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Impacts of COVID-19 on the Coping Behaviours of Canadian Women Experiencing Intimate Partner Violence

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Abstract

Background Strict public health measures central to slowing the spread of COVID-19 have, unintentionally, exacerbated risks for women experiencing intimate partner violence (IPV) while impeding their usual coping strategies. The goal of this study was to understand how coping was influenced by COVID-19 for women who have experienced IPV and identify changes in coping strategies and gaps that need to be addressed to support coping.

Methods A qualitatively driven, sequential, cross-sectional design, where quantitative data informed and was embedded within qualitative data collection, was used to explore the experiences of IPV (CAS-R-SF scale) and coping (Brief-COPE scale) specific to IPV of 95 Canadian women. A subset of 19 women was invited to complete an interview exploring coping strategies identified within the survey to contextualize and validate these findings.

Results Survey data subjected to quantitative content analysis identified ten themes, all of which were explored in semi-structured interviews. Thematic interview findings included (1) influence of COVID-19 on coping, (2) coping during COVID-19, and (3) needed coping strategies.

Conclusion COVID-19 had important impacts on the experiences and coping strategies of women who experience IPV. To better support this population in pandemic circumstances, in-person services should be prioritized with an emphasis on accessible and empathetic care. Public health measures in response to COVID-19, and the eventuality of future pandemics, should aim to be gender- and violence-informed.

Keywords Intimate partner violence · Coping · COVID-19 · Women

Introduction

The first case of COVID-19 in Canada was confirmed by Health Canada in late January of 2020 (Bronca, 2020). Over a year later, the country continues to employ strict public health measures such as physical distancing (formerly "social distancing") and stay-at-home orders, restrictions that have severely impacted access to services and coping strategies for women who experience intimate partner violence (IPV). IPV can be understood as any form of physical, sexual, or emotional abuse within the context of coercive control perpetrated by an intimate partner (Davies et al., 2015; Tjaden & Thoennes, 2000). Coercive control encompasses intimidation, threats, isolation, and controlling tactics used by an abusive partner to manipulate behaviours within a relationship (Stark, 2007). An estimated 85% of people who experience IPV are women, and approximately 90% of perpetrators are men — underscoring the gendered nature of IPV (Hudson et al., 2020; Kimmel, 2002). With the implementation of public health measures, stay-at-home orders[1] were most

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[1] Ontario public health measures include, but are not limited to, rigorous personal hygiene practices, physical distancing, wearing non-medical face masks, and stay-at-home orders (Government of Canada, 2020), with stay-at-home orders restricting individuals from leaving their residences for non-essential purposes (Government of Ontario, 2021).

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impactful for women who experienced IPV. As stay-at-home orders became more constricting, rates of IPV have climbed across the country as early reports emerge from specialized crisis hotlines reporting an estimated 300% increase in calls and police departments have noted a 20% increase in domestic incidents and assault reports (Bradley et al., 2020; Slakoff et al., 2020). In Ontario, the York and Durham Regional Police Departments reported a 22% increase in domestic incidents and sexual assault reports since the pandemic began (Amin, 2020). Noting that only about 50% of IPV cases are reported to police, it is likely that these statistics are underestimating the prevalence of IPV during the COVID-19 pandemic (Leslie & Wilson, 2020).

The public health crisis of IPV during the COVID-19 pandemic is being referred to as a "pandemic within a pandemic" or "the shadow pandemic" (Evans et al., 2020, p. 2302). Women's increased time with abusers — during a period where known risk factors such as unemployment/financial stress, increased alcohol use, and lack of social support are exacerbated — creates a "perfect storm" (Lange et al., 2020; Medel-Herrero et al., 2020; Slakoff et al., 2020). As such, the need for coping strategies has increased during this time of unprecedented danger for women in abusive relationships (Slakoff et al., 2020). Coping is understood as taking action to minimize distress when dealing with a negative situation (Carver et al., 1989). In a pre-pandemic study conducted by Bauman et al. (2008), the authors investigated the emotion-focused coping efforts of 460 African American women who experienced IPV and found that women used a wide variety of coping strategies. Namely, women found self-care, independence, social support, expression of emotions, imagery of empowerment, and problem-solving to be helpful in terms of coping (Bauman et al., 2008). Unfortunately, as noted by Jarnecke and Flanagan (2020), the consequences of the pandemic have reduced access to preferred coping strategies, resulting in the necessity for women who experience IPV to modify coping strategies. Women are now faced with the reality that they need to adapt their coping strategies due to the role that the ever-changing pandemic has on their lives and the nature of abuse. For example, social support is a common coping strategy for women who experience IPV, but confinement at home, from the stay-at-home orders, may prevent them from being able to access their support network (Jarnecke & Flanagan, 2020). While virtual connections are a possible strategy, abusers may restrict access to devices and/or monitor their use to extend control over their partner (Stark, 2007). When women in violent relationships face barriers to coping, this can lead to deterioration of mental health and increased relationship conflict, both of which further endanger the safety of women (Kaukinen, 2020; Luetke et al., 2020; Vostanis & Bell, 2020).

It remains unknown how Canadian women who have experienced IPV during COVID-19 have coped. The Secretary General of the United Nations has acknowledged a "horrifying" surge in domestic violence due to COVID-19 measures and urged governments to put women's safety first in their pandemic responses (Papadimos, 2020; Piquero et al., 2020, p. 602). However, there is a dearth of literature about employed coping strategies during a pandemic with stay-at-home orders. This disadvantages social services because they lack evidence-informed practices to best support women in the context of the COVID-19 pandemic. Moreover, public health decision-makers lack an understanding of the unintended, gendered consequences of groups at risk of inequitable health outcomes. To our knowledge, there have been no in-depth examinations of the coping experiences and needs of Canadian women who experience IPV at home during COVID-19. The identification of gaps and needs for women who experience IPV in emergency situations is pertinent to the development of gender- and violence-informed public health responses for the eventuality of future pandemics.

Objectives

The overarching goals of this study were to understand how coping with IPV was influenced by COVID-19 for women who experience IPV at home, as well as to identify changes in coping strategies and gaps that need to be addressed to support coping with IPV in the Canadian context.

Methods

Study Design

This study, situated within the broader "Exploring the Impacts of COVID-19 Physical Distancing on Women Experiencing Intimate Partner Violence at Home (EMPOWER)" project, employed a qualitatively driven sequential, cross-sectional design, where quantitative survey data informed and was embedded within qualitative interview data collection (Schoonenboom & Johnson, 2017) All methods were rooted in Kaufman and English's (1979) needs assessment framework that prioritizes participatory research (amplifying the voices of the vulnerable), equity (ensuring equitable representation of the population), safety (using safety and respect to inform all interactions), and convergence (using interdisciplinary measures to fully understand the problem). This study was approved by the host institution's Non-Medical Research Ethics Board in July 2020 (NMREB #116,226).

Recruitment and Participants

All participants were recruited between August 2020 and December 2020 using advertisements on Kijiji, an online community-building and marketplace platform.

Advertisements were posted across Ontario, Canada, in both rural[2] and urban areas (72 urban locations and 127 rural locations across a variety of categories). To do this, the research team selected the location of their posts (i.e. rural or urban) by inputting the respective postal codes. A disproportionate number of recruitment advertisements (i.e. 231 rural versus 188 urban) were posted in rural locations to ensure sufficient exposure to achieve recruitment goals. Interested participants were invited to email the Women's Health Matters Research Team's secure inbox to confirm eligibility and consent to participate. Women who had experienced any form of IPV while living with an abuser during the pandemic and had access to a safe computer and phone were eligible to participate. Previous research has demonstrated that women know best whether their devices are safe, so the research team respected their discretion (Eden et al., 2014; Glass et al., 2015). Eligibility was assessed using a secure online Qualtrics survey portal. In total, 115 women expressed interest in participating, of which 112 women were eligible to participate and thus provided with the survey link via email and the survey password via text message. This two-factor authentication process was applied to prevent cyber hacking (Colnago et al., 2018). Upon navigating to the survey, women were presented with the letter of information and eligibility criteria; women were asked to confirm that they met the criteria to participate. Next, women were asked via a yes/no question whether they had read and agreed to the Letter of Information and consented to participate in the study. Participants who provided their email at the conclusion of the survey were given a $10 honorarium via electronic gift card in recognition of their time and contributions.

Study Procedures

Upon emailing the researchers and passing the screening protocol, an online survey using a secure Qualtrics platform was administered to 95 women who experienced IPV during COVID-19. This sample size was based on feasibility due to the time-sensitive nature of this project. The survey took a range of 20–30 min to complete and consisted of four sections: demographics, relationship status, experiences of IPV, and coping.

At the end of the survey, all women were asked if they would like to take part in the qualitative interview portion of the study. Women who were interested in participating in an interview were asked for their email address to schedule a 1-h semi-structured Zoom- or the telephone-based interview that probed themes that emerged in the survey data, primarily addressing the impact of the pandemic on their coping strategies. In total, 26 women expressed interest in participating in an interview. All women who expressed interest in an interview were invited to participate. All participants were sent the letter of information, topic guide, and consent form to review prior to the interview. Women provided verbal consent to participate at the outset of the interview, which was audio recorded. Interviews ranged in length from 20 to 75 min. To diminish social desirability bias, at the beginning of each interview, and if appropriate during the interview, participants were told: "I want you to know that there are no right or wrong answers, we are simply interested in what is true for you" (Bates, 1992). An honorarium of $15 via electronic gift card was provided to women who participated in an interview.

Data Collection

Safety During Data Collection

Several measures were embedded in the survey to prioritize the safety of participants. First, prior to consenting, the women were presented with a safe browsing protocol that provided instructions on how to use an incognito browser to access the survey and how to delete browser history. An emergency "Exit Survey" button was programmed into each survey page to allow women to quickly exit to a safe webspace (a blank Google page). Women were provided with the Women's Helpline number and encouraged to phone if they wished to access supportive resources. Furthermore, women were automatically redirected to a blank Google page immediately upon the submission of their survey.

Prior to starting the interviews, the graduate research assistant (GRA) co-created a safety plan with the interviewee in the case her abuser were to interrupt. The safety plan included a safe word that would terminate the interview as well as instructions for what do to if the interview was suddenly terminated (i.e. call back, call police, wait for woman to call back).

Quantitative Data Collection

Measures

1. IPV

   The validated 4-item Abuse Assessment Screen (AAS) was used to determine eligibility by using binary yes/no responses to experiences of general, emotional, physical, and sexual abuse (Soeken et al., 1998). The AAS was developed as a clinical screening tool to assess

[2] The Ministry of Health and Long-Term Care (2011) classifies a rural setting as communities of less than 30,000 individuals who are more than 30 min from the nearest urban area.

women's experiences of abuse both over the life course and within the previous 12 months. The validity of the AAS has been previously confirmed through comparisons of scale items with pre-existing validated ($p < 0.01$) and reliable (97.5% using a test–retest approach) scales related to IPV. To understand how experiences of abuse may have changed during COVID-19, the short-form revised 15-item Composite Abuse Scale (CASR-SF; Ford-Gilboe et al., 2016) was used to assess experiences of IPV exposure and frequency both retrospectively (i.e. pre-COVID-19) and concurrently (i.e. during COVID-19). The CASR-SF was developed as a shorter version of the original 30-item Composite Abuse Scale (Hegarty et al., 2005a) that retained the reliability and validity estimates of the longer version; the original scale has a Cronbach's $\alpha > 0.85$ with $r > 0.5$ for the corrected item-total correlations (Hegarty et al., 2005b). The CASR-SF includes three subscales: physical, sexual, and psychological abuse, each of which was computed in accordance with scoring protocols provided by Ford-Gilboe et al. (2016). Each CASR-SF item constituted a particular experience of abuse (e.g. harassed me over the phone). Responses to questions on the tool were arranged on a Likert scale that ranged from 1 (never occurred in the past 12 months) to 5 (occurred daily or almost daily), and the sums of each response were taken.

2. Coping

   To assess coping, the validated, 28-item Brief Coping Orientation to Problems Experienced Inventory (Brief-COPE; Carver, 1997) was administered. The Brief-COPE scale was developed as a more concise version of the original 60-item COPE scale by Carver et al. (1989). Each subscale with the Brief-COPE scale has met or exceeded the general minimally acceptable reliability standard of 0.50 and has demonstrated an acceptable factor structure similar to that of the original scale (Carver, 1997). The Brief-COPE scale aims to identify women's overall coping style (approach or avoidant) and their relied upon coping strategies (e.g. self-distraction, active coping, denial, substance use, emotional support, instrumental support, behavioural disengagement, venting, reframing, planning, humour, acceptance, religion, or self-blame; Carver, 1997). Avoidant coping is rooted in distracting oneself from the problem through other people or activities (Endler & Parker, 1990). In contrast, approach coping addresses the stressful event directly in order to relieve stress associated with it. It is generally deemed preferable to exhibit approach-style coping as it is typically a more effective emotional response (Carver et al., 1989). The Brief-COPE scale was administered retrospectively, in terms of prior to COVID-19, and currently, as in during COVID-19. A different coping strategy (e.g. I've been criticizing myself") was assessed by each question using a Likert scale from 1 to 4, where 1 indicated "I haven't been doing this at all" and 4 indicated "I've been doing this a lot".

Open-Ended Question

In addition to the Brief-COPE scale described above, an open-ended question, "To help you cope, what supports would you need most during future waves of COVID-19, other pandemics, and/or other times of isolation?" was provided for women to share answers not covered by previous measures. This question was optional to complete and was provided to allow for comments important to participants' experiences that might not have been included fully in the scales, as well as to identify themes to embed within the semi-structured interview guide.

Qualitative Data Collection

The purpose of the qualitative interviews was to determine how women coped during the COVID-19 pandemic and the supports they deemed most needed during future waves of COVID-19, other pandemics, and/or other times of isolation. Semi-structured interviews, developed based on survey data findings, were conducted by three trained graduate research assistants via the telephone or Zoom, depending on the woman's preference. Prior to the interview start and to diminish social desirability bias (Bates, 1992) woman were told the following: "I want you to know that there are no right or wrong answers, we are simply interested in what is true for you." The interviews ranged in length from 20 to 75 min.

Data Analysis

Quantitative Data Analysis

Data cleaning was conducted in Excel version 16.45, and all analyses were conducted using RStudio version 1.2.5042. Measures of central tendency and dispersion were computed for demographics in addition to relevant relationship and abuse variables. Scales were tabulated in full to generate mean scores across overall scales and all subscales. All analyses were subject to assumption checking prior to the execution of tests.

1. IPV

   Total CASR-SF scores, which could range from 15 to 75, were computed for women who responded to at least 70% of items as per the protocol by Ford-Gilboe et al. (2016). Subscale possible scores ranged from 2 to 10, 5 to 25, and 8 to 40 for sexual, physical, and psychological abuse, respectively. If scores were missing, the mean of

the completed items was computed and multiplied by fifteen to form the total score. Higher CASR-SF scores are indicative of higher levels of abuse experienced.

2. Coping

   During analysis, the Brief-COPE scale was tabulated in adherence to the original protocol, such that complete cases had scores summed to form their total score (Carver, 1997). Total possible scores range from 28 to 112. To address missing values, a matched imputation protocol was adopted, such participants with missing responses were matched to cases who had completed the scale in full of a similar response pattern (Little, 1988). This protocol was performed using RStudio software using predictive mean matching via the *mice* package (van Buuren et al., 2021). Higher values on the Brief-COPE scale, single subscale, or individual domain were indicative of the participant's increased reliance on that form of coping. Counts for coping style as dicated by the Brief-COPE scale were also conducted.

Open-Ended Question

Responses to the open-ended question were categorized and coded to compute frequencies using quantitative content analysis in order to integrate and embed themes within the semi-structured interview guide (Morgan, 1993). This involved two graduate student research assistants individually and simultaneously reviewing participants' responses and assigning codes to each response. The researchers then met to agree upon and determine final codes and frequencies were computed for each (Morgan, 1993). Identified codes were then used to develop questions and probes within the semi-structured interview guide for validation and contextualization within interviews with participants.

Qualitative Data Analysis

All interviews were audio recorded and transcribed verbatim by the research team and a secure transcription service (Transcription Heroes, 2020). To increase data trustworthiness, several strategies were incorporated during the interviews and analysis (Guba & Lincoln, 1989), such as member-checking, using multiple coders, and the researchers keeping reflexive journals to document any inherent biases (Guba & Lincoln, 1989; Thorne et al., 1997). To analyze the data, interpretive description methods were applied (Thorne et al., 1997). That is, inductive content analysis was conducted concurrently to promote responsivity between data collection and analysis using interpretive description methodology (Thorne et al., 1997). In doing this, the principal investigator, three graduate research assistants, and one undergraduate research assistant repeatedly immersed themselves in the data prior to coding, to allow for comprehensive synthetization, theorization, and recontextualization of the data. Following this process, categories were identified (Quirkos 2.3.1 [Computer Software], 2020), linkages across categories were made, and a codebook was created.

Results

Quantitative

Participants

The survey sample was composed of 95 Canadian women living in Ontario, with a median age of 27 years ($\sigma = 5.2$). In total, 85% of participants completed at least some post-secondary education and 59.8% ($n = 52$) reported a net household annual income (pre-COVID-19) of CAD $50,000 or greater. While all participants were required to identify as a woman to complete the survey, diversity in gender identities was reported, including trans-women (3.4%, $n = 3$) and genderfluid (1.1%, $n = 1$) respondents. Most women identified as heterosexual (79.3%, $n = 69$); however, bisexual (13.8%, $n = 12$), gay (1.1%, $n = 1$), pansexual (1.1%, $n = 1$), and queer (2.3%, $n = 2$) women were also represented. Ethnically, participants were identified as being of non-Indigenous North American descent (36.2%, $n = 34$), Asian descent (23.4%, $n = 22$), North American Aboriginal descent (1.1%, $n = 1$), European descent (3.2%, $n = 3$), and mixed/multiple descent (25.5%, $n = 24$); however, not all women chose to answer this question (10.6%, $n = 10$). Most women were currently in a relationship (86.2%, $n = 72$) where they lived with their significant other (71.3%, $n = 62$) without children (86.2%, $n = 75$). Full demographic results are available in Table 1.

Of the 19 women who participated in an interview, 10 (52.6%) lived in an urban area and 9 (47.4%) lived in a rural area. In regard to gender, 18 identified as a woman (94.7%) and 1 identified as gender fluid (5.3%). The mean age of interview participants was 32 years ($\sigma = 7.1$). In addition, while most women identified as heterosexual ($n = 11$, 57.9%), in addition, bisexual ($n = 6$, 31.6%), pansexual ($n = 1$, 5.3%), and queer ($n = 1$, 5.3%) women were represented. The majority of the interview sample identified as being of non-aboriginal North American origin ($n = 13$, 68.4%). There was variation in level of education and net income; however, most women indicated having achieved a college or university degree ($n = 14$, 73.7%). Net household income varied, with 29.9% ($n = 26$) of women earning CAD 20,000–49,999 and 48.3% ($n = 42$) of women earning CAD 50,000–99,999. Most women interviewed indicated that they were in a relationship ($n = 11$, 57.8%), living with their partner ($n = 10$, 52.6%), and did not have children ($n = 13$,

Table 1 Demographic information (survey)

Demographic variable	Total ***n* = 95** *n* (%)
Gender	
Woman	83 (95.4)
Trans-woman	3 (3.4)
Gender fluid	1 (1.1)
Education level	
Less than high school	4 (4.6)
High school	12 (13.8)
Some college/university	11 (12.6)
College or university degree	53 (60.9)
Advanced degree (i.e. a master's or doctoral degree)	6 (11.5)
Sexual identity	
Bisexual	12 (13.8)
Gay	1 (1.1)
Heterosexual	69 (79.3)
Pansexual	1 (1.1)
Queer	2 (2.3)
I prefer not to answer	1 (1.1)
Indigenous	
Yes	3 (3.4)
No	83 (95.4)
Ethnicity	
North American Aboriginal origins	1 (1.1)
Other North American origins	34 (36.2)
European origins	3 (3.2)
Asian origins	22 (23.4)
Mixed/multiple	24 (25.5)
Prefer not to answer	4 (6.4)
Marital status	
Single	12 (13.8)
In a relationship, but not married/common law/engaged	48 (55.1)
Married, common law, or engaged	24 (27.6)
Divorced or separated	2 (2.3)
Income	
Less than $19,999	2 (2.3)
$20,000–$49,999	26 (29.9)
$50,000–$99,999	42 (48.3)
Greater than $100,000	10 (11.5)
I prefer not to answer	6 (6.9)
Community	
Large urban center (100,000 people or more)	54 (62.1)
Urban center (30,000–99,999)	16 (18.4)
Rural (30,000 people or less)	10 (11.5)
Unsure	6 (6.9)
Children	
Yes	10 (11.5)
No	75 (86.2)
I prefer not to answer	18 (20.9)
Living situation	
Live alone	4 (4.6)
Live with my child(ren)	2 (2.3)
Live with my partner	62 (71.3)
Live with parents or family	7(8.0)
Live with friend/roommate	3 (3.4)
Live in a shelter or homeless	2 (2.3)
Other	2 (2.3)
I prefer not to answer	3 (3.4)
Essential worker	
Yes	9 (10.5)
No	74 (86.0)
Unsure	1 (1.2)
I prefer not to answer	1 (1.2)

68.4%). The majority of women in this sample were not essential workers during the COVID-19 pandemic ($n = 13$, 68.4%). This study was not adequately powered to detect whether significant differences between the demographic characteristics of survey and interview participants existed. Full demographic characteristics of women of participated in an interview are available in Table 2.

In total, the Abuse Assessment Screen identified that 89 women had experienced emotional abuse, 70 women had experienced physical abuse, and 64 women had experienced sexual abuse. Most women experienced multiple forms of abuse, as only seven women screened positively for a single type of abuse. Across the sample, 42.3% ($n = 55$) of women reported ever being afraid of an intimate partner, with 65.9% ($n = 56$) women experiencing one abusive relationship in their lifetime and 27.1% ($n = 23$) experiencing more than one abusive relationship in their lifetime. While all women screened positively for the presence of abuse by an intimate partner during COVID-19, some women chose not to self-report being in an abusive relationship in response to the open-ended question, "How many abusive relationships have you been in?". Of the participants who reported that they were currently in a relationship, 35.6% ($n = 37$) indicated they were afraid of their current partner. The overall pre-COVID-19 CASR-SF mean score did not differ significantly between pre- and during the COVID-19 pandemic (39.64 versus 39.28, respectfully). Across the sample of women who completed both CASR-SF timepoints ($n = 22$), 40.9% ($n = 9$) experienced an increase in abuse, 40.9% ($n = 9$) reported a decrease in abuse, and 18.2% ($n = 4$) reported no change in abuse. Combined, the CASR-SF mean scores for

Table 2 Demographic information (interview)

Demographic variable	Total ***n* = 19** *n* (%)
Gender	
Woman	18 (94.7)
Gender fluid	1 (5.3)
Education level	
Less than high school	2 (10.5)
High school	1 (5.3)
Some college/university	1 (5.3)
College or university degree	14 (73.7)
Advanced degree (i.e. a master's or doctoral degree)	1 (5.3)
Sexual identity	
Bisexual	6 (31.6)
Heterosexual	11 (57.9)
Pansexual	1 (5.3)
Queer	1 (5.3)
Indigenous	
Yes	1 (5.3)
No	18 (94.7)
Ethnicity	
Other North American origins	13 (68.4)
European origins	2 (10.5)
Mixed/multiple	4 (21.1)
Marital status	
Single	5 (13.8)
In a relationship, but not married/common law/engaged	2 (10.5)
Married, common law, or engaged	9 (47.3)
Divorced or separated	3 (2.3)
Income	
$20,000–$49,999	9 (47.3)
$50,000–$99,999	4 (21.1)
Greater than $100,000	3 (15.8)
I prefer not to answer	1 (5.3)
Community	
Large urban center (100,000 people or more)	10 (52.6)
Rural (30,000 people or less)	9 (47.4)
Children	
Yes	5 (26.3)
No	13 (68.4)
I prefer not to answer	1 (5.3)
Living situation	
Live alone	2 (10.5)
Live with my child(ren)	2 (10.5)
Live with my partner	10 (52.6)
Live in a shelter or homeless	2 (10.5)
Other	1 (5.3)
I prefer not to answer	2 (10.5)
Essential worker	
Yes	6 (31.6)
No	13 (68.4)
I prefer not to answer	1 (5.3)

the sexual, physical, and psychological subscales in regard to pre-COVID abuse were 6.10, 10.19, and 22.05, respectively, and the during-COVID-19 equivalents were 5.85, 11.44, and 20.22; no significant differences were detected between timepoints.

Coping and COVID

Assessment of coping using the Brief-COPE scale identified a pre-COVID-19 avoidant mean score of 30.35, slightly lower than its during-COVID-19 counterpart of 31.32. The pre-COVID-19 mean score for the approach coping style was 29.63, with a slightly higher during-COVID-19 equivalent of 31.75. Across both timepoints, the most popular coping strategy was self-blame, an avoidant style with a consistent mean score of 5.5, while the least popular coping strategy was religion, an approach style with a consistent score of 4.0. Broadly, the differences in the Brief-COPE subscales (avoidant coping, approach coping, self-blame strategy, and religious strategy) from pre- to during-COVID were not significant.

Open-Ended Question

Findings from the open-ended question yielded 10 themes including the following: (1) physical activity; (2) therapy and/or counselling; (3) social support; (4) emotional support; (5) spirituality; (6) distracting activities and/or hobbies; (7) employment/financial support; (8) leaving; (9) nothing would help to cope; and (10) doctor. For a comprehensive list of frequencies associated with each theme see Appendix 1. Themes informed the following question in the semi-structured interview guide: "Women in similar circumstances suggested the following best ways to support women to cope in terms of resilience in a pandemic (social support, hobbies, therapy/counselling, employment and financial support, and spirituality). Which of these 'best way(s)' would be most important to you?". In addition, themes were used as probes to questions "What helped you to cope during the COVID-19 pandemic?", "What helped you to cope while in lockdown?", "What made it more difficult for you to cope during the COVID-19 pandemic?", "What made it more difficult to cope during stay-at-home orders?, and "What would

have helped you to cope better?", as appropriate. Discussion of coping in the context of COVID-19 was first approached generally; however, the interviewer probed for experiences of coping specific to IPV. For a complete list of interview questions related to coping, see Appendix 2.

Qualitative

Thematic Findings

The women in this sample consistently underscored the impact of the COVID-19 pandemic on the abuse experienced from their partners, as well as coping strategies used to deal with the abuse. One woman described the pandemic as the "perfect storm to be able to give him [partner] that power that he hadn't been able to have yet" (W4). Women underscored how their coping was influenced by COVID-19 and identified changes in coping strategies through three overarching themes: (1) influence of COVID-19 on coping; (2) coping during COVID-19; and (3) needed coping strategies. Many women described the impact of COVID-19 on coping in the forms of lack of privacy, isolation, and the emotional toll of isolation. During COVID-19, women described strategies that they used to cope including physical, social, financial, and substance use mechanisms. Women also identified the need for a shift in coping strategies to better support themselves in the future.

Impact of COVID-19 on Coping

Lack of Privacy Women experienced an increased lack of privacy during the COVID-19 pandemic due to the stay-at-home orders. Many women described particular challenges as they pertained to working from home with their partner, as one woman emphasized, "…with me being home, we're together all the time, but it's not like at the college where we had people around us all the time…There's a lot less privacy obviously" (W11). Similarly, another woman underscored the difference in work habits saying:

> …before the pandemic…my boyfriend would go to work, and I would go to work. And… during the pandemic we were here every minute together…So we didn't have our own stuff going on, which made it harder and we got stressed out and fought a lot more. (W15)

As a result of the pandemic, many women lived and worked at home with their abuser. The women not only described changes to their own employment situation, but also changes to their partners', thus confining them to their households. One woman explained that she felt that her and her partner were "on top of each other" (W12). This lack of space enabled increased environmental surveillance by their abusive partner during the pandemic. This woman described the escalation of abuse over time, with the COVID-19 pandemic being a tipping point for it becoming even worse, saying:

> So, me not getting out to work and [partner] not getting out to work and both of us being alone together all the time… there was clear evidence…the abuse didn't, it wasn't like an acute case of someone picks up drinking or something because COVID happened and becomes an abusive partner and then there's a recovery. This wasn't a rough patch; this was just an escalated version of what was already happening. (W5)

Women highlighted that working from home was a contributing factor to their IPV experiences. Another woman shared these experiences explaining that her partner dictated everything, including when they worked, saying:

> He [partner] would like me to be on the same shift as him. So, I was always home at the same time and available for him or even if I was on a day shift and he worked afternoons he would expect me to always be there and stay up to wait for him to come home. And then I would have to get up early… So, with [the] pandemic I was just here all the time. I [don't] have any of my own space at all and he, he decides when we go to sleep like if I fall asleep on the couch, he'll wake me up and tell me to get up and not go to bed yet and so… it was not having my own space at all. (W15)

Lack of privacy was also described more generally by one woman who was concerned about the confidentiality of her conversations saying, "And even if someone was to call… my conversations weren't private, and it was… just very different" (W8). One individual said that unlike pre-pandemic, they "can't just go away for a weekend or [they] can't just go to the grocery store on [their] own, or go to a restaurant on [their] own" (W11) to get away. This pandemic-related confinement added to their already highly confined life that was imposed upon them by their abusive partners. Another woman described the increased intensity that having to be home because of COVID-19 inflicted upon her being surveiled. She said:

> I had access to nothing… my husband had Google nest cameras all over the house. So he could watch, like, my every move. If I touched the phone, if I spoke to someone, like, I know, in other people's situation, they might have been able to, you know, call someone and say, 'What do I do?'… But I could absolutely, I could do nothing. I was completely like [under] surveillance all the time. Cameras were inside and outside the house… Everything was watched. (W4)

Overall, lack of privacy manifested in multiple forms, including work from home challenges, difficulty making phone calls, being surveilled by their partners, and not being able to leave their houses.

Isolation Almost all of the women interviewed described experiences of social isolation as a result of COVID-19 public health restrictions. For some, the restrictions amplified a previously isolating experience in terms of IPV and, for others, the isolation stemmed from the pandemic. One individual emphasized feelings of loneliness before the pandemic that only intensified as a result of the public health restrictions, saying:

> It just felt like all the doors closed. And I already felt like there wasn't much there to begin with. But it felt like everything closed. And even when things opened back up again… it just feels like everybody's away. Everybody's gone. And it just feels a lot like I'm alone more than I was before. (W13)

Another individual stated that she "hardly spoke with anybody for two months" (W6). This was echoed by another woman who said, "…I just feel like I lost everybody because, when they said they're locking everything down everybody got scared and didn't interact with anyone else then it's just me and him" (W17).

Lack of social connection with family/friends was common for many women. One woman described missing connecting with people in person saying, "I miss people… it's just him that I see for the most part and a few phone calls, or if I Skype with someone, but that doesn't happen very much… it's not the same as seeing people in person" (W10). Feelings of social isolation were summarized by one woman who said, "…things changed that we weren't seeing other people, it was just the two of us here… so like instantly really isolated" (W9).

Emotional Toll of Isolation Women consistently described isolation due to the COVID-19 pandemic, and many underscored its emotional toll. This was described by one individual who emphasized her discontent as a result of the pandemic and its compounding factors saying, "…there's just a lot of fighting going on and [sigh], it's just with COVID it feels really isolating and I can't really go far and I'm not happy" (W17). Another woman echoed this sentiment and described what contributed to her feeling depressed:

> Well, so I had to move my schoolwork online and I was just at home a lot. Plus my family, they were, they're out of the city. So they would just have phone calls and stuff. And they would like e-transfer me money for like food and stuff, but I wouldn't really go out and buy anything. Cause I was kind of like, yeah, depressed. (W14)

Not being able to turn to friends for emotional support was also highlighted by women, with one woman saying:

> And I think that made it hard cause I was, its kind of nice to just vent sometimes and I had to be careful what I said, or it was misinterpreted by him and then I'd be questioned after a call. So, I couldn't just be open and have a nice chat or even a laugh because he would question why I was laughing… So, just little things like that made it kind of hard, whereas, for other people or, or in, on a normal day before, before COVID I could do that when he was away and I could feel better or a little bit happier just to vent or just talk in general without everything being questioned. (W18)

Women described challenges accessing external resources to help them cope with their isolation and abuse during the pandemic. This was underscored by one woman who said:

> I don't have anyone to go to at this point anymore because all of my external resources have either been reduced or completely eliminated as a result of COVID. So, I'm just – and I don't have the friendships [laughs]. So, it's just – it's become more and more of a challenge, and I'm incredibly isolated, and not having anyone to even just discuss what's going on in my situation is making things a hell of a lot harder. (W12)

The emotional toll of isolation due to the pandemic for some women led to a loss of self, "I think just losing the few… things I had that were just for me. Like the few friends that were mine and not his and my own little life outside of him, that was just entirely gone" (W6). This emotional toll that the pandemic had on women led to feelings that another lock down would be unbearable, with one woman saying, "I can't do the whole isolation thing again" (W16).

Coping During COVID-19

During the COVID-19 pandemic, women reportedly coped in three different ways: (1) physical coping (e.g. spending time outside, hobbies); (2) social coping (e.g. connecting with family and/or friends); and (3) financial coping (e.g. having autonomy over their finances).

Physical Coping Many women expressed the importance of physical coping (i.e. self-care activities) to support their wellbeing throughout the pandemic. A common narrative for this form of coping manifested in their ability to spend time outdoors. One individual described, "Getting outside for sure… just to feel like you can escape, just feel that you're

not trapped" (W6). Another woman noted being outside reduced feelings of loneliness:

> Being able to go outside because, like I said even if I went on a walk and people were crossing the street to keep the distance at least there was somebody out there and didn't feel like I was entirely alone in the world. (W9)

Having a pet to walk was a common motivating factor for women to get outdoors. One woman said, "we enjoyed the pet outside" as this allowed her to "clear [her] mind and… keep [her] feeling busy and valuable" as well as "keep [her] self-esteem up" (W8). Using pets to distract from the events occurring in their lives was shared by many women, as another woman described:

> Probably my dog helped … distract from it [IPV] and to have another kind of something that was for me rather than just his friends, so you know I got to just play with my dog or give her a bath or brush her and it was just, having my own buddy around. (W7)

Distracting themselves with artistic hobbies was also common for women, as one explained, "I'd say just doing things you love. Like, hobbies, like stuff you enjoy, to distract from like, all negative thoughts and stuff" (W14). Similarly, another woman mentioned, "I do a lot of artwork, that sort of thing. It keeps me busy and I look for like craft like things to do to keep my hands busy and to distract from it all" (W15). Even if only temporary, women explained that physical coping was used as a means distract themselves from their circumstances and escape from their own minds.

Social Coping To cope with IPV intensity during the pandemic, many women described relying on social supports, such as friends and children. Specifically, one woman mentioned, "I take strength in being able to say I have amazing friends… from [activity program]. I have really great kids" (W5). Another individual highlighted the importance of just knowing that she had friends, even if she was not able to currently connect with them. This knowledge of having friends was a means of coping, with one woman saying, "I guess the thing that has helped me the most is… I do have close friends and things. And, you know, we've been able to keep in touch" (W16). The ability to rely on friends and loved ones for support was integral for women to continually cope throughout the COVID-19 pandemic.

Financial Coping A number of women reported a change in financial situation due to the pandemic and that change was problematic. For many women, having access to financial resources was an impactful coping strategy for the abuse they were experiencing and likewise not having access truly undermined coping. One woman described the importance of being able to access her finances contributed to her autonomy, explaining, "just to be able to do what you want, it makes a big difference if you have more access to finances" (W6). Another common feeling among women was that finances gave them the ability to cope with future circumstances. One woman explained:

> Well I would say financial because you can have all the counselling in the world but if you don't have any money to get out and go anywhere then it really restricts where you're gonna end up and what options you'll have. (W7)

Not having access to finances was expressed by many women as a debilitating circumstance, as one individual described, "If you have nowhere to go and no money to pay like that's paralyzing" (W5). This individual was able to leave her abusive relationship and experienced firsthand the opportunities that money can afford you, explaining, "I can cope day to day, I can be present in the moment but, … If I had not lucked out and got that money [insurance settlement], I would not have been able to move." (W5).

Substance Use Many women used substances to cope with the heightened abuse they were experiencing during COVID-19. This mechanism was notably employed more frequently among rural women. Women described their substance use as a means of temporary escape. One woman noted that "we smoked a lot of weed which normally was fine but then I started to find that it was to escape more, as like, an enjoyment" (W8). Another woman expressed similar feelings of escape and numbing of emotions, describing:

> When I was high and that, I didn't, like, I don't know how to explain it, like, I didn't really care as much. Like, I was able to, like, my emotions were more numb, more numb to, like, what was happening. Yeah, so, but, I mean, really, it wasn't – it was just a mask, right? So, right when I wasn't high anymore, like, everything came rushing back. But, like, during being high, I was able to, like, you know, stop crying and, you know, stop caring so much. (W1)

The women who employed these coping strategies recognized their importance to their mental well-being while navigating their IPV situations during COVID-1 9. As one said, "I've been smoking cigarettes a lot more, it's a bad coping strategy, but it's been helping." (W11). Substance use allowed women the opportunity to temporarily escape their circumstances and continue coping with day-to-day activities.

Needed Coping Strategies

Future Needs To fill the current gaps in services noted by women, future resources that they believed may be helpful

to introduce during the pandemic included community centers and education to help women identify signs of IPV and implement strategies to keep them safe. Although suggestions varied among women, the common thread throughout was that even throughout the pandemic, services needed to be offered in-person. Women also highlighted the need for temporary escapes from their partners. Access to community centres were highlighted as one potential resource that would afford them a temporary respite. One woman noted, "I think the community centre, if they were to facilitate any kind of walk-in group or clinic or something of the sort, that would help myself and more than likely… other people in the community" (W12). Regardless of the specific services being offered, a common narrative expressed by women was the need for education to understand that not all abuse manifests as physical abuse. One woman described what may be helpful in the future:

> Just educating people about psychological abuse, and how women can get in situations where they absolutely question everything, because they've been conditioned over time that everything they know we're doing is wrong. You know, like, I think some of the most educated people think of abuse and they think it's all physical. And they're like, okay, yeah, you know, emotional abuse. Sure. Yeah, that exists, but they don't understand to what magnitude... you know, and they don't understand, like, once you're in that situation, and you're told, 'no, you need to do this', or 'you need to say this' or 'you need to', then you absolutely have to. Because it's just not all broken ribs and black eyes. (W4)

There is no single solution that can help every woman cope with experiencing abuse particularly during an unprescented pandemic; however, it is clear that women have identified that to cope during the current pandemic, there is a need for substantive, in-person counselling, access to community-based activities to provide respite from abuse, and the need to educate people that IPV is more than physical abuse.

Discussion

The overarching goal of this paper was to (1) understand how coping was influenced by COVID-19 for women who have experienced IPV at home and to (2) identify changes in coping strategies and gaps that need to be addressed to support coping in the Canadian context. In this sample, most women experienced either an increase or decrease in abuse during the pandemic; very few women reported experiencing the same levels of abuse. The increase in abuse reported was anticipated due to the risk factors surrounding COVID-19 public health measures; however, reasons for the decrease in abuse for some women remain unclear. It is important to note, however, that women experiencing the most severe increases in abuse may have not been able to participate as a result of their current situation. Thus, conclusions cannot be drawn as to whether women were truly equally likely to experience a decrease or increase in abuse during COVID-19, as would be suggested by these findings. Preliminary survey results embedded within the semi-structured interview findings were contextualized and validated. Qualitatively, women described that COVID-19 resulted in a lack of privacy as well as heightened isolation which negatively impacted coping. Moreover, the emotional toll of isolation for women was also exacerbated by COVID-19. As a result, coping strategies during COVID-19 shifted to focus on physical strategies that were within the context of the stay-at-home orders, and focusing on knowing that they had a support network, as opposed to connecting with the social network. Women also highlighted the importance of having financial resources, access to safe places to go in community and the need for education as being paramount to the ability to cope.

Reducing person-to-person contacts through various public health measures has been used to reduce viral transmission of COVID-19 (Cardenas et al., 2020; Crasta et al., 2020; Mohler et al., 2020); however, it has exacerbated risk factors for experiencing abuse for women in violent relationships. This exacerbation was evidenced in the current sample, with almost half of the women who completed both timepoints reporting an increase in abuse during COVID-19. This finding is juxtaposed against the increase in mean scores on the CASR-SF physical and psychological abuse subscales across timepoints that was not found to be statistically significant. However, the practical importance of finding an increase in abuse should not be overshadowed by a lack of statistical significance, especially because many women described COVID-19 as exacerbating their experiences of abuse in the interview setting. Given this context, it can be concluded that many women did experience increases in abuse during COVID-19. This interpretation is consistent with preliminary reports from police services and crisis lines in Canada confirming an increase in IPV-related incidents/calls (Bradley et al., 2020; Slakoff et al., 2020), in addition to reports of increased abuse from countries around the world dealing with the pandemic (Graham-Harrison et al., 2020).

Results from the Brief-COPE scale indicated that self-blame was the most used coping strategies across the pre- and during-COVID-19 timepoints. These avoidant coping strategies may be the result of experiencing an abuser's coercive control, as researchers have found that women who experience higher rates of abuse are at risk of reduced self-confidence and poorer mental health outcomes (Karakurt et al., 2014). A common tactic employed by abusers is to blame and shame (e.g. gaslighting) their partners to create feelings of extreme guilt as a manipulation tactic (Rakovec-Felser, 2014). Resultantly, it is reasonable that abusers have

reduced the self-esteem of women in this study, especially during the circumstances of COVID-19, such that they have adopted self-blame as a common coping strategy. In addition, women stressed the importance of physical and social coping; both forms were rooted in having time away from their abusive partner. This was reflected in the Brief-COPE scale survey findings, as using both instrumental/social support and self-distraction as coping strategies was popular during both timepoints. The importance of physical and social coping is thoroughly discussed in previous IPV literature, as described by Merritt-Gray and Wuest (1995), as a method of "fortifying" (p. 1). Fortifying is a defense employed by women against IPV that includes creating space between oneself and the abuser, distancing from them physically and emotionally, creating caring relationships with others, and making a leaving plan. Ultimately, women in this sample relied on physical and social coping strategies to fortify themselves to cope with their circumstances amid a public health crisis.

It is troubling that public health measures employed to protect the community from COVID-19 erected several barriers for women who experience IPV and prevented them from accessing key services and supports. Many women in this sample described their desire to access in-person services; however, the majority noted that public health measures caused service providers to transition to virtual administration. This is corroborated by evidence that the majority of services had to transition online, and those that did remain open did so with additional barriers to usefulness (e.g. physical distancing, negative COVID-19 test results, masks reducing non-verbal communication) (Duchensne, 2020). Services that did remain available, but in an online format, were often described as inaccessible by women due to surveillance and control tactics employed by their abuser; finding a private space to talk was not always possible. Many women stressed that the lack of in-person access to services meant they found it challenging to connect with sources of social support. This is consistent with previous COVID-19 research by Kaukinen (2020), who suggested that the pandemic has made it easier for abusers to fully isolate their partners from their social networks and social services. If a woman is overheard by their abuser while discussing abuse or talking on the phone in secret, this can seriously jeopardize their health and safety (Slakoff et al., 2020). As such, it is essential that services designed to support women in abusive relationships recognize the dissonance between current formats of service delivery and the reality of women in need being unable to safely access said service due to stay-at-home orders.

Given changes in financial situations due to the pandemic, access to finances was a coping strategy of extreme importance to women in the current study, principally due to the autonomy associated with access to funds. Without financial resources, leaving an abusive relationship can be extremely difficult (Stanley & Markman, 2020). Abusers are aware of this and may confiscate and/or restrict the money earned by their partner to exert further control over her (Roesch et al., 2020). This confiscation of funds was reported by the women in our sample, as women described being limited in what they could do or access as a result of their financial situation. As such, despite feeling a desire to leave, women can become trapped in their current relationship and forced to cope with the abuse due to a lack of personal resources (Alini, 2020). This finding aligns with the results from the current study, as one woman explained that had she not received her insurance settlement, she would not have been able to leave her abusive relationship. Exiting a violent relationship during the COVID-19 pandemic is especially complex due to stay-at-home orders that place women in constant proximity to their abusers and the reduced capacity of shelters. As such, many women must escape to a friend or family's house, or alternatively, to a place of their own; however, knowing the extent of social isolation of women who experience IPV, especially during COVID-19, the former may be unrealistic or even against the law for many women (Kaukinen, 2020; Merritt-Gray & Wuest, 1995). As a result, the only option for some women may be to find (and fund) a place of their own. Unfortunately, the dire economic consequences of the pandemic led to Canada's unemployment rate reaching 13% in April 2020 (nearly three times that of the rate of April 2019 (Statistics Canada, 2020)). Women are more likely to be employed in sectors prone to layoffs (hospitality, travel, education, and retail) and also more likely to stop work for childcare duties due to school closures; thus, many women experienced financial insecurity during this period (Ryan & El Ayadi, 2020; Wenham et al., 2020). Resultantly, some women may have become more financially dependent on their partners during COVID-19, which led to them stressing the importance of access to personal finances in this study. It is clear that access to finances is a major facilitator to accessing desired coping strategies and exiting a violent relationship, and the circumstances of the pandemic have created immense barriers for doing so.

Limitations and Future Research

The limitations of this study should be considered to contextualize the findings. The recruitment of this community sample was via Kijiji, which resulted in a generally younger cohort of women being included in this study. Given the online nature of the study, it is possible that this study did not include women experiencing the most severe forms of IPV during COVID-19 because of increased abuse and coercive

Table 3 Recommendations for supporting the coping of women who experience IPV during the COVID-19 pandemic

1. Increase the list of essential services to included spaces that would afford women who are experiencing violence respite from their homes
2. Prioritize enabling shelters to increase capacity to support the needs of women during COVID-19 pandemics
3. Ensure that policy makers are aware of the impact of lockdowns on this already marginalized and highly at-risk population in order for them to consider women who experience IPV when decision making
4. Prioritize education for service providers on a trauma- and violence-informed approach

control that prevented them from safely accessing a device to participate. Future research should explore how to safely include the perspectives of women who experience severe levels of abuse, as their voices are underrepresented in IPV research as well as purposive sampling to ensure participants more accurately reflect the Canadian population. The cross-section approach used in this study means that how participants coped were, in part, a product of the pandemic-related public health guidelines at the time of the data collection. Longitudinal data collection that followed participants as the rules and regulations evolved would have provided a more fulsome picture of participants experiences throughout the COVID-19 pandemic. Moreover, the tools employed in the survey and interviews relied on self-reporting, which can lead to social desirability bias particularly in interview responses. To counter this, honesty demands were used (Bates, 1992) in each semi-structured interview. An additional limitation is that the CASR-SF scale relied on retrospective reporting for experiences of IPV pre-pandemic, which may have introduced bias in self-reporting. It is unknown whether this would over- or under-state experiences of abuse prior to COVID-19.

Situating these findings in the context of the larger body of available knowledge-related to gender-based violence and coping leads to recommendations that merit consideration during both the ongoing COVID-19 pandemic as well as future pandemics and times of isolation (see Table 3). It is imperative that public health guidelines consider the needs of women who are experiencing violence at home and take explicit action to not only mitigate their risk, but avoid contributing to it through public health measures. It is recommended that in-person provision of services related to IPV is maintained despite stay-at-home orders to improve accessibility for women who cannot safely access these services from their own home. As such, services need to find creative solutions for providing in-person services that meet all public health regulations, while also providing women with much-needed coping supports. Moreover, this requires that women be permitted outside despite stay-at-home orders, as well as the formal designation of shelters and other IPV-related social services as essential and, thus, fully operational during the pandemic. This should include spaces in which women can obtain brief respite from their homes. Furthermore, it is critical that policymakers realize the impacts of public health measures on women who experience IPV and practice gender- and violence-informed policymaking. In the future, this should include education around abuse for the broader public and improved access to social services, such as counselling, by increasing the duration of subsidized care.

Conclusion

Strict public health measures, principally stay-at-home orders, have been central to slowing the spread of COVID-19. Unfortunately, these restrictions have unintentionally exacerbated risk factors for experiencing IPV for women, specifically regarding lack of privacy, heightened isolation, and the emotional toll associated with isolation. As a result, women's coping strategies during COVID-19 have shifted to include strategies that were within the context of the stay-at-home orders. At the time of writing, this is the first study to identify how Canadian women who experience IPV coped during COVID-19, in addition to their desired coping strategies and recommendations for change in social service delivery. The findings of this study suggested that many women struggled with coping with abuse during COVID-19 and underscored the particular challenges associated with stay-at-home orders, including a lack of privacy, increased isolation, and the emotional toll of isolation. When reaching out for help, some women were unfortunately confronted with inaccessible or dismissive services. The most important type of coping identified by women was access to financial resources, although not all were able to exercise financial coping due to resource constraints and abuser control. In addition, physical and social coping strategies were identified as helpful to women. Finally, the need for empathetic, in-person service delivery was stressed by most participants as essential to their coping during COVID-19. Future studies should evaluate current coping supports and services available to women who experience IPV and identify the best practices of those that have been able to manage the limitations of delivery during COVID-19 while providing accessible care to women in abusive relationships. Moreover, current social services should take note of unique barriers to accessibility during COVID-19 and work towards better serving women who

experience IPV, while public health measures should aim to be gender- and violence-informed. Change is essential to empower women who experience IPV to cope with future waves of the COVID-19 pandemic, in addition to the eventuality of future public health emergencies.

Appendix 1. Categorization of open-ended question: coping in future waves

Coping strategies	*N*
Physical activity	1
Therapy and/or counselling	10
Social support	33
Emotional support	3
Spirituality	1
Distracting activities and/or hobbies	5
Employment/financial support	3
Leaving	2
Nothing would help to cope	2
Doctor	1

Appendix 2. Coping-related interview questions

1	What helped you to cope during the COVID-19 pandemic?
2	What helped you to cope while in lockdown?
3	What made it more difficult for you to cope during the COVID-19 pandemic?
4	What made it more difficult to cope during stay-at-home orders?
5	What would have helped you to cope better?
6	Of the coping strategies you mentioned today, which is the most important?
7	Women in similar circumstances suggested the following best ways to support women to cope in terms of resilience in a pandemic (social support, hobbies, therapy/counselling, employment and financial support, spirituality). Which of these 'best way(s)' would be most important to you?
	a. Can you suggest any other 'best ways' to support women?
	b. What is it about that particular way that makes it so important?
8	What else haven't we asked about with respect to coping and coping strategies during the pandemic that we should know?

Letters (a) and (b) denote probing questions. Question 7 was informed by the open-ended questions in the survey.

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Declarations

Ethics Approval This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Non-Medical Research Ethics Board of Western University (NMREB #116226).

Consent to Participate Informed consent was obtained from all individual participants included in the study.

Conflict of Interest The authors declare no competing interests.

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