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Self-Care Strategies and Barriers Among Female Service Providers Working with Female Survivors of Intimate Partner Violence
Les stratégies et les barrières de soins auto-administrés parmi les femmes travaillant avec les femmes ayant survécu la violence domestique

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ABSTRACT

Research has made several links between work-related stress and emotional exhaustion or burnout. What have been less often explored are what strategies are used and the perceived benefits of self-care among individuals. The present study sought to better understand the perceived value of self-care and how it is employed in a sample of female service providers working with female survivors of domestic violence. Participants (n = 7) included women who work in a variety of mental health and supportive counselling roles. Data were analyzed using thematic analysis and led to the identification of 14 themes related to how well-being is affected by counsellors' work, barriers to their self-care, and self-care strategies. Implications of the findings are included within the article.

RÉSUMÉ

La recherche a établi plusieurs liens entre le stress relié au travail et la fatigue émotionnelle ou « *burnout* ». Moins souvent examinés sont les stratégies employées et les bénéfices perçus par des individus quant à l'auto-soin. Cette étude vise à mieux comprendre la valeur perçue de l'auto-soin et comment on l'applique chez un échantillon de femmes travaillant dans les services de soin qui fournissent ces services aux survivantes de la violence domestique. Les participantes (n = 7) de l'étude incluent des femmes qui travaillent dans une variété de rôles de soins de santé mentale ou de services de conseil de soutien. Les données ont été analysées avec l'analyse thématique, qui a permis d'identifier 14 thèmes reliés aux effets du travail des conseillers sur leur bien-être, aux obstacles à l'auto-soin, et aux stratégies d'auto-soin. Les implications de ces résultats sont examinées dans l'article.

Research has made it very clear that stress in the workplace can lead to burnout. This has been demonstrated in research with nurses (Cubias, 2013), teachers (Friesen, Prokop, & Sarros, 1988; Kyriacou, 2001), police officers (Burke, 1993; Martinussen, Richardsen, & Burke, 2007), accountants (Sweeney & Summers, 2002), and psychologists (Rupert & Morgan, 2005), amongst many other professionals. Burnout, in its most widely adopted conceptualization, is a three-dimensional concept, characterized by (a) emotional exhaustion, (b) dep-

ersonalization or a negative shift in responses to others (particularly clients), and (c) a decreased sense of personal satisfaction and accomplishment (Maslach, 1982). Workload and role stress have both been found to consistently be linked to burnout (Hansung & Stoner, 2008; Maslach, 1982; Yürür & Sarikaya, 2012). Contributors to role stress can include role conflict, when an individual may have two or more role requirements that work against each other, and role ambiguity, which involves uncertainty about one's responsibilities in the workplace (Matteson & Ivancevich, 1982).

One of the most emotionally exhausting fields of work is arguably within the field of mental health (Leiter & Harvie, 1996), and thus burnout is likely to be high for individuals in this field, with Falkoski (2012) calling such occupations "high-risk." According to Leiter and Harvie (1996), who performed a review of burnout among mental health workers, perception of a large caseload (rather than the caseload itself) was positively correlated with burnout. Moreover, personal distress (i.e., feelings of personal unease and of anxiety in tense interpersonal situations) was also linked to burnout, as were client anger, aggression, and negative behaviour. Social support (through talking with a friend) was negatively correlated with burnout, while physical exercise, relaxation, and sleep were not related to burnout (Leiter & Harvie, 1996). Mental health workers of trauma can sometimes bear the brunt of this exhaustion and burnout.

The American Psychiatric Association's (2013) description of posttraumatic stress disorder notes that a traumatic event does not need to occur directly to an individual (i.e., one can learn about the traumatic event occurring to someone else) for them to meet the criteria for a diagnosis. Some literature may refer to this indirect reaction to trauma as secondary traumatic stress, or vicarious trauma. Secondary traumatic stress, the emotional duress and stress response that occurs when a person is secondarily influenced by the trauma of another person (Figley, 1995), is thought to be an acute reaction that likely develops suddenly, with symptoms being extremely similar to those of posttraumatic stress disorder (Sodeke-Gregson, Holttum, & Billings, 2013). Vicarious trauma, on the other hand, focuses on the disrupted frame of reference that can occur due to exposure to traumatic experiences (Sodeke-Gregson et al., 2013) and that may permanently impact therapists' beliefs about their "sense of self, world view, spirituality, affect tolerance, interpersonal relationships, and imagery system of memory" (Pearlman, 1999, p. 52). Regardless of its categorization, those counsellors working within the field of trauma and abuse are at a higher risk of being negatively affected by the work that they do (Pross, 2006; Shapiro, Brown, & Biegel, 2007). A study conducted by Sodeke-Gregson and colleagues (2013) found that much of their sample was at elevated rates of risk for secondary traumatic stress and compassion fatigue (ranging from 38% to 70%), with more than a quarter of their sample being at high risk for burnout. It is possible that the combined high risk for burnout amongst mental health professionals (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012) and the additional risk for vicarious trauma and secondary traumatic stress (Pross, 2006; Shapiro et al., 2007) for those working with trauma may put

these service providers at higher risk for experiencing negative consequences for their work.

According to Baird and Jenkins (2003), some of the major identified risk factors for experiencing vicarious trauma in counsellors working in the area of sexual assault and domestic violence include being less experienced, having a personal trauma history, and greater exposure to traumatized individuals (generally represented by a heavier caseload). Moreover, despite what is taught in training programs about separating one's work from one's personal life, this can be a very difficult and perhaps unrealistic task (Goldblatt, Buchbinder, Eisikovits, & Arizon-Mesinger, 2009), especially for those working within the field of domestic and sexual violence. Some service providers observe that they compare their own intimate relationships to those of their clients, are more aware of the respect (or lack thereof) from their partners, and notice their emotional reactions from their work being carried home into their personal lives (Goldblatt et al., 2009; Schauben & Frazier, 1995). Female service providers may especially be affected, as they may be more likely to see similarities between themselves and the experiences of the women with whom they work (Schauben & Frazier, 1995).

There are many ways to mitigate and prevent emotional exhaustion and burnout. For example, research has demonstrated the need, from an organizational perspective, for ensuring that therapists have adequate training in psychotherapy and diagnosis, that they have regular supervision, that there are opportunities for professional education and additional training, and that there is time allotted to keep themselves updated with research (Pross, 2006; Wheeler, 2007). Moreover, Pross (2006) argues that there needs to be more social recognition and value given to those working in the fields of trauma, as individuals in such professions are often underrecognized. Many studies also advocate for a lessening of therapist client caseload, for therapists to have some authority and decision-making power within an institution, for a supportive work environment (especially from supervisors and administrators), and for a decrease in bureaucratic responsibilities (e.g., notes, reports; Leiter & Harvie, 1996).

The World Health Organization (2009) has defined self-care as intentional activities undertaken with the purpose of promoting health, preventing disease, and maintaining health. From an individual perspective, much has been published about the importance of self-care. For example, it has been suggested that therapists should create space for themselves to think and reflect, and engage in an introspective thought process (Barlow & Phelan, 2007; La Torre, 2005). This can be done by secluding one's self in a physical space or by engaging in a process such as journaling. Trippany, White Kress, and Wilcoxon (2004) also stress the importance of more traditional self-care activities, such as eating well, sleeping enough, drinking adequate amounts of water, and engaging in physical activity. Oerlemans and Bakker (2014) discuss the benefits of engaging in leisure activities that are outside of one's work environment; the value of social support from individuals outside of one's work place have also been demonstrated to be helpful (Boren, 2014; Hamaideh, 2011; Oerlemans & Bakker, 2014). Although

such strategies may not be adequate for intervening when the effects of vicarious trauma have already begun, they may be effective for preventing and mitigating the potential effects of exposure to trauma.

Self-care may mitigate the effects of exposure to clients' traumatic experiences; however, while many therapists will respond to clients' traumas with empathy, some may have a more emotionally reactive response, feeling upset and angry for the client. Therapists who frequently react emotionally to their clients may begin to feel overwhelmed by such experiences. If they find it challenging to separate themselves and their lives outside of work from how they are impacted by their clients, they may be at risk of experiencing emotional exhaustion and/or burnout. The risk of emotional exhaustion and burnout can be minimized in several ways, including organizational factors within the workplace, and one's own behaviours within and outside of the workplace.

PRESENT STUDY

The current project sought to better understand the thoughts and strategies of female service providers who work with female survivors of sexual and domestic violence. While much literature (e.g., Oerlemans & Bakker, 2014; Pross, 2006) has offered suggestions for self-care strategies (e.g., physical activity, mindfulness exercises), less literature has explored what strategies are actually used by service providers working with these populations. Thus, the current study sought to better understand the thoughts about self-care of female service providers who work with women who have experienced domestic or sexual violence. Specifically, the study was designed to focus on exploring (a) how their well-being is affected by their work, (b) what they perceive as barriers to self-care, and (c) what self-care strategies they employ. This study explored these thoughts and experiences specifically with female service providers as they are likely uniquely affected by working with this population and may be at an increased risk of experiencing vicarious trauma and burnout (Schauben & Frazier, 1995).

METHODS

Participants

Participants included seven women from Thunder Bay, Ontario, who work in different organizations in the city and in a range of health and service professions. The participants were given pseudonyms to protect their identities: Amy, Angelica, Danielle, Jessica, Katie, Sarah, and Viola. Limited demographic information was collected from participants; approximately half of the women who participated identified as Aboriginal, and all women were over the age of 25. All of the participants were actively engaged in the interview process.

Procedure

Participants were contacted, through their agencies and organizations, as part of a larger project to understand Aboriginal women's experiences of intimate

partner violence. Each participant was asked several questions related to self-care, including (a) "What are some ways in which you engage in self-care?" (b) "How important is self-care to your overall well-being?" and (c) "Have you ever felt that the level of your self-care was related to your ability to treat your clients or the people with whom you work? For example, after having a relaxing weekend, have you found that your ability to provide care and support to others was changed? If so, how?" However, data related to self-care were not restricted to responses to questions specifically about self-care. Instead, the complete transcripts from the larger study were used to extract data related to the self-care of the service providers interviewed. Each interview was audio recorded; however, one interview took place with two individuals, leading to six audio recordings representing seven women. Each recording was then transcribed and analyzed using a thematic analysis (guided by Braun and Clark's six phases, see Table 1 for details), using an inductive and a semantic approach (Braun & Clark, 2006). This project was approved by the Lakehead University Research Ethics Board.

Table 1
Braun and Clark (2006) Approach to Thematic Analysis

Phase	Description
Phase 1	Becoming familiar with the data: - Reading the data - Creating an initial list of ideas about data content
Phase 2	Generating initial codes: - Identifying features of the data that appear interesting - Organizing the data into meaningful groups
Phase 3	Searching for themes: - Sorting different codes into themes - May result in potential themes and subthemes
Phase 4	Reviewing themes: - Refining the themes created in Phase 3 - Making decisions about whether there is enough evidence to substantiate theme, and whether data fit well into theme - Considering whether the themes accurately represent the whole data set
Phase 5	Defining and naming themes: - Identifying the essence of each theme, and determining what aspect of the data each theme is capturing - Identifying subthemes as applicable
Phase 6	Producing the report: - Telling the story of the data - Providing sufficient evidence for the themes

RESULTS AND DISCUSSION

All of the women who participated in this study recognized the importance of self-care and seemed to be thoughtful in the assessment of their own needs. Fourteen themes emerged from the responses and are organized into three broad categories: how well-being is affected, strategies for self-care, and barriers to self-care—consistent with the questions that were posed for this study (see Table 2 for a summary of the themes organized by category). Thus, the results and discussion section of this paper will be organized accordingly.

Table 2
Emerging Themes Organized by Category

Category	Theme
How well-being is affected	1. Clients with very complex concerns
	2. Effectiveness of therapy
	3. Feeling worried about clients
	4. Own experiences of abuse and trauma
	5. Institutional barriers to care
	6. Lack of community resources
	7. Systemic oppression
	8. Sense of fulfillment and purpose
Barriers to self-care	1. Other priorities
	2. Difficulties engaging in mindful/intentional self-care
Self-care strategies used	1. Traditional self-care strategies
	2. Selfless self-care
	3. Celebration of strengths
	4. Continuing training and education

How Well-Being Is Affected

Clients with very complex concerns. All of the participants discussed how they often work with clients with very complex concerns related to crisis, poverty, mental health needs, and more. When working with such clients, solutions are not generally easy to find, and this can become difficult for the service provider. For example, Amy shared:

> I think that on the one hand, I want to say situations are often kind of much more complex and multilayered, and kind of exist in this ongoing system of oppression that we're still stuck in this country and stuff. I've done, for example, safety planning tips with women in group, and one First Nations woman stands out because she's like "you know this doesn't work, these don't work for me. They're not realistic on my reserve. When my partner is being abusive, if I ran to my brothers' house they would tell me to get out because they are also afraid of him." So I feel like sometimes the dynamics like that, the things that

> we maybe have are not enough or not encompassing all of the challenges and the problems … I often have this sense of what we're doing is just [a] tiny little piece, and there is, you know, you are dealing with poverty, you are dealing with housing, their whole family, a lot of them are dealing with chronic health issues. The amount of losses that you've been through are staggering, you know?

Trying to appropriately create a safety plan to reduce women's risk to violence was a difficulty voiced by many of the participants, as was access to housing and poverty. Although many of the participants had information about resources and could try to support women as much as possible, some of these barriers to clients' well-being were out of the participants' control. Feeling a lack of control and ability to support one's clients may lead to feelings of helplessness (Sarata, 1974), and this can contribute to burnout in some service providers (Peterson, Maier, & Seligman, 1993). Moreover, clients who present with complex needs have been reported to be amongst the hardest to work with (Acker, 1999), which may negatively contribute to job satisfaction and increase levels of stress for service providers.

Effectiveness of therapy. Similarly, not knowing whether one is helping a client, or feeling as though one is not helping, has been related to burnout in some care providers (Peterson et al., 1993). This is what five of the women who participated in this project experienced. This was due to few "success stories," inadequate evaluation of outcomes, and being able to see some clients for a very short period of time. Due to the nature of many of the participants' places of employment, engaging in crisis or transitional work was their primary role. As such, there is rarely time for evaluation, and needs are so varying. Moreover, because they see women when they are experiencing crises, it becomes very difficult for service providers to be aware of progress over a longer period of time, and "success" is unlikely to be achieved while in crisis. Even in roles where service providers get to have contact with their clients over a longer period of time, many of the presenting concerns are so complex that "success" (in the service provider's perspective) may not be achievable.

Feeling worried about clients. While encountering barriers through the process of trying to ensure client well-being was one way that a client's situation brought about frustrations for the service provider, many of the participants also discussed their own internal processes and how these affected their well-being. Somewhat related to this was the fact that service providers wanted to help their clients as much as they could. This may lead to feeling worried about clients (i.e., taking the stressors of work home). Amy shared:

> I think I bring it home … I still think about that woman with the broken nose issue and just kind of wondering where people are at … if anything it's more just kind of picturing their situations, picturing their relationships and kind of all the crap they have to put up with … I think if anything it's more kind of a bit of a hauntingness, or a worry, or kind of feeling like, you know, "What more could I have done?" or "What else do they need that I'm missing?" or

> something. So I think sometimes it can be kind of easy to let it seep into the rest of your day … I think that it probably wears on me or something.

While caring about one's clients and wanting to help them to the best of one's abilities is admirable, and arguably one of the motives for working in this field (as reported by the participants), there seems to be a fine balance between putting one's whole self into one's work and allowing one's work to be the sole focus of one's life. When the stress from work begins to be inescapable, one may be at risk for developing burnout (Baird & Jenkins, 2003). The stress from work may also affect one's personal relationships, as Angelica commented.

Own experiences of abuse and trauma. Many of the women who participated in this project disclosed their own experiences of abuse and trauma. While this may be one way through which individuals heal from their trauma (Herman, 1992), this can also interfere with one's work and lead to experiences of retraumatization. Katie shared how she learned she still had much work to do in processing her own traumatic experiences:

> I think I probably realized that I wasn't well enough while I was working, right? Because I started when I was really young. When I started working, I jumped into the addiction field and certified myself in addiction when I was 25/26 and I worked with hardcore users. So I was working in detox with Aboriginal people and I didn't know I wasn't healthy. I actually thought I was because I was just following, you know, go to school, do your college, certify and go work in the field, right? And so you have this understanding that you think you know what you're doing and then you get in the field and you realize that you do, you do, to a degree, but there are a lot of things that, again because I was umm … my trauma healing was so fresh to me, I was always getting retraumatized. The vicarious trauma was so high with me back then. Like I remember burning out three times in one year because it was so … I couldn't … I didn't have enough self-care stuff.

Research has demonstrated that experiences of trauma may heighten the likelihood of being retraumatized by one's clients (Pearlman & Mac Ian, 1995). Vicarious trauma has been defined as a transformation that can occur in being exposed to others' experiences of trauma (Pearlman & Mac Ian, 1995). This can lead to enduring changes in the ways in which the individuals experience themselves, others, and the world, mirroring the effects of being exposed directly to a traumatic event. Similar to the way posttraumatic stress disorder can be debilitating, so can vicarious trauma. Considering that more than half of the women who participated shared having experienced violence in their intimate relationships, this may be a common life history among service providers working in this field. This likely increases the risk of individuals working in this field experiencing vicarious trauma or similar effects.

Institutional barriers to care. Some of the participants also discussed their frustrations that come from the workplace, most of which were related to feeling that

the workplace created barriers preventing them from doing their job the way they would like to. For example, most women shared that the institutional policies of their organizations limited the way they could support their clients. Some women alluded to not being able to engage in cultural practices (such as smudges) that their clients wanted, not being able to participate in activities that some of their clients may have wanted (such as cooking), or being restricted by time limits (for example, being able to offer services for only 10 weeks). Katie shared:

> And the shelters are different now because there are so many policies that don't … or so many rules that don't work, they've become more institutionalized that they're not home. So for a woman who is leaving an abusive relationship and leaving a home now, it's not fun to come in here. It's not home. It's not as helpful. You know, as much as I say I would be in here in a heartbeat if it happened to me again, I probably wouldn't because it's not helpful. It would destroy me or set me back 10 times back … But this is the stuff that we don't do here and it doesn't work for people. Yeah we provide a place for 8 weeks, and yeah we provide counselling but it's not enough, it's never going to be enough. It's just allowing some people to have a little bit of support and a little bit of advocacy, and you let them go, and you hope they come back but once people start wanting to get back to normal, or functioning again, they easily forget about the healing because they don't have anything to hang on to. You know. Not enough. Some people do, don't get me wrong, some people do, but not enough.

Similarly, Jessica shared:

> I'd like to be able to connect women with a more positive outdoor experience of healing and … I interviewed a woman a couple of years ago and she talked about working with the women in—working with families, and one of their approaches was to take that woman to the bush. And the strength and the beauty of—because for some women, that's very, very healing and nurturing. It's harder to do in a ministry-funded agency like us, in the middle of the city. We don't have the space, we don't have the property … but the thought of that—being able to connect with people while we're fishing and to give some—because yes, in the last 20 years, organizations have taught—we've taught, we've fostered, we've encouraged female arts. But very few programs encourage male arts. So we'd be a hundred times ahead of the game if we had spent more time teaching men and women, boys the skill of hunting and fishing. And survival. Because it would give them another focus in life. So, if one of the punishments against the crime of abusing your partner was you had to feed three people in the community and you actually had the skills to fish and hunt to do it, it might take away some of the focus. I just think that … I guess … funding is set up for violence against women.

Many of the women felt as though there were not enough opportunities to spend time and connect with clients. Seeing as all of the women talked about wanting

to help the women who seek out their services, not being able to spend time and really care for one's clients created frustration for some women. Katie shared how caring for women, despite institutional policies, was a self-care strategy for her:

> I spend a lot of time with women, just doing nothing (laughs). I mean I could be doing stats, and I could be [doing] paperwork, and I could be doing that, but that's the stuff that doesn't keep me well, and I know that. And it also doesn't keep the girls well. So I'd rather float around and chat with them. Because we have limitations, that's all I'm allowed. You know, back in the day when we used to cook with ladies, and we used to chat and we used to have these really quality times with people and getting to know you. We're not allowed to do any of that anymore. And that sucks. And so I never lose focus of that "you're important and I want to get to know you and treat you like human" and that kind of stuff. That's the stuff that keeps me well, because it keeps me grounded, it doesn't put me in a position where I feel like "no, I'm here to do a job I'm not here to care …" I don't know. I have a good balance with that. And, I don't know. I've always put the women first, and why they're here versus my job. And, you know, whether I get my hand slapped 10 times a day for "you need to be doing this, or that", you know, no. No, she's not my client but I'm still talking to her because she still needs someone to talk to. Doesn't anybody see that?

Research has demonstrated that burnout is decreased when individuals are able to have some control over how their time is spent in the workplace, and what kind of programming they implement (Baird & Jenkins, 2003). Unfortunately, even when women had some say in the programming they implemented (as was the case for almost all of the participants), there were still restrictions placed upon them that created a sense of limitation. Stunting their ability to do their job—especially when doing their job keeps those individuals well and is a protective factor for burnout—is likely to lead to higher levels of frustration and stress, and may decrease the satisfaction and sense of personal accomplishment that they receive from their work—characteristics that allow women to feel well and maintain heavy and emotionally stressful workloads without experiencing burnout.

Lack of community resources. Lastly, many women discussed factors outside of their institutions that affected their well-being, as well as the well-being of their clients. One of the most commonly discussed examples of this was a lack of community resources, and unclear information about who can access such services. Amy shared:

> I feel like I don't have enough information about what's available for clients and how they can access it and stuff. And sometimes I find the clients know better than me where they can kind of, you know, sign up for this one thing and get food this month or whatever, and so people are really awesome at kind of finding their own resources. But I think that's maybe almost something that would be useful—if something were in place that was more integrated and you were able to see across the board in this city what's available, rather than—it

> seems like everything's on one pamphlet over here and like you know it's just very kind of—and then, you know, you think there's a program that you can access but it's been over for like two years or something. And so just a lot of disconnects in terms of kind of referring people to places and stuff so … And then sometimes we find if we make a referral to St. Joe's or something, now the person needs a doctor's referral to get in … So sometimes there's just barriers we're not even expecting or are aware of. And we're sending people around and they're coming back and being like "No, they wouldn't accept me" or "I didn't have this" or—so that's kind of tricky too. But I think that just comes with experience. Like I'm sure people that have worked in the field for a while kind of know the ins and outs of what's available for their clients but that's one area that I feel like I lack.

Interestingly, even clinicians who did have more experience felt similar frustrations. It seems that part of what makes this process so challenging is the short-term nature of funding. For example, Danielle was sharing about a program she runs that has funding for a few years. She stated:

> What does that mean beyond our three-year pilot phase? You know, is this going to be yet another service that is going to be deemed not necessary, or deemed no dollars or whatever the case may be? And for many of our programs and projects that are in this sector often are not on permanent funding.

She continued to explain the frustration behind such processes, because it takes some time for potential clients to learn about a service and to trust it, as well as its service providers. This was frustrating for her because she felt that just as people were beginning to open up, share, trust, and use the services as they were intended, their funding would run out. This creates further hesitation for people to use such services, creating an even wider gap in needs.

Thus, although there are several ways that clinicians try to support their clients, they seem to encounter barriers that make it difficult to help their clients in the way that they would like to. Moreover, it is likely that many service providers spend a significant amount of time trying to figure out what services their clients could access, and what the best way to access such services would be. (For example, does the client need a doctor or a referral?) If such information were readily accessible, service providers would save time and avoid frustration, and it would be clearer for individuals to assess where current gaps exist.

Systemic oppression. Many of the participants shared how racism and a lack of community accountability make their jobs much more frustrating, and make it difficult for them to best support their clients. Two women shared how they wished men would be held more accountable for their violent behaviour. They expressed that men should be forced to leave the house in cases of violence, instead of women having to leave to keep themselves safe, restoring a sense of security for women. Another woman shared that she felt there was too much emphasis on men engaging in violent behaviour against women, and that society should pay more attention to women engaging in violence against men. Although this is

likely a less popular perspective, it is often one that is explored less critically (e.g., Johnson, 2008). However, a common experience that many of the participants faced was racism toward themselves or their clients. Sarah shared:

> I had a [First Nations] lady today. She lives at [name of organization excluded]. Police bring her in. She's too intoxicated to do anything. They keep her in the drunk tank overnight. They bring her back in the morning. She's vomiting through the whole thing, but you know I went over her options [for what one can do after being sexually assaulted] and she wanted them all. So, we just did them in between vomiting episodes, you know? We did everything that she wanted. You know, the room stinks, and she's unkempt, and she'd probably rather be in a nice comfy bed somewhere. But you know, that's not her reality. She lives at [name of organization excluded]. And I offered her all the options I would offer any other woman and she took them and it took us, you know, about four hours or something? But I will do that, right, and I'm not sure that, you know, all places where people access care, that they will get that.

There seems to be a general attitude within the community that some people, based on their ethnicity or socioeconomic status, are less deserving of care, access to resources, and basic kindness. Because of such attitudes within the community, many of the participants' clients had experienced overt racism, being denied services, and being victims of violence because of their ethnicity. This was very frustrating for the service providers, but also made the service providers feel less capable of creating change for their clients—some things were completely out of their hands. Danielle said:

> I think there's a lot of really bad misinformation out there. And I think in light of a lot of the conflict that's been happening and stuff like that, I really think people are really misinformed. And I think as I get older and work more cross populations, I realize how misinformed people are. And I think not having the visual face of an Aboriginal person, I'm privy to hearing some pretty awful things. And I think the horrors of—and I'm very quick to speak up and say "How can you say that?" or "How can you not understand the systemic racism that happens?" or … you know?

This creates more feelings of powerlessness among service providers, and can negatively affect their well-being. For some women, this means not only that their clients are treated worse than others, but that their work is devalued because they are perceived as helping individuals who choose not to help themselves. The constant advocating against racism for one's self and for others can be taxing and can negatively affect one's mental health and well-being (Landrine & Kolnoff, 1996).

Sense of fulfillment and purpose. Although there were many examples of how well-being is negatively affected by the work done in this field, some participants explicitly shared the sense of fulfillment and purpose that their work brought to them. Considering that many of the participants in this study were survivors of violence themselves, it is likely that engaging in this work was part of their own

healing journey (Herman, 1992). Moreover, while participants shared some potential negative effects, this does not mean that they all experience these consequences, or that they experience all of these at any given time—these are potential ways through which their well-being can be affected. Thus, while participants shared the negative effects of this work on their well-being, there was also a sense that the work being done is important, and that the benefits of contributing to the well-being of others outweighed the negative ways in which well-being could be affected.

Barriers to Self-Care

Other priorities. Recognizing the importance of self-care did not lead to regular and explicit self-care practices. Some women discussed not being very effective at engaging in self-care strategies. For example, three of the women discussed having responsibilities within the home that take precedence over engaging in traditional self-care activities. As Viola stated:

> [I try to] do the kind of things we tell most of our clients to do. But it's … for me it's challenging because I have a busy family. And so, when I leave here, I hear some workers talking about going home and taking a nap. You know, those kind of things that are kind of like "Yeah … that's not happening at my house." I go home to a five-year-old that is challenging and wants attention, which is understandable. Suppers need to be made, and that type of thing …

Pressing responsibilities taking priority over traditional self-care was not a unique experience. It is possible that there is an unrealistic and unfair division in discourses of balance between home and work responsibilities, leading to an exclusion of many women's experiences. Most burnout literature refers solely to the workplace and factors within it (Maslach, Schaufeli, & Leiter, 2001), but for many individuals, and especially women, taking care of household responsibilities can use up a significant amount of time and energy as well. Interestingly, some literature argues against the conceptualization of burnout as occurring solely within the context of the "workplace," as the driving factor is chronic stress, which can occur due to a number of factors and their interactions (Bianchi, Truchot, Laurent, Brisson, & Schonfield, 2014). This is not to suggest that choosing one's home responsibilities over traditional self-care will lead to burnout, but more that it becomes even more difficult to justify self-care when one's workload (both workplace and home responsibilities) is so heavy.

Difficulties engaging in mindful/intentional self-care. Amy discussed the importance of engaging in self-care strategies mindfully (i.e., while focusing on and engaging with the activity in the present moment). She described that she often walks her dog and that, although sometimes she can focus on what she is doing, at other times her mind is focused on work and the stresses of her daily life. The importance of letting go of stressors in order to fully engage in one's self-care activities is essential to reap the benefits of such practices (Christopher & Maris, 2010; McGarrigle & Walsh, 2011). And although this was a self-care strategy used by several participants, it was not always possible to do this regularly and effectively. This may contribute to how effective individuals find self-care strategies.

Self-Care Strategies Used

Traditional self-care strategies. All of the participants listed some of the more traditional self-care strategies that they use, including seeking out and maintaining regular social support, engaging in physical activity, eating well, drinking water, connecting with one's spirituality, and taking time out of one's day with the purpose of engaging in self-care. These are strategies that are often included in the literature as ways of engaging in self-care (Mullenbach & Skovholt, 2014).

Selfless self-care. Interestingly, many of the women also mentioned engaging in activities that may be considered "work." For example, several women mentioned getting involved in initiatives that allow them to further contribute to their communities. Viola shared:

> Over the years, I've been involved with other types of committees, which fuels my passion, so to speak. And I've—for the last—it'll be 16 years I guess now, 15 or 16 years—I've put on a free clothing exchange, both in the spring and … in the fall. It's a lot of work but I get so much joy out of doing that so it's—it doesn't sound like a self-care thing but it really, you know, it just sort of fuels me and gives me that sense that I'm giving back to the community in a different way.

Thus self-care is found not only in engaging in activities that are considered "time off," but in knowing that one is contributing to society and helping improve the lives of others; the rewards seem to outweigh the cost of the work. Similarly, as mentioned earlier, some women ensure that they are fulfilling their purpose of connecting with their clients, regardless of what their organizational policies suggest, as this is what is needed to feel well. Research has explored the benefits of volunteer work on one's well-being and has found that it can improve happiness, life satisfaction, self-esteem, sense of control over life, and physical health (Thoits & Hewitt, 2001). It is noteworthy that many of these women, simply in doing the work they do for their clients, are living a life of service; however, many of them feel that this is not enough, and continue to contribute. This may be an indication of their well-being as well, as Thoits and Hewitt (2001) found that people with greater well-being invest more hours in volunteer service.

Celebration of strengths. Some of the participants discussed the value in seeing one's own strengths, as well as one's clients' strengths. In engaging in such processes, the participants were able to be kinder and more forgiving with themselves. Moreover, considering how difficult and complex their clients' situations often were, noticing their clients' strengths allowed them to feel more hopeful for their clients. They were able to recognize how resilient their clients were for having already overcome so many obstacles, providing the service provider with a sense of reassurance that their clients would be survive.

Continuing training and education. Lastly, many of the participants discussed the importance of continuing their training and education. This allowed them to ensure that they were offering their clients the best services possible, and was a good opportunity to exercise their minds. Considering that continuing education

was a form of self-care and would allow service providers to better support their clients, it is unfortunate that many organizations do not provide enough time, funding, or flexibility for their staff to seek out additional training. For example, Katie explained:

> And I'm lucky that I have that flexibility to say "this is what I want to do" or "this is what I think I'm going to be able to do," or—I've always known anger was an issue. I had never had any training in anger until I took the course. But, it's when you can be in a position to say "holy man, I see a lot of this" and "how do I help?" And that's how I started. I was certified in addictions when I started working in addictions, but there was lots of people we were sending elsewhere. Saying "OMG, I'm not qualified to do assessments, I can't do this, I can't do that." We don't have money to do that. I found a way. I found a way to tap into some money and get trained. So I've been providing services for seven years, doing specific things that there's only three or four of us who do it in the city. So I'm lucky. But I found a need, and was able and had the support to do that, and provide something for the ladies that we weren't doing for them. That always has to happen, I think we always need to do that to help ladies, because things change all the time. And I don't see much change in the 12 years. We're still doing things the same. And when are we going to realize that things need to be different, or that we're missing a great opportunity to catch them for eight weeks? And how are we going to run things differently? But yeah, things needs to be changed.

implications and conclusions

When asked about how their well-being was affected by working with female survivors of intimate partner violence, participants disclosed many experiences of frustration that related to their work and their workplace. Although it is unclear how exactly the obstacles, barriers, and frustrations they face affect their health, research has demonstrated that stress within the workplace can lead to psychological exhaustion, overinvolvement with clients, overwork, emotional distress, and the potential exploitation of clients (Everall & Paulson, 2004). Additional symptoms can include helplessness, hopelessness, and negative attitudes toward the self, work, and life itself. Moreover, it can lead to anger, boredom, cynicism, impatience, paranoia, denial of feelings, loss of confidence, irritability, impatience, rigidity of perception, and increased physical ailments (Swearingen, 1990). This research demonstrated that many service providers' frustrations and stress emanate from not being able to provide the best care for their clients. Moreover, many of the reasons for not being able to support their clients the way they would like are perceived to be due to institutional and organizational policies that restrict how the service providers can work with their clients.

Fortunately, it seems that many service providers are quite resourceful in trying to support their clients (without always being aware of the outcomes of their

work). Many of the women who participated seem to have an understanding about what policies their organization will allow more flexibility with, and how to appease one's management while still offering the best care they can to their clients.

Service providers also seem to be resourceful and creative in their self-care strategies. It seems as though, for many individuals, there are not clear distinctions between "work" and "self-care," contrary to the distinction that is often made in literature. Thus, perhaps a broader conceptualization of self-care would better inform how well-being and burnout relate to each other. Similarly, it seems as though the workplace is not the only source of stress for many of the service providers, with discussions of responsibilities in the home and caring for one's families as part of one's stress load. Viola shared that she once had someone close to her experience a violent relationship. It seems that when one's personal life too closely resembles one's work, this can be quite emotionally taxing; however, the stress of such incidents would not be considered workplace stress. Future research should take Bianchi and colleagues' (2014) lead in widening the scope of burnout, in order to better address how individuals' health and well-being are affected; this may include developing a broader measure of role stress and burnout that does more than discuss these experiences as they relate to the workplace.

Even though all of the participants addressed barriers to providing adequate services to their clients, it seemed as though they still felt supported in the workplace, and understood, for the most part, the rationale for many of these policies. However, considering how closely tied self-care, well-being, and providing best care for one's clients are, organizations should perhaps explore how to better support their employees' desires to provide good care to their clients. This would be best for the clients, for the service provider, and for the organization. Providing better care may also accelerate the clients' healing process and thus allow more women to access services, decreasing the length of waitlists, reducing the barriers to accessing services, and potentially increasing the visibility of client "success stories." Part of providing "better care" likely involves meeting clients' cultural needs and conceptualizations of trauma and its effects. Considering this project utilized data gathered by service providers who work with Aboriginal women survivors of intimate partner violence, being able to actively listen to women's experiences and connect with them, as Katie explained, might be essential.

This project has demonstrated that there are many ways through which the well-being of service providers who work with survivors of intimate partner violence can be affected. Although some of these are based on the complexity of cases seen, most were related to institutional regulations, lack of training and trust in one's self, and systems within society that create injustices. And while many of the service providers engage in self-care strategies, how these are performed seems to play an important role in the benefits that can be gained from their implementation. Lastly, it is possible that engaging in more "work" may actually be a method of self-care, as helping others and contributing to overall community well-being seemed to be very important for some of the service providers.

This research project focused on the unique effects of trauma work on female service providers' well-being and self-care. Considering that most studies in the area of trauma often have a large female participant sample and that the clients with whom participants work are also often female, it may be of interest to explore the dynamics of gender roles of how individuals are affected by their clients, and to better understand the self-care strategies employed. It is possible that men are less emotionally affected by their female clients because of less overlap in experience; however, this is currently unknown.

Organizations should attempt to include service providers in policy development and maintenance in order to ensure that service providers feel as though they have the ability to provide the best care they can to their clients. Better supervision, structured opportunities for reflection on well-being, more program evaluation, opportunities for additional education and training, and formal feedback processes from clients would also help alleviate some service providers' concerns. Lastly, it may be helpful for organizations to incorporate advocacy into their mandates, so that service providers have the ability to make change on an individual and community level.

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