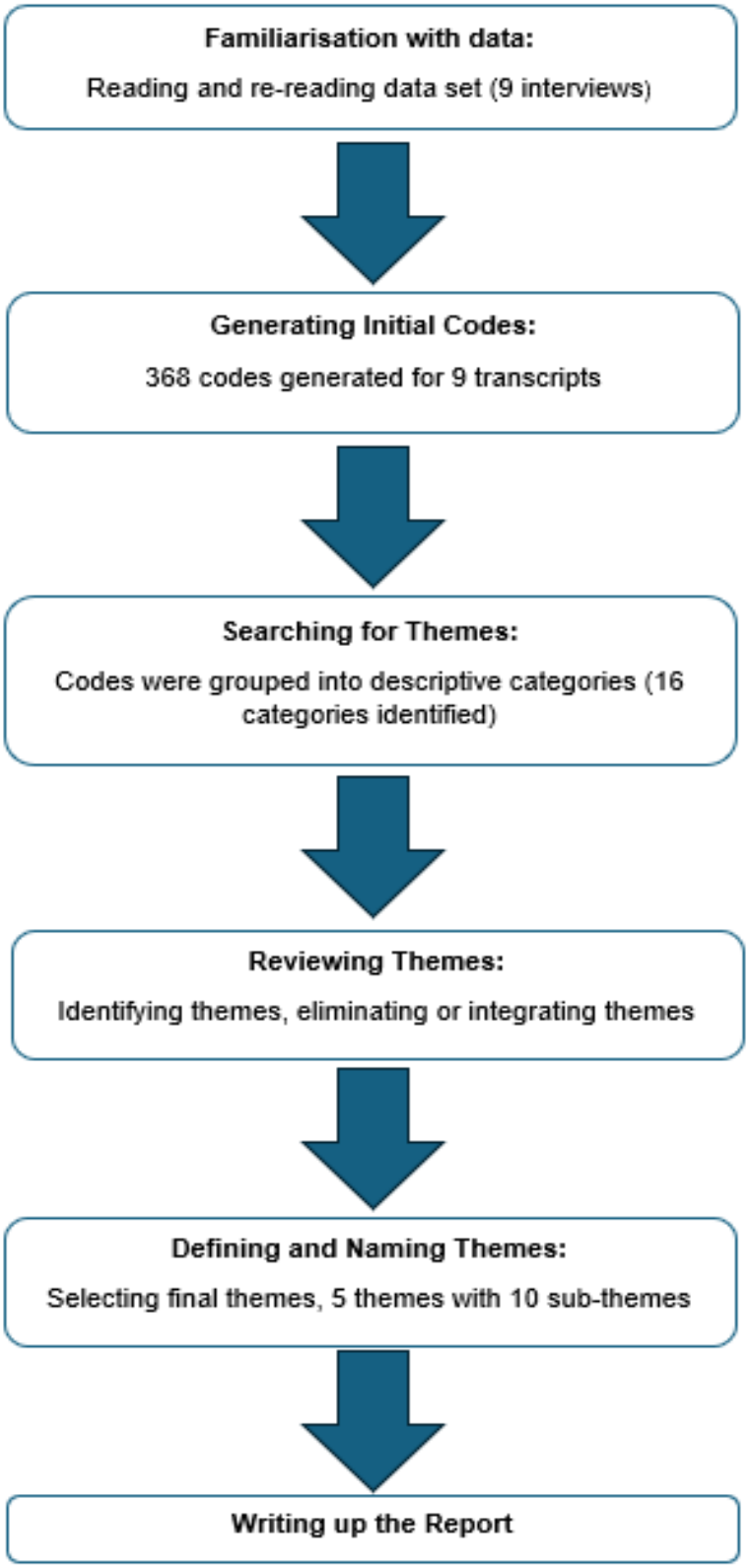
Dr. Sarah Rose

Ethics Co-ordinator - HEPS

Appendix I – Reflective Journal Extract (Documented Virtually)

***19/01/2025** - 5th out of 9 interviews transcribed today. Experienced emotions of sadness and anger whilst listening back to original recording to do transcription. Systemic failings across the board including mental health services, maternity services, primary care services, 3rd sector services and the legal/court system. Mother ordered to pay towards supervised contact for ex-partner to see child - how is this fair giving the mother was a victim of abuse? Why should their finances impact on them in a negative way just because they earn more than the perpetrator? Participant also made interesting reflections about the rise of the alt. right and how this can give 'permission' to men to behave in abusive ways and questions whether, did domestic abuse rise during COVID, or did more women simply understand what was going on for them and tried to seek help?*

Appendix J – Braun and Clark (2021) 6 step Thematic Analysis Process



Paper 3: Executive Summary

Executive Summary

This executive summary is primarily aimed at the participants of the research, healthcare professionals, policymakers, domestic abuse services and other stakeholders involved in supporting survivors of, or those experiencing, intimate partner violence (IPV) during pregnancy. This summary highlights key findings from the research and outlines recommendations for future improvements in practice and policy.

The participants have been actively involved in shaping the outcomes of this research. They were encouraged to provide feedback and insight into the study, contributing to the accuracy and relevance of the findings. A summary of the research has been shared with participants, ensuring that their voices have been acknowledged throughout the research process.

Introduction:

The outbreak of COVID-19 in 2020 led to lockdowns, social distancing and restrictions that severely impacted individuals' lives. While these measures were necessary to curb the spread of the virus, they also placed a significant strain on individuals experiencing intimate partner violence (IPV). The pandemic amplified the challenges faced by survivors, with increased isolation, heightened abuse, and limited access to support services (Usher et al., 2020). IPV is a widespread issue, affecting approximately one in four women in the UK (Refuge, 2023), and the COVID-19 lockdown exacerbated this vulnerability, particularly for pregnant women (Bailey, 2010; Devries et al., 2010).

Previous studies have shown that pregnancy often escalates IPV, with physical, emotional, and psychological abuse intensifying during this time (Bailey, 2010; Devries et al., 2010). Additionally, the pandemic contributed to a rise in IPV-related incidents, with domestic abuse-related homicides more than doubling in the first few weeks of lockdown (Grierson, 2020). Despite this, research into the intersection of IPV, pregnancy and public health crises remains limited, especially in the UK. This research aims to fill this gap by exploring how survivors navigated IPV during pregnancy and the COVID-19 lockdown, focusing on coping strategies, help-seeking behaviours and the systemic challenges faced by participants.

Research Objectives:

The key objectives of this research were:

1. To explore how survivors of IPV coped with abuse during pregnancy and the COVID-19 lockdown.
2. To examine the barriers to help-seeking and the role of formal and informal support.
3. To investigate missed opportunities for intervention by healthcare professionals, police and other services.
4. To make recommendations for policy and practice improvement to better support survivors of IPV.

Methodology:

Qualitative research design was adopted, using semi-structured interviews to explore the lived experiences of nine women who had been pregnant and living with an abusive partner during the UK's COVID-19 lockdown. Ethical approval was obtained from the Staffordshire University Ethics Committee, and participants were provided with detailed information about the study, including their right to withdraw. All interviews were conducted online via Microsoft Teams, with verbal consent obtained prior to recording.

The study employed a reflexive thematic analysis (Braun & Clarke, 2021), which allowed for an in-depth exploration of participants' experiences while acknowledging the researcher's positionality. The data was coded and categorised to identify themes and sub-themes that were relevant to the research questions.

Key Findings:

1. **Coping Strategies:** Participants often relied on psychological coping strategies, such as hopefulness and avoidance. Some believed that their partners would change after the birth of their child, while others minimised their distress to avoid further conflict. Informal support, particularly from family members, played a crucial role during the lockdown, but formal services were not commonly accessed until post-separation.
2. **Navigating IPV During Pregnancy and Lockdown:** Pregnancy and the COVID-19 lockdown(s) significantly exacerbated the severity and frequency of intimate partner violence (IPV) experienced by survivors. Participants described how pregnancy became a turning point, with abusers using it to strengthen their control, leaving

survivors feeling trapped. For example, some survivors reported increased humiliation and psychological abuse, particularly around physical changes during pregnancy. The lockdown further intensified these dynamics by isolating survivors from external support and exacerbating the abusers' behaviours, such as substance abuse.

3. **Missed Opportunities for Intervention:** The study revealed multiple missed opportunities for healthcare professionals to intervene and provide support. Many participants were not asked about IPV during healthcare appointments, were not seen alone by professionals, or were asked in an inappropriate manner. Police were identified as failing to provide adequate protection or follow-up, leaving survivors feeling unsupported.

4. **Barriers to Help-Seeking:** Fear of social services involvement and the stigma associated with IPV were significant barriers to help-seeking. Many participants feared that disclosing abuse would lead to their children being removed by social services. The pandemic intensified these barriers by limiting access to support services and making it harder to reach out for help.

5. **Systemic Failures:** Systemic failures were a key issue, with participants describing how lack of access to housing and financial support left them trapped in abusive relationships. Many reported seeking help from services, such as Women's Aid or housing services, but were either met with insufficient responses or left feeling unsupported.

6. **Future Directions for Improvement:** Survivors highlighted gaps in healthcare professionals' IPV knowledge, with distress misdiagnosed as mental health issues rather than responses to abuse. They called for improved training for healthcare professionals and better legal protections. Community-led, peer-based support services were seen as crucial for empowering survivors and providing informal, safe spaces for connection.

Implications for Practice:

This study highlights significant gaps between national guidelines and practice, particularly in primary care and maternity settings, especially during the COVID-19 lockdown. Many women were not asked about abuse during maternity appointments or when presenting with unexplained symptoms at medical appointments. For others, questions surrounding abuse were sometimes inappropriately asked and distress was commonly medicalised as pre/post-natal depression. The IRIS programme, a domestic abuse training software for GP's, is not

currently mandatory across all UK practices, meaning IPV identification is dependent on the clinician's knowledge. To address this, GP training should be mandatory, including trauma-informed communication skills, abuse identification and safe disclosure processes (IRISi, 2023).

In maternity care, systemic challenges such as staff turnover, burnout and the national midwife shortage impact care continuity and trust-building with patients. Implementing trauma-informed training, such as the POPPY programme, could reduce burnout and improve service delivery (Slade et al., 2019). Additionally, psychoeducation about social services should be incorporated into antenatal classes or community groups to reduce fears of child removal, which often prevents help-seeking (HM Government, 2023).

In response to IPV, police and courts need consistent training on the heightened risks during pregnancy and the importance of providing victims with safe opportunities to disclose abuse. Systemic failures, including misogyny within some police forces, further deter help-seeking and erodes trust (Casey, 2023). To address these issues, mandatory cross-sector training is needed to improve professionals' understanding of IPV and ensure safe, supportive responses. Clinical psychologists can contribute to reform by advocating for trauma-informed practices, supporting organisational culture change and ensuring survivor-centered approaches across healthcare, social care and criminal justice systems

Conclusions:

This research has highlighted how the COVID-19 pandemic exacerbated the challenges faced by survivors of IPV during pregnancy. It emphasized the need for better integration of IPV support within healthcare services, more robust training for professionals and a more coordinated approach across sectors to ensure that survivors are given adequate support. The study also suggests that community-based support systems could play a crucial role in supporting survivors, particularly when formal services are inaccessible or unresponsive.

Strengths and Limitations:

The strengths of this research include its focus on the intersection of IPV, pregnancy and public health crises, a gap in the literature for the UK. The qualitative design allowed for a deep understanding of survivors' experiences and the geographical diversity of participants ensured that the findings were reflective of a range of perspectives. However, while a sample size of 9 is typical for qualitative studies, it limits the generalisability of the findings, which quantitative approaches are better equipped to address. Additionally, the lack of ethnic diversity may affect the broader applicability of the results.

Suggestions for Future Research:

Future research could explore the intersectionality of IPV and pregnancy by including larger, more ethnically diverse samples. Longitudinal studies examining survivors' help-seeking behaviours over time would provide valuable insights into the long-term effects of IPV and the support needs of survivors' post-separation. Research into systemic barriers, particularly in healthcare, policing and social services, is also needed to improve institutional responses to IPV.

References

Bailey, B. A. (2010). Partner violence during pregnancy: Prevalence, effects, screening, and management. *International Journal of Women's Health, 19*(10), 183–197. https://doi.org/10.2147/IJWH.S8632

Casey, L. (2023). *The Casey Review: A Review into the Standards of Behaviour and Internal Culture of the Metropolitan Police Service.* UK Government. https://www.gov.uk/government/publications/casey-review-into-standards-of-behaviour-and-culture-in-the-metropolitan-police-service

Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., & Heise, L. (2010). *Intimate partner violence during pregnancy: The impact of maternal mental health*. The Lancet, 375(9713), 1661-1669.

Grierson, J. (2020). *Domestic violence killings during UK lockdown more than doubled*. The Guardian.

HM Government. (2023). *Shifting the Scales: Transforming the Criminal Justice Response to Domestic Abuse.* Retrieved from https://www.gov.uk/government/publications/transforming-the-criminal-justice-response-to-domestic-abuse

IRISi. (2023). *Identification and Referral to Improve Safety (IRIS) programme*. Retrieved from www.iris-safety.org.

Refuge. (2023). *Domestic abuse statistics.* Refuge UK. https://www.refuge.org.uk/our-work/domestic-abuse-statistics/

Slade, P., Sheen, K., Collinge, S., Butters, J., & Spiby, H. (2019). A programme for the prevention of post-traumatic stress disorder in midwifery (POPPY): Indications of effectiveness from a feasibility study. *European Journal of Psychotraumatology, 9*(1), 1518069. https://doi.org/10.1080/20008198.2018.1518069

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International Journal of Mental Health Nursing, 29*(4), 549–552. https://doi.org/10.1111/inm.12735