SN Soc Sci (2022) 2:92
https://doi.org/10.1007/s43545-022-00343-6

ORIGINAL PAPER

Riding on resilience: impacts of the COVID-19 pandemic on women experiencing intimate partner violence

Katie J. Shillington[1] · Kimberley T. Jackson[2] · Cara A. Davidson[1] · Julia Yates[1] · Jennifer D. Irwin[1,3] · Brenna Kaschor[4,5,6] · Tara Mantler[1,3]

Received: 25 June 2021 / Accepted: 28 March 2022 / Published online: 21 June 2022

Abstract

The COVID-19 pandemic and resultant public health measures, although helpful in reducing the spread of the disease, have disproportionately impacted women experiencing intimate partner violence (IPV). Despite these adverse circumstances, women continue to show resilience. Although difficult to define, resilience can be conceptualized as a dynamic process in which psychosocial and environmental factors interact to enable an individual to survive, grow, and thrive despite exposure to adversity. This research identifies facilitators and gaps in supports to promoting resilience among urban and rural women experiencing intimate partner violence (IPV) during the COVID-19 pandemic, via an online survey ($n=95$) and interviews ($n=19$). T-tests, Wilcoxon rank sum tests, and interpretive description were utilized for analyses. Almost 41% of participants experienced an increase in abuse during COVID-19, and resilience significantly decreased during COVID-19 ($t(44)=2.91$, $p=0.006$). Qualitatively, four parent themes (coercive control, social services, resilience, and future) and seven sub-themes emerged. Changes are needed in accessibility and delivery of support services for women experiencing IPV during COVID-19, and future pandemics.

✉ Tara Mantler
tara.mantler@uwo.ca

1 Health and Rehabilitation Sciences Program, Faculty of Health Sciences, The University of Western Ontario, London, ON, Canada

2 Arthur Labatt Family School of Nursing, Faculty of Health Sciences, The University of Western Ontario, London, ON, Canada

3 School of Health Studies, Faculty of Health Sciences, The University of Western Ontario, HSB Room 332, 1151 Richmond Street, London, ON N6A 5B9, Canada

4 Department of Family Medicine, Schulich School of Medicine and Dentistry, The University of Western Ontario, London, ON, Canada

5 Citywide Department of Family Medicine, London Health Sciences Center, London, ON, Canada

6 PRISMA Health Care Collaborative/G.R.O.W., London, ON, Canada

Keywords COVID-19 · Women · Intimate partner violence · Resilience · Rural

Introduction

Since the first case of COVID-19 was reported in Wuhan City, China in December 2019, the COVID-19 pandemic has swept the world (World Health Organization, 2020a). Characterized as a respiratory virus, COVID-19 has tragically claimed the lives of over 20,000 Canadians as of February 2021 (Government of Canada 2021). Public health measures have been implemented in Canada to slow the spread of the virus, including physical distancing, practicing good hygiene (e.g. hand washing), cleaning and disinfecting surfaces, staying home as much as possible, wearing masks in public areas, and reducing non-essential travel (Government of Canada 2020a). While studying the future of the COVID-19 virus, Kissler et al. (2020) found that physical distancing is likely to continue into 2022, while a complete resurgence in the virus has been predicted to occur before 2024. In Ontario, the provincial government has issued a number of restrictions[1] to reduce the spread of COVID-19 (Government of Canada 2020a). While such public health restrictions aim to slow and reduce the spread of the COVID-19 virus, they confine individuals primarily to being with their immediate family members and home environments. This can have serious implications for women whose homes are not safe, such as those experiencing intimate partner violence (IPV; Evans et al. 2020).

IPV can be understood as a pattern of physical, sexual, and/or emotional abuse by an intimate partner in the context of coercive control (Tjaden and Thoennes 2000). Worldwide, nearly one in three women will experience IPV during their lifetime (World Health Organization 2021). IPV is gendered in nature, as prior to the COVID-19 pandemic 79% of cases of IPV in Canada were reported by women, and rates of reported IPV were four times higher for Canadian women than men (Government of Canada 2020b). While abuse is often characterized as physical, sexual, and/or emotional, perpetrators might also use women's finances as a method of coercive control (i.e. economic abuse; Stylianou et al. 2013). Economic abuse can take many forms including preventing women from working, harassing women at work, monitoring women's expenses, and not accounting for women in financial decisions (Postmus et al. 2012). Such abuse is often compounded by other forms of IPV; for example, in a study conducted by Stylianou et al. (2013), women who experienced physical and/or psychological abuse were more likely to experience economic abuse on top of their existing forms of violence. Further, IPV is known as the great equalizer, in that it can impact women of different race, income, and/or education (Cho 2012; Hyman et al. 2009). One contextualizing factor that shapes differences in

[1] These restrictions have included stay-at-home orders, physical distancing, limitations on gathering, and rigorous hygiene practices (Government of Canada 2020a). The restriction most impacting women who experienced IPV being stay-at-homes orders (Dangerfield 2021), wherein individuals are only permitted to leave their households if it is essential (Government of Ontario 2021). As such, 'stay-at-home orders' will be language used throughout the paper.

experiences of violence is rurality[2] (Mantler et al. 2020). Women living in rural settings experience IPV differently and at higher rates compared to their urban counterparts (Government of Canada 2020b; Mantler et al. 2020). These higher rates of IPV are due, in part, to the unique circumstances of rural living that can be more conducive to a partner using coercive control (e.g. isolation, lack of privacy, lack of social resources, surveillance and regulation of daily behaviours, etc.; Mantler et al. 2020; Stark 2007). However, this is not to say that IPV is uncommon in urban areas. Because the global pandemic has resulted in multiple stressors, urban women are also at exacerbated risk of IPV as perpetrators of abuse are known to respond to environmental stressors with violent acts (Capaldi et al. 2012; Ferguson and Dyck 2012). In fact, financial stress is frequently cited as one of the most common antecedents to IPV (Byun 2012; Slep et al. 2010); knowing that unemployment rates have increased across Canada and interrupted access to employment (Statistics Canada 2020), it is also likely that women in both rural and urban areas are at greater risk of experiencing abuse.

In the context of COVID-19, the stress being placed on individuals and families is exorbitant (Miller and Blumstein 2020). The collective enduring state of emergency, not surprisingly, has led to increased rates of IPV, a phenomenon noted world-wide (Weeks et al. 2020; World Health Organization 2020b). Stay-at-home orders have forced women who experience IPV to isolate with their abusive partners, exacerbating their risk of violence and jeopardizing their health (Kofman and Garfin 2020). Several Canadian cities have reported an increase in domestic violence service calls, with reports from specialized crisis lines citing over a 300% increase in calls (Daya and Azpiri 2020). The stay-at-home orders have unintentionally created conditions conducive to IPV, including increased financial strain, isolation from social supports, and reduced access to social services (Moffitt et al. 2020). Furthermore, increased time spent at home results in a lack of privacy for women who are experiencing IPV, enabling constant and intensely scrutinized surveillance which may prevent women from accessing support services and from using previously helpful coping mechanisms (Kofman and Garfin 2020).

One solution put forth by the Canadian government during the COVID-19 pandemic is a *build back better* approach, which underscores how Canadians are to emerge from this pandemic stronger and more resilient (Trudeau 2020). However, resilience is complex and how society uses this construct reveals core beliefs about power and social responsibility (Orsini 2020). By enacting a *build back better* approach the government is imploring resilience without addressing the collective trauma associated with the COVID-19 pandemic or the structures and systems responsible for ongoing adversity (Orsini 2020). This approach to resilience creates

[2] It is important to note that defining "rural" has been recognized as a challenge within the literature, as cultural, economic, and social characteristics vary greatly among rural locations (Donnermeyer 2018). This said, the universal method of defining rural places is by population size and density (Donnermeyer 2018). For the purpose of this study, rural settings were understood as communities of less than 30,000 individuals with a travel time of more than 30 min to the nearest urban centre (Ministry of Health and Long-Term Care 2011). The authors recognize that defining rurality by population size negates the diverse nature and differences that exist among rural locations.

a dichotomy of those who are *not* resilient and therefore, need to toughen up and become resilient, and those who *are* resilient who need to do nothing but continue in their space of privilege (Orsini 2020). While individual resilience is important in the face of a pandemic, both of these outcomes shift social responsibility to the individual negating what is needed to build and bolster resilience in the context of COVID-19.

Resilience is a challenging concept to define and conceptualize, as it can be understood as a trait, as a process, and as an outcome (Crann and Barata 2016). Such conceptualizations matter in theory, although Crann and Barata (2016) argued there are no meaningful differences in practice (Crann and Barata 2016). For the purpose of this study, resilience will be understood as a dynamic process in which psychosocial and environmental factors interact to enable an individual to survive, grow, and thrive despite exposure to adversity (Howell et al. 2018; Munoz et al. 2017; Prime et al. 2020). There is variation in the literature regarding how resilience among women who have experienced IPV has been described (Crann and Barata 2016). Researchers have largely focused on the protective factors (e.g. social support, self-esteem, positive attitudes) that shape women's resilience which, while important, negate the social and cultural context where resilience is embedded (Ungar 2003). It is challenging to identify the specific protective factors that influence resilience, as what might be viewed as protective for one woman may not be relevant in a different social or cultural context (Masten 1994; Ungar 2003). Specifically, the notion of resilience in the Canadian context is grounded empowerment within a neoliberal political framework wherein responsibility for cultivating resilience is positioned at the individual level all while ignoring structural constraints which hamper people's ability to survive, grow and thrive (Joseph 2013). Conceptualizations of resilience often assume that women develop resilience as a result of abuse (i.e. as an outcome) and do not take into account the dynamic nature of IPV and its interplay with resilience (Crann and Barata 2016).

Researchers have suggested that one's response to stress is a consequence of combination of individual differences (Walsh et al. 1994) and contextual and environmental factors (Crann and Barata 2016). To study resilience in its totality, there is a need for qualitative work that seeks to identify the multiplicity of factors that enable and/or impede the resilience of women who have experienced IPV (Luthar et al. 2000; Rutter 2006). Few researchers have conducted qualitative studies to investigate resilience in the context of women who have experienced violence (Crann and Barata 2016); among those that have (e.g. Anderson et al. 2012; Young 2007), women were only included if they had not experienced IPV for at least one year (Crann and Barata 2016). This eligibility criterion limits the conceptualization of resilience, and thus our understanding of it in the context of IPV (Crann and Barata 2016). Thus, there is a need for qualitative work that addresses the lived experiences of women who are currently experiencing abuse.

While resilience is a difficult concept to understand and conceptualize, researchers have found women who have experienced IPV and left the relationship are resilient as a result of their experiences (Crann and Barata 2016). Previous researchers have failed to account for the various individual, environmental, and contextual factors that can shape women's resilience, such as the current COVID-19 context.

To this end, the purpose of this paper was three-fold: (1) to identify strategies relied upon by women who experienced IPV during COVID-19 to maintain and/or increase their resilience; (2) to identify any gaps in access to resilience-building strategies during the COVID-19 stay-at-home orders; and (3) to identify the impacts of the COVID-19 stay-at-home orders on the resilience of women who experience IPV in urban environments compared to rural.

Methods

As a part of a larger mixed-methods study entitled "**E**xploring the I**m**pacts of COVID-19 **P**hysical Distancing **o**n **W**omen **E**xperiencing Intimate Partne**r** Violence at Home (EMPOWER)", the current paper serves as a sub-analysis that focused on the role of resilience in women's lives. By applying a convergent parallel design (Creswall and Clark 2011), this mixed-methods study allowed for complementarity of results as the qualitative data elaborated on, enhanced, illustrated, and clarified quantitative results (Greene 2007). The project is grounded in a feminist framework of intersectionality (Crenshaw 1991) to explore the lived experiences of women (Cho et al. 2013). This framework emphasizes the identification of social dynamics and their interplay to contextualize the unique experiences of women across social strata (Ard and Makadon 2011; Coker et al. 2005). This consideration is critical to gaining a comprehensive perspective of IPV due to its disproportionate impacts on women (Kimmel 2002; Zorn et al. 2017). The study received ethics approval from the host institution's Non-Medical Research Ethics Board (NMREB #116,226).

Study procedures

Participants were recruited as part of the broader EMPOWER study through advertisements on Kijiji (an online community building and marketplace platform) and Facebook (social media platform) posts across Ontario, Canada. Recruitment took place from August to December 2020. To recruit women from urban areas, 72 Ontario, Canada, cities/towns were targeted via Kijiji and 188 advertisements were posted across various categories (e.g. Buy and Sell, Community, Services). To recruit women from rural areas, the research team posted in 14 Facebook groups, with one post per group (e.g. End Rural Silence, Living Off Grid in Ontario). Further, 127 rural cities/towns were targeted via Kijiji and 231 advertisements were posted across various categories (e.g. Free Stuff, Missed Connections, Hobbies and Crafts). Kijiji categories posted in were the same between urban and rural locations and only appear to differ for the purpose of providing multiple examples. The disproportionate number of postings in rural areas was to ensure that there was sufficient traffic on the advertisements to achieve the desired recruitment. Interested women were invited to email the research team's secure inbox to receive more information and instructions for participation. In total, 111 women contacted the research team via email expressing interest in participating in the study and provided a phone number to receive the survey password. Potential participants were asked to confirm

their location and were provided with the letter of information. Eligible women must have experienced any form of IPV while living with an abuser during COVID-19 and have access to a safe computer and phone. Presence of IPV was screened using the validated, 4-item Abuse Assessment Screen that prompted yes/no responses to experiences of emotional, physical, and sexual abuse (Soeken et al. 1998). Women determined the safety of devices by answering a yes/no question, a procedure recommended by Eden et al. (2014) and Glass et al. (2015). Two-factor authentication was adopted to combat cyber hacking by Internet robots ("bots"); both email and texting were used to ensure our participants were potential participants and not bots. Of the 111 women who expressed interest, 86 urban women and 9 rural women completed the survey. A $10 e-gift-card was emailed to women who provided their email address at the conclusion of the survey in recognition of their time and contributions to the study. Upon survey completion, all women were provided with the Women's Helpline number and encouraged to phone if they wished to access supportive resources. Women were also given the opportunity to enter their email if they wished to be contacted for a Zoom- or telephone-based interview in the secondary portion of the study. Consequently, 10 urban and 9 rural women participated in the subsequent in-depth semi-structured interview and were provided with a $15 e-gift-card as a token of gratitude immediately following their interview. While all participants identified as living in Canada, only women who were interviewed were asked for their specific location; 18 women were from Ontario and 1 woman was from Quebec.

Data collection

Quantitative

Demographics In keeping with the project's grounding framework in structural intersectionality, several key social identities were measured to gain an understanding of the sample. Demographic data included gender, age, level of education, indigeneity, sexual orientation, employment status and income pre- and during-COVID-19, essential worker status, geographic location, living situation, physical distancing adherence, and number of children.

Abuse The short-form 15-item Composite Abuse Scale Short Form (CASR-SF; Ford-Gilboe et al. 2016) was used to explore histories of intimate partner violence. CASR-SF scores were computed for all women who responded to at least 70% of items (Ford-Gilboe et al. 2016). If scores were missing, imputation was performed by taking the mean of completed items and multiplying it by fifteen to form the total score. Total scores range from 0 to 75 for overall CAS-SF scores, with ranges of 2–10, 5–25, and 8–40 for sexual, physical, and psychological abuse, respectively. High CAS-SF scores are indicative of greater, or more intense experiences of abuse.

Resilience To assess resilience, the validated, 10-item Connor-Davidson Resilience Scale (CD-RISC 10) was used (Connor and Davidson 2003). Participants were asked

to report on their experiences both before COVID-19, and currently (i.e. during the COVID-19 pandemic). To the author's knowledge, there are no scales validated for retrospectively measuring resilience in any population. As such, the only possible way to glean information about pre-pandemic levels of resilience, an integral element of this study, was to retrospectively administer the CD-RISC 10 scale. Items are presented on a 5-point Likert scale ranging from 'not at all true' (0) to 'true nearly all of the time' (4; Connor and Davidson 2003). The CD-RISC 10 ranges from 10 to 50 points, where higher scores indicate more resiliency. The CD-RISC 10 has demonstrated good reliability ($a=0.85$; Campbell-Sills and Stein 2007). Women who completed at least seven items of the CD-RISC 10 were included for analysis. Imputation was performed for missing values by taking the mean of completed answers and using that value as the score for the remaining items in accordance with the protocol outlined by Connor and Davidson (2003).

Open-ended questions

To uphold equity and empowerment, we wanted to make sure that women completing the questionnaire scales also had the opportunity to speak freely and in their own words (consistent with Kaufman and English's (1979) needs assessment framework). Therefore, in addition to the CD-RISC 10, two open-ended questions were included at the conclusion of the survey to further supplement our understanding of participants' experiences of resilience. First, 'to help you survive, what supports would you need most during future waves of COVID-19, other pandemics, and/or other times of isolation?' And second, 'to help you build resilience/bounce back from difficulties, what supports would you need most during future waves of COVID-19, other pandemics, and/or other times of isolation?'. These questions were optional to complete and were provided to allow for comments important to participants' experiences that might not have been included fully in the scales.

Qualitative

Interviews were conducted by three graduate research assistants trained in qualitative interviewing with women who have experienced IPV. All interviews took place via Zoom or telephone, depending on the participant's preference, and ranged from 20 to 75 min in length. Prior to the start of the interview, a safety plan was established between the interviewer and the participant, in the case of an emergency (e.g. being interrupted by the abuser). To diminish social desirability bias (Bates 1992), at the beginning of each interview, and if appropriate during the interview, participants were told the following: "I want you to know that there are no right or wrong answers, we are simply interested in what is true for you."

Data analysis

Quantitative

All analyses were run using RStudio (version 1.2.5042). Measures of central tendency and dispersion were computed for all demographic items and relationship and abuse variables.

Scales The CASR-SF and CD-RISC 10 scales were tabulated in full, inclusive of applicable subscales. Categorization and counts were also completed for both scales and their respective items. Assumption checking was conducted for all analyses prior to their conduction. A paired-t-test was used to determine whether CD-RISC 10 scores were significantly different from the pre-COVID-19 to during-COVID-19 timepoints. To explore how experiencing an increase in abuse during COVID-19 (as determined by CASR-SF scores) was related to CD-RISC 10 total scores, another t-test was administered. In addition, Wilcoxon rank sum tests were used to determine if binary evaluations of rurality and motherhood had significant impacts on CD-RISC 10 scores during the pandemic.

Open-ended questions

Responses to open-ended questions were analysed using quantitative content analysis (Morgan 1993). Quantitative content analysis initially involved members of the research team (i.e. two graduate research assistants) independently and simultaneously reading through participants' responses and assigning codes to each. The researchers then met to agree upon final codes and counts and tabulations were computed to summarize findings (Morgan 1993). Identified codes were then incorporated into the semi-structured interview guide for validation and contextualization within interviews with participants.

Qualitative

Interviews were audio-recorded and transcribed verbatim as they were completed. Inductive data analysis was completed concurrently to promote responsivity between data collection and analysis using interpretive description methodology (Thorne et al. 1997). Interpretive description "is a grounded approach to articulating patterns and themes emerging in relation to various clinical phenomena" (Thorne et al. 2004, p. 8). To ensure data trustworthiness during the interviews, we employed several strategies by Guba and Lincoln (1989). These strategies included: credibility (i.e. member checking after responses to each question asked); confirmability (i.e. multiple coders performed analysis independently and then met to compare findings); dependability (i.e. debriefing and summarizing findings after each interview; reflexive memoing through the analysis procedure to identify biases; Birks et al. 2008); and providing details to help with potential transferability (i.e. outlining the research process detail). Data analysis initially involved each member of the coding team (the principal investigator, three graduate students, and one undergraduate research

assistant) immersing themselves in two interviews of data and forming, independently, a rudimentary coding structure. Next, dyads who coded the same interviews met to discuss the emerging coding structure and refine the structure through discussion. The entire coding team then met again to discuss the emerging coding structure and create codes and labels. Finally, each dyad analysed, independently, an additional two interviews using the coding structure and noting any changes needed. The coding team then met and agreed upon the coding structure which would be used for the remaining interviews. The use of multiple coders was in an effort to ensure confirmability and dependability (Guba and Lincoln 1989). In the coding structure categories were identified (Quirkos 2020), then linkages across categories were made; subsequently, relationships/patterns were explored across data sources (Thorne et al. 1997). Specifically, the team focused on synthesizing the data into codes, and through the use of memos and team discussion, theorizing the relationships between codes and finally contextualizing the findings within the broader literature.

Results

Participants

The survey was completed by 95 women in total. The median age of the sample was 27 years ($\sigma = 6.1$). All participants identified as female, with two (2.1%) identifying as a trans-woman, and one (1.1%) as genderfluid. Although the dominant reported sexuality was heterosexual (80.0%, $n = 76$), the sample exhibited variation in sexual orientation, including bisexual (13.7%, $n = 13$), queer (2.1%, $n = 2$), gay (1.1%, $n = 1$), and pansexual (1.1%, $n = 1$) women. In total, 81.1% ($n = 77$) of women lived an urban setting and only 12.6% ($n = 12$) lived in a rural area. Overall, the sample exhibited a high socio-economic status, with 82.1% ($n = 78$) indicating at least some post-secondary education, and 61.1% ($n = 58$) having a reported household annual income of $50,000 or greater (pre-COVID-19). The sample exhibited a wide distribution of ethnicities, with 37.9% ($n = 36$) identifying as non-Indigenous North American (i.e. American or Canadian, but not Indigenous to the land), 26.3% ($n = 25$) as Asian, and 29.5% ($n = 28$) as mixed/multiple origins. In total, 4.2% ($n = 4$) of women identified as Indigenous to Canada. The majority of women reported being in a relationship, married, common law, or engaged (83.2%, $n = 79$) where they lived with their partner (70.5%, $n = 67$) and did not have children (85.3%, $n = 81$). Full demographic results are reported in Table 1. In total, 87.4% ($n = 83$) reported adhering to physical distancing measures during the COVID-19 pandemic, including staying over two metres away from people with whom they did not live (86.3%, $n = 82$) and wearing a mask outside the home when physical distancing was not possible (70.5%, $n = 67$).[3]

[3] Please note that asking about mask use was prior to the development of mandatory mask mandates in Ontario jurisdictions.

Table 1 Summary of demographic variables

Demographic variable	Total **n = 95** n (%)
Gender	
Female	92 (96.8)
Trans-woman	2 (2.1)
Genderfluid	1 (1.1)
Sexual orientation	
Heterosexual	76 (80.0)
Bisexual	13 (13.7)
Queer	2 (2.1)
Gay	1 (1.1)
Pansexual	1 (1.1)
I prefer not to answer	1 (1.1)
Did not answer	1 (1.1)
Community	
Urban	77 (81.1)
Rural	12 (12.6)
Unsure	6 (6.3)
Education level	
Less than high school	4 (4.2)
High school	13 (13.7)
Some college/university	15 (15.8)
College or university degree	56 (58.9)
Advanced degree (i.e. a master's or Doctoral degree)	7 (7.4)
Income	
Less than $19,999	3 (3.2)
$20,000-$49,999	28 (29.5)
$50,000-$99,999	45 (47.4)
Greater than $100,000	13 (13.7)
I prefer not to answer	6 (6.3)
Ethnicity	
North American Aboriginal origins	1 (1.1)
Other North American origins	36 (37.9)
European origins	3 (3.2)
Asian origins	25 (26.3)
Mixed/multiple	28 (29.5)
Did not answer	2 (2.1)
Indigenous	
Yes	4 (4.2)
No	91 (95.8)
Marital status	
Single	12 (12.6)

Table 1 (continued)

Demographic variable	Total **n = 95** n (%)
In a relationship, but not married/common law/engaged	55 (57.9)
Married, common law, or engaged	24 (25.3)
Divorced or separated	3 (3.2)
Prefer not to answer	1 (1.1)
Living situation	
Live alone	5 (5.3)
Live with my child(ren)	3 (3.2)
Live with my partner	67 (70.5)
Live with my partner and child(ren)	7 (7.4)
Live with my parents/family	4 (4.2)
Live with a friends/roommate	2 (2.1)
Live sometimes with parents/family and sometimes with partner	3 (3.2)
Live in a shelter or homeless	2 (2.1)
Prefer not to answer	2 (2.1)
Children	
Yes	13 (13.7)
No	81 (85.3)
Prefer not to answer	1 (1.1)
Physical distancing	
Yes	83 (87.4)
No	3 (3.2)
Sometimes	6 (6.3)
I prefer not to answer	2 (2.1)
Did not answer	1 (1.1)
Essential worker	
Yes	10 (10.5)
No	82 (86.3)
Unsure	1 (1.1)
Prefer not to answer	1 (1.1)
Did not answer	1 (1.1)

Only 10.5% ($n = 10$) of women identified as an essential worker during the COVID-19 pandemic.

Quantitative findings

Across the entire sample, 50.5% ($n = 48$) of women had ever been afraid of an intimate partner, with 28.4% ($n = 27$) of women reporting two or more abusive relationships in their lifetime. Of women in relationships ($n = 80$), 55.7%

Table 2 Summary of abuse variables

Abuse variable	Total n = 95 n (%)
Ever afraid of a partner	
Yes	48 (50.5)
No	42 (44.2)
Prefer not to answer	4 (4.2)
Did not answer	1 (1.1)
Number of abusive relationships	
1	61 (64.2)
2	19 (20.0)
3	5 (5.3)
4	3 (3.2)
Prefer not to answer	6 (6.3)
Did not answer	1 (1.1)

($n = 44$) indicated that they were currently afraid of their partner. To examine whether women who experienced an increase in abuse during the pandemic (as determined by the CASR-SF) had significantly different resilience during the pandemic as compared to pre-pandemic levels (as determined by the CD-RISC 10), a paired t-test was conducted ($t(16.28) = -23.27$, $p = 0.006$). The corresponding effect size was medium-large ($d = 0.72$; Cohen 2013). A summary of abuse variables is reported in Table 2.

CASR-SF scale

In total, 40 women completed the pre-COVID-19 CASR-SF and 22 women completed the during-COVID-19 CASR-SF. Of the women who completed both the pre-COVID-19 and during-COVID-19 CASR-SF ($n = 22$), 40.9% ($n = 9$) experienced an increase in abuse, 40.9% ($n = 9$) experienced a decrease in abuse, and 18.2% ($n = 4$) experienced the same level of abuse. The pre-COVID-19 overall CASR-SF mean score was 39.64 (range 47.60, $s = 13.47$) as compared to its during-COVID-19 equivalent of 39.28 (range 57.00, $s = 16.43$). The CASR-SF sexual, physical, and psychological subscales for the pre-COVID-19 timepoint were 6.10 (range 9.00, $s = 3.37$), 10.19 (range 12.00, $s = 4.04$), and 22.05 (range 22.00, $s = 6.52$), respectively; the during-COVID-19 equivalent scores were 5.85 (range 10, $s = 3.3$), 11.44 (range 17, $s = 5.82$), and 20.22 (range 30, $s = 7.72$)-indicating similar experiences of physical and psychological abuse during COVID-19. A series of t-tests were conducted to determine whether any significant differences existed between the pre-COVID-19 and during-COVID-19 measurements for general CASR-SF scores and all subscales, however, none emerged as significant.

CD-RISC scale

The mean score of the pre-COVID-19 CD-RISC 10 was 31.29 (range 28.00, $s = 7.08$); however, when re-administered in relation to during-COVID-19 resilience, the mean score dropped slightly to 29.00 (range 30.00, $s = 7.97$). A cut-off score of 32 or higher was adopted to determine high resilience scores in accordance with Buttell et al. (2021), who administered the CD-RISC 10 within a sample of women who experienced IPV during the COVID-19 pandemic. In total, 45 women completed both timepoints (pre-COVID-19 and during COVID-19); with 24 women reporting high levels of resilience and 21 women reporting low levels of resilience pre-COVID-19. In the context of resilience during COVID-19, only 17 women reported high levels of resilience, and 28 women reported low levels of resilience, indicating a decrease in overall resilience. When asked about what would be most needed during future waves of COVID-19, 39.6% ($n = 21$) of women replied that social support was crucial, while 28.3% ($n = 15$) of women stressed the importance of employment and financial support. Notably, 7.5% ($n = 4$) of women felt that nothing could help them to survive future waves of COVID-19 or additional pandemics/isolation. When women were asked what they would need to build resilience/bounce back from difficulties in the future, the most needed items were social support (48.1%, $n = 25$) and therapy or counselling (30.8%, $n = 16$).

A two-way paired t-test was conducted to determine whether resilience (as measured by CD-RISC 10 scores) changed significantly from before COVID-19 to living through COVID-19 at present; the result was significant ($t(44) = 2.91$, $p = 0.006$) with a small-medium effect size of $d = 0.25$ (Cohen 2013). Two Wilcoxon rank sum tests were conducted to evaluate the relationship between (1) motherhood and during-COVID-19 resilience; and (2) rurality and during-COVID-19 resilience. This non-parametric test was selected due to significant violations of normality in the motherhood and rurality variables as determined by the Shapiro–Wilk test. The motherhood test emerged as significant ($W = 0$, $p < 0.001$) with a small effect size of $r = -0.11$ (Cohen 2013). The rurality test also emerged as significant ($W = 0$, $p < 0.001$) with a medium effect size of $r = -0.41$ (Cohen 2013).[4]

Qualitative findings

Participants described how the COVID-19 pandemic impacted the abuse they experienced. For many, their experiences of abuse far surpassed their experiences of the pandemic. One individual emphasized this by stating, "The things that were going on [with my partner], like, the pandemic didn't really seem like anything compared to it" (W3).[5] Many underscored their partner's coercive control leading to increased abuse and lack of financial autonomy. Although many women turned to

[4] The negative direction of both effect sizes suggests that having children and living in a rural environment during COVID-19 impeded overall resilience.

[5] The identification code 'W#' was used to represent different participants. That is, the letter 'W' stands for 'woman' and the associated number is their ID.

social services while experiencing the violence, some found that living in a rural area prevented them from accessing services, while others faced structural barriers to access; few women were able to access the services they needed. Many women underscored their resilience in the form of safety-oriented behaviour and described what they would need to be resilient in future pandemics.

Coercive control

Increased abuse Many women described increased physical and psychological abuse in the context of coercive control as a result of the COVID-19 pandemic. In the words of one woman, "…suddenly COVID was becoming this thing that he was obsessing about and trying to control me with" (W5). This same woman underscored how the COVID-19 pandemic was a tipping point for their relationship saying:

> …it [IPV] got worse and worse and one night just as COVID hit, I came home and he's [partner] yelling at me that he doesn't like me working, it's not fair… and we had not… had [as] much sex as he would like…(W5)

Women also emphasized how their partners controlled their day-to-day activities. One participant said, "…the more engaged I became in sewing the more he tried to keep me from sewing" (W18). This sentiment was echoed by another woman who illustrated how her partner controlled who they were able to see, saying:

> … ever since we've had more restrictions lifted I, I find I'm questioned a lot more as to where I'm going… I still get comments that I shouldn't be going anywhere, and I shouldn't be seeing anybody… So, it's just different. (W6)

The increases in experiences of abuse, in turn, impacted self-esteem, as evidenced by one participant who stated, "So because I felt really bad about myself and, and I didn't feel like worthy…I just started like, taking less care of myself" (W2). For some women the heightened experiences of abuse helped them to realize just how controlling the relationship had become, as one woman reported, "COVID kind of… ma[d]e [them] realize how controlling he was" (W5). The resulting impact of the increased abuse and lowered self-esteem was that women described feeling confined, helpless, and dependent on their partners, as a result of the pandemic. For example, one woman said:

> There's this feeling that I couldn't go anywhere, that… it wasn't just him that was making me feel confined, it was like the world was on his side… Like this is where I was stuck and… and there are no options and… I don't know because you're, you're… connected only to your own little household. (W6)

Feeling as though there were little to no options was common among women. Another individual said that they "felt like helpless… that there was nothing [they] could do… so, it made [them] feel, like [they] didn't have any options" (W7). This helplessness increased feelings of reliance on abusive partners. With one woman saying her partner "wouldn't let [her] go out" (W6) and other women identifying they were forced to count on their partners for basic needs. One

woman described this, stating "[she] was relying more on [her] partner for just about everything and that increased his stress and then the violence just became more… more repetitive, more consistent" (W8). The culmination of the increased abuse and helplessness made clear to underscore for some women just how unsafe home was with one woman explaining, "The government was saying stay home, stay home, stay home, stay home. And home is the last place I want[ed] to be" (W4).

Lack of Financial Autonomy Many women expressed having no control over their finances and purchases. Some women described this as a challenge pre-pandemic that got much worse when public health measures were implemented as a result of COVID-19. One woman expressed that she "lost a lot of [her] independence" regarding her money and since the pandemic, her money is "pooled together" and she is "questioned more" (W10). The lack of financial autonomy was intertwined with experiences of coercive control and gaslighting, as illustrated by one woman who said:

> … he gets angry at me [saying], "And we agreed you're going to stay home." So… if I spend something – money on something, I can be in trouble for getting the wrong thing or spending too much. But then if I don't get exactly what he wants, which can cost a lot, he's very fussy – then I'll get in trouble for not spending enough, because he wanted the better product. (W10)

Similarly, another woman described her finances being monitored by their partner saying, "…he took over everything and he would tell me exactly how much was coming in, and before that I didn't have very much but he still knew about it…" (W17). This woman went on to explain that her bank cards were taken away and that her partner kept a "close eye on everything" once they received the Canada Emergency Response Benefit (W17). The COVID-19 pandemic was not the only life circumstance that perpetrators used as leverage to control women's finances. One woman said that she "used to pay the bills" until she went on maternity leave and was then forced to instead "give him [her partner] all the money" (W3). Women also expressed lack of financial autonomy even after their abusive relationship ended. This was underscored by one woman who said:

> I feel like he did it – like, he's doing it on purpose, not paying me back, he's doing it on purpose because, like, he gets money every week… so he can pay me, he just isn't because – I don't know if it's, like, a way to keep me around. Like, he told me the other day that he, even though we broke up, he still cares, but like, you know, I don't want him around, you know. I feel like he's just doing it because he wanted to keep one foot in my life… (W1)

Lack of financial independence and autonomy negatively impacted women's lives, putting them in impossible situations. This was summarized by one individual who said, "I didn't have a leg to stand on because, you know, I no longer had my vehicles. I no longer had my bank accounts. I no longer had anything" (W4). Not being able to access and have control over their finances limited the options

that women had, and the COVID-19 pandemic made an already challenging situation that much more difficult to survive.

Social services

Rural context Women who lived in rural locations described unique challenges to accessing services in their areas. This was largely in relation to not having services available, as well as not being able to access services due to geographic barriers. These structural challenges were further perpetuated by the pandemic, as explained by one woman who said:

> We moved to the middle of nowhere. He was the only driver, and we live in – well, I live in a town where you need a car. I guess in a sense, the pandemic kind of helped him be able to isolate me a little easier. (W3)

Other women described isolation even before the pandemic; for example, one woman described a time where she had nowhere to go in the midst of an abusive situation:

> Like, even before COVID. Last winter – I mean this one time he locked me out of the house – and I'm like I have nowhere to go. It was pitch black and it was – I was freezing. And he's in there laughing. And he's like, "I'm not letting you back in." And he thinks it's hilarious and it was freezing outside. And I'm looking around and there's nowhere to go. (W10)

While some women described not having services available to access, even if they wanted to, one participant said, "…we lived in a pretty rural area. And… there's no resources there" (W4), while another described challenges associated with homelessness saying, "Like, there's not a homeless shelter and there's not any kind of, like, emergency housing for people like me…" (W1). Other women described services that were available but often not to them; to access them they had to commute upwards to an hour. One participant said, "I live right on the highway and there are no stores. Even to drive, the closest store for me is about 15 min and that's just like a convenience store" (W10). Women also noted the challenging dynamics of living in a rural location, in addition to service access and use. For example, one individual stated that "even if there was [resources], [we live in] such a small town, such a small base, everybody knows everybody. So that was really hard through the pandemic" (W4). Not only was accessing services in rural locations challenging, but navigating the contextual factors embedded within rural environments amplified the barriers women faced.

Structural barriers Women experienced structural barriers when accessing services. Structural barriers took the forms of long wait times, delays in service access, lack of empathy, unaffordable services, and inappropriate service delivery. Many women expressed challenges regarding long wait times; something that was a barrier prior to the pandemic and exacerbated due to shifting public health priorities. The multifaceted nature of this problem was made evident by women whose only option for

accessing services previously delivered in-person, to do so via online platforms or the telephone while isolated with their abuser. One woman expressed that while she was trying to participate in counselling this presented a problem in terms of ensuring her partner did not know saying, "I don't think I'd want him to know about it [counselling]. So, I'd have to find ways to… have a reason why I'm not responding [to his calls/messages] on a regular basis, for however amount of time" (W11). This woman also emphasized how expensive services, such as counselling, can be – a sentiment that was echoed by other women. As one said, "you hardly get past your intake interview before your funds [are] running [out]" (W4). In addition to the wait times and expenses of counselling services, one individual mentioned facing barriers with the legal system, wishing that services were quicker. Another woman experienced barriers in the form of structural violence stating:

> And it feels like – and I don't want to get upset – but it feels like nobody cares. Then you call [the Assaulted Women's Helpline] and it's just, you know they say they're there for you and you just get a click. And it's like, "Okay... It doesn't matter to you either then." And so, you just kind of give up. (W13)

Women experienced structural barriers that were amplified as a result of the pandemic and their living situations, preventing them from accessing services.

Resilience

Safety-Oriented Behaviour Many women demonstrated resilience through surviving their abusive relationships during the early stages of the pandemic. This survival primarily required safety-oriented behaviours, such as recognizing what triggered their partners' violence, self-awareness, dissociating from themselves and their abuse, and connecting with others. Many women described heightened self-awareness by anticipating their partners' behaviours. This was underscored by one individual who said:

> I'm more careful with things I'm doing or really things I'm saying. I'm just more overall aware of my presence and my activities and my thoughts, I guess, like what I'm – how I'm going to express myself and what I should be expressing. (W11)

This sentiment was echoed by another woman who described "playing along" (W13) as easier than the alternative and striving to do "everything in [their] power to maintain the level of balance that he [partner] has set out for himself" (W12), to avoid conflict. A few women expressed awareness of their inner strength, as noted by one individual who said, "I can be pretty resourceful when I need to be" (W8). Another woman underscored how working in the mental health field allowed her to recognize her words and actions saying:

> I worked in mental health for a long time and I was so good at extending compassion to others. I really had to start doing that to myself, and I have to take a step back sometimes and be like you would not say this to a friend, a child, and [a] stranger. (W5)

The benefit of social support in building resilience was identified by several women with one saying, "Social support is like the key, for me, to help me like be resilient in situations" (W14). This was echoed by another woman who described reaching out to their friends and family for support saying, "I'll sometimes have a video chat or a phone call with my friends and my dad of course" (W11). Many women demonstrated resilience by monitoring their own behaviour and simultaneously being aware of their partner's actions. In the words of one woman, "I had to become a completely different person to get through everything day to day" (W4). Disassociation, as a protective mechanism, was another strategy used by women, with one woman stating, "I just try not to think about it [the abuse] too much. I just try and think about something else and not get upset by it" (W13).

Future

Desire to Access Counselling Access to counselling was the primary service that women wished they had. Some described being able to access these services prior to the pandemic; however, their access had been limited due to public health restrictions. This was highlighted by one individual who said, "I haven't seen my counsellor in like, a pretty long time during the COVID-19 thing. Like we would sometimes email each other, but I couldn't really go into depth with how I was doing" (W14). This was echoed by another woman who said that being able to access counselling services during any potential future pandemics would be beneficial as they had a counsellor prior to the pandemic. Reflecting on the first lockdown, one individual expressed, "It would have been nice to see a counsellor in person" (W7). Access to counselling services was a common desire among women who felt that having an understanding and non-judgemental person to "to talk things through with" (W13) would make a substantial difference in their coping abilities. One woman explained:

> Some kind of third party that I can express my situation to without fear of lash back or anything, just … just to receive that motivation, like, to know that someone knows what's going on and knows that it's not right and can help remind me to remind myself that I need to keep trying. (W12)

With the emergence of COVID-19 came unforeseeable challenges for women, including service access, which was emphasized by this individual who said:

> …for a little while before the pandemic I was seeing one [counsellor]. And the only way I could even possibly see her [during pandemic] would, would have been to be on Skype or to somehow make a call. And I couldn't do that with him there. (W15)

Women highlighted the desire to talk with someone who genuinely cared. As one woman explained:

> …if somebody would talk to you without just sending you somewhere else. It just felt like every time that I would call somewhere, they'd send me somewhere else and then they thought their job was done and they helped, and they didn't. (W9)

As a consequence of the COVID-19 pandemic, women had limited access to the few resources and services that were available to them pre-COVID-19, while others had no access at all. As a result, to build resilience during future pandemics women suggested accessible counselling services.

Discussion

The purpose of this paper was to: (1) to identify the needs of women who experience IPV to maintain and/or increase their resilience in the context of the COVID-19 pandemic; (2) to identify the gaps in how women wanted to build resilience but lacked the capacity and/or resources to do so during the COVID-19 stay-at-home orders; and (3) to identify the impact of the COVID-19 stay-at-home orders on women who experience IPV in urban environments compared to rural. Women experienced increased coercive control from their partners during the pandemic, heightened barriers when accessing social services, and described recommendations for the future, as well as experiences of resilience. There was a statistically significant difference in women's resilience pre-COVID-19 to during-COVID-19, as over half of the women in the sample experienced the same level or increased abuse during the pandemic, and the mean resilience of this sample decreased during COVID-19. Overall, this points to the exacerbation of conditions that enable an abuser to increase coercive control and thus undermine women's resilience as the pandemic progresses.

It is difficult to understand the severity of the COVID-19 pandemic on women who have experienced IPV, as the pandemic is ongoing and the data remains unclear (Jarnecke and Flanagan 2020; Kaukinen 2020). With this said, numerous researchers have published commentaries, perspectives, and reviews regarding the potential negative impacts of the pandemic on women experiencing violence (Evans et al. 2020; Jarnecke and Flanagan 2020; Kaukinen 2020; Slakoff et al. 2020; Zero and Geary 2020). Findings from the current study align with previous commentaries (Evans et al. 2020; Jarnecke and Flanagan 2020; Kaukinen 2020; Slakoff et al. 2020; Zero and Geary 2020), as women described increased abuse and lack of financial autonomy during the early stages of the COVID-19 pandemic. This is consistent with the qualitative findings, as women felt that the pandemic allowed their partners to gain power over them and made them realize how controlling their abusers were. They described feelings of isolation and confinement, leaving them with little to no options. These sentiments are in line with the work of Kaukinen (2020) and Slakoff et al. (2020), who suggested that the COVID-19 pandemic might provide perpetrators with unique opportunities to assert control over women. In a review by Kaukinen (2020), the author suggested that the COVID-19 public health restrictions/mandates (inclusive of stay-at-home orders) might perpetuate the perpetrator's coercive control and power over their partner. Abusers might take advantage of women while confined to their households, by controlling decision-making and day-to-day outcomes, and isolating them from friends and family (Kaukinen 2020).

Given the closing of businesses associated with COVID-19 restrictions, it is not surprising that women in our study reported wanting greater access to services, especially given that women's shelters were not deemed an essential service until

April 2020, approximately one month after the province declared initial lockdown (CTV News 2020; Sharp 2020). This is particularly concerning as women's shelters offer more than housing. Shelters offer housing, counselling, community, and resources, and can provide a vital link to women as a means to maintain or increase their resilience and cope with their abuse (Ozbay et al. 2007). In terms of service access, women from rural locations described distinct challenges due to their location. Previous researchers have reported challenges in rural settings, as accessing services was difficult for women pre-pandemic, due to issues with anonymity and confidentiality (Fikowski and Moffit 2017; Wuerch et al. 2019). Researchers have reported that transportation and communication challenges existed pre-pandemic and services are not as accessible in rural locations compared to urban, if available at all (Bosch and Bergen, 2006). Due to the COVID-19 pandemic, women's abilities to access these options are even more limited (Moffitt et al. 2020). While lack of service access was prominent in the rural context, surprisingly, women in urban areas expressed similar difficulties, which highlights the role that the COVID-19 pandemic has played on IPV more broadly. Specifically, both urban and rural settings described lack of privacy, delays in service access, lack of empathy and unaffordable services. While such challenges might have been unique to rural settings pre-pandemic (Mantler et al. 2020), COVID-19 has further marginalized women from urban areas. In an article by Jarnecke and Flanagan (2020), the authors acknowledged that services to support women were stretched thin prior to the pandemic, positioning women at a disadvantage compared to others during the COVID-19 pandemic, as there were fewer resources available to them. The lack of external options at a time of increased need demonstrates the abundance of resilience within women in this sample. This type of systemic/structural violence is not uncommon to women who have experienced IPV, and the pandemic has only reinforced this reality (Evans et al. 2020).

The safety-oriented behaviours reported by our sample differ from the dominant view of resilience, in that women demonstrated resilience in the moment, rather than as a result of their situation (i.e. outcome). This finding is not surprising, given that women in the current study were in abusive relationships, where they might be more likely to demonstrate resilience in the moment, compared to women out of their abusive relationships. However, our findings are consistent with Grynch et al. (2015) Resilience Portfolio Model. That is, rather than focusing on qualities or resources that individuals *have* to be resilient, the Resilience Portfolio Model emphasizes how individuals *act* and respond in stressful situations (Grynch et al. 2015). This framework is used to explain and conceptualize the factors that promote resilience in individuals exposed to violence; it takes into account individuals' inner strength and protective factors that, together, result in individual dependent positive outcomes, while considering resilience across one's life span (Gynch et al. 2015). The current study fills a gap in the literature, as the dominant discourse focuses on resilience as an outcome, which fails to acknowledge the internal and external factors that shape one's resilience *during* stressful experiences (Crann and Barata 2016).

The findings from our study – in the context of the larger body of available knowledge related to COVID-19, resilience, and gender-based violence – lead to important recommendations for efficaciously supporting resilience during the

Table 3 Recommendations for Bolstering Resilience for Women who have Experienced IPV during COVID-19

1. Prioritize extending basic counselling services as COVID-19 is compounding experiences of trauma for women who have experienced IPV (e.g. increased duration of general benefits)
2. Prioritize designating shelters as essential services and communicating this to the general population to ensure they can maintain their operations throughout pandemics
3. Prioritize opening and maintaining walk-in social services, legal services, and housing services for women experiencing IPV during stay-at-home orders
4. Prioritize the provision of counselling and other social services through multiple mediums to accommodate those who need to evade surveillance to reach out for help (i.e. telephone, text-based, in-person with physical distancing, etc.)

COVID-19 pandemic (see Table 3). It would seem evident that bolstering resilience in the face of COVID-19 safety measures should be considered carefully in the context of women's lives. While stay-at-home orders offer a means to slow the spread of a deadly virus the implications on women who experience IPV must be considered. The implications of stay-at-home orders reveal a tension between health and safety and safety and resilience and may prolong danger for women. Considering these tensions will be important during recovery from the COVID-19 pandemic, and beyond.

Limitations

Although previously validated tools were used to collect the survey data and honest demands (Bates 1992) were used in the interviews, it is important to recognize that that social desirability bias may still have influenced women's responses. Additionally, while this is a Canadian study, most participants were from Ontario. Also, despite efforts to obtain a sample that is representative of the broader Canadian population, the vast majority of women in this study lived above the average household income range of $49,000 for Ontarians (Statistics Canada 2021), meaning that these results may not be generalizable to women of other socio-economic situations. This study is also missing the experiences of women whose first language is not English. Researchers of future studies might expand recruitment strategies to ensure a more diverse and representative sample of the Canadian population. Further, given that only 9.5% of the sample was from a rural location, it was difficult to compare the impact of the pandemic on rural and urban women. This is not surprising given that it is notoriously difficult to recruit women from rural areas (Pribulick et al. 2010); however, future research should aim to recruit a larger sample to avoid this concern. Moreover, the cross-sectional nature of this study as well as the timing of data collection, during various stages of COVID-10 restrictions, has implications on perspectives that women have offered about the experiences related to COVID-19 and resilience. With the everchanging public health guidelines and stay-at-home orders associated with COVID-19, it is possible that the culmination of such mandates impacted experiences of resilience in ways not brought to light by this study. Longitudinal data collection that followed women as the rules and regulations shifted,

as well as retrospective data that reflects the experiences over the entirety of the pandemic on resilience would provide a more fulsome picture. Another important limitation is the reliance on self-report data of a retrospective nature despite there being no validated tool for measuring resilience retrospectively. As such, these data may be affected by recall bias. There is a need to develop an accurate tool to measure retrospective resilience, as traumatic events cannot be anticipated (i.e. generally researchers cannot knowingly measure resilience prior to life-altering events), yet it is valuable to observe changes in resilience over time and compare pre- and post-levels in response to life events.

Conclusion

The current paper highlighted women's experiences of IPV during the stay-at-home orders of the COVID-19 pandemic. Quantitatively, over half of the women in the sample reported experiencing the same level or increased abuse during the pandemic, and women's resilience significantly from pre-COVID-19 to during-COVID-19. Qualitatively, women reported increased abuse in the form of coercive control and challenges accessing social services, they described their experiences of resilience, and provided recommendations for the future. While the resilience of the sample decreased, women demonstrated resilience through safety-oriented behaviours. Unfortunately, during a time of heightened vulnerability, support services were inaccessible or unavailable, particularly for rural women. The current paper provides a foundation from which future pandemic-related research can build when investigating the resilience of women who have experienced IPV. Findings from this work might inform changes in service access and delivery for women during the COVID-19 pandemic, any future pandemics, and other times of isolation.

Acknowledgements We are grateful for the many women who shared their experiences with the research team. We would also like to thank C. Safar, F. Kryacos, S. Liang, D. Peres, S. Chondon and The Women's Health Matters Research Team for their contributions to data collection, analysis and transcription.

Author contributions All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Katie Shillington, Cara Davidson, Julia Yates and Tara Mantler. The first draft of the manuscript was written by Katie Shillington, Cara Davidson and Julia Yates and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Funding The study was funded by a Western University Catalyst Grant.

Data availability The datasets generated during and/or analysed during the current study are not publicly available out of ethical obligation and confidentiality agreements.

Code availability Not applicable.

Declarations

Conflict of interest The authors have no conflicts of interest to declare that are relevant to the content of this article.

Ethical approval Received from Western University's Non-Medical Research Ethics Board.

Consent to participate Verbal and/or written informed consent was received from all participants.

Consent for publication All authors give their consent for the publication of all details included within the text "Riding on Resilience: Impacts of the COVID-19 Pandemic on Women Experiencing Intimate Partner Violence" to be published in *SN Social Sciences*.

References

Anderson KM, Renner LM, Danis FS (2013) Recovery: resilience and growth in the aftermath of domestic violence. Violence against Women 18(11):1279–1299. https://doi.org/10.1177/1077801212470543

Ard KL, Makadon H (2011) Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. J Gen Intern Med 26(8):930–933. https://doi.org/10.1007/s11606-011-1697-6

Bates BL (1992) The effect of demands for honesty on the efficacy of the Carleton skills-training program. Int J Clin Exp Hypn 40(2):88–102. https://doi.org/10.1080/00207149208409650

Birks M, Chapman Y, Francis, K (2008) Memoing in qualitative research. J Res Nur 13(1):68–75. https://doiorg.proxy1.lib.uwo.ca/10.1177%2F1744987107081254

Bosch K, Bergen MB (2006) The influence of supportive and nonsupportive persons in helping rural women in abusive partner relationships become free from abuse. J Fam Violence 21:311–320. https://doi.org/10.1007/s10896-006-9027-1

Buttell F, Cannon CEB, Rose K, Ferreira RJ (2021) COVID-19 and intimate partner violence: prevalence of resilience and perceived stress during a pandemic. Traumatology 27(1):20–28. https://doi.org/10.1037/trm0000296

Byun S-H (2012) What happens before intimate partner violence? Distal and proximal antecedents. J Fam Violence 27:783–799. https://doi.org/10.1007/s10896-012-9464-y

Campbell-Sills L, Stein MB (2007) Psychometric analysis and refinement of the Connor-Davidson Resilience Scale (CD-RISC): validation of a 10-item measure of resilience. J Trauma Stress 20(6):1019–1028. https://doi.org/10.1002/jts.20271

Capaldi DM, Knoble NB, Shortt JW, Kim HK (2012) A systematic review of risk factors for intimate partner violence. Partn Abus 3(2):231–280. https://doi.org/10.1891/1946-6560.3.2.231

Cho H (2012) Racial differences in the prevalence of intimate partner violence against women and associated factors. J Interpers Violence 27(2):344–363. https://doi.org/10.1177/0886260511416469

Cho S, Crenshaw KW, McCall L (2013) Toward a field of intersectionality studies: theory, applications and praxis. J Women Cult Soc 38(4):785–810

Cohen J (2013) Statistical power analysis for the behavioral sciences. Academic Press, New York

Coker AL, Smith PH, Fadden MK (2005) Intimate partner violence and disabilities among women attending family practice clinics. J Women's Health 14(9):829–838. https://doi.org/10.1089/jwh.2005.14.829

Connor KM, Davidson JR (2003) Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC). Depression Anxiety 18(2):76–82. https://doi.org/10.1002/da.10113

Crann SE, Barata PC (2016) The experience of resilience for adult female survivors of intimate partner violence: a phenomenological inquiry. Violence against Women 22(7):853–875. https://doi.org/10.1177/1077801215612598

Crenshaw K (1991) Mapping the margins: intersectionality, identity politics, and violence against women of color. Stanford Law Rev 43:1241–1299. https://doi.org/10.2307/1229039

Creswell JW, Plano Clark VL (2011) Designing and conducting mixed methods research, 2nd edn. Sage, Thousand Oaks

CTV News (2020, April 3) What's essential? List of services and workplaces allowed to be open gets smaller. https://toronto.ctvnews.ca/what-s-essential-list-of-services-and-workplaces-allowed-to-be-open-gets-smaller-1.4865668

Dangerfield K (2021, January 13) Lockdowns, curfew, stay-at-home order: What's next in Canada's COVID-19 fight? Global News. https://globalnews.ca/news/7567857/coronavirus-travel-restrictions-canada-lockdown/

Daya R, Azpiri J (2020, May 7) Calls to Vancouver domestic-violence crisis line spike 300% amid COVID-19 pandemic. Global News. https://globalnews.ca/news/6789403/domestic-violence-coronavirus/

DeKeseredy WS, Hall-Sanchez A, Dragiewicz M, Rennison CM (2020) Intimate violence against women in rural communities. Routledge international handbook of rural criminology. Routledge, London, pp 171–179

Donnermeyer (2018) The future of a critical rural criminology. In: DeKeseredy WS, Dragiewicz M (eds) Routledge handbook of critical criminology, 2nd edn. Routledge, London, pp 387–397

Eden KB, Perrin NA, Hanson GC, Clough AS, Barnes-Hoyt JS, Glass NE (2014) Use of an online safety decision aid by abused women effect on decisional conflict in a randomized control trial. Am J Prev Med 48(4):372–383. https://doi.org/10.1016/j.amepre.2014.09.027

Evans ML, Lindauer M, Farrell ME (2020) A pandemic within a pandemic – intimate partner violence during Covid-19. N Engl J Med 383:2302–2304. https://doi.org/10.1056/nejmp2024046

Ferguson CJ, Dyck D (2012) Paradigm change in aggression research: the time has come to retire the general aggression model. Aggression and Violent Behaviour 17(3):220–228. https://doi.org/10.1016/j.avb.2012.02.007

Fikowski H, Moffitt P (2017) A culture of violence and silence in remote Canada: impacts on service delievery to address intimate partner violence. In: Exner-Pirot H, Norbye B, Butler L (eds) Northern and Indigenous Health and Healthcare. University of Saskatchewan, Saskatoon, pp 198–222

Ford-Gilboe M, Wathen CN, Varcoe C, MacMillan HL, Scott-Storey K, Mantler T, Hegarty K, Perrin N (2016) Development of a brief measure of intimate partner violence experiences: the Composite Abuse Scale (Revised)-Short Form (CASR-SF). BMJ Open 6(12):e012824. https://doi.org/10.1136/bmjopen-2016-012824

Glass N, Clough A, Case J, Hanson G, Barnes-Hoyt J, Waterbury A, Alhusen J, Ehrensaft M, Grace KT, Perrin N (2015) A safety app to respond to dating violence for college women and their friends: the MyPlan study randomized control trial protocol. BMC Public Health. https://doi.org/10.1186/s12889-015-2191-6

Government of Canada (2020a) Intimate partner violence. https://cfc-swc.gc.ca/violence/knowledge-connaissance/ipv-vpi-en.html

Government of Canada (2020b, October 15a) Community-based measures to mitigate the spread of coronavirus disease (COVID-19) in Canada. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/public-health-measures-mitigate-covid-19.html#_Hand_hygiene_and

Government of Canada (2021, January 21) Coronavirus disease 2019 (COVID-19): epidemiology update. https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html

Government of Ontario (2021) COVID-19 public health measures and restrictions. https://covid-19.ontario.ca/zones-and-restrictions

Greene JC (2007) Mixed methods in social inquiry. Jossey-Bass, San Francisco

Grych JH, Hamby S, Banyard V (2015) The resilience portfolio model: understanding healthy adaption in victims of violence. Psychol Violence 5(4):343–354. https://doi.org/10.1037/a0039671

Guba EG, Lincoln YS (1989) Fourth generation evaluation. Sage, Newbury Park

Howell KH, Thurston IB, Schwartz LE, Jamison LE, Hasselle AJ (2018) Protective factors associated with resilience in women exposed to intimate partner violence. Psychol Violence 8(4):438–447. https://doi.org/10.1037/vio0000147

Hyman I, Forte T, Du Mont J, Romans S, Cohen MM (2009) Help-seeking behavior for intimate partner violence among racial minority women in Canada. Womens Health Issues 19(2):101–108. https://doi.org/10.1016/j.whi.2008.10.002

Jarnecke AM, Flanagan JC (2020) Staying safe during COVID-19: how a pandemic can escalate risk for intimate partner violence and what can be done to provide individuals with resources and support. Psychol Trauma Theory Res Pract Policy 12(S1):S202–S204. https://doi.org/10.1037/tra0000688

Joseph J (2013) Resilience as embedded neoliberalism: a governmentality approach. Resilience 1(1):38–52. https://doi.org/10.1080/21693293.2013.765741

Kaufman RA, English FW (1979) Needs assessment: concept and application. Educational Technologies, New York

Kaukinen C (2020) When stay-at-home orders leave victims unsafe at home: exploring the risk and consequences of intimate partner violence during the COVID-19 pandemic. Am J Crim Justice 45:668–679. https://doi.org/10.1007/s12103-020-09533-5

Kimmel MS (2002) "Gender Symmetry" in domestic violence: a substantive and methodological research review. Violence against Women 8(11):1332–1363
Kissler SM, Tedijanto C, Goldstein E, Grad YH, Lipsitch M (2020) Projecting the transmission dynamics of SARS-CoV-2 through the postpandemic period. Science 368(6493):860–868. https://doi.org/10.1126/science.abb5793
Kofman YB, Garfin DR (2020) Home is not always a haven: the domestic violence crisis amid the COVID-19 pandemic. Psychol Trauma Theory Res Pract Policy 12(S1):S199–S201. https://doi.org/10.1037/tra0000866
Luthar SS, Cicchetti D, Becker B (2000) The construct of resilience: a critical evaluation and guidelines for future work. Child Dev 71(3):543–562. https://doi.org/10.1111/1467-8624.00164
Mantler T, Jackson KT, Shillington K, Walsh EJ, Tobah S, Jackson B, Davidson CA (2020) Factors influencing rural women's disclosure of intimate partner violence: a qualitative study. SN Soc Sci 1:19. https://doi.org/10.1007/s43545-020-00027-z
Masten AS (1994) Resilience in individual development: successful adaptation despite risk and adversity. In: Wang MC, Gordon EW (eds) Educational resilience in inner-city America: challenges and prospects. Lawrence Erlbaum Associates Inc, pp 3–25
Miller JM, Blumstein A (2020) Crime, Justice and the COVID-19 Pandemic: toward a National Research Agenda. Am J Crim Just. https://doi.org/10.1007/s12103-020-09555-z
Ministry of Health and Long-Term Care (2011) Rural and northern health care report. http://www.health.gov.on.ca/
Moffitt P, Aujla W, Giesbrecht CJ, Grant I, Straatman A-L (2020) Intimate Partner Violence and COVID-19 in Rural, Remote, and Northern Canada: Relationship. J Fam Violence, Vulnerability and Risk. https://doi.org/10.1007/s10896-020-00212-x
Morgan DL (1993) Qualitative content analysis: a guide to paths not taken. Qual Health Res 3(1):112–121. https://doi.org/10.1177/104973239300300107
Munoz RT, Brady S, Brown V (2017) The psychology of resilience: a model of the relationship of locus of control to hope among survivors of intimate partner violence. Traumatology 23(1):102–111. https://doi.org/10.1037/trm0000102
Orsini M (2020, October 19) COVID-19 responses are full of the "plastic word" resilience, a feel-good narrative that ignores the structures and systems that cause the trauma. Policy Options. https://policyoptions.irpp.org/magazines/october-2020/stop-asking-us-to-be-resilient/
Ozbay F, Johnson DC, Dimoulas E, Morgan CA, Charney D, Southwick S (2007) Social support and resilience to stress. Psychiatry 4(5):35–40
Postmus JL, Plummer SB, McMahon S, Murshid NS, Kim MS (2012) Understanding economic abuse in the lives of survivors. J Interpers Violence 27(3):411–430. https://doi.org/10.1177/0886260511421669
Pribulick M, Williams IC, Fahs PS (2010) Strategies to reduce barriers to recruitment and participation. Online J Rural Nursing Health Care 10(1):22–33
Prime H, Wade M, Browne DT (2020) Risk and resilience in family well-being during the COVID-19 pandemic. Am Psychol 75(5):631–643. https://doi.org/10.1037/amp0000660
Quirkos 2.3.1 [Computer Software] (2020). Retrieved from https://www.quirkos.com
Riddell T, Ford-Gilboe M, Leipert B (2009) Strategies used by rural women to stop, avoid, or escape from intimate partner violence. Health Care Women Int 30(1–2):134–159
Rutter M (2006) The promotion of resilience in the face of adversity. In: Clarke-Stewart A, Dunn J (eds) The Jacobs Foundation series on adolescence. Families count: effects on child and adolescent development. Cambridge University Press, Cambridge, pp 26–52
Sharp M (2020, March 17) Doug Ford declares state of emergency as Ontario records first COVID-19 death. Canada's National Observer. https://www.nationalobserver.com/2020/03/17/news/doug-ford-declares-state-emergency-ontario-records-first-covid-19-death
Slakoff DC, Aujla W, PenzeyMoog E (2020) The role of service providers, technology, and mass media when home isn't safe for intimate partner violence victims: best practices and recommendations in the era of COVID-19 and beyond. Arch Sex Behav 49:2779–2788. https://doi.org/10.1007/s10508-020-01820-w
Slep AMS, Foran HM, Heyman RE, Snarr JD (2010) Unique risk and protective factors for partner aggression in a large scale air force survey. J Commun Health 35(4):375–383
Soeken KL, McFarlane J, Parker B, Lominack MC (1998) The Abuse Assessment Screen: a clinical instrument to measure frequency, severity, and perpetrator of abuse against women. In: Campbell JC

(ed) Sage series on violence against women Empowering survivors of abuse: health care for battered women and their children. Sage, Thousand Oaks, pp 195–203
Stark E (2007) Coercive control: how men entrap women in personal life. Oxford University Press, Oxford
Statistics Canada (2020, August 7) Labour Force Survey, July 2020. https://www150.statcan.gc.ca/n1/daily-quotidien/200807/dq200807a-eng.htm
Statistics Canada (2021, February 14) Table 11-10-0239-0 Income of individuals by age group, sex and income source, Canada, provinces and selected census metropolitan areas. https://doi.org/10.25318/1110023901-eng
Stylianou AM, Postmus JL, McMahon S (2013) Measuring abusive behaviors: is economic abuse a unique form of abuse? J Interpers Violence 28(16):3186–3204. https://doi.org/10.1177/0886260513496904
Thorne S, Con A, McGuinness L, McPherson G, Harris SR (2004) Health care communication issues in multiple sclerosis: an interpretive description. Qual Health Res 14(1):5–22
Thorne S, Reimer Kirkham S, MacDonald-Emes J (1997) Interpretive description: a non-categorical qualitative alternative for developing nursing knowledge. Res Nurs Health 20:169–177
Tjaden P, Thoennes N (2000) Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the national violence against women survey. Violence against Women 6(2):142–161. https://doi.org/10.1177/10778010022181769
Trudeau J (2020) A Stronger and More resilience Canada. [Internet]. Speech from the Throne to open the Second Session of the Forty-Third Parliament of Canada. 2020 [cited 2020 Nov 20]. https://www.canada.ca/en/privy-council/campaigns/speech-throne/2020/stronger-resilient-canada.html
Ungar M (2003) Qualitative contributions to resilience research. Qual Soc Work 2(1):85–102. https://doi.org/10.1177/1473325003002001123
Walsh JJ, Wilding JM, Eysenck MW (1994) Stress responsivity: the role of individual differences. Person Ality Individ Differ 16(3):385–394. https://doi.org/10.1016/0191-8869(94)90064-7
Weeks L, Stilwell C, Rothfus M, Neeb D, Jackson L, Macdonald M, Carson A, Moody E, Helpard H, LeBlanc K (2020) What initiatives have been created to meet the needs of women experiencing domestic violence during COVID-19
World Health Organization (2020a, April 23) Coronavirus disease 2019 (COVID-19): Situation report – 94. https://www.who.int/docs/default-source/coronaviruse/situation-reports/2020a0423-sitrep-94-covid-19.pdf#:~:text=The%20first%20human%20cases%20of,%2C%20in%20December%202019
World Health Organization (2020b) COVID-19 and violence against women: what the health sector/system can do. https://apps.who.int/iris/bitstream/handle/10665/331699/WHO-SRH-20.04-eng.pdf?ua=1
World Health Organization (2021) Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. https://apps.who.int/iris/bitstream/handle/10665/341337/9789240022256-eng.pdf?sequence=1
Wuerch MA, Zorn KG, Juschka D, Hampton MR (2019) Responding to intimate partner violence: challenges faced among service providers in Northern communities. J Interpers Violence 34(4):691–711. https://doi.org/10.1177/0886260516645573
Young MD (2007) Finding meaning in the aftermath of trauma: Resilience and posttraumatic growth in female survivors of intimate partner violence. [Doctoral Dissertation, The University of Montana]. Graduate Student Theses, Dissertations, and Professional Papers. https://scholarworks.umt.edu/cgi/viewcontent.cgi?referer=andhttpsredir=1andarticle=1468andcontext=etd
Zero O, Geary M (2020) COVID-19 and intimate partner violence: a call to action. R I Med J 103(5):57–59
Zorn KG, Wuerch MA, Faller N, Hampton MR (2017) Perspectives on regional differences and intimate partner violence in Canada: a qualitative examination. J Fam Violence 32:633–644. https://doi.org/10.1007/s10896-017-9911-x