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Resilience among Rural Public Health Leaders during the COVID-19 Pandemic: A Hermeneutic Phenomenological Study

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ABSTRACT

Purpose: This study explored how rural public health leaders in Wisconsin experienced and sustained resilience during the COVID-19 pandemic, with particular attention to the role of relational connections across professional, personal, and community domains.

Methods: Using hermeneutic phenomenology, the study examined the lived experiences of rural county health officers and other supervisory leaders. Twenty semistructured interviews were conducted via Zoom between September and November 2023. Participants were purposively sampled from rural counties, as defined by the National Center for Health Statistics' Urban-Rural Classification Scheme. Interviews were recorded, transcribed, and thematically analyzed through iterative coding and synthesis.

Findings: Resilience was closely linked to the embeddedness of rural communities. Longstanding trust, shared history, and a sense of mutual responsibility strengthened leaders' resolve. At the same time, this closeness also increased feelings of scrutiny, blurred personal and professional boundaries, and exposed leaders and their families to hostility. Leaders relied on tightly knit staff teams, cross-jurisdictional peer networks, and supportive governing officials.

Conclusions: In rural settings, resilience is co-constructed through community connections. Strengthening peer support and preparing governing bodies to lead with empathy are important for sustaining this workforce.

1 | Introduction

Resilience is widely recognized as an important factor for withstanding adversity, especially in high-stress professions [1]. The American Psychological Association [2] defines it as "the process and outcome of successfully adapting to difficult life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands." Resilience reflects factors related to coping strategies of individuals, how they interact with their environments, and the relationships they have [2]. Research has shown that it supports mental health, workplace performance, and employee retention [3].

Across studies, interpersonal support from colleagues, supervisors, or communities has been shown to enhance resilience, buffer stress, prevent burnout, and improve morale in various professions, including healthcare and other high-stress frontline settings [4–6]. These high-trust relationships often function as both emotional touchstones and professional lifelines [7].

The COVID-19 pandemic placed immense strain on the public health workforce [8]. It intensified pre-existing challenges and led to greater levels of burnout and moral distress. Public health officials had to make urgent, high-impact decisions while dealing with conflicting guidance, limited resources, and constant scrutiny from the public and political figures [9, 10]. They encountered threats, harassment, and ongoing pressure as they attempted to implement evidence-based mitigation strategies [11].

These stressors were particularly acute in rural public health, where pre-existing vulnerabilities intersected with the demands of crisis. Rural health departments often operate with limited staffing, broad responsibilities, and limited backup for important roles [12, 13]. In these areas, public health leaders typically handle both administrative and operational tasks. This includes delivering direct services, coordinating emergency response, and engaging with the public [13]. This unique role potentially places them at greater risk for exhaustion and isolation.

Furthermore, the sociopolitical dynamics of rural communities shape how resilience is experienced. In small towns and counties, public health professionals are often extremely embedded within the communities they serve. They interact regularly with neighbors, elected officials, and local organizations both in professional and personal settings. These close relationships can foster greater trust and a shared purpose [14, 15]. However, they can also lead to increased emotional labor and public scrutiny, especially when health measures are controversial or politically charged. The close relational fabric of rural life means that professional decisions carry personal ramifications and blur boundaries between the two spheres.

These same community connections can also serve as powerful assets, though. Longstanding partnerships, collaboration across sectors, and a shared responsibility for community wellbeing are often features of rural public health work [16]. Professional relationships in these spaces reflect mutual investment and moral commitment. This helps build personal and collective resilience within a framework of shared decision-making [6, 17, 18]. Understanding how such relational and ecological dimensions function during times of crisis is essential to supporting and sustaining the rural public health workforce.

This study examines how rural public health leaders in Wisconsin maintained their resilience during the COVID-19 pandemic, with a particular focus on the role of relational connections among professional, personal, and community domains. Using hermeneutic phenomenology, we examine how these leaders drew on support systems to manage burnout, moral distress, and sustained visibility under pressure. As future public health emergencies arise, this work highlights the importance of investing in proactive relational infrastructure that reflects the sociocultural realities of rural practice.

2 | Methods

2.1 | Research Design

Guided by hermeneutic phenomenology, this study centers the lived experiences of rural public health leaders during the COVID-19 pandemic. Hermeneutic phenomenology is an interpretive qualitative research methodology that focuses on the nuanced lived experiences of individuals, aiming to uncover the underlying meanings and structures embedded within these experiences. Rather than seeking to describe experiences as isolated phenomena, hermeneutic phenomenology emphasizes the interpretation of experiences in context and acknowledges the co-construction of meaning between participants and researchers [19, 20]. This approach enabled a systematic interpretation of how participants made meaning of their roles and challenges within specific cultural and organizational contexts and how this affected their perceptions of their personal resilience.

2.2 | Participant Selection

Eligible participants were leaders in rural county health departments who began their employment before January 1, 2021. Rural counties were identified using the National Center for Health Statistics Urban-Rural Classification Scheme [21]. They were identified as noncore areas, characterized by towns with fewer than 10,000 residents, located outside metropolitan or micropolitan commuting zones.

Participants were recruited via state directories and snowball sampling. Thematic saturation was reached after completing 20 interviews as determined by the research team [22].

2.3 | Data Collection

Video interviews were conducted via Zoom between September and November 2023. A semistructured interview protocol, grounded in established qualitative research methods, was designed to explore participants' resilience and the support they received from their organizations during the COVID-19 pandemic. The interview guide included questions on experiences of workplace resilience and coping strategies. While the interview questions primarily focused on how the organization supported resilience, participants often expanded their answers. They included responses about factors beyond the organizational level, such as interpersonal relationships, community dynamics, and individual coping strategies. The data naturally aligned with aspects of the social–ecological model, offering insights into how resilience was shaped by interacting factors among personal, professional, and community relationships.

Each interview lasted approximately 60 min and was audio-recorded with the participant's consent. Transcriptions were developed with Otter AI software and manually reviewed for accuracy. Confidentiality was ensured by de-identifying participant information and securely storing all data on encrypted drives.

2.4 | Data Analysis

Data analysis followed hermeneutic phenomenological principles. It included iterative coding and thematic synthesis. Through inductive analysis, recurring patterns were identified and clustered into conceptual categories that reflected how

participants experienced resilience across multiple levels of influence. This article focuses specifically on the theme of connection and support, which emerged prominently across the interviews. This theme encompasses professional, personal, and community relationships that shaped how rural public health leaders endured emotional strain and navigated moral complexity during the COVID-19 pandemic.

While this article focuses on the theme of connection and support, it draws on a larger qualitative study that examined multiple dimensions of resilience among rural public health leaders during the COVID-19 pandemic. Additional themes identified through analysis included individual resilience orientation, intentional well-being practices, and work role context and demands. Analysis of these themes is currently in development for future manuscripts. The present article presents an intentional analytic focus on relational resilience, given its salience across interviews and its relevance to workforce sustainability in rural public health contexts.

2.5 | Manuscript Preparation and Editing

To support clarity and readability, the author used Grammarly (Grammarly Inc.) and ChatGPT (OpenAI) as tools for grammar checking and formatting suggestions during manuscript preparation. These tools were not used for data collection, analysis, or interpretation. All substantive interpretations and conclusions reflect the authors' original work.

2.6 | Human Participant Compliance Statement

This study was approved by the Institutional Review Board (IRB). The research adhered to the ethical principles outlined in the Belmont Report and complied with federal regulations for the protection of human subjects.

3 | Results

This study involved 20 in-depth interviews with rural public health leaders in Wisconsin from 19 jurisdictions, most of whom served as county health officers during the pandemic (see Table 1). Nearly all identified as white women, with most in the 31–40 or 51–60 age range and fewer than 10 years of tenure with their current organization.

TABLE 1 | Participant demographics.

Variable		*n*	%
Age			
	21–30 years of age	1	5
	31–40 years of age	8	40
	41–50 years of age	2	10
	51–60 years of age	8	40
	61+ years of age	1	5
Gender			
	Woman	19	95
	Man	1	5
Race			
	White	20	100
Health officer			
	Health officer	18	80
	Other supervisory role	2	10
Agency tenure			
	0–5 years in agency	6	30
	6–10 years in agency	5	25
	11–15 years in agency	2	10
	16–20 years in agency	3	15
	21+ years in agency	4	20

3.1 | Resilience Through Connection: A Relational Phenomenon

The findings affirm resilience as a multidimensional process that is affected by shifting relational continuums that rely on organizational cultures, interpersonal ties, and local sociopolitical contexts consistent with a social ecological perspective. Participants described sustaining themselves during crises through relationships within three interconnected domains: professional, personal, and community. These connections shaped leaders' actions and endurance. In rural settings where closeness amplifies both support and scrutiny, the nature of relational connection influences the experience of resilience. The relational domains and truncated illustrative evidence supporting these interpretations are summarized in Table 2.

3.2 | Professional Relationships: Staff, Peers, and Governing Entities

At the innermost circle of professional connection were relationships with staff and colleagues with whom leaders worked side by side every day. In the unique role that rural public health leaders occupy, often as the sole or most senior public health authority in their jurisdiction, professional relationships play an outsized role in shaping their experiences of stress, support, and resilience. These relationships were forged through constant interaction and mutual reliance in small, resource-limited teams. This bidirectional care defined many relationships between public health leaders and their staff, where staff and supervisors depended on one another for moral anchoring and operational stability. The relational intimacy of rural departments blurred the line between professional obligation and familial care.

Moving one step outward, beyond the daily rhythms of internal teams, participants described the vital role of cross-jurisdictional peer networks in sustaining their emotional endurance. One leader recalled, "That health officer group…people would reach out after meetings and send positive vibes…[and say] 'You're not in this alone.'" These gatherings became spaces of shared vulnerability, where leaders voiced their burdens in psychologically safe

TABLE 2 | Relational domains of resilience and illustrative evidence.

Relational domain	Domain description	Illustrative quotation
Professional	Navigation of interdependent relationships with staff, peers, and governing entities, shaped by trust, shared history, affirmation, and moral accountability.	We had a lot of group meetings so that people could talk through stuff. Most of us here are going through the same thing, and you have the same feelings, so it was someone you could talk to who could relate to what you're going through.
Personal	Management of close personal and familial relationships as sources of refuge, boundary-setting, and emotional containment amid sustained professional strain.	I also could go home and not have to fight fights there [about COVID-19]…it was a safe spot to be.
Community	Engagement with community relationships marked by longstanding embeddedness that simultaneously fostered solidarity and heightened vulnerability.	There is no one else. You have to do this for your community because no one else is going to be able to do it.

environments. These relationships served as emotional refuges grounded in deep understanding and humanity.

At the outermost layer of professional proximity were relationships with elected officials, county board members, and other local governing entities. Even though interactions were sometimes less frequent, resilience among health officials in rural public health departments was shaped by the actions or lack of action on the part of these individuals. Participants who received visible, empathetic, and clear support from these figures described it as a powerful shield against burnout and feelings of isolation. County board chairs and administrators who affirmed public health decisions, offered encouragement, and shared operational burdens reinforced shared responsibility. "Our county board chair was incredible. He called me every single day just to say, 'How are you?'" In small communities, where elected officials are both personal connections and formal opinion leaders, supportive governing relationships carry great influence. Some participants described feeling emotionally supported and professionally validated by board chairs, administrators, or elected leaders who affirmed their efforts and maintained public health guidance.

Others faced the opposite from their governing entity: absence or outright undermining. "Leadership, in general, was largely absent. And if they weren't absent, they were critical of what we were doing," one participant said. Without affirmation, public health leaders felt adrift, their expertise questioned, their labor invisible. In rural systems where governance structures are flat and relational proximity is high, support from governing bodies was not trivial; it was foundational. Respect for institutional knowledge, transparent communication, and moral solidarity shaped whether public health leaders felt protected or exposed.

3.3 | Personal Relationships

During this time of significant professional demand, for many public health leaders, home offered a rare place of refuge. "I also could go home and not have to fight fights there [about COVID-19]…it was a safe spot to be," one participant said. Family members provided routines that protected against exhaustion. Leaders found solace in everyday rituals: a meal shared, a quiet moment by the river, or an evening free from COVID-19 talk.

Still, not all home experiences were restorative. "Even if you went home and tried to talk to your family, they just couldn't understand the intensity," another explained. The unique burdens of public health leadership created a sense of isolation, even in the most familiar settings. Answering questions and providing support for family and friends lingered long after work hours ended.

Over time, many participants set boundaries to protect themselves. They removed work emails from their phones, turned down weekend commitments, and made time for rest. One participant shared, "Recognizing that I couldn't work 24/7…being very intentional [about not checking my emails after hours]" became a strategy for survival.

3.4 | Community Embeddedness

Living and working in rural communities significantly influenced how public health leaders perceived and demonstrated resilience during the COVID-19 pandemic. Their strong ties to the social, geographic, and cultural aspects of their jurisdictions affected their professional interactions and personal relationships. This closeness meant that leaders were not only visible but also closely connected to the people they served. This connection made resilience a process linked to community interactions.

Participants noted that the close-knit nature of rural life offered significant advantages. Longstanding relationships, shared history, and the close ties in small communities built trust and a sense of shared purpose. Leaders felt a strong responsibility to their communities. One leader explained, "There is no one else. You have to do this for your community because no one else is going to be able to do it." This belief reflected the deep loyalty participants had to the communities they served. In many communities, this commitment was mutual. Acts of kindness, like delivering meals, sending cards, or offering words of encouragement, supported leaders during the pandemic. These actions were often small, but carried significant emotional value and strengthened a shared commitment to community wellbeing.

However, this same closeness often had its downsides. Familiarity blurred boundaries and increased scrutiny. Participants recalled facing backlash in both their professional and personal lives, particularly on social media. In these communities, "everybody knows everybody," which makes public scrutiny feel very personal. One participant shared, "It is one thing for people to attack me; I signed up for that job, I get paid for that job, but when you start to bring in my family members, especially my kids, that's totally uncalled for." For many, being connected to their rural community was both protective and a source of stress, creating ongoing tension between the trust it built and the vulnerability it created.

3.5 | Relational Resilience in Rural Public Health

These findings show rural public health resilience as a co-constructed process, cultivated through connection among professional, personal, and community areas. In situations where relationships create both care and criticism, the presence of trust and affirmation influenced whether leaders received support or faced challenges alone.

4 | Discussion

This study aimed to investigate how rural public health leaders experienced and sustained resilience during the COVID-19 pandemic. Through a phenomenological lens, researchers explored what occurred and how it was experienced. This highlighted the emotional, cultural, and relational realities of rural public health leaders. Participants described resilience as a dynamic continuum. They noted that it is influenced by support from others, the culture of their organizations, and the unique sociopolitical fabric of rural communities. These findings contribute to the body of literature [23] that emphasizes the importance of contextualized resilience in public health, offering actionable insights for sustaining rural public health leadership wellbeing and revealing both protective assets and persistent gaps within rural public health systems.

A central concept in this study is the continuum of community connectiveness in the rural environment, which functioned simultaneously as a protective asset and a source of emotional strain. While previous research has identified rural relational ties as an advantage for disaster response and recovery [3, 24], the current study highlights the complexity of these ties in prolonged crises. Participants benefited from strong local networks, long-standing trust, and the relational intimacy of small communities. Such community connections may be especially impactful in rural areas, given research that suggests rural healthcare workers experience greater satisfaction from helping others or adding to the betterment of society than their urban counterparts [25]. However, these same dynamics also heightened vulnerability to scrutiny, public conflict, disruption of life, and moral injury when local norms clashed with public health mandates [9, 26]. In this way, community embeddedness did not exert a uniformly positive or negative influence; instead, it shaped the experiences of rural public health leaders across a continuum of relational and emotional experiences, where solidarity could quickly shift to alienation, and appreciation could give way to hostility.

In practice, this continuum of connectedness was navigated not in abstract terms, but through relationships with specific individuals. Several participants shared that the people supporting or questioning their decisions were not distant stakeholders; they were longtime acquaintances tied to their personal histories, such as former classmates or parents of their children's friends. One leader described the tension of working under a county board supervisor who was also a close family member. This situation required them to manage both political disagreement and the potential strain on family bonds. Another participant recalled the disorientation of hearing a former teacher, who had once been a trusted mentor, speak harshly about their public health work in community settings. These situations highlight the dual nature of rural connections. The closeness that can offer support can also lead to damaged trust and self-image when expectations in relationships are violated.

From a sociological perspective, these experiences show the reality of life in small communities, where overlapping social roles create tight networks of accountability and scrutiny [14]. The inability to separate professional and personal identities means that public health leaders work in a social environment where every decision is viewed through multiple lenses.

Theoretically, these findings fit with ecological models of resilience. These models position resilience as the ability to navigate and negotiate resources within complex and changing social systems that do not remain static [27–29]. These findings also align with moral injury frameworks that highlight the distress in the betrayal of tightly held relational and ethical expectations for both healthcare and public health practitioners [14]. In rural public health, where close relationships are essential to community functioning, resilience requires resourcefulness, adaptability, and the ongoing renegotiation of trust. This suggests that sustaining resilience in such settings depends as much on relational currency and management as it does on individual coping and institutional support.

Public health leaders also relied on tightly woven staff relationships that blurred the line between professional and familial care. They highlighted mutual support rather than a one-way function of leadership. While much literature [29–31] positions leadership as a provider of support, this study reveals mutual reinforcement [32–35] within small, rural teams. Participants described a strong emotional and operational connection in their teams, consistent with research on high-stress jobs. Team members filled leadership gaps, shared emotional burdens, and created a sense of psychological safety within small, multitasking departments [7, 34, 35]. These relationships often transcended professional boundaries and bore a resemblance to familial bonds. This aligns with studies that show workplace relationships help reduce job stress and promote wellbeing [35]. Many participants noted that these connections were central to their decision to remain in their roles during tough times. As one participant shared, "If I had left the position, it would have caused too much turmoil and disruption…I didn't want to leave my community and my teammates high and dry."

Beyond their own departments, leaders turned to peers in other jurisdictions for affirmation and validation that may have been unavailable internally. Governing officials also played a part,

serving as anchors through visible, empathetic support. However, their absence or opposition could deepen isolation. These findings align with crisis leadership literature, which emphasizes the importance of open and supportive engagement [36]. Recognition and validation were also important for maintaining morale. Participants noted that small gestures, like receiving thank-you notes or having encouraging conversations, were significant. Consistent with existing research, such recognition was linked not only to greater resilience but to reduced intent to leave, especially in under-resourced rural settings [37]. Resilience was described as episodic, fragile, and rooted in connection rather than individual willpower.

This constellation of findings affirms and extends prior research suggesting that public health resilience must be contextualized within social, organizational, and cultural environments [1]. The data align with ecological and moral models of resilience [27, 38], which emphasize the interplay among interpersonal, institutional, and cultural systems. Notably, in this study, resilience was shaped as much by the moral dissonance of being both embedded in and accountable to one's community as it was by institutional supports or stressors.

This work also deepens the understanding of moral injury in rural public health. Participants shared how being caught between competing political, cultural, and organizational expectations resulted in emotional exhaustion and psychological strain. One participant recalled, "I had so many phone calls from people and legislators, and everybody was mad about something. I felt like I had my head in a vice, and like, one side is like 'you're doing too much, let us do what we want to do.' The other side is like 'you're not doing enough, you have to issue orders.' I felt like the vice is getting tighter and tighter on my head as the pandemic went along." The metaphor of being in a "vice," with pressures from all sides, offers a powerful phenomenological insight into how public health leaders *felt* the moral, emotional, and even physical compression of their roles. These pressures were not abstract; they were experienced through strained relationships, broken trust, and the physical toll of continuous visibility in tight-knit communities. This extends existing frameworks [5] by showing how moral injury in rural leadership is often relationally mediated, compounded by closeness and ties to the community.

4.1 | Implications

Resilience for rural public health leaders comes from relationships in professional, community, and personal spheres. Supporting this workforce requires shifting from individual-focused wellness programs to structural strategies that strengthen relational trust, affirmation, and shared responsibility. Supporting both individual and collective resilience provides protective layers and is influenced by connections to community, family, friends, and colleagues.

Potential actions include: (1) strengthening peer networks to reduce isolation and sustain mutual support; (2) preparing governing bodies to show strong, supportive, and understanding leadership; (3) institutionalizing practices that protect boundaries, such as flexible schedules and work-life separation; and (4) proactively addressing the dual nature of community embeddedness by developing strategies that leverage longstanding trust while minimizing risks associated with public conflict, social media harassment, and blurred personal–professional boundaries. This could involve including skills for managing conflict and community engagement into leadership training, establishing rapid-response communication support during a crisis, and creating clear policies for handling harassment to ensure staff safety.

These findings suggest that structures that promote resilience should be part of preparedness planning, leadership training, and workforce policy. Integrating these elements into funding requirements and accreditation standards could enhance sustainability and reduce burnout in rural public health leadership.

4.2 | Limitations

Several limitations should be considered when interpreting the findings of this study. First, the demographic makeup of the sample was racially and ethnically uniform, with all participants identifying as white and 95% identifying as women. While this reflects much of Wisconsin's rural leadership, it limits the ability to apply the findings to more diverse populations. Experiences of resilience may vary across different racial, ethnic, and gender groups, particularly given the intersectional nature of inequities and workplace dynamics. Future studies should prioritize the inclusion of more demographically diverse participants to capture the full spectrum of rural public health leadership experiences.

Second, this study focused exclusively on rural counties in Wisconsin. While many themes likely apply to other rural contexts, regional variations may influence experiences in other areas. Generalizability beyond the Wisconsin context is limited. Comparative or multistate studies would help validate and expand upon these findings across broader geographical areas.

Third, the voluntary nature of participation may lead to self-selection bias. Individuals who chose to participate may differ systematically from those who declined, perhaps being more reflective or open to sharing their stories. This could have led to an underrepresentation of views from those who faced more severe burnout or disengagement and chose not to participate. Additionally, the willingness to discuss traumatic or controversial experiences may have varied depending on participants' trust in the research process, their current employment status, or perceived risks. These factors may have influenced the depth and honesty of their responses. Additionally, because the lead researcher shared professional experience with participants, they may have assumed shared understanding or been more willing to disclose. While reflexive journaling and analytic bracketing were employed, this positionality may have subtly influenced both data collection and interpretation.

Finally, although the study identified five overarching themes, the current analysis focused solely on the theme of "connection and support." The findings presented here offer a partial view of the broader resilience concept.

Despite these limitations, this study contributes valuable insight into the interpersonal and contextual dimensions of resilience

in rural public health leadership. It offers a foundation for future research and applied workforce strategies in similarly under-resourced settings.

The process has also reinforced the value of reflexive and interpretive inquiry in public health research. Rather than reducing participants' experiences to categories or measurable stressors, hermeneutic phenomenology invited a slower, deeper listening. Metaphors like "the vice" showed not just the conditions but also the meanings the leaders used to understand their endurance and exhaustion.

5 | Conclusion

While it may be tempting to move past COVID-19, the reality of future public health crises requires us to reflect on the lessons learned. This study offers important insights into rural public health leadership. It affirms that resilience is a dynamic process that develops through connections within teams, institutions, and communities. Resilience is seen through a unique lens in rural areas where leaders are often tightly woven into the social and cultural fabric of their communities. These connections serve as both a powerful source of trust and solidarity and a potential conduit for heightened scrutiny and strain.

The findings highlight that resilience among rural public health leaders was sustained through both structural and relational support, rather than relying solely on individual coping mechanisms. Recommendations from this study include creating cross-jurisdictional peer networks to reduce isolation, integrating trauma-informed supervisory practices into routine operations, offering flexible work arrangements that protect work-life boundaries, and establishing recognition and affirmation practices that acknowledge leaders' contributions. Additionally, considering the dual nature of rural embeddedness as both a source of trust and a point of vulnerability, agencies should use strategies that build on longstanding community relationships while actively reducing risks from public conflict, harassment, and blurred personal–professional boundaries.

While this study aimed initially to explore various factors of resilience, the narrative immersion approach revealed that relational connection was not simply a theme; it was the primary mechanism shaping how leaders managed crises. By highlighting the importance of the nuanced connections that rural public health leaders experience within informal and formal systems during times of crisis, this research contributes to a deeper understanding of resilience within this specific professional context.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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