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ORIGINAL ARTICLE

Resilience is more than Nature: An Exploration of the Conditions that Nurture Resilience Among Rural Women who have Experienced IPV

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Abstract

Purpose Intimate partner violence (IPV) is a significant public health concern exacerbated by the pandemic. Experiences of violence vary based on geographic location and living in rural communities has been found, in some contexts, to amplify consequences of IPV. Resilience, the ability to survive and thrive despite facing adversity, has long been a dominant narrative within IPV literature, yet little is known about how resilience is cultivated among rural women experiencing violence. The purpose of this study was to explore how rural women experiencing IPV cultivate resilience.

Methods Using Interpretive Description, in-depth qualitative interviews were conducted with 14 women who experienced IPV and 12 staff from women's shelters across rural communities in Ontario, Canada to elicit perspectives about women's resilience and environmental conditions that may shape resilience in the context of IPV.

Results Women's resilience was cultivated by personal changes aimed at surviving or thriving, and aspects of their environment that enabled or created barriers for resilience. Women adopted a positive, hopeful mindset and bolstered their inner strength through living from a place of integrity, being resolute in decisions, and using mental resistance when faced with doubt. Women faced barriers to resilience in the form of unhelpful help and COVID-19 public health guidelines. Paradoxically, living in a rural community *both* cultivated and undermined resilience.

Conclusions Supporting women to cultivate resilience through modifying environmental factors to enable personal strengths to flourish is paramount in supporting women who have experienced IPV, particularly in rural contexts.

Keywords Intimate partner violence · Resilience · Thriving · Rural · Stigma · Isolation · Shelter services · COVID-19

Introduction

Gender-based violence (GBV) broadly encompasses the gendered elements within all forms of violence (Montesanti & Thurston, 2015). Intimate partner violence (IPV) is a form of GBV that transcends geographic, racial, social, and economic classes (Heise & Garcia-Moreno, 2002). IPV impacts an estimated 44% of Canadian women (Cotter, 2021) and is understood to be a pattern of physical, sexual, or emotional violence perpetrated by an intimate partner in the context of coercive control (Tjaden & Thoennes, 2000). While IPV is typically thought of as an interpersonal issue, the far-reaching social and economic consequences include broadly perpetuating the patriarchal nature of society, interrupting education/job training opportunities (Germano, 2019), and decreasing socioeconomic mobility for women experiencing violence (Flury et al., 2010; McLean & Bocinski, 2017; Montesanti & Thurston, 2015). Research on COVID-19 has provided insights into the extent and impacts of structural inequalities for marginalized groups, including women experiencing IPV (Enekwechi et al., 2020; Moffitt et al., 2020; Webb Hooper et al., 2020). As a result of the pandemic, there has been a rise in IPV and, more specifically, the severity of violence experienced (Peterman et al., 2020; Roesch et al, 2020). Throughout

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the COVID-19 pandemic, the United Nations has referred to IPV as a "shadow pandemic" (UN Women, 2020). While this messaging was likely intended to illustrate how IPV is common but still exists in the shadows or privacy of individuals' homes, this terminology inadvertently creates a hierarchy wherein COVID-19 is the main pandemic, and IPV is a secondary one (Mantler et al., 2022b). As such, Khanlou et al. (2020) posit that these co-occurring pandemics be referred to as *syndemic* (Mendenhall, 2017). A *syndemic* acknowledges how diseases are provoked by socioeconomic, political, or environmental contexts, and when co-existing interact and lead to synergistic vulnerability for marginalized groups, thus amplifying social and structural inequities (Willen et al., 2017). The convergence of COVID-19 and IPV pandemics places women at a disproportionate risk of experiencing violence compared to if they had experienced either pandemic alone (Khanlou et al., 2020).

As with many public health concerns, geographic location, and more specifically living in a rural community, can, in some contexts, further amplify some of the consequences of IPV. Specifically, women experiencing IPV while living in rural communities are at an increased risk of femicide (Davies et al., 2009; Logan et al., 2005, 2007; McFarlane et al., 1999; Roy & Marcellus, 2019). Results of a recent systematic review (Edwards, 2015) in the United States also suggests worse psychosocial and physical health outcomes among women who have experienced IPV and live in rural versus urban communities. These heightened experiences of violence are exacerbated by existing inequities embedded in the rural health and social systems, such as a lack of available services and qualified personnel (Lanier & Maume, 2009). The structural barriers impeding access to support for women experiencing IPV are entrenched in rural community norms that perpetuate and stigmatize experiences of violence, including hegemonic masculinity (Tyler & Fairbrother, 2013), fear of breach of patient-provider confidentiality, and traditional gender and family norms (Annan, 2008; Kaur & Garg, 2010; Merritt-Gray & Wuest, 1995; Zorn et al., 2017). Together, the heightened experiences of violence, existing inequities in health and social services, and the existence of community norms that undermine help-seeking behaviours create an environment conducive to an increased risk of continued violence. This environmental context may impede rural women's ability to be resilient through adversities.

The topic of resilience, a person's ability to survive, grow, and thrive—despite exposure to adversity (Howell et al., 2018; Munoz et al., 2017; Prime et al., 2020), has long been a dominant narrative within IPV literature, including throughout the COVID-19 pandemic. Within these narratives, resilience has been framed primarily as a personal trait, with little attention given to *how* women experiencing IPV develop resilience or the contextual factors/conditions that make this possible (Goodman et al., 2003). Some studies have focussed on identifying resilience among women who have experienced IPV. For example, Humphreys (2003) found women who experienced IPV and resided in shelters exhibited resilience despite exposure to physical and psychological stressors. More recently, a study of Canadian women experiencing IPV during the first six months of the COVID-19 pandemic reported that women struggled to cope with the abuse because of the stay-at-home measures which negatively affected their resilience (Mantler et al., 2022a). Furthermore, the neoliberal positioning of the resilience narrative during the COVID-19 pandemic has emphasized a need for individual adaptability, overlooking governmental responsibility and societal structures that exacerbate existing inequities and conditions needed to support resilience (Blundell et al., 2020; Joseph, 2013). While there is evidence that urban-dwelling women who experience IPV demonstrate resilience (Anderson et al., 2012; Humphreys, 2003; Mantler et al., 2022a), there has been limited attention to unpacking how resilience develops among rural women who have experienced IPV and under what conditions. Given the uniqueness of rural communities, and the dearth of literature (Crann & Barata, 2016), there is a need to understand how resilience is cultivated among rural women experiencing violence in ways that attend to geographic realities.

Purpose

The purpose of this study was to explore how rural women experiencing IPV cultivate resilience, the ability to survive and thrive in spite of adversity, and the environmental of IPV.

Methods

Study Design

This cross-sectional qualitative study used interpretive description (Thorne, 2016), a pragmatic qualitative approach that is both constructivist and naturalist, to generate knowledge relevant to applied disciplines.

Sampling, Recruitment, and Eligibility

A combination of purposive and snowball sampling was used to recruit rural women experiencing IPV and service providers from rural women's shelters to gain perspectives on IPV from multiple lenses (i.e., those who have experienced IPV and those providing support). Study information was posted on Kijiji sites in rural areas and emailed to rural women's shelters. To be eligible for the study, women needed to live in a rural area in Ontario; identify as resilient;

have experienced IPV and survived; and have access to a safe computer/telephone. Service providers needed to have worked at an Ontario rural women's shelter for a minimum of six months. Interested participants contacted the research team via email (found on the study advertisement) and were screened for eligibility. A total of 14 women and 12 service providers were eligible and verbally consented to participate in the study.

Participants

The women and service providers who participated in this study were from 12 different communities across Ontario, with populations ranging from 2,000 to 42,000 people. Women's ages ranged from 18 to 57 years old ($M = 34.86$ years, $SD = 9.31$). The education of the sample was generally high, with approximately 60% of participants achieving a college or university-level education. The employment status of the sample was diverse, with five women working part-time, four working full-time, four being unemployed, and one woman identifying as self-employed. The average annual household income after taxes varied greatly among women, ranging from $15,000 to $110,000 Canadian dollars (CAD). Approximately 65% of this sample identified as heterosexual, 29% as bisexual, and 6% identified as having a fluid sexuality.

Service providers had worked for their various agencies for a minimum of 6 months, with the majority of staff (n = 10) being employed full-time. All service providers were women with an age range of 27 to 59 years old ($M = 42.25$, $SD = 11.73$). The education and income of the sample was generally high, with all staff achieving college diplomas and/or university degrees and half averaging an annual household income of more than $100,000 CAD.

Procedures

Ethics approval was obtained from the host institution's Research Ethics Board (< redacted for blind review >), and interviews were completed between November 2020 and June 2021. Individual, semi-structured interviews were conducted at two time-points, approximately four months apart. Phase one interviews were conducted between November 2020 and February 2021, with women ($n = 14$) and service providers ($n = 12$), from 8 shelters. Phase two (i.e., follow-up interviews) occurred between May and June 2021with six women and five service providers for the purpose of member checking to ensure accuracy and resonance with participants' experiences (Guba & Lincoln, 1989). At the outset of each interview, resilience was defined to all participants as "a dynamic process in which psychosocial and environmental factors interact to enable an individual to *survive*, *grow* and *even thrive* despite exposure to adversity". The phase one interviewers lasted approximately 60 min and were conducted by two members of the research team (i.e., KS and CD) and an optional phase two interview lasting approximately 60 min. The second interview was conducted with only six women and five service providers and was used to member check emerging findings and refine themes. Table 1 presents the questions asked during both phases of interviews. Phase 2 interview questions were based off preliminary findings from phase 1, thus affording participants the opportunity to expand upon or clarify their experiences. All interviews were audio-recorded and transcribed verbatim, and each transcript was anonymized prior to analysis. The data collection and analysis process were guided by Guba and Lincoln's (1989) and Thorne et al. (1997) principles of auditability, fit, dependence, and transferability. To reduce barriers to participation, women and service providers were offered a $25 gift card in recognition of their time for the first interview, and a $10 gift card for the second interview.

Data Analysis

Interpretive description following Thorne's (2016) approach guided analysis. Initial data analysis occurred after phase one interviews were completed. In line with Thorne (2016), the collection of data occurred concurrently and iteratively while researchers reflecting, asked questions, and considered options for making sense of the data. The initial analysis then informed the creation of the semi-structured interview guide for phase two interviews with the goal of clarifying, expanding, and confirming findings from the phase one analysis. Transcripts from all interviews were organized using Quirkos qualitative analysis software (Quirkos, 2021). The 37 transcripts were each independently coded by two of the five researchers involved. Initially, those who conducted the interviews (KS, TM) and the principal investigator met and created a preliminary coding structure with definitions based on field notes and what was known from the literature. Next, random coding dyads were created, and each dyad was initially assigned two transcripts to analyze using open and line-by-line coding (Blundell et al., 2020). Then, each dyad, and subsequently the larger group, met to discuss the applicability of the coding structure and code definitions, with refinements to the coding structure and definitions made, as needed. This process was repeated twice until the entire coding team was confident the coding structure sufficiently covered the data. Next, each interview was assigned to two people for final analysis. Throughout the coding process, the coding team utilized memoing to identify theoretical outliers, theorize the relationship and structure of the data, and extract meaning from the data set (Thorne, 2016). Once all transcripts were analyzed, Quirkos files from each coder were merged, and queries/reports were run on each code and associated data related to the concept of 'resilience.'

Table 1 Interview questions asked to women and service providers

Phase of interview	Participant group	Interview questions
1	Women ($n=14$)	1. What helps to support your resilience?
		2. What undermines your resilience?
		3. What are some challenges/barriers that you have faced to being resilient?
		4. What did [do] you need to thrive over time?
		5. What adaptations have you used to be resilient?
		6. What has contributed [contributes] to your inner strength?
1	Service providers ($n=12$)	1. What do you think helps to support women's resilience?
		2. What do you think undermines women's resilience?
		3. What are some challenges/barriers that you have seen women encounter that prevent them from being resilient?
		4. How have you seen women thrive over time?
		5. What adaptations have women used to be resilient?
		6. What do you think contributes to women's inner strength?
2	Women ($n=6$)	1. In your relationship, what made you feel stuck? How did you overcome that feeling of "stuck-ness"?
		2. How would you describe your mindset, and how do you feel your mindset has played a role in your experiences, and your resilience?
		3. What enabled you to keep moving on when things were difficult? When there were moments of crisis
2	Service providers ($n=5$)	1. What forces women to stay in their relationships (or keep them "stuck" there)? How do you see women overcome that feeling of "stuck-ness"?
		2. How do you feel a woman's mindset can influence their experiences and resilience?
		3. What enables women to keep moving on when things are difficult? When there were moments of crisis?

The coding team then met to discuss and interpret the findings and to build consensus around how resilience is cultivated among women experiencing IPV and living in rural communities.

Results

Women and service providers (SP) described how experiences of IPV impacted resilience. A common narrative shared throughout interviews was that, despite adverse experiences, "[resilience] is just a part of being a woman" and that "[women] are resilient by nature" (SP11). However, in spite of both women and service providers framing women's resilience as 'natural' or innate, their interviews also reflected a more comprehensive understanding of resilience as *more than nature*, but a capacity that was nurtured and shaped in multiple ways by context. Five themes were identified that reflect this connection: 1) inner strength; 2) transitioning to a positive mindset; 3) unhelpful help; 4) COVID-19: more and less time; and 5) rural communities: *a double-edged sword.*

Inner Strength

Inner strength, understood as the integrity of character, resoluteness of will and/or mental resistance to doubt/discouragement, was described by both women and service providers as a key source of resilience in the context of IPV. Integrity of character or living in a way that aligns with one's true self was important to women's resilience as it helped reassure them that they were on the right path to recovery. One woman described the importance of being reminded by others, as well as reminding herself, that leaving was the right decision and allowed her to begin living from a place of integrity saying, "[I remind] myself I guess, that what I did is the best choice… Because even hearing it from other people, it doesn't really, like it helps, but you have to tell yourself the same thing" (N2). This inner strength and actively living from a place of integrity was observed by many service providers as being a key component of resilience, with one service provider explaining that, "Everybody has inner strength, its whether or not they recognize how much inner strength they have, and act on it. It's there, it's having the confidence to trust your inner strength and to act on your inner strength" (SP10). For many women, ongoing

connection with their informal support system was critical in helping them live from a place of integrity. One woman described her reliance on her informal support system in times of need as be strong when she was wavering:

> That support system outside of work, as soon as I get a break, I'll call them, and I'll say I'm having a really hard day. Y'know, this person is really getting to me and they're just making it very difficult to get through the day, and they'll just kind of like, talk me down back to a- a normal level. (N5)

Beyond integrity, being resolute in decisions made is another aspect of resilience that many women drew upon to thrive despite their experiences of abuse. Many spoke of reaching the point of being resolved in their decision to leave, but needing to reach a breaking point where they felt they could not go on living in the abusive relationship any longer. One woman described this saying "and so you hit this point where you're just rock bottom, literally. And you have no choice but to heal" (N3). The reality of "rock bottom" was described by several women in our study as a life-or-death situation, one woman explained:

> Because at some point, it could become you know life or death situation, so yeah, I guess it's when it became you know, physical and there was actually bruising. That's when it became ok this is it, this is the be all end all point. (N12)

With an awareness that they deserved better than remaining in an abusive relationship, many women began the process of finding the inner strength to leave. One woman described that decision process saying, "You need to find that inner strength saying, I need to get out of this situation no matter what." (N2). This sentiment was reiterated by another woman who underscored that determination or resoluteness of will had to come from within, explaining "something has to stem from yourself… like some sort of willpower" (N6).

Women also described mental resistance to doubt or discouragement as important to cultivating resilience. Being able to cast aside doubt and trust in their integrity and resoluteness to change their situations was key. For example, one woman described the need to rely on her mental resistance daily to keep her moving forward:

> [Reassure] myself, every single day…because everything that comes out of a person's mouth, whether intentionally trying to hurt me, or unintentionally hurting me, reverses my progress, even just a smidgen, and so *every day* I have to reaffirm that everything I'm doing is positive, and that I've come really far compared to where I was, say, a year ago, and things are moving in a forward manner, and they're not going backwards anymore. (N5)

To cultivate mental resilience, service providers underscored the importance of their role in shelter of encouraging and building women's confidence to increase their mental fortitude and resistance to doubt. One service provider explained, "Women have shown how resilient they are… with sharing information, discussing their fears and concerns, we are able to encourage them to be resilient and to be able to thrive and not just survive" (SP10).

Transitioning to a Positive Mindset

Having a positive mindset and focusing on the desire to thrive and not only survive was described by both women and service providers as a factor that was important to women's resilience. For many women, this meant overcoming a mindset where their judgement was constantly questioned or they blamed themselves for the abuse, a tool commonly used by abusers to control women and diminish their sense of worth. One woman explained this saying:

> For the decade that we were married… I let him convince me that my own judgement was questionable, and it took a really long time for me to understand that it wasn't, and then once I finally got that through my head, it has been pretty life changing. (N14)

For many women, taking on a positive mindset meant shifting away from seeing themselves as victims and replacing that with a sense of hope. One woman explained,

> When making the switch from feeling or thinking or behaving like a victim, to that of a survivor…I feel like I can look back on things with less of the, like guilt and shame, and some of the things that like I would beat myself up with… and then I'm able to look at it with more of a sense of like, like strength and hope. (N4)

Similarly, service providers underscored the importance of women transitioning to a positive mindset as important to their ability to sustain themselves and create the life they imagine. For example, one service provider noted, "If a woman has a positive mindset, she is going to have that *energy* and have that positive experience to move forward and to be resilient." (SP8).

Transitioning to a positive mindset was an active process for women that required constantly remembering their inner worth. Many women spoke about how using affirmations, a practical tool taught through counselling, helped them keep their own value and worth in mind. One woman described repeating the mantra she had learned, "I am worth it, I'm worth- I'm worth this position at my job…I've earned the right to walk down the street and say hi to the person coming towards me that's smiling" (N5). Service providers underscored that that transitioning to a positive mindset was difficult for many women whose identities were based

on primarily on their experiences of abuse. In this context, service providers identified their role in helping women recreate a new identify or "making this whole new image of themselves" (SP8) to support a more positive mindset.

The active process of transitioning to a positive mind set for many women was anchored to becoming future-oriented. Many women attributed this future orientation as the reason they were thriving after being in an abusive relationship. Woman described the transition to a future orientation was shaped by having community support and neighbours that served as allies meaning they could switch from survival to goal setting. The importance of this shift to a positive mindset and becoming future oriented provided women with a source of ongoing strength that helped them to thrive over time. One woman said, "I think a positive outlook really is underrated… I can't really stress enough how much that has probably saved me over the last ten years" (N14).

Unhelpful Help

The sentiment of "unhelpful help" reflects the notion that help was inaccessible and/or misaligned with the needs of women, often experienced as systemic barriers experienced by those seeking help. Service providers often described these systemic barriers as stemming from a fundamental lack of understanding about IPV. "I find on a whole people don't really have a whole lot of understanding about how abuse works. And I just feel like if that was understood, then you wouldn't see… quite the same critical [negative] attitude" (SP6). A critical or negative attitude toward women was often observed in social services external to the shelter, such as police and the justice system. A lack of understanding of abuse often impeded women's sense of safety and made many reluctant to report their experiences to police. Specifically, failure to have their safety concerns taken seriously in reporting their experiences also undermined women's future help seeking, whether with police forces or other social services by reinforcing those systems in general could not be counted on for help. One woman explained how she often felt like service providers weren't really interested or responsive to her situation, "they're just saying whatever they're supposed to read off to you. And then they're like, okay, well checklists, checklists, checklists" (N2). Despite the apparent barriers to seeking help from services, some women did find solace in having their experiences acknowledged by family members. For example, one woman discussed the benefits of family members being aware of her situation, stating that "they've offered support and guidance… or, you know, [tried] to lend a friendly ear and be open or honest and actually be sympathetic" (N12).

COVID-19: More and Less Time

Experiencing IPV during the COVID-19 pandemic further exacerbated personal and environmental barriers to women's resilience as the public health measures enabled abusers to isolate women further and limit their ability to access services. The stay-at-home orders meant many women were confined at home with their abuser. One woman stated, "if [women] were being abused in any manner, now they're stuck" (N10). However, for some women, COVID-19 offered them newfound *time* to do the work of engaging with counselling and shelter services that was important in cultivating their own resilience and moving toward the life they wanted. Women discussed having more time as they were working from home, had become unemployed, and/or commitments outside the house had decreased due to stay-at-home orders. One woman spoke of the benefits she gained from the pandemic:

> It was so *empowering* because I was like when you only have one way but up, and the pandemic is also a gift too because it gave me time to say hey I am not doing this again. I am going to come out of this pandemic stronger. I'm not going to let this happen again, so you know I did use the time. I said I'm not going to waste any time. And I didn't. (N3).

At the same time, closures and changes to services offered during COVID-19 impacted women's ability to access services. This was summed up by one service provider who said, "it's harder for [women] to leave or harder for them to reach out and get the support that they need" (SP1). Many women discussed how their access to services was interrupted during the pandemic due to their abuser's constant presence, leaving them with no opportunity to covertly engage with shelter services that had been helping them to cultivate resilience. One woman described the negative impact of service disruption for her, "it's just difficult dealing with healing having just left abusive relationship like right before the pandemic you know it was very hard to, do anything like I couldn't see my counselor anymore" (N3). Moreover, the COVID-19 restrictions such as quarantine and physical distancing further impacted service provision within the shelters. Early in the pandemic, women entering some shelters were required to quarantine for two weeks to prevent the spread of COVID-19, a policy consistent with public health guidance given to communal living organizations at the time. This isolation meant women experienced delays in accessing the typical supports received when they enter shelter. One service provider explained,

> [Women] have to isolate for two weeks, which makes you know, searching for housing, and getting just daily

tasks completed that we would normally have no problem getting completed, but with women in isolation it makes it a lot more complicated. (SP9)

Rural Communities: A Double-Edged Sword

Living in rural communities was seen as both a benefit and barrier in cultivating resilience for women experiencing IPV. Women described the tensions of: how rurality led to both feelings of isolation and connection, support and stigma, and barriers and innovations in service provision.

Isolation and Connection

Living in a small community, often with distance between houses, was regarded by some women as a positive feature of their communities that helped bolster their resilience. This 'benefit' was particularly apparent in the COVID-19 context. Women described that having physical space allowed them to cope with the abuse and pandemic and to do so privately. One woman noted that "being sort of in a rural situation has really helped with coping with the pandemic, because you get that sense of being away from all of this, right, when you don't really have anybody else around" (N14). However, for some women, living in a rural community was very isolating and lonely, making it more difficult to be hopeful about the future and to see a way out. One woman explained:

> Once you're isolated, things become pretty bleak. It's hard to be hopeful and it's hard to think about how you're going to be able to get out because it's all you know, it's all you see, it's all you experience. (N6)

Other women shared their rural locations made them feel *trapped – physically, mentally, and emotionally.* Women were aware that their experiences of abuse were largely invisible to people outside the home and that this contributed to hopelessness. One woman described that compared to an urban location, "[You] can't yell, nobody's gonna hear me like, you, you literally you feel way more trapped" (N10).

Tight-Knit Community: Support and Stigma

For some, living in a rural community meant that informal social networks were closer with fewer people in them, and this both bolstered and inhibited resilience. A close-knit community helped women cultivate resilience when they had access to support and allies beyond shelters. One woman noted that "community support and having neighbours as allies like having safe places like you know a church or a grocery store" (N5), was integral to her feelings of safety. For many women, strong relationships with neighbours brought them comfort knowing they could access help should they need it. One woman noted that this sense of community provided "a lot of stability" (N12) following abusive events. A service provider reiterated this, explaining that neighbours tend to be more likely to express concern and provide support when they suspect IPV as part of natural, day to day encounters with women, "sometimes it's- it's helping with [farming activity], or you …have a supper. Like there's ways of—it's just finding ways to present [concern for a woman's safety] information safely" (SP2).

However, living in a tight-knit community was also seen as a drawback when knowing everyone and being known created barriers to privacy and confidentiality and make it difficult for women to access services. One SP explained that in rural communities, "there's a lot of judgment I think from you know, the public in accessing our services as well as their family and probably their friends" (SP1).

Women described the varied ways that stigma was enacted in their rural communities. Some understood that rural culture, such as hegemonic and patriarchal norms, created a context where abuse is passively accepted as a normal part of life. One woman described her understanding:

> I feel like there was a sense of like culture within like males there, whether it's the way their family structures were or family cultures were but like I feel like that type of behaviour was acceptable where you know it would be witnessed by majority of males around or no one would do anything like you shrugged it off or no one would do anything. (N5)

These experiences of stigma within their communities undermined women's resilience further by hindering their desire to access various services. One woman commented on this saying, "I know there's like shelters that women can go to get away uh but there is a stigma and like a feeling that goes with those shelters" (N10). Concurrently, norms perpetuated abuse-related stigma, undermining resilience as women felt further isolated and embarrassed to access resources. For instance, a value for privacy and not having others intrude in personal affairs meant that witnesses of violence were more inclined to look the other way. One woman described this saying:

> I feel like in a lot of rural communities it's a lot of hush hush you know like, you see someone scrapping at a gas station you just let them do their thing. You don't interject. Its none of your business. You don't interject - you keep to yourself. (N5)

While stigma around violence was described as a common problem for women, some reported observing changes in their communities, resulting in them feeling better supported. One woman described the gains in her community in terms of knowledge surrounding IPV and how it helped her to feel the community was more supportive and services were more accessible, "We have good neighbours, and we

have community organizations that are fairly accessible to us. Now in the circumstance of COVID-19 maybe a little less but we're well surrounded" (N12).

Resources: Barrier and Innovations

Scarcity of resources in rural communities undermined resilience of women leaving abusive relationships in tangible ways, such as lack of space for them in a shelter or the inability for women to physically access needed services. One service provider explained this reality:

> I think it takes a lot of strength and coordination and effort for women to access the shelter period. So, you know, when they get the courage to access the shelter, and they make that call, and then they're being denied space because there isn't there isn't room for them. I think that can really undermine their resilience. (SP1)

Beyond the lack of available service, accessibility issues also undermined resilience for some women. One woman described how her lack of access to transportation as contributing to a "total isolation from the world" (N10), a particular challenge for women trying to cultivate resilience. One service provider explained, "if they don't have transportation… they rely on their partner to get them to places. And their partners aren't typically going to drive them to counselling sessions. So, I think they probably just feel defeated" (SP1). However, although service providers often tried to work around access barriers, the migration of many services to online platforms in response to the COVID-19 pandemic was a silver lining for some. Offering services online allowed women who would not have otherwise accessed services because of existing systemic barriers with a critical opportunity to access support. One woman was unaware of the many support services available to her in the rural context, explaining "I just didn't know that there were a lot of resources out there" (N9).

Discussion

This cross-sectional interpretive description qualitative study explored rural women's ability to cultivate resilience in the context of IPV. Both women and service providers articulated that women's ability to cultivate resilience was dependent upon 1) transitioning to a positive mindset and bolstering their inner strength through living from a place of integrity, 2) being resolute in their decisions, and 3) using mental resistance when faced with doubt and/or discouragement. Barriers to resilience that were identified included unhelpful help, or rather, help that does not account for the holistic impact of abuse on a women's life as well as the public health guidelines associated with the COVID-19 pandemic. Specifically, the need for physical distancing reduced the capacity of services to support women, and the isolation requirements in communal living organizations slowed women's ability to engage with support services. Living in a rural community was viewed as both a source of cultivating resilience as well as undermining resilience. The isolation associated with rural living afforded women the physical space to deal with the trauma of abuse on their own terms while also offering further opportunities for abusers to control women. The closeness of rural communities meant that neighbours could watch out for warning signs of abuse and find ways to support women but also inhibited women's ability to access shelter services anonymously. Moreover, stigma associated with hegemonic norms and lack of resources including shelter beds and transportation were barriers to women leaving and access resources, respectively. Overall, findings from this study underscore the complexity of resilience being influenced in unexpected ways by the reality of living in rural communities.

In a theoretical analysis of inner strength, Lundman et al. (2010) reported an overlap between the constructs of resilience and inner strength. Through harnessing one's inner strength, individuals stood firm and creatively adapted, enabling them to redirect their life purpose and endure adversity. While this analysis was theoretical, our study extends this understanding as it demonstrated that rural women who had experienced abuse cultivated inner strength with the support of environmental factors to build resilience. This provided a nuanced understanding of how rural women experiencing IPV are becoming resilient in the face of abuse. Rural shelter service providers further illuminated that by providing ongoing social support to women, they can support their cultivation of resilience. This is in line with a previous study by Jose and Novaco (2016), who found that social support and resilience attenuated the effects of psychological distress among women experiencing IPV; however, our study further described this phenomenon in terms of the connection of social support to building resilience among women. For many women in the current study, adapting a positive mindset meant shifting away from seeing themselves as victims and finding a sense of hope. This finding aligned with research conducted by D'Amore et al. (2021), who reported that women who experienced IPV had a new perspective on life and experienced hope for the future. Similar to women in the current study, participants "drew hope and strength from their children and their pursuit to provide them with better lives" (D'Amore et al., 2021, p. 14).

Barriers to help seeking for those experiencing IPV have been well established in the literature (Calton et al., 2016; Overstreet & Quinn, 2013; Robinson et al., 2021). A systematic review by Robinson et al. (2021) reported the six most common barriers, one of which was system failures. The notion of unhelpful help found in this study aligned with

the idea of system failures; however, the connection of this barrier to service and its impact on undermining resilience was unique to the study. A previous study of service providers identified minimizing experiences of abuse as a primary barrier to engagement with services (Overstreet & Quinn, 2013). While this is a form of unhelpful help, our study provided new insights into how women are grappling with various forms of unhelpful help while also highlighting the need to address existing system failures such as minimizing experiences of abuse or negating the totality of the effects violence on women's lives.

The impact of COVID-19 on experiences of IPV have been well-established as a syndemic (Khanlou et al., 2020; Mendenhall, 2017). Studies have emerged citing the increased incidence and severity of violence (Peterman et al., 2020; Roesch et al, 2020) and the negative impact on coping among women experiencing IPV (Mantler et al., 2022a) during the COVID-19 pandemic. Unique to this study was the linking of specific aspects of public health guidance such as quarantine requirements and physical distancing on the ability to access service, and in turn, the impact on resilience. Specifically, our study revealed that these public health guidelines undermined resilience impeding access to vital support services by decreasing the capacity of social services. The unintended consequence of this COVID-19 public health guidelines was that women were unable to access vital services during the pandemic, which underscores the need of the government to consider how enacting a policy to address one pandemic inadvertently made another pandemic worse. While COVID-19 restrictions hampered women's ability to cultivate resilience, for some women the slowed-down pace of life during a pandemic meant they were afforded the time to engage with support services and start doing the 'work' to shift from surviving to thriving.

The rural sociocultural context has been linked with heightening women's vulnerability to IPV due to a lack of resources, increased geographic isolation, stigma associated with violence, acceptance of violence within the 'good ol' boy' network, and traditional gender stereotypes (Bosch & Schumm, 2004; Eastman & Bunch, 2007; Edwards, 2015; Lanier & Maume, 2009; Peek-Asa et al., 2011; Websdale, 1998). While these sociocultural contextual factors have been previously linked to both increased experiences of violence and limited community response to violence, this is the first study examining how the rural context can both support and undermine resilience. There is a tendency in previous literature to examine constructs using a dichotomy, specifically that rurality as a sociocultural contextual factor either increases or decreases the risk of IPV; however, there is a need to examine the duality of the role rurality in the context of IPV.

Limitations & Future Research

The methodology of this study afforded a cross-sectional look at experiences of resilience among rural Canadian women who experienced IPV; however, the results should be considered within the context of the paper's limitations. Firstly, the demographics of women and service providers in this study do not reflect the diverse community of women that access shelters in Canada as we are missing the experiences of racialized women, women whose first language is not English, and older women. More research is needed on the topic of resilience among rural Canadian women who have experienced IPV, particularly research that examines the role resilience plays in women's decisions to leave abusive relationships. Future studies should also further explore the tools women use to cultivate inner strength and a positive mindset, as well as how best to leverage beneficial resources and overcome limiting sociocultural contextual factors to better support women who have experienced IPV.

Conclusion

Women used inner strength and transitioning into a positive mind which were cultivated through environmental factors such as counselling, access to women's shelters, and informal support networks to promote resilience in the context of continued adversity. From the perspectives of women and service providers, rural sociocultural contexts such as geographic isolation, living in a tight-knit, and resource availability within communities were all seen as both facilitators and barriers to bolstering resilience depending on how they were enacted. Stigma in rural communities further undermined women's resilience pointing to the need to find ways to overcome existing system failures in health and support services, services designed to support rural women who have experienced IPV. Ultimately, finding ways to support rural women in cultivating resilience through modifying environmental factors to enable the personal factors to flourish is paramount in the context of IPV.

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Declarations

Conflict of Interest The authors have no conflicts of interest to declare.

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