

Did domestic violence really increase in the early phase of the COVID-19 pandemic? Results of an interview-based observational study¹

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Summary

Objectives: The COVID-19 lockdown may lead to rising numbers of domestic violence (DV), especially among previously victimized individuals. The aim of this study was to investigate the development and influential factors of DV during the early COVID-19 lockdown.

Methods: In this telephone-based study, previous participants with (n = 34) and without (n = 33) DV completed questionnaires on DV, attachment and COVID-19 related stressors. Development of DV and influential factors were investigated with repeated measures ANOVAs and linear regression models.

Results: Individuals with prior DV reported significantly higher DV than previously not affected individuals. However, a statistically significant decrease of DV was found in the group with prior DV. Past DV, childlessness and insecure attachment, but not COVID-19 related stressors predicted current DV.

Conclusions: In light of an insecure attachment style lockdown measures may have led to a temporary relationship stabilization. However, a reassessment is necessary to evaluate whether this stabilization was a short-time trend only.

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Key words

Domestic Violence – COVID-19 – Attachment Style – Trauma

Zusammenfassung

Gab es wirklich mehr häusliche Gewalt zu Beginn der COVID-19-Pandemie? Ergebnisse einer interview-basierten Beobachtungsstudie

Fragestellung: Aufgrund der COVID-19-Ausgangssperre wurde eine erhöhte Gefahr für häusliche Gewalt (HG), insbesondere für frühere Opfer, befürchtet. Das Ziel dieser Studie war es, die Entwicklung von beziehungsweise Einflussfaktoren auf HG während der ersten Phase der COVID-19-Ausgangssperre zu untersuchen.

Methode: In dieser telefonbasierten Interviewstudie wurden frühere Studienteilnehmer*innen mit (n = 34) und ohne HG (n = 33) zu aktueller HG, Bindungsstil und COVID-19 bezogenen

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Belastungsfaktoren befragt. Die Entwicklung von beziehungsweise die Einflussfaktoren auf HG wurden mit ANOVAs mit Messwiederholung und linearen Regressionsmodellen untersucht.

Ergebnisse: Patient*innen mit früherer HG berichteten auch in dieser Phase eine signifikant höhere HG als zuvor nicht betroffene Personen, wobei sich auch eine statistisch signifikante Reduktion der HG in der vorbelasteten Gruppe zeigte. Risikofaktoren für HG waren frühere HG, Kinderlosigkeit und unsichere Bindung, aber nicht COVID-19 bezogene Belastungsfaktoren.

Diskussion: Vor dem Hintergrund eines unsicheren Bindungsstils könnten die Lockdown-Maßnahmen zu einer vorübergehenden Beziehungsstabilisierung geführt haben. Um die zeitliche Stabilität dieser Ergebnisse zu evaluieren, ist eine Folgeuntersuchung notwendig.

1. Background

Austria was among the first countries in Europe to face large outbreaks of COVID-19 infections during the emerging pandemic in Spring 2020. During the lockdown from March 13th to April 30th, a large proportion of the population was not allowed or unable to go to work and was required to refrain from leaving their apartment or house. At the same time, there was a severe uncertainty in the population about the short and long-term economic effect of the COVID-19 pandemic. Several national and international agencies warned about the increasing risk for domestic violence (DV) during the COVID-19 pandemic as a side effect of the curfew since families were forced to spend long-periods of time together while potentially facing severe financial difficulties at a time when counseling centers were typically not available (FRA 2020; UN 2020). In May 2020, an alarming increase of 60 % in emergency calls from women subjected to domestic was recorded within states across the European Union (Mahase 2020).

The warnings are underlined by the preliminary results of a cross-sectional study conducted in Germany: women and children were at an increased risk for DV if they were in home quarantine, had financial worries, one of the partners was psychologically distressed or if younger children (< 10 years) lived in the household. A total of 3.1 % of the women reported physical violence and 2–5 % reported emotional violence (Steinert & Ebert 2020). While these numbers do not indicate a significant increase of DV when compared to previous studies (Austrian Institute for Family Studies 2011; Devries et al. 2013; FRA 2014), the authors warn to underestimate the numbers as they refer to a relatively short period of time, while most previous studies employed longer inclusion periods. A recent cross-sectional study from the USA reported a substantial higher prevalence of 18 % for intimate partner violence (Jetelina et al. 2020).

These numbers should not be taken lightly since DV is a serious health issue associated with manifold and often long-lasting consequences for the victims' mental and physical health (Campbell 2002; Riedl et al. 2019b). It is important to better understand predictors and risk factors for DV and revictimization. Amongst other factors, the combination of adverse childhood experiences (ACEs) (Kimber et al. 2018), insecure attachment styles (Velotti et al. 2018) and previous experiences of DV (i. e. revictimization) (Bockers & Knaevelsrud 2011) have been identified as risk

factors for DV. The risk of violence victimization increases with stressful psychosocial impacts as reported during the COVID-19 pandemic, especially among previously affected individuals.

However, so far only few studies have investigated aspects of DV in the light of the COVID-19 lockdown and existing studies show a rather ambiguous picture, indicating differences in DV rates for different geographical areas. Additionally, only cross-sectional studies are available and, to our best knowledge, no study to date has specifically included high-risk samples, such as previous victims of DV.

Since we had information from a previous study about participant's DV (Riedl et al. 2020), we decided to conduct a follow-up study to evaluate the current situation of previously identified victims of DV and to offer support if necessary. The primary aim of our study was to evaluate whether experiences of DV increased during the first weeks of the COVID-19 pandemic curfew and if differences between a sample of patients with prior experiences of DV could be observed when compared to a previously unaffected sample. Secondary aims were to investigate differences between these groups regarding aggressive thoughts and impulses and to identify potential factors influencing current DV victimization.

2. Methods

2.1. Sample and procedure

This is a cross-sectional follow-up interview study including participants from a previous study (Riedl et al. 2019a). In this previous study, approximately 2,600 general hospital patients were screened for experiences of DV, ACEs, and a range of current physical and mental health problems. Among the patients who consented to being contacted for future studies, we identified those with experiences of DV (i.e., above a weighted cutoff for DV; referred to as 'DV+' from here on) and randomly drew an age- and sex-matched control sample who had reported neither DV (i.e., below the weighted cutoff for DV) nor ACEs in the previous study (referred to as 'DV-' below). A priori power calculations indicated that a sample size of $n = 54$ patients was sufficiently powered to detect mean differences of medium effect size between the two groups across two time-points in a repeated measures ANOVA design ($\alpha = .05$; $\beta = .95$; $r = .50$). G*Power 3.1 was used for sample size calculations.

A total of 102 participants were contacted between April 14th and 30th 2020, of which 67 (65.7 %) agreed to take part in the study (34 patients, 33 controls). Reasons for non-participation were lack of interest (60.0 %), lack of time (22.9 %), grave physical or mental health problems (8.6 %), language barrier (2.9 %), not wanting to conduct a phone interview (2.9 %) or immediately hanging up (2.9 %). Participants and non-participants did not statistically differ in regard to previously assessed overall number of ACEs (2.0 vs. 2.7), previous DV victimization (6.9 vs. 6.3 points), age (48.5 vs. 43.4 years), or sex (female: 65.7 % vs. 76.1 %) (all $p > .05$).

All selected individuals were contacted by phone and were informed about the study (provided they were alone and could speak freely). If they agreed to participate in the study, a date for a phone interview typically within the next two days was planned. Participants were then contacted again and (provided they were alone and could speak freely) were asked to answer the assessment instruments verbally. To minimize the risk for participants, several precautions were taken: a discreet password was agreed upon to rapidly end the interview in case a potential aggressor would enter the room; patients received written information only if they wished so and if this would not pose a risk for them (and accordingly provided verbal rather than written informed consent); in case of current DV or heightened psychological distress, participants were informed about supportive measures such as psychotherapeutic treatment, the local protection against violence center, and other helplines. The study design was approved by the ethics committee of the Medical University of Innsbruck (1108/2020).

2.2. Assessment instruments

Sociodemographic data included age, gender, relationship status, living situation, and social class. To evaluate a potential impact of the COVID-19 quarantine, participants were also asked about their living environment, if they had been affected by the COVID-19 curfew with regard to their job and whether they or a member of the household had been tested positive for COVID-19.

2.2.1. *Hurt-Insult-Threaten-Scream-Scale (HITS)*

DV levels at the time of assessment were evaluated using an adapted German version of the Hurt-Insult-Threaten-Scream (HITS) scale (Sherin et al. 1998), which consists of four items asking whether the participant was (1) screamed at or insulted, (2) threatened, (3) cursed at, talked down to or (4) physically hurt by a partner within the last two weeks. As many patients also suffer from violence committed by other people living in the same household (e. g., father, mother, sibling, brother-in-law), the HITS instructions were adapted to read “your partner or other persons living in the same household”. All patients who were living with other household members or confronted with previous household members completed the HITS scale. The items were answered on a five-point scale: “never” (1), “rarely” (2), “sometimes” (3), “fairly often” (4) and “frequently” (5). The score range was from 4 to 20 points, with higher scores indicating more frequent DV. In our sample, good internal consistency for the HITS total score ($\alpha = .83$) was found.

2.2.2. *Adult Attachment Scale*

The AAS was used to evaluate the attachment style in our sample. It consists of 18 items on a five-point Likert scale, assessing three dimensions of adult attachment styles, namely ‘close’, ‘dependent’ and ‘anxious’. A total score can be calculated, with higher values indicating a more secure and lower levels a more insecure attachment style. In our sample an excellent internal consistency could be observed for the total score of the AAS ($\alpha = .90$).

2.2.3. COVID-19 stressor checklist

To assess if participants had to face COVID-19 associated stressful life events during the last two weeks, a stressor checklist based on the items in the PHQ-D (Löwe et al. 2002) was constructed. The adapted stressor checklist consists of 9 items on a five-point Likert scale, assessing if during the last two weeks participants were distressed by worries about their own or a loved one's health, taking care of their children, work or school related issues, financial problems, having no one to talk to, fatalities in the family, potential or real loss of employment, and COVID-19 caused isolation.

2.2.4. Previously assessed data

Assessment of ACEs was based on previously collected data: in the primary study, patients had completed the German version of the *Maltreatment and Abuse Chronology of Exposure Scale* (MACE). The MACE consists of 75 items that retrospectively gauge the severity of exposure to different types of ACEs (including physical and emotional neglect and abuse, peer-abuse, sexual abuse, and witnessing intrafamilial violence). The MACE has good test-retest reliability and validity (Isele et al., 2014; Teicher & Parigger, 2015). Past DV was assessed with the HITS (see above). In accordance with Miszkurka et al. (2016), a weighted cut-off was used to define DV: if participants reported physical violence (item 4) at least "rarely" or psychological violence (items 1–3) at least "sometimes", they were considered DV+ cases. Participants below this weighted cut-off were considered DV- cases.

2.3. Statistics

Two groups of participants were differentiated; the DV+ group consisted of participants with (i.e., scores above the cut-off on the HITS scale) and the DV- group of those without (i.e., scores below the HITS cut-off) previous experiences of DV. Group differences were investigated using independent sample t-test and Pearson correlation coefficients for metric data and χ^2 -test for nominal data.

To investigate the primary aim of our study, the change of mean HITS score over time was calculated using repeated measures analysis of variance (ANOVA) with group (DV+ vs DV-) as between-group factor. Effect size of the group difference in the ANOVAs was evaluated using partial η^2 . Effect sizes of $\eta^2 = 0.01$ and $d = 0.3$ were considered small, while $\eta^2 = 0.06$ and $d = 0.5$ indicated a medium, and $\eta^2 = 0.14$ and $d = 0.8$ a large effect, respectively. For 2×2 contingency tables ϕ -values (0.1 = small, 0.3 = medium, and 0.5 = large effects) are reported, while Cramer's V is given for contingency tables exceeding 2×2 (Ellis, 2010).

For the secondary analyses, hierarchical multiple linear regression models were calculated to identify influential factors for current DV (HITS total score) during the lockdown across all participants. The model consisted of four steps: (1) ACEs (dummy variable: no ACEs vs ≥ 1 ACE), (2) adult attachment style (AAS total score), (3) DV victimization (HITS total score), (4) COVID-19 associated stressful life events (COVID-19 stressor checklist). Additionally, the association of sociodemographic

variables with current DV victimization was tested using independent sample t-tests, univariate ANOVAs and Pearson correlation coefficients and all significantly associated variables were added to the fourth step of the models. R^2 was calculated to evaluate the explained variance of the dependent variable. Standardized coefficients and p -values are presented for each independent variable. Durbin-Watson statistic was calculated to test for autocorrelation, with values between 1.5 to 2.5 considered acceptable. P -values $< .05$ (two-sided) were considered statistically significant. Statistical analyses were performed with IBM SPSS (v22.0).

3. Results

The majority of the included 67 participants was female (76.1 %) and the mean age was 48.5 (+/- 13.6) years. Most participants were in a relationship and more than half of the sample was living in a flat. Participants in the DV+ group reported to be single and to be living alone more often than participants in the DV- group and reported more COVID-19 associated stressors. Details for sociodemographic variables are presented separately for the DV- and DV+ group in table 1.

3.1. Reported DV

In our sample, 49 participants (73.1 %) were living with other household members within the last two weeks and thus were able to complete the HITS questionnaire. The mean HITS score for the whole sample was 5.0 (+/- 1.3) points. Of those, 22.4 % ($n = 11$) scored above the cut-off for DV within the last two weeks, $n = 9$ from the DV+ group and $n = 2$ from the DV-group. Amongst affected individuals, most frequently reported forms of abuse were being screamed at or insulted ($n = 6$, 54.6 %) and being cursed at or talked down to ($n = 6$, 54.6 %). Physical violence was reported less frequently ($n = 2$, 20.0 %) and no participant reported threats against them. Current DV victimization within the DV+ group was significantly higher than in the DV- group with a large effect size (5.6 vs. 4.4 points; $p = .005$; $d = .97$).

When the mean past and current DV victimization were compared between the two groups, a stable main effect for group was observed, with significant group differences at both time points (past DV: $p < .001$; current DV: $p = .005$). In addition, a significant time*group effect with a large effect size was found ($p < .001$, $\eta^2 = .44$). Surprisingly, within the DV+ group the mean HITS score had significantly dropped over time, while remaining stable in the DV- group as shown in Figure 1.

Since living situation and relationship status might have influenced the HITS score, both variables were compared for the two time points. In regard to relationship status basically no change was observed in the whole sample and only slight changes took place regarding the participants living situation, mainly moving from a shared flat to live with a partner/family. Across the whole sample, no significant associations of current DV victimization was found with sex, age, relationship status,

Table 1: Sociodemographic properties of the included samples

	DV- (n = 33)		DV+ (n = 34)		t -value	p-value	Cohens d
	mean	(SD)	mean	(SD)			
Age (years)	47.4	(12.8)	49.5	(14.6)	0.62	.54	.15
Number of persons in household	2.6	(1.1)	2.2	(1.3)	1.54	.13	.33
Square-meter living space	121.7	(72.7)	98.3	(87.7)	1.14	.26	.29
COVID-associated stressors	6.9	(4.9)	10.0	(6.5)	2.19	.032	.54
	n	(%)	n	(%)	χ^2 -value	p-value	Φ /Cramers V
Gender					0.41	.51	.08
Male	9	(27.3 %)	7	(20.6 %)			
Female	24	(72.7 %)	27	(79.4 %)			
Relationship status					8.82	.032	.36
single	4	(12.1 %)	12	(35.3 %)			
married/long-term relationship	25	(75.8 %)	15	(44.1 %)			
widowed	2	(6.1 %)	1	(2.9 %)			
Divorced/separated	2	(6.1 %)	6	(17.6 %)			
Living situation					8.37	.039	.35
living alone	5	(15.2 %)	15	(44.1 %)			
living with partner/family	26	(78.8 %)	16	(47.1 %)			
living with family of origin	2	(6.1 %)	2	(5.9 %)			
living in shared apartment	0	(0.0 %)	1	(2.9 %)			
Parenthood	23	69.7 %	21	63.6 %	0.27	.60	.06
missing data							
Social class					3.54	.17	.23
Lower class/working class	3	(9.1 %)	9	(26.5 %)			
Middle class	25	(75.8 %)	20	(58.8 %)			
Upper class	5	(15.2 %)	5	(14.7 %)			
Living environment					9.64	.008	.38
Flat without balcony/garden	1	(3.0 %)	10	(29.4 %)			
Flat with balcony/garden	18	(54.5 %)	10	(29.4 %)			
House	14	(42.4 %)	14	(41.2 %)			
Affected by COVID-19 curfew					4.16	.84	.25
unemployed	3	(9.1 %)	3	(8.8 %)			
loss of employment	0	(0.0 %)	1	(2.9 %)			
Home-office	7	(21.2 %)	9	(26.5 %)			
reduced employment	6	(18.2 %)	4	(11.8 %)			
Child care at home	2	(6.1 %)	0	(0.0 %)			
Retirement before COVID-19	7	(21.2 %)	8	(23.5 %)			
Ongoing employment	3	(9.1 %)	5	(14.7 %)			
Sick leave	2	(6.1 %)	2	(5.9 %)			
other	3	(9.4 %)	2	(5.9 %)			

SD=standard deviation; COVID-19= Corona Virus Disease 2019

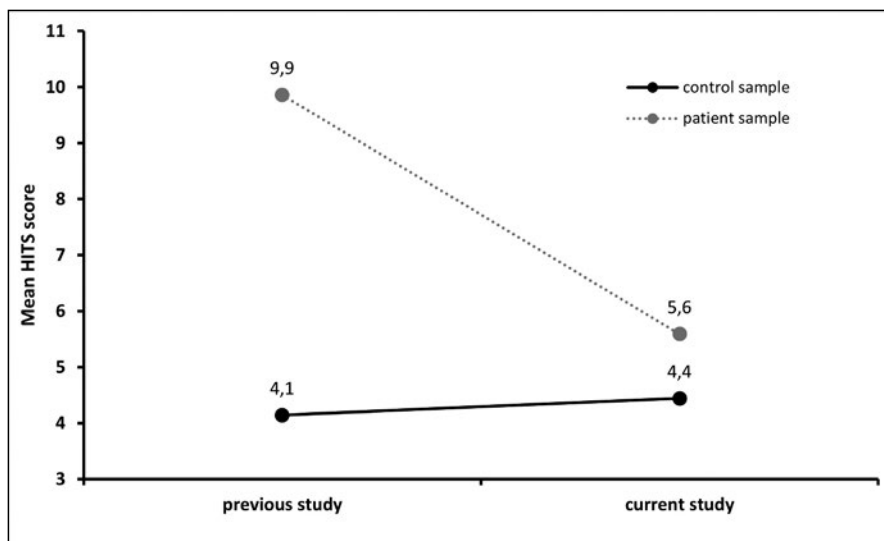


Figure 1: Mean HITS values for patients and controls in the previous study and current study

living situation, living environment, social class, the way participants were affected by the COVID-19 curfew, mean living space or the number of persons living in the household (all $p > .05$). However, participants with children reported less experiences of current DV victimization (4.6 vs. 5.3 points; $p = .053$)

3.1.1. Influential factors for current DV victimization

To investigate influential factors for current DV, a hierarchical linear regression model across the whole sample was designed. Model statistics indicated neither multicollinearity ($VIF = 1.15-1.52$) nor autocorrelation (Durbin-Watson values = 2.09), thus the model was deemed suitable. The variable 'parenthood' was added to the model in step 4 together with Covid-19 stressors. Three of the five predictors in the final model – namely previous DV victimization, not being a parent and a more insecure attachment style – were significantly associated with a higher current DV victimization. Predictors added in each step lead to a significantly improved explained variance. The final model explained 44 % of the variance for current DV victimization.

Table 2: Hierarchical multiple linear regression model for current DV victimization

	Step 1		Step 2		Step 3		Step 4	
	β	<i>p</i> value	β	<i>p</i> value	β	<i>p</i> value	β	<i>p</i> value
ACEs	.27	.06	.17	.23	-.06	.69	-.13	.38
Attachment style	--	--	-.35	.016	-.33	.014	-.27	.036
Previous DV	--	--	--	--	.47	.002	.44	.003
COVID-19 related stressors	--	--	--	--	--	--	.21	.09
Parenthood	--	--	--	--	--	--	-.30	.019
R ² (Sig. model)	.07	(.06)	.19	(.010)	.35	(<.001)	.44	(<.001)
Δ R ² (Sig. of Δ R ²)	--	--	.11	(.016)	.16	(.002)	.10	(.032)

β : standardized coefficient; ACEs = adverse childhood experiences; DV = domestic violence; significant predictors displayed in bold

4. Discussion

DV was broadly discussed as a major societal problem during the COVID-19 lockdown. However, only very limited data is available on this topic. The aim of the present study thus was to examine actual rates of DV during the COVID-19 lockdown in a sample of at-risk individuals and a control sample.

Overall, 22 % of the participants reported experiences of DV during the first weeks of the lockdown. While previous research has indicated regional differences in the prevalence of DV (Jetelina et al. 2020; Steinert & Ebert 2020), the prevalence rate of study collected in a sample from the Austrian region of Tyrol are comparable with previous data (Devries et al. 2013; FRA 2014; World Health Organization 2013). Participants with prior experiences of DV reported significantly more DV than the control sample. However, the overall reported abuse significantly decreased in the at-risk sample, while remaining stable in the control sample when compared to the values reported before the lockdown. This is in accordance with data recently presented by the Austrian Ministry for Interior Affairs, which showed no significant increase in reported DV (Brickner 2020) and a cross-sectional study from the USA (Jetelina et al. 2020). In the latter, about 80 % of the participants stated that DV had not changed or had even gotten better within the first weeks of COVID-19 lockdown in the USA. One possible explanation for the discrepancy in expected DV victimization and data from our and other studies is that the forced lockdown and the accompanying social isolation may have met the perpetrators' often very strong need for control in the relationship (Langhinrichsen-Rohling et al. 2012). DV may be understood as a dysfunctional attempt by the perpetrator to cope with avoidant behavior or withdrawal from closeness and intimacy by their partner (Bartholomew et al. 2001), which in itself may be motivated by an insecure attachment style (Dumas et al. 2008). Thus, perpetrators with an insecure attachment pattern may use violence to force their partners to focus on them and become violent especially when they fear separation

or rejection. Due to the externally imposed stay-at-home order, perpetrators might not have had the need to control their partners using physical or mental force. Furthermore, the increasing social control through the continuous presence of neighbors and children as well as the increasing sensitization of the population to DV through public media may also have had a protective effect on DV victimization (Jewkes 2002).

In our sample, insecure attachment styles, previous experience of DV, and childlessness significantly predicted current DV-victimization. Those findings are mostly in line with previous research, indicating a link between insecure attachment and an increased risk for re-victimization (Kuijpers et al. 2012). However, other previously described risk factors for DV such as adverse childhood events, difficult socio-economic circumstances and cramped housing conditions (Kaukinen 2020) were not identified as causes for the current DV victimization in our sample.

Several *strengths and limitations* of this investigation may be pointed out. One *limitation* for the generalizability of our results is the relatively short recall period during the lockdown, while most other studies refer to assessment periods of over a year. This may partially explain the lower DV-rates in our at risk sample as also pointed out by Steinert and Ebert (2020).

One of its *strengths* is the applied study methodology. While most studies on DV are questionnaire-based, in the present study carefully conducted telephone-based structured interviews were conducted by highly trained and specialists in psycho-traumatology. This approach was not only chosen to improve the quality of collected data, but also to guarantee safety of this highly vulnerable patient collective and to support affected persons if necessary. To our knowledge, this is the first study to present longitudinal data on DV in the same set of patients, before and during the first weeks of COVID-19 lockdown measures, thus allowing a better comparability.

5. Conclusion

At-risk individuals reported a surprising decline in DV during the first weeks of the COVID-19 lockdown compared to at a previous assessment. However, they still reported significantly more DV than a previously unaffected control sample. Considering the increase in violence perpetration in families under high psychosocial pressure, psychosocial help offers should be directed to this at-risk population during quarantine to prevent an increase in violence. Future studies should focus on mechanisms for revictimization and violence perpetration to develop specifically tailored psychosocial intervention programs.

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