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Mental Health among Domestic Violence Survivors during the COVID-19 lockdown: The Malaysian COMET-G study

(Kesihatan Mental di kalangan Mangsa Keganasan Rumah Tangga semasa COVID-19 Perintah Kawalan Pergerakan: Kajian COMET-G Malaysia)

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Abstract

During the COVID-19 lockdown, home isolation increased the opportunity for domestic violence (DV). Being trapped in an abusive situation can lead to mental health problems. This study, part of the larger COMET-G study, a COVID-19 mental health global initiative of more than 40 countries, aimed to determine the prevalence of DV during the pandemic and to compare the differences between depression, anxiety, and suicidal behavior of those with and without self-reported DV. It is a cross-sectional survey conducted via online self-administered questionnaires. The questionnaire contained a self-reported DV, socio-demographic, and the COMET-G questionnaire on the Risk Assessment Suicidality Scale (RASS), the Center for Epidemiological Studies Depression (CES-D), and the State-Trait Anxiety Inventory (STAI). The total number of participants was 627. The proportion of participants with self-reported DV was 12.4%. Of those who had self-reported DV, the main types of DV were economic (57.7%) and mental abuse (44.9%). Univariate analyses show significant associations between self-reported DV and depression, suicidal intention, and the changes in suicidal tendencies before and during the pandemic. Regression analyses indicate only suicidal intention ($p<0.001$; OR=1.128; 95%CI=1.043-1.220) and changes in suicide tendency before and during the COVID-19 pandemic ($p<0.001$; OR=1.751;95%CI=1.328-2.310) increase the odds for self-reported DV. This study highlights the importance of recognizing the dangers of DV escalation during a pandemic and its link to depression and suicidal ideations among the victims. It also underscores the crucial need for support measures to be put in place to help DV victims, especially during lockdowns.

Keywords: Mental Health, Depression, Suicidal behaviour, domestic violence, COVID-19,

Abstrak

Perintah kawalan pergerakan sewaktu COVID-19 telah membuka peluang untuk berlakunya keganasan rumah tangga (DV). Mangsa DV yang terasing dan terperangkap di dalam keganasan boleh menyebabkan masalah kesihatan mental. Kajian ini adalah sebahagian daripada kajian antarabangsa COMET-G study, iaitu suatu inisiatif global kesihatan mental COVID-19 yang melingkungi 40 buah negara. Ianya bertujuan menentukan kelaziman DV sewaktu pandemik serta perbandingan diantara kemurungan, keresahan, dan tingkah laku bunuh diri dikalangan mereka yang melaporkan DV dan tanpa DV. Kajian ini dijalankan melalui soal selidik di atas talian, dan peserta yang bersetuju akan memberi respons kepada soalan DV, sosiodemografi dan soalan COMET-G seperti Skala Risiko Tingkah-laku Bunuh Diri (RASS), Skala Kemurungan Pusat Epidemiologi (CES-D) dan Inventori Tingkat Keresahan Masyarakat (STAI). Jumlah responden adalah 627 orang. Kelaziman DV yang dilaporkan adalah 12.4%. Daripada responden yang melaporkan DV, penderaan ekonomi adalah tertinggi (57.7%) dan diikuti oleh penderaan mental (44.9%). Analisis univariat menunjukkan kaitan yang ketara diantara DV yang dilaporkan dengan kemurungan, tingkah laku bunuh diri dan perubahan dalam kecenderungan bunuh diri sebelum dan semasa pandemik. Analisis regresi pula menunjukkan tingkah laku bunuh diri ($p<0.001$; OR=1.128; 95%CI=1.043-1.220) dan perubahan kecenderungan bunuh diri sebelum dan semasa pandemik COVID-19 ($p<0.001$; OR=1.751;95%CI=1.328-2.310) adalah pencetus kepada mereka yang melaporkan DV. Kajian ini mengikhtiraf bahawa pandemik boleh menyebabkan peningkatan DV serta kaitannya dengan kemurungan dan tingkah laku bunuh diri di kalangan mangsa. Tindakan mitigasi perlu diperhalusi untuk memberi lebih sokongan kepada mangsa DV terutama semasa perintah kawalan pergerakan.

*Kata kunci: Kesihatan Mental, Kemurungan, Tingkah laku bunuh diri, Keganasan rumah tangga, COVID-19, *

INTRODUCTION

The COVID-19 pandemic from 2020 until 2022 led to stringent lockdown measures worldwide. Although this was necessary to prevent the spread of the virus, it led to several severe consequences socially, psychologically, and economically. One of those was the rise in domestic violence (Indu et al. 2021). The United Nations (UN) defined Domestic violence (DV), domestic abuse, or 'intimate partner violence' as a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner.' The abuse can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person and behaviours that cause fear, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone (United Nations 2023).

According to Kourti et al. (2023), there was an increase of around 10-27% in reported DV in the United Kingdom, Europe, Asia Pacific countries, and other parts of the world following these lockdown measures. The presence of COVID-19-related stressors was reported by Gresham et al. (2021) to have increased DV cases within homes. In Malaysia, the prevalence of DV in general before the pandemic was around 4.94% to 35.9% (Kadir-Shahar et al. 2020). There was an upward trend of calls on helplines relating to DV during lockdowns, especially when a longer duration of lockdowns was in place (Jung 2020).

The report found that lockdowns made it extremely difficult for victims and DV survivors to seek help or to escape from their abusers (Jung 2020), and this was related to an increased risk of depression and anxiety among individuals experiencing DV (Chiaramonte et al. 2022). The increase in mental health conditions such as depression and anxiety during the pandemic is not surprising. Statistically, the pooled prevalence of depression increased up to 7 times worldwide during the COVID-19 pandemic, with the highest prevalence of up to 48.3% (Bueno-Notivol et al. 2020) and the highest prevalence of anxiety of up to 50.8% (Xiong et al. 2020). Malaysians suffered higher mental health issues during the pandemic. An online survey by Marzo et al. (2021) found that 25.1% suffered from severe depressive symptoms, 18.1% had mild depressive symptoms, and 34.1% had mild to moderate anxiety symptoms. However, these studies did look at DV and mental health outcomes during the pandemic separately, with any correlation being incidental.

As for suicidal behaviours, systematic reviews found that suicide rates reduced during the early phase of the lockdown but started to increase as the pandemic continued; this was mainly attributed to economic difficulties and unemployment during the pandemic (Pirkis et al. 2021; Dube et al. 2021). A China study found that 11.84% of community members experience suicidal ideation, an increase of 2.37 in 20 individuals compared to 1 in 20 pre-pandemics (Luo et al. 2020). A US study also found that 10.7% considered suicide compared to pre-pandemic times (Czeisler et al. 2021). The literature found no published comparative records for suicide intentions or behaviours among Malaysians who experienced DV. This study provides a unique perspective within unchartered territory to identify mental health issues among DV sufferers during COVID-19. The study aimed to determine the prevalence of self-reported DV during the pandemic and to compare the differences between the socio-demographic background, depression, anxiety, and suicidal behaviours of people with and without self-reported DV.

MATERIALS AND METHODS

This is a cross-sectional online survey via convenience sampling. Convenience sampling was chosen because this is an online survey conducted during a pandemic. This study is part of a larger, global joint project involving more than 40 countries. This worldwide study was initiated by the Aristotle University of Thessaloniki and the Mental Health Sector of the Scientific Research Institute of the Pan-Hellenic Medical Association, Greece. The Malaysian COMET-G study is significant as it provides a unique perspective within the global initiative, offering insights specific to the Malaysian context.

Data Collection

The data collection was conducted online via Google Forms on social media platforms such as Facebook and Twitter during the first wave of the COVID-19 pandemic. The survey was distributed from 1 July 2020 until 6 October 2020.

The study selection criteria included participants aged 18 years and above who could read the Malay or English language and had access to the Internet. On the introductory page, participants were greeted with an explanation regarding the study's objective, risk, and benefit, as well as a confidentiality clause. Participants who agreed and consented to participate were invited to go to the next page and answer the questionnaire. Implied consent was obtained when the participant agreed to proceed to the next page, where the survey began. The local institutional research ethics committee approved this study; REC/06/2020 (MR/109).

Measurement Tools

The questionnaire consisted of socio-demographic details, including sex, age, marital status, area of residence, educational level, employment, being a health care worker, and living conditions such as the number of people living together, number of children, status of living with a vulnerable family member, and presence of a chronic disease. The detailed categorization of independent variables followed the main COMET study as published (Razali et al. 2022).

The participants were then asked self-reported domestic violence questions by answering a dichotomous (Yes or No) of exposure to any violence at home. The violent behaviours were categorized into five areas which are (a) mental or emotional abuse such as using words to humiliate or make a person feel worthless, either directly or through online or social media applications, (b) physical abuse or aggression such as hitting, pushing, punching, slapping, kicking, throwing objects or strangling a person, (c) sexual abuse or aggression such as using sex to control or humiliate the victim, including intimidating the victim into engaging in unsafe sex or sexual practices in which she does not want to participate, (d) economic or financial abuse such as limiting a person's financial freedom or security including withholding or refusing to give sufficient money for household expenses or taking away a person's income or (e) any other type of abuse or aggression. The questionnaire also included a question on the participant's experience with the change of tendency to think about death and suicide before and during the COVID-19 pandemic. These changes were assessed using a Likert scale of very much decreased, decreased a little, neither increased nor decreased, increased a little, and very much increased.

Participants were assessed for depression and anxiety using the Centre for Epidemiological Studies Depression (CES-D) (Radloff 1977) and the State-Trait Anxiety Inventory (STAI) (Spielberger 1983), respectively.

The CES-D is a short self-report scale designed to measure depressive symptoms in the general population. The CES-D has 20 questions; each item is answered with a 4-point Likert scale. The CES-D has no cut off point but the higher the score, the greater the depressive symptoms (Radloff 1977). It went through a vigorous development and validation process with good reliability (Cronbach alpha = 8.5) (Radloff 1977). The CES-D has been translated into the Malay language with a Cronbach alpha of 0.75 (Mazlan & Ahmad 2014)

The STAI is a psychology inventory of 40 self-reported items on a 4-point Likert scale. The STAI has two subscales that measures two types of anxiety: state anxiety (S-anxiety) and trait anxiety (T-anxiety). Each subscale has 20 items. The STAI has no cut off points, but the higher scores are positively correlated with higher levels of anxiety (Spielberger 1983). Various reliability studies of the STAI English have been between Cronbach alpha values of 0.86 to 0.95. The STAI has been translated into the Malay language with a good Cronbach alpha value of 0.94 for the S-anxiety and 0.84 for the T-anxiety (Hashim et al. 2018).

The COMET-G lead collaborating centre newly developed the Risk Assessment Suicidality Scale (RASS) (Fountoulakis et al. 2012). It was developed in English and then translated into many different languages, including Malay, via the forward-backward translation process and expert discussions. (Razali et al.2022). RASS has 12 items and three domains: 'Intention,' 'life,' and 'history.' The respective domains' Cronbach Alpha was 0.85, 0.69, and 0.52. The total score of RASS indicated overall suicidal behaviour. The entire protocol has been published elsewhere (Fountoulakis et al. 2012).

Statistical analyses

Descriptive statistical analysis was calculated for the prevalence of self-reported DV, suicidal behaviours, and key socio-demographic variables (including sex, age, marital status, educational level, residential area, number of people living together, number of children, employment, status as health care workers (HCW), the status of living with vulnerable people and), health status (status of chronic medical illness, depression, and anxiety). Data was not normally distributed; hence, non-parametric statistical analyses were used. The associations between socio-demographic characteristics and self-reported DV were analyzed using the Chi-square test. The associations between the total scores of mental illnesses (CES-D for depression and STAI for anxiety), as well as scores for variables related to the RASS scale of suicidality (intention, life, history, and changes in suicidal tendency before and during the pandemic) and self-reported DV, were analyzed using Mann Whitney test. Finally, all independent variables that have significant ($p<0.05$) associations with self-reported DV were included in the logistic regression. The statistical test used for regression was the Stepwise Forward Likelihood Ratio Binary Logistic Regression. All statistical analyses were performed by using IBM SPSS version 26.

RESULTS

The total number of local participants in the survey was 963. Of this total number of participants, 637 answered questions on domestic violence and ten were incomplete answers therefore, the total participants analyzed were 627 cases. The prevalence

of self-reported DV was 12.4% (n=78). Of those who reported experiencing abuse, 57.7% (n=45) reported experiencing economic abuse; 44.9% (n=35) mental or emotional abuse; 47.4%(n=37) other abuses, 2.5% (n=2) sexual abuse and 1.2% (n=1) physical abuse. Therefore, the main forms of abuses were economic, mental or emotional abuse.

Table 1 represents the socio-demographic details of the participants. The mean age of the participants was 40.1 ± 12.0 years. There were more female (54.5%) participants than male (34.3%) and the remaining did not specify their gender (11.1%). Regarding age class, the lowest percentage was those aged 20 years and less (0.6%) and the highest was those aged between 31 and 40 years (38.0%). More than half of the participants were living in the city (52.9%), with three to four occupants (61.9%), had at least two children (60.9%), and had attained at least a diploma (71.3%). About 1 in 5 participants lived with someone vulnerable during the pandemic. The percentage of those with chronic medical conditions was 22.9%. Those with underlying mental illness were 14.6% and from this, 24.7% with anxiety, 19.4% with depression and 6.5% with psychosis, 7.5% has bipolar disorder and the remaining 37.6% has other nonspecific mental illness.

Table 1. Sociodemographic factors of the participants and self-reported Domestic Violence (DV)

Sociodemographic factors		**Total**	**Self-Report Domestic Violence n (%)**		**Statistical Analyses**		
			No (n=549)	Yes (n=78)	χ^2	p-value	df
Gender	Female	342	296(53.9%)	46(59.0%)			2
	Male	215	187(34.1%)	28(35.9%)	3.295	0.193	
	Others	70	66(12.0%)	4(5.1%)			
Age class	<20	4	3(0.5%)	1 (1.3%)			4
	21-30	112	100(18.2%)	12 (15.4%)			
	31-40	241	206(37.0%)	35 (44.9%)	3.172	0.529	
	41-50	131	119(21.7%)	12 (15.4%)			
	>50	139	121(22.0%)	18 (23.1%)			
Marital status	Single	122	105(19.1%)	17(21.8%)			5
	Married (or civil partnership)	409	360(65.6%)	49(62.8%))			
	Divorced or estranged	46	41(7.5%)	5(6.4%)			
	Live with someone without an official relationship	7	5(0.9%)	2(2.6%)	6.407	0.269	
	Widower	34	31(5.6%)	3(3.8%)			
	Others	9	7(1.3%)	2(2.6%)			
Residence	Capital city	230	205(37.3%)	25(32.1%)			5
	City<1 million	65	61(11.1%)	4(5.1%)			
	City (100k-1million)	37	33(6.0%)	4(5.1%)			
	Town (20k-1000k inhabitants)	47	42(7.7%)	5(6.4%)	6.407	0.269	
	Town (<20000 inhabitants)	125	106(19.3%)	19(24.4%)			
	Rural area/ village	123	102(18.6%)	21(26.9%)			
Education	Elementary /primary /no more than 9 years of education	33	26 (4.7%)	7(9.0%)			4
	High school/secondary /no more than 12 years of education	147	127(22.7%)	20(25.6%)	3.291	0.510	
	Bachelor /diploma/degree	280	250(45.5%)	30(38.5%)			
	Master degree	134	117(21.3%)	17(21.8%)			
	Doctorate PhD	33	39(5.3%)	4(5.1%)			
Employment	Working at public sector	35	32(5.8%)	3(3.8%)			4
	Working at private sector	137	118(21.5%)	19(24.4%)			
	Self-employed	3	3(0.5%)	0(0.0%)	2.530	0.639	
	University or college student	82	75(13.7%)	7(9.0%)			
	Unemployed/Housewife/Others	370	321(58.5%)	49(62.8%)			
People living in the house	1 live alone	26	22(4.0%)	4(5.1%)			4
	2 people	104	95(17.3%)	9(11.5%)			
	3 people	213	180(32.8%)	33(42.3%)	4.160	0.385	
	4 people	175	157(28.6%)	18(23.1%)			
	5 or more	109	95(17.3%)	14(17.9%)			
Number of children	0(Do not have any children)	162	145(26.4%)	17(21.8%)			3
	1 child	83	74(13.2%)	9(11.5%)			
	2 children	189	157(28.6%)	32(41.0%)	5.57	0.235	
	3 children	103	94(17.1%)	9(11.5%)			
	4 or more children	90	79(14.4%)	11(14.1%)			
Living with vulnerable people	Yes	149	131(23.9%)	18(23.1%)			1
	No	478	418(76.1%)	60(76.9%)	0.023	1.000	
Chronic medical condition	Yes	144	118(21.5%)	26(33.3%)			1
	No	483	437(78.5%)	52(66.7%)	5.411	0.030*	
History of mental illness	No	535	476(86.7%)	59(75.6%0			1
	Yes	93	73(13.3%)	19(24.4%)	6.675	0.016*	

Notes: χ^2=Chi-Squared test with Fisher Exact test if necessary; *significant p-value <0.05

Table 2 represents the association between self-reported domestic violence and psychological disturbances. Data was not normally distributed. Hence, the associations between the variables related to psychological disturbances and self-reported DV were analyzed using the Whitney U-test. There were significant differences between self-reported DV and depression, suicidal intention, and the changes in suicidal tendencies before and during the pandemic.

Table 2. The Association between Self-reported Domestic Violence and Psychological Disturbances

Psychological Disturbances	Self-Reported Domestic Violence				
	No		Yes		
	Med	IQR	Med	IQR	p-value
Depression (CESD)	28.00	19.75	31.00	3.25	0.000*
Anxiety (STAI)	50.00	5.00	50.00	5.25	0.308
Suicidality:					
Intention	3.00	6.00	5.00	4.25	0.000*
Life	5.00	3.00	4.00	2.00	0.163
History	1.00	1.00	1.50	2.00	0.285
Changes in suicidal tendency before and during pandemic	0.00	1.00	1.00	1.00	0.000*

Med=Median; IQR=Interquartile Range
The statistical test used is the Mann Whitney test

Table 3 refers to the regression analyses among the participants who self-reported domestic violence and to identify factors associated with experiencing DV. From the univariate analyses, the independent variables that have significant ($p<0.05$) associations with self-reported DV include depression, suicidal intention, changes in suicidal tendencies before and during a pandemic, and chronic medical conditions. All these variables were included in the logistic regression. The statistical test used for regression was the Stepwise Forward Likelihood Ratio (LR) Binary Logistic Regression. From the final analysis, those who reported DV, were significantly associated with the suicidal intention ($p<0.001$; OR=1.128; 95%CI=1.043-1.220) and changes in suicide tendency before and during the COVID-19 pandemic ($p<0.001$; OR=1.751;95%CI=1.328-2.310) but not associated with depression and chronic medical conditions. The overall predictive value for self-reported DV was 87.3%. The model fit was statistically significant, as indicated by Hosmer and Lemeshow Test ($\chi2=6.024$; df=8; $p<0.001$). The explained variation in self-reported DV based on the model ranges from 4.7% to 8.9%, as indicated by the Cox & Snell R2=0.047 (<0.05) and Nagelkerke R2=0.089 <0.1), respectively.

Table 3. Logistic Regression Analyses for Self-Reported Domestic Violence

		B	S.E.	Wald	df	p-value	OR	95% C.I.for OR	
								Lower	Upper
Step 1[a]	Changes in suicidal tendency before and during the pandemic	.580	.136	18.122	1	.000*	1.785	1.367	2.332
	Constant	-2.257	.160	199.899	1	.000	.105		
Step 2[b]	Suicide Intention	.120	.040	9.008	1	.003*	1.128	1.043	1.220
	Changes in suicidal tendency before and during the pandemic	.560	.141	15.717	1	.000*	1.751	1.328	2.310
	Constant	-2.719	.239	129.208	1	.000	.066		

a. Variable(s) entered step 1 Changes in suicidal behaviors
b. Variable(s) entered on step 2: Suicide Intention
The statistical test used is the Stepwise Forward Likelihood Ratio Binary Logistic Regression.

DISCUSSION

The prevalence of DV in this study was 12.2%. This falls within the range of around 4.94% to 35.9% of DV prevalence in Malaysia, as reported by Kadir-Shahar et al. (2020). This suggests that the prevalence of DV during the COVID-19 pandemic is consistent with or slightly higher than the pre-pandemic levels. Compared to cross-sectional studies of women attending primary healthcare clinics, the prevalence is between 5.6% and 22% (Kadir-Shahar et al. 2020; Othman & Mat-Adenan 2008).

Among those who reported DV, the principal reported abuse is economic and mental abuse. Economic abuse, which is often interchangeably used with financial abuse, is defined as a deliberate pattern of control in which individuals interfere with their partner's ability to acquire, use, and maintain

economic resources. This type of abuse often leads to financial insecurity for the abused. Financial abuse, on the other hand, is more specific to a person's financial independence, and such abuse threatens or limits the person's actions and choices (Postmus et al. 2020). This type of abuse may occur during the pandemic due to the poor financial situation related to and affected by the COVID-19 pandemic. These COVID-19-related stressors can also contribute to abuse and abusive behaviors (Gresham et al. 2021). A Malaysian study found that economic stability, higher education level, and urban upbringing are better at preventing DV despite the challenges faced during COVID-19 (Baqutayan et al. 2021). On the contrary, financial difficulties and unemployment were found to be associated with psychological conditions, substance abuse, and behaviours that can lead to DV (Pirkis et al., 2021). Mental abuse is related to psychological abuse and may become more predominant due to living near one another and the inability to go outside or find other places of sanctuary (Mukhtar 2023)

This study reported higher rates of depression, suicidal intention, and changes in suicidal tendencies before and during the pandemic among DV survivors as compared to those who did not report DV. It is not surprising as many studies also found that DV can lead to depression or consideration of suicide (Luo et al. 2020; Czeisler et al. 2021). The study did not find significant differences in anxiety between the two groups. This could be because anxiety is known to increase during a pandemic, and the anxiety is not explicitly related to DV (Xiong et al. 2020). Further analysis among those who reported DV found that having suicidal intentions and changes in suicidal tendencies before and during the pandemic are factors that encourage people to report DV. This is interesting because although the link between DV and suicidality is understood, on the contrary, having suicidal thoughts can encourage a person to report the DV; this has not been commonly reported in the literature. Perhaps this is due to the victim's realization that help is needed.

This study highlighted the risk of depression and suicidal intention among DV survivors during lockdown periods. The lesson learned is to prevent this by implementing mitigation action plans to improve the safety and home environment and increase awareness and exit strategies during future pandemics. Policymakers, government agencies, and non-governmental agencies are vital in ensuring continuous public awareness and support measures for victims. For example, during the initial part of the lockdown, the Ministry of Women, Family, and Community Development (MWFCD) announced discontinuing the non-essential services, including the Talian Kasih hotline, which is a crucial resource for DV victims (Ismail et al. 2022). However, they reopened the hotline amid criticisms, and this announcement led to a surge in the number of calls up to 53% (Mukundan 2020). The MWFCD's actions demonstrate the importance of government support in addressing DV during the pandemic. Women's Aid Organization (WAO) which is an NGO reported that many public or private shelters were operating at reduced capacities, and this led to fewer safe places for DV victims (Ismail et al., 2022). Women shelters need to remain open during the lockdown, and the Emergency Protection Order (EPO), needs to be accessible for victims. For future pandemics, recognizing DV support as an essential service is crucial in ensuring safety for DV victims (Jung 2020). United Nations Development Program (UNDP) reported that Malaysia is still lagging in providing safe places, with the availability of up to 1 in 70,000 families and lacking first responders such as social workers and police officers to tackle and handle DV cases (Mukundan 2020). Clear regulations and pathways for victim support need to be communicated for all involved in handling DV cases so that no victims are turned away and forced back into the clutches of the perpetrator.

It is important to note the role of healthcare services such as general practitioners and psychiatrists in identifying, referring and counseling DV victims. However, during the pandemic, only what is deemed 'essential services' are allowed to operate and often the public hardly get access to hospitals, clinics, counseling and therapy. The government, non-governmental organizations (NGOs), healthcare professionals and all DV advocates, can use the media, television, and social media platforms to educate and reach out to victims of DV and to send a clear message to perpetrators and DV will not be tolerated. Therapy and counseling sessions can be conducted online once the DV victim is in a safe environment.

This study had limitations since it was collected during the pandemic, and the data was collected online. Therefore, only those with an internet connection or access to gadgets can answer the questionnaire. This may have been biased towards those who are socially excluded or do not have access to the Internet or gadgets. Some may also be worried about answering accurately due to fear of reprisal.

CONCLUSION

The pandemic, with lockdowns and home isolation, increased the risk of DV, which can lead to mental health conditions among sufferers. Actionable steps forward include increasing awareness and access to information, helplines, safe environment and exit strategies to prevent escalations of DV during lockdowns. This pathway needs to be put in place

before any future pandemics. Future studies may benefit from community interventions and policy studies to identify successful measures for reducing DV during a pandemic.

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