

THE IMPACT OF COVID-19 AND COVID-19 STRESSORS ON INTIMATE PARTNER
VIOLENCE IN RACIAL AND ETHNIC MINORITIES

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DEDICATION

For my husband Jon, my parents, and the many family members who provided me with constant love and support. Additionally for mis abuelos and my grandma who were with me in spirit throughout this process, and who greatly shaped who I am today. I love you all.

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ABSTRACT

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Intimate partner violence (IPV) has been a global public health issue for decades. There is a large amount of research looking at IPV that has helped researchers and mental health providers better understand IPV and help inform treatments and services for IPV. However, most research on IPV focuses on White individuals. This focus on White individuals in IPV is detrimental to racial and ethnic minorities because IPV can impact them differently. Due to the current COVID-19 pandemic, IPV risks factors, such as financial insecurity and social isolation, have increased. There is a small amount of research that has been published about COVID-19 and IPV, but representation of ethnic and racial minorities (REM) in these studies is inadequate. To help fill the gap in the literature about IPV and REM and to add to the emerging literature on COVID-19 and IPV, the researcher investigated the impact that COVID-19 had on IPV within the REM population, and how financial insecurity and social isolation contributed to the increase. Participants were recruited through social media, and mental health services. Participants filled out a demographic questionnaire, and scales measuring IPV, social isolation, and financial insecurity. Data from 193 participants were analyzed. Results showed that the largest percentage of participants reported that their experience during the COVID-19 pandemic with physical (38.9%), psychological (37.8%), sexual (35.2%), and economic IPV (40.9%) abuse stayed the same relative to before the start of the COVID-19 pandemic. Further, both financial insecurity and social isolation were predictors of physical, sexual, and psychological IPV. Social

isolation was also a significant predictor of economic IPV while financial insecurity was not a significant predictor.

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CHAPTER I

INTRODUCTION

Intimate partner violence (IPV) is a dangerous public health concern (Centers for Disease Control and Prevention [CDC], 2014). Despite steps to combat IPV, it continues to be widespread. Normally, IPV victimization occurs at an early age, with approximately 70% of women and 54% of men experiencing IPV before they are 25 years old (CDC, 2014). Many environmental factors influence IPV. A recent factor is the novel Coronavirus 2019 (COVID-19) global pandemic. COVID-19 has changed the lives of many and has affected how people interact with each other. Sadly, many individuals have been infected with COVID-19, and many have lost their lives. In addition to the physical health challenges, COVID-19 has impacted the mental health, financial security, and overall wellbeing of many (Vahratian et al., 2021; Wu et al., 2021). COVID-19 has also affected risk factors for IPV, such as social isolation and financial insecurity (Gresham et al., 2021). At the time of this writing, there have been very few studies that have examined how COVID-19 has directly influenced IPV, and those studies have not been representative of racial and ethnic minorities (REM; Gresham et al., 2021; Lyons & Brewer et al., 2021). This is noteworthy because the COVID-19 pandemic has disproportionately impacted REM individuals (Boserup et al., 2020b; Fortuna et al., 2020; Ruprecht et al., 2021). The goal of this study was to explore how COVID-19 has influenced IPV in the REM population.

Intimate Partner Violence

IPV affects millions of people across the globe (World Health Organization [WHO], 2013). IPV includes physical, sexual, or psychological harm caused by intimate partners through aggression, coercion, and other controlling behaviors (WHO, 2013). IPV impacts individuals of all genders; however, IPV rates for women are higher (Davilla et al., 2017), and the consequences are typically more dire (CDC, 2014). In the United States, approximately one in

four women and one in 10 men will experience either stalking, physical, or sexual IPV (CDC, 2018). There are multiple types of IPV, including physical, psychological, sexual, stalking, and economic. Much of IPV research tends to focus on physical, sexual, and psychological IPV, which, while important, leaves out pertinent information about other forms of IPV (Grest et al., 2018). One form of IPV that is often overlooked in research is economic IPV. Economic IPV is commonly used by perpetrators to manipulate their partners and to create a financial dependency on the perpetrator (Postmus et al., 2012).

Although the majority of IPV research has studied the impact on heterosexual women, research on sexual minority and trans women and nonbinary individuals is emerging. The rates of IPV for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals vary. According to some studies, LGBTQ+ individuals experience higher rate of IPV than heterosexual individuals, while other studies indicate that LGBTQ+ individuals experience IPV at the same rate as heterosexual individuals (CDC, 2014; Edwards et al., 2015; Graham et al., 2019; Scheer & Baams, 2019). LGBTQ+ folx have unique experiences that impact rates of IPV differently than non-LGBTQ+ individuals. For example, they may experience identity abuse where their partners discriminate against them for their sexual orientation or nonbinary gender identity (Callan et al., 2021; Scheer & Baams, 2019). Most of the research conducted with LGBTQ+ folx and IPV focus on individuals who do not identify as heterosexual and tend to exclude transgender individuals. This is a problem within IPV research because the studies that have focused on transgender individuals have found that transgender individuals experience higher rates of IPV (Scheer & Baams, 2019).

Similarly to the lack of research on IPV and LGBTQ+ folx, there is a lack of research on IPV and REM individuals (Cho & Kim, 2012a). This gap in research is concerning because

many studies show that REM individuals experience high rates of severe IPV and experience higher rates of IPV-related deaths compared to White individuals (Azziz-Baumgartner et al., 2011; Cho & Kim, 2012a). REM immigration status can also affect rates of IPV and help-seeking behaviors. Research shows REM immigrants are more likely to die from IPV than White individuals born in the United States and are less likely to report IPV due to fear of repercussions because of their or their families' immigration status (Cho & Kim, 2012a). However, there are some studies that show there is no difference in rates of IPV between REM and White individuals (Clark et al., 2016). These mixed results could be due to factors such as small sample sizes, social class, and age (Clark et al., 2016).

Risk Factors for IPV

There are multiple risks factors for IPV, including mental health problems. Specifically, depression can increase the likelihood of IPV because individuals struggling with depressive symptoms normally have less social support and may not be able to identify threats of violence from partners (Kim & Lee, 2013; Lehrer et al., 2006). Childhood abuse and neglect is another risk factor of IPV. Childhood abuse and neglect can create negative interpersonal schemas and can impact how individuals interact with their partners as adults (Breitenbecher, 2001). Breitenbecher (2001) also found that child abuse can cause trauma bonding and dependency, which could be possible reasons why child abuse and neglect increases the risk of IPV. Also, one dangerous risk factor of IPV is firearms. Many of the IPV-related deaths include firearms (Diez et al., 2017). Lack of strong firearm policies make it difficult to negate IPV-related deaths even with the Violence Against Women Act (VAWA; Diez et al., 2017).

Two other risk factors of IPV, and the ones this researcher focused on, are financial insecurity and social isolation. Financial insecurity is impacted by many factors, such as the state

of the economy and job loss. Research has found the financial insecurity can increase risky financial behaviors and decrease psychological need satisfaction (Weinstein & Stone, 2018). Financial insecurity has been found to impact economic IPV (Fox & Benson, 2006). Examples of economic IPV includes perpetrators interfering with their partner's ability to earn money, and perpetrators purposely reducing their partner's access to funds and not paying bills (Postmus et al., 2020). In fact, individuals with lower income are at an increased risk for all forms of IPV (Fox & Benson, 2006). Financial insecurity can also lead to food insecurity, another IPV risk factor for Black and Latinx participants (Ricks et al., 2016).

Social isolation is another important IPV risk factor that can influence both physical and mental health (Coyle & Dugan, 2012; Hurtado-de-Mendoza et al., 2014; Pahl et al., 2021). Coyle and Dugan (2012) found that social isolation in older adults could lead to such physical health impacts as increased infections or decreased cognitive functions. Social isolation can also increase the rates of depression, anxiety, stress, suicidal ideation, loneliness, and risk of dementia (Coyle & Dugan, 2012; Giardino et al., 2020; Leigh-Hunt et al., 2017). While the research on social isolation and IPV is limited, the research does show a link between social isolation and IPV victimization (Kim, 2019).

In another study focusing on IPV and social isolation, Eckhardt et al. (2022) explored the Instigating-Impelling-Inhibiting model, which hypothesizes that social isolation, stress, and alcohol use can create an environment for couples that increases the risk of IPV. Due to the limited research on IPV and social isolation, it can be helpful to see how social support, a similar concept, is linked to IPV. Researchers have found that social support and lower perceived social support can increase rates of IPV and distress from IPV (Panchanadeswaran et al., 2008; Thompson et al., 2000). Specifically, social support can attenuate distress of IPV in women

(Fortin et al., 2012). Even though perceived social support and social isolation are similar, there are strong differences between the two concepts. Social isolation is the absence of social interaction or relationships (Coyle & Dugan, 2012). Social isolation is dangerous due to the lack of social interaction and is a reason why more research on the link between social isolation and IPV is needed.

Intimate Partner Violence in the Racial and Ethnic Minority Population

Although there is an abundance of research on IPV, research is lacking on IPV in the REM population (Kolsky & Gee, 2021). This gap in research is harmful to REM individuals, and more research is needed in this area to inform treatment and services. In a study conducted by Cho and Kim (2012a), the researchers found that about one-third of Black and Latinx participants reported experiencing severe IPV, and 20% of Asian participants reported experiencing severe IPV. There have been multiple studies that show that rates of IPV in REM population are higher compared to White individuals (Azziz-Baumgartner et al., 2011; Cha & Masho, 2014). However, there has been research that shows there is not a difference in rates of IPV and White individuals, and studies that show a difference may be due to small sample size, social class, and age (Cho, 2012; Clark et al., 2016). As well, social isolation may impact IPV in REM individuals. REM individuals tend to seek mental health services less often, and this could negatively impact social isolation because of the support that comes from mental health services (Maura & Weisman de Mamani, 2017).

The Novel Coronavirus 2019

A new risk factor, which emerged in 2019, is the COVID-19 pandemic. In January 2020, the first case of COVID-19 was detected in the United States (CDC, 2021a). COVID-19 became a public health emergency, and many measures were put into place to attempt to combat the

spread of COVID-19 (CDC, 2021a). However, there were obstacles for policymakers when making decisions about how to combat COVID-19. At the beginning of the COVID-19 pandemic, the knowledge about how it spread was limited, and data were difficult to gather because each state reported positive COVID-19 cases differently (Galaitis et al., 2021). The measures that were put in place included mandatory mask orders, stay at home orders, and social distancing. The policies varied by state, and policy was influenced by the state governors' political party (Baccini & Brodeur, 2021). Baccini and Brodeur (2021) found that Democratic governors were more likely to issue mask mandates and quicker to issue stay-at-home orders than Republican governors. COVID-19 has influenced politics in the United States and has created a divide between political parties. For example, individuals who hold more conservative views were more likely to trust the national government under former President Donald Trump, and individuals with more liberal views were more likely to take precautions against contracting and spreading COVID-19 (Kerr, Panagopoulos, & van der Linden, 2021).

There has been a strong emphasis on physical health research and COVID-19, but COVID-19 also impacted mental health. The CDC found that rates of anxiety and depression for adults increased from August 2020 to February 2021 (Vahratian et al., 2021). There are multiple reasons for these increases, including stay-at-home orders and isolation, and loss of loved ones from COVID-19 (Killgore et al., 2021). Although everyone has been impacted by COVID-19, REM individuals have been disproportionately impacted by COVID-19. Data have shown that REM individuals in the United States are more likely to contract COVID-19, develop severe symptoms, and have a higher death rate from COVID-19 (Boserup et al., 2020b; Ruprecht et al., 2021). There are many systemic factors that may impact these rates, which include discrimination, lack of access to childcare and healthcare; and higher rates of trauma, stress, and

psychological disorders, poverty, unemployment rates, and racism (Boserup et al., 2020b; Fortuna et al., 2020; Ruprecht et al., 2021).

Another public health issue, which has been affected by COVID-19, is IPV. Many cities such as New Orleans, San Antonio, and Portland reported an increase in domestic violence calls (Boserup et al., 2020a; Buttell & Ferreira, 2020). One possible explanation for this increase is that measures set in place to protect people from contracting COVID-19 increased the risk of IPV in already high-risk homes (Bradbury-Jones & Nikupeteri, 2021) For example, stay-at-home orders increased the risk for many people. In theory, home would be a safe place for individuals, but for people living in homes with people who are violent, home is not a safe place (Bradbury-Jones & Nikupeteri, 2021). Even if individuals did not live with perpetrators, advances in technology permitted perpetrators to cyberstalk and create false lawsuits and child abuse allegations during stay-at-home mandates during COVID-19 (Bradbury-Jones & Nikupeteri, 2021). Along with IPV, the COVID-19 pandemic has adversely influenced the finances of many individuals. Unemployment rates reached record highs since the Great Depression during the COVID-19 pandemic (Wu et al., 2021). Also, social isolation was impacted because many individuals were forced to spend more time with perpetrators due to the stay-at-home orders (Gresham et al., 2021).

At the time of this writing, few studies had explored how COVID-19 had impacted IPV. In one study by Gresham et al. (2021), the researchers found that stressors such as social isolation and financial insecurity were linked to higher reported incidents of IPV. In their qualitative study, Lyons and Brewer (2021) found a positive relationship between COVID-19 stressors, such as social isolation and financial insecurity, and rates of IPV. Both Gresham et al. (2021) and Lyons and Brewer (2021) provided important information about how COVID-19 has

impacted IPV. However, Gresham et al.'s (2021) sample included primarily White participants, and Lyons and Brewer (2021) did not collect demographic information. This creates a gap in the literature that is concerning because of what is known about IPV rates in the REM population, and how REM individuals are disproportionately impacted by the COVID-19 pandemic.

Definition of Terms

Below is a listing of major terms and their definitions.

Economic Intimate Partner Violence: “A deliberate pattern of control in which individuals interfere with their partner’s ability to acquire, use, and maintain economic resources” (Postmus et al., 2020, p. 262).

Financial Insecurity: The experience of concern that one’s assets will not be enough to pay for one’s expenses or future goals (Odlé-Dusseau et al., 2018).

Intimate Partner Violence: Any “behavior by an intimate partner that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors” (WHO, 2013, p. vii).

LGBTQ+: An acronym for lesbian, gay, bisexual, transgender, queer individuals, or other folk not covered in the letters in the acronym.

Novel Coronavirus 2019 (COVID- 19): A respiratory illness caused by a virus that spread across the world causing a global pandemic.

Social Isolation: When an individual lacks a social network. (Kim, 2019).

Racial and Ethnic Minority: An individual who identifies as Black/African American/Caribbean, Latinx/ Latino(a)/Hispanic, Asian/Asian American/Pacific Islander, Native American/Indigenous/Alaskan Native, or Multiracial/Biracial.

CHAPTER II
LITERATURE REVIEW
Intimate Partner Violence

IPV has been a growing concern in U.S. culture for decades (CDC, 2014). Even though there have been many changes in policy and a growing awareness of IPV, it remains pervasive. IPV is defined as any “behavior by an intimate partner that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors” (WHO, 2013, p. vii). To date, millions of individuals, particularly those who identify as women, continue to be affected by IPV (Davilla et al., 2017). Internationally, a study by the WHO estimated that about 13% to 61% of women experience physical IPV in their lifetime (Garcia-Moreno et al., 2005). In the United States, roughly 36% of women and 33.6% of men will experience some form of IPV during their lifetime (CDC, 2018).

Types of Intimate Partner Violence

The most common types of IPV are psychological, physical, sexual, stalking, and economic. Most studies predominantly focus on physical, sexual, and psychological IPV, which limits researchers’ knowledge of other forms of IPV (Grest et al., 2018). Physical IPV includes hitting, slamming, choking, kicking, burning, hair pulling, and more acts of physical violence (CDC, 2014). Psychological IPV is another form of IPV that occurs often. This includes speaking down to a partner, humiliating a partner, and belittling a partner to make them dependent on the perpetrator (Postmus et al., 2012). Sexual IPV includes forced or coercion of sexual activity or sex. Approximately 21% of women experience sexual IPV in their lifetime (Preiser & Assari, 2017). Stalking is another form of IPV. Stalking is defined as “a series of actions directed at a specific person, including repeated visual sightings or physical proximity, nonconsensual communication, or verbal, written or implied threats or a combination thereof”

(Becker et al., 2021, p. 73). Stalking can occur in person or online. The National Intimate Partner and Violence Sexual Survey Data Brief reported that 10.4% of women and 2.2% of men will experience stalking by an intimate partner during their lives (CDC, 2018). Most perpetrators know the individuals they are stalking and were in a previous romantic relationship with them (Garza et al, 2020). Stalking is not often included in studies looking at rates of IPV, possibly because stalkers are typically former rather than current partners.

One form of IPV that is not understood by many people is economic IPV. Most people in the United States do not associate economic control with abuse (Postmus et al., 2012). Economic IPV is defined as “a deliberate pattern of control in which individuals interfere with their partner’s ability to acquire, use, and maintain economic resources” (Postmus et al., 2020, p. 262). Economic IPV is a common way IPV perpetrators control their partners (Postmus et al., 2012). Even though economic IPV occurs often, there is not as much research on economic IPV compared to other forms of IPV. Research shows that women who become financially dependent on their partners are also at an increased risk of psychological IPV and have a lower chance of leaving an abusive partner (Postmus et al., 2012). Unfortunately, societal norms make it easier for male perpetrators to control women using economic IPV (Postmus et al., 2020). This is because of gender inequalities that allow women to earn less money than men as well as the fewer job opportunities available for women (Postmus et al., 2012; Postmus et al., 2020). Even though there are fewer opportunities for women, more than half of women with children in the United States are a part of the workforce (Ruppaner et al., 2021). Many working mothers struggle with guilt and conflict between their work and home life because of societal norms that mothers are supposed to put their children’s needs and wants before their own. In a recent study by Ruppaner et al. (2021), the researchers found that women who have college degrees and

children are more likely to be unemployed if they live in a state that emphasizes traditional gender norms. Societal norms are just one of the factors that affect rates of IPV; having childcare can also impact a woman's ability to work. McConnon et al. (2021) explored how heterosexual college students viewed working mothers and found that the majority of college students believed mothers should have a choice on whether they want to work. However, their answers pointed to an expectation that women should remain more flexible in changing their work schedules to meet family demands than men.. Childcare needs and societal norms often intersect to deter women from joining the workforce. For example, fathers in the United States are more likely to support their wives working if they believe their situation necessitates having two incomes, and while fathers support their wives working, many of them might believe they should be the sole or primary provider for their family (Lyonette et al., 2011). Lyonette et al. (2011) found that many fathers believed that, if needed to avoid the high cost of childcare, their wives would be the ones to leave the workforce to care for their children.

Another factor is the limited information about economic IPV. Victims of economic IPV may not recognize the behaviors as IPV until after they leave their partners (Postmus et al., 2020). For the purpose of this study, this researcher examined physical, sexual, psychological, and economic IPV. While stalking is important to study, stalking is predominantly perpetrated by previous romantic partners, and therefore it was not explored in this study (Miller, 2012).

Differences in Intimate Partner Violence Based on Gender and Sexual Orientation

IPV affects women and men in different ways. Most of the research on IPV has focused on men as perpetrators, and women as victims, as this is most commonly the case (Grest et al., 2018). This does not mean, however, that men cannot be victims of IPV. In fact, approximately 33.6% of men experience IPV in the United States (CDC, 2018). That said, women are more

greatly impacted by IPV than men. In a brief using the National Intimate Partner and sexual violence survey data from 2010, the CDC (2014) found that 24.3% of women experience severe physical IPV in their lifetime compared to 13.8% of men. In an updated brief using data from 2015, the CDC (2018) reported a change in those numbers, with 21.4% of women experiencing severe physical IPV in their lifetime, and 14.9% of men experiencing severe IPV in their lifetime. Death from physical and sexual partner violence is also more common for women. The rates of sexual violence by an intimate partner for women is approximately 18.3% for women and 8.2% for men in their lifetime (CDC, 2018). It is unclear whether the data from the CDC (2018) include same-sex couples because sexual orientation is not discussed in the article. Similar to other forms of IPV, women are more likely to experience economic hardship as a result of IPV (Postmus et al., 2012). Although there is less known about individuals in same-sex relationships, it is clear that women (Graham et al., 2019) and men in same-sex relationships can also perpetrate and be victims of IPV (Callan et al., 2020; Graham et al., 2016).

Individuals who identify as LGBTQ+ experience IPV at different rates than heterosexual cisgender individuals. In the same brief mentioned above, the CDC (2014) found that bisexual women experience the highest rates of stalking, physical, and sexual IPV, at 61.1% compared to lesbian (43.8%) and heterosexual (35%) women. Additionally, bisexual men experienced higher rates of stalking, physical, and sexual IPV, at 37.3% compared to heterosexual (29%) and gay (26%) men. However, the rates of IPV that LGBTQ+ individuals experiences vary, with some studies showing equal rates of IPV compared to cisgender individuals and other studies showing higher rates of IPV compared to heterosexual cisgender individuals (Edwards et al., 2015; Graham et al., 2019; Scheer & Baams, 2019). For example, in a study conducted with college students by Graham et al. (2019), the researchers found that participants in same-sex

relationships experienced higher rates of physical injury from IPV and perpetration compared to mixed-sex couples. Additionally, a unique factor LGBTQ+ individuals face within IPV is identity abuse. Identity abuse occurs when a person's partner devalues their sexual orientation and/or gender identity, which can lead to fear of seeking help because of their sexual orientation (Callan et al., 2021; Scheer & Baams, 2019). There is growing research on IPV and sexual orientation but less research on IPV within transgender and non-gender conforming individuals (Scheer & Baams, 2019). In a systematic literature review by Peitzmeier et al. (2020), the authors found that transgender individuals are 1.7 more likely to be victims of IPV than cisgender individuals. Transgender individuals are 37.5% more likely to experience physical IPV and 25% more likely to experience sexual IPV in their lifetime compared to cisgender individuals.

Among other negative impacts, people who experience psychological, physical, and sexual IPV often suffer from a variety of mental health issues (Davilla et al., 2017; Howard et al., 2010). Women have more fear of IPV-related injuries than men, and women experience more negative and recurrent physical and mental health problems from IPV (Clark et al., 2016). Mental health outcomes from IPV for women include depression, anxiety, and traumatic stress that can become chronic without treatment even if the woman is no longer in a relationship with the perpetrator (Clark et al., 2016).

Intimate Partner Violence in the Racial and Ethnic Minority Population

Research on intimate IPV in the REM population is limited compared to the overall research on IPV (Cho & Kim, 2012a). Targeted research in this area is necessary given the high rates of IPV in the REM population. In a study conducted by Cho and Kim (2012a), the researchers used data from the Collaborative Psychiatric Epidemiology Surveys from adults aged

18 and older in the United States between 2001 and 2005 and found that approximately one-third of Latinx and Black participants were victims of severe IPV, while about 20% of Asian American participants were victims of severe IPV. Research has also shown that Latinx and non-Latinx Black women experience higher rates of IPV during pregnancy compared to other racial groups (Cha & Masho, 2014). Similarly, IPV-related deaths in REM individuals are higher compared to White individuals. In a study conducted by Azziz-Baumgartner et al. (2011), the authors reported that Hispanic and Black individuals have higher rates of death from IPV compared to White women. Further, REM immigrants have a higher chance of dying from IPV than REM and White women born in the United States. Disclosure of IPV can also vary between REM groups. Asian victims of IPV typically disclose their experiences to friends instead of seeking professional help (Cho & Kim, 2012b). As well, REM individuals who are immigrants may not report IPV or seek help due to their immigration status or their families (Cho & Kim, 2012a). Another reason REM individuals may not report IPV is because the perpetrator is also a REM (Gómez, 2019). By reporting another REM individual, it could be viewed as a cultural betrayal and breaking racial loyalty (Gómez, 2019).

Of note, even though there is substantial research that shows that REM individuals experience IPV at higher rates, there is also some research that shows there is no difference in the rate of IPV between REM and White individuals (Clark et al., 2016). The mixed results of rates of IPV in REM and White individuals occurs for multiple reasons. One reason is that the studies that compare REM to White individuals normally have smaller samples of REM in their study (Clark et al., 2016). In many instances, researchers comparing rates of IPV between REM and White individuals have not found a significant difference when researchers controlled for social class (Cho, 2012; Clark et al., 2016). For example, Cho (2012) found that when

controlling for social class and age, the increased risk of IPV for Black and Latinx participants compared to White participants disappeared.

Risk Factors for Intimate Partner Violence

There are many risk factors for IPV ranging from social isolation to financial insecurity. One risk factor for IPV is mental health (Solinas-Saunders, 2021). Depression and past suicide attempts can increase the risk of individuals experiencing IPV later in life (Kim & Lee, 2013; Renner & Whitney, 2011). Individuals experiencing depressive symptoms may have less social support and limited ability to gauge threats from others which therefore increases their risk of experiencing IPV (Kim & Lee, 2013; Lehrer et al., 2006). For example, Kim and Lee (2013) explored the relationship between IPV and depression in women in Korea and, found that married women experiencing depression symptoms reported higher rates of IPV. Another risk is adverse experiences in childhood, such as childhood sexual abuse and childhood neglect (Iverson et al., 2013; Renner & Whitney, 2011). Individuals who experienced child abuse or neglect are at increased risk for IPV in romantic relationships (Renner & Whitney, 2011). There are multiple reasons as to why childhood abuse leads to an increased risk of IPV later in adulthood, including trauma bonding, dependency, and differences in interpersonal schemas in women who have experienced childhood abuse versus women who did not experience childhood abuse (Breitenbecher, 2001).

One risk factor for severe IPV and IPV related death is firearms. Diez et al. (2017) found while analyzing data from the Federal Bureau of Investigation that in the United States, more than 1,800 individuals are killed by physical IPV (Diez et al., 2017) and that about half of all annually reported IPV-related deaths include the use of a firearm (Diez et al., 2017).

Nonetheless, there is an absence of strong gun control policies in place for individuals charged

with IPV. The 1994 VAWA prohibits individuals who have criminal charges or protective orders due to IPV to purchase a firearm (Diez et al., 2017). However, the VAWA does not mean that an individual charged with IPV related crimes has to give up a gun already in their possession. In some cases, due to loopholes in the law, a person charged with a crime of IPV has to be the one to surrender their gun; it cannot be taken from them (Diez et al., 2017). Since the VAWA became a law, there have been provisions added. One of these provisions states that law enforcement must inform individuals convicted of crimes of IPV of the restrictions of firearms (Diez et al., 2017). In 2016, there were only 15 states that mandated individuals with IPV-related orders of protection to surrender their firearms and 11 states that require individuals who were charged with an IPV-related crime to surrender their firearms (Diez et al., 2017). These policies are just one example of where policy has fallen short to protect victims of IPV.

Financial insecurity and social isolation can also increase the risk of IPV (Fox & Benson, 2006; Gresham et al., 2021). For the purposes of the current study, financial insecurity and social isolation were examined in depth.

Financial Insecurity

Financial insecurity is a stressor for many individuals. One financial stressor is job loss. Job loss, particularly involuntary job loss can be a stressful life event, that worsens mental health (Wu et al., 2021). Job loss does not just impact the individual; it can impact the mental health of the spouse and children (Bubonya et al., 2017). Financial insecurity is also linked to riskier financial behaviors and lower psychological need satisfaction (Weinstein & Stone, 2018). In a series of four studies, Weinstein and Stone (2018) found that financial insecurity decreased psychological need satisfaction. The basic psychological needs used in this study were autonomy, competence, and relatedness, and the researchers measured whether individuals felt

those needs were satisfied. Participants who experienced financial insecurity, measured by the Personal Financial Wellness Scale, felt as if their choices were limited, they felt disconnected, and felt an increased frustration over lack of psychological satisfaction. As well, Weinstein and Stone (2018) found that participants with lower psychological need satisfaction engaged in riskier financial behaviors, such as financial cheating.

Previous research has demonstrated that financial insecurity influences rates of IPV and families with lower income are at higher risk of IPV (Cuellar et al., 2020; Fox & Benson, 2006). Financial stressors linked to IPV include inability to pay housing or utilities, utilities and phone being turned off, eviction, and fear of not being able to afford food (Schwab-Reese et al., 2016). Financial insecurity can also be a consequence of IPV (Postmus et al., 2020). Victims of IPV may be at risk of financial insecurity if they leave their partners, and victims may experience financial insecurity from economic IPV (Postmus et al., 2020). Some behaviors of economic IPV that can lead to financial insecurity include decreased access to financial assets, perpetrators purposely not paying bills, and perpetrators interfering with their partners' jobs (Postmus et al., 2020). These behaviors of economic abuse can lead to perpetrators withholding resources needed to buy food and create food insecurity (Power, 2006). Also, victims of economic IPV who have children may not leave due to the risk of their partners ceasing financial support for their children, and causing food insecurity (Power, 2006). Further Ricks et al. (2016) found that Black and Latinx participants who reported low income were at greater risk of experiencing food insecurity as a consequence of IPV compared to White low-income women participants. Due to systemic oppression, many REM individuals have fewer financial resources. Yet, the research on how financial insecurity impacts IPV in the REM population is inadequate.

Social Isolation

Similar to financial insecurity, social isolation can be a risk factor for IPV. Humans are social and crave connection (Coyle & Dugan, 2012). Therefore, social isolation can have a negative impact on physical and mental health (Coyle & Dugan, 2012; Hurtado-de-Mendoza et al., 2014, Pahl et al., 2021). Health risks, especially with older adults, include systolic blood pressure, different types of infections, sleep disturbances, decreased cognitive function, and mortality (Coyle & Dugan, 2012). Social isolation has also been linked to increased levels of pain interference in adults receiving pain management treatment (Karayannis et al., 2018). Also, social isolation has been linked to higher rates of depression, anxiety, stress, suicidal ideation, loneliness, and an increased risk of dementia (Coyle & Dugan, 2012; Giardino et al., 2020; Leigh-Hunt et al., 2017). In a recent narrative review on the impacts of social isolation in older adults due to the COVID-19 pandemic, Sepúlveda-Loyola et al. (2020) found that many older adults experienced a decrease in physical activity and quality of sleep and an increase in depression and anxiety.

Past research on IPV has shown that social isolation impacts rates of IPV (Gresham et al., 2021). However, most research on the impact of social isolation on IPV has focused on isolation due to living in a rural area (Lanier & Maume, 2009). One study that looked at social isolation in Korean immigrants in the United States found that social isolation was linked to IPV victimization (Kim, 2019). Kim (2019) found that the participants who reported higher social isolation were 17% more likely to experience IPV. Additionally, Kim (2019) explored if social support moderated the relationship between IPV and acculturative stress and found that social support did not moderate that relationship. However, Kim's (2019) results did show that acculturative stress partly mediated the relationship between social isolation and IPV, indicating

that acculturative stress plays a role in the relationship between social isolation and IPV in that study. In another study looking at IPV and social isolation, Eckhardt et al. (2022) explored existing literature about social isolation, substance use, and IPV. The relationship between social isolation and IPV is less researched than other risk factors, and due to the lack of research on social isolation and IPV, Eckhardt et al. (2022), pulled from the Instigating-Impelling-Inhibiting model. Eckhardt et al. (2022) described how within this model, isolation is an instigating factor that can lead to IPV perpetration. The authors described the “perfect storm” aspect of the model where couples are isolated, under stress, and use substances such as alcohol to cope and how this can create an environment for IPV to occur (Eckhardt et al., 2022).

Although there is more research on social support and IPV than social isolation and IPV, social support is a related concept that can provide insights into social isolation’s relationship with IPV. In multiple studies on IPV, researchers have looked at social isolation as a lack of social network (Kim, 2019). For example, Panchanadeswaran et al. (2008) found that participants with lower perceived social support had higher rates of IPV. Social support is a protective factor for IPV (Carlson et al., 2002). In study conducted by Thompson et al. (2000), the researchers found that IPV was related to lack of perceived social support by participants and that participants who perceived less social support from others reported higher levels of distress. Fortin et al. (2012), found social support decreased distress in women participants but did not impact the level of distress for men. In fact, Fortin et al. (2012) found that participants who were men experienced more distress when talking to multiple people about their abuse. Fortin et al. (2012) stated one of their hypotheses for this finding is that men who are IPV survivors do not have their needs for support met by talking to others, and that this may be related to the stigma of men being victims of IPV.

Social isolation and perceived social support are related terms, but they are not the same. It is important to be aware of how the two terms are similar and different. Perceived social support is one's belief that they have social support readily available to them, and perceived social support can be a protective factor or a risk factor (Hansen et al., 2014). Social isolation is different than perceived social support because "social isolation is the objective lack of relationships and social interaction" (Coyle & Dugan, 2012, p. 1347). An individual with low perceived social support may still have social support in place, and an individual who is socially isolated does not have social support in place and may not be able to access avenues to create social support. Due to the negative impacts of social isolation and the complete lack of social interaction from social isolation, it is important to understand how social isolation separate from perceived social support impacts IPV.

The current study focused on social isolation in the REM population. It is important to explore how help-seeking behaviors and social isolation interact within the REM population. Racial and ethnic minorities tend to use mental health services less often and have worse outcomes with mental health services than White individuals (Maura & Weisman de Mamani, 2017). REM individuals may fear seeking professional services because of systemic oppression in our society (Cho & Kim, 2012a). In fact, Black individuals with severe mental health diagnoses are more likely to be involuntarily hospitalized compared to White individuals (Maura & Weisman de Mamani, 2017). There are different factors that affect reasons why REM individuals seek mental health services less often. One reason is that REM individuals are not able to access community and outpatient mental health services, so when they do need service, they seek services from emergency rooms (Lee et al., 2014). Also, the stigma of mental health in REM communities and families discourages individuals from seeking mental health services

(Maura & Weisman de Mamani, 2017). REM individuals lean towards informal help from friends and family members than seeking formal services more than White individuals (Cho & Kim, 2012b). Even though there is tremendous amount of research that supports that REM individuals have less satisfaction with mental health services, a study conducted by Cho and Kim (2012b) showed no differences between races when it came to satisfaction with mental health services. This inconsistency in the research shows the need for more research on REM individuals' mental health needs. Regardless of the mixed results, it is important to acknowledge the evidence which shows REMs seek mental health services less often than White participants (Maura & Weisman de Mamani, 2017). As stated above, REM individuals tend to seek informal support from peers and family members (Cho & Kim, 2012b). Mental health services can provide support and information regarding IPV that family members and peers may not be able to, and this lack of support from mental health services could exacerbate social isolation.

The Novel Coronavirus 2019

As noted above, many factors influence IPV, and several of those factors were impacted by the emergence of the novel Coronavirus 2019. In late December of 2019, the COVID-19 emerged (CDC, 2021b). At this point, very little was known about COVID-19 or about how it spread. By January 2020, the Center for Disease Control and Prevention (CDC) confirmed the first case of COVID-19 in the United States and by March 11, 2020, the WHO declared COVID-19 a pandemic (CDC, 2021a). The United States followed soon after and declared the spread of COVID-19 a public health emergency, and for many individuals living both in the United States, and all around the world, their lives changed tremendously (CDC, 2021a). For policymakers around the world and specifically in the United States, decisions had to be made for the public's safety (Galaiti et al., 2021). Data from all the states about COVID-19 cases and medical

supplies needed to be gathered, but states reported positive COVID-19 cases differently, and there was little knowledge about how COVID-19 could be spread (Galaitis et al., 2021). This inconsistency made it difficult for policymakers to make decisions about public safety (Galaitis et al., 2021).

Different measures were put in place, such as stay-at-home orders, social distancing, and in some areas mandatory mask wearing, to stop the spread of COVID-19 (Galaitis et al., 2021). Each state was able to choose what policies to put in place; therefore, the COVID-19 policies varied by state. Research found that state governors who were a part of the Democratic party were approximately 50% more likely to issue a stay-at-home order than Republican governors (Baccini & Brodeur, 2021). Additionally, Democratic governors and governors in states without term limits were quicker in issuing stay-at-home orders (Baccini & Brodeur, 2021). Sadly, even with safety measures in place, by May 2020, 100,000 people had died in the United States from COVID-19 (CDC, 2021a). By April 2022, nearly 985,055 deaths had been reported in the United States (CDC, 2022a). Unfortunately, a major impact of COVID-19 in the United States is a divide in views about COVID-19. The divide appears to fall along political party lines, with individuals who hold more conservative views tending to trust the federal government under former President Donald Trump's leadership to regulate COVID-19, and individuals who hold liberal views tending to trust scientists over government (Kerr, Panagopoulos, & van der Linden, 2021). Kerr, Panagopoulos, and van der Linden (2021) also found that individuals with more liberal views perceived COVID-19 as a larger risk and took more precautions against contracting COVID-19.

The Impact of COVID-19 on Mental Health

Along with physical health, COVID-19 impacted the mental health of many individuals. Researchers with the CDC found that the number of adults diagnosed with either anxiety or depression increased from 36.4% to 41.5% from August 2020 to February 2021 (Vahratian et al., 2021). During the early phases of the pandemic, many states and cities encouraged individuals to stay at home and only leave to get necessary items (Killgore et al., 2020), although essential workers continued leaving their homes to perform their job. For many, this led to a dramatic decrease in social interaction. Many individuals who lived with others had periods of time where they had to completely self-isolate if they contracted the virus (Killgore et al., 2020). In a study conducted by Killgore et al. (2020), researchers found that about 43% of their participants were experiencing significant rates of loneliness, and those who had reported high rates of loneliness also reported higher rates of depression. Along with social isolation, factors such as loss of a loved one from COVID-19 and the constant stream of media discussing infection rate and death tolls may have also impacted the increase of depression in the United States since March 2020 (Han et al., 2020). Additionally, Gibson et al. (2021) found that women, individuals with less education, and individuals who identified as Black, Native American, Asian, or Hispanic reported worse mental health.

Anxiety rates in individuals were also impacted by the COVID-19 pandemic. As stated above, the researchers found that adults diagnosed with either anxiety or depression increased from 36.4% to 41.5% from August 2020 to February 2021 (Vahratian et al., 2021). As well, Killgore et al. (2021) found that rates of anxiety increased as early as the first few weeks of the COVID-19 pandemic. Specifically, Killgore et al. (2021) found that general anxiety disorder was approximately 10.3 to 15.8 times higher in the first few weeks of the COVID-19 pandemic.

Another form of anxiety which increased due to the COVID-19 pandemic is healthy anxiety (Tyrer et al., 2020). Due to the high transmission rate of COVID-19, anxiety over contracting it is reasonable, but there may be long term effects on individuals' mental health (Tyrer et al., 2020). Additionally, individuals who experienced health anxiety before the COVID-19 pandemic may experience worsening of health anxiety symptoms (Tyrer et al., 2020).

The Disparities of COVID-19's Impact on Racial and Ethnic Minorities

Due to many systemic factors, COVID-19 disproportionately impacts REM in various ways compared to White individuals because many COVID-19 safety measures, such as social distancing, are impacted by privilege (Gibson et al., 2021). In the United States, REM have higher infection and death rates from COVID-19 than White individuals (Boserup et al., 2020b). Many factors such as discrimination, access to healthcare, access to transportation, high rates of heart disease, lack of access to childcare, high percentage of REM in the prison system, types of jobs held, high rates of trauma, stress, and psychological disorders impact the infection and death rate of COVID-19 in REM (Boserup et al., 2020b; Fortuna et al., 2020; Ragavan et al., 2020; Ruprecht et al., 2021). Additionally, Black, Latinx, and Native American individuals are more likely to contract COVID-19 than White individuals, and due to high rates of diseases in REM population, Black and Latinx participants are at high risk of developing severe symptoms of COVID-19 and to be hospitalized (Boserup et al., 2020b; Ruprecht et al., 2021). As well, due to higher rates of trauma, including medical trauma, increased barriers to treatment, and systemic racism, Black and Latinx individuals are more likely to experience worsening of their mental health as a result of the COVID-19 pandemic (Gibson et al., 2021; Ruprecht et al., 2021). Also, many stressors REM individuals experience such as poverty, unemployment rates, and racism are being have been amplified during COVID-19 (Fortuna et al., 2020). In a study conducted in

Chicago by Ruprecht et al. (2021) about the impacts of COVID-19 on REMs, the researchers found that Black and Latinx participants reported the most difficulty in receiving healthcare and getting food than White participants. The study also showed that Black and Latinx individuals had less access to technology to stay connected and that they were unable to isolate due to the essential jobs the participants held and living in larger households (Ruprecht et al., 2021).

The Impact of COVID-19 on Intimate Partner Violence

For many individuals, COVID-19 was not the only threat during the COVID-19 pandemic. Multiple cities reported an increase in domestic violence calls since the start of COVID-19. For example, by April 2020, domestic assaults were up 37% from the start of the year in New Orleans; by March 2020, Portland reported an increase in domestic violence calls to the police by 20% from prior weeks; in March 2020, San Antonio reported an increase of domestic violence calls by 18% from March 2019 (Boserup et al., 2020a; Buttell & Ferreira, 2020). However, as has been the case in previous pandemics, such as the Zika and H1N1 influenza pandemics, IPV has been underreported during the COVID-19 pandemic (Peterman et al., 2020). This underreporting makes it hard to gauge the true impact COVID-19 has had on IPV rates. The few studies that explore IPV and COVID-19 will be explored in greater depth in another section of this paper (Peterman et al., 2020). Many risk factors for IPV were increased during COVID-19 due to stay-at-home orders, social distancing, working from home, and increased financial stress (Boserup et al., 2020a; Buttell & Ferreira, 2020; Evans, 2020; Gresham et al., 2021; Lyons & Brewer, 2021). For victims of IPV, home kept them safe from the virus but not from their partners (Bradbury-Jones & Nikupeteri, 2021). The stay-in-place orders created more distance between social support, such as family, friends, and colleagues (Bradbury-Jones & Nikupeteri, 2021). Even if perpetrators did not have face-to-face contact with their partners

during shutdowns, technology still allowed for abusive behaviors such as cyberstalking and false lawsuits or reports of child abuse (Bradbury-Jones & Nikupeteri, 2021).

Past research shows that financial stress and social isolation are risk factors for IPV (Gresham et al, 2021). One way that the pandemic has increased risk factors for IPV is that individuals have been forced to spend more time with their abusers and self-isolate to avoid contracting COVID-19 (Gresham et al, 2021). Unfortunately, COVID-19 has also increased financial insecurity for individuals. In August 2020, approximately 42 million individuals lost their job and their health insurance (Roush, 2020). The unemployment rate has been largely impacted by COVID-19, with the unemployment rate reaching the highest it has been since the Great Depression (Wu et al., 2021). The rate of unemployment is not equal, and women, older adults, and people of color were more likely to lose their jobs during the COVID-19 pandemic, which highlights the importance of exploring how COVID-19 may impact risk factors for IPV, such as financial insecurity, within the REM population (Dang & Nguyen, 2021; Wu et al., 2021). In a study conducted by Mojtahedi et al. (2021) about job loss and mental health during the COVID-19 pandemic, the researchers found that participants were experiencing higher rates of depression, anxiety, and stress, and that individuals who had lost their jobs reported more severe symptoms (Mojtahedi et al., 2021). In addition, Mojtahedi et al. (2021) found that loss of employment or fear of loss of employment impacted overall mood.

Additionally, another factor impacting financial insecurity was the increased rate of homeschooling during the COVID-19 pandemic, which caused many parents, especially mothers, to reduce their paid work hours. Many mothers were at risk of losing their job due to increased need for childcare (Couch et al., 2022; Kerr, Rasmussen, et al, 2021; Petts et al., 2021). Petts et al. (2021) found that mothers were at a higher risk of losing their jobs than fathers, and

that mothers who did not have nonparental childcare before COVID-19 were at a higher risk of losing their jobs than mothers who did have nonparental childcare prior to COVID-19. Many parents started to work from home due to COVID-19 protocols and childcare; however, this did not prevent decreased paid work hours (Collins et al., 2021). Collins et al. (2021) conducted a study examining the impacts of COVID-19 on working conditions for parents who work from home. While mothers who worked from home were at decreased risk of job loss, they still reported a significantly greater decrease in work hours due to childcare responsibilities relative to fathers (Collins et al., 2021).

There are multiple articles about the increased risk factors of IPV due to COVID-19, but there are very few studies that look directly at the relationship between COVID-19 and IPV. One study that did look at the relationship of IPV and COVID-19 found that greater COVID-19 stressors led to higher IPV victimization rates (Gresham et al., 2021). Gresham et al. (2021) explored how COVID-19 stressors, such as social isolation, financial insecurity, health anxiety, and perceived stress impacted IPV and how health behaviors are associated with IPV. The researchers recruited from ResearchMatch, a registry in the United States associated with the U.S. National Institutes of Health (Gresham et al., 2021). The researchers used structural equation modeling to analyze their data and found that the COVID-19 stressors were linked to greater IPV victimization. However, their sample was predominantly White, with approximately 12% of their participants identifying as either Black, Asian, American Indian or Alaska Native, or mixed or other (Gresham et al., 2021). The study did not report having any Latinx participants, which is a limitation, due to the growing Latinx population in the United States.

Lyons and Brewer (2021) conducted a qualitative study also investigating the relationship between COVID-19 and IPV using online Reddit posts. The researchers found that stressors,

such as financial insecurity, social isolation, more time spent with the perpetrator, and increased alcohol and drug abuse, increased participants' risk for IPV victimization. Additionally, Lyons and Brewer (2021) found that perpetrators used COVID-19 to control their partner, by threatening partners that they would be exposed to the virus if they left, or perpetrators telling their partner's loved ones that their partner tested positive for COVID-19 to decrease their partner's social interaction. Due to the nature of using archival data, Lyons and Brewer (2021) were unable to collect demographic information from participants. They noted the lack of research on IPV in REM population and acknowledged this as a limitation in their own study.

Purpose of the Study

Past research has confirmed that social isolation and financial insecurity are risk factors for IPV (Fox & Benson, 2006; Gresham et al., 2021; Kim, 2019; Postmus et al., 2020; Schwab-Reese et al., 2016). However, the research on social isolation and financial insecurity as risk factors for IPV has not explored how these factors impact IPV in the REM population. Additionally, due to COVID-19 and forced quarantine, many people lost their employment and were more socially disconnected than ever before. Recent literature has shown that since COVID-19 quarantines, IPV has increased (Boserup et al., 2020a; Buttell & Ferreira, 2020). However, at the time of this writing, there were few studies that measure the prevalence of IPV during the COVID-19 pandemic and how an increase in social isolation and financial insecurity has impacted IPV rates. While Gresham et al (2021) did explore how COVID-19 influenced social isolation and financial insecurity and how that impacted rates of IPV, their sample was 88% White (Gresham et al., 2021). It is important to examine how COVID-19, social isolation, and financial insecurity impacts rates of IPV in REM individuals, given the research that shows how REM individuals are disproportionately impacted by COVID-19 compared to White

individuals (Boserup et al., 2020b; Fortuna et al., 2020; Ruprecht et al., 2021). Gresham et al. (2021) also did not include economic abuse in their study, which past research shows is linked to financial insecurity. The purpose of this study was to fill the gaps in the literature and explore how the prevalence of IPV have been impacted by increased social isolation and financial insecurity due to COVID-19 disproportionately impacting REM individuals. The researcher explored the following questions and tested the following hypotheses in this study:

1. Has IPV increased in REM population during the COVID-19 pandemic?

H1: REM participants will report experiencing an increase of IPV during the COVID-19 pandemic.

2. What is the impact of financial insecurity and social isolation on IPV during the COVID-19 pandemic for REM participants?

H2: High financial insecurity and social isolation will be related to increased IPV rates in REM participants.

CHAPTER III METHODOLOGY

Participants

The target population for this study was REM individuals, and the researcher originally set out to recruit an estimated 100 participants of all genders. A power analysis was conducted to determine the exact number participants needed for adequate power. Due to lack of effects sizes between social isolation, financial insecurity, and IPV, correlations from the Gresham et al (2021) were converted into Cohen's f^2 to use as the effect size in the power analysis. Gpower was used to determine that 94 participants would be required to ensure meaningful results. In Gpower, the level of power was set to .80, the alpha (α) level was set to .05, and the effect size was set to .0671 (p). The researcher recruited 240 participants who consented to participate in the study. A total of 47 participants were excluded from the study due to either incomplete survey, missing data, invalid data, or extreme outliers. The final sample for this study was 193 participants. To qualify for this study, individuals identified as Black/African American/Caribbean, Latinx/ Latino(a)/ Hispanic, Asian/Asian American/Pacific Islander, Native American/Indigenous/Alaskan Native, or Multiracial/Biracial. Non-REM individuals were excluded from the study. The researcher recruited participants through multiple venues. The researcher posted the survey on social media platforms such as Facebook, Reddit, and Instagram to recruit participants. Also, participants were recruited from approved local mental health services.

Procedure

Participants were recruited through local mental health services, and social media websites and apps, specifically Facebook, Instagram, and Reddit. Participants were able to access the online PsychData survey through a link on the recruitment flyer. Data were also collected at a

women's shelter and support agency and at a private practice that was providing services through telehealth. Data collection occurred from February 2022 to April 2022. At the women's shelter and support agency, the recruitment flyer was either posted around the site or was left in areas where participants could easily access them, such as the waiting room. Due to COVID-19, not all agencies offered in-person treatment. At the private practice, the recruitment flyer was sent out in their newsletter. The newsletter was accessible to anyone in the public who signed up for it. Therefore, neither of the mental health agencies that participated in the data collection process screened participants. The survey took participants approximately 25-30 minutes to complete.

In PsychData, participants reviewed the informed consent (see Appendix A), were provided with the researcher's contact information, and were given the option to consent to participate in the study. As well, the informed consent indicated that participants could withdraw from the study at any point. There were two exclusionary criteria for the current study; participants needed to be at least 18 years to participate and identify as a REM. After participants consented to the study and if they qualified to participate, they were prompted to complete the demographic questionnaire. After the demographic questionnaire, they were prompted to complete the Abusive Behavior Inventory (ABI), Financial Anxiety scale (FAS), Social Connectedness Scale, and the Revised Economic Abuse scale (SEA2) with the modified instructions. At the conclusion of the study, participants were able to enter to win one of 15 \$20 Amazon electronic gift cards. Participants who chose to enter the raffle were routed to a different PsychData survey where they entered their email address. The researcher randomly chose 15 of the email addresses entered by participants and sent a total of 15 electronic Amazon gift cards to participants who entered the raffle.

Measures

Multiple measures were used to collect the necessary data for this study. Participants were first asked to complete a screener question to ensure they met inclusionary criteria (see Appendix B). Participants then completed the following measures.

Demographic Questionnaire

Participants were asked to complete a demographic questionnaire created by the researcher (see Appendix C). The demographic questionnaire included questions regarding age, gender identity, sexual orientation, race/ethnicity, relationship status, education level, and social class.

IPV Measure

The ABI is a 29-item scale created by Shepard and Campbell (1992) to measure physical and psychological abuse (See Appendix D). The measure also includes questions about sexual coercion. The ABI is measured on a 5-point Likert scale on which participants were asked to estimate how often the behaviors occurred in their romantic relationship. Items on the ABI include: Since March 2020, how often has your partner called you names and/or criticize you; Since March 2020, how often has your partner pushed, grabbed, or shoved you; Since March 2020, how often has your partner pressured you to have sex in a way that you did not like or want. The ABI was created by adapting items on the “Power and control” wheel, which is commonly used by professionals when discussing IPV (Zink et al., 2007). Shepard and Campbell (1992) did not create cutoff scores for the ABI (Zink et al., 2007). In a study conducted by Zink et al. (2007) to determine cutoff scores and validity, the researchers found the cutoff score to be 39 (Gresham et al., 2021). One total score from the ABI will be used, and scores above 39 indicate IPV with higher scores indicating IPV. The ABI was modified to measure IPV

behaviors since the start of the COVID-19 pandemic. The modified instructions were similar to the modified instructions used for the ABI in the study conducted by Gresham et al. (2021). Gresham et al. (2021) ran reliability analysis on the ABI with modified instructions and found the scale to be highly reliable, $\alpha = 0.97$. Gresham et al (2021) recruited from ResearchMatch, and most participants were White women whose average age was 44. Gresham et al. (2021) did not list the validity of the ABI in their article. Additionally, to measure Hypothesis 1, after the ABI the participants were asked (See Appendix E): Since the start of the COVID-19 pandemic (March 2020), how has your experience with physical IPV changed; Since the start of the COVID-19 pandemic (March 2020), how has your experience with psychological IPV changed; Since the start of the COVID-19 pandemic (March 2020), how has your experience with sexual IPV changed? These questions used a 4-point Likert scale: *not applicable, decreased, stayed the same, or increased*. The participants were provided definitions and examples for each type of IPV. In the current study, the reliability for the full scale was found to be high, $\alpha = 0.94$.

Economic IPV Measure

The SEA2, a 14-item scale, was used to measure economic IPV (See Appendix F). The SEA2 is a revised version of the Scale of Economic Abuse and the Scale of Economic Abuse-12 (Adams et al., 2020). Adams et al. (2020) created the SEA2 to include perpetrators' use of the consumer credit system and to adequately measure economic IPV as behaviors by perpetrators used to control their partners. The SEA2 measures both economic restriction and exploitation (Adams et al., 2020). The reliability for the SEA2 from Adams et al.'s (2020) study was $\alpha = 0.93$. The SEA2 is on a 4-point Likert scale, and participants were asked to use the Likert scale to answer how frequently each item has occurred during their romantic relationship. Items on the SEA2 include: Since March 2020 how often did your partner keep you from having the money

you needed to buy food, clothes, or other necessities; Since March 2020 how often did your partner demand that you give him/her receipts or change when you spent money; Since March 2020 how often did your partner take out a loan or buy something on credit in your name without your permission. The instructions for the SEA2 were modified similarly to the ABI to measure economic IPV during the COVID-19 pandemic. The total score from the SEA2 was used, and higher scores indicate higher occurrence of economic IPV. To test Hypothesis 1, after completing the SEA2 the participants were asked, Since the start of the COVID-19 pandemic (March 2020) how has your experience with economic IPV changed? This question used a four-point Likert scale: *not applicable, increased, stayed the same, decreased*. The participants were provided definitions and examples of economic IPV (see Appendix G). The total scale reliability for the current study was $\alpha = 0.87$.

Financial Insecurity Measure

The FAS is a 7-item measure created to measure financial distress (Archuleta et al., 2013; see Appendix H). The FAS uses a 7-point Likert scale and participants were asked to use the Likert scale to answer how much they agree with each item during the COVID-19 pandemic. The FAS scale has questions that assess individual's level of anxiety regarding their financial situations and explores the ways in which financial distress may affect individual's lives (See Appendix H). For example, the FAS asks about tension, sleep difficulties, worry, difficulty concentrating, mood, and fatigue (Archuleta et al., 2013). Some items on the FAS include I feel anxious about my financial situation; I have difficulty controlling worrying about my financial situation; and I feel fatigued because I worry about my financial situation. The total score from the FAS was used for analysis. Higher scores on the FAS indicate higher financial anxiety. Archuleta et al. (2013) conducted a study with college students using the FAS and found a

reliability of $\alpha = 0.94$. The study used modified instructions for the FAS, and participants were instructed to respond to the questions on the FAS thinking about their experience during the COVID-19 pandemic (Gresham et al., 2021). The modified instructions were used in the Gresham et al. (2021) study, and the researchers found a reliability of $\alpha = 0.96$. For the current study, the reliability for the FAS total score was $\alpha = 0.83$.

Social Isolation Measure

Social Isolation was measured using the Social Connectedness Scale, an 8-item measure created by Lee and Robbins (1995; See Appendix I). The Social Connectedness Scale was created with Heinz Kohut idea of connectedness, and the idea that connection allows for individuals to feel a sense of belonging with others (Lee & Robbins, 1995). Lee and Robbins (1995) found a reliability of $\alpha = 0.91$. The Social Connectedness Scale is scored on a 6-point Likert scale, and participants were asked to use the Likert scale to identify whether they agree with each statement during the COVID-19 pandemic. Some items on the Social Connectedness Scale include: I feel disconnected from the world around me; I have no sense of togetherness with my peers; and I catch myself losing all sense of connectedness with society. The total score from the Social Connectedness scale was used, with higher scores on the scale indicate more social isolation. The scale was used with the same modified instructions as the FAS to explore social isolation during the COVID-19 pandemic. Gresham et al. (2021) measured the reliability of the Social Connectedness Scale with the modified instructions and found the scale to be highly reliable, $\alpha = 0.934$. In the current study, the reliability for the Social Connectedness Scale was $\alpha = 0.81$.

Questions to Enter for a Chance to Win an Amazon Gift Card

After the Social Connectedness Scale, the participants were asked if they wanted to enter to win an Amazon gift card. They saw the following statement: You have reached the end of the survey. Thank you very much for your participation! If you would like to be entered into a raffle to win one of fifteen \$20 Amazon e-gift cards, click yes to be sent to an independent and separate survey. If the participants clicked no, the survey ended. If the participant clicked yes, they were routed to a different online PsychData survey. In the other survey, they saw the following statement: If you would like to be entered into a raffle for one of fifteen \$20 Amazon e-gift cards, please provide your address below. There was a space for them to type in their email if they wanted to enter to win an electronic Amazon gift card.

Research Questions and Hypotheses

The following research questions were investigated by the researcher:

Research Question 1: Have rates of IPV increased in the REM population during the COVID-19 pandemic?

H1: REM participants will report experiencing an increase of IPV since the start of the COVID-19 pandemic.

Research Question 2: What is the impact of financial insecurity and social isolation on IPV during the COVID-19 pandemic for REM participants?

H2: High financial insecurity and social isolation will be related to increased rates of IPV in REM participants.

CHAPTER IV
RESULTS

Participant Demographic Data and Descriptive Statistics

The researcher ran descriptive statistics and frequencies on participants' demographic data. Demographic data included participants' age, gender identity, race/ethnicity, relationship status, education level, and experiences with IPV. Participants' ages ranged from 18 to 60 years old ($M = 31.8$ years, $SD = 9.3$ years). Most participants were either Asian/Asian American/Pacific Islander (30.6%, $n = 59$) or Latinx/Latino(a)/Hispanic (24.9%, $n = 48$), and heterosexual (58%, $n = 112$). There were about an equal number of participants who identified as men (43.5%, $n = 84$) and women (41.5%, $n = 80$). Four participants selected that they preferred to self-identify their gender; however, additional information regarding their gender identity was not gathered at the time of data collection. The most common education level was a bachelor's degree or equivalent (35.8%, $n = 69$) and the most common level of annual income was \$50,000 to \$100,000 (36.3%, $n = 70$). There was a skewness towards higher income within the data collected. See Table 1 for a more complete breakdown of participants' demographic information. Additionally, descriptive statistics were calculated on each of the measures (see Table 2).

Table 1

Participant Demographic Data

Variable	<i>n</i>	%	<i>Mean</i>	<i>SD</i>
Age	188		31.8	9.3
Race/Ethnic Identity	193			
Black/African American/ Caribbean	41	21.2		
Latinx/Latino(a)/Hispanic	48	24.9		
Asian/Asian American/Asian/Asian American/	59	30.6		

Variable	<i>n</i>	%	<i>Mean</i>	<i>SD</i>
Pacific Islander	36	18.7		
Native American/ Indigenous/Alaskan Native				
Other	9	4.7		
Gender Identity	193			
Woman	80	41.5		
Man	84	43.5		
Transgender	18	9.3		
Genderqueer/Gender Fluid	7	3.6		
Self-Identify	4	2.1		
Sexual Orientation	192			
Heterosexual	112	58.0		
Lesbian	21	10.9		
Gay	23	11.9		
Bisexual	18	9.3		
Queer	10	5.2		
Asexual	6	3.1		
Self-Identify	2	1.0		
Relationship Status	192			
Single	35	18.1		
Dating	20	10.4		
In a Committed Relationship	29	15.0		
Married	73	37.8		
Separated	17	8.8		
Divorced	12	6.2		
Widowed	3	1.6		
Cohabiting	3	1.6		
Education	193			
High School Diploma/ GED or Equivalent	17	8.8		
Some College	18	9.3		
Associate's Degree or Equivalent	30	15.5		
Bachelor's Degree or Equivalent	69	35.8		
Vocation Schooling/ Licensure Program or Equivalent	36	18.7		
Master's Degree or Equivalent	18	9.3		
Doctoral Degree or Equivalent	5	2.6		

Variable	<i>n</i>	%	<i>Mean</i>	<i>SD</i>
Annual Income	192			
Less than \$25,000	27	14.0		
\$25,000 - \$50,000	56	29.0		
\$50,000 - \$100,000	70	36.3		
\$100,000 - \$200,000	28	14.5		
More than \$200,000	7	3.6		
Prefer Not to Say	4	2.1		
Household Income	193			
Less than \$25,000	14	7.3		
\$25,000 - \$50,000	41	21.2		
\$50,000 - \$100,000	45	23.3		
\$100,000 - \$200,000	61	31.6		
More than \$200,000	31	16.1		
Prefer Not to Say	1	0.5		
Employment Status	192			
Full-Time	80	41.5		
Part-Time	60	31.1		
Seeking Opportunities	41	21.2		
Retired	6	3.1		
Prefer Not to Say	5	2.6		
Number of Dependents	192			
None	7	3.6		
1	23	11.9		
2 – 4	124	64.2		
More than 4	35	18.1		
Prefer Not to Say	3	1.6		
Number in Household	193			
1	5	2.6		
2	26	13.5		
3	58	30.1		
4	55	28.5		
5	38	19.7		
6 or More	11	5.7		

Note. Totals for age, sexual orientation, relationship statue, annual income, employment status, and number of dependents calculate to less than 193 due to missing data.

Table 2*Descriptive Statistics for Scales*

Scale	<i>n</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Mean</i>	<i>SD</i>
ABI	193	0	94	39.50	17.23
SEA2	193	0	25	9.35	5.42
FAS	193	7	46	22.16	7.27
The Social Connectedness Scale	193	9	46	22.64	6.62

Note. Abusive Behavior Inventory (ABI); Revised Scale of Economic Abuse (SEA2); Financial Anxiety Scale (FAS).

Hypothesis 1

The null hypothesis for research question one was maintained. Descriptive statistics were calculated on the four questions that asked participants how their experience with physical, psychological, sexual, and economic IPV has changed since the start of the COVID-19 pandemic. For all types of IPV assessed, most participants reported that the amount of IPV they experienced decreased or stayed the same since the start of the pandemic. See Table 3 for a breakdown of participants' report of changes in IPV frequency in their relationships since the start of the COVID-19 pandemic.

Table 3*Frequency Table for Impact of COVID-19 on IPV*

Variable	<i>n</i>	%
Physical IPV	193	
Decreased	73	37.8
Stayed the Same	75	38.9
Increased	10	5.2
Not Applicable	35	18.1
Psychological IPV	193	
Decreased	66	34.2
Stayed the Same	73	37.8
Increased	15	7.8

Variable	<i>n</i>	%
Not Applicable	39	20.2
Sexual IPV	193	
Decreased	57	29.5
Stayed the Same	68	35.2
Increased	22	11.4
Not Applicable	45	23.3
Economic IPV	193	
Decreased	67	34.7
Stayed the Same	79	40.9
Increased	13	6.7
Not Applicable	32	16.6

Hypothesis 2

Hypothesis 2 was partially supported. Before proceeding with the multiple regression analysis, reliability analyses were conducted on the ABI, SEA2, FAS, and the Social Connectedness Scale. All scales were found to be reliable, and skewness and kurtosis were checked.

Multiple Regression With ABI, FAS, and the Social Connectedness Scale

To test Hypothesis 2, the researcher conducted two multiple regressions using the total scores on the FAS, and Social Connectedness Scale, and the total scores on the ABI and the SEA2, to explore whether financial insecurity and social isolation were related to IPV. The fit for the multiple regressions were checked by conducting a residual analysis and checking for the assumption of heteroscedasticity, normality, linearity, and multicollinearity. All assumptions for a multiple regression, which include of heteroscedasticity, normality, linearity, and collinearity, were met. The overall model was found to be significant, $F(2, 190) = 61.09, p = < .001$, and the model explained 39% of the score on the ABI. Both the FAS and the Social Connectedness Scale

were significant (see Table 4). Higher scores on both the FAS ($\beta = .22, p = .005$) and the Social Connectedness Scale, which indicates higher social isolation, ($\beta = .45, p = < .001$) indicated higher scores on the ABI.

Table 4

Summary of Multiple Regression Analysis Predicting ABI Scores

Predictor	Unstandardized		Standardized	<i>t</i>	<i>p</i>
	<i>b</i>	<i>SE</i>	β		
FAS	0.53	0.19	0.22	2.84	.005
Social Connectedness	1.18	0.20	0.45	5.80	<.001

Note. $F(2, 190) = 61.09, p = <.001, R^2 = .39, \text{adjusted } R^2 = .39$. FAS stands for Financial Anxiety Scale.

Multiple Regression With SEA2, FAS, and the Social Connectedness Scale

A second multiple regression was used to see how financial insecurity and social isolation impacted the scores on the SEA2. All assumptions for a multiple regression, which include of heteroscedasticity, normality, linearity, and collinearity, were met. The overall model was found to be significant, $F(2, 190) = 59.19, p = <.001$, and the model explained 38% of the score on the SEA2. Only the Social Connectedness Scale was significant (see Table 5). Higher scores on the Social Connectedness Scale, indicating higher social isolation ($\beta = .53, p = < .001$), resulted in higher scores on the SEA2.

Table 5

Summary of Multiple Regression Analysis Predicting SEA2 Scores

Predictor	Unstandardized		Standardized	<i>t</i>	<i>p</i>
	<i>b</i>	<i>SE</i>	β		
FAS	0.09	0.06	0.12	1.49	.14
Social Connectedness	0.44	0.06	0.53	6.80	<.001

Note. $F(2, 190) = 59.19, p = <.001, R^2 = .38, \text{adjusted } R^2 = .38$. FAS stands for Financial Anxiety Scale.

Exploratory Analyses

Due to the sample's skewedness towards higher income, an additional multiple regression analysis was calculated to explore if the FAS scale would be a significant predictor of the score on the SEA2 with participants who reported an annual income of \$50,000 or less. There were 83 participants who fit this criterion. This additional multiple regression was found not to be significant $F(2, 80) = 2.76, p = .07$. As well, the result that financial insecurity was not significant in predicting economic IPV was unexpected by the researcher. It is known that women are impacted more by financial insecurity than men, and that women experience rates of IPV more often than men (CDC, 2018; Corrie, 2016). Therefore, additional analysis for research questions one and two were run to see if results would be impacted when gender is controlled for.

Three additional multiple regressions looking at how the COVID-19 stressors impacted scores on the SEA2 were conducted controlling for gender. Gender was divided into three groups (a) men ($n = 84$); women ($n = 80$); and (c) transgender, genderqueer/gender fluid, and participants who preferred to self-identify ($n = 29$). It should be noted that the small sample size within each group limited power and likely resulted in a small effect size. The regression model for men and women were significant, and the regression model examining participants who identified as transgender, genderqueer/gender fluid, and those who preferred to self-identity was not significant. The regression model for the men group was $F(2, 81) = 63.29, p < .001$ and the model explained 61% of the score on the SEA2 for men. The regression model for the women group was $F(2, 77) = 13.77, p < .001$ and 26% of the score on the SEA2 was explained by the model. As with the original multiple regression for the SEA2, only the Social Connectedness scale was significant for both the multiple regression for men and women (see

Tables 6 and 7). The regression model for men explained more of the regression model for women for the total SEA2, meaning social connectedness was a bigger factor for men than women when predicting economic IPV. The regression model for the group that included transgender, genderqueer/ gender fluid, and self-identify participants was $F(2, 26) = 1.92, p = .167$.

Table 6

Summary of Multiple Regression Analysis Predicting SEA2 Scores for Men

Predictor	Unstandardized		Standardized	<i>t</i>	<i>p</i>
	<i>b</i>	<i>SE</i>	β		
FAS	0.09	0.08	0.12	1.09	.277
Social Connectedness	0.55	0.09	0.69	6.40	<.001

Note. $F(2, 81) = 63.29, p = <.001, R^2 = .61, \text{adjusted } R^2 = .60$. FAS stands for Financial Anxiety Scale.

Table 7

Summary of Multiple Regression Analysis Predicting SEA2 Scores for Women

Predictor	Unstandardized		Standardized	<i>t</i>	<i>p</i>
	<i>b</i>	<i>SE</i>	β		
FAS	0.07	0.10	0.09	0.73	.47
Social Connectedness	0.39	0.11	0.45	3.59	<.001

Note. $F(2, 77) = 13.77, p = <.001, R^2 = .26, \text{adjusted } R^2 = .24$. FAS stands for Financial Anxiety Scale.

The researcher conducted additional exploratory multiple regression analyses examining the impact of COVID-19 stressors on the ABI, using the same gender groups mentioned above. The multiple regression models for men and women were significant, and the multiple regression model for participants who identified as transgender, genderqueer/gender fluid, and self-identify was not significant ($F(2, 26) = 0.95, p = .40$). The regression model for the men group was $F(2, 81) = 52.44, p < .001$ and the model explained 56% of the scores on the ABI. However, only the Social Connectedness Scale was significant in the model (see Table 8).

Table 8

Summary of Multiple Regression Analysis Predicting ABI Scores for Men

Predictor	Unstandardized		Standardized	<i>t</i>	<i>p</i>
	<i>b</i>	<i>SE</i>	β		
FAS	0.24	0.25	0.11	0.92	.36
Social Connectedness	1.64	0.28	0.67	5.89	<.001

Note. $F(2, 81) = 52.44, p < .001, R^2 = .56, \text{adjusted } R^2 = .55$. FAS stands for Financial Anxiety Scale.

The regression model for the women group was $F(2, 77) = 18.72, p < .001$ and the model explained 33% of the scores on the ABI. For women, both the FAS and the Social Connectedness Scale were significant (see Table 9).

Table 9

Summary of Multiple Regression Analysis Predicting ABI Scores for Women

Predictor	Unstandardized		Standardized	<i>t</i>	<i>p</i>
	<i>b</i>	<i>SE</i>	β		
FAS	0.73	0.29	0.30	2.50	.01

Predictor	Unstandardized		Standardized	<i>t</i>	<i>p</i>
	<i>b</i>	<i>SE</i>	β		
Social Connectedness	0.90	0.33	0.33	2.76	.007

Note. $F(2, 77) = 18.72, p < .001, R^2 = .33, \text{adjusted } R^2 = .31$ FAS stands for Financial Anxiety Scale.

Due to the differences in exploratory multiple regressions, which controlled for gender, additional analyses were conducted for research question one. The frequency for all four types of IPV was run again controlling for gender. The participants were divided into groups in the same manner as the exploratory multiple regressions. This analysis showed a different pattern of frequency of IPV than when the participants were not divided by gender identity. Most men reported either a decrease in IPV or that the frequency stayed the same for all forms of IPV measured (see Table 10). The pattern was different for women participants (see Table 11).

Table 10

Frequency Table for Impact of COVID-19 on IPV for Men

Variable	<i>n</i>	%
Physical IPV	84	
Decreased	41	48.8
Stayed the Same	26	31.0
Increased	2	2.4
Not Applicable	15	17.9
Psychological IPV	84	
Decreased	30	35.7

Variable	<i>n</i>	%
Stayed the Same	32	38.1
Increased	5	6.0
Not Applicable	17	20.2
Sexual IPV	84	
Decreased	29	34.6
Stayed the Same	30	35.7
Increased	6	7.1
Not Applicable	19	22.6
Economic IPV	84	
Decreased	29	34.5
Stayed the Same	37	44.0
Increased	5	6.0
Not Applicable	9	10.7

Table 11

Frequency Table for Impact of COVID-19 on IPV for Women

Variable	<i>n</i>	%
Physical IPV	80	
Decreased	19	23.8
Stayed the Same	40	50.0
Increased	7	8.8
Not Applicable	14	17.5

Variable	<i>n</i>	%
Psychological IPV	80	
Decreased	27	21.3
Stayed the Same	37	46.3
Increased	7	8.8
Not Applicable	19	23.8
Sexual IPV	80	
Decreased	12	15.0
Stayed the Same	35	43.8
Increased	15	18.8
Not Applicable	17	21.5
Economic IPV	80	
Decreased	12	15.0
Stayed the Same	41	51.2
Increased	7	8.8
Not Applicable	19	23.8

For all four types of IPV, the response chosen the most was stayed the same. Additionally, the pattern was different for transgender, genderqueer/gender fluid, and for participants who preferred to self-identify where the response that was chosen the most for all forms of IPV was decreased (see Table 12). The group that reported the largest percentages of decrease in IPV was transgender, genderqueer/gender fluid, and self-identify, and the group that reported the smallest percentages of decrease for all forms of IPV was women.

Table 12

Frequency Table for Impact of COVID-19 on IPV for Transgender, Genderqueer/ Gender Fluid, and Self-Identify Participants

Variable	<i>n</i>	%
Physical IPV	29	
Decreased	13	44.8
Stayed the Same	9	31.0
Increased	1	3.4
Not Applicable	6	20.7
Psychological IPV	29	
Decreased	19	65.3
Stayed the Same	4	13.8
Increased	3	10.3
Not Applicable	3	10.3
Sexual IPV	29	
Decreased	16	55.2
Stayed the Same	3	10.3
Increased	1	3.4
Not Applicable	9	31.0
Economic IPV	29	
Decreased	22	75.9
Stayed the Same	1	3.6
Increased	1	3.6

Variable	<i>n</i>	%
Not Applicable	4	13.8

CHAPTER V DISCUSSION

Summary of Findings

The purpose of this study was to explore how COVID-19 and COVID-19 stressors impacted IPV within the REM population. This study contributes to the gap in knowledge about IPV in REM population and how COVID-19 stressors may impact IPV within REM population.

Research Question One

The first research question assessed whether rates of IPV changed due to COVID-19 within the REM population. The null hypothesis for research question one was maintained. For all forms of IPV explored in this study, the largest percentage of IPV frequency change chosen by participants was that the amount of IPV stayed the same since March 2020. A small percentage of participants reported an increase in physical (5.2%, $n = 10$), psychological (7.8%, $n = 15$), sexual (11.4%, $n = 22$), and economic (6.7%, $n = 13$) IPV.

An interesting result from the study is the number of participants who reported a decrease in IPV from March of 2020: 37.8% ($n = 73$) reported a decrease in physical IPV, 34.2% ($n = 66$) reported a decrease in psychological IPV, 29.5% ($n = 57$) reported a decrease in sexual IPV, and 34.7% ($n = 67$) participants reported a decrease in economic IPV. When the IPV frequencies were looked at by gender, women reported the largest increase of physical, sexual, and economic IPV, and transgender, genderqueer/gender fluid, and self-identify participants reported the largest percentage increase in psychological IPV. This finding is consistent with previous literature, which highlights that women are disproportionately impacted by IPV (CDC, 2018; Grest et al., 2018; Postmus et al., 2012), as well as COVID-19, partly due to having increased caretaking responsibilities during the pandemic (Couch et al., 2022; Kerr, Rasmussen, et al., 2021b; Petts et al., 2021). This increase is noteworthy because IPV risk is already higher for

REM women compared to White individuals (Azziz-Baumgartner et al., 2011) and REM women may be less likely to seek professional services for support (Cho & Kim, 2012a). REM women are disproportionately impacted by IPV and COVID-19 than White women. REM women are similarly disproportionately impacted by COVID-19 in many ways, including higher rates of infection and death, and more severe COVID-19 symptoms (Boserup et al., 2020b; Ruprecht et al., 2021). The COVID-19 pandemic highlighted inequalities, discrimination, systemic racism, and how these systemic factors impact REM women's access to healthcare, job opportunities, and lack of access to childcare (Boserup et al., 2020b; Fortuna et al., 2020; Gibson et al., 2021; Ruprecht et al., 2021). REM women had to navigate systemic oppression within a global pandemic and the systemic barriers placed before them created by society and COVID-19.

Although there were some participants who reported an increase in IPV, the current study demonstrates a decrease in IPV rates relative to the start of the pandemic (Boserup et al., 2020a; Buttell & Ferreira, 2020; Gresham et al., 2021; Lyons & Brewer, 2021). In March 2020, during the first month of the pandemic, domestic violence related calls to police increased in multiple major cities in the United States (Boserup et al., 2020a; Buttell & Ferreira, 2020). Two studies with data collection taking place between March and May of 2020 found an increase in IPV rates as a result of COVID-19 stressors, including higher levels of financial anxiety, social disconnection (Gresham et al., 2021), financial stress, more time with their partner, the presence of other vulnerable individuals in the home, and increased substance use (Lyons & Brewer, 2021). Lyons and Brewer (2021) also identified an emerging theme in anonymous Reddit posts discussing how their perpetrators used COVID-19 to increase control and abuse. Victims of IPV posted instances of perpetrators making false accusations that they (the Reddit users) were not

isolating or were exposed to COVID-19. Victims also reported that perpetrators acted violently towards their partners for leaving their home (Lyons & Brewer, 2021).

Unlike previous studies indicating an increase in IPV during the COVID-19 pandemic, the current study pointed to evidence that this initial increase might have been brief. A longitudinal study with REM individuals that began prior to COVID-19 found similar results to the present study (Chiaramonte et al., 2022). The researchers explored how safety, housing instability, and mental health changed from before the COVID-19 pandemic. Chiaramonte et al. (2022) interviewed individuals who sought services from an IPV agency, and after the initial interview, participants were interviewed every 6 months for 2 years. As with the present study, Chiaramonte et al. (2022) discovered experiences with IPV did not increase due to the COVID-19 pandemic, and that for many participants, the level of IPV they experienced stayed the same from the start of the COVID-19 pandemic. Chiaramonte et al. (2022) also found that employment, housing services, income, and social support were protective factors for homelessness and housing stability. In another study conducted by Plášilová et al. (2021) exploring the incidence of COVID-19 in Czech women before and during COVID-19, the researchers did not find an increase of incidence of IPV during the COVID-19 pandemic but found that the incidence of IPV had decreased. Plášilová et al. (2021) interviewed 429 Czech women from November 19, 2020, to November 25, 2020, and gathered data about the incidence of IPV 3 months prior to the start of the COVID-19 pandemic, and then two more times after the start of the COVID-19 pandemic. Given these data, it is likely that IPV rates increased at the beginning of the COVID-19 pandemic, and then decreased once COVID-19 procedures such as social distancing or stay-at-home orders were no longer in effect in all states. In many states, there are no longer stay-at-home orders, more businesses are open, and more individuals are back

working in offices, which decreases the amount of time individuals spend at home. As well, there have been national changes in the United States such as removing mask mandates and no longer requiring proof of a negative COVID-19 test to enter the United States (CDC, 2022a, 2022b). Both of these federal changes allow survivors of IPV to more easily move around in public spaces and spend less time at their homes with their perpetrators.

Another important factor to consider related to the reported frequency of IPV is time and memory recollection. While there is substantial evidence that IPV incidence decreased since the start of the pandemic, it was beyond the scope of this study to assess the accuracy of participants' recall. Data collection for the current study did not start until late February of 2022, almost 2 years from the start of the COVID-19 pandemic. Rivers (2001) found that their participants were able to recall key events of bullying within a 12- to 14-month period. The current study asked participants to recall events that occurred over a 24- month period, and therefore, it is unclear just how well participants were able to remember events during this timeframe. Many factors, which were not addressed in the current study, could have impacted participants' recall of IPV. For example, COVID-19 increased sleep disturbances and subsequent memory problems in many people (Alqahtani et al., 2022).

An additional factor that may have impacted the frequency of IPV reported by REM during the COVID-19 pandemic is whether the perpetrator was also a REM. Racial loyalty and intracultural pressure, pressure by one's racial or ethnic group to remain loyal to their group, may stop REM individuals from reporting IPV (Gómez, 2019). If REM individuals do disclose information or behave in a way that is seen as going against their racial or ethnic group, they may experience a cultural betrayal trauma (Gómez, 2019). A cultural betrayal trauma and

intracultural pressure may cause posttraumatic stress and dissociative symptoms in women (Gómez, 2019).

Research Question Two

Unlike research question one, the null hypothesis was partially supported. Research question two explored whether financial insecurity and social isolation predicted IPV. Two separate multiple regressions were calculated to explore the impact of financial insecurity and social isolation on IPV within the REM population. The first multiple regression examined whether financial insecurity and social isolation predicted physical, psychological, and sexual abuse. The regression equation and both predictors were significant, meaning that social isolation and financial insecurity increased the risk of physical, emotional, and sexual abuse. The results from this analysis are consistent with literature reviewed for this study (Fox & Benson, 2006; Gresham et al., 2021; Kim, 2019; Postmus et al., 2020). Interestingly, social isolation was a stronger predictor of IPV than financial insecurity. In a study conducted by Fox and Benson (2006) that examined economic risk and IPV, the researchers found couples who presented with higher economic risk, which was calculated by looking at debt, employment history, the level of satisfaction or concerns about finances, and whether the couple had enough income for basic needs, reported higher rates of IPV. However, the study conducted by Fox and Benson (2006) did not look at economic IPV.

The second multiple regression explored whether financial insecurity and social isolation predicted economic IPV. Unlike the previous multiple regression, only social isolation was a significant predictor of economic IPV. Exploratory analyses also did not reveal a predictive relationship between financial insecurity and economic abuse for the three gender groups. This finding aligns with previous literature regarding the importance of social connection for

individuals who experience IPV (Gresham et al., 2021; Kim, 2019; Lanier & Maume, 2009), although these studies did not look at economic IPV.

Unlike social isolation, financial insecurity was not a significant predictor of economic IPV, contrary to previous research (Braaf & Barrett Meyering, 2011; Corrie, 2016; Postmus et al., 2020). Although there is limited research on economic IPV, several studies have documented a link between economic IPV and financial insecurity (for an overview of this research see Postmus et al., 2020). This research has shown that financial insecurity is a gendered issue that disproportionately impacts women. One reason financial insecurity tends to impact women more is due to factors such as the wage gap between men and women (Postmus et al., 2020). Financial insecurity puts women at a higher risk than men of experiencing economic IPV (Corrie, 2016). It is possible, therefore, that the current sample's demographics, specifically the number of men and relatively high level of income of the participants, impacted the current study's results. Similar to gender, another factor that may impact the relationship between financial insecurity and economic IPV is annual income. In the current study, only 43% of participants of the current sample reported earning less than \$50,000 annually, which could impact their level of financial insecurity. However, the mean score on the FAS for the present study was 22.16, and the mean FAS score on the validity study was 19.88 (Archuleta et al., 2013), indicating slightly higher financial insecurity in the current sample. Although the mean score for this study is higher than the mean FAS score found by Archuleta et al. (2013), it is still a relatively low score. Archuleta et al. (2013) recruited from a university sample, and the mean age of participants was 23.77 and average annual gross income was \$559.18, which is drastically different from the mean income and age in the present study. Archuleta et al (2013) hypothesized that many individuals start to struggle with financial anxiety after graduation especially if they have debt or loans from

college. This is important to highlight because nearly 91% of the participants in the present study reported taking some college, having a bachelor's degree or above, or some vocation schooling or attending a licensure program. As mentioned previously, it is possible annual income was a protective factor for REM individuals from economic IPV even though they experienced some financial insecurity.

Along with income, another possible factor influencing the relation between financial insecurity and economic IPV in the present study is the low reporting of economic IPV. Participants in the sample may have experienced less economic IPV due to their higher incomes, and it is possible the scores on the SEA2 were impacted due to the number of individuals who do not view economic control as a form of IPV (Postmus et al., 2012). Individuals who do not view economic control as IPV may be influenced by the limited information on what behaviors constitute as economic IPC and the lack of research on economic IPV (Postmus et al., 2020). Gender norms may have also impacted the reporting of economic IPV. Due to societal gender norms, it is common in heterosexual couples for men to be in control of the finances, which allows them means to control their partner (Postmus et al., 2012; Postmus et al., 2020). As well, the results may have been impacted by the number of men in the sample. Women are more likely than men to earn less money due to societal norms and job opportunities available to women (Postmus et al., 2012; Postmus et al., 2020). In addition, COVID-19 increased the need for childcare due to illness or homeschooling. This most likely influenced mothers more than fathers, as mothers are predominantly responsible for childcare and are more likely to put their children's needs over their own (Ruppanner et al., 2021).

Implications for Future Research

This study added to the gap in IPV research by focusing on the REM population and added to the small, yet growing, amount of research on how COVID-19 and COVID-19 stressors have impacted rates of IPV. This study highlighted that social isolation and financial insecurity impacts physical, psychological, and sexual IPV, and that social isolation impacts economic IPV. The ABI, used to measure IPV, combined physical, psychological, and sexual IPV into a total score. The current research highlights that COVID-19 stressors might impact the incidence of each type of IPV differently. This researcher therefore recommends that future research explore how both social isolation and financial insecurity influence the forms of IPV separately. Additionally, for all forms of IPV, most participants reported the frequency of IPV they experienced since March 2020 stayed the same or decreased. Future research would benefit from asking participants to report the frequency of IPV experienced at different points throughout the COVID-19 pandemic to see if there were any changes of frequency of IPV during the COVID-19 pandemic. This could be accomplished by conducting a longitudinal study where participants are asked directly about IPV using a validated measure for IPV.

Future research should also explore the impact of income and financial insecurity in the REM population. In the current study, more than half of the participants reported relatively low levels of financial insecurity and annual incomes of over \$50,000, suggesting that most participants may have fallen into a relatively high social class. Within the sample, only 27 (14%) participants reported earning less than \$25,000, 56 (29%) participants reported earning between \$25,000 and \$50,000, 104 (54.4%) reported earning more than \$50,000, and four participants (2.1%) chose not to report their income. Further, most participants worked full-time or part-time. It is possible, therefore, that the current sample had the financial and social resources to leave

their partners. This is important to note because previous research has shown that when social class is controlled for, there is not a difference in rates of IPV between REM and White individuals (Cho, 2012; Clark et al., 2016). Future research should focus on the link between financial insecurity and economic IPV, particularly using a qualitative design to gain a deeper understanding of this link.

Similarly, income may impact REM individuals seeking services for IPV. In the current study, participants' income appeared to serve as a protective factor against IPV during the pandemic. Further, participants with higher incomes may have sought help from professional services, which may have impacted rates of IPV. Individuals with higher income are able to access multiple types of services, including higher priced mental health services or legal services to help them get out of abusive relationships (Cho & Kim, 2012b). Previous research indicates that REM individuals tend to seek mental health services less often and experience worse outcomes from the services they receive than White individual (Maura & Weisman de Mamani, 2017). Systemic oppression within our society may cause fear for REM individuals to seek professional services, especially during COVID-19, which has exacerbated healthcare inequities (Boserup et al., 2020b; Cho & Kim, 2012a; Fortuna et al., 2020; Gibson et al., 2021; Ruprecht et al., 2021). REM folx of low-income experiencing financial insecurity are particularly at risk for experiencing IPV (Cho, 2012). Future research would benefit from exploring more in depth the link between how help seeking behaviors of REM folx impact the link between financial insecurity and IPV.

Future research should also focus on women, as the largest increase in physical, sexual, and economic IPV during the COVID-19 pandemic in the current study was reported by women. Further, it is possible that a larger sample of REM women in the current study, would have found

a predictive relationship between financial insecurity and economic IPV. In addition, due to the lack of research exploring IPV in REM transgender, nonbinary, and gender fluid folx, future research should also explore how this group has been impacted by COVID-19 and COVID-19 stressors.

Along with exploring how gender impacts the relationship between COVID-19 stressors and IPV, it would be helpful to explore how relationship status influences COVID-19 and IPV. The results from the present study may have also been impacted by whether participants lived with their abusive partners. Over 28% of participants were either single or dating, and over 16% of participants were divorced or widowed. This indicates that almost half of the participants may not have been living with a partner at the time of data collection. Participants who reported a decrease in IPV may have been living separately from their partner and as a result may have been able to get away from an abusive partner when social distancing restrictions were imposed. Additionally, only three participants reported cohabitating with their partner and 29 reported being in a committed relationship. The researcher did not provide an option for participants to note if they were both in a committed relationship and cohabitating, so participants were forced to choose one or the other. Not having an option to choose both may have resulted in an undercount in one or both categories. It would be beneficial for future research to ask participants if they had a romantic relationship end, if they started a new romantic relationship, and if participants lived with their partner during the time in which they are reporting abuse frequency, to gather context for potential changes in IPV incidence.

This present study recruited from different sources, and only one of the sources was a service for IPV. Future research exploring COVID-19 and COVID-19 stressors on IPV within the REM population should consider recruiting from IPV services, food banks, and homeless

shelters. Gathering data from the types of sites previously listed may allow for researchers to gather data from individuals experiencing higher financial insecurity. While gathering data at IPV services, researchers should provide paper versions of the survey to make completing the study more accessible to individuals of low socioeconomic status and those without access to the internet. Lastly, future research in this area may consider recruiting individuals who earn an income of \$50,000 or less to see whether income impacts the relationship between financial insecurity and IPV.

Implications for Clinical Practice

The present study helps fill the gap in the literature and provides important information for clinicians. Most participants in the current study reported that rates of IPV stayed the same or decreased. These results were surprising given the literature that points to REM individuals having limited access to IPV resources due to COVID-19 safety measures and financial insecurity (Boserup et al., 2020a; Bradbury-Jones & Nikupeteri, 2021; Buttell & Ferreira, 2020; Evans, 2020; Gresham et al., 2021; Lyons & Brewer, 2021). Due to the literature that discussed the many barriers limiting access to IPV resources and increased systemic barriers from COVID-19 stressors, it was hypothesized that many of the participants would report an increase in IPV. Although many participants reported a decrease in the incidence of IPV, a substantial number of participants reported that they were still experiencing IPV at the same rate. One way to help individuals experiencing IPV is to provide psychoeducation about how therapy can help clients cope with the negative impacts of IPV and psychoeducation about IPV (Ragavan et al., 2020). Clinicians should also provide psychoeducation about the potential danger of leaving a perpetrator and offer clients a list of resources to help (WHO, 2013).

Another important finding for clinicians is that REM women reported a higher increase in physical, sexual, and economic IPV than REM men and REM transgender, gender queer/gender fluid folx, and self-identify participants. Due to this finding, it would be particularly important for clinicians to provide psychoeducation to REM women about the possible mental health outcomes from experiencing IPV, such as depression symptoms, posttraumatic stress disorder (PTSD), and low self-esteem and self-efficacy (Karakurt et al., 2022). Cognitive-behavioral therapy (CBT) with empowerment interventions, expressive writing, and trauma-informed approaches can be useful in reducing symptoms of depression and PTSD symptoms in IPV survivors (Karakurt et al., 2022). Additionally, clinicians could have readily available a list of resources for their clients with IPV services, low-cost therapy, and community resources for REM individuals who feel more comfortable seeking support from nonprofessionals. It is also important that clinicians are aware that REM individuals may feel hesitant to seek help from professionals, and clinicians should take to the initiative to learn about their clients' culture and how mental health and IPV services are viewed by clients of different cultural backgrounds (Cho & Kim, 2012a, 2012b). Not only should clinicians be mindful of their clients' ethnicity and culture, but clinicians should also pay close attention to how their clients' identities intersect. For example, if a clinician is working with a Latinx cisgender woman with low-income, the clinician would benefit from examining how the client's ethnicity, gender, and income increase the client's risk for IPV and address how all three identities influence each other when conceptualizing the client and creating a treatment plan.

Although, safety measures for COVID-19 in the United States, such as social distancing, vary by state, individuals have had to quarantine if they contract COVID-19 (Galaiti et al., 2021). Further, there is an increasing number of individuals who now work remotely from home

(Census Bureau, 2022). These are all factors that can lead to social isolation. Social isolation can negatively impact physical and mental health (Coyle & Dugan, 2012), and this study adds to this knowledge by showing that higher social isolation can lead to higher rates of IPV, including economic IPV. This information is important for clinicians working with individuals experiencing IPV because their clients may be negatively impacted if they are dealing with social isolation. This information can be useful to researchers and clinicians when working with REM individuals. Clinicians should assess for social isolation using either formal measures such as the Social Connectedness Scale or informally by asking their clients to describe their support system (Lee & Robbins, 1995). Clinicians should utilize data from these sources in their conceptualization and treatment planning. For example, clinicians could provide clients endorsing high levels of social isolation with psychoeducation about how social isolation is a risk factor for IPV and resources for mitigating social isolation (Gresham et al., 2021; Kim, 2019; Lanier & Maume, 2009). It is especially important to mitigate social isolation when working with REM clients because REM individuals tend to seek support from family more than from formal services, such as mental health professionals (Cho & Kim, 2012b). Clinicians can do so by using a strengths-based approach to encourage clients to seek help from family especially if they do not feel comfortable seeking help from professional services (Cho & Kim, 2012b). Due to systemic oppression impacting the perceived quality of healthcare services many REM receive, seeking support from family may feel safer for REM individuals (Cho & Kim, 2012a). Additionally, clinicians can utilize other interventions to increase social support outside of the family unit, such as referring clients to programs that encourage social interaction within the community (Ernst et al., 2022). Programs that encourage social interaction can adjust to COVID-19 regulations by having virtual meetings (Ernst et al., 2022). REM individuals may feel

discouraged from seeking professional services because of possible negative outcomes, such as poor quality of care and working with clinicians who do not understand how culture impacts their presenting problem and treatment (Maura & Weisman de Mamani, 2017). Quality of relationships can also impact an individual's loneliness, and interventions aimed at increasing quality of relationships, such as communication skills can help mitigate social isolation (Ernst et al., 2022). Further, clinicians can teach their clients new ways to reframe schemas related to socializing and adjust their expectations of what social interaction during a global pandemic may look like, such as virtually interacting with others or outdoor social gatherings (Ernst et al., 2022).

Along with psychoeducation and interventions aimed at increasing social support, clinicians might consider utilizing a relational approach to highlight clients' relationships and how those relationships impact them. Clinicians should strive to create a safe environment for their clients to discuss how the clinician's and the client's identities may impact the therapeutic relationship and be mindful of how systemic oppression has been an obstacle for REM individuals seeking services from professionals (Cho & Kim, 2012a). Creating a safe environment and discussing identities may increase the relational connection between the clinician and the client, which may lessen the likelihood of a client dropping out of therapy, thereby limiting the risk for social isolation (La Roche, 2013). To create a safe environment, clinicians may consider utilizing the APA guidelines for girls and women and the multicultural guidelines (American Psychological Association [APA], 2017; APA, 2018).

Although financial insecurity was not found to be significant in predicting economic IPV, it was found to be significant in predicting physical, psychological, and sexual IPV. Previous research has demonstrated that financial insecurity increases the risk of IPV, and lower income

individuals are at a high risk of IPV (Fox & Benson, 2006). One intervention clinicians can use is to provide psychoeducation on economic IPV since it is a lesser-known form of IPV (Cho, 2012; Postmus et al., 2020). Clinicians should be mindful of discussing how financial resources are shared within REM families. Clinicians should be understanding of how collectivistic values may impact how families make financial decisions. It is suggested that clinicians take the time to learn about their client's culture and ask clients to share how their family and culture views finances. By exploring client's culture and how it impacts their presenting problem, it may allow the clinician to better choose intervention (La Roche, 2013). Throughout this process, clinicians should be mindful not to pathologize culturally specific financial practices by labeling it as economic IPV. It is important is important for clinicians to understand their client's presenting problems and symptoms within the context of their culture (APA, 2017; La Roche, 2013). Additionally, clinicians could validate the impact that financial insecurity has on one's mental and physical health. Along with validation, strengths-based vocational interventions may be useful if clients are in the process of seeking employment. As mentioned before, a list of resources for IPV shelters or food pantries for clients to seek necessities would be beneficial for clinicians to have for clients. Clinicians should also have a resource list of local public libraries that offer financial literacy programs for clients who might find it useful.

Many of the previous studies conducted about IPV have had samples that are made up of predominantly White women (Cho & Kim, 2012a; Grest et al., 2018). The results from the present study are helpful to clinicians who work with REM individuals and men. The present study solely focused on REM populations, and because REM individuals are disproportionately impacted by COVID-19 and COVID-19 stressors, it is important to understand how that may increase their risk of experiencing IPV (Boserup et al., 2020b; Gibson et al, 2021; Ruprecht et

al., 2021). REM individuals have been underrepresented in studies on IPV and in receiving services; due to this, it is critical clinicians and IPV services incorporate cultural aspects into their treatment to better serve their REM clients (Cho & Kim, 2012b). As well, clinicians should be mindful not to assume all REM individuals view their race/ethnicity, similarly, have similar cultures, and hold similar values, and that its important clinicians take time to learn about the REM client's culture, values, and how they believe their race/ethnicity impact their presenting problem and treatment (Cho, 2012). Training programs and continuing education requirements should focus on increasing clinicians' cultural competency. Clinicians should receive training around how to conceptualize clients utilizing a cultural lens, address cultural considerations in the moment with clients, and modify interventions so they are effective for folx from a variety of cultural backgrounds and with intersecting identities (Maura & Weisman de Mamani, 2017).

In this study, men made up 43.5% ($n = 84$) of the sample, which is significantly higher than other studies (Gresham et al., 2021). As noted above, women are disproportionately impacted by IPV than men, and a larger sample of women participants may have uncovered a different pattern in the incidence of IPV and the relationship between economic IPV and financial insecurity (CDC, 2018; Grest et al., 2018). That said, the datas gathered on REM men arehelpful for clinicians working with ethnically diverse men survivors of IPV, particularly around elucidating the relationship between social isolation and IPV. Clinicians could use this information in treatment by providing psychoeducation about social connection and support and choosing a relational approach to therapy. It would also benefit clinicians to discuss how gender norms impact social connection, specifically addressing barriers to social connections for REM men.

Strengths

The present study provides many insights that are useful for future research and clinical work, and this was possible due to the multiple strengths of this study. These strengths include the diverse sample, the focus on REM individuals, and the inclusion of economic IPV. One strength was the sample size and the diversity of participants. The large sample size and different race and ethnicity adds to the generalizability of how COVID-19 stressors may impact REM individuals. As well, within the sample there was almost an even number of men and women participants and over 30 participants in each race/ethnic identity category.

Another strength of this study is that it adds to the significant gap in research on IPV within the REM population, specifically how COVID-19 stressors have impacted IPV with the REM population (Kolsky & Gee, 2021). It is important for researchers and clinicians to understand how IPV is affected by COVID-19 stressors within the REM population due to how REM individuals have been disproportionately impacted by COVID-19 (Boserup et al., 2020b; Gibson et al, 2021; Ruprecht et al., 2021). As well, another strength of this study is the inclusion of economic IPV. Economic IPV is not always considered a form of IPV and there has been limited research on the topic (Postmus et al., 2020).

Limitations

As with any study, the current study was limited in several ways. One limitation of the present study was that the researcher was only able to recruit from one location that offered services for survivors of IPV. Multiple IPV agencies in the area were contacted but only one responded to the researcher's inquiry. While endorsing experiences of IPV during COVID-19 was not an inclusion criterion for the study, the researcher hoped to gather data from individuals who were experiencing IPV during COVID-19. Another limitation was the inability of the

researcher to collect data in person and to use paper versions of the study for those who did not have access to a computer. This may have limited individuals receiving services from the IPV agency who did not have access to technology to participate in the study. Another unexpected limitation was the number of participants who earned over \$50,000 annually. Previous research has shown the connection between financial insecurity and forms of IPV; however, this trend was not apparent in the current study (Fox & Benson, 2006; Postmus et al., 2020). The lack of diversity in social class limits the generalizability of this study. Also, a limitation of this study is the lack of gender diversity within the participants. There is a small amount of research on how transgender and non-gender conforming individuals are impacted by IPV, and unfortunately this study does not add to the gap in research (Scheer & Baams, 2019). This study would have also benefited from asking participants about the relationship status change. The participants were asked to provide their relationship status at the time of data collection, but did not ask about relationship status may have changed since the start of the COVID-19 pandemic. Lastly, a limitation of this study was the small number of participants in each gender group for the exploratory analysis. The small number of participants in those groups limited the statistical power.

Conclusion

Although there is a large amount of research and resources on IPV, it is still very prominent in the United States (CDC, 2018). Within the large amount of research in IPV, there is a small amount of IPV specifically conducted within the REM population which disadvantages this population and limits clinical resources for REM individuals (Kolsky & Gee, 2021). The COVID-19 pandemic and COVID-19 stressors have negatively impacted many IPV risk factors, such as financial insecurity and social isolation. This study helps fill the gap in literature and

provides important information on how COVID-19 and COVID-19 stressors might have impacted IPV for the REM population. The study emphasizes the need for clinicians to be aware of how COVID-19 and COVID-19 stressors have disproportionately impacted REM individuals and subsequently how this impacted IPV. This study highlighted many aspects that influence IPV within the REM population such as social connection, income, and financial insecurity. Clinicians can help their REM clients seeking services for IPV by providing psychoeducation about the different types of IPV and the importance of social connection, using relational based therapeutic approaches, and being mindful of how systemic oppression and their clients' cultures may impact treatment. Clinicians can also help their REM clients by having a list of resources such as, IPV shelters, community resources, and library literacy programs to help REM clients combat social isolation and financial insecurity to help reduce the risk of IPV.

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APPENDIX A

CONSENT TO PARTICIPATE IN RESEARCH

Title: The Impact of COVID-19 and COVID-19 Stressors on Intimate Partner Violence in Racial and Ethnic Minorities

Primary Investigator: Kathy Torres, M.Ed.

kmendoza14@twu.edu

Research Advisor: Claudia Pyland, Ph.D.

cporras@twu.edu

Key Information

This study is being conducted as part of the primary investigator's dissertation study. The purpose of this study is to better understand how the COVID-19 pandemic and COVID-19 stressors impacted intimate partner violence within the racial and ethnic minority population. The main study's procedures require that participants complete a questionnaire that will take approximately 25-30 minutes. Risks associated with participation in this study is a potential loss of confidentiality due to transportation of paper surveys, psychological or emotional distress, fatigue, and loss of time.

Explanation and Purpose of the Research

You are being asked to participate in a research study, conducted by Kathy Torres, M.Ed., at Texas Woman's University. The purpose of this study is to better understand how the COVID-19 pandemic and COVID-19 stressors impacted intimate partner violence within the racial and ethnic minority population. You have been asked to participate in this study because you identify as a racial/ethnic minority- Black/African American/Caribbean, Latinx/Latino(a)/Hispanic,

Asian/Asian American/Pacific Islander, Native American/ Indigenous/Alaskan Native, or Multiracial/ Biracial.

Description of Procedures

As a participant in this study, you will be asked to spend approximately 25-30 minutes of your time completing a series of questionnaires. The purpose of this study is to better understand the COVID-19 pandemic and COVID-19 stressors impacted intimate partner violence within the racial and ethnic minority population. Demographic questions will also be collected. At the beginning of the study, you will be required to indicate if you consent to participate, you will be required to answer if you identify as a racial and ethnic minority, and you will be required to answer if you are 18 years of age or older. If you would like a copy of the study summary, you may request this from the researcher at any time. This summary will be delivered via email upon study completion. Your personal information collected for this study will not be used or distributed for future research even after the researchers remove your personal or identifiable information (e.g. your name and contact information).

Potential Risks

Although the researcher will take several precautions to maintain the confidentiality of participants, there is a potential loss of confidentiality when information is collected over the Internet. There is a potential risk of loss of confidentiality in all emails, downloading, and Internet transactions. Information from your demographics questionnaire will be kept confidential through Psychdata.com, which stores information in a secure data facility. Psychdata.com employs several procedures to preserve data security including a 128-bit Secure Socket Layer data technology that encrypts both survey questions and participants' responses. Psychdata.com servers are stored in a secure data facility and are monitored by security

personnel 24 hours per days and 7 days per week; all data files are backed up by Psychdata.com daily; and Psychdata.com incorporated security measures that disallow the viewing of previous pages by individuals who use a computer after a study participant. The researcher and her research advisor will be the only individuals who have access to your demographic information and survey responses. Names and identifying information will not be collected and will therefore not be linked to your survey responses. Identifying information will be removed from the identifiable private information. The results of the study may be presented in either conferences and/or scientific publications, and no identifying information will be presented. As well, confidentiality will be protected to the extent that is allowed by law.

Another risk in this study is the possibility of emotional distress. The questions in the survey will have items regarding your experience with intimate partner violence. You may discontinue your participation at any time without penalty should you experience any psychological or emotional discomfort. If you feel the need to speak to a professional, mental health resources have been provided to you.

National Register of Health Service Psychologists

- <http://www.findapsychologist.org/>

University of North Texas Psychology Clinic

- (940-565-2631)
- Provides counseling to those in the Denton County community at a reduced cost, using a sliding payment scale that is based on your income.

APA Psychologist Locator

- (<http://locator.apa.org/>)
- Find a therapist in your area.

TWU Counseling & Family Therapy Clinic

- (940) 898-2600
- Provides counseling at a reduced cost, using a sliding payment scale that is based on your income.

Psychology Today: To find a therapist in your area

- www.psychologytoday.com

Another possible risk in this study is fatigue. If you become tired or upset, you may take breaks as needed. You may also stop answering questions at any time and end your participation without penalty.

Another possible risk is coercion. Participation is voluntary and participants can stop the participating at any point without penalty. As well, participants who decline to participate or withdraw from the survey who received information about this study from a mental health provider/agency will have no impact on the services they are receiving from the provider/agency.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time without consequence. Your involvement in this study may or may not be of direct benefit to you. Following the completion of the study you will receive the chance to win one of fifteen \$20 Amazon e-gift cards. However, your participation will help advance the research in the area of how COVID-19 and COVID-19 stressors has impacted intimate partner violence

within the racial and ethnic minority population. Another potential benefit to you is that at the completion of the study, a summary of the results can be emailed to you upon request.

TWU Disclaimer Statement

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen as a result of your taking part in this research.

Questions Regarding the Study

You may print out a copy of this informed consent form to keep. If you have any questions about the research study you should contact the researcher or her advisor: their emails and phone numbers are available at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

By clicking the "I agree" button below, you acknowledge that you have read this information and are giving your informed consent to participate in this study.

I agree

I do not agree

APPENDIX B
SCREENER QUESTION

Do you identify as a racial and ethnic minority? This may include:

- Black/African American/Caribbean
- Latinx/Latino(a)/Hispanic
- Asian/Asian American/Pacific Islander
- Native American/ Indigenous/Alaskan Native
- Multiracial/ Biracial

a. Yes

b. No

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Please answer the questions in a manner that best fits you.

1. Racial/Ethnic Identity:

- A. Black/African American/Caribbean
- B. Latinx/Latino(a)/Hispanic
- C. Asian/Asian American/Pacific Islander
- D. Native American/ Indigenous/Alaskan Native
- E. Multiracial/ Biracial

2. Age: _____

3. Gender Identity:

- A. Woman
- B. Man
- C. Transgender
- D. Genderqueer/Gender Fluid
- E. Other/Self-identify

4. Sexual Orientation:

- A. Heterosexual
- B. Lesbian
- C. Gay
- D. Bisexual
- E. Queer

F. Asexual

G. Other/Self-identify

5. Relationship Status:

A. Single

B. Dating

C. In a relationship

D. Married

E Separated

F. Divorced

G. Widowed

H. Cohabiting

6. What is your highest level of education at the time of taking this survey?

A. High school diploma/GED or equivalent

B. Some College

C. Associate's Degree or equivalent

D. Bachelor's Degree or equivalent

E. Vocational Schooling/Licensure program or equivalent

F. Master's Degree or equivalent

F. Doctoral Degree or equivalent

7. What is your individual income before taxes?

A. Less than \$25,000

B. \$25,000 - \$50,000

C. \$50,000 - \$100,000

D. \$100,000 - \$200,000

E. More than \$200,000

F. Prefer not to say

8. What is your annual household income before taxes?

A. Less than \$25,000

B. \$25,000 - \$50,000

C. \$50,000 - \$100,000

D. \$100,000 - \$200,000

E. More than \$200,000

F. Prefer not to say

9. What is your current employment status?

A. Employed Full-Time

B. Employed Part-Time

C. Seeking opportunities

D. Retired

E. Prefer not to say

10. How many children do you have?

A. None

B. 1

C. 2-4

D. More than 4

E. Prefer not to say

11. How many people live in your household?

A. 1

B. 2

C. 3

D. 4

E. 5

F. 5 or more

APPENDIX D

THE ABUSIVE BEHAVIOR INVENTORY

Here is a list of behaviors that many people report have been used by their romantic partner. We would like you to estimate how often these behaviors have occurred. Select the answer next to each item to show your closest estimate of how often it happened in your relationship with your current partner or previous partners **since March 2020**. (1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Frequently, 5 = Very Frequently).

Since March 2020, how often has your partner or previous partners ...

1. Called you names and/or criticize you

1 2 3 4 5

2. Tried to keep you from doing something you wanted to do (example: going out with friends, going to meetings)

1 2 3 4 5

3. Gave you angry looks or stares

1 2 3 4 5

4. Prevented you from having money for your own use

1 2 3 4 5

5. Ended a discussion with you and made the decision on their own

1 2 3 4 5

6. Threatened to hit or throw something at you

1 2 3 4 5

7. Pushed, grabbed, or shoved you

1 2 3 4 5

8. Put down your family and friends

1 2 3 4 5

9. Accused you of paying too much attention to someone or something else

1 2 3 4 5

10. Put you on an allowance

1 2 3 4 5

11. Used your children to threaten you (example: telling you that you would lose custody)

1 2 3 4 5

12. Became very upset because housework was not done when or how they thought it should be

1 2 3 4 5

13. Said things to scare you (example: told you something "bad" would happen, threatened to commit suicide)

1 2 3 4 5

14. Slapped, hit, or punched you

1 2 3 4 5

15. Made you do something humiliating or degrading (example: begging for forgiveness, asking permission)

1 2 3 4 5

16. Checked up on you (example: listened to your phone calls, went through your belongings)

1 2 3 4 5

17. Drove recklessly when you were in the car

1 2 3 4 5

18. Pressured you to have sex in a way that you did not like or want

1 2 3 4 5

19. Refused to do housework or help with childcare

1 2 3 4 5

20. Threatened you with a knife, gun, or other weapon

1 2 3 4 5

21. Told you that you were a bad parent

1 2 3 4 5

22. Stopped you or tried to stop you from going to work or school

1 2 3 4 5

23. Threw, hit, kicked, or smashed something

1 2 3 4 5

24. Kicked you

1 2 3 4 5

25. Physically forced you to have sex

1 2 3 4 5

26. Threw you around

1 2 3 4 5

27. Physically attacked the sexual parts of your body

1 2 3 4 5

28. Choked or strangled you

1 2 3 4 5

29. Used a knife, gun, or other weapon against you

1 2 3 4 5

APPENDIX E

IPV DURING COVID-19 QUESTIONS

Answer the following questions based on your experience during the COVID-19 pandemic. (1 = Not Applicable, 2 = Decreased, 3 = Stayed the same, 4 = Increased).

1. Physical intimate partner violence (IPV) is defined as behaviors by an intimate partner that cause physical harm, including but not limited to hitting, kicking, slapping, or assault with a weapon. Since the start of the COVID-19 pandemic (March 2020), what changes, if any, have you experienced with personal experiences of physical IPV in your intimate relationship(s)?

1 2 3 4

2. Psychological IPV is defined as behaviors by an intimate partner that cause psychological harm, including but not limited to name calling, criticizing, verbal threats, or humiliation. Since the start of the COVID-19 pandemic (March 2020), what changes, if any, have you experienced with personal experiences of psychological IPV in your intimate relationship(s)?

1 2 3 4

3. Sexual IPV is defined as behaviors by an intimate partner resulting in forced or coerced sexual activity or sex, including but not limited to pressuring or forcing a partner to have sex or sexual activity. Since the start of the COVID-19 pandemic (March 2020), what changes, if any, have you experienced with personal experiences of sexual IPV in your intimate relationship(s)?

1 2 3 4

APPENDIX F

THE REVISED SCALE OF ECONOMIC ABUSE

Since March 2020 how often did your partner or previous partners do the following (0 = Never, 1 = Hardly Ever, 2 = Sometimes, 3 = Often, 4 = Very Often).

1. Keep you from having the money you needed to buy food, clothes, or other necessities

0 1 2 3 4

2. Keep financial information from you

0 1 2 3 4

3. Decide how you could spend money rather than letting you spend it how you saw fit

0 1 2 3 4

4. Make you ask him/her for money

0 1 2 3 4

5. Hide money so that you could not find it

0 1 2 3 4

6. Demand that you give him/her receipts or change when you spent money

0 1 2 3 4

7. Keep you from having a job or going to work

0 1 2 3 4

8. Make you use your money to buy him/her things or pay his/her bills when you didn't want to

0 1 2 3 4

9. Spend his/her money however he/she wanted while your money went to pay for necessities

0 1 2 3 4

10. Take out a loan or buy something on credit in your name without your permission

0 1 2 3 4

11. Make you take out a loan or buy something on credit when you didn't want to

0 1 2 3 4

12. Put bills in your name, leaving you to pay them

0 1 2 3 4

13. Force or pressure you to give him/her your savings or other assets

0 1 2 3 4

14. Steal your property

0 1 2 3 4

APPENDIX G

ECONOMIC IPV DURING COVID-19

Answer the following question based on your experience during the COVID-19 pandemic. (1 = Not Applicable, 2 = Decreased, 3 = Stayed the same, 4 = Increased).

1. Economic intimate partner violence (IPV) is “a deliberate pattern of control in which individuals interfere with their partner’s ability to acquire, use, and maintain economic resources” (Postmus et al., 2020, p. 262). This includes but is not limited to keeping money from a partner, tracking a partner’s spending, or taking out loans or credit cards out in their partner’s name. Since the start of the COVID-19 pandemic (March 2020), what changes, if any, have you experienced with personal experiences of economic IPV in your intimate relationship(s)?

1 2 3 4

APPENDIX H

FINANCIAL ANXIETY SCALE

Please rate the extent to which you agree with the following about your experiences during the COVID-19 pandemic (1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Neutral, 5 = Somewhat Agree, 6 = Agree, 7 = Strongly Agree)

1. I feel anxious about my financial situation

1 2 3 4 5 6 7

2. I have difficulty sleeping because of my financial situation

1 2 3 4 5 6 7

3. I have difficulty concentrating on my school or work because of my financial situation

1 2 3 4 5 6 7

4. I am irritable because of my financial situation

1 2 3 4 5 6 7

5. I have difficulty controlling worrying about my financial situation

1 2 3 4 5 6 7

6. My muscles feel tense because of worries about my financial situation

1 2 3 4 5 6 7

7. I feel fatigued because I worry about my financial situation

1 2 3 4 5 6 7

APPENDIX I

THE SOCIAL CONNECTEDNESS SCALE

Please rate the extent to which you agree with the following about your experiences during the COVID-19 pandemic (1 = Strongly Disagree, 2 = Disagree, 3 = Mildly Disagree, 4 = Mildly Agree, 5 = Agree, 6 = Strongly Agree).

1. I feel disconnected from the world around me

1 2 3 4 5 6

2. Even around people I know, I don't feel that I really belong

1 2 3 4 5 6

3. I feel so distant from people

1 2 3 4 5 6

4. I have no sense of togetherness with my peers

1 2 3 4 5 6

5. I don't feel related to anyone

1 2 3 4 5 6

6. I catch myself losing all sense of connectedness with society

1 2 3 4 5 6

7. Even among my friends, there is no sense of brother/sisterhood

1 2 3 4 5 6

8. I don't feel that I participate with anyone or any group

1 2 3 4 5 6