Bystander Experiences of

Domestic Violence and Abuse during the COVID-19 Pandemic

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Violence Prevention Unit

University of Exeter

A Mixed Methods Study into Bystander Experiences of Domestic Violence and Abuse during the COVID-19 Pandemic

Research Team

Dr Alex Walker[1], Dr Rachel A Fenton[2], Lara C Snowdon[1], Bryony Parry[1], Emma R Barton[1], Prof Catherine Donovan[3] and Prof Mark A Bellis[4]

[1] Wales Violence Prevention Unit,
[2] School of Law, University of Exeter,
[3] Department of Sociology, Durham University,
[4] College of Human Sciences, Bangor University.

[October 2021]

ISBN: 978-1-78986-154-455

This study was funded by Public Health Wales.
This study was delivered by the Wales Violence Prevention Unit and University of Exeter.

For correspondence related to this report, please contact
Lara.Snowdon@wales.nhs.uk

Wales Violence Prevention Unit
Market Chambers
5-7 St Mary's Street
Cardiff
CF10 1AT

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Acknowledgements

Firstly, we would like to thank all research participants without whom this study would not have been possible.

We would also like to thank all those who supported the study whilst obtaining approvals. These include Public Health Wales colleagues from Quality Nursing and Allied Health, Risk and Information Governance, and the Research and Evaluation Division.

Advisory Group: The team would like to thank the advisory group members for their support throughout this research project; Joanne Hopkins (Public Health Wales), Natalie Blakeborough (Public Health Wales), Miriam Merkova (Welsh Women's Aid), Amy Jones (Welsh Government), Alexa Gainsbury (Public Health England and University of Exeter), Karen Hughes (Public Health Wales), Gemma Woolfe (South Wales Police and Crime Commissioners Office) and Mike Taggart (North Wales Police).

Acronyms

COVID-19	Coronavirus
CSEW	Crime Survey for England and Wales
DVA	Domestic violence and abuse
HCRW	Health and Care Research Wales
HRA	Health Research Authority
ONS	Office for National Statistics
PHW	Public Health Wales
VAWDASV	Violence against women, domestic abuse and sexual violence
WHO	World Health Organisation

Executive Summary

Background

Domestic violence and abuse (DVA) is a major public health, human rights and criminal justice concern. The COVID-19 pandemic has exacerbated conditions for DVA with experts and academics sharing concerns over the safety of victims and survivors and accessibility of support *(Sacco et al., 2020; Speed et al., 2020)*. During this period, contacts to helplines for DVA, such as the Live Fear Free helpline in Wales have surged (ONS, 2020c).

The changes in daily routines experienced by the nation as a result of the pandemic has resulted in different groups of people becoming aware of DVA. This is evidenced by the increase in third parties reporting concerns to the police or domestic abuse helplines (Ivandic et al., 2020; ONS, 2020). This study, conducted by the Wales Violence Prevention Unit (VPU) and University of Exeter, explores the experiences and behaviours of bystanders to DVA during the COVID-19 pandemic.

Methodology

This mixed methods pilot study sought to explore the following research questions:

1. What are bystanders' experiences of witnessing DVA during the COVID-19 pandemic?
2. What are the motivations and barriers for bystanders taking action to prevent DVA during the COVID-19 pandemic?
3. What was the impact on the bystanders and what support do they need?

This study used an online survey and follow-up interviews with survey participants, through online platforms. Data collection took place over a three week period, between 15th February 2021 and 8th March 2021. Participants were asked to share their experiences since the pandemic lockdowns began in Wales (March 2020).

The online survey was developed by the research team specifically for this study, with the aim of adapting it for future use with a wider target audience and/or outside of the pandemic. The survey covered demographic information, personality traits, DVA witnessed since the pandemic began, actions taken, motivations and barriers to taking action, and impact of the experience on the bystander. A total of 186 completed survey responses were analysed for this study. The data was analysed using IBM SPSS Statistics, version 24.

The interviews were offered to all those who participated in the online survey. The interviews followed a similar structure to the survey, but asked participants to offer more details of their experience. Three interviews with bystanders were completed and used to support the findings of the survey.

Results

The results highlighted that:

- The circumstances of the pandemic allowed bystanders to become aware of DVA with coercive controlling behaviours causing most concern among participants (see section 4.3).
- The majority of abuse noticed by bystanders in the study was within current or ex intimate partner relationships, with women more likely to be victims and men more likely to be the perpetrator of the abuse (see section 4.4).
- Feeling connected to their community was a significant predictor of the bystander taking prosocial action in response to the behaviour that had caused them concern.
- Most participants offered to support the victim and felt that they had the correct skills to be able to do so.
- Those who did not take action indicated that this was down to a lack of skills and not knowing what to do.
- The experience of witnessing or being concerned about DVA had a negative impact upon survey respondents, yet most would not have liked to do anything more when thinking back.
- Survey respondents who said that they had witnessed sexist banter or jokes since the pandemic began had shared their disapproval with the person saying it (see section 4.5).
- A quarter of survey respondents had noticed an increase in domestic or sexual abuse jokes since the pandemic began. These bystanders indicated that they took action against this behaviour because they recognised that it was problematic (see section 4.6).

Future Actions

Policy Options

- This study demonstrates that bystanders have an important role in the primary prevention of DVA. This could be recognised in violence prevention policy. Encouraging prosocial behaviour, when safe to do so, could be a priority both generally and particularly during a pandemic or other emergency situations, when services are not as readily accessible. Policymakers could consider the use of public awareness campaigns and training to promote knowledge about DVA, and prosocial and informed bystander behaviour. This could help mitigate any negative impact that the experience may have on the bystander themselves (see section 4.4).
- Lessons from this research suggest that public-facing bystander campaigns should be multi-faceted and should be underpinned by awareness and knowledge raising of what constitutes DVA for a public-facing audience. As noted in section 4.4, most participants had witnessed DVA behaviours within intimate relationships, when the perpetrator was a man, and the victim was a woman. Campaigns should emphasise that abuse can happen in a variety of relationships, regardless of gender identity, sexuality, age or ethnicity.
- Policy makers should consider how they can engage different target audiences in knowledge and awareness raising, and as prosocial bystanders. In particular, as noted in section 4.1, most participants in this study were women. Particular attention should be paid to ensuring men engage in bystander efforts. Awareness raising campaigns should aim to increase a sense of responsibility and motivation to act and therefore be accompanied by the offer of evidence-based bystander training to enable and empower bystanders to move (safely) through the theory of behaviour change (see section 5.1).
- The data indicated that a sense of community was found to be a significant predictor of bystanders taking prosocial action against DVA (see section 4.4). Therefore, policies could aim to nurture, sustain and further encourage this sense of community as a contributory factor, motivating bystanders to taking action against DVA.

An increasing number of calls are being recorded to domestic abuse helplines and the police from concerned third parties (neighbours, friends and family).

Practice Options

- The research demonstrated that there is a demand for bystander training programmes to empower and upskill bystanders to take prosocial action (see section 4.4). Bystander training programmes must be evidence and theory-based and must take people through the process of change (see section 2.3).
- Social norms theory should be incorporated into bystander training programmes, materials and campaigns. For an example of a bystander training programme, see the DVA bystander intervention, Active Bystander Communities (see section 2.3). As noted in section 4.4, the bystander feeling that they possess the correct skill set to take action is essential. A variety of bystander responses should be incorporated into campaigns, materials and bystander training programmes. These could be rolled out across communities as bystanders may be essential in the primary prevention of DVA, both in and out of a pandemic.
- When considering public awareness campaigns targeted at bystanders, where appropriate, organisations should make clear which services they offer that might be of relevance to bystanders. As discussed in section 5.1, bystanders are more likely to share their concerns if they know how to. Clear signposting to relevant bystander services would allow bystanders to have increased chance of building knowledge about what is available.
- An increasing number of calls are being recorded to domestic abuse helplines and the police from concerned third parties (neighbours, friends and family) (see section 1.4). Findings from this study indicate that bystanders are often negatively impacted by their experience (see section 4.4). Frontline services, including the police and specialist DVA services, could consider developing guidance and training for call handlers and first-responders to support bystanders who make contact.

Research Options

- This pilot study has tested the methodology, dissemination and topic area of bystanders to DVA during the COVID-19 pandemic. Dissemination and survey recruitment should be amended in future research, to optimise the recruitment of men, BAME groups, and elderly people (see section 5.2). Recruitment should also run for a longer period of time to optimise uptake and on a larger scale with a population level sample.
- The survey respondents indicated that their experience of taking action had a negative impact upon themselves, yet more than half indicated that there was no further actions they wished they had taken (see section 4.4). Future research could explore how these negative impacts could be mitigated with bystander training programmes and/or other adequate support resources.
- Those with a greater sense of community were significantly more likely to take action in response to their concerns (see section 4.4). Future research should determine what “sense of community” means to each participant, such as locality, religion, sports group etc. and how this sense of community reflects on the types of behaviour witnessed or the types of action taken.
- Further research could also explore the inherent difficulty in asking people to participate in research about the DVA they may have witnessed when they may not recognise what behaviours constitute DVA (see section 5.1 for discussion on this). This could be achieved firstly by increased public awareness of what DVA is, and secondly, by alternative methods of recruitment campaigning which could offer more in–depth definitions and examples of behaviours.

Conclusion

This study sought to explore the experiences and behaviours of bystanders to DVA during the COVID-19 pandemic through a mixed methods approach with the general public, including survey and interviews. Whilst implemented on a small scale, this study was the first of its kind and provides new insights into bystander experiences during a global pandemic.

Findings from this study suggest that the circumstances of the pandemic have increased people's opportunity to be active bystanders to DVA behaviours. Participants reported being more aware of 'concerning' behaviours due to increased time spent at home, coupled with less 'distraction' from the norms of regular social and work life, and a heightened sense of community. Participants also felt that the circumstances of the pandemic had increased the ability of perpetrators to control the victim, with coercive control being the most commonly witnessed behaviour.

Having received DVA training, or feeling that they possessed the correct skills to take action was a strong predictor of prosocial bystander responses. Bystanders indicated that the provision of information and training for bystanders would be helpful to mitigate barriers to taking action and guide them in how to take prosocial action against DVA.

Domestic violence and abuse (DVA) is a major public health, criminal justice and human rights issue. It is a significant cause of ill-health and inequality, and has adverse social, psychological and economic impacts for individuals, families and communities across the life course (WHO, 2021).

1.0 Introduction

1.1 Background of Domestic Violence and Abuse in Wales

Domestic violence and abuse (DVA) is a major public health, criminal justice and human rights issue. It is a significant cause of ill-health and inequality, and has adverse social, psychological and economic impacts for individuals, families and communities across the life course (WHO, 2021). Living without fear of violence and abuse is a fundamental requirement for health and wellbeing. The National Institute for Health and Care Excellence (NICE, 2014) states that: *"The cost, in both human and economic terms, is so significant that even marginally effective interventions are cost effective"*. A Home Office report estimating the economic and social costs of DVA in England and Wales, placed the annual cost at £66 billion, with 71% of that being attributed to addressing the physical and emotional harm experienced by victims (Oliver et al., 2019).

DVA can have fatal outcomes. Every day, 137 women are killed worldwide by a family member. It has been estimated that more than half (50,000) of the 87,000 women who were intentionally killed in 2017 were killed by family members or intimate partners. More than a third of these women (30,000) were killed by a current or ex intimate partner (United Nations Office on Drugs and Crime, 2019). Between March 2018 and 2019, Welsh police forces recorded 80,924 DVA related incidents (ONS, 2020a), yet recorded police data only highlights a fraction of the real picture, as incidents often go unreported. It is estimated that a total of 2.3 million adults aged 16-74 living in Wales and England have experienced DVA in the past year (ONS, 2020a).

Anyone can experience DVA, regardless of gender identity, age, sexuality, ethnicity, occupation and income. However, understanding DVA requires an appreciation that it is part of a social pattern of male violence towards women (Hester and Lilley, 2014), with data illustrating that it is predominantly women and girls who are victims and survivors of DVA perpetrated by men and boys (ONS, 2020b). Women and girls are significantly more likely to experience severe forms of abuse, including physical and sexual violence, which result in injury or death (Hester, 2013). Furthermore, they are more likely to experience repeated physical, emotional or psychological abuse. Between 2016 and 2018, 270 out of 366 domestic homicide victims, in the UK, who were killed by a current or ex intimate partner were female (ONS, 2019).

1.2 Definition

Domestic violence and abuse is defined as *"any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. It can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial or emotional"* (UK Government, 2013).

In 2015, the Welsh Government passed the 'Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act', the first piece of legislation in the United Kingdom to explicitly address violence against women as opposed to domestic violence generally.

1.3 The Policy Context in Wales

Domestic violence and abuse is a human rights issue, recognised in national and international treaties and conventions, a criminal justice issue, and a public health issue. The prevention of violence against women is a priority for:

- The United Nations (UN), through the '*Convention on the Elimination of All Forms of Discrimination against Women*'
- The European Union (EU) through the '*Istanbul Convention*'
- The UK Government through the '*Strategy to End Violence Against Women and Girls 2016-2020*'
- The UK Government through the '*Strategy to End Violence Against Women and Girls 2021-2024*'
- The Welsh Government through the '*Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015*'

The Welsh Government published its first national strategy in 2005. '*Tackling Domestic Abuse*' (Welsh Government, 2005) adopted a rights-based framework guaranteeing every citizen the right to live free from violence and abuse (McCarry et al., 2018). The '*Right to be Safe Strategy*' followed. This six-year plan focussed on four key areas; prevention, awareness raising, supporting victims, and improving the response of criminal justice services as well as health (and related) services (Welsh Government, 2010). In 2012, the Welsh Government white paper set a course for improved education, awareness and more integrated services (Welsh Government, 2012).

In 2015, the Welsh Government passed the '*Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act*' (hereafter, the Act); the first piece of legislation in the United Kingdom to explicitly address violence against women as opposed to domestic violence generally. The key purpose of the Act was to improve the public sector response in relation to the prevention of acts of gender-based violence, domestic abuse, and sexual violence, the protection of victims and support for those affected. The Act is significant for women because it sets out practical steps which national and local government and public sector bodies should implement to work together to prevent violence against women. The Act also aims to strengthen the support available to the victims of violence against women, domestic abuse and sexual violence (VAWDASV) by improving the public sector response and consistency of service provision by providing for a strategic focus with a preventative approach (Price et al., 2020, Jurasz, 2018).

1.4 COVID-19 and Domestic Violence and Abuse in Wales

Since the Coronavirus (COVID-19) pandemic began, countries worldwide have implemented various measures to limit its impact. For those living in Wales, these measures included social distancing, isolation and lockdown, and closure of retail outlets, pubs and bars, leisure facilities, places of worship and some public places. People were told to work from home wherever possible and only leave for essential shopping and daily exercise. These restrictions have varied in intensity and design since the initial Welsh lockdown in March 2020. Whilst they are intended to keep the country safe, for victims of DVA, they may have the exact opposite effect (Campbell, 2020).

For those experiencing DVA, the pandemic has created a "*perfect storm*" as conditions for DVA have been exacerbated (Welsh Women's Aid, 2020). While people are encouraged to work from home and in "*lockdown*", victims have been forced to stay with their abusers for extended periods of time with limited ability to access support or leave the situation. This has given abusers increased proximity to the victim, the opportunity to control phone use, internet use, finances, prevent access to medical services (A&E, contraception etc.), limit contact with other people and stop the victim accessing support networks (Sacco *et al.*, 2020; Speed *et al.*, 2020; Kofman and Garfin, 2020). It is likely that abusers' behaviours may have been further exacerbated by the psychological strains caused by the pandemic, including concerns about financial security, employment and childcare (Snowdon *et al.*, 2020; Kaukinen, 2020).

Experts suggest that a "*shadow pandemic*" has occurred alongside the COVID-19 pandemic, as levels of DVA have been increasing "*behind closed doors*" (UN Women, 2020). At the beginning of the pandemic, the WHO issued guidance to policy makers urging them to ensure members of the public knew what services were still available to them concerning DVA (Pearson *et al.*, 2021). Concerns logged with the Welsh Women's *Aid Live Fear Free Helpline*[1] have increased significantly. This rise has been noted across all channels: calls (41%), emails (66%), webchats (10%) and texts (768%) (ONS, 2020c). *The Live Fear Free* helpline data also indicates an increase in third parties (neighbours, friends, family, colleagues) contacting the helpline for support and advice on what they can do about someone they are concerned about (ONS, 2020c) and there has been an increase in the length, severity and complexity of calls (Wales Violence Prevention Unit, 2020). These trends are supported by Ivandic *et al.* (2020) who found an increase in domestic abuse calls to the police from third parties, especially in high density areas. This suggests that the "*stay at home*" guidance has not only increased but exposed new and different groups of people to witnessing or having concerns about DVA.

Concerns logged with the Welsh Women's Aid Live Fear Free Helpline have increased significantly. This rise has been noted across all channels:

41%
Calls

66%
Emails

10%
Webchats

768%
Texts

[1] The Live Fear Free Helpline is a free helpline for anyone living in Wales experiencing or with concerns about VAWDASV

1.5 Bystanders to Domestic Violence and Abuse

Bystanders are "*witnesses to negative behaviour (an emergency, a crime, a rule violating behaviour) who, by their presence, have the opportunity to step in to provide help, contribute to the negative behaviour or encourage it in some way, or stand by and do nothing but observe*" (Banyard, 2015, pp. 8). Everyone is a bystander, all the time.

We witness events unfolding around us constantly. Some of these events may be recognised as problematic, and we might decide to do or say something, becoming an active bystander, or to do nothing and remain a passive bystander. There are many factors that will influence why we decide to intervene or not (Fenton et *al.*, 2016).

The theory of change that influences active bystander responses is

1.  **Noticing** the event

2.  **Recognising the situation as problematic** (in this case, recognising the situation as DVA)

3.  **Feeling responsible** to take action

4.  **Possessing the right skills** to take action (Latane and Darley 1979, Berkowitz, 2009)

These steps are at the core of most bystander training programmes (e.g. Gainsbury et al., 2020); if at any point a bystander does not identify with a step, for example, they do not recognise the situation as DVA (step 2), they may not take any action in response to the behaviour they have noticed.

Social norms theory also plays a significant role in bystander responses. When applied to DVA, this means that social or communal norms can influence the way that perpetrators and bystanders behave. "*It is not necessary for the majority [of the group] to believe it, but only for the majority to believe that the majority believes it*" (Berkowitz, 2003, pp. 261). Put simply, a bystander is less likely to take action, if they become concerned about DVA, when no one else seems concerned about the behaviour. Other people may also be concerned, but not feel confident to say anything as the group norm implies that it is not a problem; this is often referred to as "pluralistic ignorance". Shifting the social norms, and empowering bystanders to feel confident enough to speak up, is therefore essential to tackling DVA (Fenton et al., 2016).

When DVA is not reported, it can have severe consequences for the victim; the most serious of which is death (Bouillon-Minois, 2020). Yet researchers have indicated that bystanders are more likely to report instances of DVA when they have proof, because they are worried that they will not be believed (Rowe, 2018). It is therefore imperative that bystanders are provided with enough information to feel confident that their concerns, even without proof, will be taken seriously and that the methods for sharing their worries are easily accessible (Borum, 2013). Bystanders are essential to tackling DVA at a community and societal level (Gainsbury et al 2020). Their support can also be vital for victims living with DVA.

1.6 Study Rationale and Aims

DVA can often be a crime that occurs behind closed doors and out of sight. The restrictive measures put in place to contain the spread of COVID-19 have meant that for some victims, DVA has been exacerbated and means to access support networks has been restricted. In turn, other people in physical (and online) proximity to the victims may have become inadvertent and unexpected bystanders to DVA and/or the warning signs of abuse, with potentially new opportunities to take action.

The National Strategy for VAWDASV (Welsh Government, 2016) states that a key commitment for Welsh Government is primary prevention. This encompasses plans to increase awareness of VAWDASV within the Welsh population, and challenge the attitudes which legitimise it. Additional key commitments outlined in the strategy are building institutional, organisational and community capacity to identify and respond appropriately to VAWDASV, and to adequately fund early intervention support services. Bystanders to DVA may be an important source of community resilience and support for victims of DVA, perhaps more so during the pandemic than ever.

This study aims to understand the experiences and behaviours of bystanders during the COVID-19 pandemic. The study has the following objectives:

Provide insights into the groups of people who have witnessed DVA and its warning signs

Identify the types of abuse bystanders are witnessing

Explore the actions taken by bystanders in response to the DVA concerns, and the motivations or barriers to taking that action

The findings from this study can be used to inform DVA prevention policy, the development of bystander training programmes and improve knowledge about bystander responses to DVA during the COVID-19 pandemic. Understanding these experiences and behaviours is crucial for creating societal resilience, both during the COVID-19 pandemic and in the future; and for the prevention of DVA as a critical public health strategy.

2.0 Literature Review

2.1 Literature Search Strategy

A scoping review was used to examine the relevant literature. Scoping reviews are useful to

- Identify what evidence is available,
- Examine the methodologies used,
- Identify key factors related to the research subject
- Identify any knowledge gaps

(Munn et al., 2018).

The review aimed to identify literature which supports the research objectives (as above). The articles identified were initially used to inform the development of the survey, and later to critique the findings.

Eleven search engines were utilised for the search: Wiley, Taylor and Francis, Springer, Sage Journals, ProQuest, Elsevier, Cochrane, CINAHL, APA, Research Gate and Google Scholar. This was accompanied by a hand search through relevant journals; “Violence Against Women”, “Journal of Gender Based Violence”, “Psychology of Violence”, “Journal of Interpersonal Violence” and “BMC Public Health”. The key search terms used were “bystander”, “bystander experiences”, “COVID”, “coronavirus”, “pandemic”, “domestic abuse and violence”, “domestic”, “abuse” and “violence”.

Search limiters included English language only, peer reviewed and full text being available. Published systematic reviews were also explored with relevant references being followed up. The scoping review was conducted between November 2020 and April 2021.

2.2 Community Bystanders' Beliefs

Several studies were identified that explore the beliefs, behaviour and perceptions of bystanders to a variety of different DVA stimulus.

Banyard et al. (2020) sent postal questionnaires to residents in New England, US to explore any links between sense of community and prosocial bystander responses to domestic and sexual violence. The 1,623 respondents were divided into three categories: non responders, occasional responders, and frequent responders. All of those within the frequent responders group had an increased sense of community compared to the other two groups. Whilst not conducted within a community setting, *McMahon et al.* (2015) found corresponding results within a university sample.

Muralidharan and Kim (2019) sought to determine the most efficient means of motivating bystanders to take action against DVA. They used two groups of participants. One group was taught facts about DVA and the other was presented with a survivor's lived experience narrative. The lived experience narrative was significantly more effective at motivating bystanders to theoretically take prosocial action against DVA. This stark difference between the groups was attributed to the empathy that bystanders were able to feel after hearing the victim's personal experience[2]. This suggests that empathy plays an important role in prosocial bystander behaviours. Empathy is an antecedent to efficacy, whereby the one logically precedes the other. The link between increased efficacy and prosocial bystander intervention is well established (Fenton and Mott, 2018).

Similar to the above study, Green (2020) showed villagers in rural Uganda videos of DVA victims sharing their stories to try and reduce violence against women and encourage bystander intervention. Several months after showing the videos, the research team revisited the villages to assess the impact of the videos. Rates of violence against women were unaffected by the videos, yet more people were reporting incidents they had seen or personally experienced. This suggests that empathy is more effective at motivating prosocial bystander responses and encouraging victims to come forward than it is at deterring abusers.

Taylor *et al.* (2016) explored the experiences of victims of intimate partner violence (IPV) in rural areas of the Southern United States when a bystander was present to witness the physical abuse. A stark number of participants indicated that the presence of the bystander resulted in higher rates of injury and poorer victim mental health. Although solely focused on physical IPV, this study highlighted that not all abuse occurs in private, and when an (untrained) bystander had been present, it resulted in worse outcomes for the victim. Bystander interventions must ensure that safety for themselves (as a bystander) and the victim is a priority when trying to help in a situation related to physical violence. This study has highlighted why appropriate training is essential, to protect the safety of all involved.

Despite not being conducted within the general community, several studies have shed light on motivations and barriers to students taking action when they witness domestic or sexual abuse. Whilst not directly relevant to this study, they still offer insight into bystander behaviours. For example, Weitzman et al., (2020) found that the relationship between the bystander and the victim was a significant predictor of taking action or not, with participants being most likely to take action if the victim was a friend or family member. Flemming and Wiersma-Mosley (2015) found that the severity of the abuse being witnessed was highly influential for the bystander taking action. The students were much more likely to report incidents where they felt there was an immediate threat to life. Christensen and Harris (2019) found that bystanders within the student population were much more likely to take prosocial action if they had personal experience of being a victim themselves.

[2] Listening to a victim's story can sometimes have the adverse effect on male attitudes towards violence against women; for example, Berg et al. (1999) found that male undergraduates reported increased likelihood of engaging in rape-supportive behaviours after hearing a female rape victim's narrative.

2.3 Bystander Intervention Programmes

There is a significant global body of literature on bystander programmes to prevent domestic and sexual violence and abuse. In a recent systematic review, conducted by Addis and Snowdon (2021), bystander programmes were the focus of seven systematic reviews (Kovalenko et al., 2020; Kettrey and Marx, 2019a; Kettrey and Marx, 2019b; Mujal et al., 2019; Jouriles et al., 2018; Storer et al., 2016; Fenton et al., 2016). All reviews found that the majority of bystander literature focuses on adolescents or young people in educational settings, mainly college and university settings with a focus on sexual and intimate partner violence prevention. Overall, the review concluded that bystander programmes have a strong aptitude for changing attitudes and beliefs that promote VAWDASV.

Additionally, seven primary studies evaluated bystander interventions including the *Red Flag Campaign* (Borsky et al., 2018, Carlyle et al., 2020), *Green Dot* (Coker et al., 2019), *Bringing in the Bystander* (Edwards et al., 2019) and *The Intervention Initiative* (Fenton and Mott, 2018). While studies were predominantly undertaken in university settings, one study indicates that the bystander approach (Active Bystander Communities) can be transferred from student populations to general communities in the UK (Gainsbury et al., 2020).

Gainsbury et al. (2020) evaluated the feasibility and potential for effectiveness of a DVA bystander intervention within UK communities. Active Bystander Communities (ABC) require participants to attend a training programme facilitated by experts over three sessions. Bystander efficacy, behavioural intent, bystander behaviours and myth acceptance were assessed at baseline using validated scales, post training and after four months. Significant changes were observed across bystander efficacy, behavioural intent and myth acceptance. At four months post intervention, these changes had been maintained, and in some cases had increased, with the exception of myth acceptance. These findings are promising and indicate that ABC can help change attitudes towards DVA in general communities within the UK.

Additional studies identified programmes with elements of bystander programming built into programme design. For example, Quigg and Bigland (2020) conducted an evaluation of The Good Night Out Campaign (GNOC). The GNOC is a UK programme that was developed for licenced premises which aims to support those who work in nightlife settings to better understand, respond to, and prevent sexual violence. GNOC facilitators worked with 11 nightlife venues, providing guidance on preventing and responding to sexual violence and bystander training for over 150 nightlife workers. The participating venues were provided with materials to display to raise awareness of the GNOC and encourage patrons to report incidents. The trainees were surveyed and findings suggest that the GNOC training programme is associated with improvements in knowledge and attitudes towards sexual violence. Quigg and Bigland (2020) also noted greater readiness and confidence to intervene in sexual violence amongst nightlife workers.

2.4 Bystanders during COVID-19

Only one study was identified which made reference to bystander behaviours during the pandemic. Campbell (2020) noted that only 8% of calls to law enforcement agencies to report DVA during the pandemic came from bystanders, compared to 80% of animal control calls which were made by bystanders. This paper further highlights how DVA is also present in a large number of the homes where animal cruelty is reported; a link that is now well established (Riggs *et al.*, 2021). Animal control units should also be trained in DVA and be made aware of the routes to report concerns they notice whilst investigating cases of animal abuse.

There is a clear gap in the evidence base for bystander behaviours during the COVID-19 pandemic, an opening this study sought to address.

3.0 Methodology

3.1 Research Question and Aims

This research seeks to explore the behaviours and experiences of bystanders to DVA during the COVID-19 pandemic in Wales. In doing so, this study will address an understudied area in the bystander and violence prevention literature. The following research questions were posed:

- What are bystanders' experiences of DVA during the COVID-19 pandemic?
- What are the motivations and barriers for bystanders to DVA during the COVID-19 pandemic?
- What was the impact on bystanders and what support do they need?

The aims of this study were to:

- Improve knowledge of bystander opportunities and behaviours during the COVID-19 pandemic.
- Inform policy and prevention strategies.
- Add to the evidence base for bystander programmes and how the primary prevention of DVA can be utilised during future pandemics.

3.2 Methods Overview

This mixed methods study used an online quantitative survey delivered through the online platform Qualtrics, combined with qualitative interviews, conducted over Zoom or Microsoft Teams. Survey and interview recruitment ran for a three week period, from 15th February 2021 to 8th March 2021.

3.3 Material Development

Survey

To the best of the research team's knowledge, no survey or questionnaire currently exists which explores the experiences of bystanders to DVA during the COVID-19 pandemic. Therefore, the team developed their own survey with the help of the advisory group (acknowledged above, pp 5). To develop the survey, an extensive search of the literature and campus climate surveys was conducted, alongside a review of the current data trends and criminal law. Participatory workshops were held with the research team and members of the advisory group to shape and refine the final survey. An academic paper outlining the process of developing this innovative survey instrument is due to be published shortly.

Details on the survey dissemination can be found below (Section 3.6, pp 22).

The final version of the survey contained the following sections:

- **Demographic** information
- **Knowledge** and attitude of DVA
- **DVA witnessed** during the pandemic
- **Sexist and misogynistic** jokes or banter witnessed during the pandemic
- **Sexual violence and domestic abuse**, jokes or banter witnessed during the pandemic
- **Training** needs

Findings from the online survey can be found below (Section 4.0, pp 22).

At the end of the survey, respondents were asked if they would like to take part in an interview to explore their experiences further. If so, they were invited to email the research team and request an information sheet which contained further information on the interviews. If they wanted to take part in the interview after reading through the information sheet, this was also arranged through email with the research team.

Interviews

Semi-structured interviews were conducted with participants via Microsoft Teams or Zoom. These interviews followed a similar structure to the online survey but also asked participants to expand on the impact of being a bystander to DVA had on them personally, and those involved. The interviews allowed the participants to share the holistic details of what they had witnessed or become concerned about since the pandemic began. They were able to paint a fuller picture of the events which the survey was unable to capture. A copy of the interview questions is available upon request.

On average, each interview lasted half an hour. Findings from these interviews have been entwined with the survey data, to further illustrate key findings.

3.4 Inclusion Criteria

This study aimed to recruit anyone aged 18 or over who may have seen or become aware of DVA since the beginning of lockdown (March 2020). This study was solely conducted in Wales with participants living or working in the country.

3.5 Ethics

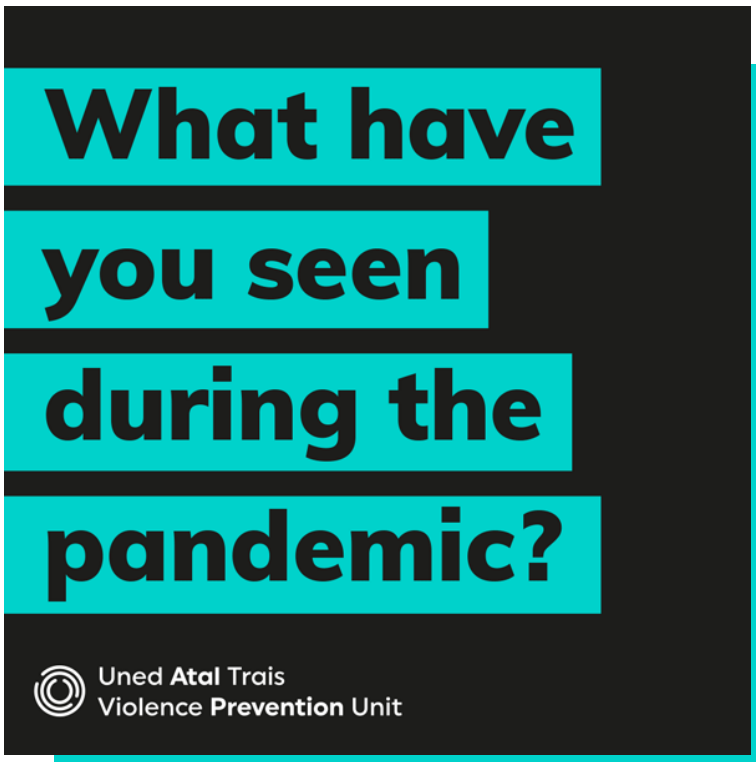
After consulting with Public Health Wales' Safeguarding Lead, this study received NHS ethics approvals from HRA and HCRW on 20th January 2021 (ref. 20/HCRW/0061). Public Health Wales' Data Protection and Public Health Wales Research and Development approved the study on 4th February 2021.

3.6 Dissemination

A communication plan was developed to advertise and optimise the reach of the survey across public and professional networks, using both remunerated and organic communications through social media and email. Key organisations and stakeholders were engaged to aid in the dissemination of the survey through public channels and professional networks.

When designing the advertisements for recruitment into this study, the word "bystander" was not used, as the team were not sure members of the public would know what this word means. Instead, the advertisements' wording (from the participant information sheet) was "a study into what you might have witnessed, noticed or been concerned about relating to domestic abuse or its warning signs since the beginning of the COVID-19 pandemic".

The (paid-for) communications were designed for social media and included the design of an advert in the form of a GIF (translated to Welsh and English) which was used to advertise the survey. Adverts were targeted at adults living in Wales, certain occupation types who were actively working within the community during the pandemic; such as delivery/postal workers, public transport workers, police, hospital staff, hairdressers, and those who had visited DVA websites. After two weeks, the data was reviewed and any identified gaps in demographics were targeted for a further week.



Communication also included an advertorial in Wales' largest online news site, Wales Online[3]. As well as the advertorial, this included two Facebook posts and two Twitter posts from the main Wales Online newsfeed. The organic communications included media and stakeholder engagement. Coverage of the survey was also included on BBC Wales Online[4], BBC News webpage, BBC Radio Wales' morning radio show, and across the three regional news cycles on the BBC.

3.7 Data Analysis

The quantitative survey data was initially cleaned, with any partial responses being removed, and codes were applied. It was then analysed using IBM SPSS Statistics Version 24 and descriptive statistical analysis and chi-squared were run. A copy of the analyses outputs can be found in Appendix B.

The interviews were audio recorded, transcribed and anonymised. They were then analysed using Atlas ti. 8 and thematic analysis was completed.

An academic paper on the results of the study is due to be published in due course.

[3] Take this survey and help tackle the rising cases of domestic abuse in Wales - Wales Online https://www.walesonline.co.uk/special-features/take-survey-help-tackle-rising-19725171

[4] https://www.bbc.co.uk/news/uk-wales-56074048

4.0 Results

This section combines the findings from the quantitative survey and the qualitative interviews. Where possible, the qualitative data is used to support the quantitative data analysis and offer additional insight.

4.1 Survey Respondents

A total number of **395 survey responses** were received over a three-week period. Of these, **186 records were fully completed** and used for this report.

95.2% of respondents were White British/Irish which is consistent with the demographics for Wales (Welsh Government, 2020). **The majority (85%) of the respondents were women (N=158 out of 186) and aged between 18 and 44 years old (66.3%)**.

A full breakdown of the demographic details of the participants can be found in Appendix A.

The majority of participants (64%) indicated that they felt their knowledge of DVA was very to extremely knowledgeable. Participants did not feel as knowledgeable about the laws relating to DVA, with most selecting the moderately knowledgeable option for this question on the survey (52.7%). There was a nearly equal divide between those who had attended DVA training within the last 5 years, and those who had not. There was a similar divide between participants whose job roles required them to have awareness of DVA and those who did not.

The survey captured data from people in a range of occupations, including health care, social care, industry, key public services, government, education, and also included those who are retired, unemployed and stay at home parents. The data also indicated that three quarters (75.4%) of the respondents had remained primarily at home during the day since the pandemic restrictions began; whether that be working from home, retired, unemployed, furloughed or stay-at-home parent.
A significant number of participants indicated that they were prosocial individuals, and wanted to help other members of their community (80%). Similarly, they felt that they could take action against DVA, and did not agree with rape myth statements.

4.2 Interview Respondents

Only six survey respondents emailed the team to ask for more information about the interviews and all six agreed to take part. Of these six, three of the interviews were discounted from the study as not meeting inclusion criteria- two were survivors and one included experiences from working in a professional capacity only.

The remaining three participants were women who had good knowledge of DVA through their own professional roles, and were able to discuss concerns about DVA that they had outside of their roles. Two had concerns about a friend, while the other was concerned about their elderly parents with dementia being abused by a caregiver.

4.3 Bystander Experiences

Coercive control behaviours and warning signs of DVA were the most prevalent behaviours witnessed by respondents (Figure 1). Coercive control behaviours included someone being monitored and/or controlled about where they are or, who they are with; someone being monitored using spyware or tracking devices; someone having their phone, social media or internet use controlled or checked. Warning signs of DVA included someone looking fearful and/or walking on eggshells around their partner and/or members of their family; or someone who behaves as if they are very worried and fearful all of the time.

This theme was also evident within the interview data, as the interview participants had not witnessed their friends or family being directly abused, but became aware of warning signs which indicated that something was not quite right.

Furthermore, interview participants felt that the circumstances of the pandemic were being used by perpetrators to control the victims.

DVA behaviours witnessed by bystanders during the pandemic

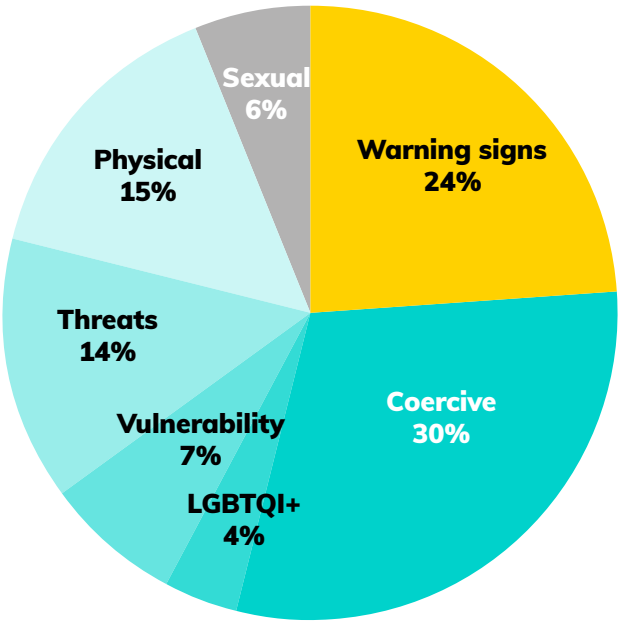


Figure 1: Behaviours witnessed during the pandemic

"There was a definite change in my friend's ability to talk freely... She was starting to mention and drop things into conversations, so we were feeling that maybe she wanted to talk about it ...but as soon as you try to offer support around that, it quickly shut down, very defensive" [Interview 3]

> **"She was quite fearful of the pandemic, he was using that fear to keep her in the house more, to control her more ...she wouldn't even go out into the garden in the end because he was telling her it was wasn't safe to do that. So, it got quite extreme"** [Interview 2]

Among the survey responses, there were substantial gender differences noted within the behaviours that had been witnessed and/or caused concern. As Table 1 shows (pp 25), on the whole, the majority of DVA behaviours were observed by women, with the exception of the abuse of a LGBTQI+ person, which was witnessed by 14.3% of men participants, compared to 12.3% of women participants, and threats of abuse, which was witnessed by 57.1% of men participants, compared to 41.1% of women participants.

For most behaviours, they were observed more by those aged between 18 and 34 (as demonstrated in Table 1), with the exception of LGBTQI+[5] abuse, the abuse of a vulnerable person and threats of abuse, which was noted mostly by those over 45 years of age (52%, 42.5% and 39.4% respectively).

Exploration of a link between occupation and behaviours witnessed showed a higher proportion of those working in health and social care or industry and other tertiary jobs[6] reported becoming concerned across all behaviours (see Table 1). 100% of participants who worked in education (N=31) reported concerns about coercive control since the pandemic began.

Although three quarters of respondents to the survey were primarily at home, the data suggests that there was no notable difference between those who were primarily at home during the pandemic (working from home, furloughed, unemployed) and those who were continuing to go to work as normal in witnessing or becoming concerned about DVA behaviours (see appendices, Table 7). Yet notably more participants (44.8%) indicated that they felt the pandemic had allowed them to become aware of the concerning behaviours (for example, working at home when they would usually be in the office).

This was also demonstrated in the interviews, as participants felt that the change in daily routines had allowed them to notice the warning signs.

> **"I think it would have been more easily hidden or we might have been distracted from it and we might not have been as proactive or as aware and worried about it if we weren't in a pandemic"** [Interview 3]

[5] Abuse aimed at lesbian, gay, bisexual, transgender, queer and intersex, + others.
[6] Industry jobs include manufacturing or construction. Tertiary jobs included hairdressers, barbers, beauty therapists, photographers, musicians, artists, transport, retail, hospitality and voluntary workers.

Table 1: Frequency and percentage of participants who witnessed the different DVA behaviours

		Behaviours Witnessed						
		Warning Signs	**Coercive Control**	**LGBTQI+**	**Vulnerability**	**Threats**	**Physical**	**Sexual**
Gender	Man	15 (53.6%)	24 (85.7%)	4 (14.3%)	5 (17.9%)	16 (57.1%)	10 (35.7%)	2 (7.1%)
	Woman	117 (74.1%)	144 (91.1%)	21 (13.3%)	35 (22.2%)	65 (41.1%)	73 (46.2%)	33 (20.9%)
Age	18-34	52 (39.4%)	66 (39.3%)	7 (28%)	11 (27.5%)	24 (29.6%)	29 (34.9%)	13 (37.2%)
	35-44	39 (29.5%)	49 (29.2%)	5 (20%)	12 (30%)	25 (30.9%)	25 (30.2%)	11 (31.4%)
	45+	41 (31.1%)	53 (31.5%)	13 (52%)	17 (42.5%)	32 (39.5%)	29 (34.9%)	11 (31.4%)
Occupation	Usually at home	19 (63.3%)	27 (90%)	3 (10%)	4 (13.3%)	15 (50%)	13 (43.3%)	4 (13.3%)
	Health and social care	19 (63.3%)	27 (90%)	3 (10%)	4 (13.3%)	15 (50%)	13 (43.3%)	4 (13.3%)
	Government or public services	26 (66.7%)	27 (90%)	3 (7.7%)	5 (12.8%)	17 (43.6%)	19 (48.7%)	7 (17.9%)
	Education	25 (80.6%)	31 (100%)	1 (3.2%)	7 (22.6%)	11 (35.5%)	15 (48.4%)	5 (16.1%)
	Industry or tertiary	32 (71.1%)	37 (82.2%)	7 (15.6%)	16 (35.6%)	19 (42.2%)	16 (35.6%)	9 (20%)

4.4 Bystander Actions, Motivations and Barriers

Actions

Bystanders were asked if they had taken action in response to the behaviour they had witnessed. Results indicate that 85.7% (24 of 28) of men and 88.6% (140 of 158) of women took some form of action. A chi–square test was run on these two variables (gender and taking action) and no significant relationship was found (X^2, p=.662).

The majority of participants in each age group took action against the DVA they had witnessed (see Table 2). The chi-squared analysis indicated that there was a significant relationship between the age of the participant and whether or not they took action, $X^2(2, N=186) = 6.296$, p=.043.

Table 2: Frequency of participants from each age group who took action

		Took action (yes)
Age	18-34	56 (81.2%)
	35-44	48 (88.9%)
	45+	60 (95.2%)

When comparing bystanders taking action (yes or no) to the respondents' trait data, the chi-square test showed that changing levels of DVA awareness (increased or stayed the same) during the pandemic was significantly associated with taking action against DVA, $X^2(1, N=186) = 4.330$, p=.037. Analysis further indicated a significant relationship between the participant having attended a DVA training course and taking action against DVA, $X^2(1, N=186) = 6.311$, p=.012. Of the participants who had completed a DVA training course, 94.4% also took action in response to witnessing DVA, compared to 82.5% of participants who had not received training, but still took action.

Most participants who took action against the DVA behaviours they had witnessed indicated that they wanted to help members of their community (89.3%) and felt more connected to their community since the pandemic began (89.3%). This suggests that those who took action are prosocial people.

All of those who witnessed the abuse of a vulnerable person, threats of abuse or sexual abuse reported that they had taken some form of action in response. 86% of those who witnessed coercive control and 74% of those who witnessed warning signs of DVA took action. The majority of participants took action after seeing the behaviour more than five times (53.7%). None of these relationships were shown to be statistically significant (see appendices, Table 9).

In the main, respondents showed that they had become aware of the behaviour either by witnessing it in person (N=75) or because the victim told them directly (N=67). Six participants became aware of the behaviour online, while 23 were told by someone else. The remaining 15 did not wish to answer (see Figure 2). The means by which the behaviour was witnessed was significantly related to whether the bystander took action, $X^2(4, N=186) = 15.400$, p=.004. This means that participants were significantly more likely to take action if they witnessed the problematic behaviours in person or they were told about it directly by the victim, than when they witnessed the abuse online or when they were told by someone else.

Means by which the bystander initially became aware of the DVA behaviours

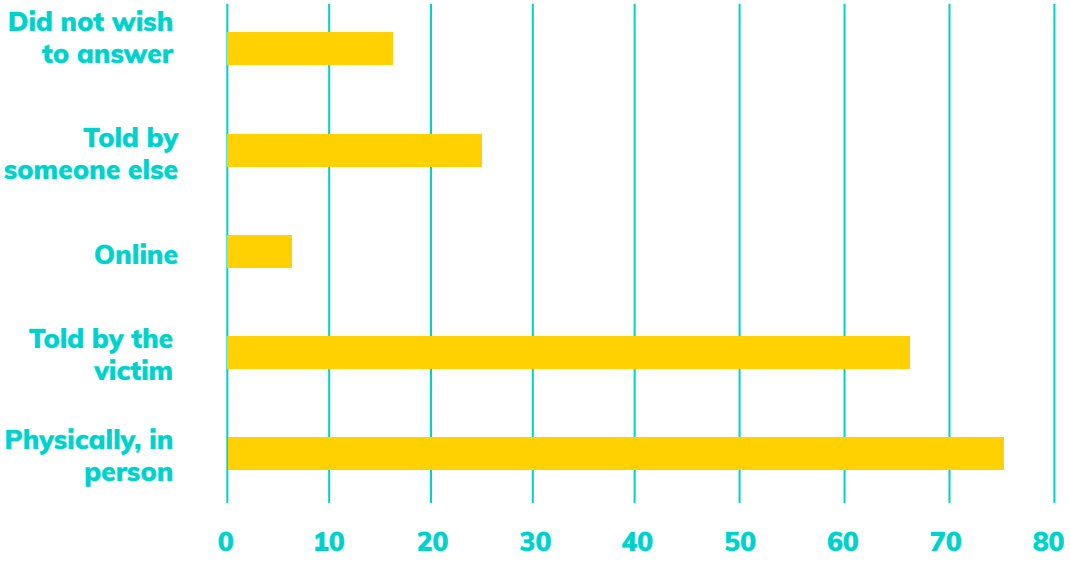


Figure 2: Means by which the bystander initially became aware of the DVA behaviour

Most participants indicated that they had seen DVA behaviours in intimate partner relationships (74.7%). There was no significant link between type of relationship (intimate partner or family members) and the bystander taking action (see appendices, Table 9).

The participants identified most of the perpetrators to be men (131 out of 186), and most victims to be women (137 out of 186). Significant associations were found between gender of the perpetrator and taking action, $X^2(2, N=186) = 17.963$, $p<.001$, and the gender of the victim and the bystanders taking action, $X^2(2, N=186) = 11.434$, $p=.003$.

Yet, as Table 3 shows, **there is only a small difference in the percentages of people who took action when accounting for the gender of the perpetrator and victim.**

Table 3: Percentage of people who took action when accounting for gender of perpetrator and victim

		Took action (yes)
Gender of perpetrator	Man	131 (90.3%)
	Woman	31 (88.6%)
Gender of victim	Man	25 (89.3%)
	Woman	137 (89.5%)

For the most part, there were no significant relationships between the type of behaviour witnessed and the type of action taken by the bystander, with two exceptions. These exceptions to the type of action taken were officially reporting the incident to the police, DVA charity or social services, and the bystander offering to support the victim. There were significant relationships between the behaviour witnessed and the bystander officially reporting the incident[7], X^2 (5, N=186) = 22.448, p<.001, and the bystander offering to support the victim, X^2 (5, N=186) = 13.336, p=.020. Bystanders are more likely to officially report the incident if they witness coercive control (25.4%), threats (76.9%) or physical violence (36%) rather than other forms of DVA. Offering to support the victim was the most common form of bystander behaviour reported by participants, with 104 indicating that they had done this (see appendices, Table 10).

The data shows that 96.2% of the bystanders who took action knew that someone else was aware of the DVA behaviours, compared to 87.2% who did not know that someone else was aware of the behaviour, but still took action. This offered another significant connection between bystander action and someone else seeing the behaviour, X^2(2, N=186) = 22.167, p<.001.

One interviewee explained that she had concerns about her friend's behaviour but was not sure. To help her decide whether to say something, she sourced allies. With other friends, she explained her concerns, found that her other friends had also noticed the warning signs and, together they came up with a plan.

The data shows that 96.2% of the bystanders who took action knew that someone else was aware of the DVA behaviours

Motivations and Barriers

Two thirds (65.6%) of survey participants shared the motivations they experienced when witnessing coercive control. The primary motivation for taking action was the bystander feeling responsible (N=122), closely followed by recognising that the behaviour was problematic and wrong (N=118). Eight participants indicated that they had taken action for "personal reasons". Personal reasons included being able to empathise with the victim from personal experience and being personally offended.

By contrast, the main barriers to taking action were not recognising the situation as an issue (6 out of 24) and lacking the skills to intervene (4 out of 24). Fourteen participants who did not take action gave no reason as to why.

Data analysis revealed that there were significant relationships between many of the bystander traits and the individual motivations and barriers for taking action. For example, survey respondents who said that they wanted to help members of their community were significantly more likely to also say that they helped the victim because they recognised the situation as problematic or they knew what to do to help. Table 1 illustrates the other statistically significant associations (see appendices, Table 11 for full breakdown).

"That informaiton gathering to see what other people [friends] had noticed. It was more a case of finding out what their experiences of it were so that I knew there was more to it than just me thinking the worse...we tried to plan out the best way to manage it [their concerns]" [Interview 3]

[7] To the police, DVA charity, social services etc.

Table 4: Significant relationships between bystander traits and motivations/barriers to taking action

Bystander	Motivation
I want to help members of my community (prosocial person)	Recognising the behaviour as problematic (p=.008) Possessing correct skills (p=.027)
Bystander knowledge of DVA laws	Possessing correct skills (p<.01)
Done course or training on DVA in past 5 years	Possessing correct skills (p<.01)
DVA awareness part of occupational role	Possessing correct skills (p=.001)
Feel more connected to community since pandemic began	Possessing correct skills (p=.004)

Bystander Trait	Barriers
DVA knowledge	Pluralistic ignorance (other people did not seem concerned or the bystander was not sure if other people would support them) (p=.032)
Feeling more connected to the community since the pandemic began	Fear of retaliation (p=.027)

All of the participants who indicated that they took action (N=163) also indicated that they felt they possessed the correct skills to know what to say or do. Possessing the right skills is important when being a prosocial bystander, as the interview participants explained,

"If you say the wrong thing to them, it can have the adverse effect to what you're trying to do so you have got to bite your tongue and be so careful with what you say and do" [Interview 2]

One interviewee explained that she had not taken any action in response to the abuse she had witnessed because she did not know how to report the person without involving the police. Furthermore, she explains that some perpetrators have psychological needs of their own which may be recognised by the bystander and prevent them from taking further actions.

"This woman who has huge needs of her own, so what I wanted to flag up is before you black and white say these are perpetrators and these are victims, she is kind of a victim. So I don't want to throw her into prison... unless I report it to the police, which I think would be cruel, what can I do?" [Interview 1]

Almost all participants explained that their experience of witnessing or becoming concerned about DVA since the pandemic began had negatively impacted upon their physical, psychological, financial or social well-being. Only 8.1% of respondents felt that their experience had a positive impact on them. When asked if they would have liked to have done more in response to their concerns, 50% of participants said "no" and a further 10% did not answer the question. For the most part, the remaining 40% indicated that they would have liked to have supported the victim or reported the incident to official bodies. 75% of respondents indicated that they thought having training on how to help in situations related to DVA would be useful. This also came across during the interviews where one participant explained:

"It has played on my mind a lot, second guessing myself, did I say the right thing? Did I push enough? Should I have pushed more? And said we are really, really worried, maybe I pushed too much by sending the message in the first place. It has been a lot of questioning myself" [Interview 3]

4.5 Sexist 'Banter'

Participants were asked if they had noticed or become concerned about general banter, jokes, videos or statements that are sexist or play on old fashioned gender roles since the pandemic began.

✗ Just over half of participants **(56%)** answered **"no"** to this question

✓ Of those that said yes **(73 people)**, the majority **(89.2%)** were women who were mainly at home during the pandemic **(70.3%)**

Respondents indicated that most of the problematic statements were made by men.

Generally, bystanders indicated that they **had taken action (68.5% of 73 people)** in response to what they had seen by reporting it as they recognised that the opinion of the individual was inappropriate and felt responsible for doing something about it.

The remaining 31% who did not take action indicated that the barrier for their behaviour was other people not being concerned or the worry that others would not support their actions as prosocial bystanders.

4.6 Sexual and Domestic Violence 'Banter'

Participants were asked if they had noticed or become concerned about verbal or written indicators which support domestic abuse, controlling and/or hurting someone, or having sexual activity with someone who did not want/could not refuse it since the pandemic began.

Almost **three quarters of participants (71.8% of 163 people) said "no" to this question.** The majority of those **who said "yes" were mainly at home during the pandemic** and had noticed that they were seeing such behaviour more since the pandemic began. They indicated that most of this content was shared by men.

For the most part, **the bystanders who witnessed this took action against it (73.3% of 45) because they recognised the views were problematic**. The main barrier for those who did not take action was them perceiving that they did not have the correct skills set.

5.0 Discussion

5.1 Key Findings

The advertisements for the survey specifically used the phrase 'domestic abuse' (see section 3.6) and thus might have signalled to potential participants that they should have some level of knowledge about domestic abuse in order to take part. Given that an important contributor to survey engagement appears to be the understanding of DVA (see section 4.1), it may be that those without knowledge of DVA did not recognise problematic behaviours and/or their bystander experiences as being DVA- related, and therefore did not think that taking the survey was relevant to them. Thus whilst the survey questions themselves explored the complex and multiple behaviours constituting domestic abuse, recruitment to the survey in the first place was dependent upon the public identifying with the short descriptor in recruitment advertisements.

These advertisements by their nature cannot be a long descriptor of the many kinds of behaviours that constitute DVA. Recruitment of those who are witnessing DVA but are unaware that it is DVA they are witnessing remains a fundamental challenge for this type of research requiring further exploration.

Women were far more likely than men to take part in the survey (see section 4.1). There is some evidence that women are generally more likely to participate in surveys than men (Smith, 2008). However, the gendered nature of victimisation, and the fact that it is predominantly women who work in the violence against women sector, may also partly explain why more women than men filled in the survey.

Most participants highlighted that they felt the pandemic had allowed them to become aware of DVA, and coercive control and warning signs of DVA were the most commonly reported behaviours that survey respondents had witnessed.

Sense of community appears to be an important factor in influencing bystanders to take action. Community action has increased during the restrictions imposed by COVID-19, which may have encouraged more prosocial bystander responses.

Most participants highlighted that they felt the pandemic had allowed them to become aware of DVA, and coercive control and warning signs of DVA were the most commonly reported behaviours that survey respondents had witnessed (see section 4.3 and Figure 1). This finding adds weight to expert academic and practitioner concerns that perpetrators may use the pandemic to (more) fully control the social lives and means of correspondence (phone, computer) of victims (Gulati et al., 2020; Boxall et al., 2020). It is a positive finding that coercive control, which became a criminal offence only relatively recently in 2015, is being noticed by bystanders.

Interestingly those responding to the survey were mostly also action takers: although in recruitment we advertised for experiences of witnessing DVA behaviours, we also found that that action takers were filling in the survey (see section 4.4). Although most respondents had noticed coercive control or warning signs, only those who had witnessed sexual abuse or the abuse of a vulnerable person were certain to take action against it (see section 4.4). This may be down to the severity of the behaviour witnessed. Kofman and Garfin (2020) suggest that bystanders who perceive an abusive behaviour to be unlawful or life-threatening are significantly more likely to officially report it to the authorities.

Bystanders were more likely to take action when told directly by the victim themselves, or when they witnessed the abuse directly in an intimate relationship. Relatively few survey respondents had witnessed the abuse of a man (see section 4.4). There are various explanations for why this may be so. It is possible that this is due to bystanders not recognising abuse towards a male victim as DVA. It is also possible that men are not offered support by bystanders due to social norms which perpetuate the idea that DVA against a man is not “as serious” as DVA against women (Warburton and Raiolo, 2020). It is also possible that because DVA is a gendered crime, men are not being abused as frequently leaving less scope for bystanders to witness it.

Having knowledge, being able to notice behaviour as problematic, assuming a sense of responsibility, and being confident in the possession of the correct skills are the crucial steps to being a prosocial bystander and taking action (Latané and Darley, 1979; Berkowitz, 2009). Interestingly, our data is consistent with this (see section 4.4). The vast majority took action. The findings illustrate that participants felt responsible and recognised the behaviour as problematic. Notably the data also showed that a key barrier to taking action was not recognising the behaviour as problematic. Further, possessing the correct skills was revealed to be a crucially important motivating factor as all participants who intervened felt they had the skills to do so. It also appears that a sense of responsibility is heightened when the victim tells the bystander themselves, or the bystander witnesses the abuse directly.

Sense of community appears to be an important factor in influencing bystanders to take action. As explored in section 4.4, a heightened sense of community was linked to several motivational factors for bystander responses to DVA. Community action has increased during the restrictions imposed by COVID-19, which may have encouraged more prosocial bystander responses. The link between sense of community and prosocial bystander behaviours is already established (Banyard et al., 2020; McMahon et al, 2015; see section 2.2).

In taking action on DVA, the role of prior victimisation appears important: being a victim/survivor oneself is revealed to be a motivator to taking action (see section 4.4). Those who have survived DVA themselves can feel a stronger sense of empathy (from experience) for the victim. The literature suggests that empathy is a significant predictor of bystander behaviours (Christensen and Harris, 2019; Muralidharan and Kim, 2019). When a survivor supports a victim, it can validate the progress they have made and give them a sense of agency (Gregory et al., 2016). Further, those who have survived DVA may also be confident in their skillset to offer assistance to people. Self-perceived possession of the skills was also true of those working in the field with relevant DVA training, and those who had done training, all of whom were more likely to take action.

The operation of social norms also appears important in our findings (see section 4.4). When someone else was aware of the abuse, the bystander was more likely to intervene, regardless of how often they witnessed it. This could be attributed to social norms theories in two ways. Firstly, a consensus that the behaviour is wrong empowers the bystander to take action in the knowledge they are going to be supported and, secondly, peer pressure can make a bystander do what is socially expected when someone is in need (Brown and Messman-Moore, 2010; Fenton et al., 2019). By contrast, the data also shows that when there were no other witnesses, bystanders were more likely to take action after seeing the behaviour multiple times; the more times they witnessed it, the more likely they were to do something (consistent with Rowe, 2018).

Despite participants being motivated to intervene, being a prosocial bystander had a substantial negative impact on them as individuals (see section 4.4). Action may leave the bystander second guessing their actions and feeling guilty for not acting sooner. This is consistent with the literature whereby bystanders often experience negative psychological impact from supporting a DVA victim and hearing the details of the abuse suffered (Gregory et al., 2016). Those who participated in interviews explained that they did not feel supported, as victims and bystanders, which may have fed into their negative experience of being a bystander. It appears contradictory that when asked if they would have liked to do more or do something differently, most said no, whilst simultaneously reporting negative effects from their actions. However, coupled with the finding that the majority would find bystander training useful, this contradiction may be explained by the fact that the wide array of bystander strategies and options were not known to them and therefore they had no options to act differently. Further, bystander training aims to increase confidence in a newly acquired skillset and support for action which may alleviate some of the negative effects such as second guessing and doubt about having done the right thing (see section 2.3).

The bystanders interviewed explained that they often did not know where to report their concerns and finding the correct advice online can be arduous (see section 4.4). Bystanders are more likely to report their concerns if they know how to, if they know they will be believed and if they know there will be no repercussions for themselves (Borum, 2013; Rowe, 2018). At the beginning of the pandemic, the WHO issued guidelines to policy makers urging them to ensure members of the public knew what services were still available to them concerning DVA (Pearson et al., 2021). However, the impact of the pandemic was also felt by participants who were not sure the extent to which they could help the victim due to government restrictions. This links with making communities aware of the services available, making these services easily accessible and offering reassurance when a bystander comes forward with concerns (Pearson et al., 2021; Bradbury-Jones and Isham, 2020).

These findings offer a preliminary insight into the experiences of bystanders to DVA during the COVID-19 pandemic in Wales, yet there are some limitations to this study which need to be taken into account when considering the findings.

5.2 Limitations

Firstly, the survey was delivered online through the web-based platform, Qualtrics. This limited participants to internet users. It is possible that data is missing from people who may not use the internet and social media, or to individuals whose access to such platforms is limited.

The survey had a large attrition rate, whereby participants stopped filling in the questionnaire part way through (see section 4.1). This is possibly due to the long-time commitment needed to complete the survey, or could be attributed to participant fatigue. Furthermore, it is possible that bystanders had witnessed DVA prior to the pandemic, and when they reached the "DVA witnessed during the pandemic" section, they felt that their experiences were no longer relevant, and subsequently closed down the survey. Similarly, participants may not have been aware that the survey was aimed at people who had witnessed DVA and as there was no option for "not witnessed DVA", they could not continue. This should be considered in future iterations of the survey.

When designing the survey, the team were careful not to use the word "bystander" as they were not sure members of the public would know what this means (see section 3.6). Instead, advertisements were aimed at anyone who had seen or become concerned about DVA since the pandemic began. Despite reiterating that the survey was specifically targeted at those who had seen this in someone else's relationship, it is likely that some victims of DVA completed the survey. Two of the interview participants were not bystanders, they were victims, and they thought that the survey had to be worded in such a way to protect their identities. It is therefore possible that other victims assumed the same and completed the survey. Unfortunately, unless they have specifically stated this in one of the open text boxes, there is no way of knowing.

Those who participated in interviews, all had good knowledge of DVA through their professional roles or personal experience of being a survivor themselves. Whilst only a small number of interviews were conducted, it suggests that only people with an increased interest in tackling DVA were willing to share their experiences further. The survey was lengthy, and participants were feeling fatigued by the time they reached the end. It might, therefore, have been too much of an ask to request them to contact the research team for additional information regarding interview, instead of a simple tick box as part of the survey.

During the interviews, some participants made comparisons between the UK and Welsh Governments' actions during the pandemic and perpetrator behaviours, namely, the person having their freedom controlled and being under restrictions in terms of limiting contact with family and friends. It is possible that survey respondents also made this link and did not distinguish between the two when indicating what behaviours they had witnessed. This may contribute to coercive control being the most reported DVA behaviour (Figure 1) as participants were not specifically focussing on DVA. For example, as one interview participant explained;

> **"This isolation period is exactly like being in the abusive relationship. Not being allowed to go out, not being allowed to see your friends, having strict conditions on your life. Essentially, the government is the perpetrator, from a survivors' perspective"** [Interview 2]

This study used an opportunistic and self-selecting sample. The views of participants may differ from others who were bystanders to DVA, or the wider community more generally. Specialist organisations supporting BAME victims and wider BAME communities were engaged during the dissemination of the survey. Despite this, a large portion of the survey respondents, and all interviewees, identified as White British (see section 4.1). Whilst this is broadly representative of the Welsh population, the data may not represent the experiences of those from other ethnic backgrounds. Likewise, the survey did not capture any responses from those over 75. How to access potentially harder to reach BAME and older age groups should be further explored and improved in future studies.

5.3 Future Actions

This pilot study was situated within the unique set of circumstances that came about with the COVID-19 pandemic and the related lockdowns and social restrictions. Whilst the exact replication of the conditions for this study may be difficult, the survey design is not COVID-specific, allowing for replication in non-pandemic contexts. Further, the learning from developing, delivering and reporting on this study can be utilised outside the COVID-19 pandemic because domestic abuse is an ongoing public health emergency not unique to the pandemic. The following suggestions are based upon this.

Policy Options

This study demonstrates that bystanders have an important role in the primary prevention of DVA. This should be recognised in VAWDASV and violence prevention policy. The actions taken by prosocial bystanders may be an essential part of tackling DVA at a community level. Encouraging prosocial behaviour, when safe to do so, should be a priority both generally and particularly during a pandemic or other emergency situations, when services are not as readily accessible. Policymakers could consider the use of public awareness campaigns and training to promote knowledge about DVA, and prosocial and informed bystander behaviour. This could help address the barriers to bystanders taking action and mitigate any negative impact that the experience may have on the bystander themselves (see section 4.4).

Lessons from this research suggest that public-facing bystander campaigns should be multi-faceted and underpinned by awareness and knowledge raising of what constitutes DVA for a public-facing audience. As noted in section 4.4, most participants had witnessed DVA behaviours within intimate relationships, when the perpetrator was a man, and the victim was a woman. Campaigns should emphasise that abuse can happen in a variety of relationships, regardless of gender identity, sexuality, age, ethnicity etc. The array of DVA behaviours should be made explicit to increase the likelihood of harmful behaviour recognition; from warning signs through to coercive control and physical abuse.

Policy makers should consider how they can engage different target audiences in knowledge and awareness raising, and as prosocial bystanders. In particular, as noted in section 4.1, most participants in this study were women. Particular attention should be paid to ensuring men engage in bystander efforts. Awareness raising campaigns should aim to increase a sense of responsibility and motivation to act and therefore be accompanied by the offer of evidence-based bystander training to enable and empower bystanders to move (safely) through the theory of behaviour change (see section 5.1).

The data indicated that a sense of community was found to be a significant predictor of bystanders taking prosocial action against DVA (see section 4.4). Other research has suggested that community action has increased during the restrictions imposed by Covid-19 which may have encouraged more bystander action. Therefore, policies could aim to nurture, sustain and further encourage this sense of community as a contributory factor motivating bystanders to taking action against DVA.

Practice Options

The research demonstrated that there is a demand for multifaceted bystander training and information programmes to empower and upskill bystanders to take prosocial action, even from those who are already knowledgeable and have had training (see section 4.4). Bystander training programmes must be evidence and theory-based (Fenton and Mott, 2017). They should take people through the process of change including: awareness and recognition of the gendered nature of DVA in all its forms; cultural contexts, gender roles and problematic masculinity underpinning and shoring up DVA; impacts and empathy; sense of responsibility, motivation and confidence to act, and skills learning.

Social norms theory should be incorporated in bystander training programmes, materials and campaigns. For an example of a bystander training programme for general communities, see the DVA bystander intervention Active Bystander Communities (see section 2.3). As noted in section 4.4, the bystander feeling that they possess the correct skill set to take action is essential. A variety of bystander responses could be incorporated into the campaigns, materials and bystander training programmes, including supporting the victim, addressing the perpetrator/abuser's behaviour[8] and encouraging the use of services (for example, support services, the police). For examples of good practice, see Snowdon et al. (2020). These could be rolled out across communities to support bystanders as an essential element in the primary prevention of DVA, both in and out of a pandemic.

When considering public awareness campaigns targeted at bystanders, where appropriate, organisations should make clear which services they offer that might be of relevance to bystanders. As discussed in section 5.1, bystanders are more likely to share their concerns if they know how to. Clear signposting of relevant bystander services would allow bystanders to have increased chance of building knowledge about what is available. These could be delivered over an array of platforms, with physical advertisements, newspapers, online, radio and television as part of the public awareness campaign.

As previously highlighted section 1.4, an increasing number of calls are being recorded with domestic abuse helplines and the police from concerned third parties (neighbours, friends and family). As noted in section 4.4, bystanders are often negatively impacted by their experience. Frontline services, including the police and specialist DVA services, could consider developing guidance and training for call handlers and first-responders to support bystanders who make contact.

Research Options

This pilot study has tested the methodology, dissemination and topic area of bystanders to DVA during the COVID-19 pandemic. The results are promising. The next step is to revisit the methodology, and make revisions based on our learning from implementation and analysis. Dissemination and survey recruitment should be amended in future research, to optimise the recruitment of men, BAME groups, and elderly people, as discussed in section 5.2. Similarly, targeting of specific groups working within the community (for example, delivery drivers or community groups) could be improved. Recruitment should also run for a longer period of time to optimise uptake and on a larger scale with a population level sample.

The survey respondents indicated that their experience of taking action had a negative impact upon themselves, yet more than half indicated that there was no further actions they wished they had taken (see section 4.4). Future research could explore how these negative impacts could be mitigated with bystander training programmes and/or adequate support resources.

Those with a greater sense of community were significantly more likely to take action in response to their concerns (see section 4.4). Future research should determine what "sense of community" means to each participant, such as locality, religion, sports group etc. and how this sense of community reflects on the types of behaviour witnessed or the types of action taken.

Further research could also explore the inherent difficulty in asking people to participate in research about the DVA they may have witnessed when they may not recognise what behaviours constitute DVA (see section 5.1 for discussion on this). This could be achieved firstly by increased public awareness of what DVA is, and secondly, by alternative methods of recruitment campaigning which offers more in–depth definitions and examples of behaviours.

[8] For a discussion of this point see Fenton et al. (2019).

6.0 Concluding Comments

This study sought to explore the experiences and behaviours of bystanders to DVA during the COVID-19 pandemic through a mixed methods approach with the general public, including survey and interviews. Whilst implemented on a small scale, this study was the first of its kind and provides new insights into bystander experiences during a global pandemic.

Findings from this study suggest that the circumstances of the pandemic have increased people's opportunities to be active bystanders to DVA behaviours. Participants reported being more aware of 'concerning' behaviours due to increased time spent at home, coupled with less 'distraction' from the norms of regular social and work life, and a heightened sense of community.

Bystanders also reported that they felt the circumstances of the pandemic (lockdown, working from home and social distancing restrictions) had increased the ability of perpetrators to further control the victim. Warning signs of DVA and coercive control were the most common types of DVA behaviours that participants had seen or become concerned about.

The most common action was offering support to the victim, with the majority of bystanders offering this. Having received training was a strong predictor of offering prosocial support to the victim. Conversely, not having the skills to notice or intervene, was the most significant predictor of inaction. Provision of evidence-based training to bystanders, providing them with the knowledge, confidence and skills to identify DVA and intervene safely and appropriately, may mitigate these barriers to taking action. Bystanders also indicated that having DVA bystander training would have been useful to them in guiding them in how to take appropriate prosocial action.

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Appendices

A: Participant Demographics

Table 5 Participant Demographics

Demographic	Number of Participants
Gender	
• Man	• 28
• Woman	• 158
Age	
• 18-34	• 69
• 35-44	• 54
• 45 +	• 63
Ethnicity	
• White British/Irish	• 178
• Arab/Asian/African/Caribbean	• 8
Occupation	
• Usually at home[9]	• 30
• Health and social care	• 41
• Education	• 31
• Local authority or government and key Public services	• 39
• Industry and other tertiary jobs	• 45
Status during lockdown	
• Primarily at home	• 141
• Primarily away from home	• 45
Knowledge of DVA	
• Extremely/very	• 119
• Moderately/slightly	• 66
• Not at all	• 1
Knowledge of DVA law	
• Extremely/very	• 71
• Moderately/slightly	• 98
• Not at all	• 17

[9] Usually at home- retired, stay at home parent, unemployed

Appendices

B: Data Tables for DVA Witnessed During Pandemic

Table 6 Frequency of behaviours witnessed

Behaviour Witnessed	Frequency
Warning signs	132
Coercive control	168
LGBTQI+	25
Vulnerability	40
Threats	81
Physical	83
Sexual	35

Table 7 Chi-squared findings for behaviours witnessed and participant demographics

		Behaviours Witnessed						
		Warning Signs	**Coercive Control**	**LGBTQI+**	**Vulnerability**	**Threats**	**Physical**	**Sexual**
Gender	Man	15 (53.6%)	24 (85.7%)	4 (14.3%)	5 (17.9%)	16 (57.1%)	10 (35.7%)	2 (7.1%)
	Woman	117 (74.1%)	144 (91.1%)	21 (13.3%)	35 (22.2%)	65 (41.1%)	73 (46.2%)	33 (20.9%)
	X^2	(1, N=186) = 4.842	(1, N=186) = .801	(1,N=186) = .020	(1, N=186) = .260	(1, N=186) = 2.478	(1, N=186) = 1.059	(1, N=186) = 2.941
	p	0.028	0.371	0.887	0.610	0.115	0.303	0.086
Age	18-34	52 (39.4%)	66 (39.3%)	7 (28%)	11 (27.5%)	24 (29.6%)	29 (34.9%)	13 (37.2%)
	35-44	39 (29.5%)	49 (29.2%)	5 (20%)	12 (30%)	25 (30.9%)	25 (30.2%)	11 (31.4%)
	45+	41 (31.1%)	53 (31.5%)	13 (52%)	17 (42.5%)	32 (39.5%)	29 (34.9%)	11 (31.4%)
	X^2	(2, N=186) = 1.748	(2, N=186) = 5.020	(2, N=186) = 4.258	(2, N=186) = 2.402	(2, N=186) = 3.668	(2, N=186) = .300	(2, N=186) = .161
	P	0.417	0.081	0.119	0.301	0.160	0.861	0.923

		Behaviours Witnessed						
		Warning Signs	**Coercive Control**	**LGBTQI+**	**Vulnerability**	**Threats**	**Physical**	**Sexual**
Occupation	Usually at home	19 (63.3%)	27 (90%)	3 (10%)	4 (13.3%)	15 (50%)	13 (43.3%)	4 (13.3%)
	Health and social care	19 (63.3%)	27 (90%)	3 (10%)	4 (13.3%)	15 (50%)	13 (43.3%)	4 (13.3%)
	Government or public services	26 (66.7%)	27 (90%)	3 (7.7%)	5 (12.8%)	17 (43.6%)	19 (48.7%)	7 (17.9%)
	Education	25 (80.6%)	31 (100%)	1 (3.2%)	7 (22.6%)	11 (35.5%)	15 (48.4%)	5 (16.1%)
	Industry or tertiary	32 (71.1%)	37 (82.2%)	7 (15.6%)	16 (35.6%)	19 (42.2%)	16 (35.6%)	9 (20%)
	X^2	(4, N=186) = 2.705	(4, N=186) = 6.879	(4, N=186) = 10.683	(4, N=186) = 8.310	(4, N=186) = 1.490	(4, N=186) = 2.247	(4, N=186) = 1.631
	P	0.608	0.142	0.03	0.081	0.828	0.691	0.803
Lockdown Status	Mainly at home	103 (73%)	129 (91.5%)	19 (13.5%)	31 (22%)	64 (45.4%)	59 (41.8%)	26 (18.4%)
	Mainly away from home	39 (64.4%)	39 (86.7%)	6 (13.3%)	9 (20%)	17 (37.8%)	24 (53.3%)	9 (20%)
	X^2	(1, N=186) = 1.226	(1, N=186) = .908	(1, N=186) = .001	(1, N=186) = .080	(1, N=186) = .804	(1, N=186) = 1.822	(1, N=186) = .054
	P	0.268	0.341	0.981	0.778	0.37	0.177	0.816

Table 8 Chi-squared results for participant demographics and taking action against DVA

		Took action (yes)
Gender	Man	24 (85.7%)
	Woman	140 (88.6%)
	X^2	(1, N=186) = .191
	P	0.662
Age	18-34	56 (81.2%)
	35-44	48 (88.9%)
	45+	60 (95.2%)
	X^2	(2, N=186) = 6.296
	P	0.043
Occupation	Usually at home	26 (86.7%)
	Health and social care	36 (87.8%)
	Government or public services	38 (97.4%)
	Education	25 (80.6%)
	Industry or tertiary	39 (86.7%)
	X^2	(4, N=186) = 5.062
	P	0.281
Lockdown status	Mainly at home	124 (87.9%)
	Mainly away from home	40 (88.9%)
	X^2	(1, N=186) = .029
	P	0.864

		Took action (yes)
Feel connected to community	Agree	75 (89.3%)
	Neither	39 (88.6%)
	Disagree	50 (86.2%)
	X^2	(2, N=186) = .324
	P	0.851
Want to help members of my community	Agree	133 (89.3%)
	Neither	27 (81.8%)
	Disagree	4 (100%)
	X^2	(2, N=186) = 1.984
	P	0.371
Domestic abuse awareness a part of professional role	Yes	80 (92%)
	No	84 (84.8%)
	X^2	(1, N=186) = 2.242
	P	0.134
Have you done DVA training in the past 5 years?	Increased	84 (94.4%)
	Stayed the same	80 (82.5%)
	X^2	(1, N=186) = 6.311
	P	0.012
Do you know someone who has experienced DVA?	Yes	157 (99.7%)
	No	7 (77.8%)
	X^2	(1, N=186) = .980
	P	0.322

		Took action (yes)
Since the pandemic began, my awareness of DVA has...	Increased	98 (92.5%)
	Stayed the same	66 (82.5%)
	X^2	(1, N=186) = 4.330
	P	0.037
How knowledgeable are you about DVA?	Extremely	103 (86.6%)
	Moderately	60 (90.9%)
	Not at all	1 (100%)
	X^2	(2, N=186) = .907
	P	0.635
How knowledgeable are you about the laws relating to DVA?	Extremely	66 (93%)
	Moderately	84 (85.7%)
	Not at all	14 (82.4%)
	X^2	(2, N=186) = 2.679
	P	0.262

Table 9 Chi-squared results for details about DVA and taking action

		Took action (yes)
Behaviour Witnessed	Warning signs	106 (86.2%)
	Coercive control	11 (73.3%)
	Vulnerability	6 (100%)
	Threats	13 (100%)
	Physical	23 (92%)
	Sexual	5 (100%)
	X^2	(5, N=186) = 6.931
	P	0.226
Frequency the behaviour was witnessed	1-4 times	76 (46.3%)
	5+ times	88 (53.7%)
	X^2	(1, N=186) = .104
	P	0.747
Relationship between victim and perpetrator	Family members	32 (84.2%)
	Intimate or ex partners	125 (89.9%)
	Unsure	7 (77.8%)
	X^2	(2, N=186) = 1.915
	P	0.384
Gender of perpetrator	Man	131 (90.3%)
	Woman	31 (88.6%)
	Unsure	2 (33.3%)
	X^2	(2, N=186) = 17.963
	P	0.000

		Took action (yes)
Gender of victim	Man	25 (89.3%)
	Woman	137 (89.5%)
	Unsure	2 (40%)
	X^2	(2, N=186) = 11.434
	P	0.003
How did you initially come to be witness/ know about the behaviour?	Physically in person	65 (86.7%)
	Told by victim	64 (95.5%)
	Told by someone else	21 (91.3%)
	Don't want to answer	9 (60%)
	Online	5 (83.3%)
	X^2	(4, N=186) = 15.400
	P	0.004
Did anyone else see the behaviour?	Yes	102 (96.2%)
	No	34 (87.2%)
	Unsure	28 (68.3%)
	X^2	(2, N=186) = 22.167
	P	0.000
Relationship to victim	Family	40 (90.9%)
	Friend	44 (95.7%)
	Acquaintance	29 (82.9%)
	Part of a community group	41 (82%)
	Stranger	10 (90.9%)
	X^2	(4, N=186) = 5.637
	P	.228

Table 10 Chi-squared results for actions, motivations and barriers for each DVA behaviour witnessed

		Behaviours chosen to give details about						Chi-squared data	
		Coercive	Warning signs	Vulnerability	Threats	Physical	Sexual	X^2	P
Actions taken	Looked for more info (yes)	49 (40.2%)	4 (26.7%)	3 (50%)	5 (38.5%)	12 (48%)	4 (80%)	(5, N=186) = 5.168	0.396
	Unofficially shared concerns (yes)	53	27 (90%)	3 (10%)	4 (13.3%)	15 (50%)	13 (43.3%)	(5, N=186) = 10.207	0.070
	Officially shared concerns (yes)	31 (25.4%)	0 (0%)	2 (33.3%)	10 (76.9%)	9 (36%)	1 (20%)	(5, N=186) = 22.448	0.000
	Signalled disapproval or distracted (yes)	28 (23%)	2 (13.3%)	3 (50%)	2 (15.4%)	10 (40%)	1 (20%)	(5, N=186) = 7.114	0.212
	Victim support (yes)	62 (50.8%)	9 (60%)	1 (16.7%)	8 (61.5%)	21 (84%)	3 (60%)	(5, N=186) = 13.336	0.020
	Other (yes)	10 (8.2%)	1 (6.7%)	1 (16.7%)	2 (15.4%)	4 (16%)	0 (0%)	(5, N=186) = 2.960	0.706

		Behaviours chosen to give details about						Chi-squared data	
		Coercive	Warning signs	Vulnerability	Threats	Physical	Sexual	X^2	P
Motivations	Recognising (yes)	72 (69.2%)	7 (63.6%)	5 (83.3%)	9 (69.2%)	20 (87%)	5 (100%)	(5, N=162) = 5.756	0.331
	Feeling responsible (yes)	72 (68.6%)	9 (81.8%)	5 (83.3%)	11 (84.6%)	21 (91.3%)	4 (80%)	(5, N=163) = 6.748	0.24
	Correct skills (yes)	33 (31.4%)	3 (27.3%)	3 (50%)	5 (38.5%)	15 (65.2%)	1 (20%)	(5, N=163) = 10.788	0.056
	Personal reasons (yes)	44 (41.9%)	7 (63.6%)	4 (66.7%)	7 (53.8%)	16 (69.6%)	2 (40%)	(5, N=163) = 7.983	0.157
	No reason provided (yes)	18 (17%)	0 (0%)	1 (16.7%)	0 (0%)	1 (4.3%)	0 (0%)	(5, N=164) = 7.730	0.172

		Behaviours chosen to give details about						Chi-squared data	
		Coercive	Warning signs	Vulnerability	Threats	Physical	Sexual	X^2	P
Barriers	Not noticing (yes)	6 (31.6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	(2, N=25) = 2.493	0.287
	No confidence (yes)	2 (10.5)	0 (0%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	(2, N=25) = 3.319	0.19
	Lacking skills (yes)	4 (21.1%)	1 (25%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	(2, N=25) = .834	0.659
	Fear of retaliation (yes)	3 (15.8%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	(2, N=25) = 2.483	0.289
	No motivation(yes)	1 (5.3%)	1 (25%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	(2, N=25) = 1.938	0.379
	Pluralistic ignorance (yes)	2 (10.5%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	(2, N=25) = .686	0.709
	Victim blaming (yes)	1 (5.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	(2, N=25) = .329	0.848
	No response given (yes)	11 (52.6%)	3 (75%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	(2, N=25) = 3.017	0.221

Table 11 Chi-squared results for participant demographics and motivations for taking action

		Motivations				
		Recognising the situation as problematic	**Feeling responsible to do something**	**Possessing the right skills**	**Personal reasons**	**No reason provided**
DVA Knowledge	Very	75 (72.8%)	78 (75.7%)	45 (43.7%)	53 (51.5%)	11 (10.7%)
	Slightly	42 (72.4%)	43 (72.9%)	15 (25.4%)	26 (44.1%)	9 (15%)
	Not at all	1 (100%)	1 (100%)	0 (0%)	1 (100%)	0 (0%)
	X^2	(2, N=162) = .378	(2, N=163) = .500	(2, N=163) = 5.967	(2, N=163) = 1.863	(2, N=163) = .801
	P	0.828	0.779	0.051	0.394	0.67
DVA Law Knowledge	Very	48 (73.8%)	49 (74.2%)	38 (57.6%)	36 (54.5%)	5 (7.6%)
	Slightly	58 (69.9%)	60 (72.3%)	19 (22.9%)	37 (44.6%)	15 (17.9%)
	Not at all	12 (85.7%)	13 (92.9%)	3 (21.4%)	7 (50%)	0 (0%)
	X^2	(2, N=162) = 1.574	(2, N=163) = 2.713	(2, N=163) = 20.572	(2, N=163) = 1.467	(2, N=164) = 5.775
	P	0.455	0.258	0.000	0.48	0.056

		Motivations				
		Recognising the situation as problematic	**Feeling responsible to do something**	**Possessing the right skills**	**Personal reasons**	**No reason provided**
Attended DVA training in the past 5 years	Yes	63 (75%)	63 (75%)	43 (51.2%)	38 (45.2%)	8 (9.5%)
	No	55 (70.5%)	59 (74.7%)	17 (21.5%)	42 (53.2%)	12 (15%)
	X^2	(1, N=162) = .412	(1, N=163) = .002	(1, N=163) = 15.409	(1, N=163) = 1.023	(1, N=164) = 1.148
	P	0.521	0.963	0.000	0.312	0.284
Feel connected to the community	Agree	59 (78.7%)	63 (84%)	37 (49.3%)	35 (46.7%)	3 (4%)
	Neither	30 (76.9%)	36 (66.7%)	13 (33.3%)	18 (46.2%)	6 (15.4%)
	Disagree	29 (60.4%)	33 (67.3%)	10 (20.4%)	27 (55.1%)	11 (22%)
	X^2	(2, N=162) = 5.360	(2, N=163) = 6.188	(2, N=163) = 10.927	(2, N=163) = 1.019	(2, N=164) = 9.564
	P	0.069	0.045	0.004	0.601	0.008

		Motivations				
		Recognising the situation as problematic	**Feeling responsible to do something**	**Possessing the right skills**	**Personal reasons**	**No reason provided**
I want to help members of my community	Agree	103 (78%)	104 (78.8%)	55 (41.7%)	70 (53%)	12 (9%)
	Neither	13 (50%)	16 (59.3%)	4 (14.8%)	8 (29.6%)	7 (25.9%)
	Disagree	2 (50%)	2 (50%)	1 (25%)	2 (50%)	1 (25%)
	X^2	(2, N=162) = 9.708	(2, N=163) = 5.885	(2, N=163) = 7.194	(2, N=163) = 4.913	(2, N=164) = 6.617
	P	0.008	0.053	0.027	0.086	0.037
DVA awareness a part of professional role	Yes	59 (74.7%)	59 (73.8%)	40 (50%)	36 (45%)	9 (11.3%)
	No	59 (71.7%)	63 (75.9%)	20 (24.1%)	44 (53%)	11 (13.1%)
	X^2	(1, N=162) = .265	(1, N=163) = .100	(1, N=163) = 11.751	(1, N=163) = 1.046	(1, N=164) = .130
	P	0.607	0.751	0.001	0.306	0.718

Table 12 Chi-squared results for participant demographics and barriers to taking action

		Barriers							
		Noticing (yes)	**Confidence (yes)**	**Lacking correct skills (yes)**	**Fear of retaliation (yes)**	**No Motivations (yes)**	**Pluralistic ignorance (yes)**	**Victim blaming (yes)**	**No response provided**
DVA knowledge	Very	3 (17.6%)	2 (11.8%)	3 (17.6%)	3 (17.6%)	1 (5.9%)	0 (0%)	0 (0%)	10 (58.8%)
	Slightly	3 (37.5%)	1 (12.5%)	3 (37.5%)	1 (12.5%)	1 (12.5%)	2 (25%)	1 (12.5%)	3 (37.5%)
	Not at all	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	X^2	(1, N=25) = 1.176	(1, N=25) = .003	(1, N=25) = 1.176	(1, N=25) = .107	(1, N=25)= .324	(1, N=25) = 4.620	(1, N=25) = 2.214	(1, N=25) = .991
	P	0.278	0.958	0.278	0.743	0.569	0.032	0.137	0.319
Law knowledge	Very	0 (0%)	0 (0%)	1 (20%)	0 (0%)	1 (20%)	0 (0%)	0 (0%)	4 (80%)
	Slightly	5 (29.4%)	3 (17.6%)	5 (29.4%)	3 (17.6%)	1 (5.9%)	2 (11.8%)	1 (5.9%)	8 (47.1%)
	Not at all	1 (33.3%)	0 (0%)	0 (0%)	1 (33.3%)	0 (0%)	0 (0%)	0 (0%)	1 (33.3%)
	X^2	(2, N=25) = 1.995	(2, N=25) = 1.604	(2, N=25) = 1.264	(2, N=25) = 1.657	(2, N=25) = 1.343	(2, N=25) = 1.023	(2, N=25) = .490	(2, N=25) = 2.156
	P	0.369	0.448	0.531	0.437	0.511	0.600	0.783	0.34

		Barriers							
		Noticing (yes)	**Confidence (yes)**	**Lacking correct skills (yes)**	**Fear of retaliation (yes)**	**No Motivations (yes)**	**Pluralistic ignorance (yes)**	**Victim blaming (yes)**	**No response provided**
Training	Yes	1 (16.7%)	0 (0%)	1 (16.7%)	1 (16.7%)	0 (0%)	0 (0%)	0 (0%)	4 (66.7%)
	No	5 (26.3%)	3 (15.8%)	5 (26.3%)	3 (15.8%)	2 (10.5%)	2 (10.5%)	1 (5.3%)	9 (47.4%)
	X^2	(1, N=25) = .233	(1, N=25) = 1.077	(1, N=25) = .233	(1, N=25) = .003	(1, N=25) = .686	(1, N=25) = .686	(1, N=25) = .329	(1, N=25) = .680
	P	0.629	0.299	0.629	0.959	0.407	0.407	0.566	0.409
Professional role	Yes	2 (22.2%)	0 (0%)	2 (22.2%)	2 (22.2%)	0 (0%)	0 (0%)	0 (0%)	6 (66.7%)
	No	4 (25%)	3 (18.8%)	4 (25%)	2 (12.5%)	2 (12.5%)	2 (12.5%)	1 (6.3%)	7 (43.8%)
	X^2	(1, N=25) = .024	(1, N=25) = 1.918	(1, N=25) = .024	(1, N=25) = .405	(1, N=25) = 1.223	(1, N=25) = 1.223	(1, N=250) = .586	(1, N=25) = 1.212
	P	0.876	0.166	0.876	0.524	0.269	0.269	0.444	0.271

		Barriers							
		Noticing (yes)	**Confidence (yes)**	**Lacking correct skills (yes)**	**Fear of retaliation (yes)**	**No Motivations (yes)**	**Pluralistic ignorance (yes)**	**Victim blaming (yes)**	**No response provided**
Connected to community	Agree	4 (44.4%)	1 (11.1%)	2 (22.2%)	1 (11.1%)	1 (11.1%)	1 (11.1%)	0 (0%)	4 (44.4%)
	Neither agree nor disagree	2 (33.3%)	1 (16.7%)	3 (50%)	3 (50%)	1 (16.7%)	0 (0%)	1 (16.7%)	0 (0%)
	Disagree	0 (0%)	1 (10%)	1 (10%)	0 (0%)	0 (0%)	1 (10%)	0 (0%)	9 (90%)
	X^2	(2, N=25) = 5.507	(2, N=25) = .168	(2, N=25) = 3.314	(2, N=25) = 7.226	(2, N=25) = 1.600	(2, N=25) = .694	(2, N=25) = 3.299	(2, N=25) = 12.491
	P	0.064	0.919	0.191	0.027	0.449	0.707	0.192	0.002
Help members of community	Agree	4 (21.1%)	2 (10.5%)	4 (21.1%)	3 (15.8%)	2 (10.5%)	2 (10.5%)	0 (0%)	11 (57.9%)
	Neither agree nor disagree	2 (33.3%)	1 (16.7%)	2 (33.3%)	1 (16.7%)	0 (0%)	0 (0%)	1 (16.7%)	2 (33.3%)
	X^2	(1, N=25) = .377	(1, N=25) = .163	(1, N=25) = .377	(1, N=25) = .003	(1, N=25) = .686	(1, N=25) = .686	(1, N=25) = 3.299	(1, N=25) = 1.102
	P	0.539	0.687	0.539	0.959	0.407	0.407	0.069	0.294

C: Data Tables for Sexist Banter

Table 13 Chi-squared results for participant demographics and witnessing sexist banter

		Witnessed Sexist Banter	
		Yes	**No**
Gender	Man	7 (28%)	18 (72%)
	Woman	66 (46.8%)	75 (53.2%)
	X^2	(1, N=166) = 3.049	
	P	0.081	
Age	18-34	35 (55.6%)	28 (44.4%)
	35-44	21 (44.7%)	26 (55.3%)
	45+	17 (30.4%)	39 (69.6%)
	X^2	(2, N=166) = 7.654	
	P	0.022	
Lockdown Status	Mainly at home	52 (40.3%)	77 (59.7%)
	Mainly away from home	21 (56.8%)	16 (43.2%)
	X^2	(1, N=166) = 3.157	
	P	0.076	

Table 14 Details of the sexist banter witnessed

		Frequency
Gender of the person who shared this	Man	52
	Woman	9
	Gender fluid/ non-binary	1
	Unsure	11
Took action?	Yes	50
	No	23
Action Taken	Reported the post or shared disapproval	44 (yes) 29 (no)
	Shared concerns with others	18 (yes) 55 (no)
	Looked for more information	8 (yes) 65 (no)
	Took an alternative form of action	14 (yes) 59 (no)
Motivation for taking action	Recognised the behaviour as problematic	41 (yes) 7 (no)
	Felt responsible for doing something	34 (yes) 14 (no)
	Possessed the correct skills to take action	3 (yes) 45 (no)
	Personal reasons	23 (yes) 25 (no)
Barriers	Not noticing the behaviour	3 (yes) 13 (no)
	No confidence	8(yes) 8 (no)
	Lacking correct skills	3 (yes) 13 (no)
	Fear of retaliation	5 (yes) 11 (no)
	Not a problem, no motivation	6 (yes) 10 (no)

D: Data Tables for Sexual and Domestic Violence Banter

Table 15 Chi-squared results for participant demographics and witnessing sexual and domestic violence banter

		Witnessed Violence Banter	
		Yes	**No**
Gender	Man	8 (33.3%)	16 (66.7%)
	Woman	38 (27.3%)	101 (72.7%)
	X^2	(1, N=163) = .363	
	P	0.547	
Age	18-34	13 (21.3%)	48 (78.7%)
	35-44	18 (39.1%)	28 (60.9%)
	45+	15 (26.8%)	41 (73.2%)
	X^2	(2, N=163) = 4.197	
	P	0.123	
Lockdown Status	Mainly at home	37 (29.4%)	89 (70.6%)
	Mainly away from home	9 (24.3%)	28 (75.7%)
	X^2	(1, N=163) = .359	
	P	0.549	

Table 16 Details of the sexual and domestic violence banter witnessed

		Frequency
Gender of the person who shared this	Man	35
	Woman	5
	Gender fluid/ non-binary	4
	Unsure	1
Since the pandemic began, have you noticed this more, less or about the same?	More	29
	Less	1
	About the same	16
Took action?	Yes	33
	No	12
Action Taken	Reported the post or shared disapproval	25 (yes) 20 (no)
	Shared concerns with others	10 (yes) 35 (no)
	Looked for more information	8 (yes) 37 (no)
	Took an alternative form of action	4 (yes) 41 (no)
Motivation for taking action	Recognised the behaviour as problematic	31 (yes) 3 (no)
	Felt responsible for doing something	26 (yes) 8 (no)
	Possessed the correct skills to take action	11 (yes) 23 (no)
	Personal reasons	14 (yes) 20 (no)
Barriers	Not noticing the behaviour	1 (yes) 5 (no)
	No confidence	1 (yes) 5 (no)
	Lacking correct skills	3 (yes) 3 (no)
	Fear of retaliation	1 (yes) 5 (no)