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Special Issue
Women During COVID-19

Guest Editors
Judith L. Gibbons
& Nancy M. Sidun

International Perspectives in Psychology

Research, Practice, Consultation

Official Journal of Division 52 (International Psychology) of the American Psychological Association

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Helping women at risk for alcohol-exposed pregnancies

"This book is an excellent overview of newly developed interventions for preventing alcohol-exposed pregnancies and life-long disorders in children."

Tatiana Balachova, PhD, Associate Professor, Department of Pediatrics,
University of Oklahoma Health Sciences Center, Oklahoma City, OK

Mary Marden Velasquez / Karen Ingersoll / Mark B. Sobell / Linda Carter Sobell

Women and Drinking: Preventing Alcohol-Exposed Pregnancies

Advances in Psychotherapy – Evidence-Based Practice, vol. 34
2016, xii + 80 pp.
US $29.80 / € 24.95
ISBN 978-0-88937-401-0
Also available as eBook

Drinking during pregnancy can cause a range of disabilities that have life-long effects yet are 100% preventable. A variety of brief motivational behavioral interventions developed for nonpregnant women of childbearing age can effectively prevent alcohol-exposed pregnancies (AEP). This book outlines clinical definitions and the history of Fetal Alcohol Spectrum Disorders (FASD), epidemiology and effects across the lifespan, evidence-based prevention practices such as CHOICES and CHOICES-like interventions, and opportunities for dissemination.

Based on decades of scientific research and clinical refinement, this volume is packed with helpful illustrative case vignettes, therapist–patient dialogues, sample forms, and handouts.

The information and resources presented will help a wide variety of practitioners in diverse settings, ranging from high-risk settings such as mental health and substance abuse treatment centers to primary care clinics and universities, deliver interventions targeting behavior change.

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Vulnerabilities and Strengths

Judith L. Gibbons[1] and Nancy M. Sidun[2]

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In May 2020, the world of international psychology lost an accomplished and beloved member of our community, Jean Lau Chin, EdD, to COVID-19. Jean was a professor of psychology, a scholar, researcher, author, educator, feminist mentor, Fulbright Scholar, leader, and most importantly, an outstanding advocate for diversity, equity, and inclusion. She was a powerhouse in psychology and an international voice on diversity leadership, culturally competent mental health services, women's issues, and feminism. This International Perspectives of Psychology Special Issue on Women During COVID-19 is dedicated to Jean as a small acknowledgment of the impact and significance on international psychology and remembrance of how her legacy will continue. Many involved in the creation of this Special Issue wanted to share their memories of Jean:

"The field of international psychology continues to mourn the loss of Jean and her tireless contributions in advocating and mentoring women leaders" commented Irma Barron. "Jean Lau Chin is a role model for me: she put others first, connected people and built bridges. She fills the eternal space with kindness and wisdom and will watch over us like a guardian angel" said Polli Hagenaars.

> Dr. Jean Lau Chin's novel and ground-breaking research challenged dominant leadership paradigms by looking at the influence that diversity and social identity have on leadership styles, the exercise of leadership, and perceptions and expectations of leaders. She had a particular interest in women leaders from different cultures and backgrounds and their leadership experiences, as well as Indigenous leadership. She was a highly respected and prolific researcher, a beloved colleague, and an inspiration to many psychologists and students, especially those of Asian descent. Although her passing has left an irreplaceable void, her legacy lives in those who honor her and continue her work. Josephine Tan

When Jean Chin served as president of Division 52, she brought to the forefront the importance of engaging in leadership activities related to international psychology. Many of us have learned from her how to carry our service work in international psychology to a leadership level. Senel Poyrazli

I admired and appreciated Jean for her curiosity, perseverance, and eagerness to explore new areas in leadership and international psychology. Her passion and conviction in the importance of the research inspired many others to join her quest. She made sure that all team members knew their contributions were needed and valued. Jean not only created new understandings of leadership, but also encouraged many others to pursue these lines of research. I think Jean would be very pleased with that outstanding legacy. Mary Beth Kenkel

We are grateful for Jean Lau Chin's years with us as she initiated transformative programs we still teach and learn from. Drawing on her own Chinese immigrant family experiences and cultural knowledge, deeply analytical and immensely practical, Jean's visionary leadership and generous mentoring created a foundation for innovative partnerships defying customary borders. Like many she mentored, I remain informed and inspired by her work in multicultural and global women's organizational leadership. Ester Shapiro

https://doi.org/10.1027/2157-3891/a000025

Despite the decades of being told that leadership came in one package: white, male, forceful, competitive, Jean Lau Chin knew better. Female, of Chinese descent, warm, humble, and collaborative, Jean forged a new definition of leadership that challenged and changed psychology. The impact of her commitment to giving voice to women and racially, ethnically, and economically oppressed groups not only transformed the field internationally but has influenced healthcare, social justice, and leadership practices across society. She taught us that an effective leader listens, stays in relationship, and is respectful of others, while remaining deeply committed to both principles and values. Natalie Porter

Jean Lau Chin was a wonderful friend and colleague. She exemplified the idea of the scholar-practitioner in the way she studied and taught about leadership and then applied her expertise to the many programs and organizations that were lucky enough to have her leadership. She embraced diversity in its truest sense, respecting different perspectives and valuing what each contributes to the growth and success of all. Jean demonstrated how psychologists can advance ideas and improve the lives of people at the same time. She will continue to be missed. Andrew Simon

Dr. Chin faced the enormous weight of women leadership in a point of time of history when it was untenable that women entertained such goals. Intersectionality was compounded for Dr. Chin as a woman of colour and daughter of immigrants. Dr. Chin contributed indelibly to the field of psychology and women. [She] did not suffer fools, was indefatigable, and fearless in putting herself in arenas historically dominated by men. May she rest in power. Anjhula Mya Singh Bais

Jean Lau Chin stands tall among presidents of the International Council of Psychologists in my heart and in my mind. Jean Lau accepted the role of President Elect at the height of her busy, productive career and at a time that ICP, Inc. was struggling. Dr. Chin caringly and firmly stepped into fill the need and to facilitate a forward momentum within this independent, value-oriented group of psychologists and mental health professionals. Her impact will be felt through years to come. Ann Marie O'Roark

Perhaps what I find so amazing when I think about Jean was her quiet, yet outrageously impactful leadership abilities. When talking about moving a mountain, you would turn around and it would have already been moved. Her spirit, energy, knowledge and passion are so greatly missed. Nancy M. Sidun

Progress on Sustainable Development Goal 5, gender equality and the empowerment of women and girls, has been stymied by the COVID-19 pandemic. Although the harsh consequences of the pandemic have been felt around the world, they have disproportionately affected women. The sectors of the economy in which women work were those most impacted by the pandemic, so women were more likely than men to lose their jobs (Dang & Nguyen, 2020). The rates of domestic violence have risen (Gosangi et al., 2021; Sorenson et al., 2021). Women suffered from diminished mental health, including depression, anxiety, and lower sleep quality (González-Sanguino et al., 2020; Guadagni et al., 2020). The care burden of women has also substantially increased, and mothers are stressed from the combined demands of childcare, housework, homeschooling, and paid work (Power, 2020; Yavorsky et al., 2021). Yet, among those risks and perils, women's strengths are evident. This Special Issue addresses the diverse experiences of women internationally during the COVID-19 pandemic, including not only their hardships but also their strengths and resilience.

The lead article, by Sadé Soares and Nancy Sidun (Soares & Sidun, 2021), addresses the strengths of women's leadership during the global pandemic. Although few in number, national women leaders enacted prompt public health measures, and their citizens benefitted from lower mortality rates. Women's vulnerability to human trafficking during the pandemic was revealed by Erinn Cameron, Samantha Hemingway, Janine Ray, Fiona Cunningham, and Kristine Jacquin (Cameron et al., 2021) who analyzed country-level indicators. Gender inequality, limited educational and economic opportunities for women, lack of women's leadership, gendered violence, and women's poor health were associated with estimated prevalence of modern slavery. Because those indicators of women's well-being have been affected by the pandemic, women and girls are at greater risk for trafficking. Brazilian women's experiences giving birth during the pandemic were addressed by Vívian Volkmer Pontes, Juliana Almeida Santos, and Maria Virgina Dazzani (Volkmer Pontes et al., 2021). Among other changes in their relations with others and the physical world, the women explained that spaces previously deemed safe, such as health care settings, were now potentially dangerous. Two articles, one qualitative and the other quantitative, addressed motherhood during the pandemic. Among mothers in India, self-compassion, psychological flexibility, and less parenting stress were factors associated with their well-being, as revealed in a study by Ketoki Mazumdar, Isha Sen, Pooja Gupta, and Sneha Parekh (Mazumdar et al.,

2021). Guatemalan mothers of young children dealt with the challenges of the pandemic by readjusting their priorities, focusing on their children's well-being, gratitude, and faith, according to a qualitative study by Judith Gibbons, Regina Fernández-Morales, María Maegli, and Katelyn Poelker (Gibbons et al., 2021). A study by Yeshim Iqbal, Rubina Jahan, Ashiquir Rahaman, and Omar Faruk (Iqbal et al., 2021) that analyzed the content of calls to a helpline in Bangladesh during the pandemic, as compared to the previous year, revealed many similarities, but relatively more complaints of mental health issues during the pandemic. Finally, researchers Sevaste Chatzifotiou and Despoina Andreadou conducted a qualitative study of Greek women suffering from domestic violence (Chatzifotiou & Andreadou, 2021). Although the women faced severe challenges, especially difficulty in accessing support, they coped through consciousness-raising and awareness, establishing safety plans, and increasing self-confidence and empowerment. This collection of articles not only illustrates the common toll on women in diverse cultural settings, but also their creative and transformational responses that are unique to the ecological niche in which they are living.

We would like to thank Jill Bloom, who helped to launch this project, as well as the authors, the many participants from around the world, and our committed reviewers who helped bring the issue to conclusion.

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Special Issue: Women During COVID-19
Article

Women Leaders During a Global Crisis

Challenges, Characteristics, and Strengths

Sadé E. Soares and Nancy M. Sidun

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Abstract. Women make up almost 50% of our global population (World Bank, 2019); however, they comprise only 6% of elected nation leaders (UN Women, 2020a). Though small in number, when coronavirus disease 2019 (COVID-19) global pandemic impacted our societies in 2019, women leaders were featured for their skillful navigation of an unknown and invisible threat. An understanding of the history of work toward gender equity, the current state of female leadership, and the continued barriers facing female leadership are reviewed to gain increased appreciation for why this emphasis was placed on female leadership. Researches analyzing women leaders during COVID-19 during the early months of the pandemic are presented, showcasing the promising and significant findings. Global women leaders consistently demonstrated a trend of enacting prompt public health measures, resulting in low death rates.

Keywords: women leadership, COVID-19, world leaders, crisis leadership, gender equity, leadership barriers, women's equality

Impact and Implications. This manuscript addresses the continued barriers to increasing women in positions of power, the benefits of having women in decision-making positions, and recommendations to increase the rate of women leaders. In this global public health crisis, leadership qualities more often exhibited by female leaders will aid in building a more sustainable future, fueling the UN's sustainable development goal (SDG) #5 – gender equality.

> "I'm absolutely confident that for 2 years if every nation on earth was run by women, you would see a significant improvement across the board on just about everything . . . living standards and outcomes" (Obama, 2019).

In January 2020, only 10 of the 152 heads of state (elected national representative) and 10 of the 193 heads of government (leader of executive government) worldwide were women (United Nations [UN], 2020a). Although women make up almost 50% of our global population (World Bank, 2019), they comprise only 6% of elected nation leaders (UN, 2020a). Though small in number, when the coronavirus disease 2019 (COVID-19) global pandemic impacted our societies in 2019, women leaders were featured for their skillful navigation of an unknown and invisible threat. This paper will address the current state of female leadership globally, barriers to women gaining leadership roles, and characteristics of women's leadership highlighted by the COVID-19 pandemic.

The Current State of Female Leadership

Although 184 countries have pledged gender equality in their constitutions (UN, 2019), the work toward true gender parity continues. Currently, gender equality is the fifth of 17 United Nations (UN) Sustainable Development Goals to promote a world that is inclusive and sustainable for us all (UN, n.d.a). The Council on Foreign Relations (CFR) reports a political parity score that indicates how well women are represented at all levels of political participation in a country's government (CFR, 2020). Political parity scores range from 0 to 100, with 100 meaning that women make up at least 50% of a nation's government. Overall, only 19 countries hold a score of 50 or higher, and Costa Rica has the highest score of 74 (CFR, 2020). Indeed, women make up only 57 of the 278 speakers of parliament worldwide, and a slightly larger percentage, 25%, hold the title of deputy speakers of parliament (UN, 2020a). Throughout the world, women remain drastically under-represented in politics (UN Women, 2020). Within the field of psychology, women do not fare much better. In its 101-year history, the International Association of Applied Psychology (IAAP) has had only one female president, recently elected in 2018 (IAAP, 2021). Additionally, only a handful of women have presided over the International Association for Cross-Cultural Psychology from 1972 to present (IACCP, n.d.). These data suggest decisions that significantly impact our societies are largely devoid of women's unique perspectives and are made without substantive contributions from women.

Barriers to Female Leadership

The inequitable rates between men and women leaders cannot be explained by an inadequate number of women available for leadership. Instead, the subsequent section will discuss continued barriers to women holding positions of leadership. These ongoing barriers include stereotypes, bias, and discrimination, as well as familial tensions.

Gender Stereotypes

Across the globe, gendered stereotypes regarding leadership maintain the "think manager think male" phenomenon. Research conducted within the United States, Japan, China, Saudi Arabia, and various African nations demonstrates that men and stereotypical attributes of men are associated with effective leadership (Cundiff et al., 2010; Heilman, 2012; Hodges, 2017; Khattab & Rosette, 2017; Nkomo & Ngambi, 2009; Schein et al., 1996). Stereotypically, women are expected to engage in "communal" behaviors, defined as friendliness, concern with the well-being of others, nurturing, and high emotional expression (Cundiff et al., 2010; Lakoff, 1975; Sardabi & Afghari, 2015; Williams et al., 1999). In contrast, men are viewed as "agentic" and, therefore, expected to be assertive, independent, and authoritarian in their leadership style (Cundiff et al., 2010; Williams et al., 1999). Men are more likely to be viewed as better leaders and when women engage in behaviors typically expected of males, they are assigned negative qualities, such as being bitter and selfish, and judged more harshly than a male peer (Abdalla, 2015; Dubai Women Establishment, 2009; Eagly et al., 1992; Heilman, 2001; Rudman & Glick, 1999, 2001). Overall, men are more likely than women to be viewed as natural leaders.

Bias, Discrimination, and Intersectionality

Experiences of gender-based bias, discrimination, and violence serve as additional hindrances to women ascending into leadership positions. In total, 35% to 70% of women worldwide have experienced physical or sexual violence (UN, 2020c; WHO, 2013), and women and girls comprise over 70% of all human trafficking victims (UN, 2020c). These threats limit a woman's autonomy and choices and can serve to undermine her ambitions. Once in leadership roles, a significant proportion of women experience hostile work environments. In the United States, Japan, and Sweden, women supervisors were between 30% and 100% more likely to have been sexually harassed in the last 12 months compared to their nonsupervisory female counterparts (Folke et al., 2020). Eighty-two percent of women parliamentary leaders in 39 countries endorsed experiencing psychological or other violence (Inter Parliamentary Union [IPU], 2016; UN, 2020c). Sixty-five percent of these female parliamentary respondents reported enduring sexist remarks, and 44% described threats of death, rape, assault, or abduction toward themselves or their families (IPU, 2016). There is a dearth of research on male leaders' experience of hostile work environments. However, data collected in over 30 North American and European countries maintain that women experience sexual harassment at significantly greater rates than men (Van Dijk et al., 2007). Additionally, Nigeria's Federal Office of Statistics (2012) found that between 9% and 13% of men experienced sexual harassment at work, whereas women experienced 40% to 68% of workplace sexual harassment.

Intersectionality is also vital as several social factors interplay with gender bias to further limit potential opportunities. Minority women (e.g., Asian, Caribbean, African, Latin American, Aboriginal, Arab, and Pacific Islander) face higher ethnic and sexual harassment rates in the workplace (Berdahl & Moore, 2006). Across the globe, colorism continues to impact individuals' perceptions of themselves and the opportunities they are afforded, adding yet another barrier to leadership for darker-skinned women of historically marginalized backgrounds (Rahman, 2020; Sims & Hirudayaraj, 2015; Yeung, 2016). Indigenous women disproportionately experience domestic violence, human trafficking, poverty, and multiple other adverse consequences of colonization (United Nations Economic and Social Council [UNESC], 2013). Indigenous women may also lack identification documents, limiting them from achieving financial stability and engaging in public service (UNESC, 2013). In rural areas, established dispute processes may inherently exclude women from political processes. For example, in Bangladesh, the shalish mediation process is male-only, even if a woman is involved in the issue to be mediated (O'Neil & Domingo, 2016). Additionally, women with disabilities experience poor access to assistive technology, justice and education, and ongoing biased perceptions that serve to instill additional barriers to agency and full participation in life (UN Women, 2018).

Family Tensions and Gender Roles

Family tensions due to perceptions of gender roles may also limit women's engagement in work, thereby undermining leadership opportunities. Globally, 20% of women between the ages of 20 and 24 married before they were 18 years old (UN, n.d.b.; UNICEF, 2018), with roughly 650

million women alive today who were child brides (Whiting, 2019). Girls and women in these marriages tend to experience interrupted or discontinued education, domestic violence, social isolation, restrictions on individual rights to travel and work, and limited ability to negotiate family planning (Leclerc-Madlala, 2008; UN, n.d.b; UN, 2020c). Being married is also associated with reduced labor force participation for women worldwide. Prior to marriage, women comprise 66% to 73% of the global labor force, and this number drops to 52% for married/partnered women (UN, n.d.b). Contrastingly, when men marry, their labor force participation rate increases from approximately 85% to 96% (UN, n.d.b). Moreover, women contribute to over 76% of unpaid care work, including community, domestic, and caregiving activities (Charmes, 2019). Accordingly, when researchers examined data from 37 countries in Europe, North and South Americas, Asia, and Oceania, they found that women face more work interference with family and family interference with work (Kaufman & Taniguchi, 2019).

Women Leadership and the COVID-19 Pandemic

Leadership in Crisis

Although women face significant barriers to leadership, once they have attained positions of power, women promote policies that improve the general welfare of their communities. When women were elected in Indian district elections, neonatal mortality decreased, efforts to increase access to clean drinking water were implemented, and adolescent girls spent more time in school and reported higher occupational goals (Beaman et al., 2012; Bhalotra & Clots-Figueras, 2011; Chattopadhyay & Duflo, 2004). When Afghan village council leadership is 50% female, women rate their leaders as concerned about the entire village's welfare, whereas male leaders are more likely to support irrigation- and transportation-related projects (e.g., roads and bridges), efforts more likely to enhance quality of life for men who typically enjoy increased mobility and control over land ownership (Beath et al., 2012). Additionally, women legislators in Rwanda were more likely to focus on policies that improved healthcare and well-being of children and families (Powley, 2006).

During the current COVID-19 global health crisis, health concerns, financial insecurity, and changes to education platforms and access have resulted in significant stress and concern for the future (American Psychological Association, 2020; World Bank, 2021). Understanding how people process information and respond to crises informs us of the leadership qualities needed during the COVID-19 pandemic. During a crisis, individuals can often feel fear, anxiety, helplessness, and uncertainty (Centre for Disease Prevention and Control [CDC, 2019]; Nicomedes & Avila, 2020; Shultz et al., 2016). They may experience difficulty accurately interpreting and recalling information, changing current or deeply held beliefs, and maintaining objective awareness of the problem (CDC, 2019; Fischhoff et al., 2020).

Crises call for leadership traits empirically noted to be more associated with women. Scholars studying organizational development underscore that influential crisis leaders identify early signals of the crisis; work with professional consultants to form a crisis management team; engage in efficient decision making, coordination, and communication during the situation; and continually learn and assess throughout the process (Fener & Çevik, 2015). Eagly et al.'s (2003) meta-analysis found evidence that women tend to be less hierarchical, more cooperative and collaborative, and focused on developing and mentoring their subordinates. Men from multiple nations, however, were found to exhibit active and passive management by exception wherein there is a focus on subordinates' mistakes and limited involvement until significant problems arise (Eagly et al., 2003).

Men and women have also been found to utilize different strategies in high-stakes and high-stress situations. Three research studies found that US women demonstrate a tendency to take less risk under pressure (Lighthall et al., 2009; Preston et al., 2007; van den Bos et al., 2009). A study examining gender and leadership during COVID-19 found that women leaders are focused on macro- and state-level policies. In contrast, countries with male administration placed a focus on regulating individual behaviors (Windsor et al., 2020). In the United States, a study assessing 454 men and 366 women business leaders compared their overall leadership effectiveness, as assessed by subordinates, peers, and supervisors, during March to June 2020. Overall, North American women were rated as more effective leaders during the initial COVID-19 wave, with women having a statistically significantly higher score on 13 of 19 leadership attributes assessed (Zenger & Folkman, 2020). Leader characteristics valued during the COVID-19 pandemic included flexibility, ability to learn new skills, honesty and integrity, commitment to employee development, and sensitivity to their subordinate's challenges (Zenger & Folkman, 2020). These noted traits, found to have greater association with women leaders, likely allowed for the lower death rates in women-led nations described in the subsequent section.

Windsor et al. (2020) examined national-level data of 175 countries across the world and concluded that women

leaders' dual expectations to exhibit stereotypically feminine and masculine behavior have resulted in their optimal performance during COVID-19. These authors assert that crisis situations require both strong decisiveness and humane factors that allow women leaders to optimize the "double-bind" expectations of women leaders. During COVID-19, women demonstrated an ability to engage in decisive actions to close borders while also showing compassion and nurturance, such as when Norway's Prime Minister Erna Solberg held a special press conference for children (Fouche, 2020; Taub, 2020).

Female Leaders and COVID-19 Death Rates

Bilinski and Emmanuel (2020) examined COVID-19 deaths per capita from February to September 2020. Data were examined from 19 countries with populations greater than 5 million and gross domestic product greater than $25,000 per capita. Five women-led nations – Norway, Finland, Denmark, Germany, and Switzerland – were categorized in the "moderate mortality" group, and only one nation with a female leader was classified as "high mortality." The "moderate mortality" women-led countries reported per capita death rates of 5–20.6, while countries categorized as "high mortality" reported 36–86.8 deaths per capita since the onset of the COVID-19 pandemic. Four of the women-led nations did not exceed a rate of 11.3 deaths per capita due to COVID-19. The researchers also compared excess all-cause mortality rate per capita. Of the countries with women leaders, the most significant difference in fatalities per capita when comparing COVID-19 and all-cause mortality was 19. However, estimations of the all-cause mortality rates were more than 30 deaths per capita compared to COVID-19 death rates for some nations in the high mortality group. Belgium, whose formal government collapsed in 2018 (Rivera, 2018), was the only female-led nation in the high mortality group.

In another study, Garikipati and Kambhampatic (2020) examined whether being a female or male led-country resulted in different COVID-19 outcomes. The researchers gathered information on total COVID-19 deaths and cases during the first quarter of the pandemic in 194 countries. They matched female-led countries to their nearest neighbors based on four sociodemographic and economic characteristics: GDP per capita, population, the population in urban agglomerations, and population over 65 years old. The results yielded a definite and consistent pattern, confirming that COVID-19 deaths were lower in women-led countries. To further determine the soundness of the study's results, they removed from their sample the three nations most in the media spotlight for COVID-19, the United States, Germany, and New Zealand, to assess their impact. The finding that female-led countries had fewer COVID-19 deaths was only strengthened.

Similarly, an examination of 35 countries conducted by Coscieme et al. (2020) concluded that female leaders were more rapid and effective at flattening the epidemic's curve. Researchers utilized data from the European CDC from the start of the pandemic through July 31, 2020. Countries were included in the study if they had continuous data, a gross national income per capita of $3,956 or higher, high to very high Human Development Index (defined as lifespan, educational level, and gross national income), and a democratic government. For each country, data were analyzed on the number of COVID-19 deaths per capita, the number of days with at least one reported death, and the highest daily number of deaths as a proportion of the population. Women led 10 of these countries, and countries led by women had 1.6 times fewer deaths per capita than their male counterparts. Peaks of death were also seven times lower in women-led countries. The average highest daily COVID-19 death rate was 91 across the women-led countries, whereas it was 643 for countries led by men (Coscieme et al., 2020).

Female Leaders and Public Health Policies

Specific to the COVID-19 pandemic, female leaders demonstrated a trend of following science-based evidence and taking rapid action to address the pandemic (e.g., Iceland's Prime Minister Katrin Jakobsdottir's early crowd restriction in mid-March 2020, and Germany's Chancellor Angela Merkel considered a variety of data sources, including epidemiological models and data from medical providers, in developing Germany's coronavirus policies). Garikipati and Kambhampatic (2020) found that female-led countries locked down significantly earlier than their male-led countries. Coscieme et al. (2020) also reported a pattern of women leaders executing lockdown measures swiftly. These policies resulted in female-led countries consistently having fewer deaths from COVID-19 per capita, a lower peak in daily deaths per capita, a shorter number of days with confirmed deaths, and lower excess mortality.

Araya (2020) conducted a systematic evaluation of the performance of 166 governments during COVID-19. He examined the reaction time of when a leader publicly acknowledged the virus and the appropriateness of the leader's response. He found that many women leaders reacted quickly and adopted science-based policies. He noted Germany's Chancellor Angela Merkel sharing the "truth" about the COVID-19; New Zealand's Premier

Jacinda Ardern's and Taiwan's President Tsai Ing-wen's decisive actions; and the swift adoption to use technology to test, trace, and better understand the virus by Iceland's Prime Minister Katrin Jakobsdottir and Finland's Premier Sanna Marin. Results demonstrated that women leaders reacted faster to contain the virus. All leaders studied enacted COVID-19-specific public health policies by 32 days after an outbreak was detected in their respective countries. However, women reacted faster, with half of all the women leaders taking a measure by day 24. The women leaders were also quicker in canceling international travel, releasing informational campaigns, and instituting contact tracing (Araya, 2020). However, women leaders were slower to close schools than their male counterparts, as noted in another study (Aldrich & Lotito, 2020). This decision possibly underscores female leaders' awareness of the gendered consequences of school closures and its likely disproportionate impact on women. It is consistent with the fact that women tend to prioritize issues (i.e., education, welfare, and healthcare) that support all constituents more than men (Cowper-Coles, 2020).

While much attention has been focused on women nation leaders, Parmar and Neelam (2020) studied South Asian local women leaders' COVID-19 management. Sarpanches (heads of villages), legislative members in India, mayors in Nepal, and the Health Ministers in Bhutan and Sri Lanka were among those examined. These women leaders collaborated with relevant stakeholders and utilized technology to mobilize their communities. In Kerala, India, Health Minister K. K. Shailaja used social media channels to continuously update the public and debunk false myths and news about COVID-19. Similarly, Mayor Kantika Sequval, from a remote part of Nepal, used local TV and radio stations to convey timely information. Bhutan Health Minister Dechen Wangmo had a preparedness plan which included early screening and mandatory quarantine, resulting in significantly minimized COVID-19 deaths. Bhutan reported its first and only COVID-19 death in January 2021, 10 months into the pandemic (Parmar & Neelam, 2020). Within the United States, data collected from January 21 to May 5, 2020, revealed that female governors issued orders to stay-at-home earlier, and their states had fewer COVID-19 deaths (Sergent & Stajkovic, 2020).

Factors That May Interact to Bolster the Success of Women Leaders During COVID-19

The previous section outlined the unique qualities of women leaders and associated distinct approaches to address COVID-19. However, some scholars maintain that we are not witnessing a phenomenon due to variances in gender alone. Windsor et al. (2020) examined COVID-19 deaths, gender of countries' leaders, and several other covariates. The researchers found no statistically significant difference in COVID-19 fatalities between countries led by men versus women. Windsor et al. (2020) extended their analyses to include non-Organization for Economic Co-operation and Development countries and found limited support for lower reported fatality rates in women-led countries; however, the differences were not statistically significant. Notably, these researchers identified a nation as woman-led even if a woman was not head of state. For example, a country with a woman holding authority over the nation's military was identified as woman-led. Therefore, these data may include countries in which women leaders do not have actual authority to enact policies during COVID-19. It remains important to highlight the successes of the minority of women leaders globally and identify factors that may enhance these successes to promote women's leadership roles.

Analysis of nation-level COVID-19 protocols and outcomes offers some factors that may interact to bolster successes experienced by women-led nations. Specifically, the cultural values held by a nation's citizens and a nation's overall disaster preparedness are important to the success of women leaders, especially during a crisis (Coscieme et al., 2020; Windsor et al., 2020). Indeed, Coscieme et al. (2020) identified that women-led countries were more progressive, equitable, and healthy. These nations' citizens may be more likely to comply with efforts that support the greater good, thereby adhering to COVID-19 policies and reducing the morbidity and mortality rates. Additionally, women-led countries may have emergency preparedness systems to mitigate crises more effectively (Windsor et al., 2020). Indeed, researchers identified that nations categorized as women-led had higher disaster preparedness ratings than men-led countries (Windsor et al., 2020). Therefore, having a national plan to address crises likely allowed for ease of consensus-building in implementing health policies, thereby bolstering the success of women leaders during COVID-19.

Conclusion

The effects of the COVID-19 pandemic can degrade progress made toward women's rights and gender equality (UN, n.d.c). Women have traditionally been overrepresented in low and unpaid labor markets and assume a disproportionate majority of childcare and domestic responsibilities (Cameron et al., in press). During COVID-19,

women are involved in frontline healthcare, engage in unpaid care work at home due to school closures, experience disparate financial insecurity, and face increased violence during stay-at-home orders (UN, n.d.c; UN, 2020b, UN Women, 2020). History shows that when policies include female voices and are gender-responsive, more effective responses to infectious disease outbreaks occur (UN, 2020b).

While the data highlighting women leaders during COVID-19 are predominantly from the pandemic's early months, this research is promising and significant. Global women leaders consistently demonstrated a trend of enacting prompt public health measures. Women leaders who embraced science were more risk-averse than men when considering life versus economics, resulting in systematically locking down their countries more quickly than male leaders, resulting in low death rates (Garikipati & Kambhampati, 2021; Taub, 2020). To achieve gender equality, the world needs more women in charge of its nations (CFR, 2020). Importantly, when women throughout the world hold leadership positions, leadership perceptions become less biased and more androgynous (Dasgupta & Asgari, 2004; Koenig et al., 2011).

This focus on women's leadership is promising and important as the work toward equity continues. To further these efforts, consideration of other factors that promote women leaders is imperative. Specifically, a nation's ideals and values are likely to set the stage for women's participation in politics and related response from its citizens. Collective, inclusive, and progressive values are likely to promote equity and further the United Nation's Sustainable Development Goals, especially goal 5, gender equality (UN Women, 2020).

It is important to note that the authors maintained binary terms of male/female and women/men to highlight gender inequity and disparities. However, we acknowledge that gender identity is a much more expansive and fluid spectrum. Additionally, while speaking of the female experience, the authors recognize that many organizations and data collection efforts focus on a male–female household and partnership that does not encapsulate the many forms of partnerships in today's society.

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Special Issue: Women During COVID-19
Article

COVID-19 and Women

Key Components of SDG-5 and the Estimated Prevalence of Modern Slavery

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Abstract. Modern slavery is a significant global human rights crisis that disproportionately affects women and girls, and research indicates that the COVID-19 pandemic has exacerbated existing vulnerabilities to exploitation. Early evidence suggests that the pandemic has disproportionately affected women and girls, including an increase in lack of access to family planning and adequate sexual and reproductive care and an increase in maternal mortality rates. Additionally, the pandemic has instigated a reduction in economic opportunities and access to education for women and girls and increased violence against women. For this study, regression analysis was used to examine country-level data from 197 UN member countries. Predictor variables included indicators reflecting key areas addressed by UN Sustainable Development Goal 5 (SDG-5): gender inequality, educational and economic opportunities for females, women's leadership, gendered violence, and women's health. SDG-5 calls for gender equality and empowerment of women and girls. The criterion variable was the estimated prevalence of modern slavery across UN countries. Regression analysis revealed significant results across all models. Literacy rates and expected years of schooling for females, femicide, lifetime prevalence of violence, and several indicators of women's health were found to be strongly and significantly related to increased estimated prevalence of modern slavery. Furthermore, we propose that the pandemic has increased vulnerability to exploitation for women and girls by regressing progress across all areas addressed by SDG-5.

Keywords: modern slavery, gender inequality, violence against women, COVID-19, SDG-5

Impact and Implications. Results indicate that indicators of gender equality and women's empowerment as addressed by Sustainable Development Goal 5 are strongly and significantly related to the estimated prevalence of modern slavery across UN member countries. The COVID-19 pandemic has disproportionately exacerbated inequalities for women and girls. Women play a crucial role in leadership and recovery from the pandemic.

The novel coronavirus (COVID-19) has exposed and exacerbated global inequalities across economic, educational, health, and safety domains (Alcántara-Ayala et al., 2020). In addition to high levels of morbidity and mortality, the pandemic has increased the threat of mass poverty (International Labour Organization [ILO], 2020), disastrous levels of hunger (Food Security Information Network, 2020), and violence against women (VAW; Peterman et al., 2020; UN Women, 2020b). Globally, vulnerable populations and developing nations will be most affected by the pandemic and are at the greatest risk of falling victim to further marginalization, with preliminary reports indicating that women are already disproportionately affected (Alon et al., 2020; Connor et al., 2020).

Women have traditionally been overrepresented in low and unpaid labor markets and assume a disproportionate majority of childcare and domestic responsibilities. COVID-19 has placed women at a further socioeconomic disadvantage as the informal economy has struggled and schools have closed (Gabster et al., 2020; Power, 2020; United Nations, 2020). Many women have also lost access to social services and healthcare (Bruno et al., 2020; United Nations, 2020; United Nations Population Fund [UNFPA], 2020). Research indicates that women are at an increased risk of violence following human-made and natural disasters, and early data suggest that rates of female exploitation have risen during the pandemic (Fraser, 2020). United Nations Sustainable Development Goal 5 (SDG-5) aims to "achieve gender equality and empower all women and girls" and addresses key areas of equality and women's empowerment (United Nations, 2020a). We propose that COVID-19 has diminished gains in gender equality in the areas addressed by SDG-5, which has increased women's vulnerability to modern slavery victimization.

Modern Slavery

Modern slavery is an umbrella term used to describe all forms of commercial exploitation, such as human trafficking, forced marriage, forced organ donation, and

compelled labor (Craig et al., 2019; Walk Free Foundation [WFF], 2018). Modern slavery disproportionately affects women and girls (Sidun & Flores, 2020), representing 71% of all human trafficking victims and a majority (99%) of commercial sex-trafficking victims (ILO, 2018). Vulnerability to exploitation encompasses a complex matrix of factors across economic, political, social, and cultural arenas (Cameron et al., 2020). Due to the covert nature of modern slavery, obtaining reliable data is challenging, and global efforts to mitigate the effects of COVID-19, such as curfews, lockdowns, and travel restrictions, have pushed the illegal industry further underground (United Nations Office of Drugs and Crime [UNODC], 2020c). During COVID-19, this issue has been compounded by increased demands placed on law enforcement and social services, limiting the capacity to detect and respond to victims of exploitation (United Nations Population Fund [UNFPA], 2020). Early data suggest that perpetrators of modern slavery are using women's increased vulnerability and a decreased law enforcement presence to their advantage (UNODC, 2020c).

In the early months of the pandemic, some nongovernmental antitrafficking organizations reported up to a 20% increase in the number of victims seeking support (Franchino-Olsen et al., 2020; Polaris Project, 2020). This increase is notable because exploited individuals are likely to have fewer opportunities to seek help during the pandemic, suggesting that the actual number of victims is substantially higher than those reported. Many organizations where victims may seek protection services, such as mental and physical healthcare facilities, women's shelters, migration assistance, and legal/justice services, are no longer easily accessible. Some have closed temporarily in an attempt to minimize the spread of the virus or have long waitlists for services due to curtailed operations (Joska et al., 2020; UNODC, 2020c). Additionally, some antitrafficking organizations have transitioned to offering only virtual support services. However, for women without internet access or those afraid to risk detection by their abuser, these services are of little assistance (Mukherjee et al., 2020).

Gender Inequality

Significant variation in progress toward achieving gender equality continues, with some countries showing remarkable improvements in women's access to education and leadership positions (Hughes & Paxton, 2019). However, early data indicate that gains may be diminished due to COVID-19 (UNODC, 2020c). The pandemic and government responses to the pandemic have prompted historic levels of unemployment and income loss, which are expected to continue (Power, 2020; UNODC, 2020c). Before the pandemic, young females were already disproportionately affected by poverty (Sanchez-Paramo & Munoz-Boudet, 2018), and continued discriminatory practices across structural systems such as education and employment may largely contribute to the feminization of poverty and women's vulnerability to exploitation (Cho, 2015; Vyas & Heise, 2016). Over 70 million people succumbed to severe poverty in 2020, and nearly half of the global workforce is at risk of unemployment (ILO, 2020). Women, who are disproportionately dependent on informal labor markets for income, are uniquely vulnerable to economic instability (Lafortune et al., 2020). Jobs in industries where females have traditionally been overrepresented, such as clothing manufacturing and domestic labor, have disappeared during the pandemic (UNODC, 2020c; Wenham et al., 2020), increasing women's vulnerability to adverse consequences.

Women's Leadership

Female representation is critical to promoting and ensuring women's rights. When women are absent from positions of power and leadership, predominantly male governing bodies are not consistently held accountable for ensuring women's rights (Goetz et al., 2009). In countries with limited female leadership, gender inequality and VAW are less likely to be addressed, exposing women to increased victimization (Razavi & Turquet, 2016; United Nations Division for the Advancement of Women, 2005). In contrast, current data show that female-led countries score higher in social progress measures and gender equality (Coscieme et al., 2020). Similarly, countries with female leadership have fared better in mitigating the COVID-19 pandemic (Coscieme et al., 2020; Garikipati & Kambhampati, 2020). However, the pandemic has pushed women to take on additional domestic and childcare responsibilities amid school closures and waning resources, limiting their ability to participate fully in public life (UN Women, 2020a).

Violence Against Women

VAW is both a contributor and a consequence of gender inequality (United Nations Office of the High Commissioner for Human Rights [OHCHR], 2014). Globally, VAW has been a problem of pandemic proportions since long before the outbreak of COVID-19 (UN Women, 2020c). Before pandemic, an estimated 35% of women worldwide experienced physical or sexual violence in their lifetime (World Health

Organization [WHO], 2013). Preliminary reports suggest that, following lockdown measures in 2020, reported domestic and intimate partner violence (IPV) cases increased significantly in some countries (UNODC, 2020a). For example, in India, reports of VAW increased 100% following a nationwide lockdown (Poblete-Cazenave, 2020). Similarly, in China's Jianli County, IPV reported in February 2020 was threefold that of February 2019 (Wanqing, 2020). However, VAW reported during the pandemic may reflect only a fraction of actual cases as women may be unable to leave the house or access help while living with their abuser (UNODC, 2020a; UN Women & WHO, 2020).

In contrast with increased reports of domestic violence, the number of cases of rape and sexual assault reported to authorities in March to April 2020 decreased significantly (UNODC, 2020a). One possible explanation for this finding is women's reduced exposure to places and individuals outside the home. Social distancing, restrictions on social gatherings, and closures of stores and restaurants decrease opportunities for interactions in which IPV may take place (UNODC, 2020a, 2020b). Alternatively, decreases in reported sexual violence may be due to structural obstacles that interfere with reporting of gender-based violence, such as social isolation, lack of freedom of movement, fewer women in the workplace, and the inaccessibility of criminal justice institutions (UNODC 2020a; UN Women & WHO, 2020).

Women's Health

The pandemic has intensified existing systemic risks that endanger women's health and overall physical and psychological well-being (Conner et al., 2020). In direct contradiction with the WHO recommendations, several countries closed "nonessential" medical services to prevent the spread of COVID-19, limiting women's access to sexual and reproductive health services (United Nations Department of Economic and Social Affairs [UNDESA], 2020; UNFPA, 2020). Even where reproductive health services remained open, women were less likely to seek services, possibly due to fear of contracting the virus (Kumari et al., 2020; UNFPA, 2020). Consequently, women's access to contraception, prenatal care, medical abortion, and sexual assault care has decreased, thereby increasing the risk of unwanted pregnancies, maternal and infant mortality, and sexually transmitted infections (Bruno et al., 2020; Ravaldi et al., in press; UNDESA, 2020; UNFPA, 2020). The UN Population Fund predicts that lack of reproductive healthcare during the pandemic could result in up to 7 million unwanted pregnancies and thousands of deaths resulting from birth complications and unsafe abortions (UNFPA, 2020).

Adverse psychological consequences resulting from the pandemic are also readily observable. For instance, rates of anxiety and depression have risen among mothers in response to lockdown measures and fear for their children's health (Ceulemans et al., 2020; Parra Saavedra et al., 2020). Women, who are the primary caregivers in most families, are also tasked with caring for sick family members, sometimes neglecting their own health and safety (Power, 2020). Pandemic-related stress may also contribute to recurrent trauma. In South Africa, for example, women living with AIDS have experienced retraumatization in response to fears of COVID-19, as the virus presents a genuine threat to all aspects of quality of life (Joska et al., 2020).

The Present Study

Research is needed to understand better the complex factors contributing to vulnerability to modern slavery for women and girls. Our research addresses this need by providing empirical data regarding the relationship between critical components of SDG-5 and the estimated prevalence of modern slavery across countries. Furthermore, our study provides valuable quantitative information that can inform global and national policy in the context of SDG-5 development and antitrafficking efforts. We hypothesized that there would be a significant relationship between the estimated prevalence of modern slavery and selected predictors of VAW, women's health, and gender inequality. Our study focused on predictors informed by SDG-5 in the context of its mandate that human rights are women's rights and the call for the urgent realization of global gender equality and female empowerment. We further incorporated emerging literature regarding the effect of COVID-19 on the critical components of SDG-5 addressed in the present study.

Method

Publicly available archival data addressing structural gender inequality from 2017 to 2019 were obtained from the ILO, WHO, UNODC, United Nations Development Programme (UNDP), World Bank Group (WBG), and the Organisation for Economic Co-operation and Development (OECD). The estimated prevalence of modern slavery was obtained from the WFF 2018 Global Slavery Index (GSI). Technical details regarding calculation of the GSI can be found at https://www.globalslaveryindex.org/about/the-index/.

Indicators of gender inequality were combined into three categories of predictor variables: VAW, gender inequality, and women's health. Together, these categories represent women's empowerment and equality, as reflected in several key aspects of the SDG-5. The dependent variable across all analyses was the estimated prevalence of modern slavery. Three separate regression analyses were used to determine the best models for predicting the estimated prevalence of modern slavery. Backward removal was used to obtain the best model for predicting the estimated prevalence of modern slavery by removing one predictor at a time from the regression equation until the best model was obtained. Indicators with a β value of $p > .10$ were removed from the model.

Analysis 1: Gender Inequality

Analysis 1 contained seven indicators of gender inequality: percentage of women with some secondary education (age 25+; UNDP, 2020), women's mean years of schooling (UNDP, 2020), expected years of schooling (UNDP, 2020), share of seats in parliament (Inter-Parliamentary Union, 2018), literacy rate for females (age 15–24; WBG, 2020), estimated gross national income per capita (UNDP, 2020), and labor force participation rate for females (age 15+; ILO, 2018).

Analysis 2: Violence Against Women

Analysis 2 contained five indicators of VAW: percentage of female homicide victims (age 15+; UNODC, 2018), rape rate for women (age 15+; UNODC, 2018), percentage of women who have experienced physical and/or sexual IPV in their life (OECD, 2020), and percentage of women age 20–24 married by age 18 (WBG, 2020).

Analysis 3: Women's Health

Analysis 3 contained seven indicators of women's health: life expectancy at birth for females (UNDP, 2019), adolescent birth rate, unmet need for family planning, attendance of a skilled healthcare worker at birth, maternal mortality ratio, contraceptive prevalence, and suicide rates for females (WHO, 2016).

Procedure

Statistical analyses were conducted in SPSS v. 26 (IBM Corp, 2019). Assumptions of normality, homoscedasticity, linearity, and absence of multicollinearity were met. Data sets were combined within the categories noted above. Three separate regression analyses were conducted to evaluate possible predictors of the estimated prevalence of modern slavery per 100,000 population across countries. Backward removal was used to determine the best model for each set of analyses. Predictors were removed from each regression equation if their individual β value had $p > .10$.

Results

The results show that several indicators of VAW, gender inequality, and women's health are significant predictors of the estimated prevalence of modern slavery across countries.

Analysis 1: Gender Inequality

Correlations and descriptive statistics are reported in Table 1, and regression results are reported in Table 2. Regression analysis yielded seven models, with all models achieving statistical significance ($p < .05$). The full model of predictors of

Table 1. Analysis 1: gender inequality – correlations and descriptive statistics ($N = 90$)

Variables	1	2	3	4	5	6	7	8
1. Modern slavery	—							
2. Expected schooling	−.41**	—						
3. Mean years of schooling	−.48**	.84**	—					
4. Estimated GNI	−.28**	.67**	.64**	—				
5. Share of seats in parliament	−.05	.20**	.15**	.21**	—			
6. Females in labor force	.17*	−.10	−.12	.00	.18*	—		
7. Literacy rates	−.13	.83**	.78**	.42**	.06	−.20*	—	
8. Secondary education	−.45**	.80**	.95**	.62**	.11	−.11	.72**	—
M	6.80	13.10	7.72	11,740	20.3	52.8	85.9	55.2
SD	11.80	3.21	3.44	12,663	11.6	16.3	20.9	30.5

Note. Two-tailed significance. *$p < .05$; **$p < .01$. GNI = gross national income.

Table 2. Analysis 1: regression analysis gender inequality – full model

Variables in Model 1	*t*	β	*F*	*df*	*p*	Adj. R^2
Overall model			3.692	7, 96	.001	.155
Expected schooling	−0.88	−.18			.38	
Mean years of schooling	−0.43	−.17			.67	
Estimated gross national income	−0.72	−.09			.47	
Share of seats in parliament	0.42	.04			.67	
Females in labor force	0.53	.05			.60	
Literacy rates	−1.10	−.20			.27	
Secondary education	0.48	.15			.63	

gender inequality was significant, $F(7, 96) = 3.692$, $p = .001$, adj. $R^2 = .16$, accounting for 16% of the variance in the estimated prevalence of modern slavery. The model with the greatest ES (Model 6) contained two predictors: literacy rate for females age 15–24 (β = −.190) and expected schooling for females (β = −.277), $F(2, 101) = 12.675$, $p < .001$. These predictors accounted for 19% of the variance in the outcome variable, adj. $R^2 = .19$.

Analysis 2: Violence Against Women

Correlations and descriptive statistics are reported in Table 3, and regression results are reported in Table 4. Regression analysis yielded four models, with three models achieving statistical significance ($p < .05$). The full model of predictors of VAW was not statistically significant, $F(4, 38) = 2.174$, $p = .09$, adj. $R^2 = .11$. The model with the greatest ES (Model 3) contained two predictors: femicide (β = .355) and lifetime prevalence of VAW (β = .216), $F(2, 40) = 4.236$, $p = .021$, predicting 13% of the variance in the estimated prevalence of modern slavery across countries, adj. $R^2 = .13$.

Analysis 3: Women's Health

Correlations and descriptive statistics are reported in Table 5, and regression results are reported in Table 6. Regression analysis yielded five models, with all models achieving statistical significance ($p < .05$). The full model of women's health predictors was significant, $F(8, 82) = 4.356$, $p < .001$, adj. $R^2 = .23$, accounting for 23% of the variance in estimated prevalence of modern slavery across countries. The final model (Model 5) had the greatest ES and contained four predictors: suicide rate for females (β = −.221), adolescent birth rate (β = −.563), life expectancy for females (β = −.474), and maternal mortality ratio (β = .368), $F(4, 86) = 8.314$, $p < .001$. These predictors accounted for 25% of the variance in estimated prevalence of modern slavery across countries, adj. $R^2 = .25$.

Discussion

The results indicate that several areas of gender inequality, VAW, and women's health are associated with a higher estimated prevalence of modern slavery. Expected years of schooling and literacy rates for females were the most significant gender inequality predictors, which is consistent with past research indicating that limited access to educational and employment opportunities is associated with increased rates of exploitation and VAW (Cho, 2015; Vyas & Heise, 2016). We propose that the COVID-19 pandemic is no exception and has exacerbated female vulnerability, which is supported by emerging data.

Table 3. Analysis 2: VAW – correlations and descriptive statistics ($N = 42$)

Variables	1	2	3	4	5
1. Modern slavery	—				
2. VAW prevalence	.35**	—			
3. Femicide	−.14	−.09	—		
4. Rape rate	−.10	.25*	−.04	—	
5. Women age 20–24 married by age 18	.20*	.24*	.00	.23	—
M	6.80	28.96	24.97	11.31	23.36
SD	11.76	16.34	13.53	14.36	14.90

Note. Two-tailed significance. *$p < .05$; **$p < .01$.

Table 4. Analysis 2: regression analysis for VAW – full model

Variables in Model 1	*t*	β	*F*	*df*	*p*	Adj. R^2
Overall model			2.174	4, 38	.090	.10
VAW prevalence	1.56	.25			.13	
Femicide	1.62	.29			.11	
Rape rate	−0.73	−.12			.47	
Women age 20–24 married by age 18	−0.16	−.03			.87	

VAW = violence against women.

The results further indicate a strong positive relationship between several indicators of VAW and the estimated prevalence of modern slavery. Femicide and women's lifetime experience of violence were the strongest individual VAW predictors, supporting prior observations regarding the interconnectedness of human trafficking and gendered violence. Sexual VAW, including commercial sexual exploitation, is a particularly heinous form of violence that is often used to dehumanize and maintain women's subordinate status, perpetuating inequalities. Countries with more severe gender inequality experience increased rates of VAW and modern slavery due to the co-occurring nature of crimes against women (OHCHR, 2014). As a result, pandemic-related exacerbation of VAW may predict increased rates of modern slavery globally.

The results further indicate that modern slavery is associated with several aspects of women's health, particularly sexual and reproductive health. Higher maternal mortality and adolescent births and a lower life expectancy for females are associated with a higher estimated prevalence of modern slavery. These results highlight the importance of high-quality healthcare, primarily reproductive healthcare, in reducing vulnerability to exploitation for women and girls. However, as a result of the pandemic, mitigation efforts have led to a loss of access to critical healthcare and medical services for many women worldwide (UNDESA, 2020; UNFPA, 2020). Social programs, intervention strategies, and governmental policies aligned with SDG-5 are needed to address the increased risk of vulnerability to modern slavery for women and girls during the pandemic.

Early reports indicate that the adverse effects of COVID-19 have driven women to risk health and safety by engaging in activities such as debt-bondage, which can be a gateway to exploitation, sex work, and selling themselves or family members to traffickers (Gabster et al., 2020; UNODC, 2020c). Not only do these activities engage women directly with the modern slavery industry, but they may also heighten the risk of COVID-19 exposure. Considering current and past disproportionate inequalities, pandemic initiatives must consider gender inequality and women and girls' heightened vulnerability to exploitation. However, when women attempt to escape poverty and inequality, they may become more vulnerable to exploitation.

Limitations

Inconsistent implementation of UN data collection guidelines and variations in trafficking laws and definitions of criminal activities across countries may result in inaccuracies. Furthermore, the illegal nature of human exploitation invites underreporting and missing data, prohibiting the inclusion of all UN member countries in

Table 5. Analysis 3: women's health – correlations and descriptive statistics (*N* = 90)

Variables	1	2	3	4	5	6	7	8
1. Modern slavery	—							
2. Antenatal care coverage	−.064	—						
3. Births attended by skilled health personnel	−.254**	.749**	—					
4. Maternal mortality ratio	.243**	−.437**	−.706**	—				
5. Contraceptive prevalence	−.209*	.475**	.587**	−.667**	—			
6. Unmet need for family planning	.123	−.297**	−.494**	.541**	−827**			
7. Suicide rates for females	−.030	−.072	−.036	.045	.142	.014	—	
8. Life expectancy females	−.252	.451**	.699**	−.862**	.702**	−.604**	*.021	—
M	6.80	90.06	86.47	170.45	49.73	18.40	4.85	73.24
SD	11.8	10.72	18.97	233.06	21.56	8.66	3.39	9.00

Note. Two-tailed significance. *$p < .05$; **$p < .01$. GNI = gross national income.

Table 6. Analysis 3: regression analysis Women's health – full model

Variables in Model 1	*t*	β	*F*	*df*	*p*	Adj. R^2
Overall model			4.356	8, 82	<.001	.25
Antenatal care coverage	−1.41	−.218			.16	
Births attend by skilled health personnel	1.14	.208			.26	
Maternal mortality ratio	2.21	.467			.03	
Contraceptive prevalence	0.051	.169			.00	
Unmet need for family planning	0.115	.136			.38	
Suicide rates	0.172	−.242			.44	
Life expectancy females	0.146	−.478			.02	

each stage of analysis. In addition, our statistical analysis was based on data from 2017 to 2019, which limits our ability to directly apply the results to the current COVID-19 pandemic.

Conclusion

Women's empowerment and equality, as represented by indicators of VAW, gender inequality, and women's health, are significantly associated with the estimated prevalence of modern slavery. Substantial advancements across these key markers may represent healthier and more equitable societies. While the COVID-19 pandemic has exacerbated inequalities, efforts to "flatten the curve" may provide unique opportunities to address global inequality. While disproportionately and adversely impacted by the COVID-19 pandemic, women also play a crucial role in leadership and recovery. Future research is needed to understand better how descriptive representation can empower females to advocacy in a multicultural context. Worldwide, females remain beleaguered by diverse forms of gender inequality and discrimination, which can increase vulnerability to trafficking and other forms of exploitation. Current work to foster equity in global and national systems during the COVID-19 pandemic may mitigate future inequities while reducing vulnerability to exploitation. Further work is needed to recover previous progress across all areas of gender inequality now hindered by COVID-19. We propose that addressing key components of SDG-5 will target gender inequality and vulnerability to modern slavery while ensuring a more equitable and safer world for future generations of women and girls.

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Article

Affective-Semiotic Dynamics of the Transition to Motherhood in the Context of the COVID-19 Pandemic

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Abstract. The transition to motherhood is an important moment in the life course, in which symbolic interactive dynamics are established between self, other, and world to overcome developmental challenges. However, these challenges are intensified with the COVID-19 pandemic, which caused a radical and unexpected rupture in daily life. This article aims to analyze the affective-semiotic dynamics of Brazilian women who experienced the transition to motherhood during the COVID-19 pandemic from a qualitative multiple case study. Eight women participated in the study in the city of Salvador. Data were collected from two narrative interviews with each participant conducted through videoconference, with a 2-month interval between interviews. The main finding reveals that the emergence of the pandemic was described by the participants as an unexpected and significant rupture in the transition to motherhood that raised feelings of fear and anxiety. In addition, I–other relations were marked by intense ambivalence between the need for social support and the risk of contagion, and the perspective and experience of childbirth were marked by a feeling of insecurity in the relations with the health personnel and settings. In light of Semiotic Cultural Psychology, three interdependent affective-semiotic fields were highlighted from the narratives: the perception of oneself regulated by the sign of vulnerability, the other regulated by the sign of a potential threat, and healthcare provision regulated by the sign of risk. These findings highlight the importance of quality healthcare that helps women to reduce the disruptive impact of the pandemic on the ontogenetic structure of psychological organization.

Keywords: transition to motherhood, case study, Brazilian context, COVID-19 pandemic, cultural psychology of semiotic dynamics

Impact and Implications. The article analyzes the main challenges faced by women in the transition to motherhood in the Brazilian context during the COVID-19 pandemic. The participants' narratives reveal aspects related to gender roles, such as perceived personal vulnerability, burden with child and home care, and helplessness in relation to social support and health care. From its reflections it aims to promote gender equality and female empowerment (UN's sustainable development goal, SDG #5 – gender equality), as well as the reduction of social inequalities (SDG #10 – reduced inequalities).

In 2020, the world experienced an unexpected historical moment imposed by the rise of the new coronavirus pandemic (SARS-CoV-2 or COVID-19). The circumstances, marked by *deaths without borders* due to an *invisible enemy* of which little was known (Santos, 2020), produced an atmosphere of fear and concern. This surprising event brought about a radical and unanticipated rupture in everyday life, causing significant change in the personal and collective spheres: mobility restrictions, social distancing, work from home, homeschooling, the adoption of hygiene measures and protocols to avoid contamination, and the feeling of lurking chaos. The new coronavirus has had many subjective repercussions, such as increased uncertainties regarding the future, fear of sickness, distancing from loved ones, along with post-traumatic stress symptoms, confusion, and anger, among other negative psychological impacts (Brooks et al., 2020), such as feelings of helplessness and abandonment (Ornell, 2020).

However, the experience of the pandemic is more difficult for some social groups than for others due to pre-existing vulnerabilities. This is the case for women, who have historically endured sexual discrimination and been held responsible for care within and outside the family. With the pandemic, they have experienced work overload, stress, and violence (Santos, 2020). For women who became pregnant and gave birth during the pandemic, we can expect that this historical moment has had a significant impact on how the transition to motherhood is experienced. After all, pregnancy, delivery, and puerperium are critical moments in the course of life and require the restructuring and adaptation of women to the different physical–psychological and social dimensions related to the development of the self (Pontes, 2019).

Together with the demands of such an important developmental transition, the pandemic burdened women with yet other complex personal-collective issues, which vary significantly according to socioeconomic factors, in that maternal deaths seem to be more frequent in low- and middle-income countries, as the result of serious failures of the health system combined with the social determinants of the health-disease process (Lumbreras-Marquez et al., 2020). In Brazil, chronic problems related to women's healthcare, such as low-quality prenatal care, few available hospital beds, insufficient resources for emergency care and critical cases (e.g., lack of ventilatory assistance and difficulty of access to an intensive care unit), racial disparities in access to health services, and obstetric violence, are additional barriers in the context of the pandemic (Takemoto et al., 2020). Regarding the impact of structural racism on maternal deaths by COVID-19 in Brazil, the study by Santos et al. (2020) showed that Black women were hospitalized in conditions of worse severity, such as higher prevalence of dyspnea and lower oxygen saturation, as well as higher rate of admission to the intensive care unit and assisted mechanical ventilation, and also observed a risk of death almost twice as high in Black women compared to White women.

Thus, according to the data analyzed by the Brazilian Obstetric Observatory COVID-19, the number of COVID-19 deaths of pregnant and postpartum women more than doubled in 2021 compared to the weekly average in 2020. Moreover, the increase in deaths in this group was far above that recorded in the general population. According to the survey, an average of 10.5 pregnant and postpartum women died per week in 2020, reaching a total of 453 deaths in 2020 in 43 epidemiological weeks. In 2021, the average number of deaths per week reached, until April 10, 25.8 in this group, totaling 362 deaths this year during 14 epidemiological weeks. According to the survey, there was an increase of 145.4% in the weekly average of 2021 when compared with last year's weekly average of deaths. Meanwhile, in the general population, the increase in the weekly death rate in 2021 compared to the previous year was 61.6% (Rodrigues et al., 2021). As Souza and Amorim (2021) warn, this rate may be even higher due to factors such as underreporting, difficulties in performing laboratory tests, and possible false-negative results.

In this scenario in which women's healthcare has been affected by the pandemic, some pregnant women are afraid to seek health services due to uncertainties and fear of leaving home, increasing the frequency of anxiety and depression symptoms (Souza & Amorim, 2021). There are still few studies in the literature that address the subjective experience of the transition to motherhood in the Brazilian pandemic context. Brazilian studies that refer to motherhood during the pandemic emphasized the burden of women with domestic work (Andrade et al., 2020; Macêdo, 2020). In general, studies that address the theme of pregnancy and the puerperium during the pandemic focus on biomedical aspects.

It is relevant to investigate this complex and significant period of human development, the transition to motherhood, as it has important repercussions for the personal and transgenerational course of a family system. In the context of a pandemic, this transition can be even more challenging for women, due to the unexpected break from daily life, new family and professional demands, and the condition of vulnerability that precedes the quarantine and worsens with it.

That said, the objective of this article is to analyze the affective-semiotic dynamics of women who experienced the transition to motherhood in the Brazilian context of the COVID-19 pandemic from the perspective of Cultural Semiotic Psychology. This theoretical perspective focuses on how people develop amid the social direction present in sociocultural contexts – which are conceived not only in their physical or geographical sense, but as systems of meanings and sociocultural practices that enable some ways of thinking about the lived world and acting in it. It is important to emphasize, however, the active character of the person in the reconstruction of social messages as they appropriate them, giving them their own and personal meaning. Through the incessant construction of meanings, people seek a coherent organization of their experience in the world (e.g., getting pregnant, giving birth, and caring for a baby). In the flow of experience, unexpected events, such as the emergence of a pandemic and the intensification of uncertainties related to the next, unprecedented moment of experience, can arouse feelings of tension and ambivalence. To create stability, from a psychological point of view, people create semiotic devices – fields of meaning – that will temporarily stabilize the inevitable uncertainties of experience. So, for example, collectively shared and personally internalized meanings about risk management in a pandemic – such as staying home, keeping social distance, and wearing masks – can guide people's actions and regulate their feelings, giving them some sense of security. In this sense, the social regulation of affect occurs through the person's participation in a myriad of sociocultural practices, throughout their psychological development, that lead to the internalization of affective-semiotic fields. These fields of meaning with affective quality operate as values – conceived as beliefs imbued with affection and social and subjective significance (Branco, 2006) – such as those related to motherhood and family – which regulate all concrete behaviors and create the conditions for the dynamic development of the self system (Valsiner et al., 2007/2012).

Table 1. Participant description

Name	Age	Approximate family monthly income (Real/Dollar)	Professional occupation	Civil status	Condition during first interview	Condition during second interview
Elaine	36	R$2,700/$530	Public servant	Single	5 months postpartum	7 months postpartum
Gabriela	25	R$10,000/$1,970	Student	Single	2 months postpartum	4 months postpartum
Isadora	22	R$800/$160	Architect	Married	Pregnant	Postpartum
Karla	28	R$3,600/$710	Makeup artist	Married	Pregnant	2 months postpartum
Letícia	34	R$10,000/$1,970	Psychologist	Married	Pregnant	Pregnant
Marcela	27	R$10,000/$1,970	Journalist	Married	4 months postpartum	6 months postpartum
Sandra	27	Could not inform	Philosopher	Married	1 month postpartum	3 months postpartum
Silvana	23	R$1,500/$295	Telemarketing	Single	Pregnant	Pregnant

Method

We performed a qualitative multiple case study (Stake, 2006). As described in Table 1, eight women participated in the study, all of whom experienced the transition to motherhood in the context of the COVID-19 pandemic in the city of Salvador, Bahia, Brazil. To interview the participants, we used the "snowball" technique, a form of nonprobability sampling that uses reference chains (Vinuto, 2014). We interviewed women with different family income and different professional qualifications to explore the socioeconomic aspects involved in the focused experience. Data were collected from two narrative interviews done with each participant by videoconference, with an approximately 2-month interval between interviews. This interval was established to obtain a deeper understanding of the narratives and to follow the experiences of the participants over time, including changes in the transition to motherhood and the situation of the pandemic in their social contexts. Saturation was used as a criterion for establishing the number of participants, especially related to the heterogeneity of the participants, the volume, and richness of the data collected (Minayo, 2017).

The narrative interview is a nonstructured and in-depth method that promotes a reflective process (Moura & Nacarato, 2017). We used the following starting question: How is it for you to become a mother (or mother once again) during a pandemic? The interviews were audio-recorded. The research was approved by the Committee of Ethics on Research with Human Beings (Opinion No. 4.255.261).

All participants were Brazilian, except Sandra, who is from Mozambique and temporarily in Brazil. All the interviews were conducted in Portuguese. Isadora did not participate in the second interview because she had recently given birth. Data were evaluated using Consensual Qualitative Research (CQR), a method of consensual qualitative analysis that studies, in depth, the unique experiences of the person, seeking to minimize researcher bias. CQR has, in its basic components, the use of open-ended questions for data collection, use of multiple points of view (judges), consensus decisions, auditor to check consensus, valuing personal narratives, importance of context, use of small samples, ethical care, and continuous return to the raw data to check the veracity of understandings (Hill, 2012). The data analysis was carried out by the authors of this article: All are women, and two have experienced the transition to motherhood (the first and third authors), while the second author works assisting women in childbirth. These aspects probably contributed to the participants being receptive and cooperative in sharing their personal experiences, while the researchers were familiar with the subject matter of the narratives. However, although the researchers were immersed in the same sociocultural context as the participants, they had differences related to socioeconomic status and racial belonging when compared to some interviewees, which may offer a limited field of insight and interpretation. The first stage of data analysis was to define the thematic axes, establishing general terms that encompassed the main aspects to be evaluated in the interview. In the second step, the central ideas of each speech were highlighted in the interview to fill in the thematic axes. For this, the first and second authors individually coded each interview, agreed on each central idea, and sent it to the auditor, the third author of the article. The function of the external audit is to assess the consistency of the findings, minimizing inferences by the researcher (Hill, 2012). In the third step, the duo who coded the interview created categories uniting the central ideas on the same theme and sent them again for audit.

Results

The main themes that emerged in the narrative interviews were as follows: (1) The perception of personal

vulnerability and of the future as uncertain gave rise to the emergence of an affective field characterized by intense fear and anxiety; (2) I–other relations marked by intense ambivalence between the need for social support and the risk of contagion; and (3) from this scenario of deep uncertainty and ambivalence, the perspective and experience of childbirth were marked by a strong feeling of insecurity in the relationship with the health contexts, with negative repercussions on the puerperium experience.

The emergence of the COVID-19 pandemic in the Brazilian context was perceived by the participants as an unexpected and significant rupture of personal-collective expectations about the transition to motherhood. This event was described as something that interrupted the possibility of a certain predictability of events from pregnancy to childbirth and amplified uncertainty about the future. According to the narrative of the participants, this event was depicted as something that "threw everything down the drain" (Karla), was "a very big scare" (Letícia), "a reason to pause everything [. . .] to change our routine," "something that turned our lives upside down" (Isadora), "caught us off guard" (Karla), leaving them "disoriented" (Silvana), "not sure of anything" (Isadora), and "not having control, not knowing what to do" (Karla). Sandra's account illustrates the great challenge faced by women dealing with such a surprising event taking place at the same time as their transition to motherhood:

> It's a great challenge (laughter). It's a challenge because it's as if it were the end of the world. . . as if everything is going fall apart at the same time [. . .] And what traumatized me the most while I was pregnant was turning on the TV and seeing [. . .] pregnant women who caught Covid and went into a coma. (Sandra)

For the participants, in general, the pandemic made personal and family planning difficult or even impossible – leaving the future on hold. This included, for example, organizing oneself professionally prior to the baby's birth, buying the basic baby products, or performing cultural rites such as baby showers. In this sense, the common concerns of women during the transition to motherhood – like the moment of birth and the changes in the family system – were relegated to a second plan due to other concerns related to the pandemic:

> Becoming a mother during a pandemic is knowing that besides all the other normal concerns [. . .] there is a problem [. . .] that is the reason why everything is paused in our lives [. . .]. So it's something significant, and a reason for concern, because we don't know if . . . we are not sure of anything. (Isadora)

Immersed in this scenario of uncertainty, the feelings most described by the participants were fear of contagion, their own or their babies' deaths, and anxiety:

> When this virus arrived, completely. At first I was scared, I was a little psychotic. Everything I bought did not pass through the door without washing, alcohol, bleach, alcohol again, soap. I didn't leave, I didn't have the courage to open the door, I was really afraid to open the door. (Elaine)

These feelings, most of the time, were accompanied by physical symptoms, as described by Gabriela: "I started having anxiety crises. I didn't sleep, I had arrhythmia, I had trouble breathing." The emergence of this affective-semiotic field, marked by a perceived vulnerability, was intensified by the socially constructed and personally internalized notion that pregnant women were part of the risk group. This view was corroborated by mass media with news on deaths of pregnant women in Brazil. As a result, the notion of protection in terms of how pregnant and puerperal women may protect their babies has changed. Under such circumstances, they could not isolate their babies from themselves. There was an intense fear of being a source of contamination:

> I have someone inside me who needs support, who needs care , and if anything different happens it can make her very fragile, so. . . this really scared me, [. . .] not having control over this moment and thinking that contamination happens in a fraction of a second [. . .]. (Leticia)

In order to mitigate the feeling of vulnerability and fear of contagion, the participants followed government measures adopted to control the pandemic, focused on social distancing strategies, which brought about significant changes in the I-other relations, especially with regards to the perceived support <> lack of support from the most important members of each woman's social network: "It's just me and her [baby] [. . .]inside the house just me and her, so all the care inside the house just me." (Elaine)

For women who had partners, these were signaled as someone who *helps* in domestic and childrearing activities. However, the other sources of support mentioned – even if not activated due to social distancing requirements – were women, such as the mother, mother-in-law, or friends. Housework overload, including the almost exclusive responsibility for childcare, had important physical-mental

implications: "[...] I developed tendinitis in both wrists [...] The child's weight [...] repetitive effort [...] I got used to the pain [...] there's no one to help me [...] I can't share the weight with other people." (Gabriela)

It is important to highlight that the transition to motherhood brings with it significant transgenerational bonds that reach back to the previous generations and the continuity of the family in the future, especially in the Brazilian context where the family has a fundamental value. In this sense, the Ministry of Health's suggestion to extend the period of social distancing was a significant obstacle to the shared experiences of motherhood:

> I'm very close to my family [...] right at the end of pregnancy [...] until her birth, like, I had to isolate myself from everyone [...] we see each other from the door, [...] video calls and stuff, but like, from a distance, so it's very different. [...] Nobody can come near, nobody can come see her... [...] Hold her in their arms. (Gabriela)

In general, the I–other relations were described by the participants as marked by the emergence of intense ambivalence. On the one hand, given that the other can be a potential transmitter of the virus, the risk of contagion requires strict social distancing. On the other hand, the supposed protection that social distancing offers to the woman and her baby can lead to a devastating experience of helplessness:

> one thing the pandemic brought I think was generalized distancing [...] this makes me feel a little helpless right now [...] these people [mother, mother-in-law] who are an example to me, anyways, who tell me what it is to be a mother, what motherhood is [...] this worries me a little, that is, not being able to count on them, in the sense of being together. (Leticia)

The experience of giving birth in a pandemic context was described by Sandra as "a challenge", especially due to the need to go through this moment with no family member to support her, because her husband had to take care of their two other children. In addition, maternity hospitals do not accept the presence of companions during the pandemic:

> I knew that I will not have my mother, that in the other two deliveries my mother was present. And knowing that I am going to a situation where I don't feel well, I am in severe pain, [...] I didn't even know if I could keep disinfecting my hands [...] I didn't know if I would be able to keep the mask. [...] Because having a companion, you already know that if the mask comes off, the mother, aunt, or husband, the family member who is accompanying will help [...]. (Sandra)

The emergence of the pandemic – perceived by the participants as an abrupt rupture in the ongoing developmental trajectory – interrupts a certain predictability of events and raises ambivalence in the relationship with others, amplifying uncertainty about the future. In this sense, for the women who were pregnant, one of the main concerns was to imagine and plan the moment of birth in the context of the pandemic, especially due to the perceived risk of contagion. After all, they feared that during the critical moments of the experience of childbirth, they might fail to take some protective measures properly such as using masks or constantly sanitizing their hands:

> "My childbirth issue is (...) a very great fear of contamination at that moment (...). Even if I use a mask, there will be some moments when I won't be able to use a mask (...) and it scares me a little (...) the fact that I don't know if I will sustain protection until it's time to give birth, so that worries me." (Leticia)

A participant who had the experience of childbirth during one of the critical moments of the pandemic in Brazil revealed the intense fear she felt when she was admitted to the hospital unit. Her account shows that the services provided by hospitals and maternity units – so often associated with the safety of specialized assistance – were perceived, in that context, as unsafe and threatening. The emotional repercussions of this experience of uncertainty and imminent risk were observed during puerperium, with the intensification of emotional instability commonly experienced by many mothers after childbirth:

> And when I went to the hospital to give birth [...] it was already chaos [...]. And then there was this fear, [...] of what it was going to be like, because we would have to stay for a while in the hospital, and then, like, we were apprehensive about everything [...] Afraid of everything. Then I came home, [...] I cried every day. [...] I had these anxiety crises. (Gabriela)

The experience of becoming a mother was also affected by the assistance offered by health services in monitoring pregnancy, childbirth, and puerperium. With the pandemic, this factor became even more evident, especially because in this context pregnant women are a risk group, making quality assistance essential. However, it is worth mentioning that this phenomenon is determined by intersecting factors and must be understood using social markers such as gender, class, and race. To illustrate the

issue of intersectionality, especially the issue of the country's existing social inequalities, we can mention the temporary closing of some public maternity hospitals in the city of Salvador during critical moments of the pandemic. This increased the perceived vulnerability of the impoverished pregnant women:

> [...] why did the hospital have to be closed? They didn't give any details, they just said "because of Covid, yes, we're admitting a small number of patients." Yes, but what is the solution? What can we do? Send the patient home? [...] And at some point I asked myself is this some kind of action to somehow kill pregnant women and say they died of Covid? (Sandra)

Discussion

The narratives of participants in the study describe that the event of the pandemic consisted in a non-normative rupture of their life trajectories, represented by signs[1] such as "destructuring," "collapse," "break," and "end of the world." These fields of meaning related to the emergence of the pandemic have an affective quality. The emotional flow was characterized by intense fear (of contagion, of death itself, and of losing the baby) and, in an interrelated way, by a strong anxiety (apprehensive expectation of the future). From the interactions between the intrapsychological resources of each woman and the suggestions of culture, new fields of meaning with affective quality begin to form their self systems (Valsiner, 2007/2012). From the participants' narratives, three main interdependent affective-semiotic fields were emphasized: the perception of oneself regulated by the sign of vulnerability (main tension: protection <>[2] lack of protection); the other regulated by the sign of a potential threat (main tension: support <> helplessness); and healthcare provision regulated by the sign of risk (main tension: security <> insecurity). The emergence of the pandemic and the socially constructed notion that pregnant women are at some risk – based on scientific studies and fostered by the mass media with news about deaths of pregnant women in Brazil – leads to subjective processes that aim to integrate new meanings of oneself and the world to preserve a sense of subjective continuity. In this sense, the first affective-semiotic field highlighted is related to the emergence of meanings of oneself regulated by the sign of vulnerability. Being pregnant in the midst of a pandemic was perceived by the participants as a special risk situation due to the greater risk of COVID-19 evolving into more severe symptoms and even death. In addition, the country is going through a situation of great economic, social, and political vulnerability. From the mediation, the sign of vulnerability, an affective field emerged dominated by fear and anxiety of leaving home – described a place of protection – and meeting others – possible transmitters of the virus. The home as a place of protection during the pandemic is also marked by various tensions due to gender inequalities at various levels, such as the housework overload on women (Andrade et al., 2020; Macêdo, 2020). Another aspect worth highlighting is the ambivalence felt during pregnancy in relation to the mother's own body: The female body, which houses the developing baby and which should protect it, can also be the transmitter of a virus that threatens its integrity (main tension: protection <> lack of protection).

Closely related to the affective-semiotic field regulated by sign of vulnerability is the I–other relationship regulated by sign of potential threat, marked by the tension between support <> helplessness. In general, Brazilian pregnant women have a family support network during the days before and after delivery. During the pandemic, the presence of a support network is not possible. The socially suggested notion that the others are potential transmitters of an invisible enemy that threatens the physical integrity of pregnant women and their babies comes to mediate women's relations with other people, including other members of the extended family. However, other central aspects of the transition to motherhood, such as the shared experience of pregnancy, childbirth, and puerperium – so important for Brazilian mothers – were blocked, leading to a deep feeling of helplessness and of disintegration of transgenerational bonds.

Finally, we highlight healthcare provision regulated by signs of risk. Here, the main tension consisted in safety <> insecurity. In general, women reported feelings of fear and anxiety when they needed to leave their homes and avoided this movement due to their

[1] According to Peirce (1868), a sign is anything that, under certain aspects and qualities, represents something to someone, creating in the mind of the person-interpreter a representation, an idea, and a feeling.

[2] The signs "<>" represent the constant, reciprocal dynamics between opposing domains – dynamically maintained within a system, that is defined by its mutual relationship (Valsiner, 2007/2012).

vulnerable condition. The main exception was for medical reasons. However, going to the doctor or to a medical examination raised intense tension between the perception of security – permeated by meanings related to mother and child healthcare – and insecurity – being with other people who could potentially transmit COVID-19. To circumvent the intense fear and anxiety related to this highly ambivalent choice, they make use of symbolic devices of protection that work as strategies of affective regulation (Valsiner, 2007/2012), attenuating the perceived danger, such as wearing protective masks, keeping distance, and reading the Bible.

However, in the case of the Brazilian reality, access to healthcare is determined by different intersecting factors and must be understood by using social markers such as social class. Social inequalities regulate the access to health services (Takemoto et al., 2020). In the case of women who do not have health insurance or lack the financial resources to pay for visits to the doctor or examinations in the private network, public healthcare appears as the only alternative. However, Brazilian public healthcare, despite its fundamental importance for the population, is characterized by scarcity of resources and largely impermeable frontiers – as in the situation of contingent and temporary closing of maternity units during a pandemic period – leading to an experience of deep insecurity.

Final Considerations

This article addresses the Brazilian women's experience of transitioning to motherhood in the midst of the COVID-19 pandemic. The challenges of this experience are intensified to the extent that these women are immersed in a sociocultural context marked by deep social inequalities, governed by a political system that prioritized the economy over social protection, assisted by a precarious public health system that neglected women's health and that, despite the high number of maternal deaths – the highest in the world – for a long time did not make vaccination available to pregnant and postpartum women. In this scenario, the future was perceived by them as an uncertainty that threatens their physical–emotional integrity, that interrupts the shared and transgenerational experience of motherhood, and that undermines the effective participation of a social support network in a critical period of developmental transition, leading to a profound sense of helplessness. Therefore, quality medical care for pregnant and postpartum women that welcomes and protects them is essential, restoring some sense of security, mitigating the sense of personal vulnerability, and reducing the potential impact of such a dramatic event on the ontogenetic structure of psychological organization.

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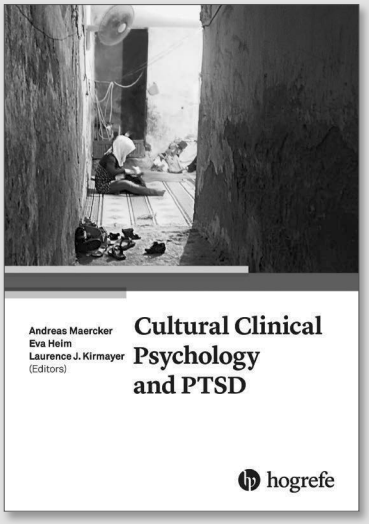

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Special Issue: Women During COVID-19
Article

Psychological Well-Being of Indian Mothers During the COVID-19 Pandemic

The Roles of Self-Compassion, Psychological Inflexibility, and Parenting Stress

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Abstract This study explored the associations among psychological well-being (PWB), self-compassion, psychological inflexibility (PI), and parenting stress (PS) in 242 urban Indian mothers of children 10 years old and younger in the context of the COVID-19 pandemic. Regression analysis revealed that greater self-compassion (SC), less PS, and greater psychological flexibility were associated with psychological well-being among the participants. Findings from this study contribute to research on maternal mental health by showing that, even in the context of the COVID-19 crisis, SC, PI, and PS are related to the PWB of urban Indian mothers, thus highlighting a need for evolving gender-based policies and emphasizing specific interventions for this vulnerable population.

Keywords: mothering, self-compassion, psychological inflexibility, well-being, parenting stress, COVID-19

Impact and Implications. Findings of the current study revealed that psychological well-being (PWB) of Indian mothers during the COVID-19 pandemic was negatively related to parenting stress and psychological inflexibility, and positively related to self-compassion (SC). These findings provide a rationale for developing and disseminating compassion-based interventions and suggest additional ways to advance United Nations Sustainable Development Goal 5, Gender Equality.

Since the onset of the COVID-19 pandemic and sudden lockdown in March 2020, mothers have taken on countless responsibilities. Mothers' work includes engaging in multiple roles, as a parent, partner, employee, employer, sibling, caretaker/guardian, friend/peer, and teacher, and ensuring the smooth running of the household. With little or no support in the form of school, day care, nannies, grandparents, or domestic help, mothers are stressed and depleted of resources (Coyne et. al, 2020; Davenport et al., 2020). Parenting stress (PS), feelings of losing control, and daily challenges (Calarco et al., 2020; Janssen et al., 2020; Miller et al., 2020; Prime et al., 2020; Spinelli et al., 2020) have substantially increased during the pandemic (Chung, 2020; Cooney, 2020). In a study by Lee and Ward (2020), 50% of parents reported social isolation, 52% reported financial worries as obstacles to their parenting, and 61% reported yelling at their children at least once in the past 2 weeks, despite also extending warmth. These challenges can be even greater for mothers (Davenport et al., 2020; Pandey, 2020a). A study conducted in the United Kingdom revealed that mothers were interrupted over 50% more often than fathers while working from home (Andrew et al., 2020).

Like women around the world, Indian women engage in more unpaid care work than their male counterparts (Chauhan, 2020). A report from the International Labor Office by Charmes (2019) reported that prepandemic, urban Indian women spent a total of 312 min daily on unpaid care work compared to 29 min by men, whereas rural Indian women spent 291 min compared to 32 min by men. Moreover, recent statistics on time spent on overall paid and unpaid work by women in India was 536.6 min/d contrasted with an average of 442.3 min/d being spent by men (OECD, 2020). COVID-19 has deepened this inequality between mothers and fathers. Deshpande (2020a) reported that while the lockdown made both Indian men and women spend more hours on chores, women were

largely still responsible for the major share of the household and childcare duties. With the disproportionate burden on mothers under the current pandemic and the added physical and emotional labor (Alon et al., 2020; Calarco et al., 2020; Craig, 2006; Deshpande, 2020a, 2020b; Power, 2020; United Nations [UN], 2020), there is a higher toll on mothers' mental health (Hamel & Salganicoff, 2020; Jungari, 2020).

Mothering in India is a multilayered process, dictated by a mother's family, faith, religion, customs, practices, superstitions, and sociocultural contexts (Pandey, 2010). Contrary to Western societies, Indian society is primarily a collectivist one where emphasis is placed on cohesion and family goals over individual goals (Avasthi, 2011; Triandis, 1993). Mothering is central to a woman's identity, placing her in a position of being revered by society (Oxfam India, 2020). Thus, Indian women's efforts and exhaustion may remain invisible (Pandey, 2020a; Sarkar, 2020). Gender role expectations in India push women toward "family roles," leaving professionally employed mothers to experience higher levels of parental role-overload compared to their spouses (Aryee et al., 2005; Buddhapriya, 2009). Although there is a substantial rise in the number of Indian women joining the workforce, women participate in employment and decision-making much less than men (Komarraju, 1997; Rajadhakshya & Bhatnagar, 2000). Little has changed in the social narratives that construe mothers as the primary and preferred caregivers for children (Krishnaraj, 2010; Sinha, 2007).

A considerable number of Indian homes are not equipped with vacuum cleaners, dishwashers, or even washing machines, leaving much housework to be done manually (Buddhapriya, 2009; Pandey, 2020a). Being labor-intensive, those chores often get outsourced to hired domestic help, such as cleaners, cooks, and nannies, especially in urban areas. Those employees become an indispensable part of household functioning, above all for women in the formal labor sector living in nuclear family units (Basnet & Sandhya, 2020; Dickey, 2000). Consequently, the pandemic and lockdown resulted in many mothers having to manage without the presence of usual support structures (Deshpande, 2020a, 2020b; Hazarika & Das, 2020; Pandey, 2020a, 2020b). The pressures of never-ending tasks led to potential stress among mothers, raising concerns about how they have been coping with the new reality of COVID-19 (Chauhan, 2020; Deshpande, 2020a, 2020b; Jungari, 2020).

SC has been found to be an important factor in effective coping strategies (Neff, 2003b; Neff & Faso, 2015), especially when facing difficult life circumstances that are outside our control (Sirois et al., 2019), such as the COVID-19 pandemic. SC is compassion directed inwards. Neff (2003a; 2003b) operationalized SC as kindness to oneself, common humanity, and mindfulness. It is found to be important in mothering as it amplifies parental well-being (Sirois et al., 2019). Without SC, one may become irritable, experience fatigue, and suffer maternal guilt, all of which might hinder mothering capability (Bogels et al., 2010).

PWB emphasizes eudaimonic well-being, which is understood as the fulfillment of human potential and living a meaningful life (Ryff, 1989). PWB has been found to be consistently related to SC (Akin & Akin 2015; Beshai et al., 2017; Neff, 2011; Neff & Germer, 2017) and to promote resilience by buffering against and reducing the adverse effects of negative life events (MacBeth & Gumley, 2012; Sirois et al., 2015). In the context of the pandemic, however, the increased time families have been able to spend with each other has increased the feeling of positive bonding (Grover et al., 2020; Roshgadol, 2020) that may have contributed to positive well-being and partially counteracted the pandemic-related stress.

PS has been defined as an aversive psychological reaction resulting from a mismatch between perceived parenting demands and available parenting resources (Deater-Deckard, 1998; Rantanen et. al., 2015). PS in mothers is indicative of higher anxiety, lower well-being, less happiness, more fatigue, less time for oneself (Meier et al., 2018; Musick et al., 2016; Nelson-Coffey et al., 2019; Skreden et al., 2012), and parental burnout (Mousavi, 2020). Research has also shown that PS relates to dysfunctional parenting and negativity toward the child (Deater-Deckard, 2004) and PS may lead to maternal anxiety and ineffective parenting strategies (Grant et al., 2012).

Psychological inflexibility (PI), defined as the "rigid dominance of psychological reactions over chosen values and contingencies in guiding action" (Bond et al., 2011, p. 678), may occur when people attempt to get rid of unwanted thoughts and feelings. Because it results in increased distress, PI is seen as a maladaptive psychological state (Calvo et al., 2020). In contrast, a psychologically flexible coping style has been found to be related to several aspects of psychological health (Butler & Ciarrochi, 2007).

SC was positively associated with life satisfaction, hope, and goal re-engagement (Neff & Faso, 2014). It was also found to be positively associated with well-being and psychological flexibility, and negatively associated with parental stress (Marshall & Brockman, 2016; Neff & Faso, 2014; Sirois et al., 2019).

Urban Indian mothers are juggling multiple responsibilities including household work, childcare, and care for other family members, while often maintaining a full-fledged professional career. The current study aims to

study the association among PWB, SC, PI, and PS in Indian mothers with children 10 years old and younger. It was hypothesized that SC, PI, and PS would be predictors of PWB. Furthermore, we hypothesized that SC, PI, and PS would predict a larger proportion of unique variance compared to sociodemographic factors.

Method

Participants

This study consisted of 242 urban Indian mothers with children 10 years and younger, who had completed their higher secondary education, living in India during COVID-19. All had completed higher secondary education. They were recruited through a snowball sampling method. The study received ethical clearance from the Institute Review Board of the Tata Institute of Social Sciences, Mumbai.

Procedure

Given the restrictions of mobility in India during COVID-19, quantitative data were collected through an online survey, which included a brief sociodemographic profile followed by four scales measuring SC, PWB, PI, and PS. The web link to the survey was shared widely to Indian mothers through social media such as Instagram, Facebook, and WhatsApp.

Measures

The study used the following self-report measures to explore the psychological constructs.

The Self-Compassion Scale-Short Form (SCS-SF; Raes et al., 2011) was used to measure SC. The scale consists of 12 statements divided over six subscales corresponding to six components of SC like "When something painful happens I try to take a balanced view of the situation." The total score on this scale ranges from 12 to 60. SCS-SF has demonstrated a near-perfect correlation with the long form of SCS ($r \geq .097$; Raes et al., 2011). The Cronbach's α for the current study was .79 indicating adequate internal consistency.

PWB was measured using the Psychological Well-Being Scale–Short (Ryff, 1989), the short form of the 42-item scale. It consists of 18 items like "The demands of everyday life often get me down." It measures six aspects of well-being and happiness. The total score on this scale ranges between 18 and 126. Cronbach's α was .81 indicating good internal consistency.

To measure PS, the Parental Stress Scale (Berry & Jones, 1995) was used. It consists of 18 items like "Caring for my child(ren) sometimes takes more time and energy than I have to give" that measure that assesses positive and negative components of parenthood. The total score for this scale ranges between 18 and 90. Cronbach's α of .79 indicated adequate internal consistency.

PI was measured using the Acceptance and Action Questionnaire-II (Bond et al., 2011) to assess PI. It consisted of 7 items like "I worry about not being able to control my worries and feelings" with the total score ranging from 7 to 49. Cronbach's α of .91 indicated excellent internal consistency.

Analytical Plan

The quantitative data were analyzed using IBM SPSS Statistics version 25. To examine the intercorrelation between different variables that were continuous but not normally distributed, bootstrapping was done followed by Pearson's correlation. This was followed by hierarchical regression analyses that were used to examine the extent to which SC, PI, and PS were associated with PWB in mothers. Age, education, and employment status were entered in Step 1, and psychological variables were entered in Step 2. To facilitate the regression analysis further, the categories for education and employment were coded using dummy variables.

Results

The sample consisted of 242 Indian mothers with the age range of 26–47 years (M = 35.50, SD = 4.25). Their sociodemographic details are provided in Table 1.

The Shapiro–Wilk test for normality revealed that the data from all four scales were not normally distributed. Thus, the data were transformed using the bootstrapping method to enable the usage of Pearson's correlations. It was found that SC had a positive moderate association, while PI and PS had a negative moderate association with PWB (see Table 2).

The first hierarchical regression model examined the unique contribution of sociodemographic characteristics, age, education, and employment status on PWB. Overall, the two-step model (including both sociodemographic characteristics and psychological variables) accounted for 46.6% of the variance in PWB (see Table 3).

Table 1. Sociodemographic characteristics of participants

	N = 242	
Sociodemographic characteristic	*N*	%
Highest educational level		
Bachelor's degree	72	30
Master's degree	170	70
Employment		
Employed	176	73
Homemaker	66	27
Location		
Mumbai	63	26
Delhi NCR	37	15
Kolkata	36	15
Bangalore	26	11
Pune	19	8
Others	61	26
Family type		
Joint	82	34
Nuclear	160	66
No. of children		
One	168	69
Two	67	27
More than two	7	3

Discussion

The experience of mothering is largely associated with the trope of femininity and gender (Arendell, 2000). In Indian society, women are pushed toward family roles over professional roles (Aryee et al., 2005; Buddhapriya, 2009), and mothering is intrinsically tied to a woman's identity (Oxfam India, 2020). Urban Indian mothers during the COVID-19 experienced higher levels of stress while working for home and from home due to the increase in unpaid care work, household chores, and sometimes professional engagements, without much support in place (Basnet & Sandhya, 2020; Deshpande, 2020a, 2020b; Hazarika & Das, 2020; Pandey, 2020a, 2020b; Sarkar, 2020).

Table 2. Descriptive statistics and correlations for psychological well-being, SC, PI, and PS

Variable	*n*	*M*	*SD*	PWB	SC	PI	PS
PWB	242	90.40	14.97	—			
SC	242	38.66	7.74	.564**	—		
PI	242	23.88	11.34	−.589**	−.641**	—	
PS	242	38.20	9.21	−.544**	−.449**	.468**	—

Note. PI = psychological inflexibility, PS = parenting stress, PWB = psychological well-being, SC = self-compassion. Bootstrap results are based on 1,000 bootstrap samples.
*$p < .05$, **$p < .01$.

Table 3. Summary of hierarchical regression analysis for variables predicting PWB (*N* = 242)

	Model 1			Model 2		
Variable	*b*	β	ΔR^2	*b*	β	ΔR^2
Age	0.107	.028.	—	−0.126	−.033	—
Education	0.525	2.130	—	0.759	.023	—
Employment status	1.178	2.115	−.010	1.902	.059	—
SC	—	—	—	0.493***	.253	—
PI	—	—	—	−0.396***	−.300	—
PS	—	—	—	−0.473***	−.288	.466

Note. PI = psychological inflexibility, PS = parenting stress, PWB = psychological well-being, SC = self-compassion.
*$p < .05$, **$p < .01$, ***$p < .001$.

Of the mothers in this study, 70% were professionally employed in some capacity or engaged in advanced studies while 30% were homemakers. However, although employed, Indian mothers continue to be the preferred and primary caregivers for their children (Krishnaraj, 2010). Despite research about parental attitudes (Jambunathan & Counselman, 2002), work–family balance and conflict (Buddhapriya, 2009; Munn & Chaudhuri, 2016), nutrition education (Agarwal & Udipi, 1989), and postpartum depression (Goyal et al., 2015) among Indian mothers, there is limited information on the experiences of urban Indian mothers in the context of PWB, SC, PI, and PS.

The results indicated that the psychological variables, SC, PI, and PS, accounted for 46.8% of the variance in PWB. In line with the existing literature, mothers were found to be high on SC if they were high on PWB (Akin & Akin 2015; Beshai et al., 2017; Neff, 2011; Neff & Germer, 2017). It is possible that those mothers who were accepting of their own situation and limitations, thereby being compassionate to themselves, allowed themselves more space to grow and experienced greater resiliency. Conversely, those who experienced higher feelings of well-being were able to better manage parenting challenges and consequently gave themselves more time and care (Bogels et al., 2010; MacBeth & Gumley, 2012; Sirois et al., 2015).

The current study found PI and PS to be inversely related to PWB. This finding was consistent with the existing literature (Calvo et al., 2020; Kashdan & Rottenberg, 2010; Leary et al., 2007). PI is seen as a maladaptive psychological state (Calvo et al., 2020). It is also possible that lack of support, inequality of gender norms, high societal expectations of motherhood, and increased workload due to the pandemic contributed to PS in mothers (Calarco et al., 2020; Deshpande, 2020b; Meier et al., 2018; Mousavi, 2020; Musick et al., 2016;

Nelson-Coffey et al., 2019; Pandey, 2020a). PS when associated with dysfunctional parenting and potential negativity directed toward the child (Deater-Deckard, 2004) may also be a factor in decreasing overall PWB (Calarco et al., 2020; Janssen et al., 2020; Miller et al., 2020; Prime et al., 2020; Spinelli et al., 2020).

Other factors potentially influencing these findings may include the buffering effects of increased time with partners, family, and children leading to improved relationships and greater bonding, increasing positive moods and feelings of well-being (Grover et al., 2020; Roshgadol, 2020). Moreover, stronger interpersonal relationships may develop when people realize the merit in reconnecting with their families (Calarco et al., 2020; Foster, 2020; Grover et al., 2020). Despite these positive protective factors, the pandemic has still seen a rise in feelings of loneliness, sadness, fear, anxiety, depression, stress, and parental burnout (Calarco et al., 2020; Grover et al., 2020; Mousavi, 2020). It is also possible that due to the pandemic, for some families, there was a shift toward realignment of traditional gender roles and norms, where many fathers took on active parenting and homeschooling duties and easing some of the burdens that mothers otherwise experienced (Alon et al., 2020; Deshpande, 2020b; Power, 2020).

Limitations

The sample of largely educated mothers from Indian urban cities limits the applicability of our findings in clinical and community samples. The study was available to those mothers who had access to smartphones or computers to fill out the survey form. The participants were not representative of all Indian mothers across the country. However, this methodology was the most practical approach given the COVID-19–related movement restrictions in the country.

Implications and Future Research

The findings of this study add to the limited empirical evidence on mothering experiences in India. Moreover, a qualitative enquiry aimed at delving into the lived experiences of these mothers could help identify factors contributing to SC, PI, PWB, and PS and further explore their coping strategies, information that could aid in developing effective interventions to improve maternal mental health and well-being. Thus, interventions for mothers need to look at SC, PI, and PS as important components contributing to overall well-being. As India is a culturally vibrant and diverse country, it is also crucial to extend this study to community and rural populations where caste and class differences are more prevalent.

The results also highlight the need to establish and enforce stronger policies around recognizing and appreciating unpaid care and domestic work in keeping with the United Nations Sustainable Development Goal 5 (UN, 2016). Gender inequality in India persists despite high rates of economic growth (UNDP, 2020). India has policies in place to improve the child sex ratio through protection of the girl child and free education for girls (Ministry of Women & Child Development, Government of India, 2015). However, there are no schemes or policies aimed at gender equality in the workplace or in the home. These may be enacted through psychoeducation and advocacy around a realignment of traditional gender roles and norms, by encouraging shared responsibilities within the family units, and through the development of appropriate infrastructure, social protection policies, and delivery of public services.

Conclusion

The current study explored the roles of SC, PI, and PS on PWB of urban Indian mothers with children of 10 years and below. The findings indicated that SC, PI, and PS were associated with PWB in Indian mothers.

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Special Issue: Women During COVID-19
Article

"Mi Hijo es lo Principal" – Guatemalan Mothers Navigate the COVID-19 Pandemic

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Abstract. In the context of the COVID-19 pandemic, motherwork has increased. Mothers, including in Guatemala, have taken on expanded responsibilities of virtual schooling and keeping the family safe and healthy, in addition to prepandemic familial and professional contributions. Twelve Guatemalan mothers of children under age 7 were interviewed about how they negotiated the pandemic; data were coded using thematic analysis and consensual qualitative research frameworks. Analysis revealed six themes: daily stressors, fostering children's development, implementing coping strategies, utilizing technology, establishing closer relationships, and achieving personal and occupational growth. Guatemalan mothers tapped into existing ideologies of motherhood, relied on traditional values of Guatemalan culture – faith, family, and gratitude – prioritized their children's well-being, and found unexpected benefits. Social policies that specifically address women's conditions, agency, and strengths could forward achievement of Sustainable Development Goal 5, Gender Equality, in Guatemala.

Keywords: mothers, parenting, Guatemala, COVID-19, pandemic

Impact and Implications. This study examined the experiences of Guatemalan mothers of young children during the COVID-19 pandemic. Mothers reported many challenges including confronting fear and sadness and the burdens of caring for their children and others, but also strategies of resilience such as prioritizing their children and relying on faith and family. Government policies and efforts that focus on women's agency and strengths could forward achievement of Sustainable Development Goal 5, Gender Equality, in Guatemala.

Motherhood, or motherwork, is a socially constructed role, shaped by culture, socioeconomic condition, and historical context (Glenn, 1994). During the COVID-19 pandemic, women, in general, and mothers, in particular, have faced severe challenges. They have been burdened with extra nonpaid work, especially as care providers (Power, 2020). Moreover, they are more likely than men to have lost their paid jobs. In Central America, almost 60% of women worked in jobs that were greatly affected by the pandemic (e.g., tourism, small businesses, the informal sector, and domestic work), whereas only about 35% of men worked in those sectors. Therefore, the economic impact of the pandemic was greater for women and exacerbated already existing inequalities (Comisión Económica para América Latina y el Caribe, 2021).

Even before the pandemic, Guatemala, a Central American country, was marked by economic, ethnic, and gender disparities (PNUD, 2016). The Gini ratio, a measure of economic inequality, was the sixth highest in Latin America (Index Mundi, n.d.). Although individuals of Indigenous Maya descent make up almost half the population, they fell well behind non-Indigenous people on indicators of education, health, and economic condition (Programa de las Naciones Unidas para el Desarrollo, PNUD, 2016). Gender inequality was also profound; Guatemala's Gender Inequality Index (based on political empowerment, reproductive health, and labor force participation) was 0.479, ranking it 116th of 162 countries and the highest in Central America; gender parity has been achieved only in education. There were also gender gaps in time use, with Guatemalan women spending more than three times as much time in unpaid work as men (an average of 6.1 vs. 2.7 hours per day; Landa Ugarte et al., 2018). Moreover, this gap has widened during the pandemic as Guatemalan women devote even more time to unpaid work, such as care of children, older people, and those with disabilities (Vásquez, 2020).

Gender ideologies and attitudes are embedded in cultural norms and values; they also shape everyday behaviors and thoughts. In Guatemala, traditional gender

role attitudes are widely shared, with broad adherence to the notion that men should be the family providers and women the primary caregivers (Gibbons & Luna, 2005). Women are seen as the family's central pillar and responsible for the family's well-being, placing the onus of family care on women, especially mothers (Sierra de Gamalero et al., 2014). According to Martín-Baró, the primary gender ideology in Central America is based on machismo, emotional absence of the father, and idealization of the mother (Gaborit et al., 2003). Specifically, the mother is idealized as kind, saint-like, self-sacrificing, warm, and faithful. This depiction is similar to that prescribed by marianismo, the belief that women should emulate the archetypical mother in Christianity, the virgin Mary – that they should be the family's primary source of strength and spirituality, and should remain virtuous and chaste, subordinate to others, and silent (Castillo et al., 2010). In sum, indicators of gender disparity and gender ideologies confirm the description of Guatemala as "a patriarchal and male-dominated society" (Landa Ugarte et al., 2018, p. 12).

The COVID-19 pandemic has led to additional challenges for Guatemalan women and the population in general. All schools were closed in March 2020, public transportation halted, mask-wearing mandated, and a nighttime curfew instituted. Well-being of the population was impacted; shortly after the lockdown, one quarter of Guatemalan adults surveyed reported low levels of well-being (Fernández-Morales et al., 2020). In August 2020, the Guatemalan government initiated the reopening of the country, adopting a color-coded alert system. By mid-September, public transportation was reinstated, and curfews ended (Business Law Partners, 2020). However, as of mid-January 2021, most schools remain closed, providing only distant or virtual education to children of all ages.

In this study, we explored Guatemalan mothers' experiences of parenting during COVID-19. Specifically, we were interested in their challenges, emotions, and agency during the pandemic. As is customary in qualitative, phenomenological research, we were guided by a central question: "How are Guatemalan mothers of preschoolers navigating the COVID-19 pandemic?"

Method

Participants

Twelve Guatemalan mothers (M_{age} = 33.08 years, SD = 4.21, range 26–39 years) of children ages 6 and younger participated. We applied snowball sampling, making efforts to achieve educational and ethnic diversity (see Table 1 for more information).

Procedure

The research protocol was approved by institutional review boards at Saint Louis University and Universidad del Valle de Guatemala. A recruitment statement, shared in advance and read aloud to each potential participant, described the risks, benefits, and procedures for maintaining confidentiality; all invited participants provided informed consent. We conducted semistructured interviews, designed to elicit the experiences of participants during the COVID pandemic, via Zoom or telephone between November 2 and December 4, 2020. Interviews focused on participants' experiences during the pandemic, including typical daily routines, experiences of raising young children, how life has changed, and coping strategies they use to manage challenges. At the end of the interviews, mothers provided demographic information (e.g., age, ethnicity, religion, number of children, and children's ages and genders). The audio-recorded interviews, in Spanish, lasted from 11 to 79 min (M_{length} = 41 min). To increase trustworthiness, two of the participants read a complete draft of the manuscript and concurred that their perspectives had been faithfully represented.

Data Analysis

Transcribed interviews were coded in the original Spanish using the steps of thematic analysis, a bottom-up, data-driven coding approach (Braun & Clarke, 2006). In Step 1, coders read the transcripts multiple times to familiarize themselves with participants' responses. In Step 2, 42 initial codes were generated and applied to the data corpus by two independent coders (one from Guatemala and the other from the United States). Then, codes representing similar ideas were merged and those mentioned by two or fewer participants eliminated, yielding 29 codes. Kappa, a measure of inter-rater agreement between the two coders, was 0.77 (good); discrepancies were reconciled through discussion between the two coders according to Hill's (2012) consensual approach to qualitative research. In Step 3, codes were combined into themes. A post hoc examination of the coded interviews revealed that inductive thematic saturation had been reached after six interviews (Saunders et al., 2018); however, we included all 12 interviews to increase the trustworthiness of the findings and provide richness to the data.

Reflexivity

As is customary in qualitative studies, the research team reflected on how our own positions – including experiences,

beliefs, and values – may have shaped our contributions to this study. The research team was culturally diverse (two from Guatemala and two from the United States), but no member of the research team was a mother. All were highly educated and economically secure, unlike some of the participants. Thus, as a team we did not share some salient experiences of the participants.

Results

Although mothers acknowledged the stress, fear, and sadness generated by the pandemic, they also reported benefits, joy, increased closeness with children and family, and personal growth. Cristina[1] expressed this sentiment clearly:

> The pandemic has brought many negative things, a great deal of fear. But I believe that learning to appreciate and value time with family, among all the bad things, is the best thing that has happened to me in a long time.

The analysis of the interviews and the grouping of codes revealed six themes, including daily stressors, fostering children's development, implementing coping strategies, utilizing technology, establishing closer social relationships, and achieving personal and occupational growth. See Table 2 for a list of codes and themes ordered from the most negative experiences to the most positive.

Daily Stressors

Among the many stressors provoked by the pandemic, the most common, expressed by all participants, were negative feelings, especially of fear and sadness. Laura said, "So, one always is afraid of the illness, right, worried for the children ... as a mother...." And Alicia noted the accompanying sadness, "It gives me a lot, a lot of sadness." Often, the sadness was for the situation of others, as stated by Andrea, "It makes me very sad, I am not going to lie ... because I know that there are many families who have suffered a lot." Other negative emotions included worry, anxiety, and anger.

Housework, including cooking, bathing children, washing dishes, sweeping and dusting, and doing laundry, was also a stressor. Even though some had employees who helped with those tasks, the assumption was that the mothers were ultimately responsible for completing them. Cristina relayed that during the pandemic she began to undertake housework,

> I devoted myself to the things of the house that I had never done much, and I am very bad at it, but [I took on] those chores of overseeing the laundry, food preparation, dish washing, house cleaning, and I started organizing little by little.

Along with the above stressors, many mothers reported economic stress, from loss of jobs, having to support other family members who had lost jobs, or needing to move. Alicia described the dire circumstances of the entire family, "During the quarantine I could not go to work, lost my job, had my son during the pandemic, my mother was depending on me, but I could no longer help her either." Alicia's brother-in-law is now supporting seven people, including Alicia and her son.

Mothers often had to supervise and assist with children's academic activities, even when a curriculum was provided by the school. "There are things that are difficult for me to understand well enough to be able to explain them," said Jimena. Celeste said, "In my case, I don't speak English, I cannot explain to [her children] in the same way as the teacher ... in the computer class, it is the same." Sofia described the preparation and time required to teach her children, "I had to sit beside [her children].... A pain preparing the materials every morning." Andrea pointed out that, "It is easier [for children] to fight with your mother than with the teacher."

Other stressors, reported by half or more of the mothers, included dealing with their children who were bored and wanted to go out, feeling irritable with their children, and missing their own parents. Celeste reported the stress of being confined with her children for weeks and months, "Living together with the children turned out to be irritating at moments because of the lockdown."

Fostering Children's Development

Attending to their children's welfare and development was a major concern for the participants and encompassed both positive and negative comments. Although most mothers praised their children's teachers, they also

[1] All names used in the text refer to pseudonyms (see Table 1).

Table 1. Participant information (*N* = 12)

Pseudonym	Age	Education (highest level completed)	Religion	Marital status	Ethnicity[a]	No. of children	Children's ages and genders	Occupation or field of work	Working virtually or in-person
Andrea	35	Licenciatura[b]	Catholic	Married	Ladina	3	• Girl – 5 years • Boy – 2 years • Boy – 2 months	Publicist	Virtual
Laura	35	Secondary school (accounting specialty)	Evangelical Christian	Married	K'iche'	1	• Girl – 3 years	Vendor of handicrafts	In-person
Jimena	29	Secondary school (specialty in secretarial work)	Catholic	Married	Ladina	2	• Boy – 7 years • Boy – 2 years	Homemaker	Not employed
Alicia	26	Completed law school (has not passed equivalent of Bar Exam)	Catholic	Separated	Ladina	1	• Boy – 4 months	Waitress	Not employed
Juliana	31	Secondary school	Evangelical Christian	Married	Ladina	1	• Boy – 5 years	Swimming instructor	In-person
Celeste	30	Junior high school	Seventh Day Adventist	Separated	Ladina	4	• Girl – 11 years • Boy – 8 years • Girl – 5 years • Boy – 3 years	Domestic worker	In-person
Sofía	34	Master's degree	Catholic	Married	Ladina	3	• Boy – 4 years • Boy – 2 years • Baby due in January 2021	Marketing	Not employed
Ana	31	Licenciatura plus 1 year additional training	Catholic	Married	Ladina	1	• Girl – 1 year	Clinical psychologist	Hybrid (in-person and virtual)
Martina	28	Junior high school	Evangelical Christian	Single	Ladina	1	• Girl – 6 years	Cosmetologist	In-person
Gabriela	39	Licenciatura	Catholic	Married	Ladina	2	• Boy – 8 years • Boy – 2 years	Teacher	Hybrid (in-person and virtual)
Sandra	36	Master's degree	Catholic	Married	Ladina	2	• Girl – 2 years	Publicist	Virtual
Cristina	37	Master's degree	Catholic	Married	Ladina	3	• Girl – 4 years • Boy – 3 years • Girl – 3 weeks	Physician	Not employed

[a]Ethnicity in Guatemala is commonly described as Indigenous (Maya) or Ladino/a (mixed Indigenous and European descent). K'iche' is a specific Maya identity.
[b]A licenciatura is a degree based on a 5-year program of study, equivalent to a bachelor's degree plus preparation for a profession (e.g., psychologist, lawyer, and physician).

Table 2. Themes and codes emerging from analysis of the interviews

Theme	Codes	Frequency
Daily stressors		
	Negative emotions	General
	Housework	Typical
	Children bored, want to go out	Typical
	Mother as teacher	Typical
	Economic stress	Typical
	Irritable with children	Variant
	Missing own parents	Variant
Fostering children's development		
	Respect for teachers	Typical
	Children's social development/friends	Typical
	Children's schooling	Typical
	Less academic progress	Typical
	Young children are more adaptable	Typical
Implementing coping strategies		
	Attention to hygiene	Typical
	Self-care	Typical
	Spend time in nature	Variant
	Serve as a role model for children	Variant
	Follow routine	Variant
Utilizing technology		
	Zoom	Typical
	Selective use of social media	Variant
Establishing closer social relationships		
	Time with children	Typical
	Rely on others, social support	Typical
	Family more united	Typical
	Husbands' contributions	Typical
Achieving personal and occupational growth		
	Gratitude	General
	Empathy with others' suffering	General
	Faith	Typical
	Reset priorities to reflect values	Typical
	Focus on the positive	Typical
	Entrepreneurship, innovation	Variant

Note. The frequency labels are based on Hill (2012). General refers to a code that occurred in all or all but one interview, typical ranges from half of the interviews to the general lower limit (here a maximum of 10), and variant represents more than two, but fewer than half, of the interviews.

mentioned that their children missed friends, that in-person schooling had promoted social development, and that online learning was not equivalent. Andrea stated, "So, for me, now, it is much more important that she develop well socially… she is going to learn to read and write… but those relations with her friends and teachers…." Sandra commented, "I love the teachers. Or rather, from now on, I have incredible respect for them." Sandra continued, "Yes, really the experience that we had with the early stimulation preschool was spectacular … to have children of this age [2 years] engaged with the screen…." Other comments about their children's development included worries that the children were not making sufficient academic progress and noting that young children more easily adapted to the lockdown.

Implementing Coping Strategies

In their daily activities, mothers reported a number of coping strategies to adapt to the new conditions. Many described their efforts to teach young children good hygiene. Several made a game of sanitation, including naming a bottle of soap "Santa COVID," or gathering plastic keys, a child's purse, and a mask as the accessories needed to leave the house. Self-care was another way of coping and included breathing deeply, taking a bath, or putting fewer demands on oneself. Participants advocated for spending time in gardens or taking a walk as helpful to themselves as well as their children. Sofia said that she spends, "An hour in the garden in the afternoons, or if not, we at least go for a walk ... activities in the fresh air." Several recommended following a routine to structure children's days. Ana recommended, "Flexible routines ... flexible goals ... the routine gives children security." In addition, some participants pointed out the importance of serving as good role models for their children. Celeste said, "We are an example for our children ... we have to manage our emotions to not affect our children."

Utilizing Technology

The use of technology, both Zoom and social media, played a role in participants' lives during COVID. Some mentioned the usefulness of Zoom for their children's schooling, celebrating events, and keeping up with friends. Three participants celebrated baby showers virtually using Zoom. Andrea shared her opinion, "Clearly, I feel that technology has helped a great deal [in keeping up with friends]. In spite of not being able to see someone physically, in person, Zoom has been a great tool." On the other hand, social media were used selectively and sometimes avoided. While several mothers sought information on social media, Cristina said,

> "It stresses me to see the statistics of other countries, and hospitals, and everyone's opinion.... I feel that there was a point where I said, 'I no longer want to know anything, I do not want to know how things are going....'"

Establishing Closer Social Relationships

Beyond the stressors and difficulties, mothers reported that they came to depend on others, especially their families, for help and support during the pandemic. Andrea's family had become even closer during the pandemic, "My family is very united, we have become even closer from missing each other." Gabriela expressed a similar sentiment, "I feel that [the pandemic] has brought us closer, to my grandmother, aunt, and cousins." The participants also relied on friends, neighbors, husbands, and sometimes Facebook groups for help and social support. Jimena and her neighbors have combined forces, "Union creates strength. If you do not have something and I have it, we do each other favors." While he was working at home, Cristina's husband would step in to help deal with the children, "I mean, when there was a tremendous tantrum, he would come out and calm the waters."

The added time spent with their children was rewarding to mothers, and sometimes surprisingly fulfilling. Andrea shared, "I am happy because I can spend more time with the baby," and Ana elaborated that the lockdown has been,

> Difficult, but also most satisfying because I have seen everything – from the first crawl, the first step, the first bump, the first of everything. I have seen all firsthand. So, to a certain extent, I am grateful that the pandemic gave me the chance to spend much more time with my daughter than I would have thought, and perhaps I did not realize the importance of it until it happened.

Achieving Personal and Occupational Growth

A prominent theme was personal and occupational growth stemming from the difficult conditions of the pandemic. Gratitude and empathy with others' suffering were central to mothers' experiences during the pandemic. They were grateful for good health, safety, shelter, and food. Celeste thanked God for basic provisions, "Thanks to God ... that with my children, we never lacked a plate of food during this time...." And as Gabriela shared,

> Grateful because, in spite of not being able to go out, and not being able to do what we used to do before, well, we are alive and healthy, so I think that is one of the most important things for which we should be grateful.

Related to gratitude was the recognition that many others had suffered severely during the pandemic. From Juliana, "Where I live many people died." From Sofia came this thought, "I can't complain, I know that there are people who have suffered much more, I don't have permission to complain." Cristina, a physician, commented on the possibility of a vaccine, "But it is also sad because many people here in Guatemala will not have the ability to get [the vaccine] and although everything will return to normal, they are at risk."

Faith in God was central to many of the mothers in responding to and facing the pandemic. Jimena put it succinctly, "We put faith in God." Celeste elaborated further, "Thanks to God ... God gives one life and health ... I am a believer.... For me the main thing is to put everything in the hands of God ... as families, we pray." And Martina said, "One has to get closer to God.... Look, God has been so faithful."

Along with gratitude, empathy, and faith, many explained that they had reset their priorities during the pandemic, turning away from materialism to valuing family, health, and affection. In Alicia's words, "Because money is worthless if there isn't health and love." Celeste echoed this sentiment in describing the refocus on values, "Perhaps not so much on material things, but rather on the people that we have around us."

Vital to this theme was advice to others to focus on the positive. Cristina emphasized this strategy for coping with the pandemic,

> Well, the main thing ... was focusing on the positive, the good that this has brought me, and the blessing that we are healthy ... when I lose strength or enthusiasm, I focus on the positive.... Try to see the positive in sharing with your children ... no one is perfect ... everyone makes mistakes, the most important thing is to focus on the good, and that makes us still be better and have more energy to continue doing our best.

During the pandemic, some mothers took the initiative to either start new businesses or to redesign their existing occupations to accommodate the new restrictions. Laura described the new venture she has undertaken with her husband,

> but for the virus, I believe we would not be thinking of another business, or doing other things ... I say that nothing ever brings only good or bad ... we don't know anything about clothing, but now we are working with that and we found a location and we established a small business.

Discussion

The quote in the title of this article, "My child comes first," suggests both the influence of the image of the idealized mother as kind, all-giving, and self-sacrificing but also hints at the agency that mothers realized among constraints. Mothers were empowered through their ability to support their children's development and to keep them healthy and safe throughout the lockdown. The choice to enact agency was clearly stated by Ana, "I can live happily through this [pandemic], or I can live tormented." She chose the former.

Although there was no shortage of challenges for these mothers raising children during a pandemic, there were also many examples of resilience. Daily stressors varied widely from emotions like fear and sadness to serving simultaneously as teacher and mother, to confronting economic hardship. In spite of the stressors, mothers readily reflected on their strategies for negotiating the pandemic. The unanticipated benefits of quarantine and virtual school and work were commonly described by mothers and suggested a renewed emphasis on family, faith, and a sense of gratitude given that many others faced far worse challenges. Ana was grateful for additional time at home with her family, where she was able to witness firsthand her daughter's early developmental milestones like crawling and taking her first steps, which she would have likely otherwise missed. The search for meaning amid hardship and trauma is not uncommon (Frankl, 1985; Walsh, 2020); these Guatemalan mothers searched for meaning among the values inherent in their culture and daily lives.

The coping strategies that mothers adopted reinforced tapped into core Guatemalan values – dedication to the family (*familismo*), gratitude in life, and a devotion to religion. The increased dependence on familial support during COVID-19 as described by Andrea's experience of her extended family growing stronger and more united in spite of not being able to spend time together suggests that prioritizing familial relationships remains a top priority for these mothers. Prioritizing family and child well-being are central to collectivist cultures in general (Trommsdorff et al., 2004), as well as characteristic of Guatemalan culture, labeled as one of the most collectivist societies of the world (Dries-Daffner et al., 2007; Hofstede, 2001).

Like *familismo*, gratitude has long been championed in Guatemalan culture (Poelker et al., 2017). Sayings like "*Gracias a Dios*" [Thanks be to God] frequently flank the beginning and end of conversations. Social connections with and support from family and close friends were the source of gratitude expressed by Guatemalan adolescents (Poelker et al., 2017). For mothers in the current study, gratitude was focused on health and basic resources. In both cases, adolescents and mothers thanked God as the provider of blessings.

Mothers' reliance on faith during the pandemic is not surprising in light of high levels of religiosity in the country; nearly 90% of Guatemalans identify as believers, largely as members of Catholic and Protestant Christian traditions (U.S. Department of State, 2019). For the participants, putting faith and trust in God was especially critical during

the pandemic. In some cases, they submitted to God's will and acknowledged their own inability to change the situation. Jimena said, "we do what we can, but God has the last word." Although faith appears to sustain participants, the cultural acceptance of the idealized mother as subordinate and self-sacrificing could reinforce male dominance and patriarchy (Sierra de Gamalero et al., 2014).

The limitations of this study are numerous. Given the qualitative methodology used, the results are not generalizable beyond the study sample and historical time frame and cannot be assumed to reflect the views of all Guatemalan mothers, especially because Indigenous women and those with less education were underrepresented here. Economic diversity, although represented, is profound in Guatemala. During the pandemic, even well-educated individuals, such as Alicia, have fallen into severe poverty.

Because face-to-face interviews were unworkable during the pandemic, the use of technology, Zoom or telephone, may have influenced the findings. Only participants with access to and comfort with technology could be recruited. Rapport might also have been diminished by the distance imposed by technology. Furthermore, the use of an interview, rather than an anonymous online survey, may have led mothers to overstate the positive aspects of the pandemic. For example, participants put a positive spin on husband's (limited) participation in chores. They assumed that housework and childcare fell on their shoulders and were grateful to husbands for small favors, such as "helping a little around the house."

The research team, although culturally diverse, were not mothers and were economically comfortable. Thus, it is possible that they were insensitive to the particular challenges of motherhood and economic hardship despite engaging in self-reflection. To faithfully represent the mothers' positions, we privileged their voices and implemented member checking, achieving saturation, and establishing coding reliability.

Women's empowerment and gender equality need to be approached through both individual and systemic approaches. The current study suggests that women, despite living in a patriarchal culture, may feel empowered through their ability to care for and protect their children and families. They may also gain sustenance through friendships with other women and community members. It is clear from the findings that women's unpaid work in the home is often not recognized as real work, even by the women themselves. Public recognition of the value of women's contributions would be a first step toward achieving the United Nations Sustainable Development Goal 5, Gender Equality (United Nations, 2015).

At the institutional and policy level, the Guatemalan government has recognized that it has fallen behind in its plan to achieve the United Nations sustainable goals and has proposed 10 programs to advance those efforts (Instituto Centroamericano de Estudios Fiscales, 2020). They include providing vouchers for health personnel and for family sustenance, as well as establishing a working capital credit fund. We recommend that those efforts be expanded to address the specific needs of women and families, such as strengthening and supporting those sectors of the labor force where women are located, as well as specifically targeting women-owned businesses for investment. In the long term, the Guatemalan government might mandate family-friendly employment policies that allow women in the workplace to experience the joys of motherhood while earning income.

Conclusion

Guatemalan mothers openly shared their challenges as well as resilience and agency during the COVID-19 pandemic – a time of extraordinary stress and uncertainty. The pandemic exacerbated existing stressors like housework and introduced new ones like virtual schooling. In spite of those challenges, mothers showed displays of resilience and a commitment to finding the good amid the difficulties they faced. In doing so, they relied on cornerstone values of Guatemalan culture – the importance of family, gratitude, and faith. As the world awaits the widespread distribution of a COVID-19 vaccine, we must consider how we can continue to support mothers and others around the world as they raise the next generation.

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Article

Women's Experiences During COVID-19 in Bangladesh

A Content Analysis of Helpline Data

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Abstract. This study is a content analysis of women's experiences during the COVID-19 (coronavirus) pandemic in Bangladesh, using a unique data set from Bangladesh's only emotional support and suicide prevention helpline. Each call to the helpline has a written description, completed by the individual answering the call, of the caller's condition and reasons for calling. We coded descriptions of calls received from female callers in the first 6 months of the pandemic (N = 276) and in the same 6-month period from the previous year (N = 224) for comparison. Findings revealed that for the most part, reasons for calling were largely similar across the 2 years, with the majority of calls involving relationships of various kinds (namely, parents, husbands, or romantic partners). Key differences between 2020 and 2019 include mental health concerns in relation to the pandemic and academic concerns being absent from the pandemic year. These findings contribute to the emerging literature of women's experiences during the pandemic and have implications for intervention and future research.

Keywords: Women, COVID-19 pandemic, suicide prevention helpline, Bangladesh

Impact and Implications. This study uses a data set from a suicide prevention helpline in Bangladesh to examine the experiences of female callers in the first 6 months of the COVID-19 pandemic in comparison to the prepandemic period. The findings indicate that the most commonly occurring issues during this time were about relationships (with parents or husbands/romantic partners) and mental health concerns (in relation to both the pandemic and in general), with academic concerns noticeably absent during the pandemic. The occurrence of these issues provide targets for intervention for mental health support for women.

The COVID-19 pandemic unleashed a global health emergency, impacting public and mental health. While anxiety, depression, and stress have been high for the general population, women have been at increased risk of experiencing such conditions (Xiong et al., 2020). The present study aims to add to the literature on the experiences of women during the pandemic, as revealed through issues shared on Bangladesh's only suicide prevention helpline during the first 6 months of the pandemic. Below, we provide a brief review of the literature of women's experiences of the pandemic, followed by an introduction to the helpline and the objective, methods, and results of the present study.

A number of studies from around the world have shown that women had increased levels of stress, anxiety, depression, and loneliness during the pandemic (Almeida et al., 2020; Jacques-Aviñó et al., 2020; Sediri et al., 2020). Several already-existing risk factors were intensified, such as chronic environmental strain and preexisting anxiety/depressive disorders (Almeida et al., 2020). Women also reported higher posttraumatic stress symptoms after the outbreak (Liu et al., 2020) and greater perceived helplessness following a positive COVID-19 test than their male counterparts (Thibaut & van Wijngaarden-Cremers, 2020). The pandemic and associated lockdowns have also led to increased domestic violence (Maiti et al., 2020; Sediri et al., 2020), online violence such as stalking, sexual harassment, and verbal attacks (Thibaut & van Wijngaarden-Cremers, 2020), and burdens inside the home (e.g., McLaren et al., 2020). Much of the literature from around the world has focused on pregnant women and new mothers in the COVID-19 cohort, revealing higher levels of depressive/anxiety symptoms compared to mothers in the prepandemic period (Ceulemans et al., 2020; Davenport et al., 2020; Hessami et al., 2020; Taubman et al., 2020; Thibaut & van Wijngaarden-Cremers, 2020).

In Bangladesh, the COVID-19 pandemic has had similar adverse effects on the population's mental health (e.g.,

Banna et al., 2020; Iqbal et al., 2020; Mamun et al., 2020). Emerging research indicates that women in Bangladesh are disproportionately experiencing the impact of the pandemic, through increased domestic violence (Antara, 2020); patriarchal practices against women-owned businesses (Jaim, 2020); and socioeconomic difficulty, food insecurity, mental health concerns, and intimate partner violence (Hamadani et al., 2020).

The global health community has acknowledged the immense mental health cost of COVID-19, fueling questions on who will need support and how to provide it. While many of the studies listed above indicate the presence of high rates of mental illness, caregiving burdens, or pregnancy/parenting-related issues, most of them use survey methodology to assess the symptoms that women are experiencing. This leaves a gap in understanding details of the lived experiences of women under the pandemic. The present descriptive study takes a step toward filling this gap by using qualitative data from a suicide prevention helpline in Bangladesh to understand the circumstances and experiences of women who sought help.

Method

Data

The data set is from *Kaan Pete Roi*, Bangladesh's only suicide prevention helpline. It contains demographics and brief written descriptions of each call, completed by the volunteer receiving the call. Here, we examine female callers in the period from March 1 to September 1, 2020 (in Bangladesh, an official lockdown began on March 22, 2020; the data set represents the first 6 months of the pandemic's effects; $N = 742$), in comparison to callers from the same 6-month period in 2019 ($N = 979$). From both years' data sets, we excluded callers who were only seeking information, inappropriate callers, and frequent callers to avoid their disproportionate presence (personal communication with helpline staff indicates that all frequent calls came from no more than three callers), leading to a total of 276 calls coded from 2020 and 224 calls coded from 2019.

In 2020, 70.2% of the callers were in the 20–39 age range, 17.4% were in the 13–19 age range, and 2.2% were in the 40–65 age range, with the rest in other age ranges or unknown; 52.6% of the callers were students, 12.7% were employed, and 9.3% were housewives. The average call duration was 21.7 min.

In 2019, 64.4% of the callers were in the 20–39 age range, 21.8% were in the 13–19 age range, 1.9% were in the 40–65 age range, with the rest in other age ranges or unknown; 56.4% of the callers were students, 13.3% were employed, and 8.8% were housewives. The average call duration was 18.1 min.

Across both years, the calls were approximately evenly distributed across the open hours of the helpline.

Analytic Procedure

The written descriptions of the calls were coded into categories. Two analysts (the second and third authors) first examined subsets ($N = 20$) of the data set to individually arrive at themes occurring in the calls. Using these, in consultation with the first author, they constructed a codebook and used it to establish interrater reliability (Kappa = 1 after one code was dropped, described below) on a new set of 20 calls, before applying this codebook to the full set of data. Approximately half of these descriptions were originally written in Bengali and half in English; they were coded in the original language by bilingual coders.

Chi-square tests/Fisher's exact tests (when cell sizes were zero) were conducted for each code to test for significant differences between 2020 and 2019. Those that were significant are indicated in Table 1 and reported in the text.

Results

The results in Table 1 are displayed by code, corresponding percentage of occurrence (in 2020 and 2019 respectively), a description of the code, and an example of the full text originally written by the volunteer, translated from the Bengali in some cases. Because there were several different codes involving relationship-related problems, these codes were further grouped into subcodes based on the type of relationship (i.e., parents, husband/marriage-related, and boyfriends/romantic relationships). Table 1 summarizes the codes and their respective frequencies.

Of the calls in 2020, 57.2% had one code, 24.3% had two codes, 13.7% had three codes, and 4.7% calls had four or more codes. Of those in 2019, 64.3% had one code, 20.9% had two codes, 7.5% had three or more codes, and 7.1% had four or more codes. Due to the limited sample size, we do not analyze patterns in co-occurring codes or relate these codes to suicidal risk.

The codebook also originally contained codes for explicit mention of emotions, but those codes were not be useful because mentions of depression, anxiety, and sadness were highly overlapping and present in almost every call. Given this, we assumed that every caller was

Table 1. Percentages of codes from pandemic and prepandemic years

Global themes	Subthemes	Codes	Percentage of calls in 2020 (n = 276)	Percentage of calls in 2019 (n = 224)
Relationships	Parents	Conflict	7.2	11.1
		Lack of validation/rejection	14.9	9.3
		Pressure	4.0	2.2
	Married	Extra-marital relationships	2.9	3.1
		Conflict[a]	13.0	4.4
		Divorce	1.1	0
		Problems with in-laws	2.1	0
	Romantic partners (unmarried)	Conflict	11.6	10.7
		Cheating	3.6	2.2
		Abusive behavior	4.3	3.1
		Breaking up	12.7	15.6
Mental health concerns			16.3	10.7
Social/contextual issues		Lack of social support	6.2	5.3
		Bullying/discrimination	4.7	7.5
Physical complaints			7.6	3.5
COVID-19/lockdown		Financial	1.4	0
		Mental health concerns during lockdown[a]	11.8	0
Negative thoughts about self			3.6	3.1
Abuse		Sexual abuse	4.7	3.1
		Physical abuse	4.3	4.9
Academic		Anxiety about examinations[a]	0	3.5
		Difficulty studying[a]	0	8.4
Other			5.4	7.5

Note. [a]Indicates statistically significant differences between 2020 and 2019 at $p < .01$ using χ^2/Fisher's exact test.

experiencing emotional distress and therefore dropped these codes.

Relationships

Parents

Conflict (7.2%, 11.1%)

This category comprised conflict with callers' parents, including parents wanting to control the caller, treating the caller as a burden, or interfering in the caller's decisions and life choices. It also included fighting among parents or siblings, issues with family assets, and other conflict in the home. For instance:

> The caller was hopeless about her family. She felt that her home and her family were like a hell. Her university dorm is not very far from her home, but she still almost never goes there because she can't tolerate her family's problems and constant fighting.

Lack of Validation/Rejection (14.9%, 9.3%)

Callers reported how their life had been affected due to a lack of support from their parents. Feelings of not being loved and cared for by parents were a prominent feature here. Callers also described experiencing rude behavior and rejection of their opinions by their parents. This affected their sense of belonging in the family and often their social, academic, or personal lives.

> She never felt loved, not even by her family members or husband. There is a huge gap in her and her husband's mentality. She talked about this with her family so that they could reach out to her husband to mediate the issues between her and her husband. Unfortunately, they didn't and asked her to adjust no matter what.

Pressure/Expectations (4.0%, 2.2%)

This category included callers who experienced pressure from parents around expectations of marriage,

education, career/employment, and the nature of their social circle (especially their romantic relationships). This category also included parents' comparisons of the caller to peers/cousins, with the caller found lacking.

> The caller has a bad relationship with her parents. They always try to force her to be Islamic in everything she does. The caller does not like this. She likes to draw and write poetry. But her family does not support these activities.

Marriage

This category contains all calls from married callers (all heterosexual relationships in this data set).

Extramarital Relationships (2.9%, 3.1%)

Callers shared a range of experiences regarding this issue including, feeling guilty of engaging in extramarital relationships themselves, trying to return to existing relationships, difficulty accepting their husband's extramarital affair, and trying to save marriages for the children's sake despite infidelity.

> She was talking about her extramarital affair. The person she loved has broken her trust. She had fallen in love with him because her husband wasn't giving her enough time and was engaged with other girls. She had done many things for the person she loved but the trust was a big thing for her.

Conflict (13.0%, 4.4%)

This category includes the husband's lack of support or respect, undermining, neglect, or controlling behavior toward the wife (the caller). Calls about conflict with husbands were significantly more frequent during 2020, than in 2019, $X^2 = 10.89$ ($N = 500$), $p < .001$.

> This is the caller's third marriage. She is not at peace in her household. She has two daughters, one from the previous husband and one with the present husband. She hasn't seen either of them in a long time. Her husband always demeans her. At the end of the month he takes all her income.

Divorce (1.1%, 0%)

The husband's irresponsibility, physical problems, infidelity, falling out of love, lack of understanding, and problems in adjustment were some of the topics brought up in association with discussing divorce.

> Recently she got divorced from her husband with whom she had been separated from for more than a year. They had 7 years of married life. Before him, she was married to another man by her family when she was 16. But after a year she divorced him as they couldn't cope with each other.

Problems With In-Laws (2.1%, 0%)

This includes callers' difficulties mentioned in relation to in-laws: lack of support, imposition, and cutting down callers' social interactions with friends or family.

> Her husband's sister constantly emotionally abuses her and she needs her [the husband's sister]'s permission to do anything. Her relationship with her husband was all right but he doesn't support her in this.

Unmarried

This category contains all calls from women who are not married, all of which were about their romantic relationships (i.e., boyfriends).

Conflict (11.6%, 10.7%)

This category encompasses all cases of fighting, the caller's feelings of being misunderstood, or the caller feeling wronged in the relationship.

> She was supposed to marry someone who lived abroad. The man first lied about having a degree. He said he had an engineering degree and an MBA. But he didn't have any of these things. He lied because his own parents didn't know that he never studied engineering. He had said he would take her abroad as soon as they were married, but then he started saying it would take longer. After all this, her proposed marriage to him broke up.

Cheating (3.6%, 2.2%)

This includes all calls where the caller's boyfriend engaged in romantic, sexual, or marital relationships with another person(s).

> She's been in a relationship for 13 years. But her boyfriend is not serious about marriage. In 2016 she found out her boyfriend was married to someone else abroad. But her boyfriend said that marriage was just a technicality! She tried to get out of the relationship with the help of a psychologist.

Abusive Behavior (4.3%, 3.1%)

Using derogatory language, not respecting the caller, restriction of social company and on certain activities, or unreasonable dominance from boyfriends, this category also included ignoring the caller or not paying adequate attention to her.

> The caller had relationship problems. They have been together for 3 years. For the past year the boyfriend has not been talking to her properly. He treats her badly and shouts at her. The caller is very hurt by this but can't say anything about it to anyone. He never talks to her when she wants to, only when he wants to. He gets angry if she calls him. They don't really have an emotional connection anymore, but the caller cannot imagine leaving the relationship. She still loves him. She thinks she will never be able to love anyone else.

Breaking Up (12.7%, 15.6%)

Some callers shared their experiences with breaking up in the past that were still affecting them, while others discussed present experiences.

> The caller was constantly crying and trying to get herself together. She is very bothered about the fact that she still holds strong feelings for her ex-boyfriend; in spite of the damage that he has done to her in the past during their relationship. They broke up in September, last year. Following their break-up, she has left no stones unturned to keep herself from being in contact with her ex-bf, realizing that he is not at all good for her.

Mental Health Concerns (16.3%, 10.7%)

This category included any callers who reported having a diagnosed mental health illness/disorder, including obsessive-compulsive disorder (OCD), clinical depression, anxiety, schizophrenia, anorexia nervosa, drug addiction, panic attacks, and trauma. The most frequently occurring mental health concern was OCD. Callers mostly shared stories of suffering from mental illness: How others do not understand their pain, long-term path to recovery, and how overall quality of life has been compromised due to mental illness. Some callers shared the need for a mental health professional.

> She shared that she has been suffering from severe OCD for more than 5 years. She has many unusual thoughts in her head and it always tortures her. She also has some specific numbers like three, five, and seven, and those numbers frequently come to her mind. Those different numbers have different characteristics. She shared that three is the number of bad luck and bad things for her, and seven is the number of confusing thinking. She sometimes washes her face again and again just to move from her any specific repeated thoughts. Sometimes she takes a shower twice or thrice to remove tension.

Social/Contextual Issues

Lack of Social Support (6.2%, 5.3%)

This category was primarily about facing societal/family issues and having no social supports to work through them.

> She was supposed to get part of her father's property and part of her grandmother's [maternal] property. But she can tell that nobody wants her to get it and would be glad if something happened to her. Her father encouraged her to enroll in a private university, but then he stopped paying for it so she had to drop out and go to National University instead. She can't tell anyone about this. She is embarrassed about it. She tried to share her experiences with one or two people but they did not respond well. She once helped a friend with quite a lot of money but that friend doesn't talk to her anymore, and ignores her requests to give the money back.

Bullying/Discrimination (4.7%, 7.5%)

These callers experienced body shaming and/or bullying. Callers also reported experiencing discriminatory behavior in academic institutions or in the workplace, bullying from neighbors and relatives, and harassment from boyfriend's friends.

> She sometimes goes out with her classmates, but she can never really blend in with them. Everyone tells her to open up but she can't find anything to speak about and thinks she's a misfit. People call her weird and judge her often which really hurts her.

Physical Complaints (7.6%, 3.5%)

This category included physical complaints such as diabetes, obesity, sleep disturbance, headache, lack of appetite, kidney problems, ovarian infections, and physical weakness. The caller is suffering from obesity. She wants to start her weight loss program again.

COVID-19/Lockdown

Financial Problems (1.4%, 0%)

These calls are about income insecurity due to job loss during the pandemic. Two of these callers described dropping out of university as they could not bear the expenses anymore.

> She works at a beauty parlor. In the lockdown, she got last month's pay but not this month's. She wanted to know if KPR could provide financial support. She said that there are four employees at the beauty parlor and

now they are just in the parlor all the time and are even eating all their meals at the parlor's owner's home. She feels bad that they are taking so much from the parlor's owner but not managing to contribute. She was worried about how long this will go on.

Mental Health Symptoms Under Lockdown (11.8%, 0%)
A significant portion of callers reported one or more mental health symptoms which had emerged in the lockdown, such as panic attacks, distress, anxiety, depression, loneliness, or fear of contracting COVID-19. Many callers were students who reported how suddenly stopping their academic life led to mental health symptoms. They also discussed general fear about the new virus. Several callers specifically described being affected by the discontinuation of their regular therapy/consultation due to lockdown. The difference between 2020 and 2019 for this category of calls was statistically significant ($p < .01$, Fisher's exact test).

She is having trouble with day-to-day life because of the lockdown. She keeps thinking she's going to die. She feels like she has become very mentally weak and feels useless and like she cannot do anything so she might as well die now.

Negative Thoughts About Self (3.6%, 3.1%)
This category includes doubting one's appearance or abilities, feeling inadequate, or lacking confidence. Some shared that they have poor confidence due to parental lack of validation or criticism from a husband/boyfriend. Some also mentioned perceiving themselves as insufficiently beautiful because of criticism from family members.

Caller is very upset because she thinks she can't communicate with anyone properly. She feels very useless and talentless. She suffers from lack of confidence and feels that no one admires her.

Sexual/Physical Abuse

Sexual Abuse (4.7%, 3.1%)
This category included experiences of being sexually abused/molested at different points of their lives. In all cases, this had occurred at the hands of relatives, private tutors, or boyfriends (i.e., not strangers).

The caller has always lived in an abusive home. Her cousin sexually abused her. Her mother knew about this but didn't take any steps against it. She has no close friends to talk to.

Physical Abuse (4.3%, 4.9%)
These were all calls about experiencing physical violence from husbands/boyfriends.

A few months after marriage, due to the influence of her mother-in-law, her husband hit her. Since then, she has been beaten numerous times and now she lost count. Her parents know about this, but her husband is very good at mind games. So he convinced her parents that everything is her fault. Now her parents blame her too.

Academic Concerns

Anxiety About Examinations (0%, 3.5%)
This category included all cases of anxiety due to upcoming examinations or when waiting for examination results, with the difference between 2020 and 2019 statistically significant ($p < .01$, Fisher's exact test).

She took the HSC examination and is worried about her results. She has no one close to her to share this and needed someone to talk to. Sometimes she wants to hurt herself.

Problems Related to Studying (0%, 8.4%)
This included being overwhelmed by academic pressure, difficulty concentrating, and being uninterested or unmotivated in studies, with the difference between 2020 and 2019 statistically significant, ($p < .01$, Fisher's exact test).

She is a medical student. There is too much pressure from her exams and trying to keep up with her studies. Work is piling up and she had bad results recently. Her parents are having problems and she's unable to concentrate on studying.

Discussion

This study provides a descriptive analysis of issues raised by women in Bangladesh who sought help from a suicide prevention helpline during the first 6 months of the COVID-19 pandemic in 2020, including a comparison to the same 6 months in 2019 as a prepandemic period. Findings revealed a large array of experiences with relationship issues constituting the majority of calls.

This research makes three important contributions. First, it provides insights into women's experiences during the pandemic. An important finding is that most categories of calls display approximately the same frequency across

both 2020 and 2019. This indicates that regardless of the pandemic, certain issues, such as relationship difficulties, are key drivers of distress and remain central to the women's experiences – indeed, potentially impervious to ongoing global crises (although existing literature suggests that these issues are likely compounded by the pandemic). However, there are a few noteworthy differences between the 2 years. Mental health concerns specifically related to COVID-19 do not, of course, occur in 2019. The most frequently occurring explicitly pandemic-related concern (almost all the 13% of calls in 2020 where the pandemic was explicitly raised) was the occurrence of mental health symptoms because of the pandemic. This supports existing literature and underscores the need for mental health services that can reach these populations. Given the constant presence of family members in these women's lives as can be gleaned from these data, and women's restricted mobility due to the pandemic and in general, ensuring adequate privacy and accessibility is vital to consider when designing mental health services. Another difference between the 2 years is that concerns related to academics appear in 2019 but are noticeably absent from 2020. This is almost certainly because most academic institutions were closed during the pandemic, with academic activities paused. The impact of academic stressors on students' lives is immense (for instance, *Kaan Pete Roi* tends to be open for extended hours and carries out specific campaigns during the results of public examinations due to the heightened risk of suicide; A. Abdullah, personal communication, March 2021). That some women may have gotten relief from this set of pressures may have been a surprising source of resilience during the pandemic. Finally, it appears that conflict with husbands appears more frequently in 2020 than in the previous year; this is unsurprising given the emerging literature on domestic difficulties during the pandemic (e.g., Hamadani et al., 2020). Why this is only the case for conflict with husbands, but not for other family members remains unclear.

One striking overarching finding is that most existing literature about women's experienced during the pandemic is about pregnancy/motherhood, but none of the calls in this data set were about motherhood/related issues. This is simultaneously a weakness and a strength of the data set. It indicates that mothers may not be making use of this helpline and are therefore a demographic that the helpline organization should reach out to further given the compounded mental health challenges that may exist during pregnancy/postpartum period. However, the data here also serve as a reminder that not all women are mothers and provide nuance to the kinds of issues that women face in their personal lives unrelated to motherhood.

The second major contribution of this paper is that the content of the calls themselves shed light on the experiences of Bangladeshi women's lives, beyond a focus on the pandemic. Some of these findings confirm what is already known from the literature; sexual abuse, for instance, tends to happen not from strangers, but from acquaintances/relatives, and mental illnesses represent a significant proportion of calls to the helpline, as would be expected. Other findings were more surprising. For instance, loneliness/isolation did *not* appear as a unique code pre-pandemic or during the pandemic. Women calling this helpline did not express isolation as a driver of distress. Instead, the nature of the problems was on the opposite end of the spectrum from loneliness: conflict, interference, and harmful behavior from parents, in-laws, or husbands/boyfriends; perhaps "too much involvement from others" instead of "too little" that loneliness would have indicated.

Finally, this study adds to the literature on helpline data. This is one of the few papers analyzing the content of calls to a suicide prevention helpline in detail. Previous literature has examined categories of reasons for calling in broad strokes, analogous to the "Global Themes" listed here (see, e.g., Fukkink et al., 2016; Turkington et al., 2020), but this paper begins to provide nuance: "relationships" as a global theme remains broad, but "pressure from in-laws" or "abusive behavior from boyfriends" is far more specific. This information is useful in directing potential interventions. It also serves to inform the helpline's trainings for volunteers who receive these calls. We hope that the methodology used here will inspire other helplines around the world to share detailed findings on call descriptions.

There are several limitations to this study. The volunteers answering the calls are given instructions to summarize the content of the calls, but there is great variation in the depth and thickness of the descriptions of the calls, with most not as detailed as we would have preferred. Due to space constraints, here, we only provide one example quotation for each code, although there was great variation within each code as well. Some of the codes are overlapping. The present research does not explore this, but investigating a larger sample size could indicate the types of issues that tend to occur together. Future research could employ techniques such as machine learning on larger sets of data to understand patterns of co-occurring terminology in these qualitative descriptions, potentially in relation to severity/suicidal risk of the caller. Finally, the helpline's caller population represents a particular, relatively homogenous demographic: an urban, middle-class, mostly young group who are on social media (Iqbal et al., 2019). Demographics who are not calling the helpline are not represented here. Notwithstanding these limitations, the findings here are a glimpse into kinds of issues that cause women distress in Bangladesh and can be used to drive future research and intervention design.

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Article

Domestic Violence During the Time of the COVID-19 Pandemic

Experiences and Coping Behavior of Women from Northern Greece

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Abstract. Domestic violence against women by their partners is a form of gender-based violence, and it has been recognized as a major social issue worldwide. Under the framework of feminist empowerment theory, we investigated the experiences and coping behaviors of 15 abused women from northern Greece during the COVID-19 (coronavirus) crisis. We conducted a qualitative study, utilizing in-depth interviews that were analyzed via content analysis. Our findings highlight the women's coping strategies, such as raising consciousness, being more aware of the situation, establishing safety plans, increasing self-confidence, and eventually reclaiming control of their lives. Our study allows educators, researchers, policy makers, and other women to learn lessons about dealing with violence in times of crisis, and for social welfare professionals to become more effective in meeting the needs of women in similar situations in the future.

Keywords: domestic violence, COVID-19, coping behavior, qualitative research

Impacts and Implications. The work presented in this article provides important information about potential ways to address United Nations' Sustainable Development Goals 5 (gender equality), 10 (reducing inequalities), and 16 (peace, justice, and strong institutions).

Based on feminist empowerment theory (FET) and coping theory, we conducted a qualitative study exploring the experiences, empowerment pathways, and coping behaviors of northern Greek women who had experienced intimate partner violence (IPV) during the COVID-19 pandemic. Via the lens of feminist theory, IPV is a continuous pattern of behavior that violates a woman's right to autonomy, privacy, and self-esteem (Stark, 2007). Empowerment is an essential component of feminist theory, serving as a key motivation leading to the achievement of inner goals, such as mental health, safety, and recovery from IPV (Cattaneo & Goodman, 2015).

Empowerment refers to the ways in which individuals, organizations, and communities work to reshape women's surroundings so that the women have the ability to recover control over their own lives and are able to cope with the results of experiencing IPV (Peterson & Zimmerman, 2004).

Feminist theories focus on oppression and privilege from gendered perspectives (Wood, 2014). The effective use of feminist approaches in interventions for victims of IPV is supported by several studies (Dominelli, 2002; McNamara et al., 2008; Petrectic-Jackson et al., 2002). FET targets the individual's and/or group's wellness, sense of control and development, critical awareness, participatory behaviors, and social inclusion (Anczewska et al., 2012).

Furthermore, FET recognizes the importance of women's own experiences in making them more competent and autonomous, stressing how social, political, and economic structures shape power and oppression between genders (Crenshaw, 1991).

In parallel with empowerment theory, coping theory can be used to frame women's adaptive responses to stress, loss of control, and powerlessness (Gutierrez, 1994). Coping theory appears extensively in literature and research, although research with samples of victims of IPV is limited and mainly qualitative and descriptive (Waldrop & Resick, 2004). Coping refers to the cognitive and behavioral efforts of a person to manage a troubled person–environment relationship (Folkman & Lazarus, 1985). In other words, it is about the thoughts and behaviors that people use to manage the internal and external demands of stressful situations. The theory provides two broad categories: (a) emotion-focused coping, in which various strategies are used to regulate the distress associated with specific problems, and (b) problem-focused coping, in which various strategies are used to

manage a specific problem. In both categories, people use the strategy that helps them preserve their physical and psychological functioning and well-being during the time they are facing a stressful situation such as IPV. There is a great deal of variability in the number of coping strategies described in the literature, and the selection a person makes is associated with the ways they want to deal with the situation and its effects. This is not a limitations-free decision as various constraints that affect this choice are present, namely personal, environmental, and extreme threat ones.

Both approaches focus on how individuals change their cognitions, emotions, and behaviors to manage life stresses and how they develop strategies for improving themselves and their environment through use of internal, as well as external, resources. We adopted both FET and coping theory approaches to understand women's subjective experiences and coping behaviors related to IPV, highlighting the important variables that impacted women's lives and shaped their experiences during the COVID-19 pandemic.

COVID-19 and Domestic Violence in Greece

In Greece, during the COVID-19 lockdown of March and April 2020, restrictive measures were implemented regarding people's mobility and socializing (Geniki Grammateia Oikogeneiakis Politikis Kai Isotitas Ton Fylon, 2020). Leaving the house and meeting people were forbidden by the state, resulting in difficulties for women seeking help due to IPV. Through this period, the main source of contact and information for abused women was the national SOS Helpline, with calls increasing dramatically in April 2020 (Geniki Grammateia Oikogeneiakis Politikis Kai Isotitas Ton Fylon, 2020). The most dominant form of gender-based violence against women in both March and April 2020 was domestic violence, accounting for almost 84% of calls (Geniki Grammateia Oikogeneiakis Politikis Kai Isotitas Ton Fylon, 2020).

Approximately 28% of women who called received psychological support and 26% received legal support.

Greece was not alone in increased contacts regarding IPV during the pandemic. In several countries, there was a similar increase in emergency calls. Calls to IPV helplines rose by 20% in Spain, 30% in Cyprus, and 40–50% in Brazil (Ertan et al., 2020). As Campbell (2020, p. 2) noted, "the growing global trend of increasing reports of domestic violence cases is likely to continue throughout the pandemic and may only represent a 'tip of the iceberg' as many victims still find themselves trapped with the perpetrator and unable to report the abuse."

Challenges of the pandemic, including restructured household routines, increased time with partners, and isolation from people outside the household – not to mention the economic crisis – all significantly contributed to increases of stress in already-strained relationships (da Costa & Moreira, 2020). According to Bradbury-Jones and Isham (2020), lockdowns to manage COVID-19 granted greater freedom to abusers. During lockdowns, abusers may be able to better know where their victims are, control victims' access to others, and manipulate victims without physical violence, simply by preventing access to phones and computers (Kaukinen, 2020). It is likely that new threats and psychological abuse, such as blaming the female partner for infection or exposure to the virus, may rise in association with fear of infection (da Costa & Moreira, 2020). Perpetrators might also deprive victims of access to necessary items for their personal hygiene, like soap or hand sanitizer, or even limit reliable information concerning the pandemic, while spreading fake news to manipulate victims even further (da Costa & Moreira, 2020).

Victims of IPV are at risk for both physical and emotional harm. US reports of IPV incidents in which perpetrators use COVID-19 as a weapon have increased (Campbell, 2020). In those cases, handwashing, for example, is forbidden in an attempt to amplify the victim's fear of the virus, as well as threats to deny victims medical treatment if they become infected (Campbell, 2020).

The economic impact of COVID-19, with job loss and social distancing, may, in fact, undermine decades of progress in keeping women and children safe at home and able to make their own decisions (Kaukinen, 2020). Previous research revealed that economic dependence triggers IPV (Mittal & Singh, 2020), and related exploitation, by compromising victims' economic independence; it may also impede any plans the victim may have for leaving the abusive relationship. All of this is likely exacerbated by the pandemic. Finally, in families that adhere to rigid gender rules, the impact on women is even more significant (Mittal & Singh, 2020).

Female victims of IPV might be unable to ask for help, disclose, or even seek professional advice, as they could have limited opportunities for social contact during the lockdown, or decide not to seek professional guidance because of fear of infection (da Costa & Moreira, 2020). Women's Aid UK stated that calls to support lines or health care services are often overheard by perpetrators, which can precipitate retaliatory violence (da Costa & Moreira, 2020) and discourage victims from seeking help. Similarly, victims may be forced to allow perpetrators access to email

and other accounts, decreasing the likelihood and ability of victims to look for help from formal support services. It is also important to note that in some impoverished areas, access to the internet or phone can be practically nonexistent (da Costa & Moreira, 2020).

Even with these limits, victims have increasingly used internet resources. For example, a UK website about IPV received extensive traffic, with a 150% surge after lockdowns. In addition, Bradbury-Jones and Isham (2020) also note that the leading IPV organization in the United Kingdom reported that calls to its domestic violence hotline increased by 25% within the first week of strict social distancing and stay-at-home measures (Bradbury-Jones & Isham, 2020).

FET and IPV Victim Support

The ultimate goal of FET-based counseling is for victims of IPV to increase autonomy, competence, self-knowledge, understanding, and management of their personal and social lives (Worrell & Remer, 2003). Safety planning is implemented in FET-based approaches to support women in situations of threat and violence so that they are able to leave the environment safely when they decide to do so (Laing et al., 2013). The safe escape plan is a woman-centered, participatory, and dynamic process between the woman and the counselor, who supplies the victim with information on resources. It entails the woman's own choices and recognition of potential risk factors (Laing et al., 2013).

In most cases, victims of IPV tend to feel that they are responsible for their abuse, having distorted beliefs and thoughts about their experiences. In the same vein, the ways they can react and cope with the abusive situation varies greatly from one woman to another.

In our study, we explored the perspectives of women in northern Greece who are victims of IPV and living with their husbands. We sought to understand their experiences during the pandemic, including their coping strategies and in-person and virtual use of services. These women engaged with pathways and help-seeking behaviors related to feminist empowerment by seeking FET-focused support.

Method

Participants

A center for women identified 15 women who were victims of IPV, all receiving counseling at the time of our research. These women were invited to participate in the study, and all agreed to be interviewed about coping mechanisms for dealing with IPV during the pandemic. All participants came from the northern part of Greece, still live with their abusive partners, and have asked for help and support from formal services in their communities. They have all experienced physical, verbal, psychological, and some of them sexual IPV. Participants had completed only primary education and were married with children and unemployed. Their ages ranged from 30 to 50 years.

Procedure

Researchers asked staff at a local center for women in northern Greece to mediate recruitment of participants, women who were victims of IPV and met the criteria above. The aim of the local center is to mobilize women who suffer violence in the family, providing them with counseling, psychosocial, and legal support. Specifically, the mission of the center is to inform women about their rights and to support and empower them, so that they can comprehend the situation they live in and the consequences that violence has on them and their children. Staff aided in inviting potential participants to be interviewed, and all potential participants were provided information on the objectives of the research and were assured of confidentiality. All the women invited agreed to participate and gave both verbal and written informed consent. All procedures were approved by the Institutional Review Board (IRB) and followed ethical guidelines (IRB protocol: AP 09/11/2020/DUTH/ETHCS/17037/76).

Interviews were semistructured, an appropriate method when the research explores sensitive issues and/or involves vulnerable groups (Wolgemuth et al., 2015). The interview guide included general demographic questions which were followed by core questions about coping behaviors, access to community social services, general handling of the crisis situation at home, and strategies used to deal with IPV.

Interviews were carried out at a place and time convenient to the participants, and each interview lasted, on average, one hour. Interviews were audio-recorded and later transcribed verbatim. Interviews were conducted in person by one of the researchers during the lockdown period, considering and following all necessary safety and protective measures.

Data Analysis

We analyzed data via content analysis (Krippendorff, 1980). oth researchers repeatedly read the transcripts,

establishing the trustworthiness of the findings. Codes were defined via a conceptual process of exploring the relevance of the data within the context of the study, formulating and analyzing constructions while also applying available knowledge of their meanings and relationships (Krippendorff, 1980). Both researchers coded the data twice, allowing for a gestation period of 1 to 2 weeks between codings (Anney, 2014). Both researchers together discussed in detail the results from the two coding periods, and outcomes were essentially the same, reaching an agreement of 90%.

Results

Based on our interviews, during the COVID-19 social distancing and stay-at-home restrictions, perpetrators' coercive control and power were intensified. With victims and perpetrators in close proximity, abusers could control decision-making, determine day-to-day outcomes, monitor behavior, and isolate victims from family and friends. The pandemic circumstances provided offenders a pretext to control women through threats to expose them and their children to the virus. Victims feared that their abuser would take the children out of the house and that they would not be able to control to whom their children were exposed to or whether proper hygiene and social distancing were practiced. The themes we identified in the data are presented in more detail below. To maintain confidentiality of our participants, we attribute quotes to participants by number (e.g., Participant 1, Participant 2, etc.).

Theme 1: Challenges and Difficulties Imposed by the COVID-19 Pandemic

Participants discussed the general challenges they faced during the lockdown, including isolation, increased abuse, and financial hardship. We divided this theme into four more specific subthemes (codes).

Code 1.1: Abuser-Controlled Communication and Isolation From Support Networks

In this specific code, we identified ways in which participants discussed how abusers attempted to control their ability to communicate with others and how the abusers strived to isolate them from support networks. Participant 11 stated, "during . . . quarantine he did not hit me, but . . . constantly checked on me . . . did not let me communicate with anyone or go out to the supermarket, he decided . . . everything." Participant 13 added to our understanding of this behavior by claiming, "due to the pandemic, he was at home all the time . . . constantly checked on me and did not let me communicate by phone or through the Internet, neither with friends nor with my parents, he isolated me."

Code 1.2: New Threats and Psychological Abuse

Many participants discussed how the number of threats (a kind of psychological abuse) increased during the lockdown. Participant 13 said,

> He threatened . . . that if I coughed, he would drive me out of the house along with the children and . . . told me that if we got infected it would be my fault . . . he would not let us wash our hands . . . nor use antiseptics. I was afraid that my children would catch coronavirus.

Participant 9 added to this by stating:

> He was threatening me that he would take the children . . . go out without masks, I was afraid for my children not to get infected. He wanted us to stay at home, but not to keep the hygiene measures we wished to.

Code 1.3: Economic Impact of the COVID-19 Pandemic

Throughout the quarantine, as women lost their jobs, they experienced a greater array of impacts, becoming economically dependent on their partner.

Participant 10 made this clear, saying "before the coronavirus I was thinking of leaving him, but now with the pandemic, I was fired from my job and had no income." Participant 11 underscored this code when she stated:

> I am economically dependent on him, he does not give me any money . . . my parents do not help me financially, and they tell me that a woman does not need money; when she needs something, the man will buy it ... how to leave without money?

Code 1.4: Restructuration of the Regular Household Routine

Beyond examples of clear physical and psychological abuse, the pandemic created changes in daily routines, which led to increased tension, fear, and anxiety. As Participant 8 put it,

> now with the pandemic things at home are difficult ... there is a constant tension when we are all together and ... I have children to take care of ... because they do distance learning ... but they cannot concentrate ... I'm very anxious; I do not know how to manage it . . . I have to adapt with the children to a new reality.
>
> This creates extra stress for me.

Theme 2: Negative Feelings of Women Toward Abusers During Quarantine

IPV during the pandemic has negatively impacted the private lives of abused women. The psychological impact of violence generated a variety of issues, from sleep disorders to anger and other emotions, like fear, frustration, and sadness. Quotes from participants, such as Participant 7, make it clear the women were dealing with many strong emotions: "In quarantine, feelings are too many ... disappointment, sadness, anxiety, sadness ... sometimes out of isolation and loneliness, I feel I want to die."

Participant 9 discussed how these emotions affected her and her children's sleep quality: "I was not asleep for most of the quarantine. We did not sleep at night, neither me nor my children...we are afraid of him being drunk and aggressive all day." Finally, Participant 1 discussed how difficult it was to control her emotions, even though it was something she attempted to do for the benefit of her children:

> I felt like I was losing my temper ... I couldn't stand it all day with him at home, it was difficult ... I have exceeded my powers in quarantine. I try to be strong for the children, who are now all day at home ... I try not to show my emotions, the sadness I feel, I try with all my strength left to support them.

Theme 3: Difficulties in Seeking Help or Accessing Protective Resources

Within the framework of the restrictions of the lockdown, participants avoided counseling services for fear of contracting COVID-19. Many women had less access to services during the pandemic because their access was denied by their abuser's exercise of coercive control, a general lack of internet access, and constant monitoring. We identified two specific codes for this theme.

Code 3.1: Fear of Contracting COVID-19

In addition to the fear of seeking help because of how their abusers might react, participants were also fearful of seeking help because they did not want to contract COVID-19. One participant put this succinctly by saying, "I was afraid to go to the service for help, not to get infected with the virus."

Code 3.2: Limited Access to Services and Coercive Control by the Abuser

Participants talked about difficulty in accessing services because their abusers actively limited their access. Participant 5 said,

> he ... placed various ... bugs in the house and listened to everything ...so I cannot get a phone call, because then he will find out and hit me ... I sent 2 emails to the service, but then they cut off the Internet ... I'm afraid I do not know what to do.

Participant 14 echoed this sentiment, abuser control of communication – heightened by a general lack of Internet access – by stating,

> We do not have internet at home. It was difficult for me to get a call for help, because I was with my husband all day. He is constantly tapping or monitoring me and, if he listened to me, he would hit me in front of the children.

Theme 4: Help Seeking Behavior and Victim Empowerment Services

Services helped women by offering support in various ways other than physical visits, such as phone calls or email. Still, sometimes victims found it difficult to disclose abuse in this distant, nonpersonal setting. This was partially because of risks of being overheard, but also because of lack of more meaningful face-to-face interactions. The services women availed included psychological and legal counseling, with some women reporting they developed a safety plan with the help of the specialist. Throughout the counseling, professionals, acting as guides and facilitators rather than saviors, helped women deblame themselves, find their lost self, and increase autonomy, competence, self-confidence, and self-esteem. We focused on four codes in this theme.

Code 4.1: New Ways of Communicating With Services

Participants discussed pandemic-related methods they used to engage social services. Participant 15 said, "now due to COVID, I do not go to the counseling center ... I send an email to the service and make an appointment, and ... the psychologist supports me online." Participant 7 used a similar tactic with the telephone, saying "in the evening, I would go to the bathroom when everyone is asleep and I would make a phone call for psychological support." However, Participant 2 noted how difficult it was to have these conversations over the phone or online:

> I would prefer to talk to a social worker on the phone ... I had a hard time revealing over the phone what was happening to me. I do not like impersonal communication; I feel uncomfortable expressing what I am feeling and going through, and I am afraid my husband will be listening to me.

Code 4.2: Empowerment Pathways Through Counseling

Many participants talked about how the FET-focused approach allowed healing and psychological growth, safety plans, and an increase in self-confidence. Participant 11 said,

> they help me psychologically and legally, they inform me about my rights, about the services ... with the social worker we talked to recently we made a security plan in case my life was in danger and for my children as well, to know what to do, where I have to call on the phone ... The social worker helps me a lot because he encourages me and makes me not feel guilty.

We developed two specific subcodes within Code 4.2 because many women discussed these two issues specifically related to the FET-focused services. The first subcode was *establishing safety plans*, which Participant 8 discussed: "The social worker supported me psychologically on the phone, encouraged me and we tried together to plan in case of danger, what to do and where to go; this was very helpful for me, it made me feel safe."

The other subcode of Code 4.2 was *increasing self-confidence and awareness of equal rights*. Participants discussed how FET-focused services helped them understand their rights and self-worth, as when Participant 15 said:

> I find it difficult to say what I go through and feel, but the psychologist helps me understand that I should not blame myself for everything that happens to me and she encourages me ... when I talk to her, even on the phone I feel more confident that I can really make it without him ... I used to believed that the man is responsible for the family ... was wrong.

FET is also reflected in the following quote by Participant 10:

> when I talked to the social worker, she encouraged me to believe in myself, in my strengths ... I felt more confident and I realized that my husband is not superior to me, we are equals and he should treat me like that ... my parents used to say that a woman should obey and tolerate her husband but I do not believe it anymore.

Discussion

By understanding the dynamics of and risk factors associated with IPV, scholars can extrapolate how emergencies like COVID-19 can influence and exacerbate violence. According to our participants, situations that increase relationship stress, power dynamics, control, isolation, victim manipulation, restricting victims' capability to protect themselves, and access to help, as well as a lack of resources, are factors in the perpetuation of IPV in remote areas.

Unfortunately, fear and uncertainty related to COVID-19 and social policies adopted to control the pandemic harm victims by further straining already stressful relationships and allowing for even more isolation.

Professionals who utilize an FET approach and coping theory in their work help victims recognize strengths, abilities, skills, inclinations, and interests rather than focus on weaknesses. Through FET-based counseling, therapists – acting as guides and facilitators rather than saviors – help women increase their self-confidence and self-esteem, and discern the complexities of their lives, including the many forms of oppression that might affect them (Latta & Goodman, 2005). FET counseling contributes to the disengagement of women from the abusive relationship, women's awareness of the abuse, victims' management of internal conflicts, victims' increased sense of empowerment, and their reshaping of themselves and their social identities.

In addition to FET-based counseling, coping theory provides a framework for understanding the coping strategies women develop during the violent relationship by taking situational variability and subjective preferences for a particular strategy into account. For example, women in our study used strategies such as establishing a safety plan or setting future goals that would enable them to break from the abusive relationship, but at the same time, they were faced with coping constraints such as limited resources and difficulties in accessing those resources.

Overall, FET shapes programs in IPV service agencies by paying attention to power differences, focusing on clients' needs, creating avenues for women to make decisions, building strength, and creating safe spaces for survivors to make their own choices without fear (Clevenger & Roe-Sepowitz, 2009). In our interviews, participants highlighted how the FET approach can be successful even within the restrictions of the COVID pandemic.

Limitations

One limitation of this study is that our participants are relatively unique and uniform with respect to demographics, including marital status (all married), employment status (all unemployed), education status (all attained only primary education), and residence (all rural).

Those factors may influence findings regarding help-seeking behaviors and coping strategies. As a result, the issue of intersectionality could not be addressed due to the uniformity of the sample in its major categories such as all being Greek, living in a rural area, with low educational and economic conditions. Finally, the rural area where we conducted our research likely restricted help-seeking behavior compared to a more urban area, because of lack of transportation and resulting difficulty in obtaining access to social services.

Conclusions

Women who live in abusive relationships are victims of violence by their partners, risking not only the women's immediate well-being but also their overall quality of life. Our research, based on women's lived experiences with IPV, points to the empowering strategies that women have managed to develop during the COVID-19 pandemic (with the aid of empowerment-focused service providers), helping them use coping strategies so as to regain control over their lives. Empowerment and coping were found to be important to women for taking control and mastery over their environment, including cognitive and affective processes and changes in behavior.

Overall, our participants gave voice to their personal experiences as well as coping behaviors during the pandemic, allowing other women and service providers to learn lessons about dealing with IPV in times of crisis. Feminist empowerment and coping strategies were catalysts in helping them curtail self-blame, raise self-consciousness, increase awareness of their situation, and develop insights into improving their lives. We argue that their example can help professionals become more effective in meeting the needs of clients in similar situations and offering the best assistance for the future. Although COVID-19 has and can be expected to continue to exacerbate existing inequalities against women, empowerment-focused approaches foster gender and health equality; those are vital to increasing fundamental rights for an inclusive, equal, and sustainable world, as clearly laid out in the United Nations' Sustainable Development Goals (United Nations, n.d.).

Finally, it is necessary that social welfare professionals who treat women victims of IPV, such as psychologists and social workers, are properly trained in empowerment and coping-focused approaches and are gender-sensitive to confidently deal with the complexity of IPV. In addition, while offering services to IPV survivors, they should always consider the specific sociocultural context of the women in question. In the case of our research, the Greek culture and society, with its patriarchal structured institutions and unequal gender rights, will play an important role in the professionals' ways of empowering and supporting the women. It is important for professionals to be prepared to respond to IPV cases proactively, so as to be able to identify and curtail issues of power and control within intimate relationships.

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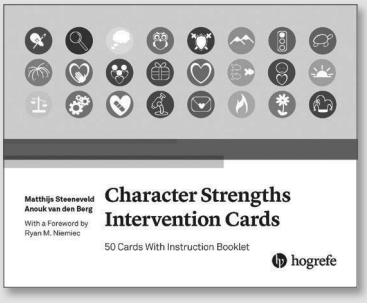

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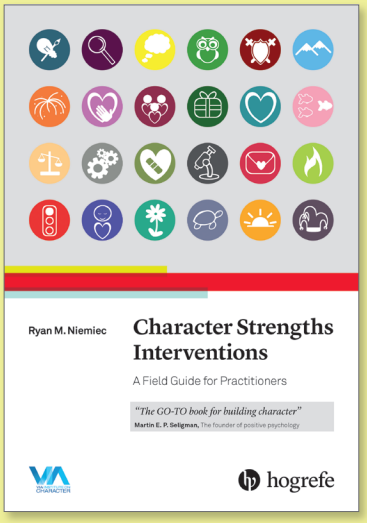

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