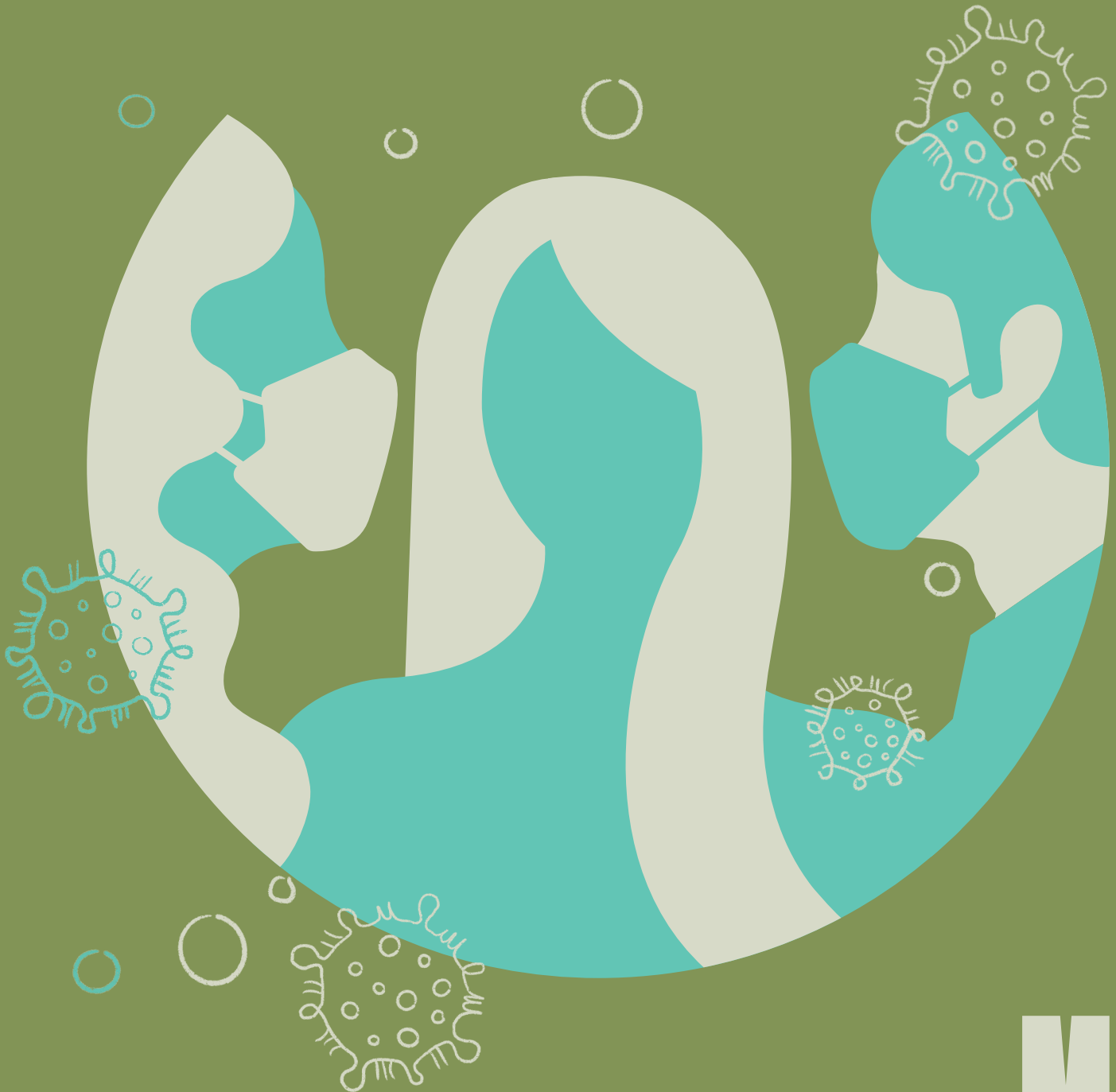
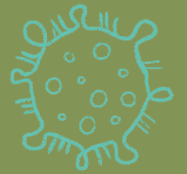


Disconnected & Insecure:

The intersection between
experiences of long COVID
& intimate partner violence



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GENDER AND
FAMILY VIOLENCE
PREVENTION CENTRE



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In partnership with:

SAFE+EQUAL

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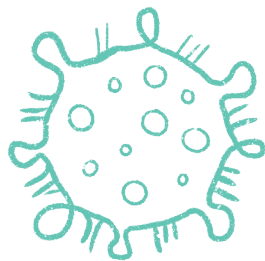


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We are extremely grateful to the 28 victim-survivors who participated in our survey and shared their experiences of long COVID and intimate partner violence with us. Delivering upon the aims of this study would not have been possible without them generously taking the time to detail their experiences.

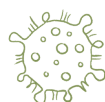
We are pleased to continue to work in partnership with Safe+Equal, the Victorian peak body for specialist family violence services, to build the knowledge base on how the COVID pandemic continues to impact women's safety and victim-survivor experiences of family violence.

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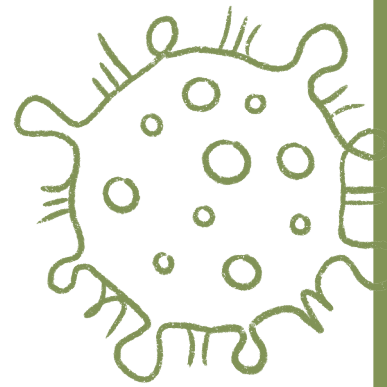
Professor Kate Fitz-Gibbon contributed to this report in her capacity as a member of the Faculty of Arts at Monash University. The Report findings are wholly independent of Kate Fitz-Gibbon's role as Chair of Respect Victoria.

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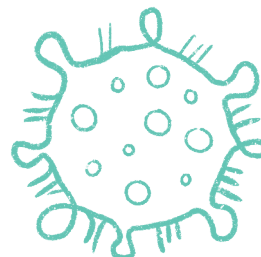
This work was funded by the Monash University Faculty of Arts as part of the Health and Medical Research Accelerator Funding Round 2023.



Acronyms



ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
DSS	Department of Social Services
DFV	Domestic and family violence
DVNSW	Domestic Violence New South Wales
IPV	Intimate partner violence
NACCHO	National Aboriginal Community Controlled Health Organisation
PCR	Polymerase chain reaction tests
PWDA	People with Disability Australia
RAT	Rapid antigen tests
UK	United Kingdom
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
UNICRI	United Nations Interregional Crime and Justice Research Institute
VAW	Violence against women
WHO	World Health Organisation



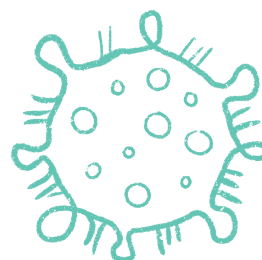
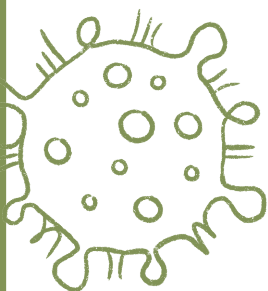
Introduction

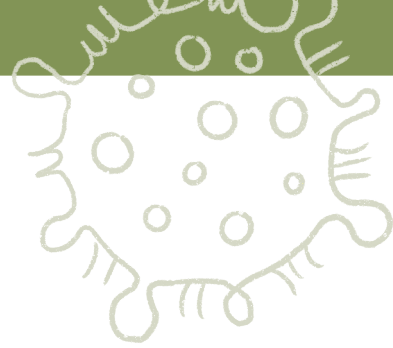
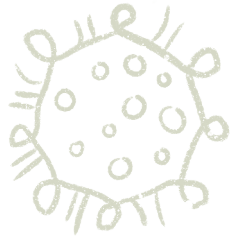
Violence against women is a pressing global issue (UN Women, 2023; World Health Organisation (WHO), 2021). Research by the United Nations (UN) shows that the 'home' is the most dangerous place for women and children worldwide, and it is where their personal safety is most in jeopardy (UNODC, 2018). Almost one in three women globally have been subjected to physical or sexual violence by another person at least once in their life (WHO, 2021), and the number of women and girls killed by an intimate partner or family member equates to five women or girls being killed every hour (UNODC, 2022). In 2023, in Australia, at least 63 women were killed by men's violence (Boecker, 2023).

Evidence suggests that the COVID-19 pandemic and associated restrictions intensified women's experiences of intimate partner violence (IPV). Restrictions largely targeted social interactions via 'stay at home' orders, unintentionally escalating the risk of intimate partner violence (IPV); some victim-survivors experienced abuse for the first time, while others were subject to heightened forms of IPV (see, among others, Boxall, Morgan & Brown, 2020; Pfitzner et al., 2023; Pfitzner, Fitz-Gibbon & True, 2022). Research conducted during the first two years of the pandemic also found that victim-survivors' access to support services was impeded during periods of government-imposed restrictions, and that new forms of IPV emerged during this time (see, among others, Carrington et al., 2020; Pfitzner et al., 2023; Pfitzner, Fitz-Gibbon & Meyer, 2022; Richardson Foster et al., 2022).

As the pandemic wore on and restrictions remained in place, impacts such as the rising cost of living, the scarcity of safe housing and the increasing use of alcohol and drugs proliferated and, in turn, compounded the known drivers of men's violence against women. Drawing on research conducted following the 2008 Global Financial Crisis (UNICRI, 2015; True, 2012), the Australian bushfires (Parkinson & Zara, 2013) and natural disasters across the globe (True, 2013; Kinnvall & Rydstrom, 2019), this project recognises that times of disaster and public health emergencies heighten the risk of intimate partner violence.

Despite well-established evidence of the increased risk of IPV during the first two years of the pandemic (see, among others, Bagheri Lankarani et al., 2022; Boxall & Morgan, 2021; Pfitzner, Fitz-Gibbon & True, 2022; Piquero et al., 2021), to date there has been no global research examining how victim-survivors' experiences of long COVID uniquely impact their safety and support needs. Recognising that this critical global issue intersects with public health, women's economics and safety priorities, this project sought to address this significant gap in current knowledge in Australia and internationally.





What is long COVID?

Long COVID is defined by the World Health Organisation (WHO, 2022) as the continuation, or development of new symptoms three months after the initial COVID infection (see also Commonwealth of Australia, 2023). Global studies estimate that 1 in 10 people infected with COVID go on to develop long COVID symptoms and that at least 65 million individuals globally have long COVID (see further Davis et al., 2023). A review conducted by the Australian Institute of Health and Welfare (AIHW) found that middle-aged adult women in Australia were at higher risk of experiencing severe COVID-19, along with individuals with comorbidities (2022). Like the initial infection, symptoms of long COVID include respiratory issues, cognitive dysfunction and fatigue – all of which can impact a person's everyday functioning.


Why study the intersection between long COVID and intimate partner violence?

A growing body of Australian and international research is being devoted to women with pre-existing chronic health conditions and disability who experience IPV (see, among others, Dowse et al., 2013; García-Cuellar et al., 2022; Iudici, Antonello & Turchi, 2019; Mathew, 2013; Mitra-Kahn, Newbigin & Hardefeldt, 2016; Nicolaidis & Touhouliotis, 2006; Robinson, Frawley & Dyson, 2020). It is important to note that the phrases 'chronic health condition' and 'disability' are umbrella terms. Some research focuses on victim-survivors with chronic health conditions or disability generally (see, among others, Dowse et al., 2013; Mathew et al., 2013; Nicolaidis & Touhouliotis, 2006), while other research considers women with specific chronic health conditions or disability (see, for example, Ballan et al., 2016; Toccalino et al., 2022). The former research provides a vital understanding of the general issues faced by women victim-survivors and offers a foundation for more specific research. The latter research provides nuanced understandings of the experiences of victim-survivors with specific chronic health conditions or disability. Both bodies of work maintain that any research in this field is valuable, but that projects should be narrowly scoped where possible to avoid making undue generalisations about a community of women comprised of smaller groups with vastly different lived experiences (see Maher et al., 2018; Thurber et al., 2021). This project contributes to this body of research by looking at specific chronic health conditions and disability: it is the first of its kind to explore the experiences of IPV victim-survivors who have or are experiencing long COVID. This project also contributes to an emerging body of research that explores chronic health conditions and disability resulting from IPV, as opposed to being pre-existing (see Webster, 2016; Cadilhac et al., 2015; Stubbs & Szoeki, 2022; Ahmadabadi et al., 2020).

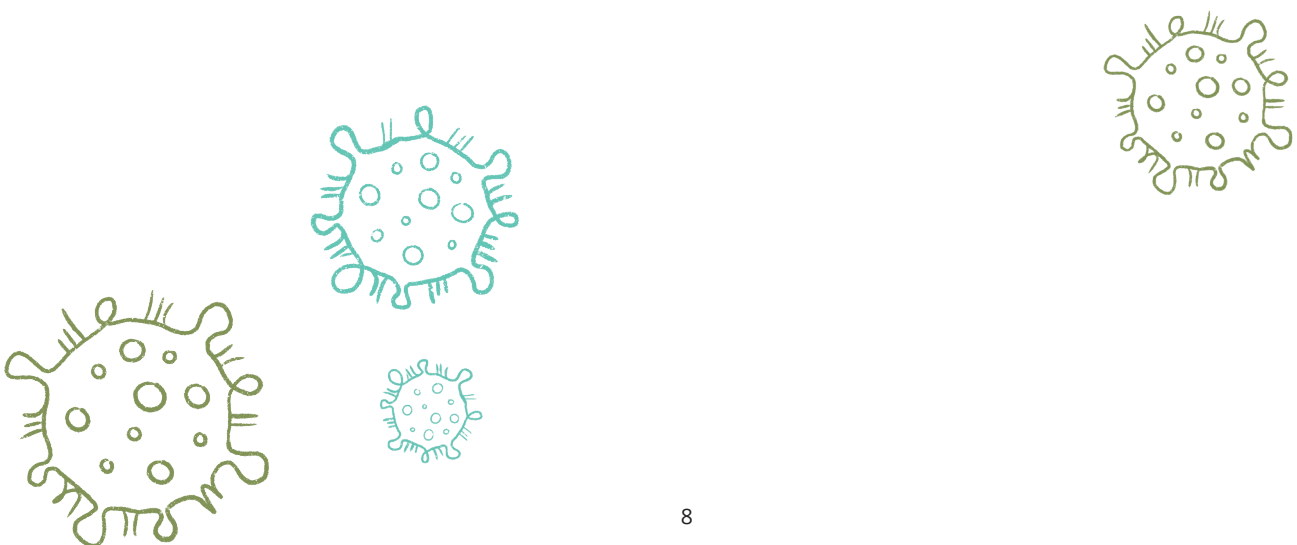


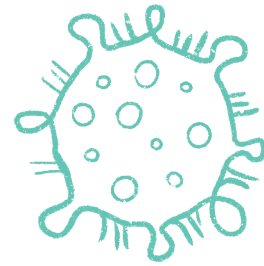
About this project

This project aimed to generate new evidence on the intersection between long COVID and IPV. The project was framed by four key research questions:

- 
1. For victim-survivors of IPV diagnosed with long COVID, did their partner's violence occur for the first time or change in nature following their long COVID diagnosis?
 2. Do individuals living with long COVID experience different risks, patterns of abuse and/or new forms of IPV?
 3. What are the impacts of living with long COVID on the help-seeking experiences of victim-survivors of IPV? – including, how does living with long COVID impact victim-survivors' access to, and engagement with, support services?
 4. How can policy and practice best adapt to meet the safety and recovery needs of individuals living with long COVID who are experiencing IPV?

This project utilised an anonymous national online survey to undertake the first Australian study of the intersection between long COVID and intimate partner violence. It sought to build new knowledge about the risks, nature and impacts of violence, help-seeking behaviours, and service and support needs. While the data was solely collected in Australia, the findings from this study are relevant internationally.





Report overview

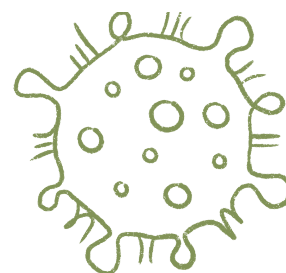
This report has four substantive sections. The first is an overview of relevant background research on the prevalence and nature of IPV among women with chronic health conditions and disability. Next, we examine the current evidence base on how chronic health conditions and disability impact help-seeking behaviours among victim-survivors of IPV. This is followed by an overview of the research design and a demographic profile of 28 individuals who participated in this research. It includes information on how contracting long COVID has impacted each of these individuals, details about the status and duration of their intimate partner relationship, and details about the abusive behaviours experienced. In the second half of the report, we present the key findings, which are organised into six key themes:

- The impact of long COVID on experiences of violence and safety within an intimate partner relationship;
- The increased risk of abuse and the weaponisation of long COVID symptoms to perpetrate abusive and controlling behaviours;
- The impact of experiencing long COVID on victim-survivors' decisions to remain in an abusive relationship;
- Victim-survivor help-seeking behaviours and the intersection with experiences of long COVID;
- Access to support services; and
- Impacts on victim-survivor recovery and healing.

Throughout the report, we draw heavily on direct quotes from the victim-survivors who participated in this study. Our aim is to centre their experiences and ensure that it is their voices that drive the analysis and findings.



Background



This study builds upon two growing bodies of research: the first documents experiences of IPV victimisation among individuals with chronic health conditions and other disabilities; the second examines the impacts of the COVID-19 pandemic on women's safety and experiences of IPV, and their help-seeking behaviours. In this section we provide a brief overview of these bodies of research, with a specific focus on Australia-based scholarship, given the geographical focus of data collection for this project.

Prevalence and nature of IPV among women with chronic health conditions and disability



Women with chronic health conditions and disability face significantly higher levels of all forms of violence, including IPV (Thurber et al., 2021). Australian research has found that women with chronic health conditions and disability are approximately twice as likely to experience IPV than women without chronic health conditions or disability (see, among others, People with Disability Australia & Domestic Violence NSW 'PWDA & DVNSW', 2021; Frawley et al., 2015; Australian Bureau of Statistics, 2021; Dowse et al., 2016).


Compounding social, political, economic, and geographic factors can impact a person's independence and can, in turn, place them at higher risk of IPV victimisation. For example, women with chronic health conditions and disability are more likely to face unemployment and subsequently fall into a lower socio-economic status, or poverty (Mitra-Kahn, Newbigin & Hardefeldt, 2016). Women with chronic health conditions or disability often reside in suburban and rural areas, as they are more affordable; however, specialist care for chronic health conditions and disability tends to be both expensive and centralised in inner-city areas, making it hard to access for women who do not drive or have difficulty using public transport (see PWDA & DVNSW, 2021; Stavrou, Poynton & Weatherburn, 2016). These are just some factors which, taken together, can make a person with a chronic health condition or disability more dependent on a partner, family member or caregiver than they would be otherwise (see Didi et al., 2016). Thurber et al. (2021) maintain that this dependence is often weaponised, which highlights how chronic health conditions and disability intersect with IPV.

Women with chronic health conditions and disability can experience unique forms of IPV, along with those experienced by other women (PWDA & DVNSW, 2021). Unique forms of violence can involve a perpetrator exploiting a specific need that a woman with chronic health conditions or disability may have (Mitra-Kahn, Newbigin & Hardefeldt, 2016). Examples include restricting or withholding aids; withholding, restricting, or forcing medication; denigration, embarrassment, or humiliation, in public or in private; involuntary sterilisation or pregnancy termination; and refusing assistance with personal care tasks such as using the bathroom or dressing (Mitra-Kahn, Newbigin & Hardefeldt, 2016, p. 26). Emotional and financial abuse can manifest in unique ways for women with disability and/or chronic health conditions, such as criticism of the victim-survivor's disability, or refusal of access to finances to pay for treatment, medication, aids, or support (Mitra-Kahn, Newbigin & Hardefeldt, 2016 p. 26; Thurber et al., 2021).


How chronic health conditions and disability impact help-seeking behaviours among victim-survivors of IPV

Victim-survivors with chronic health conditions and disability may face many barriers to seeking help – both those unique to their experience of violence and those faced by people without chronic health conditions and disability (see Ballan et al., 2016; Maher et al., 2018). Commonly cited barriers to help-seeking for victim-survivors of IPV include: minimisation of the violence by victim-survivors themselves and a belief that the abuse is not serious enough to report; fear of repercussions from the perpetrator; fear of not being believed or not being taken seriously; lack of access to support services; coercive control; cultural barriers; fear of racism, homo/transphobia, or other bigoted responses; and shame (see generally Ballan et al., 2016; Barret et al., 2009; Maher et al., 2018; Stavrou, Poynton & Weatherburn, 2016). Barriers faced specifically by women with chronic health conditions and disability include fear of stigma around disability from police, health professionals or service providers; health professionals without adequate training around disability or IPV; and a lack of accessible support services (see Ballan et al., 2016; Maher et al., 2018; Shelton, 2021).

There is some research on the impact that the COVID-19 pandemic and subsequent lockdowns had on help-seeking generally (see, for example, Lund, 2020; Morley et al., 2021; Pfitzner et al., 2022; Pfitzner et al., 2023; Shelton, 2021; Toccalino et al., 2022). Research has found that impacts on help-seeking during periods of lockdowns and throughout the pandemic were different for victim-survivors, and not universal among them (see, in particular, Pfitzner & McGowan, 2023, p. 16). Among other influential factors, victim-survivors were unable to seek help because of the way IPV manifested (such as coercive control limiting their movement), or they were unaware that they could still seek help during the lockdowns (see Carrington et al., 2020; Morley et al., 2021; Pfitzner, Fitz-Gibbon & True, 2022; Smyth et al., 2021). While this research provides a foundational understanding of help-seeking behaviours at the height of the pandemic, there is very little research on the help-seeking experiences of victim-survivors with chronic health conditions and disability during this unique time (Pfitzner & McGowan, 2023; Yonemoto & Kawashima, 2023).



Furthermore, while some research has examined the impact of the COVID-19 pandemic on the mental health of Australians (see, for example, Boxall & Morgan, 2021; Australian Bureau of Statistics, 2020; Hammarberg et al., 2020), and other studies have considered changes in help-seeking behaviours during periods of lockdown (see, for example, Smyth et al., 2021), there is minimal insight into the specific help-seeking behaviours of IPV victim-survivors with pre-existing mental health conditions during the pandemic (Yonemoto & Kawashima, 2023). Similarly, only a small body of research explores the help-seeking behaviour of First Nations Australians who have experienced IPV (see, for example, Fiolet et al., 2019; Meyer & Stambe, 2020; Ragusa, 2012; Spangaro et al., 2019). This research finds that, while First Nations victim-survivors generally face the same barriers to seeking help as their non-Indigenous counterparts, they also face unique barriers, including fear of racism and stigma, geographic isolation, and a lack of culturally and linguistically appropriate and safe support services (Fiolet et al., 2019; Meyer & Stambe, 2020). However, there has been little research on the specific experiences of IPV, or help seeking, among First Nations Australians who have a chronic health condition or disability. Given the known disproportionate impact of chronic health conditions and IPV on First Nations women and children, this particular intersectional demographic requires more scholarly and industry attention.





Research Design

To date, no research in Australia or internationally has considered the intersection between long COVID and IPV, including experiences of abuse, impacts on safety, and recovery and help-seeking behaviours. This report presents the findings from 28 individuals' accounts of their experience of IPV following their diagnosis with long COVID. While drawing from a small survey sample, this study advances understanding in Australia and internationally on these important intersecting issues. We hope that this exploratory research and timely contribution to building the evidence base will assist in informing improved policy and practice responses in this space.

Survey design

Australians aged 18 years and over who were affected by IPV and diagnosed with long COVID were invited to participate anonymously in an online survey.¹ The survey combined a series of demographic questions with multiple-choice and open-ended questions. The survey was administered using Qualtrics online software, which has a high degree of security, to ensure both anonymity and data protection for participants. Calls to participate in the survey were sent out on social media platforms (Twitter/X, LinkedIn, Facebook), via relevant support services and community organisations, and through the professional networks of the research team and the Monash Gender and Family Violence Prevention Centre. Given the specific population from whom we sought participation, we utilised a purposive non-probability sampling method for this research. The research is exploratory in nature and neither representative nor generalisable to the broader population.

The survey was open for a six-month period, from April to October 2023.



¹ Monash University Human Research Ethics Committee (MUHREC) approval was granted for this study, project number: 37799.

Data cleaning and analysis

The survey data set was downloaded from Qualtrics into an Excel file and cleaned prior to analysis. The focus of this survey – both in terms of women’s experiences of IPV and individuals with long COVID – attracted a number of sceptical individuals who responded to initial open-text questions in the survey with sarcastic and/or rude content. These survey entries were easily identifiable and were excluded from the final survey sample during the analysis phase. For example, in response to survey questions, a participant (whose survey response was excluded from the final data set) wrote:

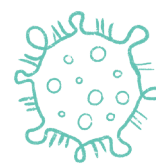
My dog peed on me. He only does that when I have the covidoids ... It is not real.

In response to questions about the impact of their experience of long COVID on their employment and their help-seeking behaviours, two excluded survey participants wrote:

You people need to give it up already, It is the vaccine causing all these problems... I have no health issues unlike my vaxxed friends.

You should be ashamed, bolstering this lie and perpetuating misinformation.

Following the data cleaning process, descriptive statistical analysis was conducted using the Qualtrics survey platform analysis tools, and thematic analysis of the qualitative data was conducted using NVivo. The four research questions outlined in the Introduction formed the primary themes; additional sub-themes were conceived throughout the analysis. We took an inductive thematic approach to our analyses. In line with this method, we began by immersing ourselves in survey participants’ experiences of IPV and their views on the intersection between long COVID and IPV. We aimed to capture the ‘intuitive insights’ and patterns in the data. Having reached an interpretive consensus, we formulated the key thematic findings, which are presented in the study findings sections of this report (Janesick, 2003, p. 65).



A stylized illustration of a person with long hair wearing a blue face mask, looking slightly to the side. Above them is a large, detailed illustration of a virus particle with a green outer shell and a red core. Several smaller, simpler virus particles are scattered around the main one. The background is a light blue gradient with some faint, abstract shapes.

Survey Participants Overview

There were 28 participants included in the final survey data set. In this section we provide an overview of the demographic profiles of these individuals, information on how contracting long COVID has impacted them, and details about the status and duration of their intimate-partner relationship and the abusive behaviours they experienced.

Gender identity

The majority of survey respondents identified as female (n=18) with nine survey respondents identifying as male and only one survey respondent identifying as non-binary. That over 60 per cent of the survey respondents were female is unsurprising, given the focus of the survey and the gendered nature of IPV in Australia (and globally).

Sexual orientation

The vast majority of survey respondents identified as heterosexual (75%, n=21). The remaining seven survey participants identified as bisexual (n=4), pansexual/queer (n=1), lesbian (n=1) and asexual (n=1).

Participants' Ages

Age Range	Frequency
18 – 24 years old	2
25 – 30 years old	5
31 – 40 years old	7
41 – 50 years old	9
51 – 60 years old	5

First nations identity

Of the 28 survey participants, 11 identified as Aboriginal and one as Torres Strait Islander. First Nations respondents accounted for over 40 per cent of the overall survey sample. This is a significant proportion.

There is minimal data on Indigenous Australians' experience of long COVID (National Aboriginal Community Controlled Health Organisation 'NACCHO', 2022; see also de Leeuw, Yashadhana & Hitch, 2022; Sorrell, Hensher & Sanci, 2023). This can be attributed to a number of factors, such as existing disparities in healthcare access for Indigenous Australians, or that current research on long COVID, which is in its infancy, may not differentiate participants based on Indigeneity (NACCHO, 2022). Research maintains that chronic health conditions and disability are more prevalent in First Nations communities due to compounding inter-generational and socio-economic inequalities, including inequitable access to healthcare, education, and mental health and IPV support services (see NACCHO, 2022; Thurber et al., 2021). It is in part because of these factors that First Nations Australians are at a higher risk of contracting COVID-19 (see NACCHO, 2022). As such, NACCHO (2022) maintain that, despite there being little to no data from which to draw conclusive understandings, Indigenous Australians may experience long COVID at different – most likely higher – rates than non-Indigenous Australians. Furthermore, it is likely that the health consequences for Indigenous Australians will be compounded by the above-mentioned inequalities (see NACCHO, 2022; Thurber et al., 2021). It is also important to consider the unique position in which First Nations Australians with pre-existing chronic health conditions and disability find themselves when facing long COVID and IPV. This is a complexly niched demographic about which no current research exists.

Location & area of residence

While the survey was advertised nationally, and we sought to attract a sample of participants from every Australian state or territory, the geographical distribution of survey participants was heavily dominated by individuals living in Victoria (n=11) and New South Wales (n=7). Indeed, participants from these two states accounted for over 60 per cent of the total survey participants. At the time of completing the survey, other survey participants were living in Queensland (n=3), Tasmania (n=3), Western Australia (n=2) and South Australia (n=2).

The majority of survey respondents identified as living in a metropolitan area (n=17). However, a number of survey participants came from rural (n=6) and regional (n=4) areas across Australia, and one participant identified as living in a remote community.

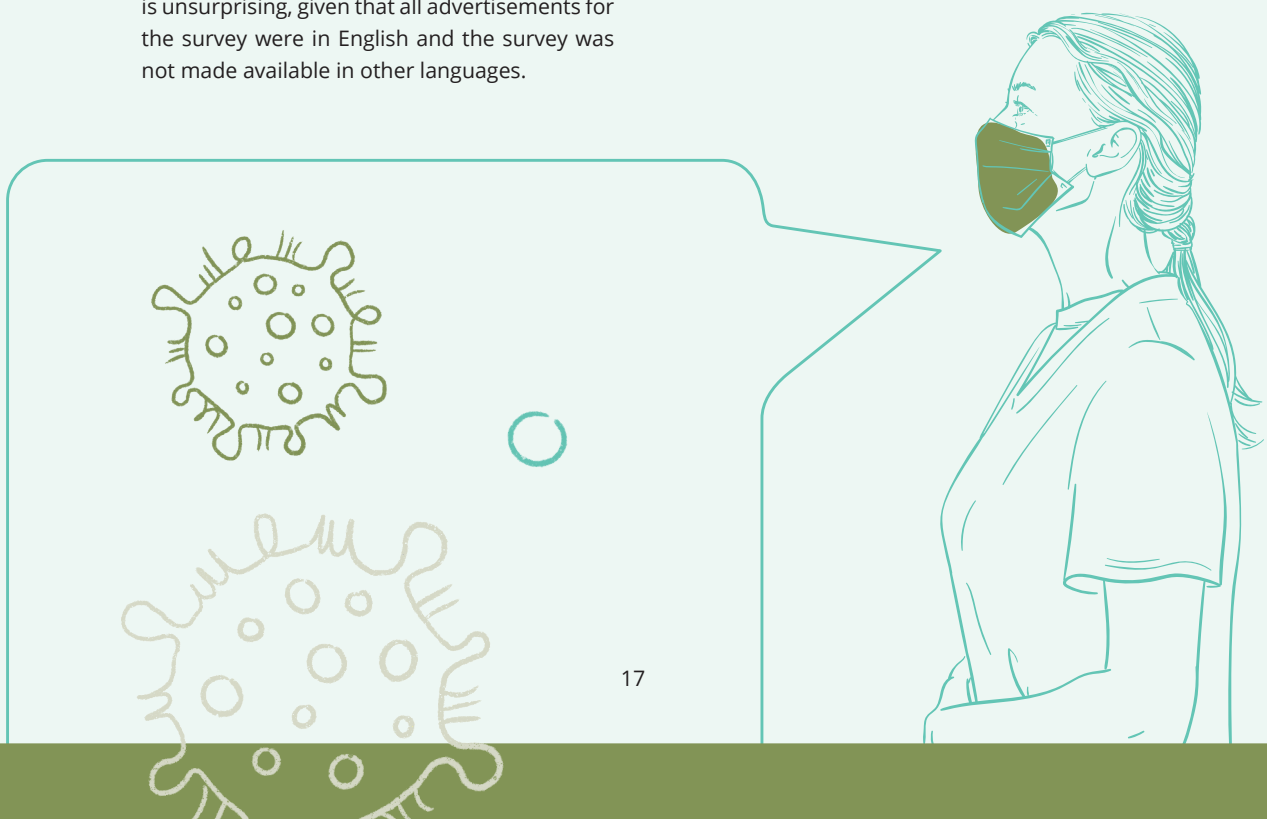
Main language spoken at home

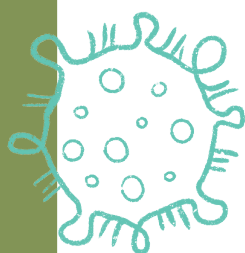
Twenty-six survey participants identified English as the main language spoken in their home. This is unsurprising, given that all advertisements for the survey were in English and the survey was not made available in other languages.

Experiences of co-occurring disability

Survey participants were asked to identify whether (other than long COVID) they have a disability/chronic health condition and/or mental health condition. Seventeen of the 28 survey participants (61%) identified that they experience another disability, including chronic health and/or mental health conditions. While the survey did not require participants to detail these conditions, numerous survey participants did. In addition to experiencing long COVID at the time of survey completion, these individuals were also experiencing:

- Poor mental health affecting day-to-day functioning (n=1)
- Intellectual disability (n=1)
- Attention deficit hyperactivity disorder (n=2)
- Physical impairment (n=1)
- Chronic neurological condition (n=1)
- Anxiety and/or depression (n=2).





Experiences of long COVID

It was a prerequisite that survey participants had experienced or were currently experiencing long COVID. The majority of survey respondents contracted long COVID in 2022 (n=13), with a small number of participants identifying that they had contracted the disease in another year:

- 2020 – 5 participants
- 2021 – 5 participants
- 2023 – 4 participants.

The survey invited participants to identify how they were diagnosed with long COVID. Of the 28 participants, 16 were diagnosed by a medical practitioner, and 11 participants were self-diagnosed. One participant did not detail how they were diagnosed with long COVID. We also asked participants whether their initial diagnosis of COVID was confirmed by a PCR test (n=2) or a RAT (n=8). The majority of survey participants (n=18) did not respond to this question.

There is no single set of symptoms experienced by an individual with long COVID. The virus can impact each person infected in different ways and to varying degrees of severity. Research conducted by Davis et al. (2023) estimates that there are more than 200 symptoms that have been identified among long COVID patients. Survey respondents reported experiencing a range of symptoms following their diagnosis with long COVID, including: chest pain, persistent cough, erratic heartbeat, joint inflammation, muscle and joint weakness and pain, Postural orthostatic tachycardia syndrome (POTS), shortness of breath, runny nose, brain fog, cognitive impairment, dizziness, tremors, fever, sleep-related problems including insomnia, eyesight problems, vertigo, migraines and headaches, loss of or change in smell and taste, irritable bowel syndrome, loss of appetite, anxiety, depression, lethargy, fatigue and exhaustion.

Noting the significant range of symptoms experienced by survey participants, we were interested in understanding how long these symptoms had persisted (including those continuing). For the majority of survey respondents, the symptoms of long COVID had persisted for over a year (n=10).

Duration of symptoms	Time (n=)
For longer than a year	10
6 months to 1 year	5
3 to 6 months	7
Up to 3 months	3

The survey also invited participants to identify the degree to which long COVID had impacted their day-to-day functioning. Of the 28 participants, 21 reported that long COVID had ‘significantly’ impacted their day-to-day functioning (75%) and six participants identified that it had ‘somewhat’ impacted their day-to-day functioning (21%). The following table outlines the reported impacts of long COVID on survey participants’ engagement with work.

Impact of long COVID on work	% of survey respondents
I have not changed my job since my diagnosis	7%
I have changed my job but am still working at the same level	7%
I have reduced my work responsibilities or role	19%
I am working less hours or days	4%
I have changed to working from home/remotely	7%
I am now on leave from work	11%
I am now unemployed	11%
Other	33%

These findings mirror experiences shared more broadly by Australians infected with long COVID via the Commonwealth Government's inquiry into long COVID and repeated COVID infections (Commonwealth of Australia, 2023, see Chapter 4 for a discussion of impacts on employment, income, and social activities).

Relationship duration and status

To contextualise the study findings and to inform our analysis, the survey included a number of questions about the abusive relationship. For the significant majority of survey participants (n=20), the victim-survivor had been in an intimate partner relationship with the abuser prior to contracting long COVID. Only five victim-survivors participating in this study had begun the relationship with their abuser since being diagnosed with long COVID. The vast majority of victim-survivors were cohabiting with their abusive partner (n=23), with only two survey participants reporting that they did not cohabit with their abusive partner.

At the time of data collection for the survey, the majority of participating victim-survivors (n=13) identified that they were still in the abusive relationship. Eleven victim-survivors identified that they were no longer in the abusive relationship, while two victim-survivors identified that the relationship status was uncertain at the time of survey completion.



Experiences of intimate partner violence

As shown in the table below, victim-survivors who responded to the survey had experienced a range of different forms of abusive behaviours within their intimate-partner relationship since contracting long COVID. Survey respondents could select as many behaviours as applied to their experience.

Abusive behaviours experienced in an intimate partner relationship since contracting long COVID

% of survey respondents



Emotional/psychological abuse (including gaslighting behaviours, such as repeatedly making you question whether you did or said something, whether you're right or wrong about something)

10%

Humiliation and degradation

8%

Verbal abuse



8%

Intimidation

7%



Limited access to money and finances, and other forms of economic abuse

6%

Isolation from family and/or friends



6%

Physical abuse

5%

Threats to harm you if not complying with abuser's rules

5%

Infliction of rules on day-to-day living (i.e., dressing in a certain way, hair a certain way, micromanagement of everyday life)

5%



Stalking

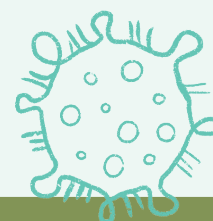
5%

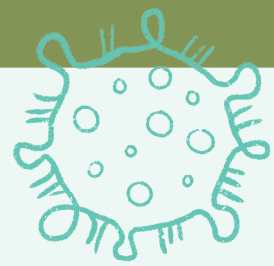
Sexual abuse (including making you do things that you aren't/weren't comfortable with, making things/life/every day difficult for you if you don't agree to having sex)

4%

Other behaviours

4%





Strangulation (including choking, pinning you down or against the wall by your throat, covering your mouth so you can't breathe, during sex without your consent)

3%

Limited access/controlled access to transportation (i.e., shared car, restricting access to public transport)



3%



Digital surveillance (including monitoring spyware, social media accounts, cameras installed in the home, children's devices)

3%

Depriving access to support services

3%

Restricting, controlling and/or depriving access to medications and/or treatments

3%



Threats to harm your children if not complying with abuser's rules

2%



Threats to harm other family members/friends if not complying with abuser's rules

2%

Limited/controlled access to education and/or employment opportunities

2%

Depriving access to health services, including medical assistance

2%



Threats to 'out' you or reveal information about your gender identity or sexuality

2%

Coerced or pressured to take hormones/medication

2%

Coerced or pressured to stop taking hormones/medication

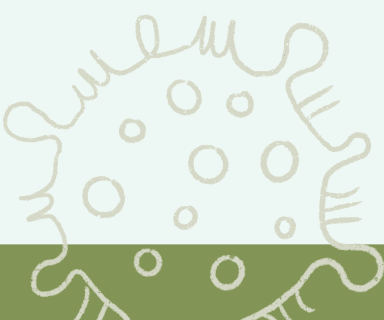
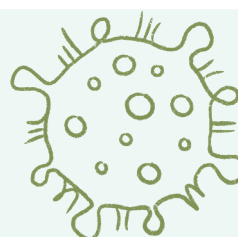
2%

Destroying your children's property as an intimidation tactic

1%

Threats to control or influence migration status

1%





Project Findings

The impact of long COVID on experiences of violence & safety within an intimate partner relationship

Thirteen of the victim-survivors surveyed had experienced abuse in the relationship prior to their diagnosis with long COVID, and seven experienced abuse for the first time in the relationship following their long COVID diagnosis. For those victim-survivors who experienced IPV for the first time following their long COVID diagnoses, the impact of the disease on the onset of abusive behaviours was keenly felt. This is captured in the comment of one victim-survivor:

I think the illness on top of my other conditions made him perceive me as more of a burden, leading to poor behaviour. There were a few signs of this prior to my having covid but I think my being vulnerable when I had previously been the 'strong' and 'independent' partner really threw him off and he rejected that.

Another victim-survivor – who had experienced abuse prior to COVID but for whom that abuse worsened during the pandemic – attributed the escalation in abuse in the relationship to the wider social living conditions of the pandemic. They commented that living during lockdowns and largely in isolation:

[The pandemic] gave us too much time to know so much about each other. That worsened the abusive tendencies.

For those victim-survivors who had experienced abuse in their relationship both prior to and following their long COVID diagnosis, six identified that the severity of their partner's abuse changed following their diagnosis and four reported that the frequency of the abuse changed. Seven victim-survivors said there was no change in the severity of the abuse and nine victim-survivors said there was no change in the frequency of abuse experienced before or after contracting long COVID.

In addition, the survey also asked victim-survivors whether the type of abusive behaviours experienced changed following their diagnosis with long COVID. Nine victim-survivors reported a change in abusive behaviours experienced. For these victim-survivors, the long COVID symptoms they experienced shaped the forms of abuse perpetrated by their partners. Describing the unique forms of abuse experienced after their long COVID diagnoses, one victim-survivor described them as:

Alternating between claims I wasn't sick at all and should be able to work more than I did before, or claims I was severely unwell to the point that my claims of abuse by her were delusional.

Regardless of when the abuse first began during the relationship, for the 28 victim-survivors within this study, the frequency of abuse experienced varied significantly, from a daily to an occasional basis.



Frequency of abuse	N=23 ²
Daily	7
Almost daily	8
Weekly	5
Monthly	2
Occasionally	1

Previous research shows that victim-survivors with chronic health conditions and disability experience higher rates of IPV (Thurber et al., 2021). The reported changes in the frequency and severity of partner abuse in this study suggests that chronic health conditions such as long COVID also shape the nature and intensity of abuse experienced by victim-survivors.

Increased risk of abuse and the weaponisation of long COVID symptoms to perpetrate abusive and controlling behaviours

Eighteen of the survey participants reported that contracting long COVID had put them at higher risk of IPV. Increased perceptions of vulnerability to victimisation held by these victim-survivors were attributed to a range of factors, including the cognitive impacts of their long COVID symptoms, reduced perceptions of self-worth, social isolation associated with COVID restrictions, and the burden of care on their partners. This is captured in the reflections of several victim-survivors:

It's possible that he took advantage of the fact that my memory became a little less clear as it had been before I contracted COVID. He hadn't been prone to gaslighting or shifting stories and controlling behaviour before and would act like my memory was suddenly very untrustworthy because I had been unwell.

My self-worth has decreased and my need for help and support has increased. He makes me feel like I need him.

I seemed to be a burden at all times.

Covid left us too isolated from society.

² All survey question were voluntary. There were five survey participants who did not respond to this question.



As I'm now more clouded mentally, I can't see if it's full-on abuse, or just a partner with issues and trauma. I can't make decisions clearly, and I'm much weaker now.

Victim-survivors also reported that their partners weaponised their long COVID symptoms to perpetrate abusive and controlling behaviours. One victim-survivor described:

Yelling and pushing due to me not knowing what I want to say quickly and words getting muddled up.

During the pandemic, Australian-based research illustrated how perpetrators were weaponising the public health lockdown measures – such as social isolation and guidelines on personal hygiene – to enact new forms of abusive behaviours (see, among others, Pfitzner, Fitz-Gibbon & True, 2020). To that extent, it is neither new nor surprising to hear that the deterioration in some victim-survivors' health due to long COVID has similarly been weaponised by the perpetrator to further entrap them within the abusive relationship.

Two victim-survivors reported that the diagnosis of long COVID led to an escalation of coercive and controlling behaviour in the relationship:

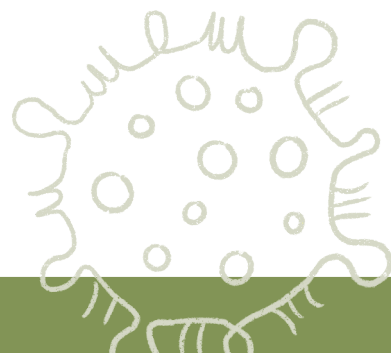
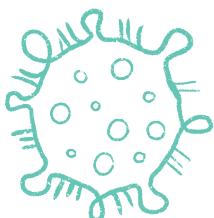
Controlling behaviour and abusive violence due to stress of me having long covid.




Due to brain fog he [the perpetrator] took over the finances and became more controlling.

Another victim-survivor reported that there was a distinct shift towards sexually abusive behaviours stemming from their loss of sex drive, symptomatic of long COVID (Haroon & Subramanian, 2022). They explained that:


He is very resentful that I'm not meeting his needs. And that he has to support me financially.

The experiences of participants in this study indicate that while victim-survivors with long COVID are affected by similar forms of abuse as victim-survivors in the broader community, they also experience forms of physical, psychological and sexual violence unique to their health condition. These findings clearly demonstrate that experiences of IPV are contextual; moreover, they illustrate how perpetrators can utilise a deterioration in a person's health to inflict new and intensified forms of abuse within relationships.





The impact of experiencing long COVID on victim-survivors' decisions to remain in an abusive relationship



Beyond investigating how victim-survivors' experiences of IPV were impacted by contracting and living with long COVID, this study was also interested in understanding how experiences of long COVID impact victim-survivors' decisions to remain in an abusive relationship, and/or safely exit an abusive relationship. This information provides critical insights that can inform the development of victim-centred supports and services to better support women leaving an abusive relationship.

Unsurprisingly, several victim-survivors in this study said that they were too unwell as a result of long COVID to even consider leaving their abusive partner. As three victim-survivors succinctly described:

[I] Could not defend myself.

I felt that I had no choice but to stay. I can't handle another huge change or unknown.

It was another thing to target, and I had less capacity to do anything about it.

Another victim-survivor highlighted the inextricable connection between their physical and mental health and their ability to consider leaving the abusive relationship. They explained:

It [long COVID] makes me feel helpless. My health is my ticket to a better life. I'm not actioning my thoughts to leave as it all seems too big, too messy. I won't cope physically or mentally. I cannot take care of 5 children on my own.

The crushing of a victim-survivor's self-confidence and worth by their perpetrator is well evidenced as a tactic of coercive control (see, among others, Hamberger, Larsen & Lehrner, 2017; Stark, 2009; Toews & Bermea, 2017). The insights of victim-survivors in this study demonstrate how an individual's mental and physical vulnerability while experiencing long COVID is harnessed by perpetrators to further entrap the victim within the coercively controlling relationship. As one victim-survivor described:

It's impacted me staying because he makes me feel like no one else would want me now that I can't work and can barely handle being out in public due to my anxiety and panic attacks. I've always suffered depression and anxiety, but it was manageable but now it's been triggered by my inability to work and live a normal life, so it's increased. I feel like I can't leave him because no one else would want me like this. He tells me he puts up with a lot by being with me. It's very much emotional and verbal abuse and sometimes threats of physical violence that he claims are jokes.

Previous research on women, disability and violence (Maher et al., 2018, p. 36) found that cultural norms, which cast women with disability and/or health needs as 'burdensome', work to exacerbate the existing difficulties this victim-survivor cohort has in reporting abuse and seeking justice. Research participants in that project spoke, as survey participants in this project have, about various barriers to seeking justice including, for one woman, feeling as if she had 'to be grateful' that 'anybody ... wanted to be with me' (Maher et al., 2018, p. 36). These cultural narratives were present in the experiences reported by two victim-survivors in this study. For example, one victim-survivor who had left their abusive partner at the time they completed the survey, described their decision to leave the abusive relationship:

I didn't want to be with someone who saw me as a burden or being needy when I was unwell. I left because I felt disrespected and insulted and unsafe, and when I asked him if he thought I deserved to feel like that he just shut down, so I had to walk away from 5 years of love and trust.

Likewise, another victim-survivor who had also left their abusive partner explained how their perpetrator framed their health condition as the cause of their relationship problems:

It [contracting long COVID] has also provided yet another distraction from the violence being perpetuated against me and my children, and an even greater focus on my health and wellbeing as the 'core problem' all along, completely separated from the violence which has caused the harm.

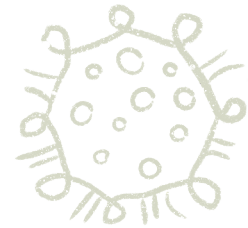
Such narratives are well supported by previous research on the normalisation of the idea that women with disability are 'lucky' to have a partner and therefore should put up with any abuse experienced (Maher et al., 2018). This builds on an increasing recognition in Australia that caring needs can impact an individual's safety within a relationship – and on the extent to which they can place individuals with disability and/or chronic health conditions at higher risk of abuse.



Victim-survivor help-seeking behaviours and the intersection with experiences of long COVID

Nineteen of the victim-survivors surveyed responded to the question asking whether they had told anyone about their experience of IPV. Twelve of these said they had disclosed their experience of IPV (63%). The range of individuals, within both their formal and informal networks, to whom these respondents had disclosed experiences of IPV is captured in the table below.

Whom victim-survivors disclose their experience of intimate partner violence to	% of survey respondents (n=12)
A friend/s	69%
A family member/s	67%
Psychologist or counsellor	58%
Specialist sexual assault, family and domestic violence service	50%
General Practitioner (GP)	50%
A work colleague/s	42%
Police	33%
Family law practitioner	33%
Child protection	33%
A neighbour/s	25%
Other health practitioner	25%
Child and family service practitioner	25%
Social worker	4%
Legal practitioner	4%



That victim-survivors were most likely to tell a friend or family member is consistent with findings from other recent Australia-based research examining coercive control (Reeves et al., 2021). This finding further highlights the importance of ensuring that the general community are equipped with the basic information needed to respond to informal disclosures from family and friends. Research has also consistently pointed to the key role that psychologists and GPs can play in connecting victim-survivors with specialist DFV services (see, for example, Hegarty & O'Doherty, 2011; Royal Commission into Family Violence, 2016).

The survey invited those seven victim-survivors who had not told anyone about their experience of IPV to explain their reasons for not disclosing. Victim-survivors' reasons were diverse, spanning from fear of consequences and escalation of abuse if they disclosed to a desire to protect the relationship and the reputation of the perpetrator. For example, two victim-survivors commented:

Scared and also at least I know where he is at.

I wanted to protect the relationship.

Another victim-survivor reported that they had disclosed that they were experiencing IPV – however, they had not disclosed the severity and range of abusive behaviours. They said that:

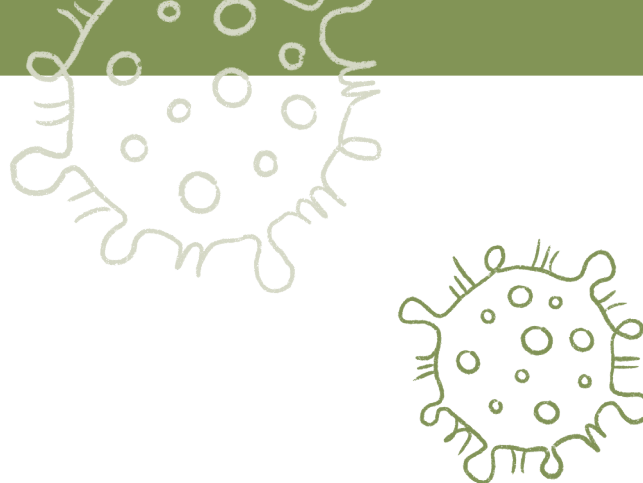
I have to some degree. I just don't tell anyone just how bad it is because I'm ashamed that I've stayed knowing how bad it is. Some people do tell me to leave, and I don't know why I won't or can't. It's like I can't live without him and need him, yet I know this relationship is slowly killing me and driving me insane.

Beyond the decision to disclose their victimisation, the survey also invited victim-survivors to describe whether they had sought support via formal services, and if so, what the outcome of that help-seeking was. Of the 28 survey participants, 12 victim-survivors had sought support for their experience of IPV. Common among the experiences of these victim-survivors was a perception that services lacked accessibility and that, often, they had struggled to locate information on which services they needed. One victim-survivor explained that they had initially sought support, but due to lack of accessibility and trust they had disengaged:

I did attempt online counselling. It was really difficult with links and portals. The only bulk billing sessions were weeks away and when a session came up, I had to cancel it as I had all the kids home. Living in a remote community, I do not trust the discretion of workers, or my privacy.

A perceived lack of available services was identified by numerous survey participants. Another victim-survivor commented:

Nothing was able to be provided in a practical sense, the best that could be done is acknowledging that there's a gap in services.



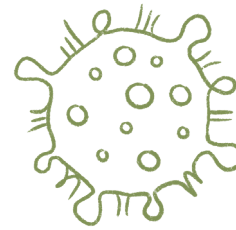
Of those victim-survivors who had not sought support via formal pathways, two said they did not need support, while other victim-survivors reported that they already possessed the tools they needed (from previous counselling) to navigate the relationship. For example, one victim-survivor highlighted the challenge of identifying coercive and controlling abuse within a current relationship:

I think emotional abuse is poorly understood and poorly identified until it becomes too hard to bear. Most of the behaviours I experienced I was able to 'justify' while I was in the relationship because of my compassion for my partner and understanding of what he was going thru in his life. It was only when I realised how much I was hurting and didn't recognise our relationship anymore that I reflected that what he was doing was a type of abuse I had learned about, not just a 'bad relationship breakdown' or 'bad communication'. Having experienced sexual violence before and received counselling for that, I found that leaving the relationship was very rewarding and I was able to use the tools I had from that therapy in the past. My friends have been amazing too.

Access to support services

The victim-survivors who accessed support services were asked to identify what method they utilised to do so. They were also asked to discuss the degree – if any – to which experiencing long COVID had impacted their service use. As shown in the table below nearly half of the victim-survivors who accessed services did so via the phone or a webchat service. Only 16 per cent of victim-survivors who accessed support did so in person.

Method for accessing support	% of survey respondents (n=24)
Over the phone	24%
Webchat service (an online conversation or live chat)	20%
In-person	16%
Video call, such as Zoom and Microsoft Teams	16%
Home visit	12%
Other method	8%
Text messaging	4%



Given the health vulnerabilities of victim-survivors experiencing long COVID, this trend is unsurprising; it highlights the critical need to ensure continued funding for remote service delivery of DFV support services beyond the pandemic. Since the outset of the pandemic, the Australian government has invested substantially in telehealth services. In 2021, the Australian government announced \$106 million in funding over four years to establish permanent telehealth for Australian patients (Hunt, 2021). Recognising the value of telehealth for patients with chronic health conditions, the then Minister for Health and Aged Care, The Hon Greg Hunt MP (2021), stated:

Telehealth has been transformational to Australia's universal health care and has played a critical role in ensuring the continuity of care for hundreds of thousands of Australian patients during the COVID-19 pandemic, protecting the health of patients and health professionals. It offers greater flexibility to health care as part of universal Medicare.

In 2023, The Royal Australian College of General Practitioners (RACGP) advocated for increased federal funding to expand the availability of telehealth consultations; they also advocated the reintroduction of rebates for phone consultations for mental health items (Liotta, 2023). Funding for DFV services, including to support remote service delivery, is primarily the responsibility of state and territory governments. It is critical, however, to ensure that the support and safety needs of individuals with chronic health conditions, including those with long COVID, are considered within federal plans to deliver a fully funded telehealth model.

For several victim-survivors, services were either less accessible or entirely inaccessible due to their long COVID symptoms. As two victim-survivors commented:

The impact of Covid made those services inaccessible because they didn't operate like they did before the pandemic.

I have even less capacity to access services ... than I had before and have even less capacity to coherently articulate what's happening and what I need.

A number of victim-survivors said that their experience of long COVID contributed to high levels of fatigue and a general lack of energy, which is needed to attend appointments and engage in help-seeking. This was cited as a key barrier to physically accessing services:

...inability to get to appointments, no energy.

Too tired to make it a priority to action.

...due to being unwell with no energy and tired.

As another victim-survivor commented:

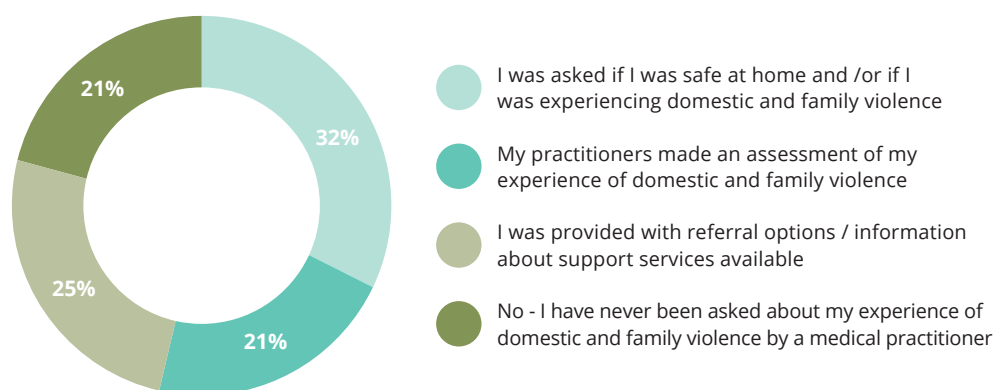
[Having long COVID] made it hard to attend medical appointments and treatments, physically and financially. Feel isolated. Lack of empathy, like I'm doing this sickness on purpose, to make his life hard.

Many victim-survivors reported that increasing the accessibility and availability of information is key to enhancing safety outcomes for victim-survivors with chronic health conditions. As one victim-survivor commented:

I guess more funding for accessible support services would be great, and to have these promoted within health providers. I think because for me and lot of other [people] there is a both a mental and physical impact of long covid so health professionals should be trained to empower [people] with the condition to have the information and support they need without relying on a partner, and to remove judgement from people who are struggling to 'get better'.

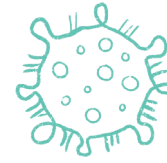
Beyond the method of service access, the study also explored the degree to which health practitioners and health services that engage with long COVID patients are presently providing information on DFV services. The survey asked victim-survivors whether, in their interactions with health practitioners and health services since contracting long COVID, they were provided with information about and/or referrals for specialist DFV services. Similar numbers of victim-survivors had never been asked about their experiences of DFV by a health practitioner. One in five victim-survivors surveyed (21%) reported that they had never been asked about DFV by a medical professional.

Figure 1: Help-seeking and victim-survivor experiences with health practitioners



Several of the victim-survivors whose medical practitioner had never asked them about their experience of DFV expressed acknowledgement of the missed opportunities to be connected with services and for their safety to be enhanced. One victim-survivor commented:

I don't think health providers are aware of the need to identify, support or prevent violence for people who have this condition. There is a mental and physical impact of long COVID which can be targeted for abuse in many aspects but there's just not very much on offer for the condition broadly.



Primary healthcare professionals, in particular trusted GPs, have been consistently identified as key points for disclosures and the provision of support and referrals to victim-survivors of DFV (see, among others, Royal Commission into Family Violence, 2016). Research into victim-survivor help-seeking during COVID lockdowns in Victoria made a similar finding and suggested that ‘health services could be better utilised as a pathway to specialised DFV support during crises’ (Pfitzner & McGowan, 2023, p. 16).

We note that access to healthcare can be more difficult for First Nations Australians, that it can be culturally, linguistically, geographically, and/or financially inaccessible (see Thurber et al., 2021). Compounded with the specialised diagnosis and treatment needed for long COVID, this means that access to long COVID treatment and diagnosis for Indigenous Australians may be particularly limited (Thurber et al., 2021).

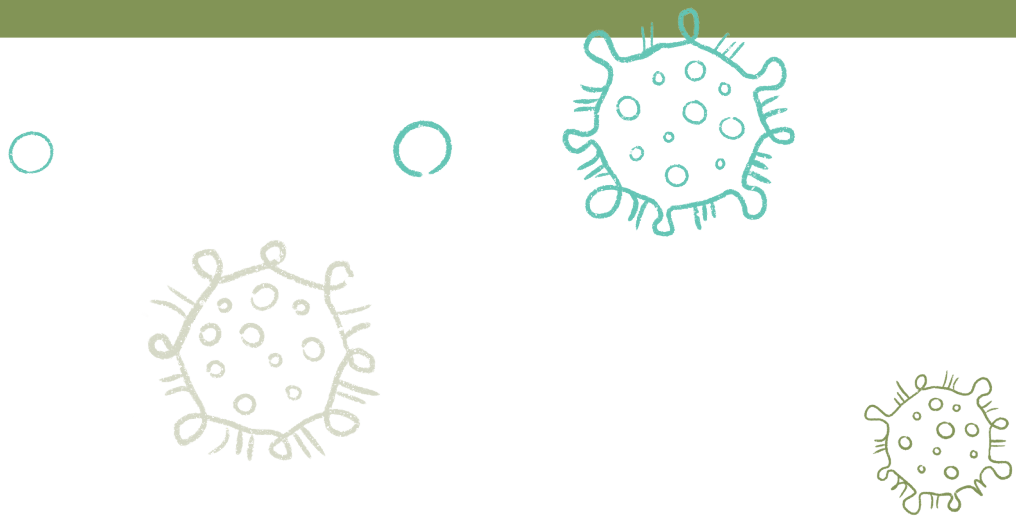
Impacts on victim-survivor recovery and healing

In 2022, the Australian Commonwealth Government, in partnership with each of the state and territory governments, released the Australian National Plan to End Violence against Women and Children (DSS, 2022). The National Plan, which represents the second ten-year national strategy on violence against women in Australia, includes the ambitious goal of ending gender-based violence in one generation (see further, Powell, 2022; Meyer & Fitz-Gibbon, 2022). The National Plan is organised into four overarching focuses – prevention, early intervention, response, and recovery and healing. The focus on recovery and healing is new. The prior National Plan in Australia did not recognise, as this Plan does, that women and children who have experienced domestic, family and sexual violence must be able to access a range of immediate and long-term support for their recovery and healing. Importantly, these supports must extend beyond those at the point of crisis response.

Reflecting the focus on recovery and healing in the National Plan (DSS, 2022), this study recognises that experiences of long COVID and IPV, both individually and collectively, have significant impacts, requiring significant support for recovery. As such, the study was interested in understanding from victim-survivors what they perceive as required moving forward.

Several victim-survivors in this study identified safety and freedom from violence as a prerequisite to recovering from the health and wellbeing impacts of long COVID. Particularly apparent among the reflections of those individuals who had separated from their abusive partner at the time of their survey participation, this requirement is captured in the comments of one victim-survivor:

Even though it was hard, and we had a lovely history together, I am glad I left that relationship because I can focus on my health and happiness. I think if I was still feeling as stressed and trapped in that dynamic, I would probably have had a longer time in recovery from COVID. I don't feel that it is impacting me as much now.



For those victim-survivors who had not separated from their abusive partner and were in an abusive relationship at the time of participating in this research, there was a clear acknowledgement of the impossibility of recovering from long COVID while experiencing IPV. Two victim-survivors explained:

My body is in a state of distress, it makes it harder for me to feel safe and calm. I'm lucky I have money – I'm going to remove myself from Australia for a few months over winter in the hope that it will help my recovery changing my environment. But I'm conscious this might also put me in a vulnerable situation, and I have to exercise caution.

It's impacted on my recovery because I'm so stressed about our relationship all the time. It's all consuming. I need to be focusing on my health and getting better and being relaxed and calm. The stress is making everything worse including my anxiety and cortisol levels. I now have a very low tolerance for any stress at all.

For other victim-survivors, the impacts and the needs for recovery from their experiences of long COVID and IPV were not distinct – they were intertwined. These victim-survivors could not separate what they saw as their recovery and healing needs. As one victim-survivor described:

It's all blended together now. I have no idea what's a result of the years of abuse itself on my mental and physical wellbeing, and what's a result of the long COVID. Unfortunately, I feel like I'll never be able to know, because it feels like the abuse will never stop and give me a chance to see what's left over. I wish I were safe, and my children were safe, and I could work out what deficit remained.

Australia, like other countries, continues to move into the new normal of 'living with COVID'. Understanding the intense and at times unique recovery and healing needs of victim-survivors who have also experienced, or are experiencing, long COVID is critical to ensuring there is adequate and effective provision of support services in the immediate (crisis), medium and long term. A 2016 ANROWS study found that IPV contributed an estimated 5.1 per cent to the health burden for women aged 18 to 44 (Webster, 2016). IPV is the number one risk factor contributing to the disease burden for Australian women in this age bracket. It is greater than alcohol, tobacco and illicit drug use. For First Nations women, intimate partner violence contributes an estimated 10.9 per cent to disease burden in the same age bracket (Webster, 2016). The burden of disease study was not further disaggregated; however, given what we know about the increased risk and prevalence of violence for women with disability, it is likely that the disease burden for women with disability will be higher. If the recovery and healing of all victim-survivors is to be better supported, increasing awareness about the risk and recovery needs of women with long COVID experiencing abuse must be a critical piece of the National Plan (DSS, 2022) focus on recovery and healing.



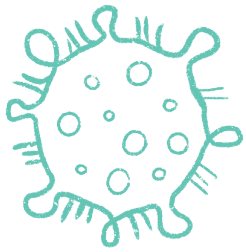
Conclusion



This report seeks to put the interpersonal safety and support needs of individuals diagnosed with long COVID on the political agenda. Globally, no attention has been paid to the intersection between long COVID and intimate partner violence. This is staggering, given that past research documents that victim-survivors of IPV against women are twice as likely to develop long-term illnesses, including chronic fatigue syndrome and fibromyalgia (Chandan et al., 2023). The significance of this project's findings lies in its ambition to make visible the previously unseen impacts of long COVID on individuals living with domestic violence.

Aligning with previous research on chronic illness and experiences of IPV, this study illustrates how chronic health conditions, in this case long COVID, dramatically shape the nature, prevalence and impact of abuse experienced by victim-survivors. Of the 28 victim-survivors who participated in this study, one-quarter said they experienced partner abuse for the first time in their relationship following their long COVID diagnosis. For those victim-survivors who had experienced abuse in their relationship prior to their long COVID status, roughly half said that the abuse changed in severity following their diagnosis, one-third said it changed in frequency, and nearly 70 per cent said the types of abusive behaviours perpetrated by their partner changed following their diagnosis. The abusive behaviours reported in this study illustrate how perpetrators often weaponise health conditions to perpetrate abusive and controlling behaviours within relationships. Taken together, the experiences of the victim-survivors in this study underscore that experiences of IPV are highly contextual, and they illustrate how perpetrators can utilise a deterioration in a person's health to inflict new and intensified forms of abuse within relationships.

In addition, this study indicates that the COVID-19 pandemic had a two-fold impact on victim-survivors with chronic health conditions. For the victim-survivors in this study, the COVID-19 pandemic triggered the initial infection that culminated in long COVID, while the associated restrictions created a sense of isolation and restricted access to support services. This led to increased perceptions of vulnerability to IPV victimisation and inhibited the victim-survivors' ability to leave their abusive relationships. Victim-survivors' reports about the factors contributing to their decisions to remain or leave their abusive relationship following their long COVID diagnosis echo previous research about cultural norms and narratives involving women with health needs and/or disability. These norms and narratives depict such women as 'burdensome' and 'lucky' to have a partner – and who therefore should put up with any abuse experienced (Maher et al., 2018). Notably, two victim-survivors in this study identified these cultural norms playing out in their own abusive relationships and explained that the burden-of-care discourses employed by their perpetrators contributed to their decisions to leave.



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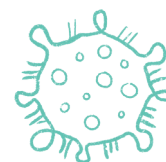
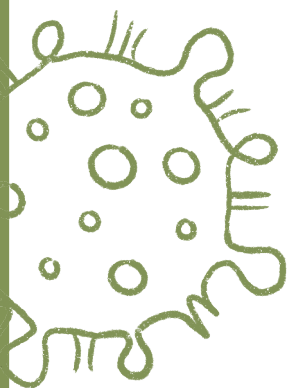
Research examining help-seeking behaviours of victim-survivors with chronic health conditions and disability is growing both in Australia and internationally (see, among others, Ballan et al., 2016; Barrett et al., 2009; Maher et al., 2018; Nichols et al., 2018; Son et al., 2020; Stavrou, Poynton & Weatherburn, 2016). Most of the existing research tends to examine individuals with chronic health conditions or disability generally (see, for example, Maher et al., 2018; Son et al., 2020). This study has sought to contribute to narrowing the scope of this valuable body of research by building the evidence base specific to long COVID and IPV (see Ballan et al., 2016). There is a dearth of research in Australia and internationally exploring the intersection occurring within women victim-survivors who had pre-existing chronic health conditions or disability and experienced a chronic health condition or disability as a result of the violence. An example relevant to our study would be victim-survivors who have experienced long COVID as well as other chronic health conditions or disability stemming from their experience of IPV. While this study contributes to a relevant body of literature, we recognise that this particular intersection requires more scholarly and service sector attention.

This study contributes to a growing body of work which has evidenced the myriad ways that the safety of individuals within intimate partner relationships has been impacted by the pandemic. It further underscores why we must ensure that DFV – and supporting the safety and help-seeking efforts of victim-survivors – continue to be considered within public health conversations at the state, national and international levels. The Commonwealth Government is moving into the second year of delivering upon the ambitions of its National Plan (DSS, 2022) – a plan which commits to eliminating all forms of gender-based violence in one generation. The unique forms of abuse experienced by victim-survivors with long COVID and other chronic health conditions must be addressed by efforts supported across the full spectrum of prevention, early intervention, response, recovery and healing. This study has, for example, demonstrated some of the recovery needs of individuals with long COVID. It has also documented some of the additional barriers to help-seeking for these victim-survivors, which will need to be tackled through work in the response pillar. This study has further highlighted the important role that health practitioners can play in early intervention. Ultimately, prevention is the goal. By centring the experiences of the 28 victim-survivors who shared their stories of partner abuse with us, this study highlights the paramount need to address the underlying drivers of violence against women. Throughout the experiences shared, victim-survivors routinely described losing control of their health and subsequently losing control of their safety within their relationship. Responding adequately to intimate partner violence for victim-survivors experiencing long COVID requires addressing the complex intersection of gender-based and ableist violence, as well as chronic illness more broadly.

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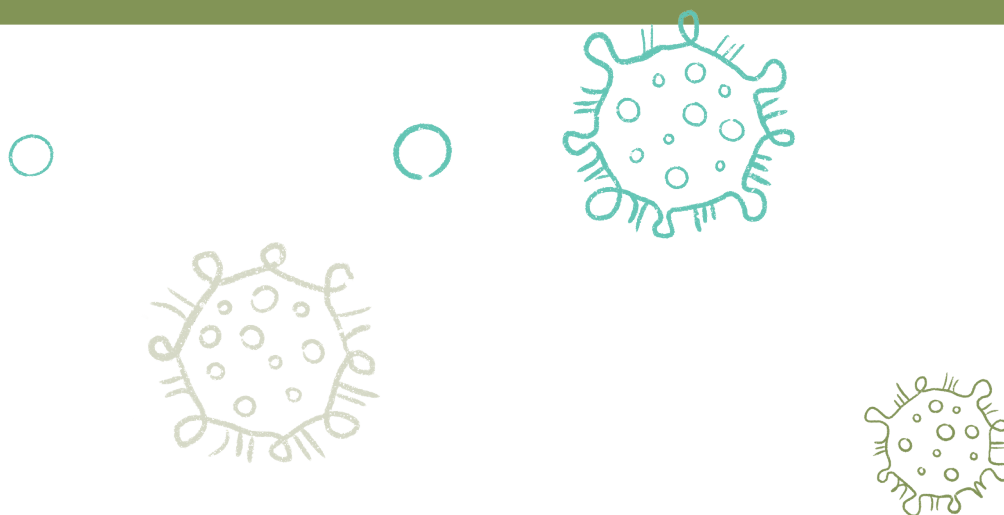
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