Experiences of Intimate Partner Violence During the COVID-19 Pandemic

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Abstract

Intimate partner violence (IPV) refers to the emotional, physical, financial, or sexual violence perpetrated by a partner and is the most common form of gender-based violence (GBV) in South Africa. Within weeks of the implementation of the national COVID-19 lockdown restrictions in March 2020, reports of GBV increased exponentially, revealing the pervasiveness of the problem. Research on the qualitative experiences of IPV and support services during the COVID-19 pandemic in South Africa is currently scarce. This study qualitatively explores women's experiences of IPV and telephonic counselling during the COVID-19 pandemic. Seven semi-structured narrative interviews were conducted in-person and telephonically with women survivors of IPV and social workers who facilitated telephonic counselling during the pandemic. Framed by a decolonial feminist framework and narrative approach, positionalities and context of both researchers and participants were central components of the research process to allow for an in-depth exploration of the stories that were told. The Decolonial, Intersectional Narrative Analysis (DINA) was employed. The findings revealed that although an ongoing and pervasive problem regardless of the pandemic, IPV is intricately linked to the structural inequalities which were exacerbated by lockdown. Additionally, the study found that the consequences of the COVID-19 pandemic interacted with the private nature of IPV, increasing the isolation of IPV. While survivors resisted silence around IPV by accessing counselling which retained IPV in the private sphere, social workers worked to maintain confidentiality. Lastly, survivors drew strength from their womanhood, in which their role as mothers played an integral part.

Key words: COVID-19 pandemic; decolonial feminist framework; DINA; intimate partner violence; qualitative; telephonic counselling

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Introduction

Intimate partner violence (IPV) makes up the largest portion of gender-based violence (GBV) in South Africa (Mathews et al., 2016). IPV is a form of gendered violence in which sexual, emotional, financial, and/or physical violence is perpetrated by an intimate partner (Mathews et al., 2016). Consequences of IPV include increased risk of HIV, mental health issues, injury, and death (Leddy et al., 2019). Although widely acknowledged as under-reported and thus difficult to establish a true measure of prevalence, a third of women in each province in South Africa report incidences of IPV (Mathews et al., 2016). Following the implementation of the national COVID-19 lockdown in March 2020, South Africa saw a surge in reports of GBV with as many as 100,000 reports in a matter of weeks (Segalo & Fine, 2020). However, given that reports of the COVID-19 outbreak only began to unfold in 2020 and the pandemic is an ongoing experience, literature reviewing the experiences of IPV and support services for survivors[1] during the pandemic is currently scarce. This study seeks to explore experiences of IPV during the COVID-19 pandemic and add to the production of knowledge on understanding the situation of those affected by COVID-19. This understanding will also inform us on how IPV survivors experienced support services such as telephonic counselling during the pandemic and how interventions might be further developed.

Representations of IPV during the COVID-19 pandemic in South Africa

The surge of reports of GBV during lockdown restrictions in South Africa have prompted differing explanations. Some scholars have understood this surge as the result of increased

[1] The terms 'victim' and 'survivor' are used to describe an individual that has experienced a form of violence. Although both appropriate, the terms serve different purposes. On the one hand, the term 'victim' recognizes harm done. On the other hand, 'survivor' encompasses a sense of empowerment and peace gained within the healing process. While the term 'survivor' is used throughout this paper, we acknowledge that it is not a default term that every individual can identify with and therefore affirm the agency of a person in utilizing a label that they feel defines their experience.

exposure to violent partners due to forced quarantining with abusive partners in their homes (John et al., 2020). Other reports have reasoned that women in South Africa are less likely to have stable employment that can be carried out remotely, such as office jobs, which require less contact (Mittal & Singh, 2020). As such, many women have become unemployed during the pandemic, resulting in increased economic dependence, making it more difficult to leave their partners and forcing survivors to stay in violent relationships to be financially secure (Parry & Gordon, 2020). These explanations of the spike in GBV reports are well-reasoned but obscure the depth of the problem of IPV in South Africa. Increased IPV is presented as one of the consequences of COVID-19, but, for many women, GBV has been a lived experience long before COVID-19.

The South African government has addressed the surge of reports of GBV during the pandemic, presenting it as a blip in an otherwise functional social order (Segalo & Fine, 2020). Presenting IPV as only a problem of the pandemic denies the real, ongoing, and pervasive experiences of IPV. In a qualitative study on IPV during the pandemic conducted by Lyons and Brewer (2021), experiences of IPV were described by participants to have continued or been exacerbated following the implementation of lockdown restrictions. However, authors note that lockdown did not initiate participants' experiences of IPV (Lyons & Brewer, 2021). Moreover, according to Segalo and Fine (2020), COVID-19 did not create a new surge in GBV instances, but it did expose the reality of the issue. Therefore, the spike in reports suggests that COVID-19 has impacted experiences of IPV, but not necessarily that it has triggered more violence. Rather, the social circumstances of COVID-19 are making GBV hyper-visible by highlighting existing inequalities (Segalo & Fine, 2020).

Situating IPV in South Africa during the COVID-19 pandemic

South Africa is still deeply impacted by the consequences of colonialism and apartheid. High levels of poverty, unemployment and structural inequalities in South Africa are rooted in these systems of oppression (Chibba & Luiz, 2011). Given the country's history, poverty and unemployment are correlated with race and thus concentrated among black people[2] (Woolard, 2002). Similarly, with the rigid construction and segregation of races during apartheid still influencing where people live, black people largely occupy spaces that make accessing basic services such as police, hospitals, and support centres difficult (Mosavel et al., 2012). COVID-19 highlighted the inequalities in South Africa by deepening the divide between those that do not face structural inequality and those that do (Segalo & Fine, 2020). The economic disruption caused by lockdown led to unprecedented levels of unemployment and increased rates of poverty which disproportionately impacted vulnerable groups (Jain et al., 2020). The widening inequality in South Africa due to the pandemic is manifesting in the private lives and spaces of its citizens.

"The home" is not a space that is investigated in research on IPV or regarded as a site of intervention (Segalo & Fine, 2020). IPV is often viewed as a private issue, and health care providers to whom it is reported may deem it inappropriate to intervene (Fleischack et al., 2020). Additionally, survivors may perceive IPV as shameful, discouraging them from reporting it (Fleischack et al., 2020). However, as lockdown confined South Africans to their homes, the reality of private spaces that are meant to be a place of shelter was exposed (Segalo & Fine, 2020). During the pandemic, access to support services was disrupted, as IPV survivors could no longer escape the home and existing inequalities were exacerbated. Those living in poverty were further impacted by systemic difficulties, exacerbating their experiences of IPV through the structural violence they face (Carol, 2014). These factors potentially interacted to prompt a surge

[2] Here referring to all individuals that were discriminated against by apartheid's racial policies

in reports of GBV, uncovering the extent of IPV in South Africa that was previously a private issue of the home (Segalo & Fine, 2020). As there is currently little research on this, it is unclear exactly how COVID-19 has affected the experiences of IPV during the COVID-19 pandemic.

The impact of the COVID-19 pandemic on services

The breakdown of social infrastructures caused by lockdown impacted services available to IPV survivors (Lyons & Brewer, 2021). Services that do not primarily target but aid survivors were disrupted (Lyons & Brewer, 2021). For instance, reduced contact with health care providers and police during the pandemic offered less opportunities for survivors to seek advice or report incidences of abuse (Morse et al., 2012). In addition, COVID-19 disrupted court operations (Mittal & Singh, 2020). As a result, the prosecution of perpetrators has been delayed or exempted (Lyons & Brewer, 2021). The postponements of cases can cause distress among survivors and the release of perpetrators puts suvivors at an increased risk of re-victimization (Lyons & Brewer, 2021). To compound this, services that specifically target survivors of IPV were additionally disrupted by the crisis.

Support services for survivors of IPV refer to the provision of emotional and practical aid in assisting survivors moving on from harm (Phaswana-Mafuya et al., 2012). Such services include psychosocial support such as counselling and specialist domestic violence services like shelters, police-based services, and court support programs (Phaswana-Mafuya et al., 2012). External support is a factor associated with leaving violent partners among survivors of IPV (Koepsell et al., 2006). Pandemic-related disruptions therefore reduce the ability of survivors to leave their abusive relationship by escaping to shelters or receiving support, thus placing them in a precarious position (Lyons & Brewer, 2021). For instance, shelters for women were repurposed as shelters for homeless people to better manage the pandemic. This diverted resources for GBV

to relief for the COVID-19 pandemic (John et al., 2020). Missteps in the provision of support in aiding relief to IPV survivors has been observed with previous outbreaks of diseases such as Cholera and Zika as well as natural disasters like the Hurricane Katrina in 2005 (Mittal & Singh, 2020). To reduce these disruptions in support services, the pervasiveness of violence against women needs to be acknowledged (Mittal & Singh, 2020). This way, gender perspectives and the needs of IPV survivors can be better integrated into emergency preparedness (John et al., 2020).

COVID-19 and survivor support services

Without a foreseeable end to the current pandemic, support services have had to adapt to meet the needs of IPV survivors while maintaining physical distancing. Counselling for survivors was a crucial service to adapt. Counselling can provide survivors with support in an environment of IPV that is isolating. This isolation is due to abusers' actions, survivors' own understandings of IPV as shameful, and the normalisation of violence that does not regard IPV as a problem, but an everyday occurrence in South Africa (Rees et al., 2014). Technology has been widely leveraged in adapting distanced GBV services around the world via emergency call centres, online court hearings and telephonic counselling (Lima, 2020). However, the ability for survivors to seek support electronically may be compromised by perpetrator-imposed restrictions such as surveillance of, or limited access to, internet, cell phones and social media (Campbell, 2020). This limitation to online and telephonic services was observed in the 50% decline in calls to a helpline number of a Non-Governmental Organization (NGO) based in Delhi, despite increased incidences of GBV (Mittal & Singh, 2020). In South Africa, attempts to receive support of this nature is compounded by the inability of a large proportion of the population to access data, Wi-Fi, and phones. Conversely, these services may mitigate the difficulties accessing face-to-face services, such as transport costs and taking time off from work (Rees et

al., 2014). Furthermore, despite attempts to provide psychosocial support to IPV survivors during the pandemic, women's experiences of these new services remain under researched.

The depth of the issue of IPV in South Africa has been revealed by the COVID-19 pandemic. The unprecedented nature of this pandemic means that new research needs to be conducted to account for the impact on experiences of IPV in South Africa. Counselling services for IPV survivors has had to adjust to physically distanced services, to safely continue during the pandemic. This has resulted in a drastic change in service delivery for IPV counselling services. The pandemic is ongoing, with no indication of when it will end, so there is a need for more research on IPV and associated support services during COVID-19.

Aims and Objectives

Aim

The current research is contributing to a larger research project[3] on gendered and sexual violence in South Africa. The study was conducted in partnership with *MOSAIC – Training, Service & Healing* – an NGO that offers support to survivors of IPV. The University of Cape Town (UCT) *Knowledge Co-Op* facilitated the research by liaising between the researchers and *MOSAIC* to ensure that the collaboration met the needs of the organization. The aim of the research was to qualitatively explore experiences of IPV during the COVID-19 pandemic. The research included the experiences of women survivors' of IPV as well as social workers who conducted telephonic counselling services during the pandemic. Inquiry into experiences of IPV provides insight into how survivors had to navigate quarantine and accessing of support services during a global pandemic. In addition, given that there is no indication as to when in-person counselling will resume without the prospects of another lockdown, this research explores

[3] The Unsettling Knowledge Production on Gendered and Sexual Violence in South Africa project

telephonic counselling during the pandemic, which may inform the advancement of future distanced services for *MOSAIC* and other organizations.

Main Research Question

What stories do women tell about their experiences of IPV during the COVID-19 pandemic?

Sub-Questions

- What impact has the COVID-19 pandemic and lockdown restrictions had on experiences of IPV?
- How did women survivors of IPV experience telephonic counselling services implemented during COVID-19 lockdown restrictions?
- How do social workers' stories about IPV during the COVID-19 pandemic coincide with women's narratives about their experiences?

Theoretical Framework

The theoretical framework of the study embraces a decolonial feminist lens. Psychology as a discipline has been critiqued for being a site of settler-colonial knowledge production (Boonzaier et al., 2019; Kessi & Boonzaier, 2018). Similarly, gender and sexual diverse experiences have been marginalised in research while the production of knowledge in psychology has centred an androcentric and heteropatriarchal status quo (Kessi & Boonzaier, 2018). The production of psychological knowledge of this nature results in the widespread stigmatisation and dehumanisation of marginalised peoples (Kessi & Boonzaier, 2018). Decolonial feminism seeks to disrupt Euro-American assumptions by amplifying the voices of those that have been dehumanised by colonial legacies (Boonzaier et al., 2019; Segalo & Fine,

2020). This was realised in our research as we focused on women that have experienced IPV, highlighting narratives that are often marginalised (Boonzaier, 2019).

Like Crenshaw's (1993) intersectionality theory, decolonial feminist perspectives demonstrate the ways in which intersections between identities such as race, gender and class determine experiences of oppression (Boonzaier et al., 2019). Decolonial feminism further alludes to embodied practices owing to colonisation, slavery and apartheid that perpetuates contemporary conditions of oppression (Boonzaier et al., 2019; Kessi & Boonzaier, 2018). The role of this colonial legacy on identity and oppression was dissected by analysing why participants tell the stories that they do, and how this reinforced or challenged the status quo (Boonzaier, 2019). Given that reflexivity is a central component of decolonial feminism, the positionalities of the researchers and participants were made visible throughout the research, illustrating how the research may have been shaped by our own identities and agenda (Boonzaier & van Niekerk, 2019; Clarke & Braun, 2019).

Instead of circulating stories of oppression that contribute to knowledge production that perpetuates marginalisation for personal institutional gain, researchers should encompass a call for social justice (Boonzaier, 2019). This was realised in the research as participants had the power to shape how they wanted their stories to be heard. Participants were viewed as experts in their own lives, with the ability to share stories that can inform knowledge production on IPV.

Method

Research Design

Qualitative research design

Given the exploratory nature of the research question, a qualitative approach to the study was employed. Unlike quantitative inquiry concerned with cause-effect relationships, qualitative

research is interested in how people experience a particular phenomenon and the meaning they attribute to it (Willig, 2013). Qualitative research therefore aims to describe and explain, rather than predict, an experience or process (Willig, 2013). An important principle within qualitative research is reflexivity. As two white, upper-middle class women researching the experiences of women who occupy marginalised intersecting identities and their stories of IPV during the pandemic, acknowledgement of our positionalities and how they shaped the stories that were told and the research that has been produced is crucial.

Narrative approach

To enhance the understandings of personal experiences, the research assumed a narrative approach. One ubiquitous characteristic of humans is the ability to use stories to share personal experiences (Fraser, 2004). It is within these stories that narrative research derives meaning about how individuals construct their reality (Fraser, 2004). More than a means to organise experience, stories reveal the socio-political world in which the story is located (Fraser, 2004). With growing acceptance of post-positivist research, narratives have become a legitimate means of knowledge production (Fraser, 2004).

Contesting orthodox scientific methods to produce psychological knowledge, narratives are often utilised within decolonial, intersectional, and feminist approaches (Boonzaier, 2019; Fraser, 2004). From a decolonial feminist stance, narrative research offers visibility to stories that have traditionally been excluded (Boonzaier & Van Schalkwyk, 2011). Furthermore, narrative approach recognises the role of power and historical, political, and economic contexts that shape experiences of oppression and notions of gender (Boonzaier & Van Schalkwyk, 2011). By foregrounding those who live on the margins of society in knowledge-making, the approach embodies a social justice agenda (Boonzaier, 2019). As a result, the current research

sought to foreground the stories of women who occupy various intersecting marginal identities and their experiences of IPV during the pandemic.

Participants and Sampling Strategy

The study utilized a purposive sampling strategy to recruit participants. Purposive sampling involves the deliberate selection of participants based on their knowledge or experience, allowing for the inclusion of well-informed individuals that can meaningfully assist in addressing the aim of the study (Etikan et al., 2016). Given that the research was conducted in partnership with *MOSAIC*, participants were accessed through the organization. Criteria for participating in the study included IPV survivors who were women and had received telephonic counselling as well as social workers who provided this service during the COVID-19 lockdown restrictions. The plan for recruitment involved social workers receiving an invitation to participate in the study. They were to identify IPV survivors who received telephonic counselling via *MOSAIC* and inform them of the research. Upon confirming the survivors' interest in the study, social workers provided the researchers with their contact details. While the study initially aimed to recruit 10 to 15 participants, only 7 women participated. Challenges with recruitment involved survivors' numbers no longer existing, not receiving responses from participants, and women deciding to not to participate. Of the 7 participants, 4 were survivors of IPV and 3 were social workers. Additionally, during the interviews, we realised that there was no one definition of an "IPV survivor." For instance, one survivor disclosed that she had perpetrated violence against her husband, and another shared stories of her daughter as a survivor of gendered violence along with her own experiences of IPV. This revealed the complexity of the problem of IPV in South Africa.

Data Collection

Face-to-face, video, and telephonic, semi-structured interviews of both social workers and IPV survivors were conducted. The difficulties experienced conducting distanced interviews included technological difficulties such as poor service, ethical difficulties, such as managing confidentiality in a telephonic format, and logistical difficulties, such as getting responses from participants and ensuring they had adequate data and airtime for the interview. Face-to-face interviews came with the increased risk of being exposed to COVID-19, though we took measures to minimise this. The semi-structured interviews were conducted using a list of open-ended questions that were flexibly interpreted and answered by participants (DiCicco-Bloom & Crabtree, 2006). This allowed participants to talk about their experiences in their own ways without being limited by the wording of questions (Magnusson & Marecek, 2015). This ensured that questions posed by *MOSAIC* were answered, whilst also allowing participants to make meaning of their experiences for themselves. All interviews were conducted in English.

Interviews are framed as encounters between researchers and participants that allow for the sharing and co-production of narratives (DeVault & Gross, 2012). While questions were listed in the interview guide for IPV survivors (Appendix A) and social workers (Appendix B), focus was given to the flow of the conversation, so topics were not rigidly set out in a specific order (Magnusson & Marecek, 2015). The focus on conversational flow required that we actively listen to participants, rather than rigidly following the interview guide. This was to ensure that we were not reproducing narratives that suit the academic institution, but kept the interests and experiences of participants at the fore (DeVault & Gross, 2012).

Data Analysis

The Decolonial Intersectional Narrative Analysis (DINA) (Boonzaier, 2019), addresses issues in research that tend to marginalise participants. This analysis requires researchers to

answer for how research may continue to marginalise participants through our representations and allows participants to challenge how they are represented (Boonzaier, 2019). The four stages set out in this approach are flexible, which allowed us to use our own judgements and keep the interests of our participants at the forefront when analysing data (Boonzaier, 2019). The four phases of DINA include: an analysis of narrative content, analysing decolonial, intersectional power, reading against the grain: articulating resistance, and crafting a plurivocal narrative.

An Analysis of Narrative Content

Thematic narrative analysis was used to investigate commonalities in narratives within a single participant and across participants (Riessman, 2008). This involved becoming well-acquainted with the interview transcripts. This stage is focused on the content of participants' stories, thus focusing on what these stories mean to them and paying attention to context (Riessman, 2008). This connects the experiences of participants to the social and structural power dynamics at work, rather than attempting to ignore the way this impacts their lives (Boonzaier, 2019). We each analysed and coded the transcripts separately. After negotiating a shared understanding, narratives were identified together. This phase of analysis was iterative and involved a continuous reframing of narratives.

Analysing Decolonial, Intersectional Power

This phase analyses how stories participants tell are shaped by their identities and how power relates to this (Boonzaier, 2019). We analysed how participants positioned themselves and what participants excluded from their stories, and how context shaped this (Boonzaier, 2019).

Reading Against the Grain: Articulating Resistance

Phase three focuses on how participants resist the way in which they have been positioned, and reject representations that marginalise them (Boonzaier, 2019). We focused on

how participants' narratives communicate resistance in this section. Asking ourselves how stories we were told presented participants to oppose discourses that marginalise them helped us understand how participants resist oppressive conditions (Boonzaier, 2019).

Crafting a Plurivocal Narrative

This last phase of the analysis involves creating a nuanced interpretation that includes our own positionalities and how this has shaped our research (Boonzaier, 2019). We hope we produced a nuanced report that interprets the stories we were told, why we chose to tell those stories, and highlight the context in which we have conducted our research (Boonzaier, 2019).

Ethical Considerations

Our research is part of a larger project which had already obtained ethical approval, to include the current research (Appendix C). However, ethical considerations still needed to be defined to ensure that our research protected the well-being of participants and followed guidelines of good practice (Terre Blanche et al., 2014).

Confidentiality and Anonymity

Confidentiality ensures that information that participants share with us is kept private (Terre Blanche et al., 2014). We conducted face-to-face interviews in a closed room at the *MOSAIC* offices to make sure that there was no risk of being overheard. When distanced interviews were conducted, researchers ensured that we were in private rooms and could not be overheard. However, an ethical concern was that we could not control the participants' environment. This made ensuring participants' privacy difficult and influenced the stories we were told. For example, as one survivor shared her story, we could hear a child in the background and could sense that she did not want to be candid about her experiences of violence. Moreover, tape recordings and transcriptions were kept on password protected computers.

Anonymity protects participants from being identified through our research (Terre Blanche et al., 2014). We protected the anonymity of participants by excluding all identifying information from our report. Transcribers signed a confidentiality agreement (Appendix D), and we analysed the interviews ourselves, to ensure anonymity.

Voluntary and Informed Consent

Research cannot be considered ethical if it did not obtain voluntary and informed consent (Terre Blanche et al., 2014). Participants need to be provided with enough information on the research (in language they can understand) to make an informed decision on whether they want to participate. Consent may be withdrawn at any time during the research with no negative repercussions (Terre Blanche et al., 2014). This was laid out in our consent forms (Appendix E) which were signed before conducting interviews. Social workers were provided with an information sheet to explain the research to participants (Appendix F). However, upon contacting survivors, we realised that many were not fully aware of the scope of our research. Some withdrew when we gave a verbal explanation of the consent form. This gave them the opportunity to make an informed decision to participate.

Risks and Benefits

Given the research explores the sensitive topic of IPV, it can be distressing to participants. A list of resources of support for GBV survivors (Appendix G) and additional counselling sessions with *MOSAIC* were made available to participants.

There is a risk in conducting face-to-face interviews during a pandemic. Strict safety measures were taken to ensure that all involved individuals were protected. After discussing transport options with participants doing face-to-face interviews, they were most comfortable with one researcher transporting them to and from the *MOSAIC* offices. Precautionary strategies

to minimise the risk of COVID-19 at the research venue included the completion of health checks, utilising personal protective gear, sanitising surfaces, maintaining a 1.5-meter distance, and promoting ventilation by opening windows.

Provision of monetary or non-monetary compensation to participants raises ethical concerns regarding its influence on the voluntariness of participants (Erlen et al., 1999). However, given the decolonising and feminist intent guiding the research process, lunch, grocery vouchers and data was provided to participants to not only reduce inconveniences, but recognise the value of their role in our research. Transport costs incurred to or from the research venue were reimbursed to those who drove themselves.

This research allowed participants to create their own narratives, facilitate an understanding of their experiences, and contribute to knowledge on IPV. Additionally, the findings will contribute to potentially improving distanced counselling services for *MOSAIC*.

Reflexivity

Our research includes reflexivity as a core component, and our analytic approach, DINA brings our positionalities into the research (Boonzaier, 2019). Our power in producing the narratives of research participants was made visible, by incorporating reflections of how our positionalities influence our understandings of these narratives in our data analysis (Clarke & Braun, 2019). We are white, upper-middle class women doing research for a tertiary institution, while the demographic of those accessing *MOSAIC*'s support services occupied different intersecting identities to our own. These differing dynamics shaped the stories we were told and how we understood them. For example, though all participants either self-identified as coloured or black, none drew on their race in their narratives, instead connecting with us as women. It is likely there were conversations they were not willing to have with us as white researchers.

In reflecting on what we brought into our research, we hoped to avoid producing stories that further marginalise the groups involved. While we are both women, and have thus experienced marginalisation and patriarchal oppression, we approached this research with the understanding that our experiences are not universal, and that our participants have vastly different understandings of their own experiences of gendered violence.

Analysis and Discussion

This research aimed to explore experiences of IPV during the COVID-19 pandemic, working with both the experiences of women survivors' of IPV as well as with social workers who conducted telephonic counselling services during the pandemic. The interviews conducted in the study were analysed using Decolonial Intersectional Narrative Analysis (DINA) as outlined by Boonzaier (2019). The following research question was addressed: What stories do women tell about their experiences of IPV during the COVID-19 pandemic? Related to this were three sub-questions, namely: What impact has the COVID-19 pandemic and lockdown restrictions had on experiences of IPV?, How did women survivors of IPV experience telephonic counselling services implemented during COVID-19 lockdown restrictions?, and How do social workers stories about IPV during the COVID-19 pandemic coincide with women's narratives about their experiences? As a result, three narratives emerged: *COVID-19 and the pervasiveness of IPV, COVID-19 exacerbated the private nature of IPV,* and *The necessity of women's strength.*

COVID-19 and the pervasiveness of IPV

Survivors' narratives of their experiences of IPV unveiled the ongoing and pervasive experiences of violence against women in South Africa regardless of the pandemic. Across interviews with survivors, each woman disclosed that their abuse began before, and was separate

to, the pandemic. To participants, "the pandemic" meant lockdown restrictions and the conditions that followed, such as quarantining with their abuser, unemployment and breakdown of infrastructure. On majority, the pandemic was not identified as having a direct effect on their intimate relationship or the violence that was experienced. For example:

> *He hit me two times, the first time no it wasn't during the pandemic…we got into an argument, we had a little bit too much to drink and words were said and violence happened. But you know when you crazy in love, or telling yourself you crazy in love then you won't believe that. Anything and everything is your mistake maybe.* [Mieke[4]]

> *But there were always red flags in the beginning but you always thing ag it's nothing. Maybe just having an anger outburst or people will change…So even though I was breadwinner he as the still the manipulator and the controller of the finances in the sense that he would still splurge. I would have to foot the bill. So it didn't really get worse, I think it was just getting progressively worse over time. And it really escalated when he knew I was going to leave. That's when my tyres get slashed. I mean he even tried to get me arrested. All these lies about what I am doing. That's when things escalated with more when he knew I was going to leave. And it is not necessarily related to the pandemic per se.* [Linda]

Mieke and Linda show that their experiences of IPV were unrelated to the pandemic. The narratives describe instances of physical, emotional, and financial abuse. Both survivors refer to "red flags" and violence in their relationships prior to the pandemic. In these narratives, survivors made themselves responsible for the continuation of IPV. Survivors explain that they

[4] Pseudonyms are utilized to protect the participants identities.

distorted their experiences at the time of the violence, either through minimisation (*ag it's nothing*) or rationalisation (*everything is your mistake maybe*) (Cravens et al., 2015). By describing IPV as continuing due to these distortions, survivors draw on dominant victim-blaming narratives, which associate experiences of violence with the actions of the survivor (Boonzaier, 2018). Furthermore, Linda attributes the escalation of abuse to the general progression of her partner's violence and as an outcome following her decision to leave the relationship. Attempts to leave abusive relationships are often associated with increased threats or acts of violence, in an effort by the perpetrator to continue controlling the survivor (Varcoe & Irwin, 2004). The women thus construct the impact of the pandemic and experiences of IPV as separate affairs rather than as an intertwined incidence. The narrative therefore reveals that there are underlying dynamics which have long preceded the pandemic that have given rise to widespread gendered violence in South Africa. While survivors framed IPV as separate to the pandemic, social workers understood this differently.

Social workers experienced an escalation of IPV cases following the national lockdown. Social workers framed the consequences of the lockdown restrictions as the cause for this escalation. The pandemic was therefore described as a trigger for violence.

> *And I think that was the cause of increase in numbers of domestic violence and gender-based violence as well. It was spending a lot of time most hours together. And also some of the partners especially male partners, they lost their jobs as well. So it was frustrating for them being at home and unable to provide for their families as well.* [Sindiswa]

> *The domestic violence has escalated due to the fact that there were people that were hiding who they are or people that were hiding their experiences but then due to the lockdown things revealed itself.* [Thandi]

Thandi and Sindiswa, social workers from *MOSAIC*, identify determinants of violence such as quarantine as a source of frustration and male unemployment as a potential risk of violence. Social workers identified conditions due to the pandemic as triggers for violence, drawing on discourses of risk. However, they also acknowledge the cycle of violence in South Africa that has contributed to IPV. For instance, Thandi recognises that lockdown revealed violence that preceded the pandemic by illuminating hidden experiences of violence. Social workers' narratives of IPV converge with those of survivors in recognising broader social issues that permit violence, but they framed the pandemic as a cause of, rather than separate to, IPV.

Survivors' narratives concur with Segalo and Fine's (2020) assertion that the surge in reports of IPV during the pandemic is not random. The public domain and scholarship present the increase in reports of IPV following lockdown as an outcome of the pandemic which in turn obscures the pervasiveness of the problem (Segalo & Fine, 2020). Research has shown that women had deep histories of IPV that preceded lockdown (Lyons & Brewer, 2021). Possible reasons for the increase in reports of IPV during the pandemic have been proposed by scholars. However, explanations often employ a language of risk factors whereby experiences of IPV are reduced to being outcomes of exposure to a risk. For instance, Kaukinen (2020) identifies economic dependency, male unemployment, and substance use as some of the factors that have led to GBV during the pandemic. A language of risk factors distorts the complexity of IPV, failing to account for "the history, the structural forces [and] the personal dynamics" that permitted gendered violence to manifest (Segalo & Fine, 2020, p. 4; van Niekerk & Boonzaier, 2019). South Africa's history is rooted in violence owing to colonialism, slavery, and apartheid (Gqola, 2007). Violence was socialised into the social fabric of the country and took on gendered forms given the patriarchal structure of society (Gqola, 2007). Consequently, violence against

women in South Africa has long been endemic, and the narratives in this research illustrate this. However, survivors' narratives indicate that the pandemic (and more specifically lockdown) amplified structural inequalities which complicated their experiences of violence.

When talking about the impact of COVID-19 on the experiences of IPV and life in general, women's narratives constructed life prior to the pandemic as 'normal'. Lockdown restrictions affected various aspects of participants' lives. This construction of life as 'normal' before the pandemic and emphasis on exacerbated structural inequalities due to lockdown demonstrates that IPV was further amplified through the breakdown of infrastructure. For instance:

> *Yes, like I said, life is not normal now, it is not normal. Before COVID everything was fine, work was fine, family and surroundings with loved ones… Also now I think because of the pandemic everything has to be postponed sometimes and it is the whole different process of doing things maybe, so everything is so delayed.* [Mieke]

Mieke's narrative highlights the ways in which COVID-19 disrupted her notion of 'normal' in the structures she encountered – work and law. These effects were predominant among survivors' narratives. The economic dislocation following the national lockdown resulted in some survivors experiencing economic insecurity or unemployment. As such, some survivors were financially dependent on their partners. Annika, who had moved out of her home, was persuaded by her partner to return after contracting COVID-19.

> *I can't stay because I could have seen I was going to die because the way I was…and late that evening he said come home I have medicine for you and whatever. So I left there, the morning and I came home.* [Annika]

The extract above illustrates the dependency Annika had on her partner when she was ill during the pandemic. Annika, who disclosed her socio-economic difficulties before the pandemic, explained how this was amplified after lockdown. Although having previously moved out, Annika went back home as her husband was able to provide her with medication which she would not have otherwise been able to access herself. Annika's experience contrasts with that of Linda. Although Linda was the breadwinner in her relationship, her husband exerted financial control. Thus, regardless of their economic status, women were victimised by their partners. Additionally, some survivors expressed their frustrations with the justice system during the pandemic.

> *Your case, your-your court case has been postponed 'til further notice. What is further notice? Now you go home. There's no court because there's COVID...you don't know what to do.* [Sonja]

Sonja explains that COVID-19 impacted court procedures, creating confusion around how to access these structures in such a turbulent time. While the survivors emphasise that their experiences of violence did not escalate during the pandemic, they identify the structural inequalities which made dealing with the consequences of IPV more difficult. The survivors' narratives of IPV reveal the lack of gendered perspectives within infrastructure, permitting violence to permeate all aspects of survivors' lives. Given that survivors occupied intersecting marginalised identities, the pandemic impacted them at these intersections. The narratives of survivors revealed that this disruption of normality was informed by their socio-economic and geopolitical contexts. Given that survivors' experiences of IPV began before the pandemic, their construction of 'normal' thus includes gendered violence. This speaks to the pervasive

entanglement of patriarchy, gender inequality, and violence in informing the everyday experiences of women in South Africa (Gqola, 2007).

Pre-existing structural inequalities were exacerbated by the breakdown of infrastructure created by the pandemic, making it possible for IPV to thrive (Pinheiro & Kiguwa, 2021). Following the outbreak of COVID-19, financial stressors and rates of unemployment increased, resulting in additional dependency of survivors on their violent partners (Lyons & Brewer, 2021). Moreover, the breakdown in law caused by the pandemic compounded an already unavailing justice system in South Africa (John et al., 2020). Consequently, survivors do not receive the support they need, and perpetrators' punishments are postponed or exempted (Mittal & Singh, 2020). The COVID-19 pandemic therefore revealed that there is an absence of gender perspectives in society despite high levels of violence against women (John et al., 2020). Instead, the South African government approached the COVID-19 pandemic through a militaristic lens, calling in the defence force to police lockdown measures (disproportionately in townships) and referring to the "war on COVID-19," constructing the pandemic as an enemy to be defeated (Pinheiro & Kiguwa, 2021, p. 73). This presents responses to the pandemic as requiring sacrifice and having inevitable damage. These presentations ignore that those on the margins were most impacted by responses to COVID-19, masking structural issues at play (Pinheiro & Kiguwa, 2021). As damage and violence were constructed as inevitable, measures to address violence were disregarded (Pinheiro & Kiguwa, 2021). Therefore, this failure to address the ongoing violence against women during the pandemic illustrates how experiences of IPV during COVID-19 are informed by the structural issues and colonial militaristic discourses present in South Africa.

While the narratives illustrated that violence against women preceded the pandemic, the exacerbation of structural inequalities during the pandemic amplified experiences of structural violence. The private lives of people were also made visible because of lockdown, and survivors experienced further isolation as they were cut off from support networks.

COVID-19 exacerbated the private nature of IPV

Survivors shared that the breakdown of social cohesion and fear of contracting COVID-19 during the pandemic made reaching out to people more difficult. In addition, survivors also constructed the violence they experienced as private, making them unwilling or unable to talk about IPV. The combined social barriers of lockdown and the private nature of IPV interacted to create a narrative in which survivors expressed that they felt alone. For instance:

> *And now it is like you can't go out, can't go anywhere, don't know who to talk with. I think the world is really crazy because you hear your own feelings, your own troubles and stuff and how you go on telling this one and that one and then people just go behind your back and you know.* [Mieke]

Mieke explains that the pandemic made accessing social support networks challenging. Furthermore, Mieke alludes to feeling like she cannot trust people. The pandemic therefore eroded social trust and support networks, creating a sense of isolation. Perpetrators often employ strategies to isolate survivors from social support networks to exert control (Lyons & Brewer, 2021). Hence, measures to mitigate the spread of the virus helped foster environments in which perpetrators can exercise abuse as quarantine increased survivors' contact with violent partners while social support networks deteriorated (Lyons & Brewer, 2021). The isolation that resulted from the lockdown exacerbated the already private experience of IPV. IPV as a private, lonely experience is framed by Sonja and Mieke:

> *You know people, it's like, in that zone of, "It's none of your business. It's my business." And then you get some of that who will say, "Wat weet jy? Jy weet niks." And then you get those victims of a silent killer. That silent killer is someone that you... is in a abuse, relationship or in a abuse marriage. But you didn't see the marks of abuse.* [Sonja]

> *I am all alone, I don't go to anybody. I don't have nobody to talk to, anybody that understands me. I have to fight my own battle, nobody knows nothing.* [Mieke]

Sonja discusses how IPV is understood as an issue to be dealt with privately. She highlights how people create a separation between what is private and what is acceptable for the public domain. She frames this privacy as dangerous, by calling it a "silent killer," something so internalised that signs of it are not visible to people outside the private sphere. *Jy weet niks*, [You know nothing] indicates the isolation felt because of IPV. Additionally, Mieke emphasises that she is alone, and cannot talk to anyone about her experiences of IPV during the pandemic, indicating the loneliness and isolation that results from the private nature of IPV. Thus, the interaction between IPV and the consequences of the pandemic meant that IPV during the pandemic became a lonelier experience than it already was.

Understandings of IPV as an issue that should be kept behind closed doors is circulated within the public realm (Boonzaier, 2018). Generally, public services such as police, healthcare workers, and the legal system are reluctant to handle matters of IPV. It is often understood as inappropriate to intervene, as it is deemed a domestic problem to be resolved within the home (Fleischack et al., 2020). "The home," particularly for marginalised people, is a space where the consequences of structural violence become enmeshed with personal issues. In turn, women bear the brunt of issues materialising in the home. Thus, the isolation of IPV centres around this issue of silence regarding the home, and is exacerbated by the COVID-19 pandemic (Segalo & Fine,

2020). This isolation is reflected in the narratives of loneliness among survivors. In addition to framing IPV as a private issue made lonelier by the pandemic, survivors' narratives drew on another notion of privacy. This notion of privacy referred to the maintenance of confidentiality in counselling.

Survivors mentioned the value of counselling, both face-to-face and telephonic, in being a space where they could discuss their experiences of IPV in a private manner. Confiding in a counsellor was framed as different to doing so with friends and family. The main difference was that counselling maintains confidentiality and thus their identities as survivors are not disclosed to their communities. Attempts to conceal one's identity as a survivor revealed that there is stigma surrounding IPV. While counselling as a private space was a source of empowerment for survivors, it too maintained silence around IPV. Sonja explains,

> *And when I feel, I feel a little bit down today I know who to call, I know who to talk to because when we talk, we talk in private, nothing is leaking out, nothing is running out. If it's running out, it's running out by yourself. But not by your counselling… So you will be surprised at the end of the day, you were sitting down, but it two three months you will be stand up on your feet like me.* [Sonja]

Counselling is an important resource to Sonja, specifically because she knows that her experiences will not become public. Additionally, she highlights the positive impact of sharing her experiences in a space she feels safe in. The tendency to retain stories of IPV within the private sphere indicate that survivors attempt to circumvent the stigma associated with IPV. Survivors may internalise and anticipate stigma about IPV (Murray et al., 2015). Survivors who internalise stigma embody negative beliefs about IPV resulting in self-blame, shame or low self-esteem and hence choose not to disclose their experiences to community members (Murray et al.,

2015). Survivors who anticipate stigma fear the negative outcomes such as judgment and blaming from friends or family if their experiences were to become known (Murray et al., 2015). By contrast, the sense of safety associated with counselling facilitates improved well-being (Ogbe et al., 2020). As a result, counselling was framed as a safe, private space in which survivors could resist isolation without stigma from the public sphere and feel empowered. Survivors thus talk back to the silencing of their narratives in the public domain by sharing their experiences with counsellors. Moreover, the notion of separation between the counsellor and the public was extended to us as researchers and informed the stories we were told. For example:

> *Like you guys it is different. I went to go speak to [counsellor], MOSAIC, it's all in a file. It is there, she won't go speak out it is there. The same with you guys. So for me to speak to you guys it is nothing. But to people outside I don't speak to them anymore.* [Annika]

In the above extract, Annika draws parallels between the counsellor and researchers. She differentiates the act of sharing her experiences of IPV between us (private) and members of her community (public). Survivors felt that they could share their experiences with us, because we, like the social workers, would not divulge this information to members of their community. The participation of survivors in the study was therefore also a form of resisting isolation and silence of IPV in way that circumvented stigma and would inform knowledge production on IPV. While confidentiality was an important feature of counselling for the survivors, social workers highlighted challenges with confidentiality when adjusting to providing telephonic counselling.

Social workers who facilitated telephonic counselling during the COVID-19 pandemic voiced the challenges they faced in relation to confidentiality. Creating and maintaining a confidential space while adjusting to working remotely following lockdown was described as

difficult. Social workers attempted to separate their work from family life to ensure confidentiality. For example:

> *So I needed a place where I could keep my files for confidentiality sake. So I needed to create a space inside the home, in one bedroom where I can do my work… Just split it, it is at home, but I need to split it. So it was a bit difficult and tough in the beginning.* [Rosalie]

> *For confidentiality like I said that I was, I would first attend to the children and then I would be in my own room alone. So that is how I was ensuring that confidentiality was there.* [Sindiswa]

Rosalie and Sindiswa recall their procedures for facilitating telephonic counselling in ways that maintained confidentiality when working from home. The narratives illustrate that the social workers created separate spaces within their homes to carry out different functions. The challenges social workers encountered with separating these spaces often involved the responsibilities placed on them as mothers and women. The social workers had to attend to their families and were expected to maintain the home. Therefore, in addition to having to adjust to telephonic counselling and working remotely, the social workers engaged in unpaid care work which had increased as a result of the lockdown (Casale & Posel, 2021). Women are often positioned as natural caregivers due to problematic constructions of gender roles and thus bear the brunt of care work (Casale & Posel, 2021). The separation between work and home was important so that activities and duties in home would not infiltrate and disrupt the sense of privacy that survivors relied on. Social workers, and the spaces they occupied, therefore played a role in assisting survivors resist silence around IPV and feelings of isolation which had been

compounded due to its interaction with the consequences of COVID-19. Although IPV was constructed as a lonely experience, survivors shared narratives of resilience.

The necessity of women's strength

Narratives of strength came through in the survivors' stories and this was explicitly tied to womanhood. Participants spoke about how they *must* be strong and how they *had* to find strength. Strength was not framed as an inherent trait of womanhood, but as something that all women inevitably learnt through their experiences in the world. This strength was honed through anger. Mieke states,

> *Yes, women like I said we are strong women, we do everything, we must do everything. We must also be strong for the children, for ourselves, but it is like we are angry now.* [Mieke]

Mieke's identity as a woman and a mother are drawn on in telling stories about strength. The world is framed as a hostile place for women, in which they have no choice but to endure. This illustrates an implicit understanding of the societal conditions that make women need to be strong, and how these conditions are making her angry. Additionally, she emphasises that *we* are strong women, including the researchers in her narrative. While issues of class and geopolitical location were drawn on in informing participants' narratives, race was notably absent. Although race was not included in their narratives, survivors emphasised gender to create a common experience between survivors and researchers. Sonya's explanation on why it was important to talk to a woman about her experiences may shed light on this.

> *So I go to court, I, I make a statement I explained everything. They have a social worker but it is a man… I don't feel comfortable to talk with a man. Yes, with a woman, yes I feel*

comfortable, because we know her, you understand what I'm going through. But a man? He don't understand what a woman's going through. [Sonja]

Sonya illustrates that only someone that shared in her womanhood would understand her experiences. Women encountering structures meant to help them, such as the court system, the police, and healthcare are often dismissed and discouraged from reporting their experiences (Fleischack et al., 2020; Rasool, 2016; Varcoe & Irwin, 2004). Thus, Sonya illustrates that she wants to talk to someone that will not be dismissive because they understand what she is going through. For her, this is someone that shares her identity. This may have been true for the participants' racialised experiences. These stories may be something that we do not get to hear. This inclusion of the researchers in narratives of womanhood but absence of stories about race may be a way for survivors to resist the potential of being further dismissed by two white researchers that do not understand their racialised experiences. As white researchers from an academic institution, we have power to frame the narratives of survivors, and by not talking about race, participants remove our power to frame their narratives of race. Instead, our common identity of womanhood is drawn on to help us understand survivors' experiences. Furthermore, motherhood was a predominant feature of womanhood in survivors' narratives.

Mieke talks about having to be *strong for the children*. Survivors spoke to the duty they felt as mothers to act in their children's best interests. This idea of "good" motherhood and sacrifice for the sake of their children comes through in all the women's narratives. Annika talks about her fear of infecting her children with COVID-19 and makes sure that we know she is doing everything she can to protect them from this,

You can have the virus, you go back you give it to your kids, you don't know if you had it. That is made me stay away for a long time. And if I go back I sanitise my hands, I take off

> *my clothes and I go bath and put clean clothes, wash my clothes. That is how I protected my kids…* [Annika]

Annika feels anxiety at the thought of putting her children at risk. She highlights the lengths she went to in ensuring that she did not bring COVID-19 into the house. These stories frame motherhood as strong, but also ties notions of duty to this strength. Mothers had to be strong because they have a duty to their children (Varcoe & Irwin, 2004). These narratives illuminate the construction of mothers in society as protectors of the child's safety and as responsible for taking care of children (Rasool, 2016). Concern for their children frames all the decisions the survivors made. Sonja, on learning that her husband had been sexually abusing her daughter, explained how she felt,

> *I don't know. I don't know what was in my mind of not thinking 'phone the police.' That whole weekend in my mind was: kill him. Kill him.* [Sonja]

Sonja describes her fury after finding out that her daughter was being harmed. This was a turning point in her relationship. Survivors all spoke about acting for their children, rather than for themselves. They sacrificed their comfort and safety until they realised their children were being affected, after which they took action by either reporting to the police, going through the court system, or leaving the environment of abuse. Much research has illustrated that the deciding factor in decisions women make about leaving or staying in a relationship is what they consider the best interests of their children (Cravens et al., 2015; Rasool, 2016; Varcoe & Irwin, 2004). Sacrifice is a central element to both motherhood and womanhood, and these narratives illuminate this (Rasool, 2016). Women endure ill treatment from partners for the sake of their children. However, ideas about motherhood as protective override this as soon as children come to harm (Rasool, 2016). This resilience is therefore framed in accordance with dominant

narratives of motherhood and womanhood as sacrificing and responsible for caring for children. However, the nuances and limitations to this resilience was also illuminated through survivors' negotiations of their representations.

Women resisted representations of themselves as victims. The women that had experienced IPV emphasised that they saw themselves as survivors rather than victims, and spoke about their agency in the violent situations they found themselves in. Linda says,

> *…you are not a victim, you weren't the abuser. It is not your fault that were abused. People were looking at me like oh you spoilt him. No I didn't, I gave him what he wanted because I knew I wouldn't have to be challenged with an argument.* [Linda]

Linda resists narratives of victimhood, by claiming her agency in her decision to appease her partner to protect herself. However, she resists the victim-blaming narratives that can come with this focus on agency, by affirming that the abuse was not her fault. In doing so, she illustrates that there is not a strict binary between ideas of victimhood and agency when it comes to IPV.

Discourses on individuals that experience IPV frame women as helpless victims, unable to negotiate their situation (Leisenring, 2006). Victim discourses minimise the agency that women occupy in protecting themselves and children when in abusive relationships. Conversely, discourses centred exclusively around agency tend towards victim-blaming, by asking why women do not leave abusive relationships (Leisenring, 2006). However, the strict binary of discourse around either victimisation or agency ignores larger contextual issues, by not considering the full scope of women's experiences (Dunn, 2005). Therefore, the strength of women was framed as a necessary characteristic of all women in South Africa, particularly in their ideas of motherhood as self-sacrificing. However, survivors also illuminated the complex

negotiations of their identities and the limitations of viewing survivors as strictly either victims or actors with agency.

Summary and Conclusion

This research on experiences of IPV during the COVID-19 pandemic illustrates that women told stories of deep histories of IPV and of pre-existing conditions which were exacerbated by lockdown and made experiences of dealing with IPV more difficult. A Decolonial Intersectional Narrative Analysis of the stories told by IPV survivors and social workers facilitating telephonic counselling aligned with literature on the subject and offered novel understandings on IPV, particularly relating to the COVID-19 pandemic. Three narratives emerged in the stories that were told about experiences of IPV during the COVID-19 pandemic: *COVID-19 and the pervasiveness of IPV*, *COVID-19 exacerbated the private nature of IPV*, and *The necessity of women's strength*.

The first narrative, *COVID-19 and the pervasiveness of IPV*, revealed that IPV and gendered violence is entrenched in South Africa. Survivors' narratives of their experiences of IPV were constructed as incidences that preceded and were separate to the pandemic. This narrative spoke to the ways in which pre-existing structural issues were exacerbated, indirectly impacting experiences of IPV through highlighting inequalities in systems that handle IPV. It illustrated how responses to the pandemic were informed by colonial ideas of militarism, and thus lacked gendered perspectives. Unlike much scholarship on IPV during the pandemic, this research moves beyond the language of risk and serves to be critical about how gendered violence has been perpetuated.

The second narrative, *COVID-19 exacerbated the private nature of IPV*, found that the isolation during lockdown exacerbated the pre-existing problem of the silencing and stigma of

IPV given that it is framed as a private issue. Survivors resisted this isolation and stigma by engaging with counselling services, which allowed them to tell their stories in a private space. This maintained the silence around IPV within their communities. However, social workers noted the challenges they faced in maintaining confidentiality during the pandemic, demonstrating that the pandemic disrupted and illuminated previously private issues. This research illustrates the necessity for distanced counselling practices to make managing confidentiality and addressing stigma a priority.

The last narrative, *the necessity of women's strength*, highlighted that survivors felt that they needed to demonstrate strength to navigate the current world. Their motherhood informed all their decisions, in attending to what they considered best for their children. Motherhood and womanhood were understood to be self-sacrificing and protective, reinforcing dominant narratives of the duty of mothers. The limitations of these discourses were recognised in survivors unpacking their understandings of themselves as victims/survivors. This study adds a new facet to research on IPV during the pandemic as it recognises the role of motherhood in these experiences.

This research was limited in several ways. Although participants agreed to be interviewed in English, in many cases, this was not their home language. As a result, meaning could have been lost in participants' attempts to communicate their stories. In addition, because our research focused on the rich and nuanced stories of a small sample of participants, narratives do not reflect the experiences of all IPV survivors and social workers. The current research was thus limited by the scale of the study and the time constraints experienced. Although survivors differentiated their experiences of IPV from the consequences of the pandemic, social workers

and research note that IPV has been initiated due to and escalated following the pandemic (John et al., 2020). However, this study illuminated significant areas of further research.

Future research should focus on the role structural inequalities play in informing experiences of IPV during the COVID-19 pandemic. However, such research should steer clear of the language of risk and constructing IPV as a problem of the marginalised. Instead, focus should be on how colonial ideologies have shaped both responses to the pandemic and pre-existing structures in South Africa. Future research should also include more participants and make interviews available in more languages to address the limitations of this work. In addition to broadening understandings of experiences of IPV and support services, research should aim to examine the ways in which change can be made in these areas.

This research aimed to understand the experiences of IPV during the COVID-19 pandemic in South Africa, working with survivors of IPV and social workers facilitating telephonic counselling. This was to address the gap in literature around the impacts of COVID-19 on IPV, as the continuously unfolding pandemic has revealed the extent of gendered violence in South Africa. This research enabled participants to share their stories of IPV, contributed to knowledge production on IPV during a pandemic in South Africa, and informed the potential areas of development for distanced counselling services.

References

Boonzaier, F. (2018). The stories we tell: Gender-based violence in South Africa. *SA Labour Bulletin*, 42(2), 56-59.

Boonzaier, F. (2019). Researching Sex Work: Doing Decolonial, Intersectional Narrative Analysis. *The Emerald Handbook of Narrative Criminology. Bingley, UK: Emerald*. https://doi.org/10.1108/978-1-78769-005-920191037

Boonzaier, F., Kessi, S., & Ravn, A. (2019). Editorial: Psychology and society in dialogue with decolonial feminisms: Perspectives from the global South. *Psychology in Society, 58*, 1-3. https://www.pins.org.za/pins/pins58/editorial-boonzaier-kessi-ravn.pdf

Boonzaier, F., & van Niekerk, T. (2019). Introducing decolonial feminist community psychology. In *Decolonial feminist community psychology* (pp. 1-10). Springer.

Boonzaier, F. A., & Van Schalkwyk, S. (2011). Narrative possibilities: Poor women of color and the complexities of intimate partner violence. *Violence against women*, *17*(2), 267-286. https://doi.org/10.1177%2F1077801210397796

Campbell, A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. *Forensic Science International: Reports, 2*, 1-3. https://doi.org/10.1016/j.fsir.2020.100089

Carol, B. (2014). The Plight of Women and Children: Advancing South Africa's Least Privileged. *The Annals of the American Academy of Political and Social Science*, *652*(1), 106-126. https://doi.org/10.1177/0002716213512086

Casale, D., & Posel, D. (2021). Gender inequality and the COVID-19 crisis: Evidence from a large national survey during South Africa's lockdown. *Research in Social Stratification and Mobility*, *71*, 1-5. https://doi.org/10.1016/j.rssm.2020.100569

Chibba, M., & Luiz, J. M. (2011). Poverty, inequality and unemployment in South Africa: Context, issues and the way forward. *Economic Papers: A Journal of Applied Economics and policy*, *30*(3), 307-315. https://doi.org/10.1111/j.1759-3441.2011.00129.x

Clarke, V., & Braun, V. (2019). Feminist qualitative methods and methodologies in psychology: A review and reflection. *Psychology of Women and Equalities Section Review*, *2*(1), 13-28. https://uwe-repository.worktribe.com/output/854611

Cravens, J. D., Whiting, J. B., & Aamar, R. O. (2015). Why I stayed/left: An analysis of voices of intimate partner violence on social media. *Contemporary Family Therapy*, *37*(4), 372-385. https://psycnet.apa.org/doi/10.1007/s10591-015-9360-8

Crenshaw, K. (1993). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241-1245. https://doi.org/10.2307/1229039

DeVault, M. L., & Gross, G. (2012). Feminist Qualitative Interviewing: Experience, Talk, and Knowledge. In S. N. Hesse-Biber (Ed.), *Handbook of Feminist Research: Theory and Praxis* (2 ed., pp. 206). SAGE Publications, Inc. https://doi.org/10.4135/9781483384740.n11

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314-321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Dunn, J. L. (2005). Victims" and "survivors": Emerging vocabularies of motive for "battered women who stay. *Sociological Inquiry*, *75*(1), 1-30. https://psycnet.apa.org/doi/10.1111/j.1475-682X.2005.00110.x

Erlen, J. A., Sauder, R. J., & Mellors, M. P. (1999). Incentives in research: Ethical issues. *Orthopaedic Nursing*, *18*(2), 84. https://doi.org/10.1097/00006416-199903000-00012

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4. doi: 10.11648/j.ajtas.20160501.11

Fleischack, A., Macleod, C., & Böhmke, W. (2020). The Conundrums of Counselling Women in Violent Intimate Partner Relationships in South Africa: Implications for Practice. *International Journal for the Advancement of Counselling*, *42*(1), 65-80. https://doi.org/10.1007/s10447-019-09384-8

Fraser, H. (2004). Doing narrative research: Analysing personal stories line by line. *Qualitative Social Work*, *3*(2), 179-201. https://doi.org/10.1177/1473325004043383

Gqola, P. D. (2007). How the 'cult of femininity'and violent masculinities support endemic gender based violence in contemporary South Africa. *African Identities*, *5*(1), 111-124. https://doi.org/10.1080/14725840701253894

Jain, R., Budlender, J., Zizzamia, R., & Bassier, I. (2020). The labor market and poverty impacts of covid-19 in South Africa. http://hdl.handle.net/11090/980

John, N., Casey, S. E., Carino, G., & McGovern, T. (2020). Lessons Never Learned: Crisis and gender-based violence. *Developing World Bioethics*, *20*(2), 65-68. https://doi.org/10.1111/dewb.12261

Kaukinen, C. (2020). When stay-at-home orders leave victims unsafe at home: Exploring the risk and consequences of intimate partner violence during the COVID-19

pandemic. *American Journal of Criminal Justice, 45*, 668-679. https://doi.org/10.1007/s12103-020-09533-5

Kessi, S., & Boonzaier, F. (2018). Centre/ing decolonial feminist psychology in Africa. *South African Journal of Psychology, 48*(3), 299-309. https://doi.org/10.1177/0081246318784507

Koepsell, J. K., Kernic, M. A., & Holt, V. L. (2006). Factors that influence battered women to leave their abusive relationships. *Violence and Victims, 21*(2), 131-147. doi: 10.1891/vivi.21.2.131

Leddy, A. M., Lippman, S. A., Neilands, T. B., Twine, R., Ahern, J., Gómez-Olivé, F. X., DeLong, S. M., MacPhail, C., Kahn, K., & Pettifor, A. E. (2019). Community collective efficacy is associated with reduced physical intimate partner violence (IPV) incidence in the rural province of Mpumalanga, South Africa: Findings from HPTN 068. *Journal of Epidemiology and Community Health (1979), 73*(2), 176-181. https://doi.org/10.1136/jech-2018-211357

Leisenring, A. (2006). Confronting "victim" discourses: The identity work of battered women. *Symbolic Interaction, 29*(3), 307-330. https://doi.org/10.1525/si.2006.29.3.307

Lima, V. (2020). The Role of Local Government in the Prevention of Violence against Women and Girls during the COVID-19 Pandemic. *Bulletin of Latin American Research, 39*, 84-87. https://doi.org/10.1111/blar.13191

Lyons, M., & Brewer, G. (2021). Experiences of intimate partner violence during lockdown and the COVID-19 pandemic. *Journal of Family Violence*, 1-9. https://doi.org/10.1007/s10896-021-00260-x

Magnusson, E., & Marecek, J. (2015). *Doing Interview-Based Qualitative Research: A Learner's Guide*. Cambridge University Press. https://doi.org/10.1017/CBO9781107449893

Mathews, S., Govender, R., Lamb, G., Boonzaier, F., Dawes, A., Ward, C., Duma, S., Baraecke, L., Warton, G., & Artz, L. (2016). *Towards a more comprehensive understanding of the direct and indirect determinants of violence against women and children in South Africa with a view to enhancing violence prevention.* Cape Town: Safety and Violence Initiative, University of Cape Town.

Mittal, S., & Singh, T. (2020). Gender-Based Violence During COVID-19 Pandemic: A Mini-Review. *Frontiers in Global Women's Health, 1,* 1-7. https://doi.org/10.3389/fgwh.2020.00004

Morse, D. S., Lafleur, R., Fogarty, C. T., Mittal, M., & Cerulli, C. (2012). "They told me to leave": How health care providers address intimate partner violence. *The Journal of the American Board of Family Medicine, 25*(3), 333-342. https://doi.org/10.3122/jabfm.2012.03.110193

Mosavel, M., Ahmed, R., & Simon, C. (2012). Perceptions of gender-based violence among South African youth: Implications for health promotion interventions. *Health Promotion International, 27*(3), 323-330. https://doi.org/10.1093/heapro/dar041

Murray, C. E., Crowe, A., & Brinkley, J. (2015). The stigma surrounding intimate partner violence: A cluster analysis study. *Partner Abuse, 6*(3), 320-336. http://dx.doi.org/10.1891/1946-6560.6.3.320

Ogbe, E., Harmon, S., van den Bergh, R., & Degomme, O. (2020). A systematic review of intimate partner violence interventions focused on improving social support and/ mental

health outcomes of survivors. *PloS One*, *15*(6), 1-27. https://doi.org/10.1371/journal.pone.0235177

Parry, B. R., & Gordon, E. (2020). The shadow pandemic: Inequitable gendered impacts of COVID-19 in South Africa. *Gender, Work, and Organization*, *28,* 795-806. https://doi.org/10.1111/gwao.12565

Phaswana-Mafuya, N., Peltzer, K., Mlambo, G., Mkhonto, S., & Tabane, C. (2012). Victim Empowerment Programme in a selected municipality of the Eastern Cape, South Africa: Service provider perceptions. *Journal of Psychology in Africa*, *22*(3), 447-450. https://doi.org/10.1080/14330237.2012.10820553

Pinheiro, G., & Kiguwa, P. (2021). *Gender and Germs: Unmasking War Frames in South Africa's Militarised Response to COVID-19.* CSA&G Press. https://www.csagup.org/download/gender-and-germs-unmasking-war-frames-in-south-africas-militarised-response-to-covid-19/

Rasool, S. (2016). Help-Seeking After Domestic Violence: The Critical Role of Children. *Journal of Interpersonal Violence*, *31*(9), 1661-1686. https://doi.org/10.1177/0886260515569057

Rees, K., Zweigenthal, V., & Joyner, K. (2014). Implementing intimate partner violence care in a rural sub-district of South Africa: A qualitative evaluation. *Global Health Action, 7*(1), 1-12. https://doi.org/10.3402/gha.v7.24588

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications.

Segalo, P., & Fine, M. (2020). Under lying conditions of gender-based violence—Decolonial feminism meets epistemic ignorance: Critical transnational conversations. *Social and Personality Psychology Compass, 14*(10), 1-10. https://doi.org/10.1111/spc3.12568

Terre Blanche, M. J., Durrheim, K., & Painter, D. (2014). *Research in practice: Applied methods for the social sciences*. Juta.

van Niekerk, T. J., & Boonzaier, F. A. (2019). An intersectional analysis of responses to intimate partner violence in two marginalised South African communities. *International Journal of Child, Youth and Family Studies*, *10*(1), 26-48. https://doi.org/10.18357/ijcyfs101201918805

Varcoe, C., & Irwin, L. G. (2004). "If I Killed You, I'd Get the Kids": Women's Survival and Protection Work with Child Custody and Access in the Context of Woman Abuse. *Qualitative Sociology*, *27*(1), 77-99. https://doi.org/10.1023/B:QUAS.0000015545.82803.90

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-hill education (UK).

Woolard, I. (2002). *An overview of poverty and inequality in South Africa*. (Unpublished briefing paper). HSRC, Pretoria. https://sarpn.org/documents/e0000006/Poverty_Inequality_SA.pdf

Appendix A

Interview Schedule for IPV survivors

1) I'd like to know a bit about how you came to be at *MOSAIC*.
2) Can you tell me a bit about your experiences with intimate partner violence?
    - Can you describe your relationship with your partner?
    - Tell me about types of violence that you have experienced?
3) Can you tell me a story about how the pandemic has affected your life, from the start of lockdown until now?
    - Tell me a bit about your relationship with your partner during this pandemic.
    - What have your experiences with your partner been like during the pandemic when compared to experiences before the pandemic?
    - Can you tell me how you have found support during the pandemic?
4) What has telephonic counselling been like for you?
    - I'd like to know if you had any difficulties with telephonic counselling.
5) I'd like to know what you expected from telephonic counselling with *MOSAIC*.
    - How did the telephonic counselling measure up to your expectations?
    - What do you think can be changed?

Appendix B

Interview Schedule for Social Workers

1) Can you tell me a bit about what working for *MOSAIC* has been like during this pandemic?
2) How have you adjusted to telephonic counselling during this pandemic?
    - What were your experiences with counselling before the pandemic?
3) What do think about telephonic counselling now that you have experienced it?
4) What difficulties did you experience in providing telephonic counselling?
5) What do you think counselling should look like during the pandemic?
6) How have your experiences with telephonic counselling informed this?

Appendix C

Ethical Approval Letter

UNIVERSITY OF CAPE TOWN

Department of Psychology

University of Cape Town Rondebosch 7701 South Africa
Telephone (021) 650 3417 Fax No. (021) 650 4104

25 July 2019

Prof. F. Boonzaier and Dr T. van Niekerk
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Prof. Boonzaier and Dr van Niekerk

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, Unsettling knowledge production on gendered and sexual violence in South Africa. The reference number is PSY2019-045.

I wish you all the best for your study.
Yours sincerely,

Lauren Wild (PhD)
Associate Professor
Chair: Ethics Review Committee

Appendix D

Confidentiality Agreement for Transcribers

UNIVERSITY OF CAPE TOWN

Department of Psychology

Confidentiality agreement between: Transcriber and Client

1. This document serves as an agreement between the following parties:

a) Companies/entities delivering transcription services for the client

b) The client who is a member of the research team on the project, entitled: *Unsettling Knowledge Production on Gendered and Sexual Violence in South Africa*

2. As the focus of the aforementioned project is of a sensitive nature, researchers involved in the project need to ensure that all transcribers engaging with the data (such as audio files) for the project practice confidentiality. This means that all information, including any personal identifiers mentioned in the data, are kept secret to ensure the privacy of those individuals.

3. To be completed and signed by the person providing transcription services:

I,_____(insert name), as an individual providing transcription services on behalf of _____ (insert company name OR 'private' if providing services in individual capacity), swear to comply with practicing confidentiality when engaging with any data concerned with the aforementioned project.

_____ _____

Signature of Transcriber **Date**

Appendix E

Informed Consent Form

UNIVERSITY OF CAPE TOWN

Department of Psychology

Exploring Narratives of Intimate Partner Violence and Telephonic Counselling during the COVID-19 Pandemic

1. Invitation and purpose

You are invited to take part in a research study about intimate partner violence and accessing telephonic counselling services during the COVID-19 pandemic. This research is conducted by researchers from the Department of Psychology at the University of Cape Town and is in partnership with *MOSAIC*. The study aims to explore experiences of intimate partner violence during the COVID-19 pandemic. More specifically, we would like to hear about your experience with telephonic counselling. Your experiences of telephonic counselling will be used to review *MOSAIC*'s services and help improve distanced services.

2. Procedures

If you decide to take part in this study, we will ask you to do a face-to-face or telephonic interview with us. The interview will focus on your stories about intimate partner violence during the COVID-19 pandemic and experiences with the telephonic counselling and should take no longer than 90 minutes.

3. Inconveniences

If at any point of the interview you feel anxious or distressed, you can choose to stop at any point without any negative consequences. The interviews will be conducted at the offices of *MOSAIC*, in Wynberg, and transport can be arranged for you. The most convenient time for you and the researcher will be arranged.

4. Benefits

You are given an opportunity to share your views and experiences and your information will contribute to the larger purpose of understanding intimate partner violence and support services provided during the pandemic. Specifically, the results will help *MOSAIC* improve their telephonic counselling services based on your feedback.

5. Privacy and confidentiality

With your permission, the interviews will be tape-recorded. The researchers will take strict precautions to safeguard your personal information throughout the study. Your information will be kept in a locked file cabinet without your name and other personal identifiers. Once the study is complete, your tape-recorded information will be stored for a further 5 years and after this period it will be destroyed. While this research will be used for educational purposes, there is a chance that this work might be published in an academic journal. In this case, your identity will still be kept confidential. Interviews will be conducted in a private room to ensure confidentiality. COVID-19 safety measures will be strictly adhered to in order to ensure that everyone involved is protected.

6. Money matters

You will be reimbursed for any transportation costs incurred to and from the research venue, and if necessary, transport will be organised for you to and from *MOSAIC* offices. You will also receive a grocery voucher and data for participating.

7. Contact details

If you have questions, concerns or complaints about the study, please contact the **Researchers:** Erin Hines on 082 044 5390 or email at HNSERI002@myuct.ac.za OR Lara Jager on 079 347 9055 or email at JGRLAR001@myuct.ac.za **OR our Research Supervisors:** Floretta Boonzaier on 021 650 3429 or email at Floretta.Boonzaier@uct.ac.za OR Skye Chirape on 063 193 7719 or email at CHRSKY001@myuct.ac.za **OR Contact for the Ethics Committee:** Rosalind Adams on 021 650 3417 or email at Rosalind.Adams@uct.ac.za

8. Signatures

The participant has been informed of the nature and purpose of the procedures described above including any risks involved in performance. He/she has been given time to ask any questions and these questions have been answered to the best of the researcher's ability.

_____ _____

Researcher's Signature Date

I (participant) have been informed about this research study and understand its purpose, possible benefits, risks, and inconveniences. I agree to take part in this research as a participant. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty.

_____ _____

Participant's Signature Date

PERMISSION TO TAPE-RECORD

I consent to the interview being audio-recorded. I understand that the interview will be tape-recorded and that the researcher will take strict precautions to safeguard my personal information throughout the study.

_____

Participant's Signature

Appendix F

Information Brief

UNIVERSITY OF CAPE TOWN

Department of Psychology

Exploring Experiences of Intimate Partner Violence During a Pandemic

You are invited to take part in a research study about intimate partner violence and accessing telephonic counselling during the COVID-19 pandemic. This research is conducted by researchers from the Department of Psychology at the University of Cape Town and is in partnership with *MOSAIC*. The study aims to explore experiences of intimate partner violence during the COVID-19 pandemic. More specifically, we would like to hear about your experience with telephonic counselling. Your experiences of telephonic counselling will be used to review *MOSAIC*'s services and help improve distanced services.

If you decide to take part in this study, we will ask you to do a face-to-face interview with us. The interview should take no longer than 90 minutes and COVID-19 safety protocols will be adhered to. The interview will focus on your stories about intimate partner violence during the COVID-19 pandemic and experiences with the telephonic counselling.

Interviews will take place at the offices of *MOSAIC* in Wynberg. The most convenient time for you and the researchers will be arranged. You will be reimbursed for any transportation costs to and from *MOSAIC*, or if necessary, transport will be organised for you. You will also receive lunch and a small grocery voucher for participating.

If you have any questions, concerns, or complaints about the study, please contact:

Researchers: Erin Hines on 082 044 5390 or email at HNSERI002@myuct.ac.za OR
Lara Jager on 079 347 9055 or email at JGRLAR001@myuct.ac.za

Supervisors: Floretta Boonzaier on 021 650 3429 or email at floretta.boonzaier@uct.ac.za OR
Skye Chirape at email at CHRSKY001@myuct.ac.za

Ethics Committee: Rosalind Adams on 021 650 3417 or email at Rosalind.Adams@uct.ac.za

Appendix G

Resource List

ORGANISATIONS DEALING WITH GENDERED AND SEXUAL VIOLENCE

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1. The National Institute for Crime Prevention and Reintegration of Offenders (NICRO):

Mitchell's Plain: 021-397 3782

Cape Town: 021-422 1690

Bellville: 021-944 3980 or visit their website on: www.nicro.org.za

2. Family and Marriage Society of South Africa (FAMSA):

Observatory: 021 447 7951 or visit their website on: www.famsa.org.za

3. Mosaic Training, Service and Healing Centre for Women:

Wynberg: 021 761 7585 or visit their website on: www.mosaic.org.za

4. Saartjie Baartman Centre for Women and Children:

Manenberg: 27 21 633 5287

or visit their website on: http://www.saartjiebaartmancentre.org.za/

5. Rape Crisis

Observatory (Head office)

23 Trill Road, Observatory, 7925, Cape Town

P O Box 46 Observatory 7935

Email: communications@rapecrisis.org.za

Complaints: complaints@rapecrisis.org.za

Telephone: 021 447 1467

Athlone

335a Klipfontein Road, Athlone

Telephone: 021 684 1180

Khayelitsha

89 Msobomvu Drive, Khayelitsha

Telephone: 021 361 9228