Exploring the linkages between substance use, COVID-19, and intimate partner violence

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Introduction

Intimate partner violence (IPV) affects 1 in 3 women globally [1]. In the context of COVID-19, UN WOMEN named violence against women a "shadow pandemic" and called for immediate action [2]. In Canada, 1 in 10 women are currently worried about their safety [3], and IPV services experiencing increased pressure. Social isolation, and lockdowns have exacerbated IPV, similar to patterns seen in previous disasters and epidemics. Available data indicate that stress, anxiety, and financial worries related to COVID-19 and containment may also lead to increases in substance use (SU).

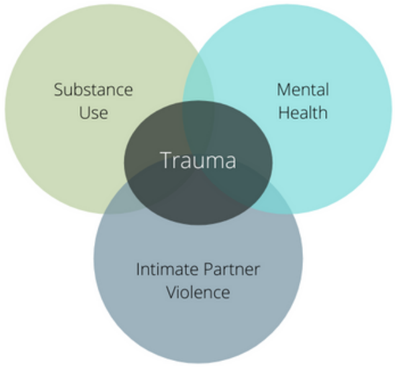
Objectives and Methods

This rapid review explores:
RQ1: The role of containment, social isolation, epidemics, pandemics, disasters, lockdowns and IPV among women; and
RQ2: The role of substance use in IPV among women.
Click here for the full methodology to date.

Findings

Evidence on Natural Disasters and IPV

- There is evidence that IPV increases after a natural disaster [4-10] with an average of 0.52 physically aggressive acts and 1.96 psychologically aggressive acts after a natural disaster [11]. Perpetrators may also use disasters to exercise control [12, 13].
- While IPV affects women regardless of their educational or social background [14], younger girls and unemployed women are at a higher risk in the context of a natural disaster [15]. Even so, responses to the IPV experience depend on socioeconomic background, personal capacity and social networks [14].
- Women who experience post-disaster IPV are more likely to report sleep and appetite dysregulation, low self-esteem, suicidal ideation [16] and a major depressive disorder [17], but it is difficult to distinguish which mental health problems are related to IPV or to the natural disaster itself.



Evidence on SU and IPV & Associated Factors

- Women with a history of IPV are more likely to be current smokers or heavy smokers [18]. Co-occurring IPV, PTSD, and alcohol use act as barriers for quitting smoking for women [19].
- There is evidence that women's alcohol use is related to the fear felt in their relationships and that alcohol use is a coping mechanism to numb feelings or avoid thinking about the IPV [20]. In some cases, perpetrators use women's mental health issues or their alcohol use as a tactic of isolation and control [21].
- Some studies indicate that poverty is linked to higher alcohol use by men, increasing the risk of IPV towards women [22] and some studies consider alcohol use a disinhibiting factor for aggression among men who perpetrate IPV [23, 24]. However, there is also evidence that the IPV is not the result of alcohol use but is related to unequal gender roles and of men's control and power over their partners [25, 26].

Implications for service providers and policymakers

- Women who report IPV seek more healthcare than other women, but may be less likely to use preventive services [27]. Limited safe housing and loss of community networks are important gaps for women experiencing post-disaster IPV [28].
- Inequities experienced by women are the product of previous gender and economic inequities that become more visible in a post-disaster context [14]. Healthcare providers (HCP) need to be ready for increases in IPV post-disaster and to provide treatment and referrals post-disaster [29] based on best practices for IPV identification and referral. Governments and policy-makers need to consider IPV prevention strategies and response a priority [10].
- It is crucial to collect accurate data on IPV and that all personnel responding to disasters (i.e. health and community service providers, police, housing providers, etc.) are included in disaster preparedness and management [10]. Subsequent responses must be trauma-informed and tailored to women who experience IPV [30].
- HCP and other frontline providers may also experience vicarious trauma or their own challenges in the post-disaster context, requiring counselling, without fear of discrimination [10].

Conclusions

The relationship between SU and IPV is extremely complex, with evidence of a bidirectional relationship, as well as multi-faceted contributing factors and numerous resulting health impacts. For frontline providers, detection and awareness is essential in disaster and pandemics. Training must be enhanced – and organized across sectors - to understand the additional burdens of IPV, substance use, and increased help seeking in the context of COVID-19. In the long term, reductions in gender inequity linked to power, control and economic supports must be addressed to reduce IPV and respond more adequately and robustly to both SU and IPV in pandemic contexts.

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