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RESEARCH ARTICLE

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Perspectives on domestic violence in rural U.S. communities during the COVID-19 pandemic

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ABSTRACT

Introduction: Services for domestic violence (DV) victims have long been limited in rural areas due to geographic isolation, lack of transportation, and limited access to legal services, housing, and health services. While virtual services developed during COVID-19 expanded access for some, this shift potentially worsened rural disparities related to Internet access, housing and transportation, and resource shortages. Theory: Evidence from research and practice demonstrate empowerment-based services improve victim outcomes by building knowledge, skills, and self-efficacy. However, little is known about the impact disruptions to social contexts due to disasters and emergencies may have on the delivery of empowerment-based services. Method: Executive directors of State and Territorial DV coalitions completed key informant interviews. Additional data were collected with open-ended questions in an online survey of shelters and service providers. Results: Coalition leaders and program staff reported limited success with virtual support for rural victims. While virtual support could help when in-person support was infeasible, it was difficult to maintain rural victim safety and privacy with poor internet connections and limited internet fluency. Sheltering in rural areas was difficult without hoteling and other unique challenges (e.g., responsibility for livestock) could not be addressed with virtual solutions. Discussion: While the shift to virtual services during COVID-19 allowed for maintenance of some services, there were challenges for the workforce and victims. There were unique obstacles to virtual services in rural areas. Equitable access to DV services for rural victims will require concerted efforts to close documented and anticipated gaps.

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Introduction

According to the U.S. Department of Justice, domestic violence is defined as a pattern of abusive behavior in any relationship that is used to gain or maintain power and control (US Department of Justice, 2025). Victims and survivors of domestic violence in rural areas of the U.S., characterized by populations of less than 50,000, have less access to domestic violence resources, physical and mental health professionals, and legal services compared to urban and suburban residents (Peek-Asa et al., 2011). They also face more barriers accessing the services that are available (Gillespie et al., 2021). In general, criminology research over the last decade has demonstrated that the rate of intimate partner violence against women is higher in rural areas in contrast to their counterparts in urban or suburban areas (DeKeseredy, 2019; Dekeseredy et al., 2016). Although rates of violence are higher in rural settings, these data may still represent an underestimate of the burden of rural domestic violence due in part to a lower likelihood of lifetime screening (Klap et al., 2007). For example, a recent study in rural Minnesota found that rural victims and survivors were at higher risk of intimate partner violence while being less likely to be screened for abuse than their urban counterparts (Fritz et al., 2024). Rural victims and survivors are more vulnerable to abuse due, in part, to the added barriers and complexities they face, which include both

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location-based factors like geographic isolation and limited transportation as well as cultural factors such as poverty, firearm availability, and a lack of privacy (Youngson et al., 2021; Moffitt et al., 2022).

Challenges to the rural domestic violence workforce

Domestic violence service providers and advocates in rural areas have long faced distinct challenges and barriers. The delivery of evidence- and empowerment-based domestic violence services in rural areas is made more difficult due to deep-seated gender inequality. Rural women have less access to education, credit, technology, healthcare, and other resources (United Nations, 2024). Rural domestic violence service providers also have less funding and fewer staff, and often have to manage complex or difficult relationships between advocates, law enforcement, and perpetrators while navigating local norms or values (Bein, 2016; Statz et al., 2022). According to a statewide survey of 379 victim services providers in Texas, rural advocates report 40% fewer annual training hours, averaging 29.76 hours versus 50.53 hours for urban providers (Yun et al., 2009) and higher levels of concern about their own safety, often reporting feeling vulnerable and threatened (Eastman et al., 2007). Studies in rural Northern Canada have reported similar findings, including a general lack of resources and services for rural service providers (Faller et al., 2021), inadequate access to training related to intimate partner violence, and a lack of cultural sensitivity among nursing and law enforcement (Zorn et al., 2017).

Gaps in rural domestic violence services prior to the COVID-19 pandemic

There are also notable gaps in the availability of key services for rural domestic and sexual violence survivors. For example, Sexual Assault Nurse Examiners (SANE), a critical component of victim services, are less likely to be available in rural areas. A study in Pennsylvania found that rural counties were more than 4 times less likely to have a certified SANE whose role in collecting forensic evidence and providing victim support can be important to the legal process (Thiede & Miyamoto, 2021). Without nurses with specific knowledge related to identification of, and response to, sexual and domestic violence, it is difficult for victims and survivors to be connected to appropriate interventions and advocacy organizations (Neill & Hammatt, 2015). Another gap reported in studies of rural victims and survivors is the lack of contextual risk assessments. Rural providers report a lack of trained risk assessors that understand the rural context. Thus, safety planning and risk management can be more difficult, including addressing the risk that rural victims and survivors could be harmed by firearms (Youngson et al., 2021).

Beyond resource barriers, rural victims and survivors face other unique challenges. Rural victims and survivors may be reluctant to report abuse because they, or their partner, may personally know healthcare providers or law enforcement officers (Rural Health Information Hub, 2024). Therefore, the only disclosure options for many rural victims and survivors in a close-knit rural community may be someone known to them personally. The inability to ensure privacy and confidentiality in rural communities likely means that the actual unmet need for rural victims and survivors is greater than what has been documented (Fritz et al., 2024). Repercussions of reporting, which already demonstrate the power imbalance present in an abusive relationship, may include victim blaming, shaming, community backlash, or even separation from children (Corbett et al., 2025; Fritz et al., 2024). Other systemic barriers for rural victims and survivors may include stigma, police dismissal of disclosures or abuse, limited access to Medicaid or other insurance coverage, and a lack of available providers who understand rural health and mental health practice (Statz et al., 2022). Indigenous rural communities may experience these barriers as well as other risks such as greater social isolation, intergenerational trauma, and exacerbation of violence (Moffitt et al., 2022).

Gaps in rural domestic violence services during COVID-19

The COVID-19 pandemic, and the public health response to it, deepened many of these documented existing inequities in access to, and the provision of, domestic violence services in rural communities. It also introduced new challenges to rural victims and survivors, service providers, and advocates. Stay-at-home orders and closures of schools and other support programs increased risk factors for violence

while decreasing reporting (Kourti et al., 2023). The shift of many services online in response to COVID-19 expanded access to courts, counseling, and other services for some, but reduced access in rural areas lacking reliable internet service and presented challenges in meeting the needs of some groups like those with less digital literacy, immigrants, and other minority groups (Emezue, 2020). The pandemic also accelerated turnover in the domestic violence workforce as leadership and staff experienced high levels of stress and operated shelters and other spaces without adequate personal protective equipment (Wells et al., 2024). A lack of staffing, crisis accommodation, and funding for domestic violence in rural areas prior to the pandemic also increased access challenges disproportionally for rural victims (Kozhimannil et al., 2024).

Before the COVID-19 pandemic, there has long been a mythology around rural resilience, or the ability of rural communities to 'survive and thrive in the face of uncertainit(ies)' such as disasters and emergencies, in the U.S. (Cox & Hamlen, 2015). This has translated in some cases to a belief that there are lower crime rates overall in rural communities and the near expectation that rural victims and survivors should 'put up with domestic violence' (Youngson et a., 2021). In fact, intimate partner violence generally, and femicide specifically, is proportionally higher in rural areas and has been steadily increasing (Abraham & Ceccato, 2022). Rural areas of the U.S. have a greater share of their populations living in poverty compared with metropolitan areas (15.9% v. 11.9%) and the concentration of rural poverty has implications for poorer housing, health, education, and employment (US Department of Agriculture Economic Research Service [USDA], 2023). This deeply embedded structural inequality challenges the popular notion of idyllic and safe rural communities (Magnus & Donohue, 2022).

This paper uses qualitative data collected from both executive directors of state and territorial domestic violence coalitions as well as staff from domestic violence shelters and programs to document perceptions and opinions about rural inequities in access to domestic violence services and advocacy during the COVID-19 pandemic. It also explores the self-reported perceptions of leadership and staff related to the ways that the COVID-19 pandemic exacerbated pre-existing issues related to rural victim access.

Methods

Key informant interviews were conducted with a census of leaders of state and territorial domestic violence coalitions (N = 56) between November 2021 and April 2022 (Horney et al., 2023). A combination of public coalition websites and referrals from leaders who completed an interview was used to reach coalition leadership, who were invited via email to participate in an interview using the Zoom (San Jose, CA) platform. A seven-question interview guide was developed to assess how COVID-19 impacted domestic violence systems, services, and advocacy (Table 1). Two authors, both with prior experience as board members for a state domestic violence coalition and expertise in qualitative research methods conducted the interviews, which lasted an average of 44 minutes (Range: 27–60 minutes) and were recorded and transcribed using Zoom (San Jose, CA). Transcripts were independently hand coded and coded using Dedoose (Los Angeles, CA) qualitative software to identify themes related to rural victims and survivors and service provision. After independent coding was complete, themes and supporting information were compared and consensus was reached by all the authors.

Between April and May 2023, an online survey was conducted with staff from a census of U.S. based domestic violence direct service agencies included in the directories of either domesticshelters.org or the Tribal Resource Tool. The survey contained 34 questions related to services provided, work environment, disruptions caused by the COVID-19 pandemic, personal and organizational preparedness, and

Table 1. Key informant interview guide questions.

In your opinion, how did COVID-19 and the response to it create barriers in your state to providing sheltering and other advocacy services like court support, visitation, batterer intervention?
Due to measures like social distancing or closures of non-essential services, what areas of system advocacy did you find your coalition engaging more in? Were there areas where you did less engagement due to COVID?
What do you think were the most critical unmet needs of the shelter programs in your state or territory during the COVID-19 pandemic?
What kinds of funding shifts occurred? How did that impact survivors and services?
Were there other barriers - created by COVID-19 or the response to it - that shelters or service providers faced?
Are there takeaways from this experience that can be carried forward to regular operations or emergency responses?
Are there other people at your coalition or within your professional networks that you suggest we talk to about this topic?

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demographic information (Horney et al., 2024). There were 6 open-ended questions included in the survey that comprised a second qualitative dataset included in this paper where survey respondents could provide additional open text responses related to the following: impacts of COVID-19 on service provision; maintenance of services during COVID-19; the 'twin pandemics' of COVID-19 and racial injustice; assistance needed to plan, prepare for, or respond to disasters or emergencies; empowerment of victims and survivors during disasters and emergencies; and personal or professional experience between 2020 and 2023. To supplement the key informant interview data, qualitative responses from the online survey were downloaded from Qualtrics (Provo, UT) and inductively hand coded by two coders independently to identify themes related to rural victims and survivors and service provision. After independent coding was complete, consensus was reached by all the authors. All materials were reviewed and approved by the University of Delaware's Institutional Review Board (#1597257). Oral consent was obtained before the interviews and those who completed the survey consented to participation by completing an initial survey question.

Results

Interviews were completed with 25 of 56 (45%) state and territorial coalition leaders representing each of the eight National Network to End Domestic Violence Regions (New England, Mid-Atlantic, Gulf States, Southern States, Upper Midwest, Lower Midwest, Mountain States, West Coast). Of 1,341 emails, 301 individuals responded to the survey (22.4%) and 180 (59.8%) complete surveys were analyzed. Respondents were primarily female (n = 164; 91.11%) and white (n = 136; 75.56%). Nearly 40% of respondents had a bachelor's degree (n = 70), and roughly 38% of respondents had graduate degrees (n = 66). More than half (56.67% had more than 10 years of experience working in the field of domestic violence. Overall, 4 main themes were identified in the two qualitative datasets: limited access to, and ability to effectively utilize, technology; limited rural housing and transportation; the lack of privacy and confidentiality in rural communities with few local support options; and limited financial, organizational, and human resources.

Limited internet access

Consistent with prior research, limited internet access in rural areas and use concerns among rural residents were prevalent among both coalition leadership and survey respondents. Many areas simply do not have high speed internet and often the services that are available are cost prohibitive for victims and survivors. One executive director pointed out, 'they [victims and survivors] needed access to Wi-Fi and [that is] very limited in rural spaces.' We were 'suggesting that people go to the park or the library or someplace with free Wi-Fi in order to have FaceTime visits with their children. It was appalling.'

When schools were closed, this added another layer of complexity to the limited rural internet access. Shelters and other service providers often tried, with limited success, to support not only 'survivors themselves' but also 'children in shelters being able to access to do remote learning.' As one executive director pointed out, when places like 'coffee shops and libraries – places where people could get internet – were closed, people were coming, especially students, to the [domestic violence] program to say 'Could I use your internet?" Another coalition leader put it this way: 'Because these areas are rural, when everything becomes dependent on something virtual, if you don't have access to the internet, you are really stuck.'

The broader shift to virtual services, in everything from schools to courts, during the COVID-19 pandemic also brought technological challenges to rural service providers as well as victims and survivors in rural areas. As one coalition executive director put it, 'we have issues in rural areas like [low] quality Wi-Fi and also cell phone signals.' Even tried-and-true virtual services like hotlines require reliable cell phone coverage if advocates were working remotely. Some advocates were driving to locations with better cell service or Wi-Fi and 'sitting in parking lots for six or seven hours just to do [their] shift.' Service providers often had to 'develop alternative ways for survivors to get access, get the technology, and for staff to get the [technology] skills necessary to open up chatlines.' In rural areas without access to wireless internet, service providers who responded to the survey 'saw huge barriers in communicating with one another and with the community.' Another survey respondent pointed out that 'staying in touch with

people without the income to have a computer was a challenge.' This comment highlights the complexities of rural internet access. While the lack of high speed internet in the rural U.S. is well documented – a 2022 report by the Pew Trusts indicated that 1 in 4 rural Americans lacked broadband internet – rural residents are also less likely to subscribe when internet is available due to a lack of affordability (Pew Trusts, 2022).

Limited housing and transportation in rural areas

Many rural areas in the U.S. have a very limited housing stock and few hotels. As one survey respondent put it, because of pandemic restrictions on physical distancing, 'it was very difficult [for rural agencies] to provide services due to limited housing resources in the community. Shelters were at half-capacity and…survivors were in more danger as a result of sheltering in place with their abuser.' Two coalition directors pointed out challenges to solving the problem of shelter shortages. In some 'small rural areas, hoteling was not easy' and because of the 'housing market, there's just no place to rent even if you have money.' This was an especially prevalent concern in expensive resort areas that are located in rural locations. In addition to shortages for victim sheltering, domestic violence service providers have a difficult time renting office space and staff have to 'live up to 150 miles away [due to the cost of housing] so they really cannot support clients in the same way.'

Transportation is difficult for rural victims and survivors as well as for domestic violence service providers. As one coalition director put it 'it is very rural, so getting to and from places is difficult anyway, but then, when you have the very limited transportation systems it [becomes] completely inaccessible, and that made it so people were just sitting ducks stuck [with] the abuse.' Many rural areas do not have access to public transportation. As one coalition leader pointed out, we 'don't have much going on in the way of taxis or Uber, so typically staff would just drive people in their personal cars.' Before vaccines were available and when physical distancing measures were in place, that was just 'really risky, really hard.' Well documented shortages in crisis housing and transportation for rural victims were greatly exacerbated by the COVID-19 pandemic and responses such as physical distancing, a shortage of personal protective equipment, and the ability of higher income remote workers to relocate to rural areas. After decades of population loss, net migration into rural areas were positive during 2020 and 2021 (Winkler & Peterson, 2024).

Maintaining rural victim safety and privacy

Rural victims and survivors have few options for local services and often providers are well-known in multiple community contexts. Given small populations and a limited number of service providers, the provision of confidential support is challenging. The small, close-knit image of rural American communities – which was magnified by stay-at-home orders, school and business closures, limited access to in-person physical and mental health care, and other public health control measures implemented early in the pandemic – presented even more challenges to ensuring privacy and confidentiality. As one coalition leader put it, 'you cannot put a survivor in the same community with their perpetrator.' Another coalition leader added, 'because it is such a small community, confidentiality can be really difficult. There are no secrets.' Even with these challenges, one coalition leader pointed out that 'in rural towns, people have gotten really creative because everyone in the town and the surrounding area knows that this program is the place that helps people.'

Resource challenges for rural service providers

Executive directors and survey respondents mentioned other challenges unique to rural areas. During stay-at-home orders, one survey respondent pointed out 'travel was suspended, making it difficult for us to serve rural populations.' With travel limited, needs had to be met locally. As another survey respondent pointed out, 'our advocates are spread out over a 20-county service area, so staying connected in general is more challenging, and during an emergency, it might be even more so.' Another survey respondent agreed, saying 'we are rural, and I'm just not sure the resources are here locally.'

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Rural agencies also have few staff resources, which can make response difficult due to individuals being responsible for multiple aspects of service provision and advocacy (Almklov et al., 2018). As one survey respondent put it, we are all 'small agencies with limited staff, so strategic thinking about how to deploy human and other resources most effectively and sustainably' is difficult. In the case of the COVID-19 public health emergency, when board members, employees, or trained volunteers tested positive for COVID-19 and needed to isolate, as one survey respondent put it 'small organizations serving rural areas had to close operations.' Another survey respondent pointed out that it was difficult for a small staff to follow safety protocols related to COVID-19. 'We don't have many employees, but we could not all work at the same time and had to split into teams. Often, we would have a one-person operation at the shelter [and one at the] hotline. Working during this time was terrifying.' To prevent burnout and turnover, greater advocacy for rural service providers is needed as part of emergency planning and response, along with more workforce supports and fewer restrictions on the use of funds, for example allowing hazard pay, during emergencies.

Discussion

From the perspective of both coalition leaders and the frontline workforce, the COVID-19 pandemic intensified existing inequities for victims and survivors living in rural communities while deepening existing challenges to rural domestic violence service providers and advocates. These pre-pandemic challenges included a lack of funding and staff, limited internet access, few housing and transportation options, and the need to serve a large geographical area. Adhering to stay-at-home and other pandemic-related restrictions made each of these challenges more difficult (Stillson & Lee, 2024). However, our study population indicated that the COVID-19 pandemic could also provide the impetus for a renewed focus on planning and preparing for emergency events among rural victims and service providers. Funds that are being invested in rural areas as part of widespread efforts to improve access to care and other social determinants of health post-pandemic, could provide opportunities to address long-standing concerns (U.S. Department of Agriculture, 2024). For example, improved interagency collaboration and outreach, as well as more public and provider education, have all been identified as ways to improve risk assessment and the response to interpersonal violence in rural areas (Youngson et al., 2021). The provision of services through non-traditional settings, such as when libraries were used to distribute COVID-19 tests, also highlights successful models for future programs that may address the needs of victims and survivors of domestic violence (Benson, 2016). Policies designating domestic violence service providers as an essential workforce of first responders before the next emergency response could provide more rapid access to personal protective equipment and other interventions like vaccines and raise community awareness of the importance of the continuity of these services (Stillson & Lee, 2024; Wells et al., 2024).

Community capital is considered the most important factor for rural resilience in a disaster or emergency (Cutter et al., 2016). Yet if personal networks in rural areas create ties that limit, rather than expand, residents' ability to seek support, this can have negative impacts (Lanier & Maume, 2009). Rural practitioners have long expressed concerns about the potential impacts on care seeking by patients concerned about privacy when they know providers both personally and professionally or when they may be seeking care for a stigmatized condition (Warner et al., 2005). These concerns have been widely studied with relation to seeking services for interpersonal violence, sexually transmitted infections, and substance use disorder (Garside et al., 2002; Mantler et al., 2021; Saunders et al., 2019). Addressing how communities and partner agencies view domestic violence victims and ensuring a victim-centered, empowered approach to all types of service delivery, even during an emergency, are steps that could be taken to destigmatize victim's needs and experiences (Stillson & Lee, 2024).

Barriers to help-seeking by victims and survivors of domestic violence, including access challenges, consequences of disclosure, and lack of resources have been well-documented (Robinson et al., 2021; Bosch & Bergen, 2006). Each of these barriers are generally intensified in a rural setting and according to leaders and service providers who participated in these qualitative interviews and surveys, all were deepened by the COVID-19 pandemic and the public health response to it. During COVID-19, difficulties in seeking assistance for victims and survivors in rural areas was compounded by well-documented

pre-pandemic challenges: limited services, a lack of trained service providers, housing and transportation barriers, and a lack of broadband and wireless internet services as well as the impacts of COVID-19. Additional subsidies for high-speed internet and other rural infrastructure are needed to incentivize providers to service rural areas and to support rural resident uptake of the technology once it becomes available (Pew Trusts, 2022).

International research and practice may also provide lessons learned that can be applied in rural areas of the U.S. In low- and middle-income settings, calls to address interpersonal violence, and its wide ranging sequalae from an increased risk of poor nutrition to reduced rates of childhood vaccination adherence, have focused on the need for active surveillance and referral in healthcare settings (Colombini et al., 2008). Globally, targets and indicators are included as part of the United Nation's Sustainable Development Goal (SDG) 5.2, which addresses the prevention of violence against women, and SDG 3.8, which focuses on ensuring access to physical and mental healthcare as well as safe environments. To make progress towards these goals, far greater and more sustained investments are needed for domestic violence services, while simultaneously addressing necessary legal and sociocultural changes. For example, in Australia, shame, the view that violence is a private family matter, and a fear of community sanctions have limited the ability of service providers to reach rural victims (Owen & Carrington, 2015). Solutions to rural domestic violence require interdisciplinary and inter-professional approaches that involve governmental and non-government organizations 'working at multiple levels: legislative, policy, programmatic and advocacy' (Jones et al., 2017).

This research has several important limitations. Only about half of state and territorial coalition leaders participated in a key informant interview, although all 8 National Network to End Domestic Violence Regions were represented. Given the variability in both the timing and scope of state-level responses to COVID-19, and in the structure of coalitions, this could limit the national representativeness of the sample. Bias could also be introduced if those who chose to participate differed from those who did not. Although political affiliations are only one potentially relevant variable, state coalitions that did participate were nearly evenly divided; 13 of 25 (52%) represented coalitions in states that supported President Joe Biden in the 2020 election. The response rate for the online survey was less than 25%, which also may have introduced bias, particularly around issues related to technology. Although the familiarity of the two members of the research team who were prior board members of a state domestic violence coalition with coalition structure and operations was considered to have increased response rates in the key informant interviews, this could have also led to response bias or a conflict of interest. Finally, this paper summarizes self-reported perceptions of leaders and staff of domestic violence coalitions and service providers and did not test hypotheses related to the impacts of the COVID-19 pandemic on rural service provision or access to services.

Conclusion

Domestic violence leadership and staff who participated in either key informant interviews or surveys highlighted the intersection of obstacles rural victims and survivors faced during the COVID-19 pandemic. As before the pandemic, leaders and service providers reported that rural victims and survivors, and their advocates, had access to fewer fiscal and organizational supports and faced other barriers to disclosure including concerns about privacy and confidentiality, stigma, and victim blaming. However, the response to the COVID-19 pandemic (e.g., shifting services online, travel restrictions, and the relocation of remote workers to rural areas with natural amenities that further reduced rural housing availability and affordability) intensified many barriers. Future research should consider the role that the politicization of the pandemic may have played on these joint challenges in rural areas as well as the differences and similarities of other isolated communities such as rural tribal communities.

Ethics approval and consent to participate

All materials were reviewed and determined to be exempt by the University of Delaware's Institutional Review Board (#1597257) in accordance with the Declaration of Helsinki. All interviewees provided oral consent prior to the key informant interview as it was conducted via Zoom. All survey respondents provided written consent by responding

affirmatively to a consent statement prior to beginning the remainder of the online survey. Consent was documented by the interviewers or in the Qualtrics software respectively.

Authors' contributions

AB conducted the literature review and worked with JAH on the initial draft. JAH, RFS, LCC, and SLM designed the study and obtained funding. RFS and SLM conducted key informant interviews and analyzed qualitative data. JAH designed the survey. All authors contributed to revising the manuscript and all reviewed and approved submission.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

The datasets generated during the current study are available from the Corresponding Author on reasonable request.

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