

## Review Article

### Intimate partner violence and sexual violence in adulthood within rural, remote, and Northern communities in the US and Canada - a scoping review

#### AUTHORS



Candice Waddell-Henowitch<sup>1</sup> PhD, Associate Professor



Andrea Thomson<sup>1</sup> MPN, Associate Professor \*



Nadine Smith<sup>1</sup> MN, Associate Professor



H. Rainer Schira<sup>2</sup> MLIS, Librarian



Sherri Dyck<sup>1</sup> BScPN, Instructional Associate



Savannah Torres-Salbach<sup>1</sup> MPH, Research Assistant



Hillary Derewianchuk<sup>1</sup> BSc, Research Assistant

#### CORRESPONDENCE

\*Assoc Prof Andrea Thomson [thomsona@brandonu.ca](mailto:thomsona@brandonu.ca)

#### AFFILIATIONS

<sup>1</sup> Department of Psychiatric Nursing, Brandon University, Brandon, Manitoba R7A 6A9, Canada

<sup>2</sup> John E. Robbins Library, Brandon University, Brandon, Manitoba R7A 6A9, Canada

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## Abstract

**Introduction:** Violence against women is an ongoing and pervasive public health issue. In North America, the rates of intimate partner violence (IPV), sexual violence (SV), and gender-based violence (GBV) increase for those living in rural, remote and Northern (RRN) areas. These individuals face distinct challenges in accessing services; however, to date, no reviews have systematically summarized the scope of evidence on this topic. As a result, there is a need for more research that explores the lived and living experiences of IPV and SV among individuals marginalized by gender in RRN areas.

**Methods:** The research team conducted a scoping review following the framework outlined by Levac and colleagues to determine the existing evidence on the lived experience of SV and IPV among those marginalized by gender in RRN areas in the US and Canada. The databases Embase, PubMed (including Medline), APA PsycInfo, Web of Science, CINAHL, SocINDEX, ProQuest Dissertation and Theses Global, and LGBTQ+ Source were searched.

**Results:** The search was conducted by a librarian. Following removal of duplicates 2329 records were screened for title and abstract eligibility. A total of 316 records were retrieved for full-text screening, and 33 records are included in this scoping review. This included 26 records focused on IPV, five on GBV, and two on SV.

## Keywords

Canada, gender-based violence, intimate partner violence, scoping review, sexual violence, USA, women.

## Introduction

The prevalence of violence against women continues to be a pervasive public health issue. Globally, one in three women have experienced intimate partner violence (IPV) or sexual violence (SV) in their lifetime<sup>1</sup>. Advocates often signify these rates as an underestimation of the problem because IPV, SV, and gender-based violence (GBV) are not often reported to the authorities<sup>2,3</sup>. There is also evidence that suggests incidences of IPV, SV, and GBV are higher in rural, remote, and Northern (RRN) geographical areas<sup>4</sup>. The psychological, physical, and financial impacts of this violence is well documented, and studies have shown that individuals who experience this type of violence have negative health and mental health outcomes that can persist for years after the abuse occurred<sup>5</sup>. Therefore, determining the lived experience of individuals who are victims/survivors of IPV and SV is an important social issue. For this reason, a scoping review was conducted to explore existing literature on the experiences of IPV and SV victims/survivors from RRN regions. To conduct the scoping review, we began by identifying key terms and definitions including the concept and context<sup>6</sup>.

### Concept: Intimate partner violence and sexual violence

Assessing the existing literature regarding IPV and SV was a difficult task, as the definitions of IPV, SV, and GBV often overlap. For instance, IPV and SV are both forms of GBV if they are directed at marginalized genders. IPV can include SV, and SV could be defined as IPV. Therefore, we used all three terms, along with commonly used terms, to identify all the relevant literature. Within

**Discussion:** Overall, the scoping review determined a paucity of research on SV in RRN areas of North America. Most records in RRN areas focus on IPV. There was discrepancy in the terminology used within manuscripts, and some did not include a definition of the concept being written about. It is important for all authors writing about IPV, GV, and SV to provide definitions to assist readers in analyzing the results. Additionally, the recruitment of participants from most research projects within this scoping review centered on services that provide care for those impacted by SV and IPV, which limits recruitment to those who have already sought out assistance. More research needs to be done to engage those who have not sought help, but who have experienced SV. Lastly, rates of IPV, SV, and GBV among Indigenous populations in Canada are higher than in all other populations, yet there was a gap in the literature reviewed regarding the experiences of individuals from this population in RRN areas.

**Conclusion:** By increasing the voice of victims/survivors in this area, there is potential to advocate for more services, as well as reduce stigma in these areas. Something must be done to decrease the rates of IPV and SV in RRN areas, and further research and knowledge development could be vital in advancing prevention efforts.

the broader categories of GBV, IPV, and SV, there are also other common terms. IPV has also been referred to as domestic violence, partner abuse, wife battering, and dating violence in the literature<sup>7</sup>.

One of the key factors of IPV is that a previous or current intimate partner initiates the abuse, and can include acts of sexual coercion, rape, unwanted sexual contact, physical violence, stalking, and psychological aggression<sup>8,9</sup>. By comparison, SV is any attempted or completed sexual act that is unwanted by the victim/survivor<sup>10</sup>. Any person can perpetrate SV, and unlike IPV the victim/survivor does not need to know the perpetrator or have had a previous relationship with them. Examples of SV include coercion, stealthing, rape, attempted rape, and sexual assault. GBV is a more fulsome term, that encompasses all violence directed at individuals based on their gender, gender expression, gender identity, or perceived gender. GBV includes physical, psychological, sexual, technology-facilitated, economic, emotional, and societal violence<sup>11</sup>. Although distinct terminology, IPV, SV, and GBV are often tangled because of the similarities between the experiences of violence. For instance, the term 'intimate partner sexual violence' is used to describe SV that occurs within intimate partner relationships<sup>12,13</sup>.

### Context: Rural, remote, and Northern

Those marginalized by gender, such as cisgender women, transgender, non-binary, and other gender-diverse individuals, are at a significantly higher risk of experiencing IPV in RRN areas compared to those in urban settings<sup>4,14</sup>. Women in RRN areas contend with more severe violence, and they are less likely to report or access the supports they require<sup>11,14</sup>. In 2022, it was determined that at least 42% of victims of femicide, the most

harmful form of IPV and GBV, lived in rural or remote areas in Canada<sup>15</sup>. Additionally, this proportion increased by 27% in 2022 when compared to 2019, which shows the issue is amplifying<sup>15</sup>. In the US, it is difficult to ascertain the exact numbers of femicide due to a lack of codification and national surveillance; however, advocates have been calling for femicide to be classified and defined within the penal code to provide better statistics and trackable data<sup>16</sup>. Considering that at least 20% of the North American population lives in RRN areas, this increased risk of IPV and SV is problematic<sup>17</sup>.

RRN areas face unique challenges in addressing IPV and SV due to factors such as geographical isolation, a lack of services that support women with IPV and SV, social stigma, and a lack of understanding surrounding the complexities of IPV and SV from rural service providers<sup>18-21</sup>. Complicating the issue, the culture in RRN communities often deters individuals from seeking and obtaining services that will support them<sup>22</sup>. Heteronormative beliefs are perpetuated in rural areas, which conforms women to traditional gendered stereotypes<sup>23</sup>. Financial dependence, commitments to children, extended family, and pets all compound this typical narrative<sup>20,24</sup>, making it harder for women to leave to access assistance. A lack of appropriate and timely services increases the risk to victims/survivors and prolongs their trauma experiences if they do seek out justice, mental health, or physical health services<sup>25</sup>. Lastly, the close-knit communities, smaller population sizes, and isolation of RRN communities may require that the victim/survivor remain in regular contact with their perpetrator, increasing the trauma they experience<sup>20</sup>.

To prepare for the scoping review, the authors conducted a preliminary review of IPV and SV in RRN communities using Google Scholar. The quick review identified 17,300 results, showing a wealth of information on the topic. However, upon further review, it was found that the manuscripts focused on outlining the risk factors for this type of violence<sup>21,26</sup>, the experiences of service providers in RRN areas<sup>4,18,27</sup>, or they focused on quantitative studies from outside the targeted area<sup>28,29</sup>. There was limited literature focusing on the lived experience of these instances of violence in RRN populations<sup>4</sup>. Therefore, a comprehensive scoping review on the topic was warranted.

## Methods

Arksey and O’Malley introduced the first methodological framework for conducting scoping reviews, which has since been reviewed and refined by other researchers<sup>30,31</sup>. This review followed the enhanced methodology outlined by Levac and colleagues, who maintained the original stages of the Arksey and

O’Malley framework while offering greater guidance on the implementation<sup>30,31</sup>. The scoping review process adhered to the following five stages: identifying the research question; identifying relevant studies; study selection; charting the data; and collating, summarizing, and reporting the findings<sup>30,31</sup>. The review utilized the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) reporting guidelines<sup>32</sup>. The protocol was registered with Open Science Framework following development of the study protocol and search strategy.

### Stage 1: Identifying the research question

Due to the broad nature of the research question, a scoping review was selected as the method, allowing for synthesis of a wide range of information on this topic<sup>31</sup>. A scoping review was conducted to answer the question ‘What is available in the evidence regarding the lived experience of SV and IPV among those marginalized by gender in RRN areas in North America?’ The aim of the review was to identify evidence available regarding the experiences of SV and IPV in RRN areas, identify key characteristics and factors associated with SV and IPV in RRN areas, and identify and analyze current knowledge gaps.

### Stage 2: Identifying relevant studies

Initial search terms were identified to best reflect the three main concepts of this study: IPV, rural, and research methodologies to be included. These were searched and refined using Embase, PubMed (including Medline), APA PsycInfo, Web of Science, CINAHL, SocINDEX, ProQuest Dissertation and Theses Global, and LGBTQ+ Source. Next, subject headings, where available, were consulted to improve the search strings. After consultation with the research team, concept keywords were selected and combined using Boolean operators ('AND', 'OR'), wildcards ('\*'), phrase searching, and proximity operators ('W#'). Proximity searches were used instead of phrase searching to ensure a wider range of relevant results for concepts that might not be expressed as a phrase. Search strings were adjusted for each database to maximize its usefulness. Finally, the reference lists of all included studies were screened to identify additional articles that met the inclusion criteria. A librarian completed the searches in collaboration with other members of the review team. We initially searched for articles published from 2005 to October 2024.

However, the publication range was narrowed to 2015 to March 2025 after screening over 60 articles that met the review criteria. The updated exclusion criterion is indicated as ‘wrong date’ in the PRISMA flowchart (Fig1). The search strategy utilized for CINAHL is presented in Table 1.

**Table 1: Search strategy for CINAHL**

Population, concept, context	(rural OR remote OR northern) AND ('intimate partner violence' OR partner W2 violence OR partner W2 abuse OR spous* W2 abuse OR sexual W2 violence OR Sexual W2 abuse OR domestic W2 violence OR domestic W2 abuse OR sex W2 offences OR rape OR stealthing OR Sexual W2 Coercion)
Study design	AND (qualitative W2 (research OR study OR studies OR method*) OR case W0 (study OR studies) OR ethnographic W1 (research OR study OR studies OR method*) OR ethnologic* W1 (research OR study OR studies) OR ethnonurs* W1 (research OR study OR studies) OR ethnonursing W1 (research OR study OR studies) OR 'focus group*' OR 'grounded theory' OR historical W0 (research OR study OR studies) OR interview* OR 'lived experience*' OR 'mixed method*' OR multimethod W1 (study OR studies) OR 'action research' OR 'participatory research' OR phenomenolog* W1 (research OR study OR studies OR analysis) OR 'phenomenology' OR 'document analysis' OR Hermeneutics OR 'Narrative analysis' OR 'Thematic analysis' OR 'participant observation' OR 'conversation analysis').

### Stage 3: Study selection

The population for this review involved individuals marginalized by gender (women, transgender, and non-binary individuals) who were 18 years or older and who had lived experience of SV and/or IPV. This population was selected because SV and IPV impacts those marginalized by gender more than cisgender males<sup>18,33,34</sup>. The context of the study is RRN locations of developed countries in North America (US and Canada). Initially, the review considered other developed countries such as Australia, New Zealand, and the UK. However, as previously mentioned, due to the large number of included studies, a geographical filter was applied to limit the included articles to the US and Canada. The updated exclusion criterion is noted as 'wrong geographical location' in the PRISMA flowchart. Developed countries in North America were selected for the review as they are high-income countries, with predominantly English-speaking residents, similar colonial histories, comparable medical standards, democratic governance, and feminist movements that have countered and challenged gendered violence and are equivalent or comparable countries<sup>35,36</sup>. The reviewers accepted all definition and descriptions of RRN identified by authors for inclusion.

Given that the research question focused on lived experiences, the review incorporated qualitative and mixed-methods studies. Mixed-methods studies were included if the qualitative component was presented in the findings. In addition, reviews, dissertations, and theses that met the inclusion criteria were considered. If publications were derived from dissertation/theses data, the dissertation/theses were included for analysis, rather than the published articles, given the wealth of information included in these sources.

Covidence was used as the review software to standardize the review process (<https://app.covidence.org/reviews/488006>). To ensure reliability of the results, two researchers reviewed the data independently during all stages of the review, including title and abstract screening, full-text review, and data extraction. A third, independent team member resolved any discrepancies that occurred during the review. When the decision was unclear, the team engaged in discussions to reach a consensus. The search identified 4502 articles of which 2173 were identified as duplicate records. Therefore, 2329 articles were reviewed. Thirty-two studies were identified as meeting the inclusion criteria, and one additional article was located after reviewing the reference lists of the included studies. A total of 33 articles were included in the review (Fig1).

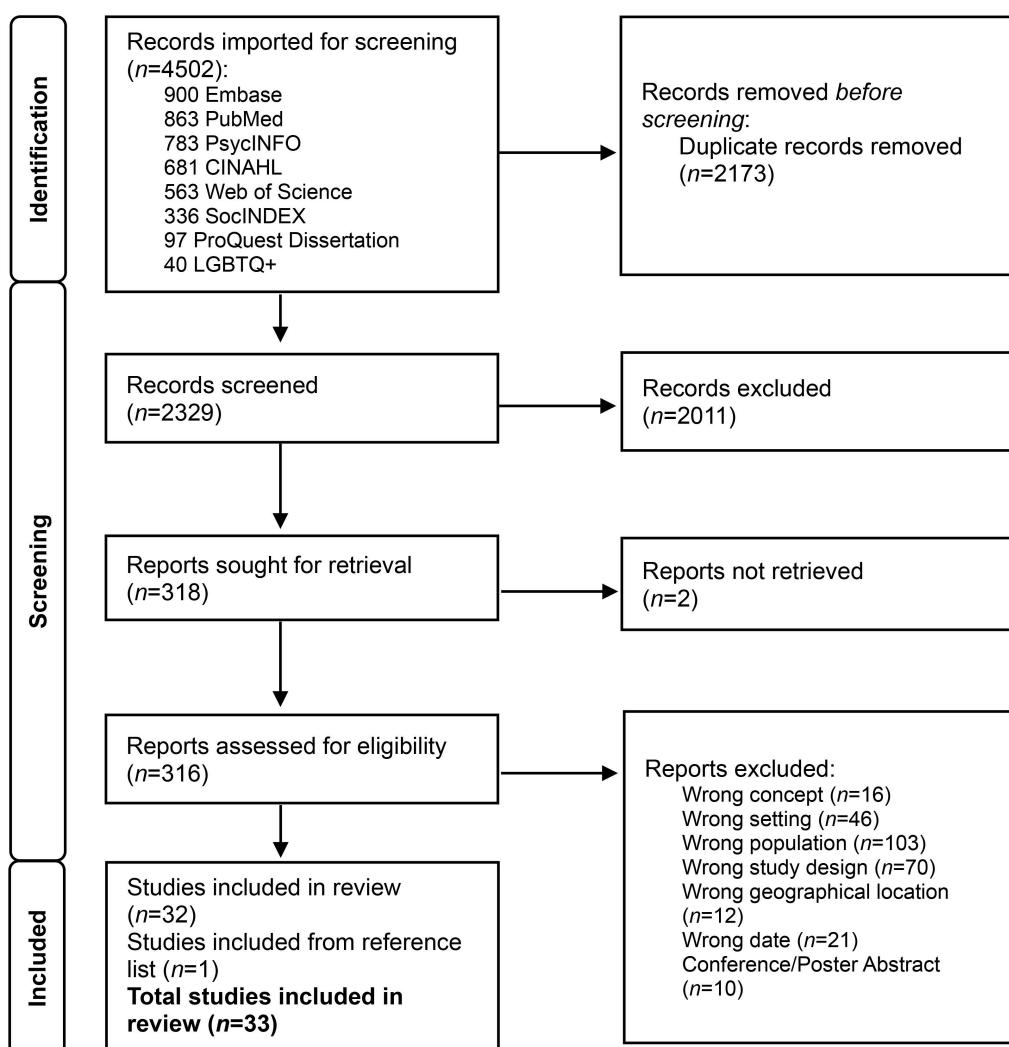


Figure 1: PRISMA flowchart for identification of relevant studies.

## Stage 4: Charting the data

Data from all 33 articles were charted using a data extraction framework developed by the research team based on JBI guidelines<sup>37,38</sup>. The framework was piloted by team members prior to finalizing. Data were extracted regarding the author, year of publication, method, data collection, recruitment strategy, conceptual framework, sample, type of violence, and setting. Definitions regarding the type of violence and RRN were also included. Two members of the research team independently completed the data extraction table. A third, independent team member compared and finalized the chart.

## Stage 5: Collating, summarizing, and reporting the findings

A descriptive approach to analysis was utilized including doing frequency counts (percentages and proportions) of data extraction items<sup>30,31,39</sup>. In addition, a narrative summary was utilized to describe how the results relate to the reviews, objectives, and research question<sup>39</sup>.

## Results

The described results refer to 33 manuscripts on the experiences of IPV, SV, and GBV of RRN women. Tables 2, 3, and 4 provide the demographics of the manuscripts, including the population, country of origin, and study design.

**Table 2: Articles by population, country of origin, and study design for intimate partner violence (n=26)**

Population	Study design	Country of origin	Author and year
Not specified (n=13)	Qualitative	US	Bryant (2020) <sup>40</sup> ; Riffe-Snyder (2017) <sup>41</sup> ; Wimbush (2024) <sup>42</sup> ; Mullany and Gubrium (2024) <sup>43</sup> ; Ravi (2024) <sup>44</sup> ; Roush and Kurth (2016) <sup>45</sup>
		Canada	Kohtala (2021) <sup>46</sup> ; Wood et al (2024) <sup>47</sup> ; Mantler et al (2022) <sup>48</sup> ; Hovey and Scott (2019) <sup>49</sup> ; Mantler and Wolfe (2017) <sup>50</sup> ; Mantler et al (2024) <sup>51</sup>
	Mixed methods	US	Bender (2015) <sup>52</sup>
Pre-natal, peri-natal, and mothers (n=5)	Qualitative	US	Burnett et al (2016) <sup>53</sup> ; Bacchus et al (2016) <sup>54</sup>
		Canada	Nixon et al (2017) <sup>55</sup> ; Jackson et al (2024) <sup>56</sup>
	Mixed methods	US	Bhandari et al (2015) <sup>57</sup>
Women aged ≥50 years (n=2)	Qualitative	US	Roberto and McCann (2021) <sup>58</sup>
		Canada	Weeks et al (2016) <sup>59</sup>
Women who use substances (n=2)	Qualitative	US	Copes et al (2021) <sup>60</sup> ; Stone et al (2021) <sup>61</sup>
Indigenous women (n=2)	Qualitative	Canada	Brassard et al (2015) <sup>62</sup> ; Gledhill and Moffit (2024) <sup>63</sup>
Women in the LGBTIA+ community (n=1)		Canada	Soares (2020) <sup>64</sup>
Women who experience homelessness (n=1)	Qualitative	Canada	Flynn et al (2023) <sup>23</sup>

**Table 3: Articles by population, country of origin, and study design for gender-based violence (n=5)**

Population	Study design	Country of origin	Author and year
Not specified (n=2)	Qualitative	US	DeKeserdy and Hall-Sanchez (2017) <sup>65</sup>
		Canada	Yates et al (2023) <sup>66</sup>
Women with disabilities (n=3)	Qualitative	US	Aguillard, Gemeinhardt et al (2022) <sup>67</sup> ; Aguillard, Hughes, Gemeinhardt et al (2022) <sup>68</sup> ; Aguillard Hughes, Schick et al (2022) <sup>69</sup>

**Table 4: Articles by population, country of origin, and study design for sexual violence (n=2)**

Population	Study design	Country of origin	Author and year
Not specified (n=1)	Qualitative	US	Giroux (2017) <sup>70</sup>
Indigenous women (n=1)	Qualitative	US	Braithwaite (2016) <sup>71</sup>

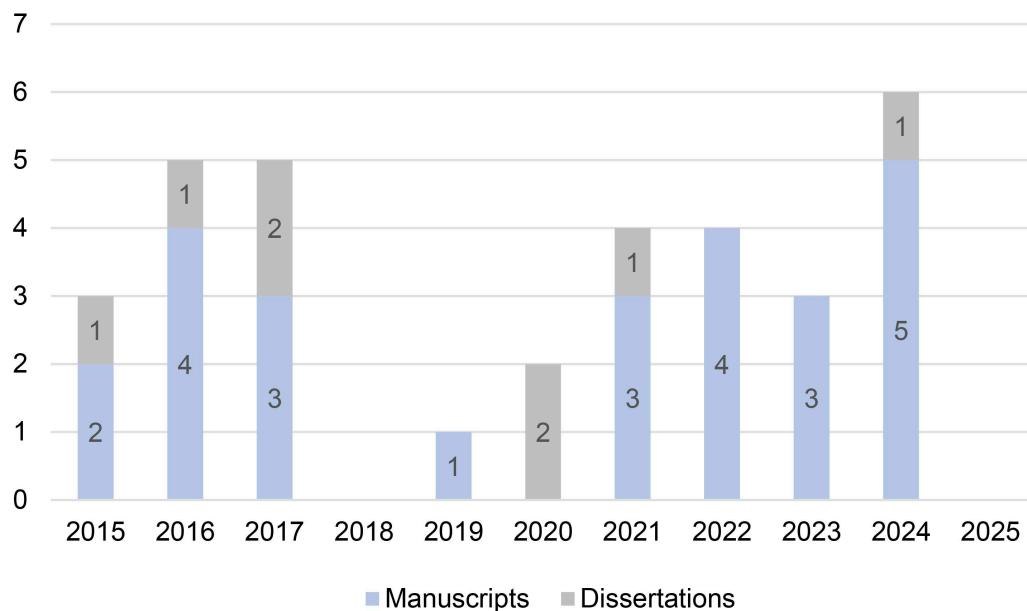
## Country of origin and study design

The articles included in the study were analyzed for country of origin and study design. Over half of the manuscripts included in this scoping review were written in the US (n=19, 58%) and 42% were from Canada (n=14). Given the nature of the research question and inclusion criteria, it is not surprising that most studies were qualitative (n=30, 91%), and the remainder utilized a mixed-methods approach (n=3, 9%). Nearly a quarter (n=8, 24%) were dissertations/theses<sup>40-42,46,52,64,70,71</sup>. Figure 2 outlines the type of publication, either articles or theses, and the date of publication.

In this review, most authors used a single source of data collection, primarily individual interviews (n=28, 85%), or less commonly focus groups (n=1, 3%). A smaller number of studies employed a variety of data collection strategies. These included combinations of interviews, observations, and field notes (n=2, 6%), as well as the use of photographs alongside interviews or focus groups (n=2, 6%).

In terms of recruitment strategies, over half of all manuscripts (n=17, 52%) described using a combination of approaches including asking service providers (eg women's shelters and crisis center staff) to share recruitment information, along with community-based methods (eg community flyers, newspaper ads, and social media). Other studies relied exclusively on service

providers ( $n=9$ , 27%) or community-based strategies ( $n=4$ , 12%) to distribute recruitment information. Three studies (9%) did not specify recruitment methods.



**Figure 2: Publication type by year.**

### Conceptual frameworks

The most frequently reported conceptual framework to be utilized aligned with a feminist and/or intersectional lens ( $n=13$ , 39%). Of these, a feminist intersectional lens ( $n=5$ , 15%), feminist theory ( $n=4$ , 12%), and intersectionality ( $n=1$ , 3%) were utilized. A few other studies applied a feminist or intersectional theory in combination with other models ( $n=3$ , 9%). Kohtala reported utilizing multiple frameworks including intersectionality, a socioecological model, and an exposure reduction framework<sup>46</sup>. Wimbush utilized the superwoman schema (a feminist model) and adult resilience theory<sup>42</sup>, whereas Roberto and McCann reported using feminist theory and life course theory to guide their research<sup>58</sup>. Additionally, the Consolidated Framework for Implementation Research, Ecological Systems Theory, family resilience theory, the interpretivist paradigm, space for action theory, standpoint theoretical perspective, story theory, strengths perspective, and symbolic interactionism were each reported as being utilized in one study ( $n=1$ , 3%). Eleven studies (33%) did not include details regarding a conceptual framework. However, Aguiard and colleagues listed feminist disability theory as the conceptual framework in one of the three articles written about the Rural Safety and Resilience Study<sup>67-69</sup>.

### Populations

As discussed, the articles reviewed were focused on the lived experiences of victims/survivors. Most focused on IPV ( $n=26$ , 79%), with only 15% on GBV ( $n=5$ ), and 6% on SV ( $n=2$ ). In addition, the definitions used to describe these experiences of violence varied. It is important to note the discrepancies, as many authors incorporated specific factors important to their population of study in the definition, a point that will be discussed later. Among all the studies, there were six distinct population groups, and the others were non-specified. The experiences of specific groups were

represented as follows: 15% ( $n=5$ ) of studies focused on prenatal, perinatal, and mothers; 9% ( $n=3$ ) on women who experience disabilities; 9% ( $n=3$ ) on Indigenous women; 6% ( $n=2$ ) on women aged 50 and older; 6% ( $n=2$ ) on women who use substances; 3% ( $n=1$ ) on women in the LGBT2+ (lesbian, gay, bisexual, transgender, and two-spirit) community; and 3% ( $n=1$ ) on women who experience homelessness. The remainder of the manuscripts, 48% ( $n=16$ ), were non-specified; however, in studies that included unspecified populations, most participants were classified as white, heterosexual, and able-bodied as outlined in Tables 2, 3, and 4.

### Aims of studies reviewed

#### *Experiences of victims/survivors*

The purposes of the studies are listed in Table 5. Almost half of the studies ( $n=16$ , 49%) aimed to explore the experiences of victims/survivors of IPV, SV, and GBV, with experience being broadly defined. Some authors aimed to determine the experiences of IPV for individuals with diverse ethnicities, ages, gender identities, and sexualities<sup>41-43,47,57,58,62-64</sup>. Some of the manuscripts focused on specificity in the intersections between IPV and other forms of marginalization, while others examined experience across intersections. Other authors aimed to determine how different social situations, such as substance use<sup>60</sup> impacted the experience of IPV. Lastly, IPV during pregnancy or motherhood<sup>53,55</sup> was also considered. Survivor experiences of transportation coercion<sup>44</sup>, and homelessness<sup>23</sup> were explored as well.

Regarding articles that featured experiences of GBV and SV, some looked at differing ethnicities, gender identities, and sexualities<sup>70,71</sup>. DeKeseredy and colleagues aimed to determine the experiences of GBV and SV among separated and divorced women<sup>65</sup>.

**Table 5: Article purposes and demographic information for included studies**

Author, year, country	Context	Aim/purpose	Participants
Flynn et al (2023) <sup>23</sup> , Canada	Rural: largely resource-based economies	To determine how violence and homelessness overlap in the life courses of women from two regions of Quebec.	n=22 women including 1 transwoman; ages 23–61 years Ethnicity Majority W, 1 I
Braithwaite (2016) <sup>71</sup> , US	Rural: author specified	To examine the problem of violence against Alaska Native women through the individual and collective voices of survivors.	18 women; ages not specified Ethnicity Alaska Native
Bryant (2020) <sup>40</sup> , US	Rural: U.S. Census Bureau	To explore psychosocial factors related to culture and community that contribute to or lead to successful outcomes for victims of IPV.	12 women; ages 27–67 years Ethnicity 5 W 6 L 1 B
Giroux (2017) <sup>70</sup> , US	Rural: population of less than 50,000	To gain a deeper understanding of the lived experiences of female sexual assault trauma survivors from a rural setting and how providers can best support them.	n=7 women; mean age 25.6 years Ethnicity 2 Alaska Native, 1 B, 4 W
Riffe-Snyder (2017) <sup>41</sup> , US	Rural: population of less than 2500	To explore past IPV as it occurs in Appalachian women residing in rural and non-urbanized areas.	n=12 women; ages 32–57 years Ethnicity 1 B, 11 W
Soares (2020) <sup>64</sup> , Canada	Rural: population less than 30,000 and more than 30 minutes away from a community with a population of greater than 30,000	To explore the intersection of gender, sexuality, and rurality on a person's experience of seeking health and social services following IPV.	n=4 lesbian, gay, bisexual, transgender, and queer women; mean age 26.75 years Ethnicity not specified
Wimbush (2024) <sup>42</sup> , US	Rural: an area with low population density	To identify the coping strategies used by African American women who have survived DV living in rural areas.	n=8 women; ages 25–69 years Ethnicity 8 B
Bender (2015) <sup>52</sup> , US	Rural: medically underserved area	To understand experiences of IPV survivors concerning providers' responses, quality of care, and self-reported outcomes after disclosure.	n=20 women; ages not specified Ethnicity 17 W, 1 MR, 1 B, 1 L
Kohtala (2021) <sup>46</sup> , Canada	RRN: Rural: population of less than 10,000; remote: areas that are not road accessible year-round; Northern- defined province and territories	To explore the barriers in preventing safety planning among DV survivors in RRN regions and determine the best practices for supporting survivors.	n=20 women; ages 20–70 years Ethnicity 7 I, 13 non-Indigenous
Roberto and McCann (2021) <sup>58</sup> , US	Rural: author specified	To explore how women experienced IPV over the course of their lives and which resources were most helpful when they decided to end their most current relationship.	n=10 older women; ages 54–70 years Ethnicity 10 W
Aguillard, Gemeinhardt et al (2022) <sup>67</sup> , US	Rural: author specified	Rural safety and resilience study. Explore women with disabilities expectations, facilitators, and barriers to help seeking and securing safety.	n=33 women; ages 19–72 years Ethnicity 24 W, 3 B, 2 L, 3 I, 1 MR
Aguillard, Hughes, Gemeinhardt et al (2022) <sup>68</sup> , US	Rural: author specified	Rural safety and resilience study. Purpose is to highlight women with disabilities process of learning about and accessing services.	n=33 women; ages 19–72 years Ethnicity 24 W, 3B, 2L, 3I, 1 MR
Aguillard, Hughes, Schick et al (2022) <sup>69</sup> , US	Rural: author specified	Rural safety and resilience study. Purpose is to highlight women with disabilities process of learning about and accessing services.	n=33 women; ages 19–72 years Ethnicity 24 W, 3B, 2L, 3I, 1 MR
Bhandari et al (2015) <sup>57</sup> , US	Urban and rural: author specified	DV enhanced home visit study. To determine if perinatal IPV differs between African American women living in urban and rural environments.	n=12 women (6 urban and 6 rural); ages not specified Ethnicity 12 B
Brassard et al (2015) <sup>62</sup> , US	Remote: author specified	To gain a better understanding of the underlying causes of the overrepresentation of Aboriginal women among victims of DV.	n=40 (22 Aboriginal residents and 18 service providers); age and ethnicity not further specified
Glecia and Moffitt (2024) <sup>63</sup> , Canada	RRN: Northern territories and northern parts of several provinces with a population less than 10,000	To understand Indigenous mothering within the contexts of Indigenous identities, IPV, and RRN places.	n=16 women; ages 25–58 years Ethnicity 16 I
Wood et al (2024) <sup>47</sup> , Canada	Rural: outside a metropolitan area including small towns and villages, farms, First Nations, and northern communities	To explore rural women's experiences of IPV and coercive control and how conditions of rurality exacerbate these experiences.	n=26 (13 women and 13 service providers); age and ethnicity not specified
Mullany and Gubrium (2024) <sup>43</sup> , US	Rural: author specified	To examine the affordances of using composite narratives in presenting research findings from rural survivors of IPV.	n=40 (32 women and 8 service providers); age not specified Ethnicity 94% W
Copes et al (2021) <sup>60</sup> , US	Rural: author specified	To understand how people who use meth make sense of their lives.	n=1 woman; age and ethnicity not specified
Burnett et al (2016) <sup>53</sup> , US	Rural: area outside of urban area with less than 2500 residents	To explore lived experience of IPV during pregnancy and the first 2 postpartum years.	10 women; ages 16–32 years Ethnicity 7 W, 3 B or L
Nixon et al (2017) <sup>55</sup> , Canada	Urban and Northern. Urban: approximately 700,000 people; Northern: small northern city with a population of 13,000	To examine how abused mothers protect their children from the harms of violence perpetrated against the mothers.	n=18 women (9 urban and 9 Northern); mean age 34.3 years Ethnicity 14 I, 4 UL

Ravi et al (2024) <sup>44</sup> , US	Urban, sub-urban, rural: author specified	To explore IPV survivors' experiences with transportation coercion.	<i>n</i> =20 women (7 urban, 8 sub-urban, and 5 rural); mean age 28 years Ethnicity 9 W, 8 B, 1 L, 1 MR
DeKeserdy and Hall-Sanchez (2017) <sup>65</sup> , US	Rural: author specified	To use a talk-back method with 12 new participants, to reflect on previous study.	<i>n</i> =55 women; age and ethnicity not specified
Bacchus et al (2016) <sup>54</sup> , US	Urban and rural: author specified	DV enhanced home visit study. To explore experiences of being screened for IPV during perinatal home visits.	<i>n</i> =26 women; ages 16–35 years Ethnicity 12 W, 8 B, 4 MR, 2 UL
Mantler et al (2022) <sup>48</sup> , Canada	Rural: populations less than 30,000	To explore the intersection of women's experiences of rural health care within the context of IPV.	<i>n</i> =8 women; ages 21–64 years Ethnicity 2 I, 6 UL
Stone et al (2021) <sup>61</sup> , US	Rural: author specified	To explore barriers to substance use treatment for women who experience IPV and opioid use in rural Vermont.	<i>n</i> =33 (32 women and 1 transgender/gender non-binary/gender queer); mean age 35 years Ethnicity majority W
Roush and Kurth (2016) <sup>45</sup> , US	Rural: population less than 50,000	To understand the lived experience of IPV for women living in a rural setting to inform efforts to provide effective care, support, and resources.	<i>n</i> =12 women; mean age 49 years Ethnicity 12 W
Weeks et al (2016) <sup>59</sup> , Canada	Rural: living some distance to a major urban center	To explore the resources that rural women in midlife and older use to leave abusive partners.	<i>n</i> =8 women; ages 50–74 years Ethnicity 8 W
Hovey and Scott (2019) <sup>49</sup> , Canada	Rural: several small towns with no public transportation linking the communities	To explore how women who have accessed a women's shelter experience harm reduction approaches.	<i>n</i> =25 women; mean age 41.5 years Ethnicity not specified
Mantler and Wolfe (2017) <sup>50</sup> , Canada	Rural: population of 20,335	To explore changes to a rural Ontario women's shelter and how the shelter has adapted to address the changes.	<i>n</i> =10 (4 women and 6 service providers); ages 15–64 years Ethnicity not specified
Jackson et al (2024) <sup>56</sup> , Canada	Rural: author specified	To explore the role of resilience in the context of mothers who have experienced IPV in rural settings.	<i>n</i> =18 (6 women and 12 service providers); women ages 36–57 years Ethnicity not specified
Mantler et al (2024) <sup>51</sup> , Canada	Rural: populations ranging from 2000 to 42,000	To explore how rural women experiencing IPV cultivate resilience and the ability to survive and thrive.	<i>n</i> =36 (14 women and 12 service providers); ages 18–57 years Ethnicity not specified
Yates et al (2023) <sup>66</sup> , Canada	Rural: populations ranging from 2000 to 42,000	To fill this gap by exploring how resilience is influenced by economic abuse in rural Ontario in the context of GBV.	<i>n</i> =36 (14 women and 12 service providers); ages 18–57 years Ethnicity not specified

### Experiences with external supports and services

Several studies explored victims/survivors' experiences with external support (*n*=13, 39%). The most common external support was formal support, which included health services, substance use treatment, counselling, and mental health supports for IPV victims/survivors<sup>45,48,52,54,61</sup> and GBV victims/survivors<sup>67–69</sup>. Researchers explored the experiences of victims/survivors with informal or community supports when impacted by IPV<sup>46,59</sup>. Authors aimed to determine the experiences of IPV victims/survivors with a variety of other services, including shelters<sup>49,50</sup>, and community culture or readiness more broadly<sup>40</sup>.

### Identifying internal strength

The remaining publications considered the victims/survivors' internal strengths (*n*=4, 12%). Determining IPV victims/survivors' resilience<sup>51,56</sup> and coping<sup>42</sup> were included in the aims of these articles. When considering internal strengths, one manuscript focused on resilience of GBV victims/survivors<sup>66</sup>.

### Definition of rural, remote and Northern

As mentioned above, for articles to be included in this scoping review the authors needed to indicate that the research was conducted in RRN areas. We categorized RRN based on how each author defined it. Studies that indicated rural participants or a rural geographical setting were included. There were inconsistencies in how authors defined RRN and only 58% (*n*=19) of authors provided a definition. Terms used to describe rural communities included areas with a low population density<sup>42</sup>, outside of urban centers<sup>47,59</sup>. Descriptions such as resource-based economies<sup>23</sup>, and medically underserved areas<sup>52</sup> were also used. The definition used most frequently among authors was an environment that had

a population of less than 30,000 people (*n*=3, 9%)<sup>48,50,64</sup> and populations less than 50,000 people based on the non-metropolitan counter from the US Census (*n*=3, 9%)<sup>40,45,70</sup>. Approximately 6% of articles described 'rural' as being less than 2500 people (*n*=2)<sup>41,53</sup> or as less than 10,000 people (*n*=2)<sup>46,63</sup>. In addition, one author described 'rural' as describing areas with populations ranging from 2000 to 42,000 (*n*=1, 3%)<sup>66</sup>. The authors who discussed remote areas included areas that were inaccessible by public transportation<sup>46,49</sup>. When the term 'Northern' was used, it was defined to include all three of the Canadian Northern Territories, as well as the areas defined as Northern by individual provinces<sup>46</sup>, and populations less than 13,000<sup>55</sup>.

### Concepts of intimate partner violence, sexual violence, and gender-based violence

The articles reviewed focused on IPV (*n*=26, 79%), GBV (*n*=5, 15%), and SV (*n*=2, 6%). For this review, we used the labels indicated by the authors to help identify and categorize the studies. Definitions changed depending on the perpetrator, and the acts of violence included in the definitions.

### Intimate partner violence

Of the articles that focused on IPV, 38% of the authors did not provide a definition for IPV<sup>23,43,44,49,53,55,59–62</sup>. WHO's definition of IPV was a common definition used by authors<sup>40,41,54</sup>. This definition indicates that IPV includes any behavior within an intimate relationship that causes, physical, psychological, or sexual harm<sup>9</sup>. Roberto and McCann added neglect and financial abuse to their definition of IPV in the context of older adult women<sup>58</sup>. Others defined violence in the same context as the WHO definition but provided more detail on what defined an intimate partner,

including current and former dates, boyfriends, husbands, and cohabitating partners<sup>46,57</sup>. Other authors added an element of coercive control to the definition of IPV<sup>42,48,50,51,56,63</sup>.

### *Gender-based violence*

Some of the authors chose to use the term GBV, rather than IPV or SV. For three authors, this definition was used to account for all forms of violence in all romantic and familial relationships<sup>67-69</sup>. DeKeseredy and Hall-Sanchez defined GBV broadly to include physical, sexual, psychological, financial, economic blackmail, and material forms of violence, withholding of a woman's earned wages, and harm to possessions and animals<sup>65</sup>. Yates and colleagues used the term GBV to recognize the specifically gendered and coercive, controlling nature of all forms of violence, meant to reinforce subordination among victims<sup>66</sup>.

### *Sexual violence*

The remaining two articles used variations of the term SV to describe the violence experienced by victims/survivors. Rape, sexual assault, sexual abuse, and IPV were the terms used to describe SV<sup>70</sup>. Braithwaite used broad terminology to describe SV and did not provide a definition for their terms<sup>71</sup>.

### **Factors associated with intimate partner violence, sexual violence, and gender-based violence**

Unique contextual factors influenced experiences of IPV, SV, and GBV in RRN areas. The most common barrier reported involved socioeconomic conditions, as 70% of studies indicated that financial difficulties and housing insecurity limited individuals' ability to access services or leave abusive relationships<sup>23,40,41,43,45,47,48,50-56,58-60,62,65,66,69,71</sup>. Similarly, over half of the studies (55%) found that geographic isolation and inadequate transportation created barriers to accessing support and escaping abusive relationships<sup>41,44-47,51-53,55,59,61,62,65-69,71</sup>. Privacy concerns, combined with fear, stigma, and shame, often discouraged individuals from disclosing abuse and/or contacting law enforcement in 61% of studies<sup>23,41-43,45-47,51-54,59-62,64,68-70</sup>. Traditional gender norms and patriarchal rural culture were described in 48% of studies as factors that normalize IPV and contribute to women's reluctance to seek help<sup>23,41,43,45-47,51-53,55,60,62,63,65,66,68</sup>.

In addition, service-related limitations, identified in 67% of studies, included a lack of specialized, trauma-informed, and culturally sensitive supports, along with insufficient provider expertise and screening related to IPV, SV, and GBV<sup>23,40,42,46-52,54,55,58,59,61-64,67-69,71</sup>. Only four studies (12%) reported a lack of awareness or knowledge of available resources and services in RRN areas<sup>40,52,54,59</sup>. Despite the barriers encountered, positive interactions with service providers were associated with healing and recovery. Forty-two percent of studies reported that knowledgeable, empathetic, trauma-informed, culturally sensitive, and non-judgmental provider responses fostered improved outcomes<sup>46,48-52,54,56,63,64,67-71</sup>. Additionally, across the literature, characteristics of resilience and internal strengths were prevalent among the victim/survivor participants<sup>23,40-56,58-71</sup>.

## **Discussion**

The authors conducted an in-depth scoping review of IPV, SV and GBV in RRN areas of the US and Canada. Overall, we determined that most manuscripts published on IPV and SV in RRN areas

focused on IPV. A paucity of literature depicting non-partner sexual violence or specifically addressing IPV existed. Furthermore, the experiences of transgender, non-binary, and other gender-diverse individuals were under-represented. Due to the overwhelming statistics associated with SV in RRN areas<sup>1</sup>, there is a need for further research examining the lived experiences of SV within this context. Although many SV victims/survivors have indicated their perpetrators are acquaintances<sup>8</sup>, this does not mean that they consider them to be intimate partners<sup>72</sup>. For instance, in over half of the reported sexual assaults in Canada, the perpetrator was identified as an acquaintance, neighbor, or friend<sup>73</sup>. By limiting the experiences by using language that includes intimate partnership, this may exclude the voices of individuals who are violated by someone they know but with whom they are not in an intimate relationship.

Throughout the scoping review, we found discrepancies in the definition of the terms. For instance, IPV was referred to as domestic violence and wife battering. When a definition was provided, it was most often consistent with the definition provided by WHO<sup>9,74</sup>. Other authors expanded the WHO definition to include concepts important to the population of study. As an example, Roberto and McCann emphasized neglect and financial abuse in their definitions of IPV in their study with older women<sup>58</sup>. This is consistent with other literature that emphasizes an increased reliance on partners for financial and health supports as women age<sup>75</sup>.

Like the definitions provided by authors for IPV, the definitions in articles that focused on SV also differed. For those that did provide a definition, whether as SV or sexual assault, it included a detailed description of numerous forms of unwanted sexual activities. This inclusive definition is consistent with those of other authors in the field of SV that emphasize the importance of honoring and recognizing all forms of unwanted sexual activity<sup>76</sup>. By recognizing all forms of SV, we minimize the opportunity for SV to be dichotomized by severity and criminality, which influences how individuals access support and understand their own experiences<sup>77,78</sup>.

Recruitment efforts typically employed a variety of strategies such as recruiting through services such as shelters as well as community-based approaches. Although successful, using services has a potential to bias the results to those that have already recognized the violence against them and have accessed services. This could also provide rationale regarding why most of the articles provide details on IPV, as SV victims/survivors might not access typical shelters for IPV victims/survivors<sup>72</sup>. Other authors suggest ways that research can be disseminated more effectively in RRN areas, including local newspapers, radio broadcasts, social media, podcasts, and sharing with local organizations; we encourage these methods to also be used in study recruitment<sup>79</sup>. Researchers need to be aware of and plan for these methods of recruitment, with the understanding that there might be an associated financial cost.

The findings of the scoping review provide insights into RRN realities. Consistent with studies focused on suicide and mental health, there continue to be barriers to attain service in these areas. As highlighted in the findings in this scoping review and strengthened by other studies, RRN environments have unique challenges such as reinforced gender stereotypes, confidentiality

concerns, and a lack of accessible services<sup>80-82</sup>. Complicating the issue, in RRN areas there is limited availability for services that support IPV and SV victims/survivors<sup>25</sup>. Concentrating on solutions for the lack of services is the next step for researchers and public health officials. Additionally, determining ways to make existing services safer for victims/survivors by emphasizing the importance of trauma-informed and culturally safe responses to disclosure is imperative.

Interestingly, the findings of the scoping review also show a paucity of information that focuses on the IPV and SV experiences of North American Indigenous women and two-spirit individuals. In the scoping review, very few manuscripts ( $n=3$ , 9%) focused on the experiences of Indigenous Peoples. This is surprising, as Indigenous women have higher rates of IPV, SV, and femicide compared to non-Indigenous women in North America<sup>83,84</sup>. The complexities of colonization, disruptions in power structures, racism, discrimination, and legacies of trauma on Indigenous women that influence the violence rates within that population are beyond the scope of this review<sup>85</sup>. Nevertheless, it is important to acknowledge that there is a deficit in knowledge regarding RRN Indigenous women's experiences with SV and IPV. More research needs to be done to learn about their experiences for targeted interventions.

## Research gaps and recommendations

From this scoping review, we were able to determine that definitions of IPV, SV, GBV, and RRN differ in the literature. Trying to find consistency among scholars is not necessary; rather, we encourage authors and researchers to ensure that they define the parameters of the research study to ensure clarity in analysis, and when comparing studies. This will assist individuals who are reviewing literature to have a clear understanding of the parameters of inclusion criteria for the study. Another recommendation is for researchers conducting studies in RRN areas to expand their methods of recruitment. By using more public forms of recruitment, there may be an opportunity to interact and engage with those who have not yet received services for their IPV, SV or GBV. Lastly, there is a need for further research on SV as there is a lack of information that specifically focuses on SV in RRN areas.

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## Limitations

The authors acknowledge that this scoping review had limitations. Focusing on the lived experience of IPV and SV in RRN areas was difficult due to discrepancies in languages of the terms. Although a thorough review of the available literature was conducted, the discrepancy in terms may have resulted in missed manuscripts. Additionally, there were eight dissertations/theses in this review. To avoid duplication, we kept only the dissertation/thesis if there was a manuscript based on the same study; however, this may have resulted in missed information. Lastly, as this was a scoping review and not a systematic review, we were able to identify the gaps in the current knowledge base and provide clarity around the concepts within the study<sup>6,39,86</sup>. Although this is a strength of a scoping review, it does not allow for detailed information to practitioners or services that are trying to improve instances and services for survivors/victims of IPV and SV in RRN. Further research, as well as a systematic review of best practices, is warranted.

## Conclusion

In addition to providing a review of the current literature regarding SV and IPV in RRN areas, this article also provides guidance for future researchers in this area. Future research could target and share the experiences of victims/survivors of SV and IPV in RRN areas. By increasing the voice of victims/survivors in this area, there is potential to advocate for more services, as well as reduce stigma in these areas. Something must be done to decrease the rates of IPV, SV, and GBV in RRN areas. Further research and knowledge development could be vital in advancing prevention efforts.

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## Conflicts of interest

The authors do not have conflicts of interest to report.

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