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“An Uphill Battle”: Psychosocial Health and Self-Care among Advocates who work Against Gender-Based Violence in South Carolina

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“AN UPHILL BATTLE”: PSYCHOSOCIAL HEALTH AND SELF-CARE AMONG
ADVOCATES WHO WORK AGAINST GENDER-BASED VIOLENCE IN SOUTH
CAROLINA

by

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DEDICATION

I dedicate this work to feminist activists everywhere, who work against the current to make this world a better place for everyone.

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It takes a village to complete the rewarding but long, challenging journey to a doctoral degree. Leading the village, there was my committee chair Dr. Mindi Spencer. Thank you for always encouraging me to engage in research that is touched by people's lives. Thank you for supporting me in dreaming, thinking, and questioning further. Your kindness, passion for mentoring, and willingness to explore uncharted territory have helped me to grow as an independent researcher. Dr. Deborah Billings, thank you for setting a wonderful example of how to weave social science into life as a feminist activist scholar. Your guidance has been essential to my understanding of the research context, and the stories that advocates who work towards eliminating gender-based violence shared with me. I would like to also thank Dr. DeAnne K. Hilfinger Messias and Dr. Alyssa Robillard, for their support and unique contributions to this research. Dr. Messias kindly met with me even during the busiest times, welcoming my questions about the exciting and messy process of data analysis. Thank you Dr. Robillard for your critical feedback which helped me to uncover the complexities of the study participants' experiences. I am ever grateful to have worked with four committee members who value and engage in social justice-oriented research. It is with their support that I was able to complete this dissertation which gives me a great sense of pride. I want to thank Rebecca Williams-Agee, for helping me establish strong relationships with the community partners, for her insights, and her enthusiasm about this research.

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ABSTRACT

Gender-based violence (GBV) is one of the most pressing public health and human rights issues in the United States overall, and more specifically, in South Carolina (SC). SC consistently ranked among the highest in the nation in terms of female homicide rates. Non-profit organizations (NPOs) that focus their work specifically on GBV constitute an essential component of prevention and mitigation efforts in SC. Advocates who work for GBV-specific NPOs experience a wide range of psychosocial health and well-being benefits and risks due to their work. This study aimed to: 1) Identify the relationships between engaging in paid GBV-specific advocacy and psychosocial health and well-being within the political, social, economic, and cultural context of SC, and 2) Understand the organizational processes that influence self-care practices among individuals who engage in paid GBV-specific advocacy. I conducted semi-structured interviews with 25 GBV-specific advocates who work for NPOs in SC. I used Constructivist Grounded Theory in coding and analyzing the data. I was also guided by Standpoint Theory, and Feminist Intersectionality in exploring the GBV-specific advocacy experiences of the participants. Major themes that relate to the organizational factors shaping psychosocial health and well-being of the advocates included: management and leadership style, interpersonal relationship dynamics, and culture of self-care. Work experiences of the advocates were shaped by their social location (i.e., race, ethnicity, gender identity, sexual identity). Advocates of color, and queer, gender non-conforming, lesbian advocates experienced tokenism and negative stereotypes in

their organizations. I also found that unique characteristics of the southern culture, including patriarchal values, religious norms, and conservative gender roles influenced advocates' work experiences, and how others received their work. GBV-specific NPOs need to acknowledge their responsibility related to supporting psychosocial well-being and self-care practices among their staff members, and develop collective self-care practices that incorporate the specific perspectives and needs of the advocates. In addition, employing organizational strategies that uncover and combat hidden stereotypes and biases is required to create an inclusive and diverse workplace culture.

Keywords: Gender-Based Violence; Advocacy; Psychosocial Health; Non-Profit Organizations; Organizational Self-Care; Qualitative Interviews

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CHAPTER 1

INTRODUCTION

Gender-based violence (GBV) is one of the most pressing public health and human rights issues in the United States overall, and more specifically, in South Carolina (SC). SC consistently ranks among the highest in the nation in terms of female homicide rates. The Supplementary Homicide Report lists SC as fifth among all states, with 43 women murdered by men in 2014 (Hess et al., 2015; Violence Policy Center, 2016). In addition to homicide, the lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner for women was 41.5% in SC in 2010, which was higher than the national average of 35.6%. Similarly, the lifetime prevalence of sexual violence other than rape by any perpetrator was 45.9% for women in SC, compared to the national average of 44.6% (Black, Basile, Smith, Walters, Merrick, Chen, Stevens, 2011). Underlying causes of the disproportionate burden of GBV in SC are multifaceted, including factors that are unique to the state's social, cultural, and political context¹ (Anderson, Shaw, Childers, Milli, & DuMonthier, 2016; Schunk & Teel, 2005). Multiple actors throughout SC, including government institutions, academia and non-profit

¹ Chapter 2 contains more detailed information about the social, cultural, and political context of GBV in SC.

organizations (NPO), work to address the causes and consequences of GBV in the lives of survivors and their families (SCCADVASA, 2015). Among these actors, the work of NPOs that focus their work specifically on GBV constitute an essential component of prevention and mitigation efforts (Inter-Agency Standing Committee, 2015). Some NPOs channel resources to providing services to survivors of GBV, whereas others also engage in community outreach and education. In addition, GBV-specific NPOs advocate for legislative changes that strengthen prevention efforts (e.g. mandatory anti-violence curricula in elementary and middle schools) at the state level and improve the quality and accessibility of health and social services for survivors (SCCADVASA, 2015). Thus, individuals working for these NPOs engage in a wide range of activities, including advocacy through supporting survivors as they report experiences of violence to police, medical professionals, and within the justice system, as well as providing direct services such as counseling, shelter, and employment assistance. Staff members of these organizations also engage in community outreach and education by establishing partnerships with government agencies, public schools, universities, and other workplaces, which then allow staff to be in direct contact with people of a wide age range and discussing issues of GBV. Some of the community outreach and education activities include development and implementation of GBV prevention programs and curricula, organizing community events and campaigns to raise awareness about GBV, and delivering bystander intervention workshops in different community settings (SCCADVASA, 2015; Wood, 2014).

Psychosocial health and well-being of staff members is a major component of the short and long-term success of GBV-specific NPOs (Wood, 2014). Staff members work

with survivors of GBV who have been exposed to multiple forms of trauma and assist them in creating safer and healthier lives for themselves, and their families. This includes helping GBV survivors identify housing, employment, and health care resources, oftentimes in professional settings that are under-resourced (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Wood, 2014). Constant engagement with GBV survivors in desperate situations, and working in low-resource environments can lead to burnout, compassion fatigue, and vicarious (secondary) trauma among staff members of NPOs (Bell, Kulkarni, & Dalton, 2003; Pross, 2006; Shakespeare & Lafrenière, 2012a; Skovholt & Trotter-Mathison, 2016). Work experiences can adversely affect both physical and mental health, especially when: 1) there are no clear policies on work schedule and hours, 2) staff members are overworked, and 3) self-care practices are not supported systematically within the organization (Lee, 2014).

Engaging in self-care practices is critical for the staff members of GBV-specific NPOs so that they can experience satisfaction in their work, grow professionally, and continue their work without compromising their own health and well-being (Mathieu, 2012; Skovholt & Trotter-Mathison, 2016). Self-care is defined as “proactive strategies, or routines, that professionals use to offset the negative aspects of working with trauma victims and promote their own well-being” (Wasco & Campbell, 2002, p. 734). There has been growing attention to the concept of self-care in service professions that include working with groups who are survivors of trauma, such as GBV, disasters, conflict and war (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015; Ho, Sing, & Wong, 2016). Much of the available research has focused on the individual psychological processes to understand the impact of working with trauma survivors and/or engaging in GBV-related

community outreach, as well as individual self-care practices that are employed to counter the negative impact of GBV-related work. In response, self-care guidelines published by NPOs mostly target individual-level prevention methods and coping strategies.

Organizational structure and practices, however, have not received sufficient attention, despite their significant contribution to the staff health and well-being (Bell et al., 2003; Bressi & Vaden, 2017). There is a need for research that examines multilevel factors (i.e., individual, interpersonal and organizational) that influence health and well-being of GBV-specific advocates who work within NPOs (Homer, 2014; Kulkarni, Bell, Hartman, & Herman-Smith, 2013a). Such research can help NPOs and practitioners working in the area of GBV develop holistic, multilevel strategies that support sustainable advocacy.

This study focuses on the psychosocial health and well-being, and self-care practices among advocates who work for GBV-specific NPOs in SC, and the organizational structures that shape those practices. I develop a framework to understand these dimensions individually as well as the interplay and intersections between them. To achieve addressing these two areas of interest, it was necessary to examine the individual and organizational processes that contribute to the psychosocial health and well-being of staff. I approached GBV-specific NPOs in eight different SC counties to recruit participants for this study. Participants consisted of advocates who either worked for these organizations in the last three years preceding the study, or were working for these organizations at the time of the study. Examining the context in which workplace experiences occurred was an essential part of this inquiry, as these workplace dynamics

are subject to change based on geography, dominant politics, leadership styles, and cultural traditions. On the other hand, certain workplace dynamics observed within the GBV-specific NPOs in SC could be relevant to similar NPOs in other states. Thus, a general goal of the study was to inform GBV-specific NPOs in developing systematic workplace policies and practices to better support self-care among their staff members.

The study adopted a *Constructivist Grounded Theory* (CGT) approach (Charmaz, 2006), and was guided by *Feminist Intersectionality* (Weber & Castellow, 2011; Weber & Parra-Medina, 2003), *Standpoint Epistemology* (Harding, 2012), and *Social Ecological Perspective* (McLeroy, Bibeau, Steckler, & Glanz, 1988). Researchers using grounded theory (GT) aim to develop an explanatory theory about social processes, structures, and human interactions that emerges directly from the data (Corbin & Strauss, 2008). My epistemological stance was that the knowledge created as an outcome of social inquiry is a co-product of the researcher and the researched (Charmaz, 2006; Taghipour, 2014). This co-production starts with the values and beliefs we bring to the table as researchers, and continues with the process of data collection and analysis during which we interact with the research participants and data. Both the researcher's understanding and interpretation of the data, and the participants' understanding of their own experiences, and the ways in which they construct their own stories are reflected in the findings of qualitative social inquiry (Mills, Bonner, & Francis, 2006). Through the use of CGT, I was able to consider the situatedness and partiality of the data I collected, and examine the interactions between me and the research participants (Allen, 2011). While I understood that perspectives of the research participants were constructed within unique social and cultural circumstances, I did not ignore the objective realities that shape their

everyday work experiences (Charmaz, 2011). Charmaz (2011) stresses the usefulness of CGT in revealing “how micro processes influence larger social entities,” (2011, p. 359) and understanding the mutually shaping interactions between “global, national, and local social and economic conditions” and “collective and individual meanings and actions” (Charmaz, 2011, p. 359). Using these insights, I examined how workplace structures and processes shaped and were shaped by individual and collective actions and meanings of self-care and well-being. Using a constructivist lens helped me delineate multiple perspectives on self-care and well-being, and understand the diverse needs of advocates that need to be taken into consideration when developing organizational policies and practices around self-care.

Feminist intersectionality and standpoint theory further guided me in placing the participants’ experiences at the center of my analysis, and exploring how multiple and fluid identities (e.g. race, ethnicity, gender, sexuality) of the participants shaped their experiences over time (Devault, 2004; Hankivsky et al., 2010; Harding, 2012; Stoetzler & Yuval-Davis, 2002; Weber & Parra-Medina, 2003). I also examined critically the power relations within the GBV-specific NPOs, and how these power relations affected psychosocial well-being of the participants (Springer, Hankivsky, & Bates, 2012).

Specific Aims

The study addressed the following specific aims:

SA1: To describe the relationships between engaging in paid GBV-specific advocacy and psychosocial health and well-being within the political, social, economic, and cultural context of SC

RQ1. What are the multi-level, work-related stressors (individual, interpersonal, organizational) faced by individuals who engage in paid GBV-specific advocacy?

RQ2. How do these individuals experience the benefits and costs of their work in relation to their psychosocial health and well-being?

SA2: To identify the organizational processes that influence self-care practices among individuals who engage in paid GBV-specific advocacy.

RQ3: What are the main self-care practices that GBV-specific advocates engage in?

RQ4. What types of strategies do NPOs that address GBV in SC employ to support and foster self-care among their staff members?

RQ5. How do the organizational culture and interpersonal dynamics within the organizations shape staff members' willingness and ability to engage in self-care practices?

With these research questions, I aimed to capture different levels of influences (i.e. individual, interpersonal, organizational) that are important in shaping psychosocial health and well-being of GBV-specific advocates. They guided me in developing an analytic story that situates individual-level agency around self-care within the context of GBV-specific organizations of SC.

The format of this dissertation includes a review of the literature (Chapter 2), a discussion of the theoretical framework and research methodology (Chapter 3), research study results in the form of two manuscripts (Chapter 4), and discussion and

recommendations for future research (Chapter 5). Manuscripts are formatted in accordance with the target journal specifications.

Significance

Knowledge produced through this study contributes to public health scholars' understanding of health and well-being among self-identified women and queer, non-gender conforming individuals² who engage in GBV-specific advocacy. Studies that focus on women's health, and health status of ethnic and/or sexual minorities in different contexts of daily life often fall short of identifying the social, political and cultural dynamics that relate to physical and mental well-being, due to taking an androcentric, Western medical approach to health (Currie & Wiesenberg, 2003; O'Donnell, Condell, & Begley, 2004; Springer et al., 2012; Weber & Castellow, 2011). Specifically, the Western medical model treats individuals as passive recipients of their environment and focuses on the individual health behaviors without a detailed consideration of the social, cultural and political determinants of health (Weber & Castellow, 2011). Unlike this reductive assessment of health, approaches that integrate feminist intersectionality acknowledge the role of macro and meso-level structural factors (i.e., gendered labor division, poverty, racial/ethnic discrimination, or discrimination based on sexual orientation, neighborhood build and social structure, workplace characteristics etc.) in shaping women and queer peoples' lives and health, as well as the agency they show in determining their wellness (Hankivsky, 2012; Hankivsky et al., 2010; Weber & Castellow, 2011). Such an approach

² Men were not included in the sample for two reasons: 1) I was primarily interested in examining women's experiences of GBV-specific advocacy, 2) At the time of the study, I identified a very limited number of men working with GBV-specific NPOs in SC all of whom were volunteers.

provides a more comprehensive and accurate analysis of the relationships between daily life experiences and health (Springer et al., 2012).

Guided by feminist intersectionality and standpoint theory, I centered the standpoints of the study participants in my analysis (Devault, 2004; Harding, 2012; Hesse-Biber, 2013), and looked directly at the experiences of a group whose invisible work is critical to transforming social and gender norms that contribute to elevated rates of GBV in SC. To achieve a holistic understanding of physical, social and mental well-being among these individuals, it was important to disentangle the mutual, co-constructive relationships between their agency, structures in which they work, and specific challenges they face due to their work in SC (Cole, 2009; Hankivsky et al., 2010; Weber & Parra-Medina, 2003). Thus, I examined not only the challenges and barriers the participants faced due to their work, but also the ways in which they responded to those challenges by mobilizing their personal assets and available organizational resources.

Public health scholarship concerning the problem of GBV have long focused on the prevention strategies, in addition to improvement of the existing services for survivors within their communities and relevant institutions like law enforcement, security forces and hospitals (Decker, Miller, Illangasekare, & Silverman, 2013; García-Moreno et al., 2015; García Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). The very people whose profession consists of working with each of these institutions, as well as developing and implementing community-level prevention and education programs however, have mostly been left out of this scholarship (Wood, 2014). More specifically, conditions that determine the success of the work that advocates engage in within non-profit organizations in the field of GBV, and how these conditions can be modified to

achieve better outcomes has not been examined. Given the crucial role that community-based organizations play in short and long-term outcomes of the anti-GBV movement, it is important to understand the non-profit workplace dynamics in which individual and collective action against GBV happens. In this study, I explored the overlooked workplace dynamics within the GBV-specific NPOs of SC, and their relationship with the psychosocial health and well-being of advocates, as well as the outcomes of their work.

Preview

This dissertation is organized as follows: In Chapter 2, Background and Literature, I summarize the literature on causes and health consequences of GBV, the socio-cultural context of GBV in SC, efforts made by GBV-specific NPOs to prevent the problem and mitigate its consequences, and potential impacts of engaging in this work on health and well-being of advocates who work for GBV-specific NPOs. Also in this chapter, I discuss the theoretical framework guided this study. In Chapter 3, Research Design and Methods, I describe the methodology used for this research. In Chapter 4, I present the study findings in the format of two academic manuscripts that will be submitted to *Violence Against Women, and Gender & Society* journals. Finally, in Chapter 5, Conclusion, Implications and Recommendations, I summarize the findings of this study, discuss their implications for research and practice, and provide recommendations for GBV-specific NPOs

CHAPTER 2

BACKGROUND

An Important Public Health Problem: Gender-Based Violence

Gender-based violence is defined as “an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) differences between males and females” (IASC, 2015, p.5). Along with acknowledging that men and boys can also be victims of GBV, this definition emphasizes the disproportionate burden of GBV experienced by women and girls (IASC, 2015). GBV takes many different forms; it can be physical, sexual, psychological, or economic and includes (but is not limited to) domestic partner violence, sexual assault, rape, harassment in the workplace, financial control, verbal abuse, sex trafficking, honor crimes, violence perpetrated by the state, and forced marriage (IASC, 2015; UNFPA & WAVE, 2014). The World Health Organization (WHO) estimated that about one in three women worldwide has been exposed to physical and/or sexual violence during their lifetime, either perpetrated by an intimate partner or non-partner individuals (WHO, 2016). Violence by intimate partners constitutes the majority of these cases; about 30% of women who have been in a relationship report being exposed to physical and/or sexual

violence by their intimate partners. Furthermore, murders by intimate partner account for 38% of all female homicides worldwide (WHO, 2016).

Underlying Causes of Gender-Based Violence

Heise and colleagues (1998) developed a socio-ecological framework to identify and examine the complex, multi-faceted, and multi-level causes of GBV (WHO & London School of Hygiene and Tropical Medicine, 2010). Macro-level factors that create social environments in which GBV is more likely to occur include gender inequality, traditional social and gender norms that are supportive of violence, male sexual entitlement, religious beliefs, cultural traditions that subordinate women's rights to make decisions and act independently, and economic systems that marginalize women (Decker et al., 2013; WHO & London School of Hygiene and Tropical Medicine, 2010). At the community level, living in poverty, norms of male dominance, acceptance of violence, and weak community sanctions against violence are important risk factors for GBV (Kiss et al., 2012; WHO & London School of Hygiene and Tropical Medicine, 2010).

Intrapersonal factors that increase the risk of GBV include low relationship/marital satisfaction, significant differences in education status of partners, and having multiple sexual partners, specifically among men who engage in risky sexual behaviors (UNFPA & WAVE, 2014; WHO & London School of Hygiene and Tropical Medicine, 2010). In addition, familial responses to GBV that put blame on women and focus on 'family honor' can make the problem invisible and encourage males to further perpetrate violence (UNFPA & WAVE, 2014). At the individual level, young age, low level of education, and low socio-economic status are among the most significant demographic factors that increase the risk of exposure to GBV. In addition, life experiences such as maltreatment

during childhood, witnessing intra-parental violence, and behavioral factors, including alcohol and/or illicit drug abuse also increase the risk for both perpetration of and exposure to GBV (UNFPA & WAVE, 2014; WHO & London School of Hygiene and Tropical Medicine, 2010).

Feminist analysis of GBV shifted the literature by bringing the significant role of power and privilege in the emergence of GBV to light (McPhail, Busch, Kulkarni, & Rice, 2007; Russo & Pirlott, 2006). Feminist scholars, researchers, and activists challenged the mainstream approaches to researching GBV as an individual-level psychological phenomenon, and suggested that male entitlement was rooted in the social construction of sex and gender roles (Johnson, 2011; Mikel Brown, Chesney-Lind, & Stein, 2007). In addition, feminists of color such as Black, Latina, Native American feminists, and/or lesbian, transsexual, queer feminists criticized the essentialist notions of GBV as one unified experience among all individuals who identify as women. They argued that women from ethnic minority and marginalized communities experience GBV in different ways than white women, and their diverse experiences need to be considered in developing services and programs (Bent-Goodley, 2009; Burnette, 2015; Chavis & Hill, 2008; Kasturirangan, Krishnan, & Riger, 2004; Sokoloff & Dupont, 2005). It was through the contributions of these scholars and activists that not only gender but other multiple systems of oppression such as race, class, ethnicity, nationality, sexuality, and spirituality were included in the analysis of social dynamics that underlie GBV (Crenshaw, 1991; McQueeney, 2016).

Health Consequences of Gender-Based Violence

Exposure to GBV is associated with a wide-range of negative health consequences, including physical, sexual and reproductive, and mental health outcomes (Tjaden & Thoennes, 2006; WHO, 2013). Serious physical trauma such as musculoskeletal injury, soft tissue injury, and genital trauma can occur as a result of GBV. Sexual and reproductive health consequences include unwanted pregnancy, abortion, HIV and other sexually transmitted illnesses. Compared to those who are not exposed to GBV, women who are exposed to GBV have a significantly higher risk of experiencing depression, post-traumatic stress disorder (PTSD), anxiety, obsessive-compulsive disorder, and suicide (Kumar, Haque Nizamie, & Srivastava, 2013). Behavioral disorders that manifest with self-harm and higher risk-taking such as the abuse of drug, alcohol, and/or substances, eating disorders, engaging in risky sexual behaviors are also common among the survivors of GBV (WHO, 2013). Other adverse effects on mental health and well-being include loss of a sense of self-worth and autonomy, loss of productivity and the ability to make decisions and shape one's life independently (WHO & London School of Hygiene and Tropical Medicine, 2010; WHO, 2013).

Physical and mental health outcomes of GBV are not independent from one another but often interact in ways that lead to complex and long-term health consequences (Nicolaidis, Curry, McFarland, & Gerrity, 2004). For instance, long-term alcohol and drug abuse contribute to cardiovascular disease (WHO, 2013), and when experienced together with unsafe sexual behaviors, increase rates of recurrent victimization (WHO, 2013). Similarly, depression, anxiety and PTSD may occur

concurrently with chronic pain syndrome, irritable bowel syndrome, and chronic pelvic pain (UNFPA & WAVE, 2014; WHO, 2013). Apart from affecting overall health and well-being of the survivors and their families, GBV has detrimental effects on society by limiting women's ability to be productive, and reach their full potential (García Moreno et al., 2005; Kumar et al., 2013).

Gender-Based Violence in South Carolina

Southern states (e.g., Alabama, Mississippi, Kentucky, Tennessee, South Carolina) are among the least favorable places in the US for women to live, based on the analysis of data from seven key areas that shape the quality of women's lives (Hess et al., 2015). These seven areas include: 1) political participation, 2) employment and earnings, 3) work and family, 4) poverty and opportunity, 5) reproductive rights, 6) health and well-being, and 7) violence and safety. Violence and safety data indicate that GBV is one of the most prevalent public health problems and human rights violations affecting women and girls in SC. SC had a rate of 1.73 women killed per 100,000 in 2014, ranking number five among all states for female homicide rate. Lifetime prevalence for rape, physical violence and/or stalking by an intimate partner was 41.5% among women in SC in 2010, which was higher than the national average of 35.6% (CDC, 2010). Results from the SC Lesbian, Gay, Bisexual, Transgender (LGBT) Needs Assessment also indicate high rates of relationship abuse or violence among LGBT couples: 30% of participants stated that they have been a victim of relationship violence (Governor's Domestic Violence Task Force, 2015).

Break the Cycle (2010), a non-profit organization (NPO), assigned a grade to each state based on the status of teens' access to civil protection orders, critical services related

to dating violence and schools' responses to the problem. Results showed that SC was among the nine states that received a grade of "F". In SC, the average rates for exposure to physical and sexual dating violence among girls in high school were 13.1% and 13.7%, respectively, and 9.5% of the young women indicated that they did not go to school at least one day in the past month because they felt unsafe (Anderson et al., 2016). Physical and sexual dating violence rates were higher among Black young women in high school (16.9% and 14.4%), compared to white young women in high school (9.4 % and 12.3%) (Anderson et al., 2016). These statistics indicate that despite varying rates by racial/ethnic and socio-economic status, GBV is a public health problem that can occur over the life course, and across race, ethnicity, class, and sexual orientation, affecting the livelihood, health and well-being of both women and young girls (Decker et al., 2013; Krantz, 2005)

Gender-Based Violence and the Social, Cultural and Political Context of SC

GBV occurs everywhere and across all socioeconomic levels due to socially-constructed gender norms that influence the control of political power, resources, and interpersonal relationship dynamics (IASC, 2015). In social contexts where gender inequality in political participation, employment, education, and access to quality health care are greater, the prevalence of GBV may be higher, and its consequences may be worse (Heise, 1998; IASC, 2015). This section will provide information about the contextual background of GBV in SC.

Table 2.1 presents letter grades for southern states on composite indices that reflect women's status in six main areas.

Table 2.1 Letter Grades on Six Composite Indices for Southern States

State	Political Participation	Employment & Earnings	Work & Family	Poverty & Opportunity	Reproductive Rights	Health & Well-Being	Mean GPA	Mean GPS (Rank)	Overall Grade
Alabama	D-	F	D-	D-	D	F	0.50	14	D-
Arkansas	F	F	C+	F	D+	F	0.61	12	D-
District of Columbia	N/A	A	B	A-	A-	D-	3.00	1	B
Florida	D+	D+	D-	D+	C-	D+	1.28	5	D+
Georgia	D-	C	C	C-	C	D	1.56	4	C-
Kentucky	D	D+	D+	D-	C	D-	1.17	7	D+
Louisiana	D-	F	C	D-	D	D-	0.84	11	D
Mississippi	D+	F	D-	F	C-	F	0.61	12	D-
North Carolina	C-	C+	D+	D+	C	D+	1.67	3	C-
South Carolina	D-	D	C-	D	C	D-	1.17	7	D+
Tennessee	D-	C-	D	D	D	D-	1.00	9	D+
Texas	F	C	D+	D	C-	C-	1.28	5	D+
Virginia	D-	B	D-	B-	C-	C	1.78	2	C-
West Virginia	F	F	C-	D-	B	D-	1.00	9	D

In the South, women are underrepresented at all levels of political participation compared to the other geographic regions of the US. For example, in 2015 only 12.2% of the seats in the US House of Representatives, and 18.4% of seats in southern state legislatures were held by women, while the national average for the same rates were 19.3% and 24.4% respectively (Anderson et al., 2016). Similar to women who work full time in other regions of the US, women in the South have lower annual earnings than men employed in similar jobs. In addition, the overall poverty rate among women is 16.4% in the southern states, whereas the average rate for all other states is 13.7% (Anderson et al., 2016). In 2015, SC ranked 43rd among all states for the rate of working women in poverty (Center for Women, 2015).

During the last decade, employment and economic opportunities have increased in the southern US (Anderson et al., 2016). However, these opportunities are not distributed equally, and disparities based on gender, race, ethnicity, socioeconomic status, immigration status, and sexuality persist (Anderson et al., 2016; Sears & Mallory, 2011). The historical legacy of slavery and long-standing institutional racism perpetuate the oppression of women in the South, particularly women of color; Black, Hispanic and Native American women in the South have higher rates of living in poverty and violent victimization compared to white women (Anderson et al., 2016; Kasturirangan et al., 2004; Sokoloff & Dupont, 2005). Women from marginalized and underserved populations in the South, such as ethnic minority women, LGBTQ women, older women, rural women, and women with disabilities are most affected by gender inequality, which also increases their vulnerability to GBV (Anderson et al., 2016; INCITE!, 2017).

Women of color constitute only 4.8% of the U.S. Representatives in the southern states, compared to the national average of 7.4 % (Anderson et al., 2016).

Women's well-being and safety indicators are strongly shaped by southern culture and politics, which perpetuate the disadvantages women and girls experience in exercising power over their bodies and health (Anderson et al., 2016; Morgen, 2002; Spruill, 2012). Historically, conservative politics and social values have shaped important laws concerning women's safety, health, and choices (e.g., protection laws for survivors of violence, abortion related laws) in SC (Anderson et al., 2016; National Right to Life Committee, 2017). Due to strictly-defined gender norms in the South, such as the notions of being 'ladylike' and obedient to the preferences of males at home and at the workplaces (Spruill, 2012), women and girls are often treated as second class citizens, increasing the likelihood of their exposure to GBV (Heise, 1998; Spruill, 2012).

"Till Death Do Us Part," a series published by the newspaper Post and Courier (2014) exposed the scope of female homicides in SC, winning the 2015 Pulitzer Price for Public Service (Pardue, Smith, Berry Hawes, & Caula Hauff, 2014). The series discussed how traditional gender norms and cultural attitudes perpetuate the problem of GBV in the state. In collaboration with the University of South Carolina and the Center for Investigative Reporting, journalists documented that since 2005, "more than 300 women were shot, stabbed, strangled, beaten, bludgeoned or burned to death" by men in SC (Pardue et al., 2014, Para. 1). In addition, the series explored the claim that legislators in SC prioritize protecting the family union over the safety of women, despite the recommendations from domestic violence advocates and public health experts about the

necessity of separating the abuser from the victim³. The authors discussed the role of prevalent beliefs in the South about the sacredness of marriage, and home as women's place in shaping men's behavior towards women in SC (Pardue et al., 2014). The statistics and patterns of GBV reported in the series also reflect the long-lasting *culture of honor* in the South (Grosjean, 2014). The culture of honor is manifested by a set of values that legitimize the use of physical violence by males who feel insulted or believe that there is a threat to the safety of their home, and to women under their protection (Grosjean, 2014; Lee, Bankston, Hayes, & Thomas, 2007; Lee & Ousey, 2011). Historically high rates of homicide in the US south are associated with the notion of male honor and practices that rely heavily on these cultural values (Grosjean, 2014), and a considerable number of these homicides comprise murders of women by male intimate partners (Violence Policy Center, 2016). For instance, 23 of the 43 female victims murdered by males in 2014 were wives, common-law wives, ex-wives, or girlfriends of the perpetrators (Violence Policy Center, 2016). These characteristics of southern culture are also represented in gun ownership by males. Although men possess guns with an intention to protect the "honor" and safety of the household, higher rates of gun ownership by males leads to increased likelihood of domestic homicide. In 38 of the 43 female homicides that happened in SC in 2014, weapon use was identified. In 63% of these cases, women were shot and killed with guns (Violence Policy Center, 2016). Despite the evidence that shows the significant relationship between having firearms in the home and intimate partner homicide (Anglemyer, Horvath, & Rutherford, 2014;

³ The term victim is used here to indicate being victim of a crime.

Wiebe, 2003), gun ownership by previous perpetrators of violence continues to be a highly controversial issue in SC (Jackson, 2016). A law enacted in 2015 prohibits the ownership of firearms or ammunition by people who have been convicted of criminal domestic violence. However, the law does not require perpetrators to surrender the firearms or ammunition after they have become prohibited from ownership. SC gun laws also do not require the removal of any firearms or ammunition present at a domestic violence scene (S.C. Code § 16-25-30 [as amended by 2015 S.C. S.B. 3]).

GBV-specific advocates in SC have long worked towards improving legislation that concerns women's health and safety, in addition to challenging patriarchal values and practices that contribute to higher rates of GBV. As a result of their work, there have been advances in SC towards women's rights during the last few decades. However, the state still needs better policies to improve the status of women and girls, particularly concerning women's health, well-being and safety (Anderson et al., 2016; Hess et al., 2015; Schunk & Teel, 2005). The following section describes such efforts made by GBV-specific NPOs in SC.

Organizational Responses to the High Rates of Gender-Based Violence

South Carolina has history of a strong feminist movement that has focused on prevention and mitigation efforts related to GBV, despite the state's ranking low on women's well-being indicators among the nation. Among the most important and influential state actors are government institutions, local NPOs, community-based organizations, academia, public schools, and religious organizations (SCCADVASA, 2015). In addition to ensuring the delivery of quality, accessible services to people who have experienced GBV, these groups work individually and collectively to address

women's rights and issues, including the high rates of GBV (Spruill, 2012). Within each of the state actors, feminist advocates and activists have continued to work on improving GBV-related legislation and services (Keane, 2009; Spruill, 2012). NPOs have long been an essential part of this struggle, simultaneously working in the areas of community outreach, awareness raising, prevention efforts, and directly supporting their clients. These organizations play an important role in primary (i.e., preventing GBV from happening in the first place) and secondary prevention (i.e., alleviating the consequences of GBV) by working towards transforming gender roles and power structures while providing better services and engaging in advocacy for people who are affected by GBV (SCCADVASA, 2015; SCCADVASA, 2017).

One of the ways in which GBV-specific NPOs engage in advocacy has been challenging the use of disempowering terms for their clients such as *victim*. Although the term victim is frequently used in legal contexts to describe a person affected by a crime, advocates argued that this term reduces people who have been exposed to GBV to helpless individuals, and undermines the agency they show in leading their own recovery. Similarly, some GBV-specific advocates criticized the term *survivor*, claiming that people who experience GBV do not always identify as a survivor, and even when they do, they might stop identifying as such at some point in their lives. To challenge the negative and disempowering social stereotypes about people who are affected by GBV, many advocates employed the term *client*. Advocates who work for GBV-specific NPOs in SC widely use the term client, since this term more accurately reflects the nature of the relationship they develop with people they serve, without reducing those people's identity to the experience of GBV. I use the terms survivor and client interchangeably in this

study. However, I also acknowledge the limitations of the term survivor, and how this term might not always accurately represent the experiences of people served by GBV-specific advocates.

Some GBV-specific NPOs focus on providing shelter services to clients; others provide counseling and/or advocate support for them during critical times of need such as hospital visits, court hearings, and reporting the exposure to violence to the police. Most GBV-specific NPOs have sub-units that consist of staff who engage in community outreach and education such as visiting schools, colleges, and workplaces to deliver trainings or give talks about GBV (Davies & Lyon, 2013; Wood, 2014). The mission of these GBV-specific NPOs is two-fold: to support survivors of violence and help them access the services they need, and to engage in community work that is required to transform the social norms and culture to reduce GBV in the long term (Bennett et al., 2004; Davies & Lyon, 2013).

As part of their prevention and mitigation efforts, GBV-specific NPOs lobby SC legislature to improve existing policies and laws, and to develop new ones concerning the social factors contributing to GBV rates, related judiciary process and the delivery and quality of services to the victims of GBV (SCCADVASA, 2015; Wood, 2014). One important example of this work is the establishment of the SC Task Force on Domestic Violence, which is a state-level initiative begun by Governor Nikki R. Haley in 2015. The Task Force's purpose is to bring GBV-specific organizations, academicians, and policy makers together to integrate their efforts in a way that leads to effective policies (SC Society for Human Resource Management, n.d.). For instance, the most recent domestic violence bill was signed into law by Governor Nikki R. Haley in June 2015 as a

result of the advocacy around gun laws. Prior to this bill, first-offense punishment for committing domestic violence was 30 days of sentence and there was no legislation in effect preventing perpetrators of violence from owning guns. The majority of female homicides by intimate partners included the use of a weapon (Gerney & Parsons, 2014). Thus, improving state gun laws is a critical component of the GBV-specific NPOs' efforts to reduce GBV rates.

In the next section, I explore the notion of advocacy, and impact of GBV-specific advocacy on psychosocial health and well-being.

Defining Advocacy

Although there is no agreed-upon definition of advocacy, it is a commonly used term in the social movement literature. A broad definition of advocacy within the context of movements against GBV indicates that an advocate is “anyone who responds directly to help abused women in an institutional context” (Davies, Lyon, & Monti-Catania, 1998, p. 2). GBV-specific advocacy involves informing clients about the resources that are available to them, helping clients with making decisions based on their values and needs, and supporting them in navigating the health care, legal, and social welfare systems (Globokar, Erez, & Gregory, 2016; Homer, 2014). In a study conducted with people who work for either non-profits or public agencies that provide services for women who experienced GBV, participants provided the following definitions for advocacy: “[Advocacy is] educating, manipulating, and holding accountable systems and key players in the systems which impact on the safety and well-being of families in which there is domestic violence.”(Peled & Edleson, 1994, p. 288); “I define advocacy as 'support.' My responsibility is to inform battered women of their options...I mention the

word 'support' because I see my role as a supporter of the women and a supporter of their decisions.” (Peled & Edleson, 1994, p. 289). Providing services and support to clients, in addition to engaging with the institutions that are responsible for addressing clients’ needs appear to be the common components among various perspectives on advocacy.

Gender-Based Violence-Specific Advocacy, Psychosocial Health and Well-Being

Potential influences of engaging in GBV-specific advocacy on psychosocial health and well-being have been examined by several studies (Homer, 2014; Trippany, Kress, & Wilcoxon, 2004; Wasco & Campbell, 2002a, 2002b; Wu, 2008). Psychosocial health encompasses the mental, emotional, social, and spiritual dimensions of one’s health (Martikainen, Bartley, & Lahelma, 2002). Assessment of psychosocial health involves the nature of social ties and relationships that influence people’s psychological states, which are often developed in collective environments such as schools, workplaces, and communities (Martikainen et al., 2002). Engaging in GBV-specific advocacy enables people to affect social change in ways that are personally meaningful. Working for the well-being of other people and future generations, within a collective structure that is built upon shared values, can facilitate a pathway to self-actualization, making the positive psychological outcomes possible (Homer, 2014; Lee, 2014; Myers, 2016).

Advocates often experience empowerment through their work, which creates a sense of direction and purpose in life (Christens, Collura, & Tahir, 2013; Klar & Kasser, 2009; Lee, 2014). Commitment to a meaningful cause, finding satisfaction in supporting their clients, and seeing them make progress towards recovery increases advocates’ self-esteem, self-worth, enabling them to feel positively connected to their social environment (Bond, Holmes, Byrne, Babchuck, & Kirton-Robbins, 2008; DeBlaere et al.,

2014; Franzway, 2000; Gilster, 2012; Klar & Kasser, 2009; Rip, Vallerand, & Lafrenière, 2012). Advocacy supports healthy psychological functioning and leads to greater life satisfaction (Klar & Kasser, 2009; Moane, 2010; Ryan & Deci, 2000). Although individuals do not engage in advocacy with an expectation to experience these benefits, they report feeling more fulfilled by being part of “something bigger than the self” (Homer, 2014; Klar & Kasser, 2009, p. 756).

In addition, engaging in advocacy may expand individuals’ informal and formal networks, facilitate better negotiation skills with opponents, and encourage individuals to be in a constant learning process, all of which may pave the way for a greater social capital (Christens et al., 2013; Gilster, 2012; Gittell, Ortega-Bustamante, & Steffy, 2000). Social capital can be critical in accessing material and emotional resources that promote health (Kawachi, 2004; Poortinga, 2006). Through greater social capital and access to resources that promote health, advocates might experience significant improvement in their quality of life (Smith, 2016; Weinstein & Ryan, 2010). Advocacy may also provide a constructive channel for expression of anger which results from experiencing or witnessing social injustices. Through advocacy, negative emotions that are challenging to cope with can be translated into social action (Blackstone, 2004; Rodgers, 2010). Greater awareness of the power relations that shape social and economic inequalities can give rise to feelings of helplessness and aggression if the individual is not able to put the awareness into the service of altering oppressive systems (Kovan & Dirkx, 2003; Malanchuk, Messersmith, & Eccles, 2010; Rip et al., 2012). Advocacy also involves mobilizing others for a cause and building community to work towards the desired social change. Therefore, advocacy may function as a survival strategy by providing a

supportive community in which individuals can maintain an emotional balance and a productive life (DeBlaere et al., 2014; Malanchuk et al., 2010; Naples, 2014).

In addition to the wide range of potential benefits, GBV-specific advocacy may expose individuals to various stressful processes (Activist Trauma Support, n.d.; Lee, 2014; Wood, 2014). The conflict-oriented nature of their work, and difficulties that advocates experience in communicating their beliefs and values to people in their close social networks (e.g. friends, family, partners) can lead to confrontations, disapproval and loss of previous relationships (Garrity, 2011; Lee, 2014). Weakening of previously existing social ties may cause significant distress and render advocates more vulnerable to mental health problems such as anxiety and depression (Lee, 2014). Due to their heightened awareness of social problems, advocates may experience emotional reactions such as anger, sadness, and helplessness. Although anger can function as a motivating source at times, it can also lead to burnout and withdrawal when advocates are not able to transform their feelings into action and meaningful outcomes (Rodgers, 2010; Wasco & Campbell, 2002b).

Advocates who work with survivors of trauma and violence have a high risk for experiencing compassion fatigue, and vicarious trauma (Homer, 2014; Skovholt & Trotter-Mathison, 2016). Compassion fatigue refers to the “overall experience of emotional and physical fatigue that social service professionals experience due to the chronic use of empathy when treating patients who are suffering in some way” (Newell & Macneil, 2010, p. 61). Vicarious trauma is defined as the secondary level trauma that results from “being exposed and empathically listening to stories of trauma, suffering and violence, caused by humans to other humans” (Sexual Violence Research Initiative,

2013, p. 2). Some of the factors that determine the level of risk for compassion fatigue and vicarious traumatization among help professionals (e.g. health care providers, counselors, social workers) are the individual's trauma caseload, availability of social support, history of trauma and abuse experiences, and the perceptions of receiving adequate training to effectively fulfill their responsibilities (Bober & Regehr, 2006). Experiencing compassion fatigue and/or vicarious trauma can affect both personal and professional lives of the advocates, and may result in withdrawal from advocacy if they are not addressed appropriately (Sexual Violence Research Initiative, 2013; Trippany et al., 2004).

Multiple contextual factors shape the extent to which GBV-specific advocates experience health benefits and/or health risks related to their work (Jenkins & Baird, 2002; Lee, 2014; Newell & Macneil, 2010; Sexual Violence Research Initiative, 2013). Figure 2.1 depicts the individual and organizational-level risk and protective factors that relate to health and well-being of advocates who work for GBV-specific NPOs (Sexual Violence Research Initiative, 2013). Individual risk factors include experience level, age, personal coping style, previous traumatic experiences, and level of support available to women from external networks (Sexual Violence Research Initiative, 2013). As engagement in GBV-specific advocacy shapes women's choices and beliefs over time, they might find it challenging to communicate their transformation to people with whom they have close relationships (Maltzman, 2011; Iliffe & Steed, 2000). They might face judgement and feel misunderstood at times when ideological conflicts arise with family, partners and friends, resulting in loss of social support (Lee, 2014). Protective factors on this level include knowledge of how to seek help when needed, belief in the necessity of

their work and potential for change, and self-care practices (Activist Trauma Support, 2006; Sexual Violence Research Initiative, 2013).

Gender-Based Violence-Specific Advocacy and Self-Care

A critical component of psychosocial well-being among advocates who work with trauma survivors, self-care is defined as “proactive strategies, or routines, that professionals use to offset the negative aspects of working with trauma victims and promote their own well-being” (Wasco & Campbell, 2002, p. 734). Rooted in the notion that “Nobody can give from an empty vessel” (McCadden, 2016), incorporating self-care practices into daily life helps advocates maintain their own well-being so that they can better care for others. Self-care strategies are beneficial not only to cope with stress and maintain positive mental health, but also to enhance long-term well-being and develop a sustainable approach to working with survivors of trauma, as well as engaging in efforts towards creating systemic change (Homer, 2014; McCadden, 2016; Wasco & Campbell, 2002a).

Self-care strategies for GBV-specific advocates consist of two inter-related dimensions: individual and organizational. Most guidelines developed for these advocates focus heavily on the individual-level practices such as eating healthy, maintaining a regular sleep schedule, exercising, and spending time with family and friends (Skovholt & Trotter-Mathison, 2016). Organizational culture and practices around self-care have not been addressed sufficiently even though they can be critical in shaping advocates’ willingness and ability to engage in self-care (Kulkarni, Bell, Hartman, & Herman-Smith, 2013b; Maltzman, 2011; Wasco & Campbell, 2002a). Advocates working with contemporary GBV-specific NPOs draw attention to the collective enactment of self-

care, and call for creating “communities that support collective well-being” of people who engage in this work (Coalition Ending Gender-Based Violence, 2017).

Organizational environments that either stigmatize the experiences of trauma and burnout or lack support for self-care pose a risk for healthy, sustainable advocacy (Bober & Regehr, 2006; Lee, 2014; Sexual Violence Research Initiative, 2013). On the other hand, workplace strategies that promote self-care, encourage peer-support, and offer resources to prevent or treat vicarious trauma can reduce stress and burnout among advocates, and prevent emergence of chronic health conditions (Lee, 2014; Moane, 2010). In addition, ignoring power differentials might cause problems in interpersonal relationships, and failing to create an egalitarian culture within the organization might negatively affect the productivity and well-being of the advocates (Cole, 2008; Greenwood, 2008). Although there are hierarchical relationships among leadership and various staff positions in GBV-specific NPOs, power can be shared among all staff members in ways that enhance both organizational functioning and staff well-being (Slattery & Goodman, 2009).

Efforts to improve the state of women’s health and well-being within politically and socially conservative environments, such as in the southern U.S., exposes advocates women to a variety of stressors (Keane, 2009; Morgen, 2002; Spruill, 2012). Therefore, it is critical for those advocates to have the necessary material and emotional resources to support them in engaging self-care, remaining resilient and healthy, while continuously facing the challenging nature of their work (Lee, 2014; Sexual Violence Research Initiative, 2013).



Figure 2.1 Organizational and Individual-Level Risk and Protective Factors Related to Psychosocial Health and Well-Being of Gender-Based Violence-Specific Advocates. Adopted from the Guidelines for the prevention and management of vicarious trauma among researchers of sexual and intimate partner violence. (2015). Sexual Violence Research Initiative. Pretoria: South Africa

Current knowledge of the stressors that GBV-specific advocates experience due to their work, and what types of structures, organizational mechanisms and individual strategies provide meaningful, effective support for advocates is limited. Supporting these advocates in effectively continuing their work while experiencing fulfillment and growth is critical in reducing the high rates of GBV, which is a serious public health problem with far reaching consequences for the society. This study contributes to efforts that aim to produce knowledge which will be put into the service of healthy, sustainable advocacy in the area of GBV.

Theoretical Framework

Feminist Intersectionality

Intersectionality stems from the early work of Black, Latina, and Indigenous feminist scholars who understood the limitations of a gender only paradigm in looking at women's lives (Collins, 2002; Crenshaw, 1991; Dill & Kohlman, 2012; Hankivsky et al., 2010; Weber & Parra-Medina, 2003). Feminist activists and scholars drew attention to the shortfalls of traditional additive models which examine race, class, ethnicity and other systems as separate categories, and suggested an alternative lens through which mutually-constructive relationships between interlocking systems of oppression could be understood (Hancock, 2007). Gender, race, class, and ethnicity were examined as intertwined systems of oppression, and over time, many other categories including but not limited to sexuality, age, nationality, able-bodiedness, and religion were recognized, acknowledging the deep complexity of social identities (Cho, Crenshaw, & McCall, 2013; Cole, 2009). To date, intersectional scholarship has evolved through the discussions around how to better conceptualize and assess the ways in which

“interlocking inequalities” (Zinn & Dill, 1996, p. 326) shape human experience (Mccall, 2005; Nash, 2008; Bowleg, 2008). Similarly, Collins defined this system as the matrix of domination and discussed the implications of placing marginalized groups in the center of our analysis:

Placing African-American women and other excluded groups in the center of analysis opens up possibilities for a both/and conceptual stance, one in which all groups possess varying amounts of penalty and privilege in one historically created system. In this system, for example, white women are penalized by their gender but privileged by their race. Depending on the context, an individual may be an oppressor, a member of an oppressed group, or simultaneously oppressor and oppressed. (Collins, 1990, p. 225)

In the following section, I describe the relevance and application of the feminist intersectionality to this study.

Intersectionality, Gender-Based Violence-Specific Advocacy and Health

Scholars who apply an intersectional lens to the study and promotion of health view people’s lives and health within the fluid, ever-changing and mutually-shaping social locations and structural forces (Springer et al., 2012). These scholars challenge the binary treatment of categories like sex and gender, and call for more nuanced ways of examining the relationships between gender and health. In this study, I focused on health and well-being of individuals who engage in paid advocacy within the GBV-specific NPOs. Intersectional framework helped me to understand the ways in which dynamics of race, gender, class, sexuality, and spirituality shaped work and life experiences of the participants in this study (Greenwood, 2008).

Applying an intersectional framework was also beneficial in understanding how and why the study participants came to be engaged in GBV-specific advocacy. Past experiences of power relations that are determined by social location closely relate to the reasons behind women's involvement in social movements, particularly those which have potential to create social change (Corning & Myers, 2002; Dill & Kohlman, 2012; Naples, 1992). For instance, a young black woman who grew up listening to the forced sterilization memories of her grandmother might choose to be involved in the reproductive justice movement as a meaningful way to honor her grandmother, as well as contribute in her own way to racial equality in accessing informed, dignified health services. In this example, the woman's experiences as an advocate would be shaped not only by gender, but also by her racial identity and the historical memory of her family.

In her analysis of the community-level political activism and mothering experiences of low-income Black and Latina women living in New York City and Philadelphia, Naples discussed how social locations of these women relate to their activist mothering. Both Black and Latina mothers who participated her study described their activism as rooted in betterment of their community and improvement of the public schools, hospital services, and welfare systems serving their communities. Being exposed to every day racism and institutional discrimination, these women found themselves involved in political movements, working towards a better future for their children (Naples, 1992). Similarly, I examined the relationships between social locations of the participants, the motivations behind their work, and their workplace experiences.

Race, ethnicity, class, sexuality, and other social identities might also impact the material and social resources that people need to work as GBV-specific advocates and

accomplish their goals. For instance, even when women of color and white women work in the same organization towards the same goals, the ways in which they experience benefits and risks of advocacy can be quite diverse due to their background and the social location they occupy (Collins, 2002; Curtin, Stewart, & Cole, 2015). Mary Heriot explained the reasons behind domination of feminist movement by white women in the US: “The feminist movement had been largely a white, middle-class movement because such women could better afford the backlash, and there was plenty of that” (Spruill, 2012, p. 387). When women of color joined the movement, what they saw as the core issues differed from those that were identified by white women (Morgen, 2002). Abortion rights remained in the agenda of feminists of color; however, instead of investing most of the movement’s time and energy on abortion, they wanted to work on other reproductive justice issues such as the right to decide when and how to give birth, the fight against the cultural residues of eugenics, violence against women of color, and help low income women in accessing to general health care (Morgen, 2002; Munch, 2006). Thus, to understand different stances within the movement to end GBV, it was necessary to consider how social location shapes advocates’ motives and practices.

Similarly, contemporary movement to end GBV tackles a wide range of issues, some of which affect women of all races and ethnicities, class levels, and sexual identities, whereas others are unique to women from minority populations (Richie, 2015). This study applied an intersectional lens to: 1) Understand the power relations within GBV-specific NPOs, and their influence on the work experiences and psychosocial well-being of the advocates; 2) Observe how similarities and shared values that exist among

diverse groups of advocates offer opportunities for promoting psychosocial health and well-being under stressful circumstances.

Standpoint Epistemology

Taking its origins from the Marxist theory of power relations, standpoint theory was built upon the critique of positivism and the belief that an uncontaminated analysis of social world is possible (Harding, 2004; Harding, 1992). The notion of ‘standpoints’ refers to the values, interests, and assumptions each individual carries with them when ‘knowing’ the world, shaped by their location in the social hierarchy (Stoetzler & Yuval-Davis, 2002). Women’s movements within second-wave feminism in the 1960s and 1970s adopted this view to expand the horizon of their political struggle in a way that captures all spheres of women’s daily lives and broadens the debate to a wide range of issues, including family life, workplaces, sexuality, and reproductive rights (Fahs, 2015; Keane, 2009; Sobnosky, 2013; Tong, 2013). “Standpoint theorists analyzed causes of the gaps between the actual knowledge and power relations and those desired by women’s movements” (Harding, 2012, p.46). They questioned how and by whom knowledge claims were produced, as well as how power relations in knowledge production were perpetuated by the notions of objectivity. As Dorothy Smith described (1990), conceptual practices of power were challenged to develop new ways of understanding social relations from a feminist perspective. Thus, by freeing themselves from knowing, feminist standpoint theorists allowed for a new array of research methods (e.g., feminist participatory action research, approaches that incorporate emotionality, connecting women for group-level analysis) to study women’s lives (Campbell & Wasco, 2000; Stoetzler & Yuval-Davis, 2002).

Standpoint epistemology guided my research in several ways. First, I examined everyday practices of the study participants in relation to their work, and challenged traditional conceptions of what counts as advocacy work, refusing the imposition of an objective, or scientific view of these notions (Naples, 1998). This enabled me to acknowledge and look at women's labor from a feminist perspective, and document the role of this labor in bringing about social change. Second, this approach allowed me to place experiences of participants at the center of my analysis. The notion of objectivity in qualitative research denies experiential knowledge as a source of data, whereas the standpoint theorists advocate for treating experiences as data, drawing attention to the close links between social location and individual experience (Harding, 2012; Harding, 2004). Harding argued that "objectivity is maximized not by excluding social factors from the production of knowledge, as Western scientific method has purported to do-but precisely by "starting" the process of inquiry from an explicitly social location: the lived experience of those persons who have traditionally been excluded from knowledge production" (Hirsh, Olson, & Harding, 1995, p. 193). Despite the long-lasting gender-blind analysis of political movements, women have always been active agents of the local struggles affecting their communities (Naples, 1998). By placing the participants' experiences of advocacy in the center of my analysis, I was able to explore less visible aspects of their work, including the emotional labor and caregiving they engaged in as part of their roles. Third, a methodological approach that brought feminist intersectionality and standpoint epistemology together enabled me to conduct an in-depth analysis of the contemporary social forces that shape advocacy experiences of individuals who work for NPOs that address GBV. These experiences were situated in a particular

period of the U.S. history, where race, ethnicity, class, and other systems of oppression constantly interact and co-construct each other in unique ways (Barnett, 1993; Smith, 1995). They were also embedded within the 21st century political context of SC. Feminist intersectionality and standpoint epistemologies together guided me in disentangling the complexity of this socio-cultural context, and reflecting the realities of study participants.

CHAPTER 3

RESEARCH DESIGN AND METHODS

Overview of Research Design

The overall goals of this study were: 1) to explore the relationships between engaging in paid GBV-specific advocacy and individual psychosocial health and well-being, and 2) to develop recommendations for GBV-specific NPOs to better support the psychosocial health and well-being of their staff members. In order to achieve these goals, the study focused on two specific aims: 1) To describe the relationships between engaging in paid GBV-specific advocacy and psychosocial health and well-being within the social, economic, cultural, and political context of SC, and 2) To identify the organizational processes that influence self-care practices among individuals who engage in paid GBV-specific advocacy.

A qualitative research design that was guided by the CGT method was used. Glaser and Strauss introduced GT in 1960s to provide systematic data collection and analysis tools to generate theory from qualitative data (Glaser & Strauss, 1967). Informed by symbolic interactionism, GT scholars assert that reality is constantly changing, shaped by the interactions between people and the social structures they live in (Richards & Morse, 2012; Charmaz, 2006), and humans engage in purposeful action motivated by

meanings that they create, rather than merely responding to their surroundings (Nusbaum & Chenitz, 1990). GT studies often start with the question “what’s going on here?” (Richards & More, 2012, p.60), and gather information about a process or situation through the understandings and experiences of participants (Suddaby, 2006). The goal is to answer the initial question by generating a theory or a “unified theoretical explanation” (Corbin & Strauss, 2007, p. 107) grounded in data (Charmaz & Bryant, 2011). Construction of theory takes place through an iterative process of data collection and analysis. Charmaz and Bryant (2011) explained:

Grounded Theory is a method of qualitative inquiry in which researchers develop inductive theoretical analysis from their collected data and subsequently gather further data to check these analyses. The purpose of grounded theory is theory construction, rather than description or application of existing theories (p. 292).

CGT method is also appropriate for the study of social structures and processes that shape and are shaped by human agency and interactions (Charmaz, 2006; Denzin & Lincoln, 2011). Paid advocacy in the area of GBV is influenced by unique institutional and social processes that are embedded in the socio- economic and political dynamics of each region in the U.S. For this study, it was important to understand the relationships between the historical, socio-political context of SC and the work of its GBV-specific NPOs. Thus, adopting a CGT method guided me in generating a holistic theoretical explanation (Corbin & Strauss, 2007) of the research phenomena that is situated within the context of SC’s non-profit organizations and government institutions. In addition, this method supported me with centering the voices of an understudied group, GBV-specific

advocates (Homer, 2014) in my analysis, and incorporating the meanings they create about their work and well-being into a theory.

When I started formulating this study, my “what is going on here?” questions were: 1) What happens to the health and well-being of an individual who engages in this type of work in SC? 2) what are organizations doing/not doing to support the well-being and resilience of their staff? and 3) what else can they do? Answering these questions required the examination of two interrelated processes. The first one was the process through which the interactions between the nature of participants’ work and their well-being took place. The nature of their work included their everyday experiences, the challenges they face, the personal price they pay, and the benefits of doing this work. The second process captured the interactions between organizational factors (e.g., the size of the NPO, the composition of the staff, the availability of resources, self-care related practices and policies, interpersonal dynamics) and the self-care behaviors and resilience capacity of the participants.

To disentangle the complex nature of these social processes and understand the ways in which participants constructed meaning through their experiences, I adopted a constructivist approach to GT. CGT scholars stress that reality is socially constructed, and believe that human knowledge is partial and constructed through interactions with the world (Charmaz, 2006; Gardner, McCutcheon, & Fedoruk, 2012; Taghipour, 2014). Data is then a co-product of the interactions between the researcher and the participants, whose experiences are embedded in a specific situation and time. It is important for researchers to be aware of how their social position, perspective, and values influence the

development of theory while interpreting the realities of research participants (Taghipour, 2014).

Although they acknowledge the multiplicity of perspectives that exist in the social world and the role of subjective meanings in knowledge creation, CGT scholars do not ignore the role of objective social and structural realities (e.g., institutional discrimination, socioeconomic inequalities, political systems) that shape the lives of individuals with whom the research is conducted (Charmaz, 2011). CGT helped me to understand how participants in my study “negotiate and manipulate the social structures” (Gardner et al., 2012, p.67) in which their work takes place, and create meaning through social interactions (Charmaz, 2011).

Sample and Recruitment Procedures

The sample consisted of twenty-five women who either engaged in paid GBV-specific advocacy within NPOs in SC in the last three years preceding the study, or were engaging in this type of work at the time of the study.

Inclusion Criteria. In order to be included in the study, participants had to meet the following criteria: 1) Aged eighteen years or older, 2) Identify as a woman and/or queer, non-gender conforming, and 3) engage/d in paid advocacy within GBV-specific NPOs and/or government agencies in SC. Due to the intention to closely examine organizational dynamics that relate to the health and well-being of advocates, individuals who engage in unpaid advocacy were excluded from the study. Experiences of the individuals who volunteer for GBV-specific NPOs for a limited term differ from those who work for these organizations as paid staff members, as the duration of advocacy and levels of exposure to workplace structures and practices differ among these groups

(Thornton & Novak, 2010). To ensure a certain level of exposure to the workload, interpersonal relationships, and administrative dynamics within the NPOs, recruitment was limited to individuals who were paid staff members.

Target Sample Size. In qualitative research, data saturation occurs when the researcher is no longer able to gather new information or when new themes are no longer observed in the data (Guest, Bunce, & Johnson, 2006; Patton, 2002; Ulin, Robinson, & Tolley, 2004). What constitutes new information depends on the research aims, design, and theoretical frameworks guiding the research; therefore, the point of data saturation can vary greatly among different qualitative studies (Fusch & Ness, 2015). In CGT studies, researchers' recruitment efforts are often informed by the concurrent data analysis they engage in (Charmaz, 2006).

Two main factors shaped the decision about the saturation point in this study. First, I examined the nature of the data that began to accumulate as I interviewed each participant, paying attention to the extent to which core research concepts were addressed. In addition, I identified the concepts that were partially highlighted by the existing data and therefore needed to be investigated further (Charmaz, 2006). Second, the framework of feminist intersectionality guided me in achieving a diverse sample that represents the multiple and intersecting identities (race/ethnicity, age, sexual orientation, nationality, etc.) of the individuals who work for the GBV-specific NPOs in SC. As I intended to observe how multiple and intersecting identities of individuals shaped their experiences and in turn, might influence health and well-being, it was necessary to collect rich (i.e., the quality of the information) and thick (i.e., the quantity of information) data (Dibley, 2011; Fusch & Ness, 2015), particularly from individuals who belonged to

under-represented and marginalized groups (Hunting, 2014). These considerations helped me to tailor the recruitment process accordingly until I achieved data saturation.

Recruitment. Participants were recruited using a combination of snowball and purposeful sampling techniques to achieve a diverse and accurate representation of the staff composition of NPOs in SC that address GBV. In the early phases of recruitment, I enlisted dissertation committee members to assist me with recruitment by sending an initial email to their colleagues who met the inclusion criteria, and followed up with invitees by email and phone upon receiving referrals. Reaching out to potential participants through the personal and work connections that my committee members and I had in Richland and other counties of the state helped me build trust with the participants.

The first few interviews I conducted helped me initiate a purposeful and snowball sampling strategy (Patton, 2015). At the end of each interview, I asked the participants whether they would be willing to recommend me to any of her colleagues who might be willing to participate in the study. Purposeful sampling is suitable in qualitative research where “particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from other choices” (Maxwell, 1997, p. 87). One of the purposeful sampling techniques – snowball sampling – also aided me in recruiting individuals with certain characteristics for the purposes of diversity (Sadler, Lee, Lim, & Fullerton, 2010; Teddlie & Yu, 2007).

One invaluable collaboration that I developed during the recruitment process has been with SCCADVASA, which became a partner in helping me reach my recruitment goals. The former Associate Director, Rebecca Williams-Agee, helped me recruit

participants from different organizations that are affiliated with SCCADVASA.

Furthermore, having access to her wide connections in the field of GBV prevention enabled me to connect with a broader, more diverse group of potential participants than would have otherwise been possible.

Setting

Through the influences of southern history, culture, and contemporary politics, SC provided a unique social and geographical context for my dissertation research. The decision to limit the sample to SC was made for the following reasons: First, SC faces GBV as a pressing public health issue; until recently, the state ranked first among all US states in the number of women killed by men (Violence Policy Center, 2015). In response to this, multiple NPOs and government agencies in the state have been working towards reducing the rates of GBV through advocacy, community outreach, and education. The latest results from the Supplementary Homicide Report released by the Federal Bureau of Investigation lists SC as the fifth state in terms of the number of female homicide victims, suggesting that statewide efforts to prevent GBV and alleviate its consequences on victims' lives have been producing positive results (Violence Policy Center, 2016). Despite the decrease in the numbers of women killed by men in SC, the need for further prevention of GBV, and improvement of services for survivors and their families continues to exist. Therefore, GBV-specific advocacy continues its significance for the state.

Second, limiting data collection to SC made the most sense logistically, both in terms of transportation and given the connections and close relationships that I have built over time with a diverse group of advocates who work for GBV-specific NPOs. In SC, 23

NPOs that are working to prevent and raise awareness about domestic violence and sexual assault, as well as provide advocacy and services for the survivors, are affiliated with a statewide coalition, the South Carolina Coalition Against Domestic Violence and Sexual Assault (SCCADVASA). SCCADVASA was established in 1981 to provide education and assistance to the GBV-specific NPOs, and to facilitate collaboration between these organizations at the state-level (SCCADVASA, 2017). Due to more than three decades of non-profit experience that SCCADVASA has in this field, it constituted the most important organization through which I was able to recruit participants for the study.

Data Collection Procedures

Development of the Interview Guide. I used a semi-structured interview guide (Appendix A) to conduct in-depth interviews with eligible study participants. Choosing a semi-structured interview approach helped me to consistently address the topics that were covered in the interview guide (Corbin & Strauss, 2015), while leaving room for potential modifications when such need arose during the interview process. I developed the interview guide by reviewing the literature and in consultation with my dissertation committee members.

The preliminary interview guide was tested during the initial interviews I conducted. I wrote down memos and recorded field notes to reflect on the extent to which the interview guide was helpful in facilitating the conversation between me and the participants. Although memoing is often described as taking reflective notes about what the data are telling the researcher, it can also be used outside of the analytical phase of the research to create a record of the researcher's thoughts, observations, and emotional

reactions (Birks, Chapman, & Francis, 2008; Maxwell, 2012). Through writing memos, researchers preserve their reflections beginning from the early stages of their inquiry, and these reflections may play a significant role in the analysis (Birks et al., 2008). After sharing these memos and field notes with my committee members and receiving their feedback, I adjusted the interview guide. I also consulted with a key informant, Rebecca Williams-Agee, regarding the content and wording of the interview guide before making the final adjustments.

The interview questions focused on the individual and work experiences of advocacy in the area of GBV. The first part of the interview guide included questions about the participants' current roles as a paid staff member in their respective NPOs, as well as their previous experiences in this field with other organizations doing similar type of advocacy and prevention work. In addition, questions regarding participants' family background and educational and life experiences prior to working in the area of GBV were included to understand the potential reasons that led them to do this work and their own sources of motivation. The second part of the interview guide focused on the interpersonal dynamics and structural factors within the work environment that influence participants' productivity, work satisfaction, and ability to engage in self-care. Questions in this section sought to obtain information on existing organizational culture and practices that facilitate and/or hinder self-care, growth, resilience, and physical and mental well-being among staff. The third part of the interview guide covered potential relationships between work experiences and personal health and well-being. Therefore, questions delved into the ways in which participants experienced the benefits, rewards, and costs of their work in relation to their mental and physical health and social well-

being. Finally, I asked the participants for their suggestions on how organizations could better support the work they do as well as support growth and resilience among their staff members in general. Example interview questions and probes are presented in Table 3.1

Qualitative Interviews. Before conducting each interview, I provided the participants with an informed consent and information form to be signed. I also described the purpose of the study and their rights as participants and invited them to share any concerns and questions they had with regards to the study. I made an effort to conduct all of the interviews in person. When geographical challenges and scheduling conflicts prevented in-person interviews, I either contacted the participant via telephone or used an online video conferencing program (Microsoft, 2017). Most of the interviews (n=21) took place in the offices of the NPOs where the participants worked in addition to libraries, coffee shops, and other places that were convenient to the participants. The main criterion for determining the interview location was its suitability as a quiet, safe place where the interviewee would not be heard by others and a confidential conversation could take place. During the interviews that I conducted over the phone (n=2), I paid attention to any changes in the voice tone of the participants and pauses in the conversation to account for the lack of in-person communication cues to provide further clarification when they had questions (Sturges & Hanrahan, 2004). As I adopted a CGT approach, I treated the interview process itself as a component of the data analysis (Charmaz & Belgrave, 2002). I observed the nature of interactions between the participants and myself, their comfort level with the issues we discussed, and how they reacted to being interviewed on these issues.

Table 3.1 Example Interview Questions and Probes

General Questions about Work	Work Environment, Structure, and Processes	Personal Health and Well-Being	Perceptions/Work Experiences	Recommendations
<p>How long have you been working with/for the {Name of ORG}?</p> <p>What are your current and past roles in the {Name of ORG}?</p> <p>Prior to working with the {Name of ORG}, what other experiences did you have in the area of GBV?</p>	<p>Tell me about the group dynamics in the {Name of ORG}.</p> <p><u>PROBE:</u> In general, how would you describe the <i>interpersonal relationships</i> within the {Name of ORG}?</p> <p><u>PROBE:</u> How would you describe your personal relationships with <i>your co-workers</i>?</p> <p><u>PROBE:</u> How would you describe your personal relationships with <i>your supervisors</i>?</p> <p>What types of organizational factors have been supportive of your work as an advocate in this field?</p> <p><u>PROBE:</u> Tell me about the <i>conditions or situations</i> within your work environment that facilitate your work.</p> <p><u>PROBE:</u> What <i>resources</i> are available to you in your organization that facilitate your development as a staff member?</p>	<p>Thinking of both the benefits and personal costs of the work you do, how has your work in this area influenced your health and well-being?</p> <p><u>PROBE:</u> Have you noticed <i>any changes in your physical or mental health</i> since you started doing this work? [If yes] – Can you tell me more about them?</p> <p><u>PROBE:</u> To what extent do you think these changes <i>relate to the advocacy work</i> you engage in?</p> <p>Tell me about how you care for yourself.</p> <p><u>PROBE:</u> What do you do to support your <i>physical health</i>?</p> <p><u>PROBE:</u> What kinds of practices do you engage in to support your <i>emotional well-being</i>?</p>	<p>What are the personally rewarding aspects and benefits of the work you do?</p> <p><u>PROBE:</u> What are some <i>important memories or significant events</i> from your work?</p> <p><u>PROBE:</u> Give me some examples of the times <i>you felt satisfied and accomplished</i> in your work.</p>	<p>What strategies would you suggest to organizations dealing with high rates of staff turnover?</p> <p>What suggestions would you have for the organizations to best support health and well-being of their workforce?</p>

I considered the positionality and past experiences of participants and made a conscious effort to understand how the ways in which they navigated answering the questions could be shaped by these factors. I also paid attention to the changes and improvements in my interviewing skills throughout the data collection process, as well as how this process transformed me as a qualitative researcher and, in turn, influenced the data that I was gathering. My ability to engage in reflexivity was limited during the two interviews I conducted over the phone, compared to the interviews I conducted in person or using Skype. Still, I wrote my observations down in memos, and recorded field notes after each interview. I used two digital recorders to capture the content of all interviews. The second digital recorder was used as a backup, in case the first one stopped working properly. Audio files collected from the telephone and in-person interviews were transcribed verbatim by a professional transcription service. To protect participant confidentiality, all identifying information was removed from transcripts prior to analysis. Data were saved on a protected computer and an external hard drive.

Data Management

Data from the qualitative interviews were organized and managed using NVivo 11 (© QSR International Pty Ltd.), which is a qualitative data analysis software. NVivo served as an organizational management tool for codes, themes, and categories from audio recorded transcripts and document analysis. I also saved the memos I created throughout my analysis with this software and linked them to relevant interviews, codes, and categories.

Data Coding and Analysis

I used a CGT approach in data coding and analysis. Figure 2 depicts the methodological process of CGT coding (i.e., initial coding, focused coding, and theoretical coding) (Charmaz, 2006) and example codes that corresponds with each stage of this process. *Initial coding* of the interview data, which corresponds to the open coding defined by Glaser and Strauss (1967), is the first step in identifying meaningful concepts in the data through conceptual labeling and categorizing (Figure 2). During the initial coding, I used an incident-by-incident approach. That is, as I observed new incidents in the data, I compared my conceptualization of those incidents to the ones that I had coded previously, leading to similar or different categories (Charmaz, 2006). I focused on the daily actions of the participants in their work settings, patterns of interpersonal relationships, and significant processes that shape health and well-being and categorized the emerging concepts as initial codes.

Grounded theory coding focuses on “processes, actions, and meanings” (Charmaz, 2012, p. 5). Charmaz argues that using gerunds “build action right into the codes”, and “allows us to see processes that otherwise might remain invisible” (Charmaz, 2012, p. 5). Compared to coding for topics and themes early on, creating initial codes with gerunds helps the researcher understand how individuals perceive, respond to and interact with their social environment (Charmaz, 2006). I made a conscious effort to “code data as actions” (Charmaz, 2006, p. 48), and used gerunds in coding to focus on how the participants described their actions and the processes in which they had been involved. This approach helped me to monitor the influence of preconceived notions on my coding, and enabled me to remain open to new ideas that emerged from the data

(Glaser, 1978). Paying close attention to the data and what they told me, I tried to keep the initial codes “short, simple, active, and analytic” (Charmaz, 2006, p.50). For example, when one of the participants talked about her advocacy experiences in SC, recounting the changes that happened in her work practices after moving to this state from another, I referred to her experiences with the code ‘working in South Carolina’. Such wording allowed me to develop initial codes that reflected what the data suggested and resist bringing an early outsider view to the analysis (Charmaz, 2006).

The second stage of coding was *focused coding*. I examined the most frequent and significant previous codes to determine which ones could be used in creating conceptual categories that adequately and completely represent the data. This stage of coding yielded more conceptual and selective codes (Figure 3.1).

The third and final stage was *theoretical coding*. Glaser (1978, p.72) referred to this process as conceptualizing “how the substantive codes may relate to each other as hypotheses to be integrated into a theory.” I reviewed the codes I selected during focused coding and identified possible relationships among and between these codes in a way that would enable me to move towards an explanatory theory. Table 3.2 includes some example codes I created during each of these stages. During all phases of data coding, I created memos to reflect on the choices I made in terms of codes and their definitions, emerging patterns and categories in the data, potential answers to my research questions, and any problems I encountered (Birks et al., 2008; K. Charmaz, 2006). I treated the memos I wrote as “interim, but sharable reports” (Charmaz, 2006, p. 86) and shared them with Dr. Billings, along with the list of codes, emerging categories, and selected quotes from the interview data.

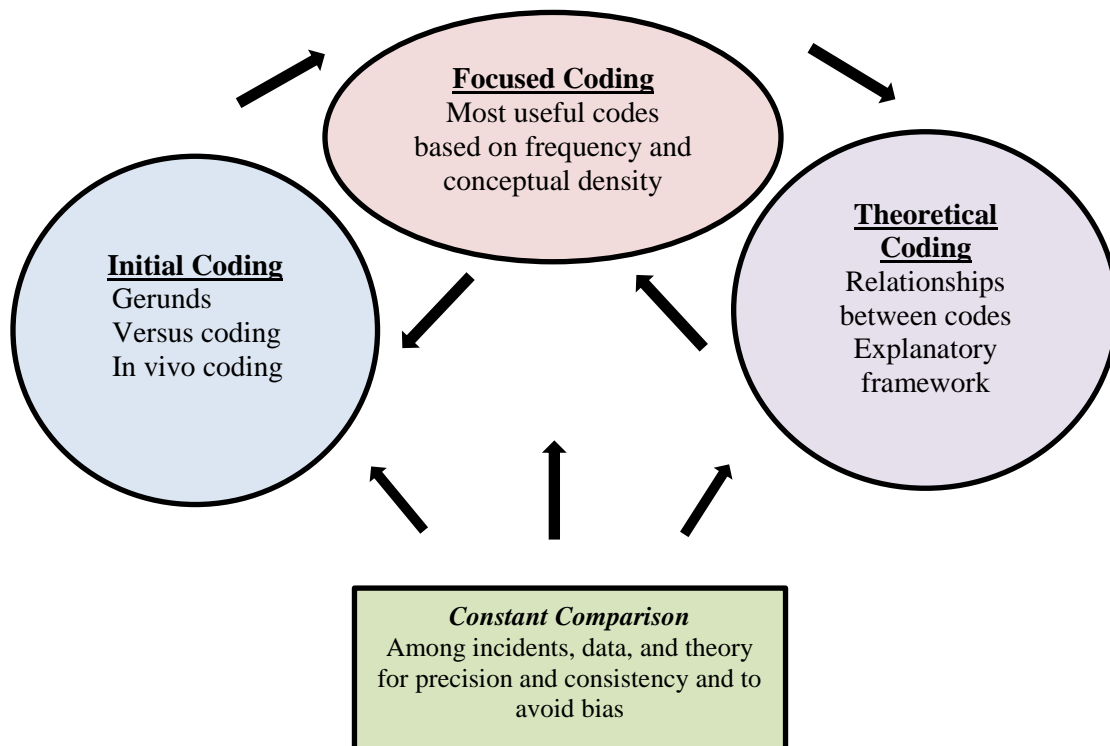


Figure 3.1 Process of data coding based on constructivist grounded theory. Adapted from “Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences” by Cho, J. Y. and Lee, E. H., 2006, *The Qualitative Report*, 19(32), p.9, and “Constructing grounded theory: A practical guide through qualitative analysis” by Charmaz, K., 2006, London: Sage.

Dr. Billings reviewed these documents and provided me feedback on the coding decisions I made, and clarity of code descriptions. She also made suggestions about alternative ways of interpreting participants’ accounts, which encouraged me to examine the data from multiple angles. I also met with Dr. Messias to discuss some of the main themes that emerged as a result of the data analysis, and consulted with her about how to link and organize these themes to form an analytic story.

The continuous process of data coding was not linear but rather iterative and included going back to previous interviews, codes, integrating memos along the way and

creating new relationships among and between the code families to reflect the data comprehensively and accurately. Consistent with the Constant Comparative Method (Glaser, 1965), I conducted different types of comparisons between and among data and codes within a single interview, between and among interviews within the same group in terms of sociodemographic characteristics and/or work experiences of the participants, and within interviews from different groups (Boeije, 2002; Charmaz, 2006).

Data Quality

Scholars who analyze textual data (e.g., interviews, life stories, archival documents) developed strategies to ensure the rigor of the research process and quality of the data, minimize the differential power of the researcher in interpretation of the results, and therefore attain a more accurate representation of the participants' realities (Ramazanoglu & Holland, 2002). In this study I employed some of those strategies including member checks, theory triangulation, frequent peer debriefing, and advisor consultations (Creswell, 2007; Patton, 2002; Ulin, Robinson, & Tolley, 2004). Member checking refers to involving the participants in the data validation process by receiving their feedback on interview transcripts, analysis results, and the researcher's interpretation of the data (Patton, 2002). Earlier on in the analysis process, I presented the preliminary results at a meeting organized by SCCADVASA. Several study participants were at the meeting, and they provided valuable feedback which guided the following stages of the analysis. I also met with two of the study participants in May 2017 to discuss some of the themes that emerged from the data, and receive their feedback on my interpretations of those themes.

Table 3.2 Example Codes Corresponding with Each Stage of Data Coding

Narrative	Initial Codes	Focused Codes	Theoretical Codes
<p>“...I think that my work has <u>impacted my personal relationships with men</u>. Like my second marriage—my first marriage, I was a baby. <u>It was all for the wrong reasons</u>. I know that now. My second marriage, <u>I was very clear on what my expectations were</u> and what I wanted. And he quickly began to show me that <u>he wasn't meeting those needs or expectations, which meant I couldn't meet his needs or expectations</u>. So that led to a divorce.”</p>	<p>Acknowledging the impact of work on personal relationships</p> <p>Marrying for the wrong reasons</p> <p>Having clear expectations</p> <p>Conflicting expectations between partners</p>	<p>Work impacting intimate partner relationships</p> <p>Reflecting on past relationships</p>	<p>Intimate partner relationships being transformed through work</p> <p>Turning points in intimate partner relationships</p>
<p>Like oh [name of the participant] is <u>bleeding hard again</u> and I'm just like this is life. This is reality. This affects everything. <u>I don't get invited to a lot of parties anymore</u> because I cannot have a conversation with people without... <u>That's not true; we have hang out. We have friends that have very similar ideas about social justice issues</u> and things that we do, but <u>I know when I have to switch it off and switch it on</u> and <u>that's frustrating</u>, because you want to be like everyone <u>why don't you see what I see?</u></p>	<p>Being perceived as bleeding hard</p> <p>Being excluded from social gatherings</p> <p>Hanging out with friends who have a similar worldview</p> <p>Switching it off</p> <p>Feeling frustrated</p> <p>Confronting others about reality</p>	<p>Isolation from friend circles</p> <p>Connecting with friends who have a similar worldview</p> <p>Switching it off</p>	<p>Social isolation due to work</p> <p>Compartmentalizing as a strategy</p>

Triangulation, although often achieved by employing multiple data collection methods, can also be done by using multiple theoretical frameworks that inform the researcher in analyzing the data (Flick, 2004). I used CGT, standpoint theory and feminist intersectionality in analyzing and interpreting the participants' narratives. CGT scholars draw attention to the multiplicity and diversity of human perspective and experience. Standpoint theory and feminist intersectionality are complementary to CGT, in that they challenge the researchers to consider socially constructed and situated nature of all knowledge (Kushner & Morrow, 2003). However, feminist epistemologies I employed in this study depart from the post-structural approaches to knowledge that render social justice-based research and action impossible. I acknowledged structural inequalities as part of the participants' *reality*, and incorporated them into the analysis of the participants' lived experiences. The tensions between social constructionism and critical analysis of the structures of inequality (i.e., race, gender, ethnicity, class, sexuality) formed a reference point in my analysis, and enhanced the validity of results by challenging me to consider alternative ways of interpreting the data.

Peer debriefing included reviewing the interview guide, discussing coding strategies, and critically assessing the interpretations of the data with the dissertation committee members who were experienced qualitative researchers. I also met regularly with my primary advisor, Dr. Spencer, to report on the research progress; to share transcripts, coding lists, and preliminary themes; and to discuss the alternative interpretations.

CHAPTER 4

RESULTS

Manuscript 1

“The Only Way We’ll Be Successful”: Organizational Factors that Influence Psychosocial Well-Being and Self-Care Among Gender-Based Violence-Specific Advocates⁴

⁴ Cayir, EC, Spencer, SM, Billings, D, Messias DKH, Robillard, A. Will be submitted to Violence Against Women.

Introduction

Over the past decade, gender-based violence (GBV) has received increasing attention in the US, and as a result, more non-profit organizations (NPO) today are focusing exclusively on GBV in their work (Inter-Agency Standing Committee, 2015). GBV is “an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially-ascribed (i.e., gender) differences between males and females” (IASC, 2015, p. 5). GBV has also been called “a human rights violation, a public health challenge, and a barrier to civic, social, political, and economic participation” (USAID, 2016, para. 1). Advocates who work with NPOs or governmental agencies that address GBV play a critical role by aiding survivors of GBV. Increasingly, the same organizations are working in primary prevention of GBV. These advocates engage in a wide range of activities that include supporting survivors when they report experiences of violence to police, medical professionals, and in courts, as well as providing direct services such as counseling, shelter services, and employment assistance. Advocates also engage in community outreach and education to raise awareness about GBV and address the underlying causes of GBV, such as gender norms and patriarchal values (Globokar, Erez, & Gregory, 2016; Wood, 2014). From a public health perspective, supporting the work of GBV-specific advocates is critical in not only alleviating the suffering of GBV survivors, but also in eliminating GBV.

Advocates who undertake GBV-specific work are often motivated by intrinsic values such as the desire to help survivors, be part of the solution, and affect social change (Homer, 2014). For advocates who have experienced GBV themselves or witnessed a family member or friend’s exposure to it, engaging in GBV-specific

advocacy may enable them to heal from their own traumatic experiences and better support their loved ones through the recovery process. Advocates also identify seeing their clients heal and transform their lives after GBV as rewarding experiences (Martin, 2005; Wood, 2014). In addition, working towards social change with others who have similar values enables GBV-specific advocates to create meaning in their personal and professional lives and feel positively connected to their social environment (Kulkarni & Shinde, 2014; Mizrahi, 2008; Myers, 2016).

Although GBV-specific advocacy can be internally and socially rewarding, the stressful nature of working with traumatized individuals can also threaten advocates' psychosocial well-being. Working long hours, receiving low salaries, and often having limited organizational resources to serve clients can intensify the emotional burden experienced by advocates (Kulkarni, Bell, Hartman, & Herman-Smith, 2013b). As a result, many GBV-specific advocates experience burnout (Bemiller & Williams, 2011; Skovholt & Trotter-Mathison, 2016), vicarious trauma and/or compassion fatigue (Myers, 2016; Shakespeare & Lafrenière, 2012b) at some point in their careers. A common consequence of chronic work stress, burnout is characterized by "the three dimensions of exhaustion, cynicism, and inefficacy" (Maslach, Schaufeli, & Leiter, 2001, p. 397). In the context of GBV-specific advocacy, burnout can manifest as difficulty in fulfilling duties, a sense of incompetence and inefficiency, experiencing chronic mental and physical exhaustion, and feeling discouraged about the potential impact of one's work (Newell & Macneil, 2010; Skovholt & Trotter-Mathison, 2016). Vicarious trauma refers to the secondary-level traumatic responses that result from engaging with clients' traumatic stories and experiences (Bell et al., 2003). Sometimes considered as a combination of

burnout and vicarious trauma, compassion fatigue is the “overall experience of emotional and physical fatigue that social service professionals experience due to the chronic use of empathy when treating patients who are suffering in some way” (Newell & Macneil, 2010, p. 61). The consequences of burnout, vicarious trauma, and compassion fatigue often extend beyond the personal health of advocates; they can also lead to lower motivation, reduced work performance, absenteeism, and higher turnover rates, all of which compromise the quality of services that organizations provide to their clients (Dworkin, Sorell, & Allen, 2016; Newell & Macneil, 2010). Since these experiences are considered likely outcomes of engaging in GBV-specific advocacy, it is in the best interest of organizations to monitor and support the psychosocial well-being of staff members.

A critical component of psychosocial well-being for advocates who work with survivors of GBV is self-care. Self-care is defined as “proactive strategies, or routines, that professionals use to offset the negative aspects of working with trauma victims and promote well-being” (Wasco & Campbell, 2002, p. 734). Rooted in the notion that “nobody can give from an empty vessel” (McCadden, 2016), incorporating self-care practices into daily life helps advocates maintain their own well-being so that they can better care for others. Self-care strategies are beneficial not only to cope with stress and prevent experiences such as burnout and vicarious trauma, but also to enhance long-term psychosocial well-being and develop a sustainable approach to working with survivors of trauma.

Despite the well-documented link between staff well-being and organizational functioning (Maltzman, 2011), little attention has been given to the role of organizational

culture and structures in the self-care practices of advocates (Homer, 2014). Most self-care recommendations developed for GBV-specific advocates focus on individual-level activities such as exercising, meditating, eating healthy, and maintaining a regular sleep schedule (Kulkarni et al., 2013). Although these recommendations provide some direction for advocates to incorporate self-care in their daily lives, they overlook the role of organizational context and how organizational structures and practices might affect one's ability to engage in self-care activities. Furthermore, this individual-level approach fails to hold organizations accountable for creating supportive workplace environments that promote employee health and well-being, both individually and collectively (Bober & Regehr, 2006).

To date, the organizational context of GBV-specific advocacy has been addressed mostly in relation to the prevention of burnout, vicarious trauma, and compassion fatigue. A limited number of studies have explored how the organizational context shapes the overall psychosocial health and well-being of staff members (Kulkarni et al., 2013b). There is a clear need to develop an understanding of how NPOs can not only maintain, but also improve the psychosocial well-being of their employees. The purpose of this qualitative study was to understand the organizational-level factors that influence psychosocial well-being and self-care practices among advocates who work for GBV-specific NPOs. A secondary goal was to develop recommendations for GBV-specific NPOs to guide them in creating and cultivating an organizational culture that prioritizes the self-care of GBV-specific advocates.

Method

Participants

To be included in the study, a potential participant had to identify as a woman, be aged 18 years or older, and be engaged in paid GBV-specific advocacy within a NPO or state-level agency in SC for at least one year. Women who were not currently working for a GBV-specific NPO but were engaged in GBV-specific advocacy in SC during the three years preceding the interview date were also included in the study in order to capture their perspectives on transitioning to new organizations and/or transitioning to a new area of work. Participants included 25 advocates who either worked for GBV-specific NPOs ($n=22$) or government agencies ($n=3$) and resided in the state of SC.

Recruitment

Using the informal networks that we have established over time by volunteering for, collaborating with, or serving on the boards of GBV-specific NPOs in the state, we first contacted three advocates who were actively engaged in GBV-specific advocacy. After being provided information about the study and confirming their own eligibility, these advocates agreed to send e-mails to their colleagues to inform them about the project and provide contact information of the primary researcher (E.C.) in case they were interested in participating. The first 10 participants were recruited through this process of informal networking and snowball sampling (Denzin & Lincoln, 2011). After conducting the first 10 interviews and concurrently analyzing the data, we applied a theoretical sampling technique (Charmaz, 2006) for two purposes: first, to achieve diversity in terms of advocates' specific roles and position in their organizations, experience level, and social location (i.e., race, ethnicity, gender, sexual identity); and second, to saturate the preliminary themes that emerged from the ongoing analysis. We obtained approval from the University of South Carolina's institutional review board (IRB) prior to participant recruitment.

Materials

We developed a semi-structured interview guide based on the previous literature that focused on work experiences and well-being of caregiving professionals that work with people who have been exposed to trauma, as well as the literature on organizational context of GBV-specific advocacy (Bloomquist et al., 2015; Homer, 2014; Kulkarni et al., 2013a; Skovholt & Trotter-Mathison, 2016). After conducting the first three interviews, we made adjustments to the interview guide using the feedback we received from the participants. The interview questions addressed work roles of GBV-specific advocates, impact of their work on health and well-being, individual self-care practices, organizational culture and practices around self-care, and relationships among advocates. Participants were asked questions such as, “What are your current roles in the organization?”, “What are the major sources of stress that you experience due to your work?”, “How would you describe your personal relationships with your co-workers?”, “Have you noticed any changes in your physical or mental health since you started doing this work? (If yes) Can you tell me more about it?”, “Can you tell me about how you care for yourself?” We also used a brief socio-demographic form to obtain information about race, age, educational status, and relationship status.

Data Collection

The primary researcher (E.C.) conducted 25 in-depth interviews between October 2015 and September 2016. Majority of the interviews ($n=21$) were conducted in person. The location and time of the in-person interviews were arranged at the convenience of the participants. When geographical challenges or scheduling conflicts prevented in-person interviews, we either contacted the participant via telephone ($n=2$) or used an online video conferencing program ($n=2$) (Microsoft, 2017). The duration of the interviews

ranged between 65 and 124 minutes, with an average of 91 minutes. Each interview was recorded using a digital recorder and transcribed verbatim by professional transcriptionists. We removed participant names from the transcripts and assigned unique identifiers to ensure confidentiality.

Data Analysis

We used constructivist grounded theory (CGT) strategies (Charmaz, 2006) to analyze the data in the current study. Qualitative researchers widely utilize grounded theory methods to examine social structures and processes that shape and are shaped by human agency and interactions (Charmaz, 2006; Denzin & Lincoln, 2011). CGT differs from other grounded theory approaches by emphasizing both the situated nature of participant narratives and the researcher's understanding and interpretation of data within a certain socio-cultural context and time. CGT guided us in generating a theoretical explanation of the organizational processes that relate to advocates' psychosocial health and well-being.

We began initial coding by focusing on the everyday experiences of the study participants in their workplace, and used *gerunds* to code data as actions (Charmaz, 2006). Charmaz argued that gerunds help the researcher to “gain a strong sense of action and sequence” (2006, p. 49). Using gerunds to create initial codes provided two distinct benefits: 1) It helped us pay close attention to the ways in which participants described their actions and the interactions that took place within their organizations, and 2) By staying focused on the participants' meanings and actions, it facilitated an emic approach and made it easier for us to monitor the level of abstraction in the initial codes we created. In addition, we used *versus coding*, which is an affective coding method that is particularly beneficial for identifying conflicting processes and structures (Saldaña,

2015). Affective coding methods focus on uncovering the emotions, values, judgements, and conflicts behind people's actions. Thus, this coding method was appropriate for exploring the tensions, disagreements, and competing interests among participants and within the organizations (Saldaña, 2015). We continued with focused coding and examined the frequency and significance of the initial codes. We then identified the relationships between these codes to form higher-level categories. This process resulted in more conceptual and selective codes.

During the final, theoretical coding stage, we assessed how these conceptual codes related to one another and how we could move towards an explanatory framework through transforming those links into an analytic story. The primary researcher (E.C.) led the coding process, and worked collaboratively with other members of the research team (peer debriefing and advisor consultations) to identify the core themes and subthemes and to discuss alternative interpretations of the data. We used a qualitative data analysis software, NVivo 11 (QSR International Pty Ltd.), to manage the data and organize the codes, categories, and themes from audio recorded transcripts and document analysis. Example codes from each stage of coding, and themes/subthemes are presented in Table 1.

We conducted member checks during the middle and late stages of the analysis to ensure the validity and credibility of our analysis. Member checking refers to the process during which the researcher receives participants' feedback on the study results and their interpretation (Creswell & Miller, 2000). Initial member checks were conducted in group settings and included a workshop we delivered during the statewide sexual assault conference (May

2016) and an educational meeting organized for GBV-specific advocates working in SC (July 2016). On both occasions, we presented the emerging categories and themes from our analysis and received feedback from the attendees, some of whom were study participants. Finally, the primary researcher met in-person with two of the study participants to receive feedback on the latest version of the themes and the analytical framework developed by the research team (May 2017).

Results

Characteristics of Study Participants

Of the 25 advocates, 16 identified as White, five identified as African American, two identified as Hispanic, and two identified as mixed race/ethnicity (Arab-American and Middle Eastern-American; see Table 2). Advocates' ages ranged between 23 and 64 years, with an average of 36. Most advocates had a master's degree ($n=16$), followed by doctorate ($n=4$), and bachelors ($n=5$) degrees. Among the 16 participants who had a master's degree, nine of them obtained their degree in social work, four of them obtained their degree in a dual social work and public health program, and the remaining four obtained their degrees in clinical psychology, rehabilitation counseling, performance & pedagogy, and divinity, respectively. Although the socio-demographic form we used to collect personal information did not include a question about sexual or gender identity, three participants volunteered information about their sexual and gender identity during the interviews: one participant identified as gender non-conforming and bisexual, one

Table 4.1 Example Codes from Each Stage of Data Coding and Related Themes/Subthemes

Initial codes	Focused codes	Theoretical Codes	Themes/Subthemes
<i>Feeling valued and appreciated</i> <i>Receiving feedback</i>	Feeling valued and appreciated Receiving feedback	Sense of professional identity and organizational belonging Being acknowledged for one's work	Management and Leadership <i>Appreciating staff and demonstrating their value</i>
<i>Rewarding for good work</i> <i>Being treated as disposable</i>		A leadership approach that values staff	
<i>Being micro-managed</i> <i>Being open to feedback</i>	Being micro-managed Participating in decision-making	Micro-management Horizontal, non-hierarchical leadership	<i>Micro-managing vs. leading non-hierarchically</i>
<i>Allowing autonomy</i> <i>Participating in decision-making</i> <i>Building trust-based relationships</i>	Building trust-based relationships	Egalitarian relationships between leaders and staff	
<i>Professionalizing the field</i>	Being a service profession	Business oriented vs. humanistic practice	<i>Business vs. service model of leadership</i>
<i>Being a service profession</i> <i>Adopting a business model</i> <i>Working with wounded human beings</i> <i>Securing funding</i> <i>Muddling effect</i>	Adopting a business model	Balancing business needs with service	
<i>Being emotionally abusive</i> <i>Displaying the cycle of violence</i> <i>Gossiping behind each other</i> <i>Feeling mistrust</i>	Being emotionally abusive Displaying the cycle of violence	Abusive relationship patterns among staff members	Interpersonal Relationship Dynamics <i>Violence within the organizations</i>

Unaddressed past trauma
Stumbling blocks to
advancing the field

Decompressing after a hard
work day
Avoiding negativity
Seeking support from
colleagues
Being vulnerable
Sharing laughter
Dealing with difficult stories

Seeking support from
colleagues
Being vulnerable
Sharing laughter

Supporting each other during
difficult times
Humor as a coping mechanism

Spirit of camaraderie

Culture of Self-Care

Experiencing burnout
Recognizing vicarious trauma
Normalizing responses to
working with trauma
Disclosing mental health
issues
Feeling like a failure
Imposing stigma on self

Normalizing responses to
working with trauma
Disclosing mental health
issues
Imposing stigma on self

Stigma of receiving help
imposed by others or self

Reducing the stigma around
“occupational hazards” and receiving
help

Paying lip service
Encouraging staff to take
mental health days
Providing resources for self-
care
Incorporating collective self-
care activities

Paying lip service
Providing resources for self-
care
Incorporating collective self-
care practices

Creating an organizational
culture of self-care
Transforming culture of self-
care into collective self-care
practices

Making it a priority vs. paying “lip
service”

participant identified as gender non-conforming and gay, and one participant identified as lesbian.

Five advocates were executive directors or co-directors in their organizations. Four advocates held director/coordinator position for the programs for survivors while four other advocates provided individual and/or group counseling. Eleven advocates held community outreach/support and education director/coordinator positions within their organizations, and one advocate provided legal advocacy. It is important to note that all of the advocates in our study, including those primarily engaged in community outreach

Table 4.2 Characteristics of the Study Participants (*N* = 25)

	Mean (range)	N (%)
Race/Ethnicity		
White		16 (64%)
African American		5 (20%)
Hispanic		2 (8%)
Mixed-Race/Ethnicity		2 (8%)
Age	36 (23-64)	
Educational Status		
Bachelors		5 (20%)
Masters		16 (64%)
Doctorate		4(16%)
Relationship Status		
Married		14 (56%)
In a relationship		3 (12%)
Separated		1 (4%)
Single		7 (28%)
Position in the Organization		
Executive Director/Co-Director		5 (20%)
Director/Coordinator of Programs for Survivors		4 (16%)
Community Outreach/Support and Education Director/Coordinator/Staff		11 (44%)
Individual and/or Group Counselor		4 (16%)
Legal Advocacy		1 (8%)

and education, had varying levels of experience with serving clients directly and were responsible for answering crisis calls during their weekly or monthly shifts. In addition, all of the advocates who were in charge of the programs for survivors ($n=4$) engaged in direct services.

Themes and Subthemes

Our analysis resulted in three broad thematic areas that represent the significant organizational processes that affect advocates' psychosocial health and well-being as well as their ability to engage in self-care. The three thematic areas included: 1) Management and Leadership Style; 2) Interpersonal Relationship Dynamics; 3) Culture of Self-Care.

Management and Leadership Style

This theme captures how GBV-specific advocates in leadership roles (i.e., executive directors, associate directors, program directors, supervisors) approach developing and overseeing the programs and services offered by their organizations, as well as the relationships they establish with the staff members to accomplish organizational goals. Three subthemes were identified under this theme: 1) Appreciating staff and demonstrating their value, 2) Micro-managing vs. leading non-hierarchically, and 3) Business vs. Service Model of Leadership.

Appreciating Staff and Demonstrating Their Value

Advocates' commitment to their organizations and their motivation to continue engaging in GBV-specific advocacy was shaped by whether their directors and supervisors acknowledged their efforts and valued them as colleagues. Although advocates often derived motivation for their work from their own personal and political values, receiving recognition from the leadership for their accomplishments was

identified as an essential part of maintaining their sense of personal and professional identity. This was particularly important in light of the challenges their organizations faced in providing a fair monetary compensation for the work they do. One of the advocates highlighted the motivational role of feeling valued in the face of limited financial resources:

I know they can't pay me well. That's the way non-profits work. They just don't have the funds to do that. So finding what your, the currency is of your employees, right? If you can't pay them well, then what can you do for them that would make them feel valued? Because I think if an employee feels valued and empowered and trusted, they'll stay, and they'll do great stuff. But if they don't, if any of those are missing, then it's not necessarily a good place. (Advocate #100)

Working for long hours in a stressful environment while not feeling appreciated by the leadership and not being provided opportunities to participate in decision-making caused advocates to question their career choices and their decision to work for their respective organizations. At times, these experiences resulted in a decision to leave the organization:

Between new management that was not receptive to feedback from employees of any level, not just the therapists, but the direct care staff, all of them are treated very very poorly and as if they were disposable and often statements of, "you are disposable" were articulated out loud. So I didn't want to work in that and also working 70 hours a week with no appreciation for what we were doing and no end in sight to that, was just like too much. It was very mentally taxing. So I stepped away from that and actually shortly thereafter three more of the therapists stepped away and took jobs elsewhere. (Advocate #119)

In contrast to these negative experiences, some advocates who held leadership positions in their organizations (i.e., executive director, director of programs) acknowledged the necessity of not only valuing their staff members, but also putting this value into action by caring for them. They understood this as part of their organizational responsibilities:

I think that you start with an attitude towards your staff, and the attitude is one of support and compassion that in what you say and what you do on a day to day basis, you give them the message that they're valuable. Because if you don't value something you won't take care of it... And I've got that printed in my office to remind my staff that what you're doing is important. It's noble work and we can't afford to lose you. (Advocate #122)

This advocate also linked the nature of relationships between the advocates in leadership positions and other staff members to the interactions that take place between GBV-specific advocates and their clients, alluding to the potential impact on organizational functioning:

The other thing is I believe that the way employees are treated translates to how they treat their clients. So if they are being stressed, the demands are rigid and harsh and they are feeling unsupported and uncared for, that's going to translate into poor service for the clients, no way around that in my opinion. (Advocate #122)

Micro-management vs. Leading Non-Hierarchically

Many advocates shared that they felt more driven in their work and they were more likely to be successful when they worked under a "non-hierarchical" leadership. Non-hierarchical leadership was described as a leadership style that operates not through the use of power, but one that is based on competency and respect and allows autonomy for advocates to manage their own time and complete tasks. Building trust-based, egalitarian relationships with their organizational leaders encouraged the advocates to be accountable for fulfilling their responsibilities:

I love the management style where I'm at right now. It's very much like here's your responsibilities. Figure it out. If you have questions let me know, but I'm not going to micromanage or dictate how or when you're supposed to do something. That works really well for me because I am great at like taking a task and managing my time appropriately and getting it done. (Advocate #119)

Advocates spoke of the ways in which they worked with the leadership supervisors and received guidance to fulfill their responsibilities. Advocates felt that the

potential they had in terms of contributing to their organization's goals was acknowledged when their leaders made an effort to get to know the unique work-related interests, knowledge, and skills that each of them possessed. Advocates' sense of organizational belonging and purpose was further enhanced by their leaders' intentionally utilizing their strengths in ways that were meaningful both to them and their organizations. Advocates expected their colleagues in leadership to recognize the multiplicity of approaches that staff members might adopt in their work based on their personal assets:

...empowering employees to be engaged and fulfilled by their work, and trusting your employees. If you hire well, you just like wind them up and set them off, and let them help brainstorm. Know what their strengths and powers are, and utilize that, instead of trying to push your employees into a little box. (Advocate #100)

Another important component of a non-hierarchical leadership was intentionally involving the staff members in decision-making processes. One of the advocates expressed her excitement over an approach her organization recently started employing to facilitate participation among advocates in the development and implementation of the programs. With this approach, their leadership intended to create a bridge between advocates' interests, expertise, and the organization's mission. She described how they were collectively working towards developing a "strategic plan" for each program:

[referring to their executive director's speech during the meeting] Let's see what your position looks like. What are things you really like to—are there any areas you want to develop in, that we haven't had that opportunity?" So that we can really figure out as a group where this program is going to go, and get everybody's buy-in and move more towards that. So I think that will continue to bring everybody together and feel like their voice is heard. It's not just people telling you what to do. You have a contribution. And how does your work fit into the overall mission of the agency? Why are you and your work important in what we're trying to achieve? (Advocate #116)

Business vs. Service Model of Leadership

The last subtheme that emerged from our analysis in relation to the different styles of management and leadership was the “business vs. service model” of leadership. The notion of “business model” was sometimes referred to as “professionalizing the field”, drawing attention to the hiring practices that were increasingly shaped by the academic degree, advanced training, and qualification requirements for advocates. On the other hand, advocates used the term “service model” to highlight the humanistic values guiding their work, and to differentiate their approaches from those that are used in for-profit organizations. There were conflicting stances on the organizational practices concerning hiring. One advocate questioned the extent to which different hiring approaches that were linked to business and service models ensured fit of staff to certain positions that involved working collaboratively with others:

There are people who think that we are too professional and that professionalizing the field of sexual assault and domestic violence is a bad thing.... But the flip side to that is that I think that like sometimes we focus a little bit too much on somebody’s qualifications and their degrees and things like that, and that doesn’t always correlate with supervision skills either [laughs], so yeah. (Advocate #109)

Many advocates discussed the business model of leadership in relation to managing the finances of the organization and securing funding for the programs and services offered by the GBV-specific NPOs. Achieving a certain level of orientation to a business model was seen as a necessary skill for the management to maintain financial security. However, advocates cautioned that business-oriented approaches should be integrated into NPO management without forgetting that they are a means to providing better services to the communities in need:

Guess [name of the participant's NPO] would be kind of a mix...the financial aspects and the fundraising and grant reporting piece of what we do is very

essential, and highly valued. But I do always feel that that aspect of the work that we're doing is always strategically focused on what type of services that we're going to be able to provide with those increased financials, and good business plan, if that makes sense. As far as culturally, I would say that we're much more a service model. A sense of trust and camaraderie among the people that are working within the agency. (Advocate #117)

You know, we are working with human beings. We don't make tires. We don't make furniture. We are working with human beings who are wounded. They are suffering. They are in pain, and so that really forms the basis of our philosophy here. We strongly believe in running the organization ethically and effectively managing the money that's given into our care carefully, really keeping a close eye on the budget. And to that extent I think that we are a business, but on the other hand, because we believe very strongly in a compassionate empowerment model, which means that we are not patriarchal. (Advocate #122)

Advocates reflected on their own personal experiences relating to the business- and service-oriented characteristics of the NPOs they worked for and stated that they observed diverse preferences among advocates working in their field in terms of these two approaches. One of the advocates who identified as being more on the service-model side in her practice thought that several aspects that were attributed to the business-model, such as having clearly defined work roles, and more efficient oversight systems could be helpful:

I think there are people that thrive in both of those [*business model and service model*], and I think you can tell folks that are in one that don't necessarily not thrive, but aren't as comfortable, like maybe need a little bit more of a business model, to have more structure, to be a little bit more specific...there are sometimes when I wish there was a little bit more specificity to this is your job today. Like this is what you have to do today, that kind of thing. That's never been the case here, I mean the ten years that I've worked here, so that's kind of an ongoing battle I have with myself and the work that I do I guess. It's just that love of the service learning or service model and oversight model. (Advocate #114)

Establishing a balance between the business and service models of leadership was commonly identified as a potential way of resolving the conflict:

Merge the two. Yeah. There is much to be said about it being one over the other. I think there's pros and cons to both. I prefer a model that's kind of both. (Advocate #118)

Also in establishing a balance between business- and service-based needs of the organizations, advocates stated the importance of clearly-defined roles that are based on the skills and interests of each advocate:

I feel like that muddling effect is what's causing a whole lot of this [*the tension between business and service models*], especially in my organization. Because nothing is very clearly defined and organized...But if you're a marketing person and you're constantly handling crisis calls, you know what I mean? ...for me it's like, have someone there who handles the crisis calls...You have people who are your case managers. So we all have just very clearly defined roles that pay kind of homage to the fact that, yes, you're a non-profit, but you're a non-profit business" (Advocate #118)

Interpersonal Relationship Dynamics

The ways in which relationships were constructed among advocates working within the same organization had a significant impact on their psychosocial well-being, and ability to solve the problems they faced in their work. Two subthemes emerged under this theme: 1) Violence within the Organizations, and 2) Spirit of Camaraderie.

Violence within the Organizations

Due to their training and work experiences, all advocates had a deep understanding of the power relations that occurred between their clients and the perpetrators of GBV. Given this, some of the advocates were taken aback by the similar dynamics of power and control they observed or experienced within their organizations. Participants likened the relationship dynamics within their organizations to the "Power and Control Wheel" (Dutton & Starzomski, 1997), which is a framework often used to describe the relationships between survivors of violence and their perpetrators:

It was an incredibly toxic work environment. My boss was emotionally abusive. She was not emotionally abusive very much, to me, but she was a bully and would pick on, like find the weak link, and would pick on that person, or emotionally abuse them, and I felt very powerless to do anything to change that system within. So, yeah. I would go to presentations, and present on like intimate partner violence and the cycle of violence, and the power and control wheel. And as I was presenting it to students, I'd be like, "Huh. That fits her. That fits her. That fits her. (Advocate #100)

You know the thing that's at the heart I know of violence is the power and control, and I think one of the things that really frustrates me is that workers, whether it's someone at the top, an executive director or an individual worker has their own struggle with feeling powerless, right, and they might not identify it. But like you can see it in their relationships where they sort of use the same dynamics, the same control dynamics that an abuser would use. (Advocate #101)

Advocates alluded to "unchecked mental health issues" and "personal struggles" as the main reasons for the abusive behavior patterns among their colleagues. A shared belief among the participants was that most advocates working in this field had a history of trauma, and this exposure (if not addressed) can adversely shape the ways in which they worked with others in the organization. As one of the advocates noted, "Hurting people hurt people". Further, the abusive relationship patterns among staff were viewed as a major barrier to advancing the work of GBV-specific NPOs:

I think that the workers just in general like in this field have their own issues, their own personal struggles and unchecked mental health issues, whether it's like a diagnosis- mental health illness or just whatever- is one of the biggest stumbling blocks to advancing this field. (Advocate #101)

Spirit of Camaraderie

Being able to share feelings of vulnerability and uncertainty related to handling stories of trauma, and receive work-related guidance from each other in the workplace was a major source of support for the advocates. They spoke of the unique and isolated world of GBV-specific advocacy, which they referred to as something they could only

share with their coworkers. Building a community of camaraderie was essential to fulfilling their responsibilities at work:

I do think it's a family [referring to the organization]. And I think that's the only way we'll be successful, especially in a close-knit environment like that. Everything has to be confidential. So we don't have anybody else to talk to about the problems we have going on...I'll go talk to my coworker about it, get her view take, see what I should do to help them [clients], and then we'll move forward. (Advocate #113)

...for the most part, I really felt fairly equipped to handle the kind of stories that I was hearing. But only because I knew I had people that I could talk to. (Advocate #111)

Making room for laughter in the face of hardship was also an important part of the camaraderie advocates experienced. Weaving humor into their daily work with other advocates helped them get through difficult times. Advocates noted though that the type of humor they shared with their co-workers was unique in that outsiders would not be able to understand:

I think in almost every field of mental health everyone develops kind of a sick sense of humor, like all of mental health people we're scary and we make jokes that people outside of our work are like 'that sounds horrible.' Like why are you joking about that? But it's kind of the way that I feel like a lot of people process how terrible that is, whatever it is, because if you can't laugh you're just going to end up fetal in a corner and not accomplish anything. So we all have like a really comedic relationship where we'll like laugh and tell jokes and be there to support or like decompress if we had a really tough hospital call or a really tough crisis call. (Advocate #119)

I think that part of it is that we hear some difficult stories, and we hear a lot of things that are sad. And so, some of it is just comic relief, because we deal with some difficult things that we have to laugh at it to deal with it. It's like a coping mechanism. And so we do. We laugh at things that are horrible. And someone on the outside looking in might say, "That's inappropriate. That's offensive." But in a way, that's our way of venting it and kind of dealing with it in a sense. (Advocate #115)

Embracing humorous moments and sharing laughter sometimes served as a collective self-care strategy:

...we can't be serious all the time. We have to bring in some fun and laughter and, if it's at the end of the day, everybody seems to pile into my office, and we have our talks...maybe I had an hour-long crisis call that just got me just in a tizzy and I'm just like, "OK, I need to go outside for a minute and blow some bubbles," or "I need to go outside and hula hoop," or "I just need to go outside," we have a picnic table. We have a cat outside that we go and talk to [laugh]. She's probably heard many stories over the years, because she has been there as long as I have been, the cat has. (Advocate #121)

A potential downside of the close relationships that advocates developed to support each other in the workplace was the blurring of personal boundaries. Although participants described these relationships as supportive and nurturing most of the time, some advocates revealed that at times, they found themselves in the midst of uncomfortable conversations which crossed their personal boundaries:

Many of the people in the office are very open about their intimate life, like sex life or whatever. I'm not. That's not something that I like to share with, I really don't share with anyone. It's something that I consider very private. But because I may not volunteer information, then the joke is made well, you know, [name of the advocate] is, she won't talk about it because she's..." ... And I know it's a joke, and I know that it's just meant to be all in good fun, but on the other hand, at the same time, it's just, hmm, it's uncomfortable. (Advocate #115)

Culture of Self-Care

Shared norms of self-care within the organizations, and the extent to which self-care practices were supported and endorsed by the leadership influenced advocates' perceptions around and level of engagement in self-care. We identified two subthemes under this theme: 1) Reducing the Stigma Around "Inevitable Occupational Hazards" and Receiving Help, and 2) Making Self-Care a Priority vs. Paying "Lip Service".

Reducing the Stigma Around "Inevitable Occupational Hazards" and Receiving Help

When they were employed, most of the advocates were informed by the leadership that people who engage in this line of work can be vulnerable to burnout, vicarious trauma, and compassion fatigue, all of which were considered as "inevitable

occupational hazards”. Advocates reported these as common experiences within their work environment and considered them as a natural response to constantly working with other people’s trauma and suffering. Reflecting on how her recent work brought back some of her own traumatic memories, one advocate said:

It’s an inevitable occupational hazard that you’re going to experience trauma doing this type of work. And so it’s not a matter of if you’re going to experience it. It’s just a matter of, it is a reality and then what are we going to do about it? (Advocate #117)

Consistent with acknowledging these “inevitable occupational hazards”, some advocates in leadership took a proactive approach to reducing potential risk factors for burnout, vicarious trauma, and compassion fatigue. They conveyed to the advocates they supervise that they would be available and willing to support them when they were emotionally overwhelmed due to their work:

I just hired my volunteer coordinator, and I told her, “We work as a team. There’s going to be days that are going to be very difficult for you just as a volunteer coordinator. You may not directly deal with clients, but still dealing with volunteers, and them having to come and talk to you about their cases that they deal with at the hospital the night before, or whatever, can be very stressful for you as well. My door’s always open. You can come in my office any time, and just spill it. Just let me know what’s bothering you. (Advocate #121)

However, there still seemed to be a reluctance among some advocates to openly share the emotional burden and mental health problems they faced in relation to their work with their colleagues. For example, some advocates expressed a concern around receiving judgmental responses from their colleagues if they were to disclose that they were seeking therapy:

I think there needs to be more of a culture of social service providers going to therapy themselves, and just like support around that because it’s silly to think that we’re telling other people to do it but we’re not doing it. And if someone comes into work and they say, ‘Oh I went to therapy,’ it’s still like oh that’s weird, even

though we're telling people to go to therapy, so it just doesn't make sense.... I do go to therapy and I don't tell my colleagues, yeah. (Advocate #123)

The fact that talking about personal experiences of burnout and vicarious trauma was stigmatized in certain GBV-specific NPOs was perceived as “hypocritical”:

I've never worked in an environment where I felt like you needed to be secretive of being burnt out or being stressed or going to therapy outside. Everywhere that I've worked has been like, 'That's super cool. I'm glad that you're doing that.' I don't think I could work in a place where that's the judgement because it just seems hypocritical. (Advocate #119)

The stigma of receiving help from mental health care providers was not always imposed by others but rather, was internalized. At times, advocates felt conflicted about receiving professional help to process and cope with work-related stress and trauma while being in the role of providing counseling to their own clients. This inner conflict led to self-imposed stigma:

I think a lot of people are just kind of hesitant to utilize it [*therapy*], because maybe some of the staff, I could see some of our staff just kind of being hesitant because they're like, “Well, if I'm having to go talk to somebody, then I must not be any good if somebody comes and talks to me.” ...They feel like a failure, I guess you could say, kind of. But we just have to kind of say, “That's not it.” We get secondary trauma, and get burned out from this. Because I mean, we can hear, gosh, numerous cases on a daily basis. (Advocate #121)

In some organizations, different layers of stigma around experiencing burnout and/or secondary trauma, as well as seeking professional help (i.e., other and/or self-imposed), interlaced to form a culture that was unsupportive of disclosing work-related vulnerability and failed to provide comfort to advocates in such instances:

There's also this really ironic sort of response to it [secondary trauma] in that like there was almost like a form of shame/pride of something getting to you. It kind of reminds me of like sort of like a tough man act, like punch me, that didn't hurt. Like punch me again...one of my colleagues who worked at the [name of the organization], and she was talking about how if after they would have a really hard forensic interview or something, like there was a room that had a really comfy couch and a beanbag chair and they could just go in and just kind of collapse and

collect themselves. And I was thinking wow, that sounds like an amazing thing and there's no way I could ever see that happening at our agency. (Advocate #112)

Making Self-Care a Priority vs. Paying "Lip Service"

All advocates highlighted the importance of engaging in self-care as a strategy to cope with the stressful nature of their work. They revealed, however, that the organizational context in which they worked was not always conducive to practicing self-care. For instance, in NPOs that were understaffed, advocates had to take on multiple responsibilities, rather than having a clearly defined role. This often resulted in a high workload and irregular work hours, which made it very difficult for advocates to invest time and energy in their own self-care. Advocates talked about the hypocrisy of being advised to engage in self-care without having access to the resources that are necessary to do so:

There was a lot of lip service about self-care at the rape crisis center where I worked, and "make sure you take flex time if you work over your forty hours." Like, "take time off". But then you wouldn't change any of the workload, and so you were expected to do forty hours worth of work in a shorter amount of time. So you could take care of yourself, and then you'd get in trouble if you didn't do it, right? (Advocate #100)

I think maybe it's because most places or many places will, because they are like non-profits and they are helping other people and the turnover and the burnout is so high that they overwork the people that they have and don't allow time for that self-care. Yet they preach the self-care, so it becomes this very vicious cycle. You're too overworked to take care of yourself so you're getting burnt out, but then you don't have time to take care of yourself because of work which is burning you out and it just continues in that horrible cycle. (Advocate #119)

Among the resources that organizations can provide to their staff members to support their self-care efforts, advocates mentioned flexible work schedule, flexibility in

work location, more vacation time, and mental health days. Without these resources, advocates felt that they were unable to effectively engage in self-care practices.

Another issue they described as a barrier to self-care was the lack of practical support and enforcement around self-care by their leadership:

Well, part of the problem is, we all, in this field, have been taught what self-care is. But none of us have been taught or encouraged or checked in on the practical application of. I know exactly what I'm not doing. You know what I mean? Like, I know all of the self-care tips and techniques and things like that. I have not practically applied very many of them because I'm exhausted. Right? The only thing I can think about when I get home is basically oozing someplace and just not moving at all. (Advocate #118)

Practical support for self-care, as described by some of the advocates, included a personalized approach that took the diverse self-care needs of advocates into consideration:

...I think other people struggle with the idea of, we're being given these ideas, but they don't really fit my lifestyle, or they don't really fit me, or my personality. They don't really intrigue me, but we're not getting any practical help in finding those things that do intrigue us, that do make us excited about, "Yay, I'm going to take care of me! (Advocate #118)

Advocates acknowledged that self-care practices could be engaged and promoted at the organizational level. Some reported collective self-care activities taking place in their organizations, such as spending time together outside of work, formal and/or informal debriefing sessions, and organizing a retreat for the staff members. One advocate who was in the leadership of her organization talked about a physical health related self-care practice they were implementing at the organizational level:

...right now our whole staff is participating in this...it's called the Survivor Fitness Challenge. And it's not about exercise so much; there's a whole list of things that people can do to increase their health and one is to drink an appropriate amount of water every day, and one is to take a walk, and one is to eliminate sugar....so we're tracking each other with that, supporting each other with that. (Advocate #122)

Another advocate criticized the lack of initiative in her organization in relation to developing and implementing collective self-care practices. She also reflected on the link between being a trauma-informed agency and prioritizing collective self-care practices. Trauma-informed practices are characterized by “an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors” (Hopper, Bassuk, & Olivet, 2009, p. 82). This advocate argued that being a trauma-informed agency needed to be reflected in not only how they interact with their clients, but also with their staff members to ensure their well-being:

I think that we do underestimate our organization’s ability to support staff, especially in this kind of work. And I think [name of the NPO] is just as guilty of it as any organization that would be similar to ours...the advice that I would give is to look at just like we are, this whole trauma-informed care approach. And looking at it from a perspective of how we should be working with our clients, but not forgetting at all that it’s also, how do we practice this work, how do we let it influence how we treat our staff, too, and what kind of supports we have for them...I think being a trauma-informed approach agency means that we have to think about our staff within that realm too, that as we are working with people who have been through trauma, we also experience trauma. And how do we help our staff and our volunteers...to be able to have a process for working through some of that secondary trauma? And having at least a voluntary opportunity to debrief on a regular basis, to find support from one another. (Advocate #117)

In Figure 1, we present a conceptual model that combines the main findings of our study with the existing literature on GBV-specific advocacy. At the center of the model, we include the common aspects of GBV-specific advocacy as identified in the literature, stratified based on whether they predispose advocates to (or prevent them from) negative psychosocial health and well-being (i.e., risk factors and costs, protective factors and benefits). On the left side of the figure, we summarize the organizational practices and structures that render the advocates more vulnerable to burnout, vicarious trauma, compassion fatigue, and diminished professional identity. On the right side of the figure,

we summarize the organizational practices and structures that support the advocates in experiencing professional growth, fulfillment, and developing a sustainable, positive professional identity.

Discussion

The work of GBV-specific advocates connects micro, meso-, and macro-level efforts that are intended to mitigate the consequences of and prevent GBV. Many of the advocates guide survivors of GBV through their recovery, raise awareness about GBV in different community settings, and engage in policy-level change (Ganz, 2014; Globokar et al., 2016; Wood, 2014). Despite being critical agents of the movement against GBV, advocates have received surprisingly little attention within the GBV literature (Maier, 2008). It is clear that fostering the psychosocial health and well-being of advocates is critical to the short and long-term success of GBV-specific NPOs (Wood, 2014). Thus, taking a holistic approach to advocates' well-being and developing organizational strategies to not only protect, but also promote the psychosocial health of their staff members can help GBV-specific NPOs succeed in their missions. The results of this study shed light on the organizational-level factors that influence psychosocial health and well-being among GBV-specific advocates who work for NPOs.

Management and Leadership Style

The leadership approach adopted by the executive directors to manage the operations of the organization – including supervision and training, the development and implementation of programs, planning and delivery of services, and distribution of different roles among the staff members – has a significant influence on advocates' sense of belonging to the organization. Demonstrating the value of staff members by

acknowledging their efforts and showing appreciation for their work appears to be an important component of a successful leadership practice. Many people are driven to GBV-specific advocacy due to internal values, and therefore feel rewarded by being able to engage in this work; yet, receiving recognition for their work enables advocates to experience greater job satisfaction and fulfillment. Being appreciated and recognized for their accomplishments by their leaders is crucial for advocates' organizational identity and sense of belonging.

Other studies have documented that advocates experience greater job satisfaction, lower levels of burnout, and less vicarious trauma when they feel valued and supported by their supervisors and coworkers (Choi, 2011; Gibbons, Murphy, & Joseph, 2011; Killian, 2008). In addition to receiving recognition for their accomplishments, advocates feel valued if their leaders and/or supervisors make an effort to get to know their unique strengths, skills, and interests, and incorporate this knowledge into their assigned job responsibilities. Being able to focus on areas that are of greater interest to them enables the advocates to actualize their personal values and goals. This self-actualization, in turn, strengthens the connection between the advocates' personal values and the values of their organizations. Such an alignment between the values of the staff members and values of the organizations has been found to support the psychosocial well-being of the staff members and protects them from experiencing burnout and secondary trauma (Kulkarni et al., 2013b; Schuler et al., 2016; Slattery & Goodman, 2009).

The extent to which the advocates were allowed autonomy in their work was another influential workplace dynamic on motivation levels and work performance. Consistent with the previous literature, we observed that advocates' motivation to be

successful in their work was higher when their leaders provided them with a certain level of autonomy in managing their time and tasks (Elpers & Westhuis, 2008; Kulkarni et al., 2013b; Maslach, 2003). Having access to this kind of flexibility causes advocates to feel more satisfied and confident with the outcomes of their work. In addition, leaders who encourage accountability through establishing trust-based relationships with staff members receive greater respect from their employees. In contrast, when executive directors and/or supervisors micro-manage the advocates they supervise and are overly critical about every step these advocates take in fulfilling their responsibilities, advocates have a harder time being productive and feel less connected to the values of their organizations. Being micro-managed can endanger the quality of the relationships between leadership and staff, and cause these advocates to experience higher levels of distress in the workplace.

Less hierarchical and more egalitarian leadership approaches were also found to support advocates' psychosocial well-being and lead to better organizational functioning (Bloom & Farragher, 2013; Slattery & Goodman, 2009). GBV-specific NPOs consist of several staff positions that have an inherent hierarchical order, such as the executive directors, associate directors, program directors, supervisors, and staff members who engage in direct-services. Egalitarian leadership approaches treat these positions as a means to benefit from different levels of expertise and skills among the staff members and facilitate the transfer of experiential knowledge among advocates from various cohorts and/or educational backgrounds (Slattery & Goodman, 2009). Leaders who strive to create a less hierarchical organizational environment share power with the staff members by endorsing collective-decision making. This is consistent with previous work

that has shown advocates are more committed to the goals of their organizations and find greater meaning in their work if they are able to participate in organizational decision-making processes (Choi, 2011; Kulkarni, Bell, Hartman, & Herman-Smith, 2013b; Slattery & Goodman, 2009).

Stated poignantly by one of the participants, GBV-specific NPOs are not businesses in the traditional sense such as the ones that “make tires” or “make furniture”, but they are human service organizations that are “in the business of working with human beings who are wounded”. Yet, like for-profit businesses, the services provided by NPOs rely on financial security, often from fundraising and applying for federal and/or private funding. A shared opinion among advocates in this study was that a business-oriented management was necessary to secure financial resources for their organizations. Another benefit of the business-oriented approach was that it provided clear responsibilities to each advocate based on their skills and specific directions about how to achieve them. Lack of these business-oriented skills within the leadership was perceived as a challenge to the organization’s survival. Advocates who were part of their organizations’ leadership also discussed their roles in obtaining financial resources and establishing oversight and accountability practices, tasks which are also part of a business model. Like the participants in our study, most advocates who work for GBV-specific NPOs have an educational and professional background in social work, health and human services, and public health (Ganz, 2014; Wood, 2014). Organizations might benefit from creating opportunities for their management staff to receive training that pertains to non-profit leadership and financial management for NPOs.

Although “business and service models” of leadership were initially discussed in opposition to each other, participants’ overall accounts suggested that these two models existed on a continuum and were not mutually-exclusive in the context of human service organizations. Advocates’ resolution for where an organization should stand on this continuum implied finding a balance, creating “a mix”, and “merging” these two models. Adopting particular features from what was described as “business model” while keeping their focus on addressing the needs of individual clients and communities with compassion appears to be the best solution for these organizations. Accordingly, a unique challenge faced by GBV-specific NPOs is to employ and/or train leaders who possess a combination of business and service-oriented skills that are necessary to manage these organizations efficiently. This combination would include identifying and securing funding to maintain financial stability of the organization, establishing accountability structures that are based on trust and commitment to the organization’s mission, keeping the organizational focus on efficiently serving the clients, and creating an egalitarian approach to supervising and collective decision-making. Future research is necessary to gain an in-depth understanding of how this fine balance could be achieved both in GBV-specific NPO leadership and in other human service organizations.

Interpersonal Relationship Dynamics

Advocates’ experiences revealed that despite one of their missions being to eliminate the power differentials that underlie GBV, GBV-specific NPOs are not immune to the abuse of power within the workplace. It was striking that although these advocates have an increased awareness of the power and control dynamics that take place in abusive

relationships (Kulkarni, Bell, Hartman, & Herman-Smith, 2013a), they sometimes experienced or observed these types of violent interactions in their workplace.

Our data indicated that having a personal history of trauma and related unmet need for mental health treatment may contribute to unhealthy relationships among GBV-specific advocates. When their own recovery needs are not addressed, advocates who have experienced GBV may develop violent behaviors in their relationships with coworkers. Violent relationship dynamics in the workplace include bullying, emotional abuse, intimidation, creating rumors and false allegations among staff members (Shier, Nicholas, Graham, & Young, 2017a). In addition to the individual risk factors that predispose advocates to developing unhealthy relationships in the workplace, power imbalances between advocates can facilitate abusive relationship patterns when they are not balanced with collective, horizontal approaches to working together (Hershcovis & Barling, 2011).

Concerning workplace violence, a specific risk factor for GBV-specific NPOs is that the abusive relationship dynamics that are observed between the clients and their perpetrators may transfer to the relationships between advocates. Choi argued that “the unhealthy dynamics of trauma victims, such as denial, blaming, and dominance and submission, could be transferred into the organizational culture and coworker relationships” (Choi, 2011, p. 228). Organizational practices such as regular debriefing, informal meetings after work hours that give the advocates an opportunity to decompress and process their emotional responses, creating a supportive community among the staff members can prevent the transmission of unhealthy relationship dynamics to the workplace (Choi, 2011; Shier, Nicholas, Graham, & Young, 2017b).

Advocates countered the emotionally taxing nature of their work by forming strong bonds with their coworkers and relying on each other to overcome specific challenges they face in their work. Kulkarni et al. (2011) argued that “highly mission driven” (p. 6) and social-justice oriented human service organizations such as NPOs that address GBV are often isolated from the communities they reside in and serve. Moreover, these organizations are sometimes “in conflict with the political status quo” (p. 6) due to the fact that they challenge traditional patriarchal and gender norms with their work. This isolation might be one of the reasons why advocates tend to develop close-knit communities within their workplaces which enable them to share overwhelming experiences, emotions, and other work-related concerns. Being part of such a community can, in turn, nurture the advocates in their personal and professional lives, serve as a buffer against the “occupational hazards”, and promote their psychosocial well-being.

GBV-specific advocates in our study felt hesitant about communicating issues related to their work to people from outside their organizational networks (i.e., family members, friends, strangers) due to the fear of being misunderstood and judged by others. Ganz (2014) found that when they talk about their work with new acquaintances, GBV-specific advocates often experience stigma due to their occupational choices. Their work with the survivors of violence and efforts to challenge traditional gender norms brings up controversial sociocultural and political issues that others avoid discussing in daily conversations (Ganz, 2014). Because advocates often feel ignored or alienated by the negative reactions people give when they talk about their occupational area, they may choose not to share the details of their work with strangers. Further, the confidential nature of GBV-specific advocacy also prevents them from talking about their work with

family and friends. Thus, advocates will often turn to their coworkers to talk about specific work-related challenges and process the emotional burden they experience due to their work, without the fear of being judged. It is important that the organizations encourage and create space for open communication and regular debriefing among the advocates.

Participants also incorporated humor into their daily experiences in the workplace to balance the impact of constantly being exposed to stories of human suffering. The type of humor they shared was also unique in that they sometimes were able to excavate laughter from the most challenging aspects of their work. Other studies focusing on the work experiences and well-being of help professionals, such as social workers and healthcare providers, also showed that laughing acted as a coping mechanism and self-care strategy, enhancing resilience among these professionals (Bloomquist et al., 2015; McCann et al., 2013). Humor in the workplace is also found to be associated with better performance, higher job satisfaction, lower levels of stress and burnout (Mesmer-Magnus, Glew, & Viswesvaran, 2012; Romero & Cruthirds, 2006). Particularly in organizations where working as a group is required to achieve positive outcomes, humor enhances group cohesiveness, productivity, and creativity (Romero & Pescosolido, 2008).

A close-knit organizational culture provides advocates with a reliable social support system and helps the organizations function and survive in the face of “limited resources” and oftentimes a “hostile political environment” (Kulkarni & Bell, 2011, p. 6). However, these organizational cultures also run the risk of violating personal boundaries and diminishing independent thinking. (Kulkarni & Bell, 2011). In our study, advocates

perceived the close-knit communities within their workplaces mostly as a supportive system. Yet, several advocates mentioned blurring personal boundaries and the need for reserving some room for individuality. Advocates may have varying needs and preferences in terms of the interpersonal relationships they develop within their workplaces. It is necessary for all staff members of a GBV-specific NPO to be cognizant of these various needs and respect personal boundaries while maintaining the spirit of camaraderie.

Culture of Self-Care

Beliefs and values that are adopted at the organizational level in relation to the advocates' responses to working with traumatized individuals (i.e., burnout, vicarious trauma, compassion fatigue) and their self-care can substantially influence whether and how these advocates cope with distress caused by their work and engage in self-care. Given their training as social workers, clinical psychologists, public health practitioners, and educators, it was not surprising that the advocates in our study acknowledged self-care as a prerequisite for both maintaining their own well-being and doing their job efficiently. However, these higher levels of awareness around self-care did not always translate into engaging in self-care practices. In a study conducted with 786 actively practicing social workers, researchers found that social workers were not engaging in self-care practices frequently, even though they valued self-care and acknowledged its benefits for coping with work-related stress (Bloomquist et al., 2015). Our findings indicate that the incongruence between the conceptualization and enactment of self-care among the advocates can be related to two factors: 1) organizational notions of self-care; and 2) the extent to which their organizations held themselves accountable for facilitating

advocates' self-care and providing the resources necessary to engage in self-care practices.

Organizational cultures in which disclosing the emotional responses to working with GBV survivors is stigmatized sends a harmful message to the advocates and implies that they are not entitled to psychological support and care. In such workplace environments, advocates may feel that assuming the advocacy and caregiving roles for their clients somehow prevents them from being the recipient of psychological care when needed. The self-imposed stigma around sharing experiences of distress and burnout due to work is often accompanied and perpetuated by stigma at the organizational level. It is important that staff members of GBV-specific NPOs have access to confidential counseling outside of their organizations through, for example, employee assistance programs. However, simply providing access to counseling without creating a culture in which seeking counseling is normalized and acceptable would not ensure that advocates would feel comfortable getting the help they need. Similarly, leaders need to acknowledge and assess their organization's capacity to create and facilitate collective self-care practices to promote advocates' psychosocial well-being. Training efforts concerning self-care strategies should always be accompanied by the provision of adequate self-care resources for the advocates.

Examining the self-care practices and professional quality of life among social work practitioners, Bloomquist et al. (2015) found that "negotiating one's own needs within the workplace" (p. 303) was one of the rarely practiced self-care activities. They also indicated that self-care perceptions were significant predictors of self-care practices among advocates who work for human service organizations. Given the established link

between self-care beliefs, values, and actual practices of self-care, it is important that GBV-specific NPOs cultivate a culture that prioritizes and supports self-care among their staff members.

Advocates reflected on the relationship between prioritizing self-care at the organizational level and being a trauma-informed agency. Main principles of trauma-informed practice include trauma awareness, safety and trustworthiness, opportunity for choice, connection, and collaboration, and empowerment in both client-staff relationships, and at the agency level (Fallot & Harris, 2009). Thus, by being trauma-informed in their practices, GBV-specific NPOs not only avoid re-traumatizing the clients they serve, but also recognize the potential effects of trauma on their workforce and develop strategies to avoid those effects (Substance Abuse and Mental Health Services Administration, 2014). Handran (2015) suggested that providing specialized trauma training for staff members can help organizations ensure that their staff members have the necessary knowledge and skills to identify and respond to secondary traumatic stress (i.e., vicarious trauma). For GBV-specific NPOs, being a trauma-informed agency involves investing time and resources into collective self-care practices at the organizational level.

Implications for Practice

Informed by the findings of our study, the following is a list of recommendations for GBV-specific NPOs:

- Provide resources for executive directors and supervisors to receive leadership training that addresses different needs of social justice-oriented human service organizations.

- Create opportunities for staff members to provide feedback on ongoing operations and participate in decision-making about services and programs.
- Include a discussion of advocates' personal goals, skills, and interests as part of direct supervision and make an effort to integrate these into the staff member's organizational responsibilities.
- Identify and address any power differentials between staff members that might contribute to unhealthy, abusive relationship dynamics, and provide confidential channels for staff members to report violent relationship patterns within the workplace environment.
- Develop written statements that include the organization's stance about self-care, and recommendations for individual and collective self-care practices. Share these at the time of hiring with potential staff members.
- Assess organizational self-care practices regularly by obtaining feedback from staff members and/or using organizational assessment tools (Stamm, 2005).
- Create and foster a culture that encourages staff members to disclose and process their emotional responses to working with GBV survivors.
- Acknowledge and work to eliminate stigmatization of burnout, vicarious trauma, and compassion fatigue and/or receiving mental health care during regular meetings with staff members.
- Provide trainings on trauma responsiveness for staff members and ensure that organizational practices are in line with the "trauma-informed practice" guidelines by using assessment tools (Harris & Falot, 2001) and/or conducting an external evaluation.

GBV continues to be one of the most pressing public health problems and human rights violations in the US. National data shows that about 1 in 3 women, and 1 in 6 men experienced GBV during their lifetime (Smith et al., 2017). GBV-specific advocates play a critical role in the mitigation and prevention of this problem, since they guide the survivors in their recovery, help them access the services they need, educate communities about GBV, and work towards needed policy change (Davies & Lyon, 2013; Wood, 2014). Engaging in this important but challenging work takes a toll on the advocates' psychosocial health and well-being (Wood, 2017). Our results emphasize the responsibility of GBV-specific NPOs to develop organizational structures and practices that support the advocates in their work and encourage self-care. Fulfilling this responsibility would enable the advocates not only to survive but also thrive in their work, and lead to better organizational outcomes.

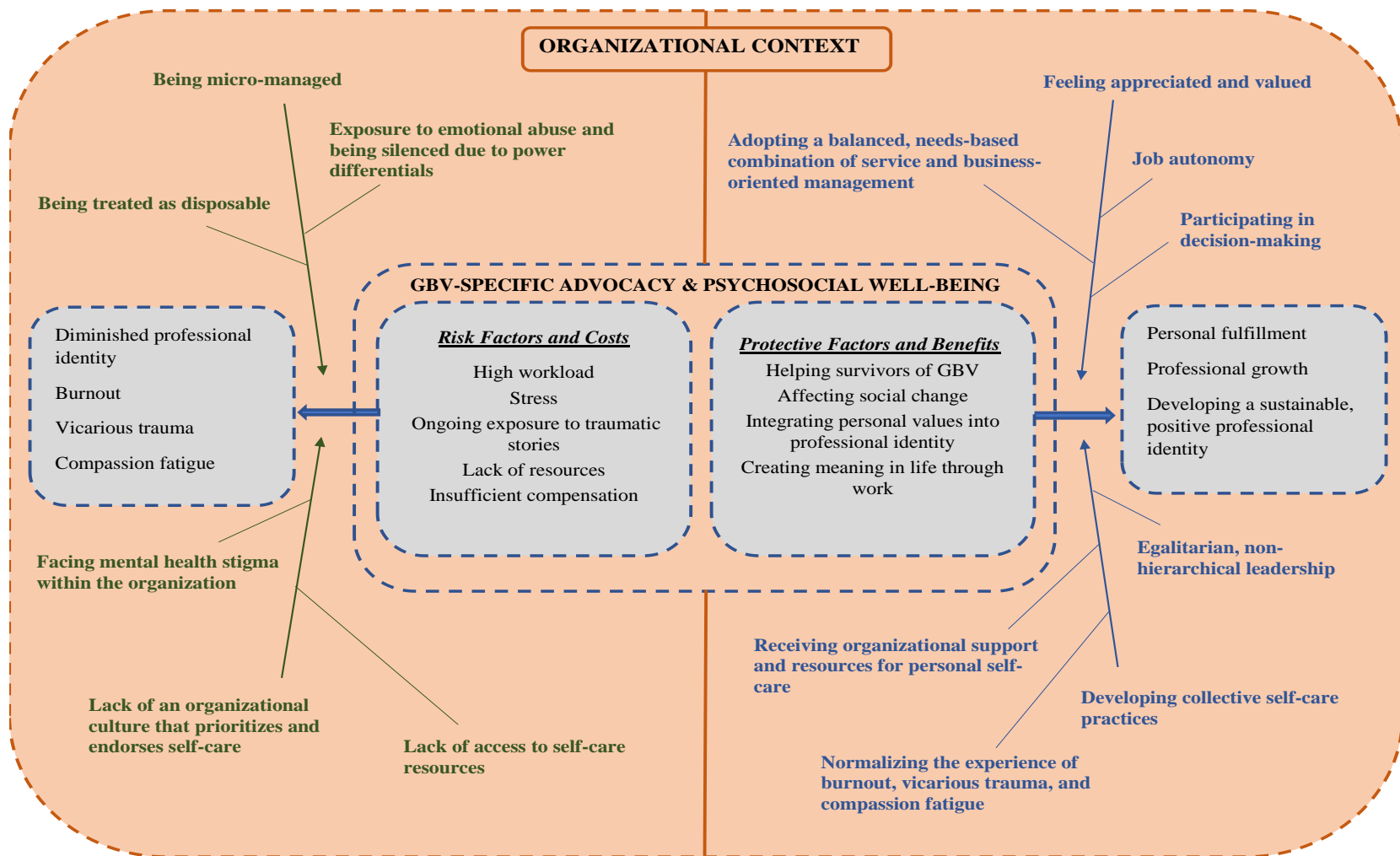


Figure 4.1 Organizational Factors that Influence Psychosocial Health and Well-Being of Gender-Based Violence-Specific Advocates

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Manuscript 2

**Working Against Gender-Based Violence in South Carolina: An Analysis of Race,
Ethnicity, Gender, and Sexuality in Advocacy⁵**

⁵ Cayir, EC, Spencer, SM, Billings, D, Messias DKH, Robillard, A. Will be submitted to Social Science and Medicine.

Introduction

Gender-based violence (GBV) is one of the most pressing public health problems and human rights violations in the US, and across the world (Decker et al., 2013; García-Moreno et al., 2015). In the US, various national and regional level non-profit organizations (NPOs) have been addressing GBV through developing and implementing programs that aim to mitigate and prevent GBV (Behounek, 2011; Globokar et al., 2016; Homer, 2014). Among those, state- and county-level GBV-specific NPOs have long provided critical support and services to the survivors, while simultaneously engaging in community education and outreach to raise awareness about, and prevent GBV. Additionally, these organizations have challenged state agencies to increase the amount of resources allocated to GBV-related programs and services, and worked towards improving state legislation concerning GBV (Globokar et al., 2016; Maier, 2008; Wu, 2008). For many survivors of GBV, these organizations constitute the only accessible support system within their region, thus playing an essential role in their recovery (Globokar et al., 2016).

As the experience of GBV cuts across multiple social categories such as race, ethnicity, class, and sexuality, clients of the GBV-specific NPOs constitute people from diverse social locations (Black et al., 2011; Sokoloff & Dupont, 2005; Violence Policy Center, 2016). Similarly, their outreach and education efforts capture diverse communities residing in their region. GBV-specific NPOs have a responsibility to understand the unique social and cultural dynamics that relate to GBV in each of these communities, and incorporate this understanding into the programs and services they offer. It is also essential for these organizations to reflect the diversity of the communities

they serve in their staff composition (Kolivoski, Weaver, & Constance-Huggins, 2014; Richie, 2015). However, developing an awareness about the processes of exclusion and discrimination at the organizational-level, and within service delivery processes have continued to be one of the primary struggles these organizations face, since the establishment of first national-level GBV-specific NPO in late 1970's (Richie, 2015).

Historically, the work of GBV-specific NPOs has been influenced by discussions that took place within the broader feminist movement. For example, GBV-specific NPOs have worked towards incorporating an understanding of the mutually constructed relationships between race, ethnicity, class, sexuality, and nationality – among other systems of oppression – into the multiple-level responses to GBV (Coker, Goodmark, & Olivo, 2015; Hall, 2015a). Feminist scholars of color raised critical questions about staff diversity, representation of minorities, and underserved and marginalized populations within NPOs that address GBV. They argued that dominant non-profit approaches used to address GBV ignored issues of racial, criminal justice, and discrimination on the basis of gender and sexual identity, perpetuating GBV within minority, underserved, and marginalized communities (Mehrotra, Kimball, & Wahab, 2016; Richie, 2015). In the last few decades, programs and trainings that address institutional racism, heterosexism, and other systemic barriers to creating inclusive cultures in NPOs led to considerable improvements (Black et al., 2011; Kolivoski et al., 2014). Yet, GBV-specific NPOs continue to face challenges that pertain to the impact of pervasive and long-standing social stereotypes, hidden biases, and prejudices on relationships among staff members, and relationships they build with diverse communities (Richie, 2015; Walter et al., 2016). Thus, identifying and eliminating the mechanisms of discrimination and exclusion within

organizational structures and practices continues to be one of the main challenges that contemporary GBV-specific NPOs face.

This study focuses on everyday work experiences of GBV-specific advocates in SC. Engaging in this work in SC presents the advocates with unique challenges as well as opportunities that are specific to the context of the Deep South. Thus, in our analysis, we incorporate an understanding of the historical and socio-cultural characteristics of the state in which the study participants live and work. Understanding the complex ways in which systems of privilege and oppression shape work experiences of GBV-specific advocates can help organizations to challenge and dispel organizational structures and practices that contribute to disadvantage advocates who belong to racial, ethnic, and/or sexual minorities, and the communities with which these advocates identify. The purpose of this study is to examine how race, ethnicity, gender, class, sexuality, and other systems of privilege and oppression shape: 1) everyday work experiences of advocates who work for GBV-specific NPOs in SC, 2) the services provided by these NPOs to diverse communities. Knowledge produced through this study can guide organizations with creating an inclusive, equitable workplace culture that transforms into inclusive, culturally responsive services.

The following sections provide information on the historical background of the work that GBV-specific NPOs do, and regional influences on GBV-specific NPOs residing in SC.

The Movement to End Gender-Based Violence in the US

Elimination of GBV has been a forefront issue within the U.S. feminist movements, beginning from the second wave of feminism that started in 1960s (Hall, 2015b; Keane, 2009; Spruill, 2012). As women started openly talking about “private” experiences within their intimate relationships and sexual life, they soon discovered the commonality of GBV within and outside of the domestic sphere (Morgen, 2002). Addressing GBV became an important component of the overall grassroots organizing that focused on women gaining control over the issues concerning their bodies and health. In doing so, feminist activists, and scholars shifted the conversation around GBV; they challenged the conceptualization of GBV as a “private” and interpersonal issue, drawing attention to the patriarchal culture and gendered power differences as underlying social dynamics (Fahs, 2015; Munch, 2006).

Like the other social justice movements within US feminist history, such as movements focusing on equal pay, reproductive health and rights, the movement to end GBV was dominated by White middle and upper-class women for almost its first century. Having greater access to resources that are necessary to organize and mobilize others, White women led the movement, and by extension shaped the issues that were prioritized, as well as the strategies used to address those issues (Alexander & Alexander, 2013; Seaman & Eldridge, 2012). Yet, women of color were also active in the movement since its beginning, despite having differential access to power and decision-making mechanisms within the organizations they joined (Morgen, 2002; Richie, 2015). The first national level organization in the US that focused on GBV was established in 1978, known as the National Coalition on Domestic Violence (NCADV). Three years later, a Women of Color Task Force was formed within the NCADV. In the following decades,

diverse groups of women (e.g., African American, Asian, Indigenous, Latina, and/or lesbian) established their own independent organizations at the national level, to address the unique challenges they faced within the movement to end GBV (Munch, 2006; Richie, 2015).

For feminists of color, the struggle for having control over their bodies and ending GBV were strongly connected to the struggle for racial justice (Morgen, 2002; Tuana, 2006). Their approach to addressing GBV within the communities of color included an understanding of the structural violence exercised by the state towards racial, ethnic, and/or sexual minorities (Coker et al., 2015). They highlighted that a deeper understanding of GBV experiences among marginalized and underserved communities, such as low-income communities of color, sexual minorities, indigenous communities, and immigrants required using a broader framework of social justice. Only then, they argued, it would be possible to take social action towards preventing GBV, and effectively address the needs of GBV survivors within diverse communities (Coker et al., 2015; Richie, 2015; Tuana, 2006).

Gender-Based Violence-Specific Advocacy in the Deep South: Political, Socio-Cultural, and Economic Context

Southern States (i.e., Alabama, Mississippi, Kentucky, Tennessee, South Carolina) are among the least favorable places in the US for women to live, in terms of political participation, employment, health rights, and safety. In 2015, only 12.2% of the seats in the US House of Representatives, and 18.4% of seats in the southern state legislatures were held by women, while the national average rates were 19.3% and 24.4% respectively (Anderson et al., 2016). The overall poverty rate among women is 16.4% in

southern states, whereas the average rate for all other states is 13.7% (Anderson et al., 2016). The culture of the southern states, which is also referred as the “Bible Belt,” has historically been shaped by strong religious and patriarchal traditions that have been maintained by the long-standing authority of White male leadership (Conlee, 2012; Grosjean, 2014).

These characteristics of Southern culture are also reflected in gun ownership by males, which is associated with high rates of domestic female homicides in the region. In 2014, 88% of the female homicides by men included the use of a weapon, and in 63% of those cases women were killed by a gun. Despite the established link between gun ownership and intimate partner homicides (Grosjean, 2014), gun ownership remains a highly controversial issue in the South (Jackson, 2016). In SC, a 2015 law prohibited the ownership of firearms or ammunition by people who have been convicted of criminal domestic violence, however, these individuals were not required to surrender their firearms or ammunition they owned prior to the law (*S.C. Code § 16-25-30 [as amended by 2015 S.C. S.B. 3]*). Notion of male honor (i.e., honor culture) continues to permeate the political decisions in the South, giving rise to the abuse of power by males. Thus, GBV remains one of the most pressing public health and human rights issues in the Southern US (Anderson et al., 2016).

The work of GBV-specific NPOs becomes even more challenging in the face of conservative politics, limited social welfare resources, patriarchal values, and high poverty rates among women and minority, marginalized, and underserved communities in SC. In this study, we situate the experiences of GBV-specific advocates within the organizational and regional context surrounding their work.

Method

Study Design

We conducted a qualitative study informed by constructivist grounded theory (CGT) (Charmaz, 2006). Grounded theory (GT) is a systematic method of qualitative inquiry that focuses on social processes, and assists the researcher with generating a theoretical explanation that is rooted in data. A constructivist approach to GT acknowledges the situated realities and multiple standpoints of the research participants and the researcher, and incorporates this understanding into the analysis of data. (Charmaz, 2006; Denzin & Lincoln, 2011). For this study, it was important to center the voices of an understudied population - individuals who engage in GBV-specific advocacy - and to understand the relationships between social processes through which their work takes place and the historical, socio-political context of SC. Using CGT, we examined the role of power within every day work experiences of GBV-specific advocates from different social locations, and how they made sense of these experiences.

Participants

Participants were individuals who were 18 years or older, and had engaged in GBV-specific advocacy within a NPO or state-level agency for at least a year. We also included the advocates who were not currently working for a GBV-specific NPO, but have engaged in GBV-specific advocacy in SC for at least a year during the three years preceding the interview date. By recruiting these advocates, we aimed to understand the reasons for quitting, or the changes they experienced in their work by transferring to a different GBV-specific NPO or to a different occupational area. Twenty two of the twenty-five participants worked for a GBV-specific NPO in SC, and three participants

worked for a government agency that addressed GBV in the same state. Five of the advocates worked as a GBV-specific advocate in SC within the last three years before the study was conducted. Two of those were currently living in another state, and they were engaged in GBV-specific advocacy in their new locations, while two others continued to live in SC but worked for state agencies that provide social services for low-income families and children. Finally, one of these advocates also continued to live in SC, and worked as an advocate focusing on women's reproductive health and rights.

Recruitment

To begin the recruitment process, we mobilized the informal networks our research team had established in the state over time by volunteering for GBV-specific NPOs, serving on their Boards, or collaborating with these organizations on various research projects. The first three advocates we contacted confirmed that they would be willing to participate in the study, and sent out e-mails to their colleagues to inform them about the current study, and provide contact information of the lead researcher (E.C.) in case they were interested in participating. The first 10 participants were recruited through this process of informal networking and snowball sampling (Denzin & Lincoln, 2011). Preliminary themes that emerged from the analysis of these 10 interviews guided us in using a theoretical sampling technique (Charmaz, 2006) for the rest of the recruitment process. By adopting a theoretical sampling technique, we aimed to achieve a diverse sample of advocates in terms of the specific roles and position they held in their organizations, experience level, and social location (i.e., race, ethnicity, gender, sexual identity), and saturate the preliminary themes that have emerged from the ongoing

analysis. The study was approved by the University of South Carolina's institutional review board (IRB) prior to participant recruitment.

Materials

We used a semi-structured interview guide to conduct in-depth interviews with the study participants. The interview guide was developed based on a literature review, and was adjusted based on the feedback we received from the first three study participants. The interview questions addressed social and cultural background of the GBV-specific advocates, their specific work roles, their relationships with coworkers, power dynamics and conflicts they experienced and/or observed in their organizations, and organizational structure and practices that might relate to the power dynamics and conflicts they experienced and/or observed. Some of the questions participants were asked included: "How would you describe the interpersonal relationships within your organization?", "What is your assessment of the role that power plays in these relationships?", "In your opinion, what types of social factors create power differences in your work environment?", "Can you give me an example where race, age, gender, socio-economic status, sexual identity, or these types of differences play out within the organization?", and "How do you find it to serve people from diverse social backgrounds?" We also used a brief socio-demographic questionnaire to collect information on race, age, educational status, and relationship status.

Data Collection

Twenty-five in-depth interviews were conducted by the lead researcher (E.C.) between October 2015 and September 2016. The lead researcher made an effort to conduct all of the interviews in person, however, when geographical challenges or

scheduling conflicts prevented in-person interviews, she either contacted the participant via telephone or used an online video conferencing program (Microsoft, 2017). Most of the interviews ($n=21$) were conducted in person. The location and time of the in-person interviews were arranged at the convenience of the participants. Two of the interviews were conducted via phone, and two others were conducted using the online video conferencing program. The interviews lasted between 65 and 124 minutes. Each interview was recorded using a digital recorder, and transcribed verbatim by professional transcriptionists. We removed participant names from the transcripts to ensure confidentiality.

Data Analysis

Constructivist Grounded Theory and Social Justice-Oriented Research

Social justice-oriented research aims to understand and transform power relations by “exposing, opposing, and redressing forms of oppression, inequality, and injustice” (Charmaz, 2017, p. 35). The set of analytic guidelines that CGT offers to examine the role of power in social processes complement the core aims of social-justice oriented research in several ways. First, CGT rejects positivist epistemological approaches, and encourages the researcher to practice “methodological self-consciousness” (Charmaz, 2017, p. 35). Methodological self-consciousness involves engaging in strong reflexivity about the value positions researchers hold by examining how these value positions may influence the decisions they make, and the actions they take throughout the research process (Charmaz, 2011).

Second, CGT emphasizes analyzing people’s meanings, experiences, and actions within the unique time, place, and culture they exist (Charmaz, 2011). It seeks to reveal

social and structural factors that create and perpetuate privilege and oppression, so that they can be altered in the way of social change. For instance, in analyzing our data, we explicated the “implicit meanings and actions” (Charmaz, 2011, p. 364), such as the answers study participants gave to certain interview questions through facial expressions instead of using words, accounts that indicated socializing exclusively with advocates of same race/ethnicity. We also explored contested practices within the GBV-specific NPOs (e.g., practices that relate to hiring diverse staff members, specific approaches utilized in serving communities of color) to understand how systems of power operate in this context (Charmaz, 2017).

During the initial phase of coding, we used *gerunds*, to help us identify everyday actions and interactions that took place within the GBV-specific NPOs (Charmaz, 2006). Gerunds are “-ing” words – verbs that function as a noun – that reflect social processes (e.g., pretending to be inclusive) in the data (Charmaz, 2006; Saldaña, 2015). Table 2 provides a list of example gerunds pertaining to the four core themes that emerged from our analysis. We continued with focused coding during which we examined the frequency and significance of initial codes. We then identified the conceptual similarities and differences between these codes, and created categories and subcategories based on these relationships. This process resulted in more conceptual and selective codes. During the final, theoretical coding stage, we further assessed how these conceptual codes related to each other, and what core themes they implied (Charmaz, 2006). The links between core themes and their subcategories led us towards an explanatory framework that captured the social processes through which multiple systems of oppression and privilege operate within the GBV-specific NPOs in SC. The primary researcher (E.C.) led the

coding process, and worked collaboratively with other members of the research team (peer debriefing and advisor consultations) to identify the core themes and subthemes, and to discuss alternative interpretations of the data. We used a qualitative data analysis software, NVivo 11 (QSR International Pty Ltd.), to manage the data and organize the codes, categories, and themes from audio recorded transcripts and document analysis.

Table 4.3 Example Gerunds for Each Core Theme

Experiences of Advocates of Color
Being treated as “two-for-one”
Pretending to be inclusive
Playing power and control games
Feeling the “pressure to perform better”
Experiences of Queer, Gender Non-Conforming, and/or Lesbian Advocates
Feeling uncomfortable to express gender identity
Redefining gender norms
Being expected to speak for the entire queer community
Serving Communities of Color
Othering communities of color
Working with certified interpreters
Understanding culture within diverse communities
Developing “cookie cutter services”
Working in South Carolina
Blaming the victim
Making something out of nothing
Withholding resources from the poor

We conducted member checks (i.e., eliciting perspectives of the participants about the emerging themes and the researcher’s interpretation of those themes) during the middle and late stages of the analysis to ensure the validity of our analysis (Morse, Barrett, Mayan, Olson, & Spiers, 2008). We presented the emerging themes and categories from our analysis during a workshop we delivered at the statewide sexual assault conference (May 2016), and at an educational meeting for GBV-specific

advocates working in SC (July 2016). In both occasions, some of the attendees were also study participants, and we received their feedback on our preliminary results. Lastly, the lead researcher had in-person meetings with two of the study participants, and received feedback on the latest version of the themes and the analytical framework (May 2017).

Results

Characteristics of Study Participants

Sixteen advocates identified as White ($n=16$), followed by five advocates who identified as African American, two advocates who identified as Hispanic, and two others who identified as mixed race/ethnicity (Arab-American and Middle Eastern-American). Advocates' ages ranged between 23 and 64 years, with an average of 36. Most advocates had a master's degree ($n=16$), followed by doctorate ($n=4$), and bachelors ($n=5$) degrees. Among the 16 participants who had a master's degree, nine of them had a degree in social work, four of them obtained their degree in a dual social work and public health program, and the remaining four obtained their degrees in clinical psychology, rehabilitation counseling, performance & pedagogy, and divinity, respectively. The socio-demographic form we used to collect personal information did not include a question about sexual or gender identity; however, three participants volunteered information about their sexual and gender identity during the interviews: one participant identified as gender non-conforming and bisexual, one participant identified as gender non-conforming and gay, and one participant identified as lesbian.

Color of Gender-Based Violence-Specific Advocacy

“Very White”: Who Is Hired, Who Gets to Lead, and Who Stays

Advocates of color and White advocates spoke of the disparities in race/ethnicity among general staff and leadership positions. They described that White women consisted majority of the staff members, and held most leadership positions (e.g., executive directors, co-directors). Sarah, a White advocate, reflected on the historical roots of this disparity in GBV-specific NPOs:

You know this movement, specifically in terms of domestic violence and sexual violence is a very white, very privileged movement historically in terms of access to resources, in terms of who was leading, in terms of who had the money to lead, that type of thing.

Sarah also talked about how experiences of African American advocates in their field differed significantly from the experiences of White advocates, despite the social justice-oriented nature of their work:

I think women of color in general, specifically African American women have really – I don't know what the best word to say is, not suffered, but have been put in a position where they had to fight harder to be in leadership positions even within this work. So even as we talk about social justice framework, we are still...even within this work and even within a number of other activist circles we still see that being an issue.

Advocates reported that only a few of the leadership positions in GBV-specific NPOs in SC were held by African Americans, and reflected on the potential reasons behind racial disparities in NPO leadership. An African American participant, Kayla described: "I think in SC, for as many African American social workers that you see you don't see as many in leadership positions." Racial disparities in leadership were discussed in relation to not only the long-standing power differences among diverse groups within the feminist movements of the US, but also the historical legacy of racial inequalities in SC. Jean, an African American advocate shared:

I will say that in all of SC, there are six African American directors out of 46 directors. And we actually have one in our office. She's African American. But I think race still plays a part somehow.

Participants who were executive and/or associate directors at organizations that were described as “very White” shared an awareness concerning the need to increase diversity among staff members of their organizations. As part of these efforts, some organizations employed more people of color in the recent years. However, advocates also discussed how the efforts to improve staff diversity within GBV-specific NPOs fell short, due to a superficial focus on the numbers instead of making further effort to build relationships that are rooted in values of inclusion and cultural understanding. In some organizations, advocates from racial/ethnic minorities were treated as a “token.” Jordan explained:

At the rape crisis center, there was only one person of color on staff, out of a staff of twelve or thirteen. I don’t know how she survived it. There were a lot of microaggressions about diverse identities, that were perpetrated largely by my boss but by some other people too. When they hired on someone who was in a wheelchair and also happened to be Latina, my boss said, before she was hired, she had offered her the job, that “we have a twofer” So like a two-for-one, in describing this. Right?

Taylor talked about covert forms of tokenism that advocates of color experience, and noted that these might be harder to identify for advocates of color who are new to this work:

As a black woman in a predominantly privileged white system of work, it becomes awkward a lot of times when you can—when you’ve done it for as long as I have, you can tell when you are—oh, I hate to use this word but I can’t think of another one right now—you can tell when you are being used as an example, or as a token in a situation. You can tell. Now, if you haven’t been in this work a long time, then it may be more difficult for you to identify this. Because it’s not like it’s said. It’s something that you observe and you know.

Another challenge that GBV-specific NPOs faced was related to hiring bilingual staff members to better serve their Spanish speaking clients. Several advocates reported that their organizations opened positions for bilingual advocates in the past but even when

they finally hired someone, “it’s been really hard to keep a bilingual advocate”. Casey, a White advocate who worked for the same organization with Jordan recalled how the last two bilingual advocates that her organization hired struggled with adjusting to the culture in their organization. She shared that both of those advocates quit their jobs under a year:

...the previous bilingual victim advocate who was also, I don’t remember where she was born, but she was born in South America somewhere, but she was a native speaker in Spanish and she also just like could not stand the environment and felt so suffocated by it and the way she was being treated that like she really left after a little under a year.

Judy, a White advocate who was working for another NPO, described her organizations unsuccessful efforts to hire and retain staff members from “other cultures”. She sought an explanation for high turnover rates among advocates of color, and brought up potential underlying reasons for this pattern, none of which related to the organizational practices:

We’ve tried to hire, I mean, we’ve had other cultures working there besides just all Caucasian. We’ve had African American. We’ve had some Hispanic. But like I said, our turnover rate is just so high. And so, I don’t know if it is a cultural thing...Mostly it’s more with our African American, that culture. Because we’ve had a few from that culture that have worked there since I have, and then they just, you know, I don’t know if it is because of burnout. I don’t know if it’s because of personal issues. So they don’t hang out as long as the Caucasian workers do. And I’ve kind of wondered that myself, because I feel bad when someone comes and tours our center, because like I said, we are all Caucasian.

Kayla, an African American advocate who had grown up in SC acknowledged race as a significant factor in how people are treated in workplaces. She shared that people “grow accustomed to everything that comes with race”, and they “just kind of take it”. She felt that African American advocates did not have the power to change organizational dynamics that are rooted in racial bias:

I feel like I recognize when things are happening are a little weird, but it's just really not much you can do when you're a minority. I mean it's just...and not that like here I don't perceive any issues here [in the organization]. You know you can kind of look at the make-up, like in the workers and the staff there's only...me and [a colleague] are both new.

Advocates pointed at the irony of working for NPOs with a progressive mission, and struggling to have open conversations about the issues concerning race, ethnicity, and culture with their coworkers. Jean emphasized the importance of talking about race in a state like SC, and its implications on the work that advocates engage in:

I don't like bringing up race because it makes people feel so uncomfortable, sometimes. But you have to talk about race. You have to talk about it. Because we have to understand what we're doing. We have to understand each other. And the only way we can understand each other is through talking about race, because we're not all the same. Everybody's culture is different. Everybody's ethnicity is different. Everybody's beliefs are different. People believe in certain things because of their culture. So if you want to understand, if we want to get better, we have to be open minded.

“There is strength in vulnerability”: The Pressure to Perform Better

Historically being minority within the staff members of GBV-specific NPOs, advocates of color felt that they had to try harder, “perform better” compared to White advocates, and keep any feelings of work-related distress to themselves to ensure the security of their jobs. The pressure they felt to constantly perform well, and be on top of their work compromised African American advocates' ability to engage in self-care practices. Acknowledging that they sometimes felt overwhelmed, or experienced burnout due to work, and therefore needed to take some time off, and/or invest more time and energy in their own well-being contradicted with the pressure to perform better, prove themselves, and get promotions at work. Beth, an African American advocate shared:

I think that they [African American advocates] feel that there may be some pressure to perform better, to keep their jobs, or to not appear sick or be vulnerable in any type of way...even though vulnerability is strength. There's strength in vulnerability.

Beth revealed that there were times she didn't "feel secure" in her position, despite having recently got a promotion from her organization. These included the times when she was critical of certain organizational decisions made by the leadership. She thought that "being vocal" about "what's wrong with the organization", particularly in relation to the issues of race, ethnicity and differential treatment, could cause the advocates of color to lose their jobs:

I'm always on my tippy toes. Because I don't know. I just, I mean, it has gotten me this far, and I know that I do an excellent job here, and I'm valuable to this organization, but I still have to be careful, because I still see myself as an African American...I have to draw a fine line in how much I voice my opinion. I have so much to offer and share, but I don't always know how it's perceived.

Essentialized Womanhood and Heteronormativity

"So much estrogen in the air": Working with Other Women

GBV-specific NPOs were operated primarily by advocates who identified as women, and therefore described as "all women work environments". There were varying, mixed feelings among advocates with regards to working in an "all women" workplace. Some advocates mentioned this aspect of their work as "fun", and that they were able to support each other in their work while "having a good time" with other women. Others spoke of the frequent tensions and interpersonal conflicts in their organizations, which they attributed to working in an "all women work environment" Lisa shared:

I really really loved [the NPO] because it was all women, and I really really really hated [the NPO] because it was all women. [Laughs] So I loved that it was women for women by women supporting women, but there was so much estrogen in the air that you know, it got caddy and gossipy and all that kind of stuff, so you had that. Well you have that everywhere, but it's nice to have some testosterone in there to kind of buffer some of that estrogen.

While some advocates thought that it was "something in the estrogen" that caused

their coworkers to talk behind each other at times and “pull each other down”, others were critical of this idea. One of these advocates, Sarah, found it condescending and sexist to ascribe the interpersonal conflicts to being women:

I hate the whole like women can't work together because they get caddy and ridiculous. I think that's crap. I don't agree with that at all. I think that it depends on a person's personality, not their gender. Certainly not their sex, but their gender. I think that we're socialized and our socialization is important, but I do think that's crap. I think that that's something that is an assumption a lot of people have that just isn't true.

Advocates who emphasized the role of socialization and gender roles in how women advocates interacted with each other also discussed the feelings of “having to prove ourselves” among women advocates, and being labeled as “angry or mean” when a woman advocate appeared to be competitive within the workplace.

Another advocate, Judy, alluded to “working with a bunch of women” as the reason for why they may “get on each other's nerves and bicker” at times, but she also felt that the stressful and emotionally taxing nature of their work led to personal conflicts among the advocates:

...most of the time I blame that because we're just all worn out, and we've just had a hard day. So, it will be five o'clock and everybody is just kind of annoying each other sometimes [laugh], getting on each other's nerves.... we have to be supportive of each other, and help each other out and try not to get too annoyed with each other.

“I am your mission drift”: Alienation of Queer, Gender Non-Conforming, and/or Lesbian Advocates

Commonly shared notions of an essentialized womanhood shaped the interactions among the advocates, and the ways in which they expressed their gender identity in the workplace. Queer and gender non-conforming advocates stated that prevailing assumptions of working in an organization that is “women for women by women

supporting women” rendered them invisible. Heteronormative values dominated the culture within GBV-specific NPOs, making it harder for queer, gender non-conforming, and/or lesbian advocates to present their authentic selves, and develop a sense of organizational belonging. In addition, normalization of heterosexist stereotypes contradicted with the organizations’ efforts to challenge and transform gendered power dynamics that contribute to GBV. Jordan, a gender non-conforming, queer advocate, talked about not feeling comfortable to disclose their gender identity in the workplace:

I sometimes felt, even though the rape crisis center where I worked, even though we discussed gender stereotypes and how they were just stereotypes, and people can be whatever they want, and those gender stereotypes really add to the cycle of violence, and to intimate partner violence...and if we could obliterate the gender stereotypes then it would actually help a lot of things, so if we got down to the root, I didn’t feel very safe or comfortable being out as queer or gender non-conforming when I was working there.

Queer, gender non-conforming advocates spoke of feeling “very isolated and not heard” when their coworkers made remarks that reinforced gender stereotypes during daily conversations. In the face of social exclusion, they contemplated what being true to themselves and expressing their gender identity in authentic ways would look like in their workplaces. However, they also feared that any attempt of being true to themselves might negatively affect their job security. Jordan recounted a large public event organized by their colleagues, and the inner turmoil she experienced:

...one of my colleagues said, “Oh, we should have a fashion show, so everyone can wear their dresses, and everyone can show off their dresses.” And my first thought was like, “I’m not wearing a dress. That’s like the last thing that’s going to happen.” But then it kept getting pumped up and pumped up, and I was like, I was pretty sure I was going to end up going in like a tie or a bowtie. But because of the work environment that I was in, I was actually afraid I might get reprimanded or even, this was irrational, but like thought I might get fired if I showed up in men’s clothes and a bowtie. And so I felt like there was a lot of isolation for myself as a queer person or a gender non-conforming person.

Casey, an advocate who identified as a queer, lesbian woman described how some of the most mundane, daily interactions with her colleagues left her feeling ignored and unseen. Having coworkers in the organization who identified as queer and understood gender identity as a spectrum rather than a dichotomy was supportive:

...when I first started everybody was like straight women. There were two who were African American, so I guess the other ten were white women, and I was the only lesbian or queer woman. We would sit down for our lunch that we were required to have together in the conference room, and they would be talking about all these things that I could care less about, and if I brought up maybe things that I was more interested in or how I had a differing opinion about I could care less about body hair removal that they would talk endlessly about, it was definitely treated like... There were some like mean girls sort of dynamics to it...When a couple of other folks, especially [a queer, gender non-conforming coworker] came on staff like it was such a breath of fresh air for me like to finally not be the only queer woman.

Another queer, gender non-conforming advocate, Harper, spoke about some of the negative consequences of disclosing their gender and sexual identity in the workplace. Being out to their coworkers resulted in a pressure to represent the whole queer community:

A lot of it is like microaggressions type of things or being the token person I think. That's probably the biggest thing. Whenever we have to move any heavy object it's always me. It's not somebody else, and I'm just like I'm not really stronger than anyone else. You know what I mean? So that's always very interesting. I get asked to speak for the entire queer community all the time. I'm like well I can't speak for a gay man. I don't know what their experience would be like. I'm sure you experience that as well when people are like, "Tell me about everyone in your culture?" I'm like, "Well I just can't.

Heteronormative values also shaped how leadership in some of the organizations approached to GBV among same-sex or same-gender couples, and their views on whether addressing this issue was among their responsibilities or not. When addressing GBV among same-sex or same-gender couples was perceived as outside of their mission, queer advocates felt that their identity was ignored and excluded, in addition to the

communities they identified with. Jordan shared an interaction with their executive director, following the time their organization took part in the state's Pride Festival:

So, even though it was made clear to me that if I wanted to bring my girlfriend to lunch, with the office, they were totally cool with that, I also experienced some very negative feedback when I wanted to post a blog about intimate partner violence between same gender partners, because I was told that it would *alienate our base*...we had had a table at one of the Pride festivals. And we had volunteers in the speakers' bureau who were working there. And one of them had been wearing like a rainbow beaded necklace, because they give them out all over Pride, right? And so, and then he had a picture, and then he was on our social media. They posted it on our social media, about being at Pride. Which is like super cool, right?

But then my boss called me into her office later and wanted to talk with me about it, and was like, "I'm not sure that he should have been wearing that rainbow necklace in that picture, because we have to be really careful about *mission drift*, and I don't want us to appear to be endorsing gay marriage." And I was like, the rainbow is a sign of unity for all diversities. She didn't realize that the rainbow wasn't just for gay marriage and was worried about mission drift. And I was like, "I'm sitting right in front of you." Like, I *am* your mission drift [laugh].

Reaching Out to and Serving Communities of Color

One of the issues that advocates from different organizations brought up was their organizations' limited ability to reach out to and serve communities of color residing in their regions. Advocates expected to encounter clients from diverse backgrounds, since they were cognizant that no community was immune to GBV. However, they noted that certain communities of color, including Hispanic, and/or immigrant communities did not seek out their services as much as other racial/ethnic groups. Some of the GBV-specific NPOs have been making efforts to develop relationships with low-income, underserved, and marginalized communities in their area, and raise awareness about their services within these communities.

Advocates reflected on how their own thoughts and perceptions about certain communities could sometimes be affected by internalized, hidden racial stereotypes.

Taylor, an African American advocate described an uncomfortable but awakening experience she had during a training:

So we're sharing stories of stigma in a training. And one of the black women is telling a story about leaving her neighborhood and seeing—no, start over. One of the white women is telling a story of leaving her neighborhood and seeing a man and his children playing in the driveway. Sort of I guess roughing it up or whatever. And how she rolled up her window in fear. Everyone in the room assumed that the man was a black man playing with two little black boys. And it wasn't. Including myself. You see what I'm saying?

A frequently discussed challenge in terms of working with people from diverse communities was related to serving Hispanic clients. Advocates reported that lack of bilingual staff members, and limited numbers of Spanish speaking certified interpreters in some regions of SC prevented the GBV-specific NPOs from delivering services that address the needs of Hispanic clients. Lisa, an advocate whose family migrated to US from Puerto Rico described her experience as the only bilingual advocate when she first started working for a GBV-specific NPO in SC. In addition to language barriers, she listed limited understanding of diverse cultures as an important barrier to providing culturally responsive services to Hispanic clients. She also noted that the gaps that existed in meeting the needs of Hispanic clients have narrowed in the last decade:

the big thing for me was Hispanic versus them, because nobody...you know when I first moved here I was Mexican. Nobody knew I was Puerto Rican. They didn't know what a Puerto Rican was. And so when I went to [the organization] there was one Spanish-speaking person before I got there...then she left and I was the only Spanish-speaking person there...I remember like one time there was a Spanish lady in shelter, and they were cooking and she's not going to eat that stuff. Like she doesn't eat what you guys eat...And I went to the Mexican store and I asked her what she wanted and she made me a list and I bought it for her...she was breastfeeding at the same time too, so I wanted to make sure that she was eating well so that she could feed her baby...so just understanding the Hispanics, the culture within...I think that [the organization] has grown culturally since then. They have like probably like a lot of Hispanic employees now that they've serviced a lot of Hispanic women...But that was hard for me back then trying to teach people about my culture versus...

The challenges GBV-specific NPOs experienced in hiring and retaining advocates of color, and/or bilingual advocates contributed to their struggle with reaching out to low-income, minority and underserved populations. Advocates shared the belief that improving their organizations access to diverse communities required increasing the representation of these communities among their staff members. Taylor, another African American advocate who had close to 15 years of experience in the field of GBV prevention talked about the low-income African American communities' responses when they meet a White advocate alone versus a White and African American advocate together:

We don't have enough women of color involved in this work. It's like the privileged white, or other privileged people or persons are getting the education and the knowledge and the experience to tell me how to handle my experience...But we can't relate. You didn't live on the streets of—you know? But, if you and I together go into the low-income neighborhood, they now will like you because they see me, and now it's OK. There's someone they can relate to, and vice versa.

However, other advocates noted that accessing to minority, underserved and/or marginalized communities sometimes required more than just matching these communities with the advocates from same racial/ethnic identity. Taylor also mentioned the heterogeneity within African American communities of SC in terms of their socioeconomic status, and different barriers an African American advocate might face entering those communities:

So if we go into Eastover, South Carolina, where there are hundreds of low-income black families, not having access to transportation to even get to birth control, all the different barriers that they have—if I go down there, trying to help them, there will be a belief that says, "Oh, she thinks she's better than us." You know, "She's coming down here to help us."

Another African American advocate, Beth, described her own experiences of feeling as an outsider while delivering trainings in churches as an African American advocate, and reflected on how a similar experience might look like for a White advocate:

We have a coordinator who is Caucasian who, I mean, who's a community engagement coordinator. How do you plan to engage African American communities, Hispanic communities? I know how hard it is for me as an African American person to kind of treat those populations...Are you [referring to her White coworker] going to sit in a black church and go through a whole sermon before you get up and do your training on domestic violence? Are you going to feel comfortable? I mean, I've had to sit in black churches where, I'm not very religious. I'm very spiritual, but not religious...it felt awkward for me. How's it going to feel for you?

Gaining a deep understanding of the culture that characterizes the communities was viewed as an essential practice for both advocates of color and White advocates to be able to create meaningful connections with, and meet the needs of GBV survivors in these communities. In addition, advocates highlighted that there was a need for acknowledging and addressing the structural inequalities and racial injustice that further complicated the experiences of GBV within racial minority communities, and the solutions they required. Beth explained:

Because if you don't understand cultures, then you won't understand why an African American survivor will stay. And then when you have black men being murdered in the streets, they're [African American women who experience GBV] more likely to not call law enforcement to their homes, even when they're in grave situations, because of fear of, number one, maybe he might not ever come back.

Working in South Carolina: “An Uphill Battle”

Advocates indicated that in SC, GBV was considered as a “private issue” or “dirty laundry that you don't talk about or share” outside the family. Even though SC has consistently ranked among the top states in GBV rates, they noted, there was a lack of

awareness and conversation about GBV among the communities in which they lived and worked. Jesse talked about the disproportionate attention their work received compared to other public health-related causes:

I think that the issues of domestic violence, sexual assault are largely, I guess they're kind of taboo, social taboo around here. People don't like to discuss those. They're not popular causes. For example, you might hear a lot of people donating to breast cancer research. People get excited about that. You see people wearing their pink ribbons and their "Save the Tatas" and all this stuff. And that's really important...But you rarely see people wearing purple ribbons for domestic violence, or teal for sexual assault. You don't see nearly as much publicity or people raising awareness of those issues.

Participants emphasized that their work took place in a "very Republican, very conservative" state. They reported that conservative politics of the state led to underfunded social welfare programs and insufficient resources for survivors of GBV, making the advocates' work more challenging and stressful. Sage was one of the advocates who engaged in GBV-specific advocacy in another state before relocating to SC. Although she was coming from another southern state that was "infamous for being the Bible Belt", she felt dismayed upon her move discovering that there were even less resources that she could offer to her clients in SC:

So it's mind-blowing how few resources exist for people [in SC] and again, because of the work that we do and because vulnerable populations are most often targeted we see that all the time, and it's so incredibly frustrating to not have anything to offer them. It's so distressing from a helper's standpoint. I literally have nothing to give you right now and that hurts me just as much as it hurts you. So that was a huge adjustment that just like realizing how few resources exist for people here was tough.

Religious norms, entangled with traditional with gender role attitudes, shaped the ways in which advocates' work was perceived and received by the community members, and the nature of collaborations they established with schools, churches, and other NPOs

in the state. Advocates described that faith could either be the “best resource” in the recovery process of GBV survivors, or their “worst roadblock in getting the help they need”, depending on the messages they received from the religious leaders or institutions. In some churches, GBV experiences that occurred within a marriage were overlooked in the name of family unity, and at the expense of the survivors’ integrity and well-being.

Erin, an advocate who identified herself as a Christian shared:

Living in what is considered to be the Bible Belt, Evangelical Christianity... There’s a lot of toxic religious beliefs in our culture that almost feed an acceptance of abuse and violence. Staying silent and just, this upholding of marriage and family, over and against an individual’s safety and well-being, is something that I think pervades our culture. And then sometimes if somebody goes to their faith community hoping to have that place be the one place they could potentially get some support, they experience the opposite, with perhaps a faith leader telling them that they need to go back, or that they need to work this out. That the marriage itself is more important than they are.

In addition, advocates discussed that the strong emphasis on religion and religious values in the region was contradictory to the social welfare policies that led to “withholding resources from the poor and downtrodden”. Amber compared her own advocacy experiences in SC to a friend’s who was engaging in GBV-specific advocacy in Seattle where they had “an abundance of resources for domestic minor trafficking victims”, and expressed her frustration with the lack of resources for their work in SC:

There is very much this idea of like we want, like you’ve got to pull yourself up by your bootstraps and you handle it. It’s like taking this weird American dream idea of we built it ourselves and we earned it to kind of an extreme, where it’s like no one deserves help. And I’m like well, for a region of the country that is called the Bible Belt where so much of your religion is based on like a person who believed, literally all he did was help the poor. I don’t know if they read what they are actually going to church for...there’s this strange resistance to wanting to help people here, like help poor people specifically or help people who have been victimized by others. There’s a lot of victim blaming and people being blamed for being poor. I’m like they [advocates and survivors] can’t make chicken salad out of chicken shit. You can’t make something out of nothing. It’s crazy.

As part of establishing community partnerships and collaborating on issues concerning GBV, advocates sometimes interacted with male leaders, such as executive directors of other NPOs, pastors, officers from the Sheriff's Department, and politicians. During those interactions, they often felt angry and frustrated, having to tolerate the sexist and ignorant attitudes men displayed towards their work. Logan, an executive director with more than 25 years of experience working in SC shared:

...at a subcommittee meeting years ago, in the state legislature, and one of the House members, who was also a pastor, saying to me, in a joking fashion, "Oh come on, Ms. Logan. You're not telling me I can't slap my wife around every now and then, are you?" And then he laughed.

Feelings of anger that advocates experienced due to the push back and ridicule they encountered sometimes acted as a "fuel", and helped them realize the importance and necessity of their work in SC. Logan continued:

It was interesting, it was such a departure from my day-to-day work and functioning to have such a contentious meeting and experience with the men, dismissive attitudes, and patriarchal. And so that was such a strong taste of really the culture and the status of the issue of violence against women at the time. So I think that only probably increased my interest in this work.

Another advocate with 30 years of leadership experience in SC also reflected on the dominant cultural beliefs and gender norms such as "men are the head of the house", "women should be obedient and subservient", highlighting that these beliefs and norms were enforced by male leaders of the most commonly followed Christian denominations.

She explained:

I don't mean to say that the church teaches domestic violence, but they have not been until very recently responsive to the problem. It has been a state that reflected that old belief that if a woman was being battered that it was something that she did. That she displeased her husband. That she made him angry. So men have been given the power to abuse their wives with impunity. There's been no real response,

because after all, it was her fault and that men have been given the right historically to discipline their wives...it's the south in general – South Carolina, Alabama, Georgia, Mississippi, Texas. All the southern states have a slow response to domestic violence and reflect that same culture.

There were other times that male leaders within the government agencies or NPOs that advocates collaborate with were supportive of the goals of GBV-specific NPOs. In some of these instances, advocates observed that the support they received from male leaders was rooted in the notion that men, who were considered the authority figure in their families and communities, were responsible for “protecting women and taking care of them”. Advocates described these attitudes as “very patronizing”, and argued that although such patriarchal attitudes seemed to be helpful when “trying to get their [men’s] buy in and get legislation passed”, they were also a barrier to creating long-term social change. Sarah described: “...it [patriarchal attitudes around protecting women] becomes problematic when we want to start looking at like primary prevention and questioning gender roles and adjusting traditional gender roles.”

Southern notion of being ladylike (i.e., southern belle, southern lady), and conservative attitudes regarding how women should talk, act, dress in professional life imposed a certain image on GBV-specific advocates. Some of the advocates who were executive and/or associate directors described struggling with exercising the power their position offered, and being called “bossy” or “another ‘B’ word” when they did so. Sarah explained:

I think we feel like we have to prove ourselves and maybe sometimes that comes out as us being angry or mean. And for those of us like myself who apologize for it it's frustrating. Like I frustrate myself because I hear myself doing it. I'm like what are you apologizing for? But when you show power outwardly and you're not socialized to do that it's really uncomfortable, and I've had years of doing it.

Patriarchal norms and sexist attitudes affected not only work experiences of advocates who identified as women, but also queer and gender non-conforming advocates. It was impossible for these advocates to comply with the salient gender role attitudes in SC as to women and professionalism:

...this idea of professionalism and what is professionalism specifically for a woman in South Carolina, it's very specific. It's like you have to wear high heels. You have to wear quite a bit of make-up and for like myself like as a queer person like that's just not going to work...I go for meetings where I wear all men's clothing. I'm perceived very differently than someone who would be, than a woman in high heels, which is most of my colleagues. So I think there's a societal norm of what is professional and what is hireable in terms of that as well, which at my organization I don't experience that discrimination, but I think a lot of people do in South Carolina. (Harper)

Discussion

Previous research has documented work experiences of historically disadvantaged groups (e.g., racial and ethnic minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals) across a variety of occupations and industries (King, 2017; Kray & Shirako, 2011; McGuire, 2002; Nadal, Whitman, Davis, Erazo, & Davidoff, 2016; Plaut, Thomas, & Hebl, 2014). However, work experiences of these groups in mission-driven, social justice-oriented human service organizations such as GBV-specific NPOs have rarely been discussed and examined in the literature (Richie, 2015). Among various mission-driven NPOs, those that address GBV are unique workplaces in that their work is informed by feminist values, with the goal of transforming gender stereotypes and gendered power differences in the society that underlie GBV (Homer, 2014; McPhail et al., 2007; Wasco & Campbell, 2002b). Feminist and humanistic values that characterize the work of these organizations also hold them responsible for addressing different forms of oppression (e.g., racial discrimination, heterosexism, classism) that affect the communities they serve (Coker et al., 2015; Richie, 2015).

In the last few decades, feminist scholars and activists drew attention to the influence of racial stereotypes and hidden biases within the movement to end GBV, and made calls to “reimagine” and reframe the movement to end GBV as a radical justice movement that is concerned with not only gendered power structures, but also other forms of oppression such as racism, socio-economic inequalities, and heterosexism (Coker et al., 2015; Richie, 2015). In the context of GBV-specific NPOs, such reimagining requires an assessment of how multiple systems of oppression (i.e., race, ethnicity, gender, class, sexuality, religion, nationality): 1) operate within the workplace structures and practices, and 2) shape the approaches these organizations utilize to access and work with minority, underserved, and marginalized communities. This study makes a unique contribution to the literature by focusing on race, ethnicity, gender, sexuality, and religion in the work context of GBV-specific NPOs in SC, and documenting how negative social stereotypes and biases shape work experiences of advocates who belong to minority groups, as well as the services these organizations provide to diverse communities.

Hiring and Retaining Advocates of Color

Achieving diversity within the NPOs was viewed as a core value by all the participants. In the last decade, most of the organizations have been working on hiring more advocates of color, and/or bilingual advocates. These efforts concerning the improvement of organizational diversity seemed to yield some positive but limited results. The number of racial and ethnic minorities in several of the organizations have increased; however, our analysis also revealed that organizational efforts fell short in terms of creating a culture in which all staff members, including those who belong to

minority groups (i.e., advocates of color, and queer, gender non-conforming, and/or lesbian advocates) could feel a sense of belonging and ownership.

Some advocates belonging to minority groups were treated as a “token” and, exposed to offensive stereotypes about their social identity. Tokenism is understood as “the symbolic inclusion of numerical minorities within a group, usually for the sake of appearances rather than for inclusiveness or true diversity” (Hirshfield, 2015, p. 2). There are several consequences of tokenism that differentiate work experiences of people belonging to minority groups from their coworkers. People who are treated as tokens are often exposed to social stereotypes and prejudices about the groups they identify with. They experience *heightened visibility*, meaning that they stand out among others in the workplace, and receive increased attention from their leaders and coworkers (Kanter, 1977). This may lead to feelings of working under scrutiny, and constantly being watched for how they act and present themselves in the workplace (Kanter, 1977; Wingfield & Wingfield, 2014). Kanter (1977) argued that heightened visibility creates *performance pressure*, and causes staff members from minority groups to experience higher levels of work-related stress compared to their coworkers from dominant groups. Studies examining the organizational consequences of tokenism documented that subjective experience of tokenism was associated with lower job satisfaction, lower performance, lower sense of identification with one’s organization, and higher turnover intentions (Jones, Peddie, Gilrane, King, & Gray, 2016; King, Hebl, George, & Matusik, 2010). Our findings were consistent with the previous literature: advocates who reported being treated as tokens also described experiencing stress and feeling isolated due to this treatment. Furthermore, African American advocates in this study experienced a

“pressure to perform better” than their White coworkers, and felt that they needed to “prove themselves” to ensure security of their jobs. In addition, advocates reported higher turnover among African American and Latino staff members.

Heteronormativity and Microaggressions Towards Queer, Gender Non-Conforming, and/or Lesbian Advocates

Another group of advocates who faced tokenism and microaggressions in the workplace were queer, gender non-conforming, and/or lesbian advocates.

Microaggressions refer to the “behaviors and statements, often unconscious or unintentional, that communicate hostile or derogatory messages, particularly to members of targeted social groups” (Nadal et al., 2016, p. 488). Microaggressions occurred during day-to-day interactions among advocates, which were often shaped by heteronormative values and gendered assumptions that rendered queer, gender non-conforming advocates invisible. For instance, conversations initiated by cisgender heterosexual advocates such as what kind of dress to wear to a gala, or hair removal experiences, alienated queer and gender non-conforming advocates. Despite having an increased awareness about the diversity of gender and sexual identity, some advocates continued to unconsciously reinforce heteronormative belief systems and values in the work place through their comments and actions. Queer, gender non-conforming, and/or lesbian advocates were also treated as tokens in the organizations they worked for, and expected to “represent all queer people”. Nadal et al (2016) referred to this as “assumption of universal LGBTQ experience”, and identified it as one of the microaggressions “that suggest LGBTQ persons are a homogenous group and are all the same” (p. 491).

Previous research examining workplace experiences of LGBTQ people showed that LGBTQ people may feel unseen and hurt as a result of these microaggressions, even when they are not intended to offend them (Nadal et al., 2016). Furthermore, microaggressions negatively impact mental health and well-being of targeted groups; people who experience microaggressions have lower levels of self-esteem, and higher prevalence of depressive symptoms (Nadal et al., 2016). Queer, gender non-conforming, and/or lesbian advocates in our study reported feelings of overwhelm, stress, and isolation. This is also consistent with the minority stress theory which suggested that cumulative exposure to prejudice and discrimination may lead to negative mental health outcomes (Meyer, 1995; Nadal et al., 2016).

GBV-specific NPOs were commonly viewed as “all women” organizations – led by women, supporting, and serving women. Having similar worldviews, and sharing a commitment to social justice and eliminating GBV led to strong bonds between advocates who identified as women, and supported them in their work. Yet, some women advocates complained about “cattiness,” “gossip,” and “mean girl” kind of behaviors among their coworkers, attributing the problem to “too much estrogen in the air.” Analysis of these accounts suggested that covert misogynistic attitudes and tendency to view other women through gender stereotypes were persistent even among advocates who work for NPOs that address GBV. Scholars argues that an assumption of universal womanhood often underlies women’s hostility and distrust towards other women (Cowan & Ullman, 2006). It is possible that internalized sexism, and the notion of universal womanhood influence the ways in which some women advocates assess the culture within their organizations. This may lead to the belief that being mean towards,

competing with, and gossiping about other women are feminine attributes carried by all women. On the other hand, some women advocates brought up and problematized the growing up and socialization of women in a patriarchal society that reinforces sexism, linking this to internalized sexism among women advocates.

Reaching Out to and Serving Communities of Color

Practices that continue to foster unconscious racism, sexism, and heterosexism within GBV-specific NPOs negatively impact not only the advocates from historically disadvantaged communities, but also the programs and services these organizations intend to deliver to those communities. For instance, queer, gender non-conforming advocates faced microaggressions and opposition from their leaders when they attempted to incorporate anti-GBV messages that target same-sex couples into their campaigns. Another example was the “cookie cutter services” that did not address specific issues and needs of African American communities concerning GBV. Providing culturally responsive services to diverse communities require employing diverse groups of staff members, valuing their perspectives, and actively involving them in decision-making processes that concern diverse communities (Chow & Austin, 2008). GBV-specific NPOs that hire advocates of color, and/or LGBTQ advocates without creating a workplace culture in which diversity is valued and treated as an asset fail to meet the needs of diverse communities, and end up doing a disservice to their mission. It is also necessary to recognize other forms of violence and systemic inequalities faced by diverse communities, such as the influence of state violence and criminal injustice in low-income African American communities. Feminists of color assert that addressing experiences of

GBV in underserved, marginalized communities requires an understanding of “all of the ways that different kinds of violence reinforce each other” (Richie, 2015, p. 266).

Working in the Deep South

Engaging in GBV-specific advocacy in a state where conservative values and traditional gender roles deeply shape social interactions can be challenging for the advocates, as they go against the status quo and aim to alter gender stereotypes with their work (Conlee, 2012). Studies conducted in the US looking at the regional differences in gender role attitudes have documented that even though these attitudes have become more egalitarian throughout the country, people living in southern regions continue to hold more traditional gender role attitudes. Scholars also linked religious fundamentalism to more traditional gender role attitudes; after controlling for individual-level variables such as sex, age, education, marital status, work status, family income, Moore and Vanneman (2003) found that residents of the states with higher proportion of fundamentalist denominations hold more conservative beliefs related to gender role attitudes.

The notion of southern lady or southern belle reflects the idea that women need to be obedient and devoted to their husbands and families, and prioritize caring for them instead of taking part in social and economic life (Conlee, 2012). In addition, men are responsible for protecting women from the dangers of the outside world, as they are physically and mentally weaker than men (Conlee, 2012; Powers et al., 2003; Spruill, 2012). Rooted in these conservative beliefs, gender roles in the South that impose how women should act are contradictory to the demands of leadership positions women take in GBV-specific NPOs. Women with more progressive belief systems who live in

conservative areas might hesitate to be in leadership positions that would provide them authority. In areas dominated by conservative ideologies, women “occupy fewer prominent, public, authoritative positions” (Moore & Vanneman, 2003, p. 119). Our findings were consistent with the literature as advocates in leadership positions faced hostile and sexist attitudes from male authority figures they interacted with, causing them feel anger and frustration. We also observed a conflict between the demands of the leadership positions these advocates held, and the expectations about not offending the local traditions. Although feelings of anger and frustration can be detrimental to the well-being of GBV-specific advocates, they can also serve as a fuel for creating social change (Iliffe & Steed, 2000; Wasco & Campbell, 2002b).

Implications for Practice

Although the work of GBV-specific NPOs is guided by feminist and social justice-oriented values, it is unrealistic to assume that these organizations are immune to long-standing racial and ethnic stereotypes and hidden biases that shape workplace culture. Walter et al. argued that “institutional racism is particularly difficult to recognize and address when it operates within organizations and institutions that actively see themselves as unbiased” (2016, p.216). If GBV-specific NPOs were to bring about social change, it is necessary that they first acknowledge inheriting a legacy of racism, sexism, classism, and heterosexism, just like other institutions in the US. This is particularly important for GBV-specific NPOs in the American South, as their work is embedded in a region with history of slavery, segregation, conservative governments, and religious conservatism.

Fong and Gibbs recommended that organizations “consider optimal ways to cluster culturally diverse staff to create a critical mass so that they are no longer singled out as tokens in various units” (1995, p. 16-18). It is necessary for GBV-specific NPOs to attract and hire diverse group of advocates; yet, our findings suggest that increasing diversity numerically itself is not enough to create an inclusive organizational culture that celebrates and values diversity. Achieving diversity and creating an inclusive organizational culture involves moving beyond greater representation in numbers and verbally acknowledging the importance of diversity, toward dialogue and action that challenges organizational structures and practices that perpetuate exclusion and discrimination (Kolivoski et al., 2014; Plaut et al., 2014; Walter et al., 2016).

Leadership in NPOs that are committed to social justice have an important responsibility to demonstrate a value position against institutional racism, conscious and unconscious bias among staff members by fostering an awareness of the ways in which racial and ethnic identity shapes individual experiences of staff members, and a respect for cultural diversity. Indeed, leaders’ “commitment to cultural diversity and inclusion” needs to “go beyond rhetoric” (Walter et al., 2016, p. 218), and be enacted by explicitly addressing bias and racism in the workplace. If they were to eliminate institutional racism and discrimination, GBV-specific NPOs need to confront interpersonal conflicts that are rooted in hidden stereotypes and biases, and create opportunities for staff members to have candid conversations about diversity issues (Walter et al., 2016; Chow & Austin, 2008; Kolivoski, 2014). These conversations can be challenging for staff members, and as one of the study participants put, “tears might be shed” while reflecting on who is negatively affected by the power differentials within the organizations.

However, these conversations can also pave the way for mutual understanding, trust, and respect among advocates of diverse social locations, and in turn, transform the organizational culture in significant ways. On the other hand, when left unchallenged, values and practices that privilege dominant groups become the norm in the organizations, and maintain processes of exclusion (Hughey, 2007). Furthermore, when practices of exclusion and discrimination among staff members are unchallenged, they compromise the organizations' ability to create meaningful connections with and efficiently serve diverse communities such as racial and ethnic minorities, and members of the LGBTQ communities. Addressing GBV within these communities requires an integration of the structural factors in developing solutions that are guided by the communities themselves. As stated by bell hooks (1984): "Feminist efforts to end male violence against women must be expanded into a movement to end all forms of violence. Broadly based, such a movement could potentially radicalize consciousness and intensify awareness of the need to end male domination of women." (pp. 130–131)

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CHAPTER 5

DISCUSSION

The overall goal of this research was to identify the relationships between engaging in paid GBV-specific advocacy and individual psychosocial health and well-being. A second goal was to develop recommendations for GBV-specific NPOs to better support self-care behaviors and promote psychosocial health and well-being among their staff members. I was particularly interested in examining how organizational structures and practices influenced advocates' willingness and ability to engage in self-care. I also aimed to understand the role of contextual factors (i.e., the state's historical, political, socio-cultural, and economic characteristics) in day-to-day work experiences of GBV-specific advocates. In this chapter, I summarize the research findings, highlight study strengths, limitations, and implications for future research.

Summary of Findings

Specific Aim 1. To describe the relationships between engaging in paid GBV-specific advocacy and psychosocial health and well-being within the political, social, economic, and cultural context of SC

RQ1. What are the multi-level, work-related stressors (individual, interpersonal, organizational) faced by individuals who engage in paid GBV-specific advocacy?

RQ2. How do these individuals experience the benefits and costs of their work in relation to their psychosocial health and well-being?

Advocates described the work they engage in as emotionally taxing and stressful, due to an ongoing exposure to traumatic stories of their clients, as well as engaging with communities about the challenging issues that relate to GBV. Previous research documented that working with people who experienced GBV takes a toll on advocates' psychosocial health and well-being, often times leading to experiences of burnout, vicarious trauma, and compassion fatigue (Homer, 2014; S. Kulkarni et al., 2013a; Skovholt & Trotter-Mathison, 2016; Slattery & Goodman, 2009). Self-reported experiences that reflected elements of burnout, vicarious trauma, and compassion fatigue were common among the participants in this study, especially among those who were in the early years of their work as advocates. On the other hand, advocates who have been working in the field for at least ten to fifteen years were able to develop adoptive coping skills such as compartmentalizing work-related thoughts or concerns, protecting personal boundaries in their work with clients, and acknowledging the limits of what they can achieve as advocates. Yet, all of the advocates experienced high levels of distress, emotional and physical exhaustion due to their work at one or multiple point/s in their careers.

Engaging in this challenging work also had an impact on advocates' relationships with intimate partners and family members. GBV-specific advocates made an effort to compartmentalize their personal and professional lives, and not carry work-related issues into their family life and personal relationships. However, when advocates experienced instances where issues around GBV would come up in conversations, and one of the

family members would make a sexist and victim-blaming comment, they could not help but wear their hats as advocates and react to those comments. Several study participants reported that after they started working as a GBV-specific advocate, they started noticing how some of the power and control dynamics that underlie GBV operated within their intimate partner relationships. This was a transformative experience since it led to either constructive discussions with intimate partners and positive changes in the relationships, or the relationships ended. Garrity examined this transformative experience among counselors who work with female survivors of sexual violence, and found that the counselors gained a critical awareness of the gendered nature of sexual violence, and they became much more concerned about the gendered power differences as a result of their work. Garrity discussed that “as participants began to develop a critical political consciousness” about the gendered nature of sexual violence, the “cognitive, behavioral, and emotional intimacy within their relationships began to change” (2011, p. 78). Having to navigate these changes in their intimate relationships adds another layer of emotional distress to the lives of GBV-specific advocates (Goldblatt, Buchbinder, Eisikovits, & Arizon-Mesinger, 2009).

In addition, advocates talked about the need to “switch it off” when spending time with friends and family, meaning that they had to be mindful about wearing their advocate hats, and avoid talking too much about issues around their work. Advocates experienced an emotional dilemma due to trying not to make people uncomfortable by talking about issues that were of critical importance to who they were. Literature demonstrates that GBV-specific advocates face occupational stigma in their experiences

outside of work because they address issues that are considered taboo and controversial subjects by many people (Ganz, 2014).

Some of the work-related stressors that GBV-specific advocates experienced were shaped by the political, economic, and social context of the state in which they worked. Working in SC - a state that has continuously ranked among the top 10 in the nation for female homicide rates - led to a heightened awareness among advocates about human cruelty and unsafe environments that women and girls live in. There were times they struggled with remaining optimistic about the work they do to make the world a safer place for everyone. As a result of constantly witnessing and hearing stories of violence in their daily lives, some advocates experienced a shift in how they see the world. The change in the worldview of advocates, shaping how they understand life, people, and relationships, have been discussed by other researchers who examined the work experiences of advocates that address GBV (Sexual Violence Research Initiative, 2013; Wu, 2008). The shift in one's worldview, also referred as "cognitive schema change" is also observed as a component of vicarious trauma, which can lead to feelings of distrust, and being more cautious when forming new relationships in personal life (McCadden, 2016; Wu, 2008).

GBV-specific advocates experienced additional stress and feelings of overwhelm when they did not have access to the resources they needed to support their clients in their recovery process. Regional factors such as limited social welfare benefits, lack of reliable transportation, and lack of low-income or transitional housing –all of which closely relate to the state politics – hindered their ability to help clients improve their living conditions. In addition, patriarchal values and conservative gender roles (e.g., the

notions of “male honor”, “Southern belle”) that characterize the state acted as barriers to the work of GBV-specific advocates as they challenged the status quo and worked towards creating social change. GBV-specific advocates whose work is located in politically and socially conservative states face greater challenges and often face pushback from the politicians, security officials, and other community members (Conlee, 2012).

Advocates also discussed the benefits and rewards that come with engaging in GBV-specific advocacy. They stated that engaging in this work enabled them to effect social change and “be part of the solution”. They perceived their work not only as an occupation but a means to creating meaning in their lives. Myers (2016) also found that social workers who worked with traumatized individuals had “the belief that their job was more than a career; it gave them a sense of meaning”, and “a purpose in life” (p. 99). Although macro-level change took longer and required a greater level of patience from the advocates, it was rewarding to “see the communities move toward a more open attitude” about acknowledging and addressing GBV. For many advocates, the most rewarding aspect of their work was being able to support the clients in their recovery, and seeing them transform their lives.

For some advocates, their work with underserved, marginalized, and vulnerable populations, such as incarcerated women, low-income ethnic minority populations, was particularly rewarding since these survivors did not have access to resources to aid them in their recovery, and therefore advocates’ work with them yielded significant results. Several participants who have started working in the field of GBV more than 20 years ago highlighted that seeing “younger generations caring about the issue”, and “how

competent and capable some of the staff members are” were among the most rewarding experiences of their long careers as GBV-specific advocates.

Specific Aim 2: To identify the organizational processes that influence self-care practices among individuals who engage in paid GBV-specific advocacy.

RQ3: What are the main self-care practices that GBV-specific advocates engage in?

Study participants engaged in various self-care practices to better cope with the stressful nature of their work, protect their long-term health and well-being, and maintain a sustainable approach to working as GBV-specific advocates. These self-care practices included spending quality time with loved ones, reading for pleasure, exercising (e.g., running, doing yoga, hiking), trying to maintain a regular sleep schedule, eating healthy, watching tv programs or shows that made them laugh and feel positive while avoiding those that involve interpersonal violence, spending time with coworkers outside of the work context, connecting regularly with their spiritual beliefs, and embracing laughter in their personal and professional lives. Similar self-care strategies among caregiving professionals who work with GBV survivors were documented in the literature. These include: allocating time for personal hobbies and interests (Tu, 2011), spending time with family and friends (McCadden, 2016; Skovholt & Trotter-Mathison, 2016; Wu, 2008), seeking support from coworkers and supervisors (Skovholt & Trotter-Mathison, 2016; Slattery & Goodman, 2009; Tu, 2011), exercising, maintaining a healthy diet, and getting enough rest (Barnett & Cooper, 2009; Lee & Miller, 2013), spiritual practices (Homer, 2014; Tu, 2011), pursuing individual counseling (Lee, 2014; McCadden, 2016), and being present with their clients (McCadden, 2016; Tu, 2011), making room for humor

(Bloomquist et al., 2015; Wu, 2008), and maintaining a clear boundary between their work and personal life (Myers, 2016; Wu, 2008). In addition, advocates who were able to take mental health days or adjust their schedule did so to ameliorate the negative emotional impact of their work. On the other hand, some advocates were not able to take time off or make changes to their schedules simply because they shouldered multiple responsibilities in their organizations, and worked for long hours, leaving them no energy and time to invest in self-care. Organizational factors that shaped advocates' self-care behaviors are further discussed in the following section that summarizes study findings related to the research questions 4 & 5.

RQ4. What types of strategies do NPOs that address GBV in SC employ to support and foster self-care among their staff members?

RQ5. How do the organizational culture and interpersonal dynamics within the organizations shape staff members' willingness and ability to engage in self-care practices?

In some of the GBV-specific NPOs, leaders made a conscious effort to talk about the importance of self-care with the advocates when they were first hired. In addition, regular social events were organized for staff members so that they could spend time and bond outside of the work context. Some advocates were provided flexibility in terms of managing their own time and tasks, whereas others working for understaffed and/or more under-resourced NPOs were not able to benefit from this type of flexibility. Having regular debriefing sessions, and meeting with their supervisors regularly supported advocates' self-care, as they gave them an outlet to process their emotions and concerns related to work.

Knowing that their work was recognized, and appreciated by their leaders was crucial to GBV-specific advocates' sense of organizational belonging and professional identity. Advocates performed better and experienced fulfillment when their leaders consulted with them in determining their responsibilities, and took into consideration their interests and expertise. Previous studies documented that receiving social, and work-related support in the workplace, and being valued by their coworkers reduces the risk of burnout and vicarious trauma among advocates who work with survivors of GBV (Choi, 2011; Killian, 2008; Slattery & Goodman, 2009). Slattery and Goodman suggested that "an environment in which there is shared power—that is, respect for diversity, mutuality, and consensual decision making—provides better protection for advocates than more traditional, hierarchical organizational models." (Slattery & Goodman, 2009, p. 1358).

All advocates acknowledged the importance of self-care in their line of work, however, most of them also admitted that they were not practicing self-care frequent enough. Organizations' efforts related to staff self-care were also described as insufficient, even though self-care was praised by the leaders. Only in one of the GBV-specific NPOs, leadership led a collective health challenge for the advocates which encouraged them to engage in a set of behaviors that promote health, such as exercising, drinking more water, and maintaining a healthy diet. Other than this example, organizations lacked the planning and/or resources that were necessary to develop collective self-care strategies for their staff members. Our findings indicate that organizations need to promote self-care not only at the individual level but also through developing collective self-care strategies with input from their staff members.

It is also important that leadership within GBV-specific NPOs acknowledge and normalize the impact of working with traumatized clients among their staff members. In a study conducted with advocates who work at a shelter for GBV survivors, Homer (2014) found that there was “a culture of silence revolving around the effects of trauma work (e.g., compassion fatigue, burnout)”, and this led to “a climate where advocates were cognizant of each other’s struggles, but did not speak of them” (p. 107). I also found that in organizational cultures that stigmatized the “inevitable occupational hazards” of GBV-specific advocacy, advocates were reluctant to disclose their experiences that reflected elements of burnout and vicarious trauma.

Another significant finding of this study was related to the ways in which race, ethnicity, gender, and sexuality shaped work experiences of advocates within the organizational context. All of the GBV-specific NPOs valued diversity and made an effort to hire more advocates of color and bilingual advocates, however, hidden stereotypes and biases continued to affect the organizational culture and relationships among the advocates. Some advocates of color reported being exposed to tokenism, and observed the continuing influence of racial stereotypes within their organizations. Similarly, queer, gender non-conforming, and/or lesbian advocates reported experiences of tokenism and microaggression. Researchers demonstrated that LGBTQ people often experience microaggression and prejudice in the workplace, and as a result, have higher prevalence of mental disorders, lower self-esteem, and higher turnover intentions (Nadal et al., 2016). To create an organizational culture that cultivates diversity and inclusion, GBV-specific NPOs need to confront practices of negative stereotyping and covert

discrimination among their staff members (Chow & Austin, 2008; Kolivoski et al., 2014; Walter et al., 2016).

Study Strengths & Implications for Future Research

To our knowledge, this is the first study to focus on GBV-specific advocates in SC, and incorporate a deep understanding of the historical, socio-political, and cultural background of the state into the examination of challenging but very important work these individuals engage in. A key strength of this study was its collaborative nature and involvement of the advocates who were also leaders in their organizations throughout the research process. My main goal in conducting this study was to contribute to the work of GBV-specific NPOs in SC, through co-producing knowledge with the advocates on what types of organizational practices and cultures best support their work and well-being. Thus, it was important to receive feedback from the participants about the questions I was asking, and the ways in which I interpreted their accounts. Collaborating with the advocates who participated this study to deliver workshops in a state-wide conference and during an educational training provided by one of the NPOs enabled me to build trustworthy relationships with the participants, and enhanced the credibility of the study findings.

Another strength of this study was the use of a qualitative design guided by the CGT (Charmaz, 2006). As a result of employing practical analytical techniques offered by CGT, I was able to disentangle the social processes and power dynamics that underlie daily work experiences of GBV-specific advocates. The findings of this study indicate that advocates' social locations (i.e., race, ethnicity, gender identity, sexual identity, age) shape their work experiences in unique ways, as well as the ways in which they relate to

other coworkers in their organizations. Recruiting more people of color who engage in GBV-specific advocacy, future research may further explore how intersecting systems of oppression and privilege interact with the organizational culture and practices within NPOs.

Although generalizability was not the goal of this study, some of the findings have implications for NPOs that address GBV in other regions of the US including the leadership approaches that support staff well-being, and the strategies these organizations can utilize in building a culture of self-care. Future research may adopt different methodologies (e.g., quantitative surveys, mixed methods designs) to expand upon the findings of this study with regards to the organizational structures and practices that promote or hinder psychosocial well-being and self-care among GBV-specific advocates.

Study Limitations

This study has several limitations. First, it is possible that some advocates did not feel comfortable answering certain interview questions that addressed sensitive issues concerning power differentials, interpersonal conflicts, and discriminatory practices within the GBV-specific NPOs, due to the concerns around confidentiality, and fear of receiving punishment from their leaders, or losing their jobs. Although I explained the study participants my intentions about protecting their own and their organization's confidentiality, and reporting the study findings in ways that would benefit their organization's work, their accounts might have been influenced by concerns related to the reputation of their organizations.

Second, my efforts in recruiting a diverse sample in terms of race/ethnicity was limited by the staff composition of the GBV-specific NPOs at the time of the study. Sixteen (64%) of the twenty-five advocates who participated in the study were White, while five were African American (20%), two were Hispanic (8%), and 2 (8%) were mixed race/ethnicity. These percentages reflect the average staff composition of the GBV-specific NPOs in SC. Even so, future research may benefit from recruiting greater numbers of advocates of color, and/or advocates whose sexual and gender identity does not confirm heterosexual and cisgender norms, to further understand their work experiences. In addition, all of the advocates who identified as queer, gender non-conforming, and/or lesbian in this study were White. Therefore, I was not able to explore the ways in which racial/ethnic identity may interact with sexual and gender identity of the advocates, leading to unique experiences of inclusion and exclusion.

Another limitation in this study which led to a lesson learned was the use of word “women” in the initial study documents (i.e., recruitment e-mails, IRB documents) to refer to the study participants. During my interactions with the participants, I learned that not all biologically female GBV-specific advocates identified as women and used “she” pronoun. I believe this limitation turned into a strength later in the research process, as it challenged me to reassess my assumptions about GBV-specific advocates, and make room in my research to understand the work experiences of gender non-conforming advocates.

It is also important to note that the interview findings are not generalizable to the work of GBV-specific NPOs in different contexts. However, qualitative methodologies

do not typically serve the purpose of generalizing the findings, and generalizability was not the goal of this study (Corbin, Strauss, & Strauss, 2014; Creswell, 2007).

Conclusions

This study makes a significant contribution to the literature focusing on work experiences of GBV-specific advocates, by producing important knowledge on organizational structures and practices that promote or hinder psychosocial health and self-care behaviors among the advocates. It also considers the intersectional nature of advocates' experiences, drawing attention to how power differentials operate within GBV-specific NPOs, and impact the outcomes of their work with diverse clients and communities. This study showed that creating and cultivating an organizational culture of self-care is essential to protect GBV-specific advocates from the negative mental health consequences of working with people who have been exposed to trauma, and challenging the status quo in terms of gendered stereotypes and social norms. Findings of this study also show that leadership in GBV-specific NPOs set the tone about inclusion and exclusion practices among the staff members. An organizational culture that treats diversity as an asset and prioritizes inclusion and equity among staff members requires a leadership that explicitly displays a value position towards diversity, and enacts this value through organizational practices.

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APPENDIX A

INTERVIEW GUIDE

ORGANIZATIONAL CONTEXT

To begin, please tell me about your work with the {Name of ORGANIZATION}

PROBES:

- What are {Name of ORGANIZATION}'s mission and goals?
- How long have you been working with/for the {Name of ORGANIZATION}?
- Thinking of the time you started working with {Name of the first ORGANIZATION worked with}, what motivated you to do this work?
- What are your current and past roles in the {Name of ORGANIZATION}?
- Tell me more about your daily activities at {Name of ORGANIZATION}. What types of activities/services do you engage in on a daily basis?
- Which populations do you work with?
- Prior to working with the {Name of ORGANIZATION}, what other experiences did you have in the areas of GBV?

Some people refer to this type of work as *advocacy* or *community organizing*, while some others refer to it as *activism*. How do you define your work?

PROBES:

- What are the characteristics of {type of work defined by the interviewee} - How does the {community work/advocacy/activism/} you do differ from {other types of community engagement/work}?
- How does your social background and identity (race, ethnicity, class, sexuality etc.) relate to your work in this area?

WORK ENVIRONMENT, STRUCTURE, AND PROCESSES

Now I would like to talk a little bit about the work environment at {Name of ORGANIZATION}.

Tell me about the group dynamics in the {Name of ORGANIZATION}.

PROBES:

- In general, how would you describe the interpersonal relationships within the {Name of ORGANIZATION}?
- What is your assessment of the role that power plays in these relationships?
 - Can you give me an example where age, gender, socio-economic status, sexuality or these types of differences play out within the organization?
 - Between staff?
 - Between staff and clients?
 - What types of social factors create power differentials in your work environment?
 - What are your thoughts on the role of categories like race, gender, ethnicity, class etc. in shaping the relationship dynamics you mentioned?
- [Ask if more elaboration on gender dimension needed] - How would you characterize (or describe) the gender relationships within {Name of ORGANIZATION}?
- How is your work within the {Name of ORGANIZATION} affected by these differences due to age, gender... {refer to the categories mentioned by the interviewee}?
- How would you describe your personal relationships with your co-workers?
- How would you describe your personal relationships with your supervisors?
- [Ask if the participant's work includes service provision, health education or other types of support services for women] - How do you find it to serve for women from diverse social backgrounds?
 - What are some benefits related to it?
 - What are some challenges?

What types of organizational factors have been supportive for your work as an advocate in this field? (SA3)

PROBES:

- Tell me about the conditions or situations within your work environment that facilitate your work.
- What resources are available to you in your organization that facilitate your development as a staff member?
- What kinds of mediums or tools do you utilize in your work?
- What other resources would you like to have available?
- What organizational changes would you suggest that would enhance your work?

What are the personally rewarding aspects and benefits of the work you do?

PROBES:

- What emotional significance do you attach to your work?
- What are some important memories or significant events from your work?
- Give me some examples of the times you felt satisfied and accomplished in your work.

How does your work fit with other aspects of your life?

PROBES:

- How does your work relate to your personal values and your world view?
- What types of social change do you envision as a result of your advocacy?

Now I'm going to change the focus and ask you about the more challenging and possibly negative aspects of your work.

What are the main challenges that you face due to your work?

PROBES:

- In what ways is your work stressful?
 - You've mentioned [type of stressor]. What about other potential stress resources, such as interpersonal relationships, organizational factors, or political climate?
 - What are some stressors that relate to interpersonal relationships?
 - What are some stressors that relate to the organization you work with?
 - What are some stressors that relate to social norms and politics concerning your work?

PERSONAL HEALTH and WELL-BEING

In this final part of the interview, I'd like to focus on your personal health and well-being as it relates to your work.

Advocates often juggle multiple work roles in their homes, families, employment and communities. Tell me about how you have managed your multiple roles.

PROBES:

- What resources have you used in managing your multiple work roles?

What are the major sources of stress for you, across your multiple work roles at home, at {Name of ORGANIZATION} and related to any other community work you do?

In what ways have you dealt with these stressors?

PROBES

- Who provided assistance or support during this process? Family? Friends? Co-workers?
- How successful were you in dealing with these work stressors? What types of strategies worked well? What strategies did not work as well?
- What advice would you give to someone dealing with this type of work stress?

Thinking of both the benefits and personal costs of the work you do, how has your work in this area influenced your health and well-being?

PROBES:

- Have you noticed any changes in your physical or mental health since you started doing this work?
 - * [If yes] – Can you tell me more about it?
 - How about any positive changes or improvements in your health?
 - How about any negative changes or declines in your health?
- To what extent do you think these changes relate to the work you engage in? How? Can you tell me more about it?

Tell me about how you care for yourself.

PROBES:

- What do you do to support your physical health?

- How about your mental health? What kinds of practices do you engage in to support your emotional well-being?

PROBES:

- During the most challenging times, what are your major sources of strength?
- What other people or resources help you to remain committed, motivated?

We know that GBV-specific advocacy is quite challenging, and people are likely to experience burnout after being involved in this work for a while. As a result, a lot of organizations experience high turnover rates among staff and volunteers. From your perspective and experience, what are the factors that contribute to turnover among advocates in this field?

What strategies would you suggest to organizations dealing with turnover?

PROBES:

- Have you ever considered quitting your work in this area (GBV)? What was your work like at the time?

So until this point you shared many personal experiences with me, including both the benefits and costs of your work. What is it in your work, you think, that keeps you going?

The purpose of this research is to learn how to better support advocates in their work, and in engaging self-care. As a last question, what suggestions would you have for the organizations to best support their workforce?

This concludes the interview. Thank you so much for the valuable information you have provided. Are there any other additional comments you wanted to share with me? Or anything else that I have not asked about, but you find it important to mention?

Thank you again for your participation. May I contact you in the future for any further questions or for your feedback about the research process?

APPENDIX B

CONSENT FORM



DEPARTMENT OF HEALTH PROMOTION, EDUCATION, AND BEHAVIOR
ARNOLD SCHOOL OF PUBLIC HEALTH

PARTICIPANT CONSENT FORM:

Introduction

You are invited to participate in research study conducted by a student from the Arnold School of Public Health at the University of South Carolina. The Institutional Review Board of the University of South Carolina has reviewed this study for the protection of the rights of human participants in research studies, in accordance with federal and state regulations. Your signature on this consent form will acknowledge that you received all the information and have been given an opportunity to discuss your questions and concerns with the investigator(s).

Purpose

The purpose of the study is to understand the processes that relate to health and well-being of people who are engaged in gender-based violence related advocacy in South Carolina. For this purpose, we would like to interview the advocates working in this field to better understand their experiences and perspectives about this process.

Description of Study Procedures

If you agree to participate, you will be asked questions about your perceptions and experiences with gender-based violence related advocacy. Each participant of the study

will complete an in-depth interview with the research investigator. Interviews will be audio recorded and written notes will be taken. There are no right or wrong answers to the interview questions. Each interview will last between 60-90 min.

Risks of Participation

There are no foreseeable risks associated with participating in this research. Appropriate steps will be followed to protect your privacy.

Benefits of Participation

You will receive a brief summary of the results when the study is completed. This brief report is expected to guide the community-based non-profit organizations in establishing strategies and practices that support the work and well-being of their staff members.

Voluntary Participation

Participation in this study is voluntary. You are free not to participate or to withdraw at any time, for whatever reason, without negative consequences. In the event that you do withdraw from this study, the information you have already provided will be kept in a confidential manner.

Confidentiality of Records

Participation will be confidential. If coded, a number will be assigned to each participant at the beginning of the project. This number will be used on project records rather than your name, and no one other than the researchers will be able to link your information with your name.

Contact Person(s)

For more information concerning this research or questions about your rights as a research participant you can contact any of the research members below:

Ebru Cayir: cayir@email.sc.edu (803-422-0783)

Dr. Mindi Spencer: mspencer@mailbox.sc.edu

Signatures /Dates

I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study, although I have been told that I may withdraw at any time without negative consequences. I have received (or will receive) a copy of this form for my records and future reference.

Signature: _____

Date: _____

As a representative of this study (and Formal Witness), I have explained to the participant or the participant's legally authorized representative the research purpose, the procedures, the possible benefits, and the risks of this research study; the alternatives to being in the study; the voluntary nature of the study; and how privacy will be protected.

Signature: _____

Date: _____